Office of the Chief Coroner
25 Morton Shulman Avenue
Toronto ON. M3M OB1

Bureau du Coroner en Chef
25 Avenue Morton Shulman
Toronto ON. M3M OB1

April 15, 2014

Mr. Julian Roy
Falconer Charney LLP
Barristers
8 Prince Arthur Avenue
Toronto ON M5R 1A9

Dear Mr. Roy:

Re: Inquest into the death of Ashley Smith.
Deceased October 19, 2007. Our file Q2013-32.

Please find enclosed, a copy of the verdict of the coroner's jury and the coroner's verdict explanation from the inquest into the death of Ashley Smith. We are also attaching, for your information, a list of the recipients that have been asked to respond to the recommendations.

As you represented a party with standing, the above material is being sent to you for your information.

Sincerely,

Dirk Huyer, MD
Chief Coroner for Ontario

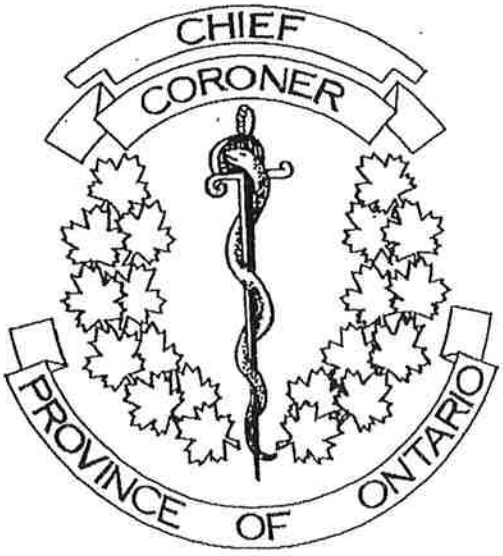
DH/pc
Encl.

File – Q2013-32
For implementation:

Don Head
Commissioner
Correctional Service Canada
340 Laurier Avenue West
Ottawa ON K1A OP9
(Recommendations – 1 to 99, 102 to 104)

The Honourable Steven Blaney
Minister of Public Safety
House of Commons
Ottawa ON K1A OA6
(Recommendation – 100)

Mr. Michael Ferguson
Auditor General of Canada
240 Sparks Street
Ottawa ON K1A OG6
(Recommendation – 101)



INQUEST

TOUCHING THE DEATH OF

Ashley Smith

JURY VERDICT AND RECOMMENDATIONS

December 2013

Office of the
Chief Coroner
Bureau du
coroner en chef

Verdict of Coroner's Jury
Verdict du jury du coroner

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

We the undersigned / Nous soussignés,

_____ of / de
_____ of / de
_____ of / de
_____ of / de
_____ of / de

the jury serving on the inquest into the death(s) of / membres dûment assermentés du jury à l'enquête sur le décès de :

Surname / Nom de famile	Given Names / Prénoms
Smith	Ashley

aged / à l'âge de 19 held at / tenue à Coroner's Court Toronto, Ontario

from the / du September 20, 2012 to the / au December 19 20 2013

By / Par Dr. / Dr John Carlisle Coroner for Ontario / coroner pour l'Ontario

having been duly sworn/affirmed, have inquired into and determined the following:
avons fait enquête dans l'affaire et avons conclu ce qui suit :

Name of Deceased / Nom du défunt
Ashley Smith

Date and Time of Death / Date et heure du décès
October 19, 2007 at 8:10 a.m.

Place of Death / Lieu du décès
St. Mary's General Hospital in Kitchener

Cause of Death / Cause du décès
Ligature strangulation and positional asphyxia.

By what means / Circonstances du décès
Homicide

The verdict was received on the / Ce verdict a été reçu le 19th (Day / Jour) day of / December (Month / Mois) 20 13

Coroner's Name (Please print) / Nom du coroner (en lettres moulées)	Date Signed (yyyy/mm/dd) / Date de la signature (aaaa/mm/dd)
Dr. John Carlisle	2013/12/19

Coroner's Signature / Signature du coroner

We, the jury, wish to make the following recommendations: (see page 2)
Nous, membres du jury, formulons les recommandations suivantes :

Office of the
Chief Coroner
Bureau du
coroner en chef

Verdict of Coroner's Jury
Verdict du jury du coroner

The *Coroners Act* – Province of Ontario
Loi sur les coroners – Province de l'Ontario

Inquest into the death of:
Enquête sur le décès de :

Ashley Smith

JURY RECOMMENDATIONS
RECOMMANDATIONS DU JURY

THE ASHLEY SMITH CASE STUDY

WE RECOMMEND:

1. That Ashley Smith's experience within the correctional system is taught as a case study to all Correctional Service of Canada management and staff at the institutional, regional and national levels. This case study can demonstrate how the correctional system and federal/provincial health care can collectively fail to provide an identified mentally ill, high risk, high needs inmate with the appropriate care, treatment and support. This case study can also demonstrate the lack of communication, cohesiveness, and accountability of a large organization such as Correctional Service of Canada.

