

## Correctional service 'suffers from corruption,' Ashley Smith hearing told

Allison Jones, The Canadian Press Nov 01, 2010



FILE--An undated family handout photo of Ashley Smith. Merely examining snippets of a teenage inmate's troubled life in the months before a strangulation attempt that went too far will not provide enough context to prevent similar deaths, the coroner's courts will hear Monday. In the last 11 months of her life Ashley Smith was transferred 17 times between prisons and other facilities. The transfers spanned four of the five regions of the Correctional Service of Canada. THE CANADIAN PRESS/HO

TORONTO - The tragic saga of a young woman who choked herself to death in prison is a "barbaric" example of how a mentally ill person was mistreated by a corrections system suffering from corruption, a lawyer said Monday.

Management had instructed correctional officers not to enter the cell when Ashley Smith, 19, placed a ligature around her neck, lawyer Julian Falconer told a coroner's inquest hearing. The Correctional Service also concealed from her family a psychiatric report suggesting the death was not suicide but an accident, he added.

The agency doesn't abide by the letter or the spirit of the law, Falconer said.

"Institutionally it suffers from corruption," he said. "(Smith) died as a result of federal correctional abuse."

The troubled teen's saga "is probably one of the most outrageous and barbaric examples of mistreatment of a mentally ill person that this country has ever witnessed," Falconer added.

In the last 11 months of her life Smith was transferred 17 times between prisons and other facilities. The transfers spanned four of the five regions of the Correctional Service of Canada.

Her family argues the transfers were done perhaps to get around a rule that inmates be kept in solitary confinement for a maximum 60 days without a psychiatric assessment. A transfer resets that clock.

Ontario's Deputy Chief Coroner Dr. Bonita Porter has decided to limit the upcoming inquest into Smith's death to the 13 weeks the young woman spent in Ontario.

Porter began hearing arguments at a pre-inquest hearing Monday from Smith's family and advocates requesting the scope be expanded to the entire time she was in federal custody.

"State acts and omissions... are as significant in contributing to her death as the ligatures she was permitted to use to end her life," Falconer said.

The 17 transfers and continuous isolation had a "seriously deleterious effect" on the mental health of a girl prone to self-injurious behaviour, and the transfers made it impossible for her to obtain proper treatment, he said.

She was subject to "atrocious" conditions, including more than 150 interventions involving use of force, not enough toilet paper, not enough sanitary products when she was menstruating and not enough soap or deodorant, Falconer said.

"This is disgusting and it should all be looked at — every inch," he said.

The Moncton, N.B., woman choked herself with a strip of cloth at the Grand Valley Institution for Women in Kitchener, Ont., in October 2007. Video evidence shows staff failed to respond immediately to the emergency.

What was originally a 90-day sentence for throwing crabapples at a postal worker became a life sentence for Smith as in-custody incidents kept prolonging her jail time, said a lawyer for a female prisoner advocacy group.

Smith's self-harming behaviour escalated throughout her time in custody, said Susan Chapman, who is representing the Canadian Association of Elizabeth Fry Societies. At Grand Valley there were 49 incidents in seven weeks.

Smith had told a psychiatrist she knew staff would come in to rescue her when she choked herself, Chapman said, citing an internal 2007 report commissioned by Correctional Services that concluded Smith's death was likely an accident and not a suicide.

"I'm not going to die, because it's your job to save me," Smith had said.

But tragically no one told Smith the rules had changed and guards had been instructed not to enter the cell, Chapman said. Falconer earlier told the coroner that when guards did enter the cell the day Smith died they removed the cloth from her neck and thought they heard a breath, so they left her lying on the floor.

If the inquest scope is limited to Smith's time in Ontario, the inquest won't be able to fully examine the escalation of Smith's desperation and the family's contention — supported by the psychiatrist's report — that the death was accidental, Chapman said.

"It's critically important to the public confidence in...our correctional facilities and to the openness of these proceedings that we be permitted to explore this alternative theory as to what directly led to Mr. Smith's death," she said.

A coroner's inquest jury can decide Smith's death was suicide, an accident or undetermined.

In September the federal prison ombudsman denounced the practice of locking up mentally ill offenders alone for long periods, saying many of the same structures and policies that failed Smith three years ago remain in place.