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SENT BY FASCIMILE AND REGULAR MAIL **October 15, 2010**
(1- 613-993-0260)
Attention: Commissioner William J.S. Elliott
RCMP National Headquarters
Headquarters Building
1200 Vanier Parkway
Ottawa, Ontario
K1A 0R2

Dear Commissioner:

Re: Ashley Smith
Request for Investigation

We represent the family of Ashley Smith. Ashley Smith was a 19 year-old woman who died at the Grand Valley Institution for Women on October 19, 2007.

We write to request that a criminal investigation be conducted with respect to the conduct of certain Correctional Service of Canada ("CSC") officials with respect to two incidents involving Ms. Smith while she was in federal custody:

1. **The Joliette incident:** On or about July 22, 23 and 26, 2007, during Ms. Smith's incarceration at Joliette Institution (Quebec), CSC officials administered intravenous anti-psychotic and anxiolytic medications to Ms. Smith without her consent, and while she was in restraints, without legal or medical justification. The family requests that these actions be reviewed to determine whether they, individually and/or cumulatively, constitute *inter alia* an assault (or assaults) contrary to section 265 of the *Criminal Code of Canada*.

2. **The Grand Valley incident:** In and around October 2007, CSC management staff at Grand Valley Institution (Ontario) issued a directive (and/or directives) that correctional officers refrain from entering Ms. Smith's segregation cell to remove any ligature around her neck unless and until Ms. Smith stopped breathing. On October 19, 2007, Ms. Smith died of asphyxiation caused by a ligature applied to her own neck. Correctional officers were present while Ms. Smith asphyxiated, but refrained from intervening on the basis of the afore-mentioned direction. The family requests that these actions be reviewed to determine whether they, individually and/or cumulatively, constitute *inter alia* criminal negligence causing death.

Background

By way of background, on October 31, 2006, at the age of 18, Ashley Smith was transferred from the youth system to the federal penitentiary system for women. From early in her incarceration, Ashley Smith engaged in repeated self-injurious behaviour, most commonly self-strangulation with make-shift ligatures.

During the 11.5 months in which she was incarcerated in the federal penitentiary system, Ashley Smith was transferred seventeen times between nine different institutions and across five provinces.

On October 19, 2007, correctional staff at the Grand Valley Institution for Women directly observed Ashley position herself between the wall and her bed and tightly tie a ligature around her neck. Approximately thirty minutes passed before correctional staff intervened, by which time Ashley had died.

The cause of death was asphyxiation from a ligature that Ms. Smith applied to her neck while confined within a segregation cell. A number of correctional officers were present at the time that Ms. Smith asphyxiated. These officers intentionally refrained from entering the cell to assist her.

Four of these officers were criminally charged with criminal negligence causing death and prosecuted by the Ontario Attorney General in the Ontario Court of Justice: Karen Eves, Valentino Burnett, Blaine Phibbs and Travis McDonald. On December 8, 2008, the accused were discharged at the preliminary inquiry after evidence emerged that the accused omitted to assist Ms. Smith in response to an order from management that, in the event that Ms. Smith applied a ligature to her neck, staff were to refrain from entering the cell to until such time as she stopped breathing. **The management staff who issued this order have not been charged or prosecuted.**

Ms. Smith's death, as well as the circumstances surrounding her incarceration for the preceding 11.5 months, has been subject to several reports and investigations. The Correctional Investigator, the independent oversight body responsible for the Correctional Service of Canada (CSC), issued a scathing report on June 20, 2008, ("A Preventable Death") outlining a litany of individual and systemic failures by prison authorities that culminated in Ms. Smith's death. The New Brunswick Ombudsman and Child and Youth Advocate also issued a report on Ms. Smith arising from her time in Provincial custody in New Brunswick. Ms. Smith's death is now the subject of an Ontario coroner's inquest, scheduled to commence in January, 2011.

The Joliette incident

As a result of a request by the Canadian Association of Elizabeth Fry Societies made under the *Privacy Act*, our clients have recently obtained a report commissioned by the Correctional Investigator pertaining to Ms. Smith's treatment at Joliette Institution several months before her death. The report (enclosed), prepared by Dr. Paul Beaudry, MD, FRCPC (Psychiatrist), makes a number of significant findings (which are referenced in accordance with the report's pagination), in relation to the events of July 22, 23 and 26, 2007:

- "A review of the video recordings of the incidents of July 22 and 23, 2007, helped determine that there was no medical condition affecting Ms. Smith's capacity to give free and informed consent and that there was no serious or imminent risk placing her life in danger [or] threatening her integrity or the integrity of others." (p.32)

- "It is therefore pertinent to question the information about Ms. Smith's status given to the psychiatrist by telephone, since this information was the basis for placing Ms. Smith in physical restraints and giving her several medications through injections, which were administered against her will, rather quickly at the beginning, and in large doses, even though this was not clinically warranted by Ms. Smith's status… The injection of four doses of antipsychotic medication over a period of two and a half hours is also disturbing. Usually injections of tranquilizers are prescribed to be given once on the hour except in cases of very severe agitation, which was certainly not the case here." (p.33-34)

