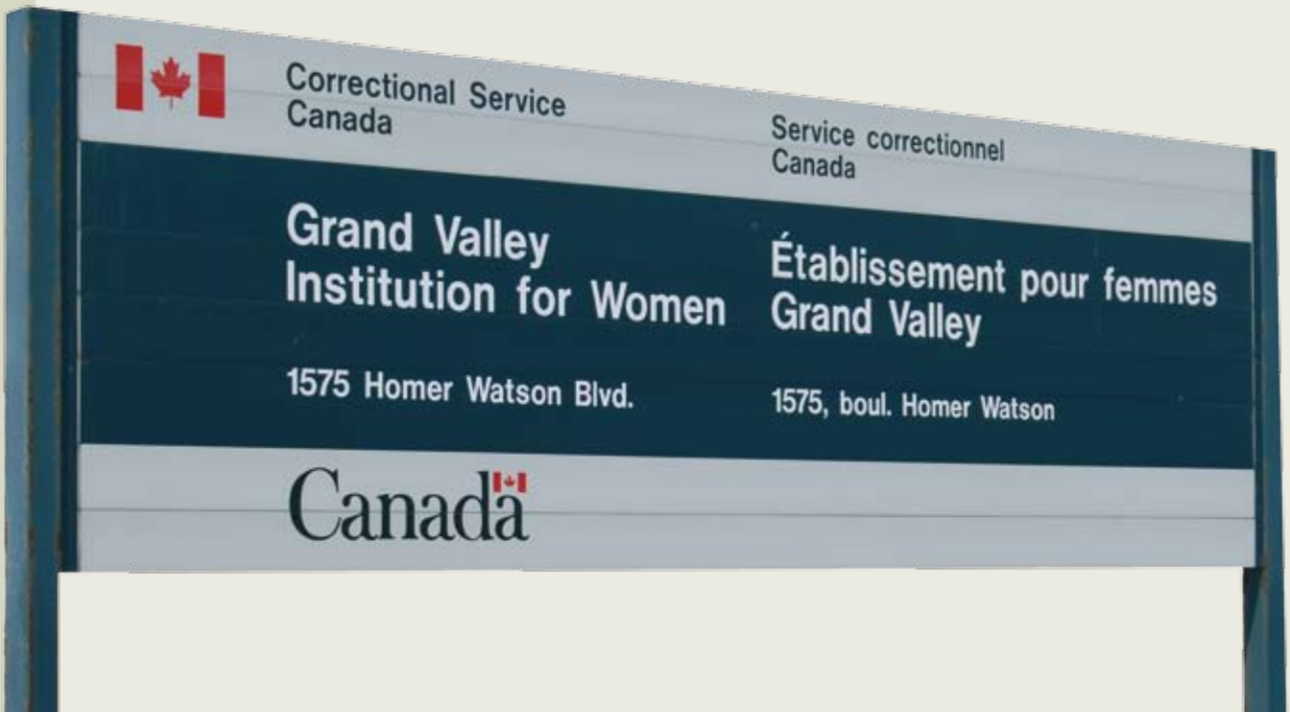
A rush to judgment

A report on the death in custody
of Ashley Smith,
an inmate at Grand Valley
Institution for Women

October 2008

**Union of Canadian Correctional Officers –
Syndicat des agents correctionnels du Canada
(UCCO-SACC–CSN)**



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1- Introduction

Ashley Smith did not have to die. That statement appears to have gained wide public support in the months since the 19-year-old inmate at Grand Valley Institution for Women tied a ligature around her neck one last time and choked herself to death. Members of the Union of Canadian Correctional Officers – Syndicat des agents correctionnels du Canada (UCCO-SACC-CSN) also believe it is a true statement.

What is not known, however, despite the great media and public interest in her last moments, is why Ashley Smith died October 19, 2007. This report attempts to answer that question, and in so doing, shed light on the catastrophically dysfunctional management culture at Grand Valley Institution, a problem that pervades the federally sentenced women (FSW) sector of Correctional Service Canada.

The following document is based on interviews with federal correctional officers, officer statement observation reports and published media reports. Because of the pending criminal charges against three correctional officers, and the constant threat of reprisals by CSC, most of the correctional officers who took part in interviews for this report will not be identified at this time.

UCCO-SACC-CSN undertook this investigation because of a widespread and well-founded lack of faith in the intent of CSC managers to divulge the full story of Ashley Smith's death. Correctional officers at both male and female institutions across Canada believe that their colleagues at GVI have been unfairly scapegoated. On January 16, CSC management fired the three correctional officers facing criminal prosecution for decisions and circumstances that were not of their making, and suspended four others for a period of 480 working hours without pay.

The union intends to set the record straight as much as possible within the constraints imposed by the impending criminal trials. Only senior CSC management is privy to the whole story of Ashley Smith's life and death, however. It will take a higher authority to compel CSC to share those facts, and, ultimately, for senior management to assume its proper share of responsibility for this incident.

2- Ashley Smith

Ashley Smith's last minutes of life are captured on videotape. It is an extremely disturbing scene. On the tape she is kneeling on the floor of her cell, wedged in a narrow space between her bed frame and the wall. She has tied a ligature so tightly around her neck it disappears under folds of skin. Her face is dark purple and her breathing has become laboured and infrequent.

At one point, a correctional officer opens her cell door to ascertain that she continues to breathe. Satisfied she is breathing, he withdraws and closes the cell door. Officers confer to establish a plan of action. A call is made for nursing staff. They then enter the cell, cut the ligature from the inmate's neck and again withdraw to assess the situation.

Agonizing moments tick by as officers try to determine whether the now inert woman is breathing or not. Again, nursing staff is summoned. Finally, a decision is made to enter the cell and begin CPR.

Correctional officers awkwardly manoeuvre the 245-pound woman onto her back in the tight confines of the cell. Their efforts are further hampered by the swelling of Smith's tongue, which blocks her air passage. But CPR is performed until the arrival of fire and ambulance staff minutes later. Despite the range of life-saving techniques they would employ, Ashley Smith could not be revived. She is pronounced dead at St. Mary's Hospital in Kitchener at 8:10 a.m., October 19.

To a person unfamiliar with the functioning of a Canadian prison for women – in other words, all but a few hundred people across Canada – this videotape raises many questions. Why did the correctional officers repeatedly enter and withdraw? Why didn't they decisively intervene sooner? Why did this inmate have access to material she could use to choke herself? Why was she choking herself? Why was she laying on the floor? Indeed, why is a person in such obvious emotional and psychiatric distress housed in a segregation cell at a federal prison instead of the secure wing of a psychiatric hospital?

The answers to those questions are not on the videotape, which was seized by police, and will likely play a central role in the upcoming trials. Nonetheless, this tape may ultimately ruin the lives of correctional officers who were present at this scene, three of whom are now facing charges of criminal negligence causing death, which carries a maximum penalty of life imprisonment.

Who was Ashley Smith?

During her last year of life, Ashley Smith's closest friends were the federal correctional officers she saw every day, including one of the three now facing criminal charges. Part of the job of a correctional officer is to engage the inmate as much as possible, to create positive human relationships. Several officers at Grand Valley Institution went to great lengths to interact with inmate Smith despite a constant threat to their personal safety.

This task was hampered by a complete lack of information about Smith's time in youth custody until her transfer to the federal system at age 18. What officers at GVI did know about her history was largely learned from conversations with the offender herself, and subsequently from media reports following her death.

Some officers who dealt with her extensively at GVI feel that Ashley Smith had suffered emotional trauma in her home life that led her to act out, though this is unclear. She made allusions to uncertainty regarding the real identity of her biological parents.

On the surface, her criminal career is difficult to comprehend. Her first conviction stemmed from throwing a crab apple at a postal delivery worker. A later charge concerned a false fire alarm. Federal correctional officers, who are accustomed to dealing with the perpetrators of the most ghastly of crimes, are perplexed that a 15-year-old girl who threw a crab apple at a mailman could end up in a segregation cell of a maximum-security unit in a federal penitentiary for adult women only four years later. After all, she was housed in the same unit as women who have murdered, tortured, taken hostages and who continually threaten to repeat those acts against correctional staff or other inmates.

Upon her arrival in federal custody in the fall of 2006, however, it was immediately evident that Inmate Smith posed a threat to the safety of staff, other inmates and, above all, to herself. It appears she was continuing the same violent behaviour that brought her a six-year sentence as a young offender.

This was manifested in repeated, often daily, security incidents that led to numerous transfers after entering the federal system at Nova Institution in Truro, NS (near her hometown of Moncton). In the first month and a half at Nova, staff recorded 18 serious incidents, including self-choking with torn blankets and clothing, spitting on staff, dismantling her cell (breaking a sprinkler head, window frames, bed frame and her desk) and hiding sharp metal objects, breaking out of her handcuffs and using them to assault an officer, and smearing feces on her cell window and camera.