2. That the Ashley Smith case study be designed for all existing and future CSC management and staff, offering a comprehensive understanding and gaps analysis of the practices that occurred leading to this case. This case study will include documents and evidence presented throughout the Ashley Smith Coroner's Inquest, specifically:

- The Jury's Recommendations, December 2013;
- Report to Coroner Investigating the Death of Ashley Smith at Grand Valley Institution for Women (GVI), October 11, 2013, University of Toronto, Professor Kelly Hannah-Moffat (Exhibit 206);
- A Preventable Death, June 20, 2008, Correctional Investigator of Canada (pages 1-30) (Exhibit 22); and
- The Ashley Smith Report, June 2008, Ombudsman and Child and Youth Advocate (excerpts) (Exhibit 6).

THE PROVISION OF MENTAL HEALTH CARE TO FEDERALLY SENTENCED WOMEN

A. WITHIN PENITENTIARIES

WE RECOMMEND:

3. That, within 72 hours of admission to any penitentiary or treatment facility, all female inmates will be assessed by a psychologist to determine whether any mental health issues and/or self-injurious behaviours exist.

a) That, should an inmate be identified as having high needs mental health issues and/or self-injurious behaviours, the Chief of Psychology will notify the Institutional Head, Rights Advisor and Inmate Advocate (RA-IA)*, Women Offender Sector, and the Regional Complex Mental Health Committee in writing within 48 hours of assessment.

b) That this process of assessment will continue to be conducted on an on-going basis and as required by the inmate.

c) That the Chief of Psychology implements a plan of effective treatment strategy which will be documented and shared as required.

*The role of the RA-IA is defined in Recommendations #73-75.

4. That a full range of effective therapeutic interventions are:

a) individualized to the needs of female inmates considering her self-identified needs, regardless of their security classification, status, or placement;

b) enhanced to include de-escalation training, and art, music, or pet therapy;

c) trauma-, age-, and gender-informed, and developmentally appropriate; and

d) determined and authorized by mental health staff.

5. That Correctional Service of Canada (CSC) create a permanent peer support program, with highly trained and qualified peer support workers in each of the women's penitentiaries that:

(a) is available to all women, including segregated women and regardless of security status, upon their request, 24 hours a day;

(b) provides training and on-going support for the peers by women-centred psychologists and social workers;

(c) ensures confidentiality between the female inmate and the peer to the greatest extent possible;

(d) can be utilized during an incident of self-injurious behaviour, if requested; and

(e) is offered to women actively engaged in self-injurious behaviour or at risk of engaging in self-injurious behaviour as a therapeutic intervention.

6. That CSC ensure nursing services are present on-site for inmates on a 24 hour per day, 7 day per week basis, as well as available to staff for consultation.

7. That CSC access community mental health services by developing partnerships with external mental health experts.

8. That there be adequate staffing of qualified, mental health care providers with expertise and experience in treating a population with mental health issues, self-injurious behaviours, suicidality, and trauma, at every women's institution to provide services and supports to female inmates. These providers will include:

(a) Psychiatrists;

(b) Psychiatric Nurses or Nurses;

(c) The Chief Psychologist*;

(d) Psychologists;

(e) Social Workers;

(f) Behavioural Counsellors** and/or Recreational Counsellors;

(g) General Practitioners; and

(h) Other professional service providers, as required.

*It is further recommended that, whether working in the position indeterminately or in an acting capacity, the Chief Psychologist must hold a Ph.D. in Clinical Psychology and be a member in good standing of the Ontario College of Psychologists (or provincial equivalent).

**It is further recommended that behavioural counsellors have qualifications to counsel in behaviour. Otherwise, it is recommended that the title of Behavioural Counsellor is amended to Behavioural Therapy Coordinator.

9. That CSC expand the scope and terms of psychiatrists' contracts to enable them to fulfill their duties in a meaningful way.

10. That all staff providing mental health care will report to, and be accountable to, health care, not security, and that the therapeutic relationship should not be compromised by the assignment of security-focused assessments.

11. That CSC organize and fund secondments for nursing staff to psychiatric wards of local Schedule 1 hospitals, or other specialized mental health institutions. These secondments are to be of sufficient length and completed with regularity. This will ensure the continual improvement of their knowledge and skills in the provision of mental health care, services and supports to female inmates, and their knowledge of

generally.

12. That the decision to disclose information to security by a mental health care provider should be governed by the applicable legislation, and professional and ethical standards, bearing in mind that reporting may affect the therapeutic relationship. The decision to disclose must also take into account the paramount duty of CSC to ensure the safety of the inmate. Service providers should be encouraged to consult with their professional governing bodies or colleagues when determining the necessity of disclosure.

13. That CSC create an institutional social worker position or positions whose responsibility will include working in consultation with local Canadian Association of Elizabeth Fry Societies (CAEFS), and other community groups, to identify, coordinate and access available community services, including mental health services and supports. The mandate of this position would include the dissemination of information regarding the availability of, and assistance with connecting to, such services and supports to female inmates and to staff (including contract-based clinicians).