- "During the incident of July 22, 2007, Ms. Smith was placed in restraints and received antipsychotic and anxiolytic medications involuntarily, although she did not pose a serious or imminent danger to her health." (p.34)

- "Throughout this entire incident [of July 23, 2007], and similarly during the incident of July 22, 2007, Ms. Smith understood the instructions she was given and never appeared to be hallucinating or delirious, or speaking incoherently, presenting signs of underlying psychotic or organic disorder that could have affected her capacity to make decisions…" (p.35)

- "The degree of agitation observed in the video recording during this incident [July 23] certainly does not meet the criteria of serious and imminent risk and did not warrant the use of physical restraints or the intramuscular administration of medication against her will." (p.35)

- "The incident of July 26 involves the fact that Ms. Smith was told that she did not have the choice to refuse the medication because it had been prescribed by the psychiatrist as being mandatory while in fact it seems that the psychiatrist had prescribed it on a PRN (as required) basis, to be given only if she was agitated before her departure and later during her transfer. Ms. Smith then agreed to take a medication that was not medically indicated because she was calm both when she woke up and at the time of departure." (p.35)

- "Furthermore, I feel that the act of using control measures such as physical and chemical restraints "because of her history", when the clinical situation did not warrant such an action does not seem to be medically indicated and leads us rather to the use of control measures for correctional purposes. It seems to me that the threatening tone used at times by the nursing staff during the incidents of July 22 reflect this attitude". (p.36)

- "From my observations, gathered from watching the video recordings of these three days, nothing indicates that Ms. Smith was incapable of giving her free and informed consent; also, her behaviour did not pose an imminent danger to her life, or a threat to her integrity or the integrity of others, as set out in article 13 of the *Civil Code of Quebec* to obviate the necessity for consent to care. Ms. Smith was therefore placed in restraints and received antipsychotic and anxioltyic medications that were not medically indicated during these events." (p.36-37)

In our view, these findings require that an investigation be conducted to determine whether there are reasonable grounds to believe that the involved nursing and correctional staff committed the offence (or offences) of assault contrary to section 265 of the *Code*. It is apparent from the report that the involved staff intentionally applied force in the form of intravenous injections of powerful antipsychotic and anxiolytic medications, without Ms. Smith's consent, and in the absence of any valid legal authority. Absent compelling evidence in support of a legal defence and/or justification, or any

suggestion that Dr. Beaudry's findings are inaccurate, the available evidence appears to support the existence of reasonable grounds with respect to assault.

Further, the application of physical restraints "without lawful authority", as described by Dr. Beaudry, would also support a charge of unlawful confinement contrary to section 279(2) (*R. v. Gratton*, (1985), 18 C.C.C. (3d) 462 (On C.A). Should reasonable grounds exist with respect to unlawful confinement, the administration of IV medication in the circumstances described by Dr. Beaudry may also support a charge (and/or charges) of administering a stupefying or overpowering drug, matter or thing for the purpose of committing an indictable offence (i.e. unlawful confinement) contrary to section 246(b) (*R. v. Bell*, [2007] O.J. No. 1725 (C.A)) of the *Code*. A charge of administering a noxious substance contrary to section 245 (*R. v. Clark*, [2008] A.J. No. 828 (C.A.)) should also be given consideration in view of the extremely large doses of IV medication administered without medical and/or legal justification.

The Grand Valley incident

We respectfully request that a criminal investigation be commenced into the conduct of the CSC management staff that made the order that officials refrain from entering Ms. Smith's cell to assist her in the event that she applied a ligature to her neck.

We enclose electronic copies of the entirety of evidence at the preliminary inquiry regarding the correctional officers who faced criminal charges arising from Ms. Smith's death for your review. In particular, we refer you to the following evidence from the preliminary inquiry:

- **Evidence of Laura Gratton (Security Intelligence Officer):**

(*R. v. Phibbs et al.*, Preliminary Inquiry, November 13, 2008 at p.103 l.23 – p.104 l.8)

Q: And was it a frequent direction to you [sp.] knowledge, to the Correctional officers, don't go in as long as she is breathing?

A: Yes.

Q: And that was a standard type of direction during Ashley Smith's second semester at GVI?

A: Yes.

Q: And that was a standard direction given by Correctional Managers to various shifts, dealing with Ashley Smith?

A: Yes.

Q: And where would the Correctional Managers have gotten that direction from?

A: They would have received it from their supervisor, being the Deputy Warden or Warden.

- **Evidence of Sherri Fairchild (Correctional Officer)**

(*R. v. Phibbs et al.*, Preliminary Inquiry, November 26, 2008 at p.67 l.8 – p.68 l.2)

Q: Okay, you've also been given direction that you've told us about; don't go in if she's breathing?

A: Correct.

Q: What did you – let's start with this. What did you take that direction to mean; don't go in if she's breathing?

A: Exactly what it was. Don't go in as long as she was breathing.

Q: Well, if somebody's not breathing, what does that mean?

A: Pardon me?

Q: If somebody's not breathing, what does that mean?