Smith was then sent to Regional Psychiatric Centre in Saskatchewan, where at least 72 serious incidents were recorded between December 22, 2006 and April 10, 2007. She transferred from there to Grand Valley Institution for Women in Kitchener, ON, then to Joliette Institution in Quebec, on to Nova Institution again, before finally returning to GVI in late August.

Hundreds of Officer Statement/Observation Reports from these institutions detail a constant litany of interventions with Ashley Smith. It was a regular occurrence for officers to forcefully remove ligatures from her neck, sometimes as many as six or seven times a day. Inmate Smith would frequently use the opportunity to wrestle with, spit on or bite responding officers. The self-initiated choking became so severe that facial blood vessels burst, leaving her face permanently discoloured. She lost sight in one eye and suffered nosebleeds.

A likeable kid

Despite her behaviour, correctional officers at GVI say they still had affection for the troubled young woman and felt sorry for her.

"The funny thing is that I liked Ashley," said one correctional officer. "She had her good qualities. She was funny. When she was choking herself I was heartbroken. I asked her, 'Why now?' and told her I would treat her the way she treated me. She seemed to respect that.

"In reality, this girl was living in a cell in which all the floor tiles were removed, all the light fixtures were gone, and the sprinkler had been covered. They retrofitted the seg shower so she couldn't get any pieces of metal. She was only ever allowed two pieces of toilet paper at a time. She wasn't allowed a food tray. We had no way of knowing if she was actually taking her medication. We don't even have direct observation rooms. She would lie down on the floor in front of the food slot on the dried tar left from the tile adhesive, right against the door where we couldn't see her well."

Another correctional officer looked back at the strangeness of a situation in which such extreme behaviour almost became normal. "You could do a 12-hour shift, getting to know her, cut a ligature off her neck, and then she would sit there laughing and joking with you," said the officer. "She was likeable. Everyone felt bad for her."

Still, one officer admitted to feeling a certain level of intimidation after reading Smith's rapidly growing file from her time in federal custody. "When I looked at all the incidents she had been involved in and her size – she weighed 245 pounds – I thought, 'That girl could do some damage to me.' But I tried to

develop a rapport with her, and I believe I succeeded in reaching her with my sense of humour."

This correctional officer understood that Smith wanted staff to enter the cell. "She would say, 'I want to fight. I want to play with you guys.' But I never had to go in that cell. I had her under control. She said to me: 'I don't like it when you're working here. I like to make you angry, but I can't.' She was like a little kid."

Staff learned tricks to get Smith to respond during her choking incidents, the officer added. They would poke her, startle her, or make jokes to make her laugh.

Getting high

Another correctional officer at GVI had worked with young offenders before joining CSC. This officer said that the "choking game" Ashley Smith engaged in is a relatively new phenomenon that is different from autoerotic asphyxiation.

"That wasn't what Ashley was doing," said the officer. "I always checked to see if she had her hands beneath her gown."

Smith told staff that she learned the practice from other young offenders in youth custody. "They are all lumped together there and trigger this behaviour in each other," the officer observed. "Eventually the behaviour becomes embedded. If you are damaged, or traumatized as a child, you will do anything to distract yourself. The choking was her way to get herself high and to help her forget."

At the same time, it was clear to this officer that Ashley Smith was a social person who craved physical interaction.

"The thing with kids in care is that sometimes the only physical contact kids get is when they cause trouble. This girl was also bored out of her mind. She was constantly accumulating data. Yet you couldn't let her out – she was impulsive and she would inevitably create an incident."

This officer said Ashley appeared to be addicted to this behaviour and that she said she received pleasure from its effects.

"I had asked her, 'What are you going to do when you get out?' She had been standing on her bed and swinging a ligature. She appeared mischievous and seemed to want to me to focus on the ligature. She stated, 'I am going to get high, it's almost as good as this' – while waving the ligature and smiling."

Recent media reports confirm this trend. A story published January 31, 2008, by the Canada east News Service, entitled, "Teen game 'toying with death'; Choking parents warn of terrifying youth trend" is a disturbing indication that this practice has become widespread in North America.

According to the report, "The choking game has had many different names over the decades, but the idea is the same. It involves cutting off the flow of blood and oxygen to the brain for a momentary euphoric rush before falling unconscious."

The article cites a group that says 30 children in Canada are known to have died from playing the game.

3- Grand Valley's troubled history

From the beginning of its decade-long existence, problems have plagued Grand Valley Institution for Women. Long-term staff members there talk of disorganization and confusion in an institution that was supposed to be part of a radical reinvention of the federal system of female incarceration following the Arbour Commission and the Creating Choices Task Force Report.

"When I arrived, GVI was fairly chaotic," according to one correctional officer, who said people without any experience in corrections were being hired to work as managers and frontline staff. "They had no idea how to operate a prison."

Staffing the institution is a long-term and constant difficulty. One veteran staff member (now retired) who worked as a supervisor at Grand Valley said that it was almost impossible to run a roster because of poor or non-existent record keeping. "Attendance records have always been incorrect," this person said.

At the time of Ashley Smith's death last October, the institution was chronically short-staffed. Of 70 correctional officer posts at GVI, only 40 were filled by regular staff members. The rest were being accommodated, on medical leave or had left and not been replaced.

"It has become a normal practice to be ordered to work overtime or extra shifts," one correctional officer observed. "They are so disorganized. We are always scrambling. That's why they are constantly ordering people to work certain shifts. Then, of course, people eventually burn out and get doctors' notes excusing them from work."

The staffing problem is even worse on the management side, almost none of whom are permanently assigned to Grand Valley. According to frontline staff, most managers view a posting to Kitchener as temporary and undesirable.

"We knew something bad was going to happen," the correctional officer added. "We were constantly warning management. But they didn't care. They are too busy trying to get out of there. So many are in acting positions and for them, Grand Valley is only a stop on their way to NHQ [National Headquarters]. They're only trying to move up and out. Nobody wants to work their whole career here."

This officer contends that the dependence on managers in acting positions creates a dangerous situation as managers start looking after one portfolio and then switch to another. "With so many managers in acting positions, few are actually properly trained to work the posts they occupy."

The Structured Living Environments

More chaos greeted the opening of the Structured Living Environments (SLEs) in 2001. The SLEs are small cottages with staff trained to assist women with mental health problems or cognitive difficulties.

A GVI correctional officer who at the time worked as a behaviour counsellor in the new SLEs describes the pressure from management to ensure the new units at least appeared to be a success.

"It still hadn't passed audit when it first opened," the officer revealed. "We were told, 'We need to pass the audit – make it happen.' But we were making it up as we went along in order to make things work. We were in transition for quite some time."

This officer says this caused much confusion for the inmates housed in the new environment. "The rules were constantly being adjusted, and for some, that kind of change can send them off the deep end. They need routine and clear rules."

The lack of clear operational rules is a recurring theme at GVI, where directives changed frequently, sometimes depending on which manager was on duty.

Then, in 2003, an inmate hung herself with a shower hose in the bathroom of a SLE cottage. "It was very unexpected and I was in shock," the correctional officer said of the suicide. "I was quite distressed as I felt connected to this inmate. No one questioned me after it happened, but I was questioning myself, asking myself how this could have happened and whether I had done anything wrong."

In the wake of this suicide, Coroner David Schooling made six recommendations, which were met with, at best, a tepid response by CSC. Had they been implemented at Grand Valley, however, at least two of his recommendations may have led to a different result for Ashley Smith. They included a call for 24-hour health care (currently nursing staff only work between 7 am and 4 pm) and the provision of an on-site defibrillator along with training for staff on its use.

Growing violence, inadequate response

In 2004 CSC finished building a new secure unit ("segregation" or the "max unit" as the unit is also called at GVI) to house up to 15 inmates unable to integrate into the general population because of violent behaviour. This unit was to be Ashley Smith's last home.

From 1997 until that year, the union had logged more than 500 security incidents at Grand Valley, among them 21 suicide attempts. One of those incidents led staff to seriously question local management's commitment to their safety.

While quelling a violent altercation involving an inmate known to be HIV-positive in November 2003, two correctional officers received a significant exposure to the inmate's blood. A CSC policy, known as the "Post-Exposure Protocol," or PEP, outlines a series of steps to follow in such a case, including the rapid administration of a cocktail of prescription drugs within a two-hour time frame.

CSC management at Grand Valley Institution reacted in painfully slow fashion, however, wasting several precious hours before grudgingly sending the officers for treatment at local hospitals. Even then, management had failed to ensure drug treatments were available in sufficient quantities at local health institutions and that local health care personnel were familiar with the protocol. In both cases, they were not.

As a result, one officer had to wait 11 hours before receiving drug treatment – well outside the two-hour window – while another did not receive treatment for seven hours after the incident.

On August 22, 2005, the violence reached a new level. Armed with a metal shank and a broken mirror shard, two inmates housed in the new secure units were able to enter the prison nursing office and take two hostages, a nurse and a behaviour counsellor. The hostages were strapped to a chair with gauze, one of them with a belt tightened around her neck.

During the three-hour ordeal, the hostages were force-fed anti-psychotic medication while their attackers threatened to slash their throats and gouge out their eyes. One woman was cut with the mirror, punched in the face and burned with a lit cigarette to the arm, shoulder and armpit. The two were finally released in return for Pepsis and cigarettes.

The leader in the attack had demanded to be taken off the restrictive management protocol for problem inmates, a status she had earned during a long series of violent, sadistic incidents. This woman would become one of Ashley Smith's best friends in the short time Smith lived in Grand Valley's secure unit two years later.

The incident was traumatic for staff, who demanded improved safety conditions and an end to forced overtime. One lingering effect of the incident was an increased reluctance among female correctional officers to work in the secure unit, which complicated the ability to respond to incidents involving

inmates. Ironically, the incident coincided with lobbying by pressure groups and certain managers to eliminate male staff from female institutions altogether.

"Male correctional officers in FSW institutions all know the policy [on interventions by male staff] like we know the backs of our hands," says one male officer. "But at GVI they over-apply the policy to the point that they are not following the policy.

"For example, if I respond to an incident and a female officer is there, managers say the female officer is to replace me. But the policy actually says the officer is to assist. They misinterpret the policy to the point of insanity, and I am constantly told to back off."

4- Federally Sentenced Women's sector

In the fall of 2005, the Union of Canadian Correctional Officers attempted to engage CSC in a dialogue over rising violence and unmanageable inmates in the federally sentenced women's (FSW) sector. The union produced a report, "A New National Strategy for High-Risk Women," which warned that current approaches were failing to respond to the needs of these inmates and were instead producing a more dangerous prison environment. The report proposed concrete solutions to address the situation.

Initially, CSC management ignored the union's efforts. Given subsequent events at Grand Valley Institution involving Ashley Smith, among others, the union continues to believe that the analysis and solutions proposed in this report are more pertinent than ever. An abridged version follows:

In 1994, The Commission of Inquiry into Certain Events at the Prison for Women in Kingston, led by Madam Justice Louise Arbour, issued a number of recommendations that continue to inform the management of the network of Institutions for Women that was subsequently developed in each of CSC's administrative regions across Canada. One of the Commission's key recommendations concerned the use of segregation: "that the practice of long-term confinement in administrative segregation be brought to an end."

Unfortunately, violent incidents in institutions for women still lead to prolonged segregation of inmates for periods as long as eight months. Disturbances in segregation areas continue to occur on a regular basis, accompanied by the withdrawal of inmate rights and privileges and at times by interventions of the institutional emergency response team.

In recent years, correctional officers, other CSC personnel and inmates have been taken hostage, severely assaulted, injured and threatened with death in a wave of incidents that repeatedly involved a hard core of female inmates.

The frequency of these events has disproved the notion that new models of incarceration and new institutions would by themselves resolve most of the problems that were common in previous penitentiary approaches. The direct impact of these incidents on staff and inmates should not be underestimated. We have no choice but to conclude that a certain percentage of the maximum-security female inmate population represents an ongoing and unacceptable threat to security.

Even if the correctional model described in the Arbour report remains an attractive goal, punitive discipline persists as a feature of prison life for incarcerated women. Simply because no other alternatives exist, numerous offenders continue to serve long terms of imprisonment in segregation under the offender management protocol. Increasingly, these inmates have different needs and require greater supervision than do most women inmates in maximum-security institutions.

These inmates have been repeatedly transferred, but the receiving institution is usually no better equipped to deal with the high-risk inmate. Another institution is thus exposed to a predictable cycle of violence. These multiple transfers prompt us to associate them with an escalation in the violent acts committed by these inmates.

The current procedure for handling management protocol cases has a direct impact upon the daily operations of the Secure Units. When the inmates are being managed according to level 1 of the protocol, three correctional officers supervise their daily movements in the segregation area. This completely mobilizes the total number of officers assigned to the Secure Unit sector during the week. For all other periods (holidays, weekends), these daily activities require the enlistment of a correctional officer from another sector.

During movements or incidents in the segregation sector, we are thus allowing offenders to avoid our dynamic security. Accordingly, this compromises the security of staff, inmates and, indeed, of the entire institution.

To address this problem during a planned intervention, inmates in the Secure Unit must cease their activities and return to their module or cell. Terminating their activities in this way and limiting their movements, often over a long period, creates dissatisfaction and increases the level of tension in the unit.

In addition, many of these inmates require much heavier supervision due to an anti-social personality or severe mental health disorder. Isolating them from interaction with the personnel can lead to an increase in their level of anxiety. We can then be confronted with aggravated situations, with a nonetheless limited capacity to take action.

While segregating high-risk women for very long periods of time does effectively provide a means for managing the risk that they represent, this practice in no way responds to their considerable needs. The fact that these inmates cannot work and be remunerated entails problems at other levels. In addition to a restrictive milieu, we decrease their autonomy by impoverishing them and preventing them from treating themselves to miscellaneous canteen, hygiene and clothing items.

We cannot turn a blind eye to women who make regular use of violence, however. We must instead work to find a reasoned response to this phenomenon.

Special Handling Unit

The union contends that CSC must create a new Special Handling Unit designed to safely accommodate female inmates who pose a greater risk than the regular maximum-security population.

In order to foster a secure and humane approach to high-risk inmates, we propose the construction of a fortified secure area in a centrally located prison that would be independent and separate from the currently existing segregation sector and Secure Unit.

Among the unit's features:

- *at least 10 cells with electrically-operated doors and an integrated wicket;*
- *an enclosed shower with a wicket in the door;*

- *an interview room with a fortified window that separates the inmate from the frontline worker with a secured letter slot;*
- *a common area with a sofa, TV and washer-dryer;*
- *access to the outdoor yard of the segregation area.*

Such a unit would help staff more effectively deal with women who have been on the management protocol for several months. These cells could also accommodate transit cases, court appearance cases or provide more space should the need arise.

The interview room would be practical for all meetings with psychologists, psychiatrists, nurses, teaching staff, members of the sisterhood, the chaplain, behaviour therapists and for all interviews with the case management team. In addition to establishing an acceptable degree of security, this interview room could guarantee the confidentiality of the interactions that take place there.

The common area would enable the inmate, depending upon her level of security, to enjoy additional activity time, wash her own laundry and generally maintain her living quarters. This would greatly enable a gradual assimilation into a structure that is less restrictive than confinement to a cell.

By offering psychiatric care, as well as opportunities for greater participation in programs and activity schedules, inmates could eventually rejoin the maximum-security population in a healthier and more secure fashion.

After Ashley Smith's death, UCCO-SACC-CSN re-engaged CSC management in a dialogue, using this report as a basis for discussion, last November. Soon after, a Joint Task Force on the Management of High-Risk Female Inmates was struck to explore solutions to the housing of this category of offender.

According to a Task Force report in January 2008, "it was clearly established that we had a pressing need for a special unit to handle high-risk female inmates. We also agreed that this unit should also be used to handle female inmates with serious mental health problems and who also represent a high degree of risk."

An initial unit is planned for Joliette Institution in Quebec. A subsequent unit will be established in the Prairie region for high-risk aboriginal and anglophone offenders. These units will be used to manage both repetitive hostage-taking cases and female inmates in phase 1 of the existing management protocol. The high-risk mental health cases would be physically separated from the high-risk security-related cases.

UCCO-SACC-CSN is optimistic that these developments will lead to a more secure, and more productive, incarceration for high-risk female offenders.

5- The road to Grand Valley

Nova Institution

Ashley Smith was placed in the federal prison system October 30, 2006, after an accumulation of convictions on dozens of charges (including 28 counts of assaulting a peace officer) in youth custody. The convictions resulted in a combined sentence of six years, one month and 17 days.