A: It probably means that they're not breathing.

Q: Okay. In your mind, does that mean that perhaps they're dead?

A: No.

Q: So you can be not breathing and still alive? Clearly the, the don't go in if she's breathing can't mean go – wait until she's dead, correct? Would you agree with me?

A: You know what? The direction at GVI was absolutely disgusting. What was going on there was disgusting. I didn't agree with any of it from the very beginning and nobody did. Everybody screamed. Everybody did everything they could. Nobody agreed with this.

- **Evidence of Melissa Mueller (Correctional Officer)**

(*R. v. Phibbs et al.*, Preliminary Inquiry, November 27, 2008 at p.38 l.5 - p.39 l.26)

Q: With all that was going on at GVI with regard to Ashley Smith, did you ever have discussions with Mr. Phibbs about the preservation of life – specifically Ashley Smith's life?

A: Did we worry about Ashley? Yes. Did we express our views to managers? Yes.

Q: And during that time period, what are you being told?

A: That we were not supposed to go in; that the use of force was too high; we had too many incidents of use of force.

Q: Was that always the way it was with Ashley? In other words…

A: I don't remember much from the first time she was with us but the second time, yes. Our numbers were too high.

Q: And who did you hear that from?

A: I heard it from Michelle Brigden; I believe I heard it from Eric Broadbent; I heard it from Ken Allan when he came down; I believe I heard it from Cindy Berry on a Sunday when she came to the unit. It was pretty well known that we were very high with our numbers of the use of force.

Q: Okay. And was that a source of frustration for you as a frontline officer?

A: Yes.

Q: A source of frustration for you and your fellow officers?

A: Yes.

Q: Would you and your fellow officers talk about that and the direction that was being given?

A: Yes.

Q: What was the direction that you were being given? What were you told with regard to going into Ashley Smith's cell?

A: I was told by one manager that I was not to enter the cell; that I was there to observe her; it was going to test me but I needed to stay strong and just watch. I was told by another manager that I would not be entering the cell; at one point he actually stopped us from entering the cell.

Q: And before you…

A: Yes.

Q: … the first manager …

A: Michelle Brigden.

Q: And the second was?

A: Eric Broadbent.

Q: Thank you.

A: And then there was a Sunday morning when Cindy Berry came into the unit and she told us that Ashley was playing a game with us; that we needed to stop going in there; enough was enough. So, I mean, she was the warden.

Q: Were you given any special instruction as to when you should or shouldn't go in?

A: We were told to – we were not to go in the cell as long as she was breathing.

The evidence highlighted above (along with the balance of the evidence at the preliminary inquiry) speaks for itself with respect to possible criminal liability on the part of those managers that gave the impugned direction. Issuing a direction that correctional staff refrain from intervening to prevent a severely mentally ill inmate to asphyxiate herself with a ligature to the point that she stops breathing, represents a marked departure from what is expected of a reasonable person in the circumstances. As

such, the evidence from the preliminary inquiry constitutes reasonable grounds to believe that the offence of criminal negligence causing death contrary to section 219 (*R. v. Tutton*, [1989] 1 S.C.R. 1392) of the *Code*. Consideration should also be given to whether there are reasonable grounds to believe that such conduct would also amount to impeding an attempt to save life contrary to section 262 of the *Code*.

It is in the public interest that the RCMP investigate

We respectfully submit that it is in the public interest that the RCMP to investigate this matter, and that the RCMP is the only policing agency with the necessary national scope to conduct an investigation of this nature. We say this for the following reasons:

- The investigation will be required to canvass evidence and information from several provinces in view of Ms. Smith's repeated (and inappropriate) transfers amongst several federal correctional facilities. In order to determine whether the alleged perpetrators had the necessary *mens rea* to commit the enumerated criminal offences, as well as to understand Ms. Smith's state of mind at the relevant times, it will be essential for the investigation to consider the events at Joliette and Grand Valley in the context of Ms. Smith's treatment throughout her incarceration i.e. while she was in custody in New Brunswick, Quebec, and Ontario. The RCMP is the only policing agency with the necessary national scope to comprehensively investigate this course of conduct on the part of CSC officials.

- The conduct that is the subject of this investigation arises entirely in the context of federal correctional facilities, and was committed exclusively by federal government officials.

- CSC officials were involved in actively concealing the misconduct that is the subject of this investigation. For example, Ms. Gratton misled the police investigation of the correctional staff at Grand Valley Institution by denying to investigators that a direction that officers were to refrain from entering Ms. Smith's cell unless she stopped breathing existed. An internal CSC Board of Inquiry into the events at Joliette Institution was found by the Correctional Investigator to be "dismissive and deficient".

- It is apparent that the RCMP has jurisdiction to investigate these allegations by virtue of section 9 of the *Royal Canadian Mounted Police Act*, R.S., c. R-9.

Please feel free to contact the undersigned should you have any questions or require further information. Your prompt attention to this matter would be greatly appreciated.

Yours very truly,
FALCONER CHARNEY LLP

Julian N. Falconer

Encl (sent by mail).

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