Inmate Smith was an extremely difficult offender from her first moments of incarceration in CSC's Nova Institution for Women at Truro, Nova Scotia. An emailed weekend briefing from a Nova manager to staff captured the pace that Inmate Smith would set during her 51 weeks in federal custody:

Email to staff, weekend briefing by ATL *[name withheld], November 3, 2006, at 9:43 pm: "It should come as no surprise that I begin the weekend briefing with Ashley Smith. It has been a long few days for everyone involved with Ashley, and before I speak any further of Ashley herself, or any other offender activity, all staff that have dealt with Ashley should be recognized for their efforts in dealing with a very difficult offender. It is very draining both emotionally and physically to deal with this type of offender. All staff did a terrific job in maintaining a safe and secure environment in less than desirable conditions. Well done.*

"Ashley was eventually removed from Cell 156 by the IERT early Friday evening. But not before she caused extensive disruption, and damage to cell 156. While in that cell she broke window frames, broke the sprinkler head, flooded the cell, and ripped paint off the floor and use the same to cover both the camera and the window in her cell. During all of this she threatened to kill staff, she spit on them, threw toilet water containing urine and feces at them, and verbally and physically assaulted them relentlessly…."

Corrections officials were aware of Smith's propensity for self harm from the outset. Written recommendations to staff, from a behavioural counsellor and psychologist, suggested a course of action in the event Smith began to tie a ligature around her neck or employ other forms of self-harm. The document, dated November 3, 2006, directed correctional officers to engage Smith verbally: "Ashley, we want to work with you. Doing that does not allow this. Hand over the (item) please."

Correctional officers were instructed to repeat this statement until she complied, "unless it's causing her to escalate. Keep the communication 'matter-of-fact' so that it minimizes reinforcing this maladaptive behaviour. If she continues to self-harm or escalate the severity of the self-harming, normal security procedures will prevail."

This plan evidently had little effect on Inmate Smith's behaviour. During the seven weeks she was initially housed at Nova Institution, CSC recorded 18 serious incidents involving the young woman. Some involved impressive feats of strength. During one of them, Smith broke out of her handcuffs and threw a piece of the broken metal into a correctional officer's face.

She continued to destroy her cell, on one occasion using her fingers to remove security screws – manufactured to withstand tampering – in order to dismantle her desk. On another she took apart the steel frame of her bed. The cell camera, window and food slot were repeatedly obstructed to prevent surveillance, and at times were smeared with fecal matter. Throughout, Smith continued to rip up fabric to use as ligatures during incidents of auto-asphyxiation.

As another internal report made clear, however, Smith's extreme behaviour was not sufficient to lead CSC mental health specialists to view her as psychotic. The following passage is from a document dated December 14, 2006, entitled, "Management and Re-integration Plan for Ashley Smith":

"While Ms. Smith appears to be of average intelligence, her presentation is frequently consistent with that of a young adolescent. She is capable of engaging in purposeful behaviour and, to date, has demonstrated no behaviours that would be considered an 'out of control' or psychotic presentation. Ms. Smith is aware of the behaviours in which she engages and is able to comprehend the probable consequences of her actions.

"Many of Ms. Smith's recent behaviours have been grossly maladaptive. These behaviours (i.e., spreading of fecal material) have served to cause both staff and other inmates distress. That said, these behaviours are unlikely to be relative of acute mental illness. She has stated in the past that she is aware of the effect that her behaviours have on staff and that she engages in them to 'bug' the officers. Further, she has stated on occasion that she feels she has been victimized by staff and, she also noted, some of her behaviour is reflective of a desire for revenge. She believes she is engaging in a power struggle, and as with most adolescents, it is challenging to turn the situation into one that can be salvaged for all parties.

"Ms. Smith's compliance with her prescribed medications has been inconsistent. It is possible that her decision to forgo her medication on occasion is having a behavioral impact. As well, at times Healthcare staff have not been allowed access to the segregation unit to provide Ms. Smith with her medications: this is equally likely to be having an impact.

"Ms. Smith has a history of self-injury. At times it appears that her self-injury escalates to the point where she poses a legitimate risk for suicide. For this reason, it is often difficult to discern her true intentions: what begins as a means for drawing attention or relieving stress via a maladaptive approach, could quickly deteriorate to a serious attempt at suicide. As of yesterday, Ms. Smith continued to he rated at a 'High' risk for harm to self and others – a large portion of this rating is result of lack of knowledge in regard to the potential that Ms. Smith might be in possession of materials that could pose a risk to both her safety and that of staff."

Despite that risk, it appeared to frontline staff that the focus of national management was on finding fault with the way correctional officers did their job in handling Inmate's Smith's continual outbursts. On December 13, 2006, staff at Nova Institution were informed that the Warden and Deputy Warden would be in conference calls with national headquarters to discuss the high numbers of Uses of Force (UOF) involving Ashley Smith.

That evening officers were assembled and ordered to extract inmate Smith from her cell. Smith had smeared feces on her observation window and covered her cell camera. Psychologist [name withheld] stated that Smith was high risk to harm herself and others, and that she possessed a length of string that could be used as an instrument for self-harm. Earlier, she had made a number of statements of suicidal nature and made threats against staff members. The previous day she had threatened to stab staff with a broken pen in her possession. Fearing for their safety, frontline staff at Nova thus initiated a refusal to work under Section 127 of the Canada Labour Code.

One manager at Nova appeared to appreciate the effect that Inmate Smith was having on correctional officers at the institution. In a general email to staff December 13, ATL [name withheld] wrote that, "We recognize that staff are tired and are giving us 110% right now. We also recognize the professionalism and compassion in the day to day interactions."

Nonetheless, this manager reiterated a contradictory and confusing direction not to interfere with Ashley Smith during her incidents of self-harm if she showed signs of life. "If she is kicking and talking, we can give this weight in determining if she is still alive. If she is actively engaging/talking, we can make some assumptions that she is alive. We cannot rely on this totally as she could be talking and preparing a noose or cutting her wrists."

Staff at Nova Institution repeatedly struggled with unclear directions on how to deal with Ashley Smith. The repeated assaultive behaviour, coupled with the ever-present threat of disciplinary action from distant management, had a major impact on staff well being, leading several officers to take stress leave after this period.

"We often end up with long-term medical cases," observed one correctional officer. "As correctional officers, we agree that Ashley Smith should not have been in federal custody for crimes she committed as minor. But we are stuck dealing with these people, who cannot function on the same level as the rest of the inmate population nor cooperate with any correctional plan."

A week after this latest incident, however, Ashley Smith was moved in the first of her many transfers during her year in federal custody.

Regional Psychiatric Centre

Ashley Smith arrived in Saskatoon on December 21, 2006. Her reputation as a difficult inmate preceded her and was the source of great apprehension among staff at CSC's Regional Psychiatric Centre (RPC), who were instructed to exercise extreme caution in dealing with her.

According to a report produced by the local UCCO-SACC-CSN union at RPC, Smith arrived at the prairie facility during a period of turmoil. A pre-existing union-management conflict concerned the lack of an all-female Institutional Emergency Response Team to deal with serious incidents involving female inmates.

As the union report notes, this situation was a central finding and source of criticism for the Arbour Commission a decade previously, and CSC policy now expressly dictates that the IERT at female facilities be uniquely composed of female correctional officers. Despite several documented attempts by UCCO-SACC-CSN in the months preceding Ashley Smith's arrival in Saskatoon to engage management on this issue, no female IERT existed when she was transferred to RPC.

"Despite the decision to admit such a problematic inmate," reads the report, "there seems to be no real attempt to come up with a management plan or protocol to use with this inmate."

Incidents of auto-asphyxiation began almost immediately, during which male officers were ordered to enter her cell to remove ligatures, and were subsequently attacked, leading to use-of-force situations. On multiple occasions both male and female correctional officers were assaulted, scratched, or splashed with bodily fluids. It was pointed out that, during interventions with the inmate, who was clothed only in an IPC gown (commonly called a "suicide gown," it is designed to resist tearing or cutting), male officers were on repeated occasions exposed to nudity, contrary to CSC policy.

Ashley Smith's four months at CSC's Regional Psychiatric Centre in Saskatoon was a period of almost unrelenting violence – except for a short period preceding and during a visit from the inmate's mother.

According to an institutional Threat Risk Assessment, dated April 12, 2007:

> **"Since her transfer to RPC on 2006-12-21 her negative behaviour has escalated on a daily basis. She started out with threats of self-harm, covering cell camera/window, threatening to spit on anyone who came to intervene, spreading feces in her cell and on her window and then breaking a sprinkler head in her cell. That occurred within the first 5 hours of her admission.**
>
> *"As documented in a Assessment for Decision dated April 5, 2007 – there has been 50+ documented incidents from 06/11/01 to 07/03/27; 12 of which were assaults on staff, 15 incidents of self-harming behaviour and 4 incidents of throwing feces/urine on staff. As documented on RADAR, there has been 2 other assaults on staff (April 9, 10/07) as well as another outside charge in relation to being assaulted by this offender (kicking/hitting and spitting in the officer's mouth). She continues on a daily basis with threats of self-harming by making nooses, grabbing at staff through the food slot and covering her camera so staff can not observe her."*

On only one occasion during this four-month period did doctors authorize the use of a restraint chair to curb inmate Smith's attempts to harm herself and others. Other than that, officers were left to manage as best they could.

"We weren't prepared at all," said one RPC correctional officer. "There was no plan to deal with her. There was no clear direction on what to do. The officers here know how to save lives and that's what they did. But after one or two incidents we can say this is not spontaneous anymore. We know she will do this all night long. We know it's going to happen and you need a team to deal with it. Instead, officers would be pulled away from other duties and sent in without the proper equipment."

Nothing was documented, he added. Some supervisors told officers to wait for Smith to pass out before going in to remove a ligature. Others would say to go in.

"There were many times we were waiting outside that cell," said the correctional officer. "We knew something could go wrong. We felt she might kill herself or seriously injure one of our members."

That's why the local union produced a detailed report, which was presented to the CSC Senior Deputy Commissioner on May 20, 2007. During that same period, a National Investigation Team from CSC headquarters was conducting a Section 20 investigation under the Corrections and Conditional Release Act into all the uses of force involving Ashley Smith during her four months at RPC. The CSC investigation did not, however, look into the conditions of Smith's confinement.

"They were only concerned about uses-of-force," observed a correctional officer at RPC. "They never looked into management practices. They were already looking for someone to scapegoat."

Soon after, a use-of-force workshop was made mandatory attendance for correctional officers at RPC.

"It was if these officers didn't know how to deal with an inmate," said the officer. "It was terrible for morale and it didn't address the actual problem: that there was no female IERT. RPC is the only correctional psychiatric centre in Canada for women; we are obviously dealing with mental health problems, but we were not given the infrastructure we needed to handle this kind of inmate."

Joliette Institution

Ashley Smith's first introduction to Grand Valley Institution followed her time at RPC. She was housed at the Kitchener facility for two months before being moved to Joliette Institution for Women, at Joliette, Quebec, on June 27, 2007.

Staff at Joliette were accustomed to dealing with serious incidents involving violent female offenders. However, "We have never had an inmate as problematic as [inmate Smith] in the 10-year history of this institution," according to a report written by the UCCO-SACC-CSN union local at Joliette.

> *"She completely destroyed a cell that had been specially prepared for her. In 10 years, never has any inmate caused as much damage. The desk in the cell had to be removed to stop her from gaining access to the cell camera, which had been destroyed and obscured several times. The wall coverings for cables, lights and electrical current had to be sealed. She ripped up a piece of Velcro that held her window curtain in place and used it to choke herself. Even while menstruating, we couldn't give her tampons because she would wrap the fibres around her neck. She would have to show us a used tampon in order to get another one. She succeeded in removing security screws from the cell furniture with her fingers, and used the screws to self-harm."*

Any available fabric became a potential ligature. At Joliette, inmate Smith even managed to unstitch and rip up a suicide gown expressly designed to resist such attempts. Interventions occurred on a daily basis, during acting-out incidents that were interpreted as attempts to attract attention.

The Joliette report notes that inmate Smith complained about the repeated use of OC spray during interventions, admitting to a management employee that the use of this tool affected her ability to provoke correctional staff. Eventually, regional CSC management chided local management for the frequent recourse to this tool.

"On certain occasions, correctional officers had to wait for the okay from a supervisor to intervene despite obvious self-mutilating behaviour, because the Institutional Emergency Response Team had already been called," the report observes. "It was mentioned, however, that if correctional officers judged that her life was in danger, that they should equip themselves, use their OC spray, and enter the cell."

On other occasions, supervisors even asked correctional officers if they themselves felt inmate Smith's life was threatened before giving the authorization to enter her cell.

Inmate Smith's stay at Joliette was brief, however. On July 26, 2007, she was returned to Nova Institution in Truro.

Return to Nova

Having learned from its previous lack of preparation, management at Nova Institution went to great lengths to prepare a risk-free environment for Ashley Smith and correctional staff upon her return.

Plexiglass was installed on the outside segregation cell window to prevent contact with bodily fluids. Her cell door was retrofitted with a new observation window that had removable panels. A special staircase was constructed to provide easier access for outdoor observation in the event other options were unavailable. A shelter to shield staff on outside surveillance from weather and insects was built.

Staff were trained on the use of a fiber optic camera. More training was provided on the use of a restraint bed and a "Prostraint chair." Extra correctional officers were hired for daytime hours.

A July 27 email from an Assistant Team Leader to the staff of Nova Institution provides an indication of the detailed instructions that were now to be employed for dealing with Ashley Smith, in marked contrast to her first stay at the facility.

> *"As a staff member assigned watch the camera monitor, you are there to provide observation of I/M Smith, however, if there is an incident with this inmate and staff are on the scene providing direct observation, either the camera or Control post person (who ever is NOT light duty) can then be a responder. If this responder isn't required for dealing with the use of force then they should immediately assume the duties of video camera operator and begin video recording the incident at the earliest possible moment."*

(The direction to film each and every intervention was a cardinal rule – a fact that would render the later criminal charge against a Grand Valley correctional officer for doing just that totally inexplicable.)

By mid-August, two weeks after Ashley Smith's return to Nova Institution, all these meticulous preparations were rapidly being undone by a chronic deterioration in the inmate's behaviour, and this, despite the proximity to her family in nearby Moncton, New Brunswick. A stack of Officer's Statement/ Observation Reports (OSORs) detail an unending litany of choking incidents and lashing out at correctional staff.

The following OSOR, dated August 29, 2007, is representative:

"Ashley Smith covered her cell camera with the bottom of a Styrofoam bowl. A visual of I/M Smith was maintained through her cell door window. Shortly thereafter, I/M Smith began banging the back of her head repeatedly against her cell door. She later banged her forehead on the cell floor. ROS [name withheld] informed I/M Smith that she would be placed in the Pro-restraint chair if this behaviour continued. I/M Smith continued to bang her head and was then given a direct order to cease this behaviour by ROS [name withheld]. Throughout the remainder of the day, I/M Smith banged her head for periods of time. She was also disrespectful to staff and other inmates. I/M Smith was at times inciting I/M [name withheld] who was emotionally disregulated and non-compliant herself.

"At approximately 1440 hours, I/M Smith moved to the corner of her cell between her toilet and the wall, which did not permit staff to visually observe her. CX [name withheld] maintained a visual from the outside cell window. I/M Smith moved to the door permitting visual observation from the door window. Several times throughout the afternoon, I/M Smith resumed her position where she could not be seen from the door window and staff was forced to maintain a visual from outside. This behaviour alternated with I/M Smith banging her head. While this writer was posted at I/M Smith's outside window, I heard her say [to another inmate], '[name withheld], let's see who can bang her head the hardest.' At approximately 1710 hours, I/M Smith said, '[name withheld] write it down, I'm gonna choke myself." I/M Smith then proceeded to tie a ligature around her neck and lay down between her toilet and cell wall.

"This writer returned to the Secure Unit and with other officers, was able to verify I/M Smith's breathing through the cell hatch. This writer took over the Control Post and other officers verified I/M Smith's breathing by opening the cell door. At approximately 1725, I/M Smith uncovered her camera. She removed her smock and began banging her head against the cell door again approximately ten minutes later. At approximately 1745 hours, I/M Smith covered her camera which staff cleared at 1800 hours using the water fire extinguisher. I/M Smith pressed her cell call several times after this for non-emergency purposes, requesting food and a blanket. At approximately 1829 hours, Smith again covered her camera. She cleaned off the camera at approximately 1855 hours, remaining naked in her cell."

This sort of report, with variations, had been produced on almost a daily basis for the previous two weeks. It was clear that a single inmate, for whom no therapy or strategy seemed to be effective, was exhausting Nova staff. Short visits to outside psychiatric hospitals provided no relief and these establishments were seemingly eager to return Ashley Smith to the care of the Correctional Service. In this instance, CSC resorted to its favoured option in cases like these: another transfer. Once again en route for Grand Valley Institution, Kitchener, Ontario, this transfer would be Inmate Smith's last.

6- Cowboys

At the end of August, Ashley Smith returned to Grand Valley from Nova Institution in Truro, NS. It became quickly apparent that her problems were rapidly escalating, even from the moment she stepped onto a CSC aircraft for the journey to Ontario. The pilot, fearing an in-flight disturbance, had Smith secured to her seat with duct tape. Things went downhill from there.

A structured casework report from September 2007 captures the challenge that Ashley Smith posed for correctional staff at GVI:

> ***I/M*** *Smith returned to GVI on August 30, 2007. Since that time she has been incredibly unstable. There have been numerous incidents of use of force and numerous disturbances caused by I/M Smith. These incidents are occurring almost daily. There have been far too many incidents to list them all so I will try to give a condensed version.*
>
> *The day that I/M Smith arrived at the institution she was transferred here wearing regular pants and a shirt. She shredded these clothes to use as ligatures for around her neck. This went on for quite a few days. There were numerous incidents where force had to be used as well as OC spray. When I/M Smith ran out of ligatures she started covering her camera all day, everyday. She has been grabbing staff through the food slot and has been throwing liquids out of her cell. She spits on the staff almost daily.*

In mid-September, however, Grand Valley management tried a novel approach in an effort to encourage more appropriate behaviour from Ashley Smith. She was moved out of the segregation unit and assigned a cell in one of GVI's three max unit pods. As an incentive, CSC paid for a television that was given to Inmate Smith and placed in her new living quarters for a few hours each day. For a few days the strategy seemed to work.

Then, on September 20, Smith suddenly demanded to be returned to the segregation unit, a request that could not be immediately granted. To add urgency to her request Smith picked up her television and smashed it on the floor of her cell, not once but three times. She then covered the window of her cell.

"Her cell floor was completely covered in broken glass," a correctional officer recounted. "This was an inmate who was not allowed to wear regular clothes, and they gave her a TV!"

The officers on the scene told the unit manager that they would not enter the cell without protection. "Inmate Smith was now in possession of innumerable weapons. The broken glass was literally coming out from under her cell door."

What happened next remains hugely controversial among staff at GVI. A CSC manager – an assistant team leader, or ATL – took matters into his own hands, unlocking Smith's cell without warning other staff of his plans.

"None of us knew what he was doing and none of us were prepared," said an officer who witnessed the scene. "We had no OC spray, no gloves, no protective vests, and no camera. And I asked, 'Why is a male manager opening the door to cuff an inmate alone?' This broke so many rules I wouldn't know where to begin. I call it his 'cowboy move.'"

Nonetheless, the manager succeeded in handcuffing Inmate Smith before escorting her to the segregation range. At this point, though Smith was under control, she was not searched for hidden pieces of glass, which may have been a fatal error.

"Smith used the glass from that day to make ligatures until she died," said the officer who witnessed this incident. "I feel there is a direct line of responsibility between this incident, how it was handled, and her death. I am enraged that this had not been dealt with."

This apparent indifference to procedure, potential threat or common sense on the part of CSC managers at GVI is a recurrent theme. Another correctional officer bristles with frustration recounting the missed opportunities or simple refusal to confiscate the materials Ashley Smith would employ in her choking games.

During the following days, staff entered Smith's cell with an industrial vacuum to remove any glass that may have been on the cell floor. After the first entry, when Smith was returned to her cell, the officer saw her stick her hand down her gown and then insert a finger in her mouth. The officer strongly suspected Smith was moving hidden pieces of glass on her person. This was communicated to senior managers on the scene.

When Smith was subsequently sent to hospital, however, this information was not passed on. "Why," this officer wondered, "did they not sedate her if necessary and remove all of the weapons or tools she required to make ligatures?"

On September 22, the same correctional officer was back in Smith's cell, helping remove a ligature Smith had tied around her neck. A correctional manager instructed the team not to look under Smith's gown to remove ligatures because that would be too intrusive.

"This seems ludicrous to me now," the officer recounted. "We were in there holding the girl straining ourselves over and over to save her life and looking for the material that she was using to cut the ligatures, and that was considered intrusive?"

This officer speculates that Smith's desire to return to the segregation unit on September 20 was motivated by the impending return to the unit of her friend, the same inmate who led the hostage-taking and torture session back in August 2005.

"This inmate had been engaged in numerous prior conversations inciting Ashley to act out," the officer explained. "This is an important factor in this situation because girls like Ashley, who are motivated by social contact with her peers and who distrust those in authority or people who are involved in her care and custody, tend to make bonds with those around her. This represents a risk, especially when the person who is a peer is motivated by her own power and control issues. Subsequently, this inmate admitted she had a made a suicide pact with Ashley, which of course she didn't uphold."

7- A rigorous adherence to policy

Just as three correctional officers and a supervisor were being charged with criminal negligence causing death in late October, the Office of the Correctional Investigator was releasing a report identifying problems inside federal prisons. Among the recommendations made in "Twelve Key Barriers to Public Safety" were obvious targets such as mental-health and suicide-prevention training for frontline workers.

The CI also took pains to insist, "staff must rigorously adhere to policy." The timing of the CI's recommendation was tragic, given that correctional staff are now facing possible sentences of life in prison for having followed orders.

At Grand Valley Institution, where a rigorous adherence to contradictory policies could sometimes trigger dizziness and disorientation, staff managed Inmate Smith as well as they could under abnormal and trying circumstances.

Said one correctional officer: "We would also have to deal with the inconsistencies from management: how we moved her; who moved her; did she get a towel; did she get a blanket; was she cuffed or not; in front or behind her back; was she allowed to talk to [name withheld] and other inmates in segregation. It all changed depending on which manager you asked."

In stark contrast, the management policy at GVI regarding staff interventions during Ashley Smith's auto-asphyxiation incidents was clear and frequently enunciated.

As early as Ashley Smith's first stay at the Kitchener prison in the spring of 2007, managers were directing staff to refrain from intervening during Smith's self-choking episodes. A bolded paragraph from a correctional officer's June 19 observation report reads, "As per direction from ATL [name withheld], staff were not to enter her [Smith's] cell to cut the ligature off. As long as inmate Smith was breathing, talking or moving, staff were not to enter her cell."

A correctional officer who has since been suspended for 480 hours without pay after Smith's death described how, in early October, a manager reviewed a videotape of a use of force to remove a ligature, yet again, from Smith's neck. On the tape, the officer recounted, Smith's face was clearly purple when they opened the cell door to check on her. "The manager told me, 'That's the hardest thing, but you have to close that door again.'

"We weren't trained to handle situations in which a person constantly strangles themselves," this officer observed. "But to me it was clear that our direction was not to go in Smith's cell until she was passed out. But we had no training on how to judge if a person is breathing."

This point was driven home by CSC management October 9 during a use-of-force training session that was specifically designed for staff interventions with Ashley Smith. Said one correctional officer who attended the session: "We were instructed specifically to wait until she stopped breathing. We were told not to enter the cell if she was breathing because the decision makers were afraid that they would be held accountable for this situation of perceived excessive number of uses of force."

Correctional officers who dealt with Inmate Smith on a daily basis had many comments and questions about this instruction, and expressed concerns over the urgency of this inmate's case. Management was firm: frontline staff were to "reassess and withdraw unless [Inmate Smith] was not breathing, referring to the use-of-force diagram," the correctional officer recounted. "We said, 'She should be in a psychiatric hospital… we are not trained to deal with this type of individual.'

"I could see my fellow staff members' anxiety increasing every time we went in to save her life. [Name withheld], our search co-ordinator, stated she had three garbage bags full of ligatures."

Another officer who attended the training noted that the managers at the session had many questions, including whether they had to stay at work while correctional officers completed their use-of-force reports after an intervention with Smith. But this correctional officer also confirmed the central message of the training.

"The bottom line is that we were told not to go in her cell if we see that she is still breathing," the officer said. "But there were no definitions given."

On October 13, six days before Smith's death, a correctional officer wrote an email to the local union executive describing a meeting with the Warden over possible discipline for a fellow officer relating to an intervention with Ashley Smith:

> ***"I** got a chance to let the Warden know that staff are being spread thin because of the growing pop [inmate population], I/M Smith, incidents and the daily duties we perform, and that all staff are working hard trying to get things done only to find out later that something that was OK in the past is now a disciplinary hearing. This is demoralizing to staff. I stated that the Max staff are working their ass off everyday keeping the best interest of the inmate in mind, preserving life constantly. They are now reviewing tapes and will be addressing*

things. I think instructions should be documented and we should slow down, I am the worst for that. I would caution staff if they feel that her life is in danger let the manager know and document it. If a manager tells the staff to time her breaths or to see if she is moving etc document it .You will be on the witness stand if something happens. I told the warden I would rather go to court defending why I went in the cell rather than why I didn't go in time. These reprisals are making staff second guess themselves and hesitate."

Staff members at Grand Valley were also questioning why Ashley Smith was not being treated at a psychiatric hospital, given her obviously deteriorating mental state. One officer described accompanying Smith to a mental health facility in Kitchener.

"I went to the hospital twice with Ashley as the officer in charge of escort. The institution tried to put her on form 1 at Grand River Hospital so that the doctor could do an exam and remove whatever was inside of her.

"The psychiatrist said that her behaviour was based on doing things to get a reaction and that she was not out-of-her-mind crazy. I'm not a psychiatrist, so I don't know. But there was something wrong. There was no consistency in the psychiatric assessments. We were the ones who dealt with her every single day and our suggestions were disregarded.

"She would see different psychologists all the time. Some would say she was only acting out, others would feel differently. What is certain is that whether she liked them or not would affect their assessment of her.

"I can think of at least seven different psychologists who saw her in the time she was there. There was absolutely no consistency."

8- October 19, 2007

At 11 pm the evening of October 18, correctional officer Blaine Phibbs took over the secure unit at Grand Valley Institution as the OIC, or officer in charge of the unit. Inmate Smith awoke during one of officer Phibbs's rounds of the unit just after midnight, and asked him who would be doing direct observation of her cell that night.

"Joe," answered Phibbs.

"Joe mama?" joked Smith, not skipping a beat.

"That's right," said Phibbs.

He had reason for not telling Smith who would be watching her through the cell's food slot, as had been the practice since she had been placed under 24-hour suicide watch. Phibbs knew Smith had made a list of staff members she didn't like, and on whose watch she had threatened to kill herself. The teenager was particularly discomfited by the presence of staff members she did not already know.

Phibbs, 31, had spent most of his brief two-year correctional career in Grand Valley's secure unit, having begun working there shortly after the August 2005 hostage-taking, when few were volunteering to work the dangerous post. He was recognized throughout the institution as one of a handful to have developed a good rapport with Ashley Smith. Smith herself had jokingly told a number of staff members that she had a crush on the young correctional officer, who had previously worked for Children's Aid at Timmins Child and Family Services and as a substitute teacher.

The two conversed about how well the previous day had gone for Smith. She admitted it had been "rough"; she had been disrespectful to a staff member by throwing water and swearing at her. Smith also admitted to officer Phibbs that she had been switching her medication, taking her daytime prescription at night and vice versa, and that this was affecting how well she slept. Finally, she said she would try to sleep and Phibbs promised they would speak later in his shift.

Karen Eves, a veteran correctional officer from a Kingston-area institution, was working only her second shift at Grand Valley since arriving that week to help the prison deal with its staff shortages. At 3:15 am she relieved an officer posted for direct observation of Inmate Smith. According to her observation report, Smith continued to sleep on the floor of her cell, stirring

briefly at about 5:30 am, and then waking again near 6 am to ask for toilet paper and for her light to be turned on.

When officer Phibbs returned to key open the cell light, Smith told him she'd had a disturbing dream. Smith was crying. She told Phibbs how she felt an urge to "tie up," and, indicating officer Eves, that she did not like to be watched, especially by a new staff member. During a conversation that lasted about 30 minutes, Phibbs tried to steer the topic toward other things Smith could do instead of choking herself.

"I know what I'm doing," she told Phibbs. "You will always come in."

Phibbs argued that she was playing a dangerous game, and Smith finally agreed to at least postpone her choking behaviour. "Fine, I won't do it right now," she said, adding that she would go back to bed.

Phibbs left to do another round of the unit. Inmate Smith asked for privacy while she used the bathroom. Officer Eves stopped observing the cell but continued to listen.

"I did not hear the toilet flush and heard weird noises," Eves later wrote in her observation report. "When I looked in she was bent over the bed (between the wall and the bed) on her knees. I believed she was trying to 'hoop' something [to insert or retrieve something from a bodily orifice] and it had gone badly."

Once again, she summoned officer Phibbs.

"When I came back she was already tied up," said Phibbs. "It looked exactly like every other event. I'd seen her at least 50 times tied up like that. At least five times she was blue in the face. And I personally cut the ligatures from her neck between 30 and 40 times."

With her positioning, it was hard to get at her, however. She was lying on her hands and wedged in between the bed and the wall.

At this time other staff, including a supervisor, were alerted and attended to the scene.

Valentino "Rudy" Burnett, yet another officer on loan from a different CSC institution to help staff Grand Valley, had just finished his shift and was about to leave the prison for his hour-long drive home to Hamilton. Hearing a call for assistance, he instead decided to head down to the secure unit, where he had never worked before. A fateful decision.

"As the new kid on the block I was given the camera, which I didn't really know how to use. My first question was, 'Where is the record button?' At one point I checked the camera because I wasn't sure if it was recording or not. I was asking, 'Is it on?' And then I continued filming."

As Ashley Smith's complexion turned dark from oxygen starvation, Karen Eves began timing and calling out the intervals between breaths: intervals increased from 15 seconds to 20 seconds to one interval of 40 seconds.

"At times there was more than one gasp; there would be 3 or 4 at once," Eves wrote. "Her face was purple and she was unresponsive to staff calling her name or banging on the door."

By this point, at 7 am, six correctional officers were on the scene. Mindful of the strict policy of Grand Valley management, they discussed their options. Phibbs decided to quickly open the cell door to ascertain that Smith was still conscious; he saw her shift after the door opened and heard her breathing deeply. He closed the door once again.

The officers then formulated a plan to remove the ligature. "As she had been seen with a sharp object and known to be cutting material (which she used to tie around her neck) we knew she had this sharp object and had to use caution," Eves wrote. "It was decided that CX Phibbs would go in to cut the cord around her neck, and we were to go in and be back up in case she became assaultive. I was to be on legs if needed."

At 7:02 am, officers all entered the cell to assist officer Phibbs as he cut away the ligature from Inmate Smith's neck. Rudy Burnett continued to videotape the scene. As the ligature was removed, several officers heard Smith take a deep breath. They then withdrew from the cell and continued to monitor her breathing.

As the inmate remained non-responsive, Phibbs re-entered the cell and with the help of another correctional officer began manoeuvring Smith so that CPR could be performed. Eves felt for and found a pulse and began CPR at 7:06 am, hampered by Smith's swollen tongue. A nurse arrived on the scene at 7:10 and assisted with CPR.

Firefighters arrived at 7:15, followed at 7:19 by ambulance paramedics, who took over trying to revive Inmate Smith. The ambulance left Grand Valley at 7:45 to transport her to St. Mary's Hospital, arriving at 7:54. After more attempts to revive Ashley Smith, a doctor pronounced her dead at 8:10 am.

9- Suicide's slippery slope

A recent Statistics Canada report, "Suicides in Prison; Setting the Context," demonstrates that the number of suicides in Canada's federal prisons is declining.

There were five inmate suicides in CSC institutions during the 2007-08 fiscal year, less than half the average of 10.3 over the last seven years (2001 to 2008). CSC averaged 12.3 suicides in the first six years of available data (1995 to 2000). While the numbers are moving in the right direction, the rate of suicide in federal prison is still almost 10 times that of the general population in Canada.

Noting that high suicide rates are common to most nations' prison systems, the report observes, "This higher rate of suicides in federal institutions compared to the community at large reflects offenders' suicide risk factors such as mental health problems, alcohol and drug abuse, lack of self-control, previous issues of abuse and feelings of isolation and anxiety associated with incarceration."

The report also focuses on suicides by aboriginal inmates, noting that they accounted for 21 per cent of CSC suicides between 1998-99 and 2006-07, a reflection of high First Nations suicide rates in the community. The socio-economic and cultural disadvantages of Canada's first people's are well documented, and they are surely a factor in this statistic, not to mention their vast over-representation, proportional to their population, in Canadian prisons.

A recent suicide by an Aboriginal offender at Warkworth Institution, near Peterborough, Ontario, drew national attention after a public report from the Office of the Correctional Investigator blamed slow intervention by correctional staff and raised the spectre of racism as a possible reason why this inmate's life was not saved. As the preceding chapters of this report demonstrates, the easy reflex to scapegoat the people who happen to be present at the end of long series of actions and decisions is unproductive, and, in this case, unjustified.

Given the sometimes poor image of correctional officers in popular culture, and especially in the cultural products on offer from Hollywood, the stereotype of the uncaring brute in a uniform comes far too easily to some people's minds. In this case as in the case of Ashley Smith, neither are true. Correctional Investigator Howard Sapers, in his May 21, 2008, report on the Warkworth incident and subsequent media statements, failed to note that

these allegations of racism had been investigated not once, but twice, and both times found to be without merit.

No matter, the damage is done. The impression left in the public mind, erroneous though it may be, is that racist "guards" stood by watching an inmate die because he was an Aboriginal. In the days since this ugly and uninformed media spectacle, the correctional officers implicated have been taken off duty because of credible threats of reprisal from other inmates at Warkworth.

What is doubly worrying is that the Correctional Investigator appeared intent on linking this case with that of Ashley Smith. The Union of Canadian Correctional Officers can only hope that he will use more rigour in his future public statements.

Another story in late May, this time in Quebec, cast a different light on the challenges facing institutions in both federal and provincial correctional services. In reporting on the death of a mental health patient held in custody while awaiting trial, Montreal coroner Dr. Paul Dionne condemned the long-term warehousing of the mentally ill in the nation's prisons, saying correctional staff are neither trained nor equipped to deal with this challenge.

In describing the November 28, 2007, death of Justin Scott St-Aubin at the Rivière des Prairies detention centre, Dr. Dionne refused to stockpile blame on the correctional officers present at the time of Mr. St-Aubin's death, instead describing a long series of institutional failures that led to his tragic end. Chief among them was the fact that, despite an "urgent" recommendation that this troubled young man be "immediately" transferred to Montreal's Phillipe-Pinel Institute, he was kept in prison for lack of space at the psychiatric facility.

Dr. Dionne also touched on the deaths of several other psychiatric patients in federal and provincial incarceration over the past several years. During his media statements, the coroner harshly criticized Quebec's ministries of health and public security for the regular transfer of psychiatric patients to correctional facilities.

"They are not qualified to hold psychiatric patients," Dr. Dionne told Radio-Canada in reference to correctional personnel. "They don't have the training. They don't have the support. They don't have all the necessary organization."

Quebec is not alone in this historic failure. The deinstitutionalization of the mentally ill over the past couple decades is creating a crisis in our correctional systems across Canada. A crisis that is increasingly being borne by correctional officers.

10- Conclusion

Three days after Ashley Smith died, on October 22, Blaine Phibbs and Rudy Burnett both received calls from the deputy warden of Grand Valley Institution, asking them to come into the institution for a meeting with the Warden the following day. Neither suspected that the deputy warden was lying to them; that the summons was part of a ruse to facilitate a humiliating public arrest by Waterloo Regional Police in the parking lot fronting Grand Valley Institution on Homer Watson Boulevard in Kitchener. GVI management even supplied police with photos of the two peace officers.

"They showed up out of the blue behind my truck," said Phibbs. "They pulled forward behind my truck as if I was going to try to escape. They asked if I was Blaine and then told me they were there to put me under arrest."

Recounted Burnett: "Deputy Warden [Name withheld] called me to come in to a meeting, saying they needed information. I drove to GVI from Hamilton and parked in the parking lot. I see two men in dark suits come over to me. They asked, 'Are you Rudy Burnett? We have to take you in for questioning.'

"I felt that was a very disrespectful way of dealing with this, unprofessional. Had they been straight with me I would have called a lawyer and come in on my own. I guess I'm resigned to the fact that CSC has sunk to a new low. I came in because she was asking me for a personal favour."

After several hours attempting to interrogate both men before allowing them to contact lawyers, police charged both men with criminal negligence causing death. Karen Eves, after CSN lawyers negotiated with Waterloo Police, was permitted to surrender herself for charges before being released. CSC immediately suspended the three pending a disciplinary investigation. Four other correctional officers who were also present, however briefly, at the scene before Ashley Smith was taken to hospital October 19 were also suspended.

The public drama was carefully coordinated between Waterloo Police, who trumpeted the arrests in a press release, CSC and the Ministry of Public Safety, both of which released prepared statements in the moments following the announcement of the arrests.

The rush to judgment on the part of Waterloo Regional Police may have been triggered by an understandable emotional reaction to viewing the incident videotape, recorded, ironically, by one of the correctional officers now facing a criminal negligence charge. To UCCO-SACC-CSN, however, it is self-

evident that the public humiliation of frontline staff was part and parcel of a strategy to deflect responsibility for Ashley Smith's death from upper levels of management. Senior managers implemented and enforced the policy that Smith was not to be prevented from choking herself until she stopped breathing. They even went so far as to establish a training session for staff to ensure that this policy was carried out as directed.

Officers such as Blaine Phibbs struggled on dozens of occasions to save Smith's life while avoiding serious disciplinary consequences for acting too precipitously. Staff members at GVI talk reverently about the hours and hours that Phibbs would lie on the floor of the segregation unit talking with inmate Smith through the food slot of her cell door, cajoling, urging, and pleading with her to remove ligatures.

Part of the motivation for this policy arose from a desire to avoid use-of-force interventions involving Ashley Smith. Because this inmate would repeatedly choke herself as a pretext to engage in physical altercations with correctional officers who entered her cell to confiscate ligatures, use-of-force reports in her file multiplied at a rapid rate.

Thus, rather than insist that Inmate Smith receive the psychiatric care she so obviously needed, she was housed 23 hours a day in a segregation cell wearing only a security gown that could not be ripped up into ligatures. Her mattress was removed for the same reason. The cell's floor tiles had also been ripped out so she could not use them to cut ligatures or employ them as weapons. Other inmates in the segregation unit, hard-core criminals serving many years in prison, would talk to her for hours a day, encouraging her to act out. And, finally, CSC management insisted correctional officers not enter her cell to remove ligatures so long as she continued to breathe.

However, management did not provide health care training so that staff could know exactly where that danger point was. Nor did management provide 24-hour medical professionals. Correctional officers working at Grand Valley believe that management, as soon as the consequences of their decisions were known, worked closely with police to ensure that only frontline staff would bear the responsibility for Smith's death.

After a cursory investigation, CSC fired the three officers January 16, and suspended the four others for a period of 480 hours without pay, or the equivalent of three months without salary. For most of the four, it is equal to a financial penalty of about $17,000.

Until now, all seven have had good or excellent work evaluations, with no disciplinary reports on their files. In his short two-year career, Blaine Phibbs volunteered on the Safer Institutions Committee and on a committee to help

the institution reduce overtime costs. Rudy Burnett, a father of three, is an active participant at his church, where he speaks to youth groups about the importance of staying away from criminal lifestyles. (When he previously worked at Grand Valley a few years ago, he would also regularly bring his church choir to sing gospel songs with the inmates during his unpaid days off). A former inmate at GVI told the New Brunswick Telegraph-Journal that she credits Mr. Burnett for helping her turn her life around. As for Karen Eves, a mother of two, she had already received a recognition letter for saving the life of an inmate.

If convicted of the charges against them, those three people would face maximum penalties of life in prison.

In May, CSC did impose sanctions on senior staff at Grand Valley Institution. The Warden and Deputy Warden at GVI at the time of inmate Smith's death were dismissed, and two other management employees received 20-day suspensions without pay.

Still, the manner in which these penalties were announced begs questions (and indeed, the strenuous discretion in this instance contrasted markedly with the media circus in the fall of 2007). For instance, a statement by the federal Public Security Ministry attributed the managers' terminations to actions that followed inmate Smith's death. For UCCO-SACC-CSN, this explanation is unsatisfactory. Nor does the union feel that responsibility for the way CSC managed this inmate is limited to management staff at Grand Valley Institution.

The Grand Valley disaster is only one chapter in a larger story of mismanagement, ideological blindness and simple incompetence. Since it was established in 2001, the Union of Canadian Correctional Officers has consistently argued that serious problems exist in CSC's federally sentenced women sector. In a meeting with then-Commissioner Keith Coulter and other senior CSC managers last fall, UCCO-SACC-CSN National President Pierre Mallette reminded those present that the union has long warned that a time bomb was about to go off in its prisons for women.

"For six years now, the union has demanded, pleaded and requested that the CSC clarify how correctional officers should be working in the institutions for women," Mallette said. "We have regularly asked that the Commissioner's Directives apply everywhere, consistently and uniformly, in both the institutions for men and for women. On several occasions, we have asked that should the Commissioner's Directives in effect not be applied in the institutions for women, then clear and precise directives that do apply to women inmates should be issued.

"To date, the CSC has always refused to listen to us regarding these proposals. The consequences of this refusal have led to a situation where ambiguity now exists in the work that correctional officers are required to perform in the prisons for women.

"In addition, over the years, this has had the effect of making correctional officers hesitate before taking action, before making decisions in the course of their work.

"Mr. Commissioner, in a workplace such as ours, our members are professionals who in order to be effective must have clear guidelines, and we can openly affirm today that this has not been the case for several years now in the institutions for women."

It is clear that, in addition to Ashley Smith, there are many other victims in this story. The people who worked diligently to save her life, despite management impediments, are being made to bear the consequences of her death. The Union of Canadian Correctional Officers will never accept this rank injustice.

The union will use every avenue it has to defend the correctional officers caught in a trap not of their making. We will continue to push for policies that deal with high-risk female offenders in a secure, humane manner that minimizes risk to staff and inmates.

Finally, UCCO-SACC-CSN strongly believes that a fully independent public inquiry into the events at Grand Valley and the broader problems facing Canada's prisons for women must be empanelled as soon as possible, and promises to encourage the full and frank participation of its members in such an undertaking.