14. That CSC be required to provide all contract physicians with copies of Commissioner's Directives, including revisions to Commissioner's Directives, that govern their practice within the penitentiary.

B. ALTERNATIVES TO PENITENTIARY

WE RECOMMEND:

15. That female inmates with serious mental health issues and/or self-injurious behaviours serve their federal terms of imprisonment in a federally-operated treatment facility, not a security-focussed, prison-like environment.

16. That female inmates who have been identified as having serious mental health issues and/or self-injurious behaviours be promptly transferred to such a facility as soon as reasonably practicable.

17. That such a facility or facilities be made available at least on a regional basis, and particularly in Ontario. It is urged that more than one federally-operated treatment facility is available for high risk, high needs women in the event that a major conflict occurs between the inmate and staff. Furthermore, and specifically, that existing male federally-operated treatment facilities be adapted to accommodate a wing for female inmates.

18. That CSC negotiate arrangements with provincial health care facilities to provide long-term treatment to female inmates who chronically engage in self-injurious behaviour or display other serious mental health problems. Further:

a) that the Government of Canada sufficiently and sustainably funds the CSC to enter into such agreements;

b) that this will include any and all capital and operating costs associated with the establishment of such facilities, and that the accommodation and treatment of female inmates therein will be the responsibility of CSC;

c) that the focus of such a facility be on the preparation for treatment of, and treatment of, the inmate; and

d) that a female inmate with mental health issues and/or self-injurious behaviour who is not consenting, and/or withdraws consent, to treatment remain in a pre-contemplative therapeutic environment for the purpose of allowing health care professionals to seek her consent to treatment.

19. That decision-making with respect to the clinical management and interventions of inmates with mental health issues are made by clinicians in consultation with the inmate, rather than by security management and staff.

20. That a treatment facility has the capacity to be designated as the home facility of a female inmate serving her sentence therein.

21. That such a facility in Ontario, or a part thereof, be designated as a Schedule 1 facility under the Ontario Mental Health Act.

22. That inmates in such facilities must have access to an independent patient advocate system, equivalent to the advocacy system to be provided to inmates in penitentiaries, pursuant to these recommendations, including the newly adopted RA-IA (see Recommendations #73-75).

MANAGEMENT OF COMPLEX HIGH NEEDS FEMALE INMATES

WE RECOMMEND:

23. That a Treatment Team is created at the institutional level to support high needs female inmates with a consistent and dedicated team of qualified health professionals, which will include [illegible]

general practitioners, and that such a team:

(a) meet during the psychiatrist's regular visits at the institution in order to provide on-going, timely, and regular care to inmates;

(b) support the inmate regardless of her security classification, status, or placement within the institution;

(c) seek input from the inmate about the efficacy of her therapeutic relationships and interventions on an on-going basis;

(d) seek input from frontline staff assigned to support the inmate with mental health care needs; and

(e) develop management plans for the purposes of therapeutic intervention and preventative measures. This plan will take into account the inmate's past experiences of trauma, and the potentially traumatic effects of being incarcerated, segregated and/or restrained, and further, that such management plans are developmentally-appropriate, and age- and gender-informed.

24. That the selection of the frontline staff assigned to a female inmate will consider:

(a) the skill and interest of the frontline staff;

(b) the wishes of the inmate; and

(c) input from the Treatment Team.

25. That CSC maintain a roster of external psychologists and psychiatrists to provide a second opinion regarding treatment, services and/or recommendations when challenging behaviours are identified.

26. That an external and independent review be conducted of the Regional and National Complex Mental Health Committees to determine their efficacy, and identify opportunities for improvements.

SEGREGATION AND SECLUSION

WE RECOMMEND:

27. That, in accordance with the Recommendations of the United Nations Special Rapporteur's 2011 Interim Report on Solitary Confinement, indefinite solitary confinement should be abolished.

28. That there should be an absolute prohibition on the practice of placing female inmates in conditions of long-term segregation, clinical seclusion, isolation, or observation. Long-term should be defined as any period in excess of 15 days.

29. That until segregation and seclusion is abolished in all CSC-operated penitentiaries and treatment facilities:

a) CSC restricts the use of segregation and seclusion to fifteen (15) consecutive days, that is, no more than 360 hours, in an uninterrupted period;

b) That a mandatory period outside of segregation or seclusion of five (5) consecutive days, that is, no less than 120 consecutive hours, be in effect after any period of segregation or seclusion;

c) That an inmate may not be placed into segregation or seclusion for more than 60 days in a calendar year; and

d) That, in the event an inmate is transferred to an alternative institution or treatment facility, the calculation of consecutive days continues and does not constitute a "break" from segregation or seclusion.

30. That conditions of segregation be the least restrictive as possible for inmates and determined on a case by case basis – female inmates in segregation should, as much as possible, have access to programs, activities, and facilities and have contact with other inmates, staff, visitors, and non-governmental organizations, such as CAEFS.

31. That, as a mandatory duty, the Institutional Head will visit all inmates in segregation, seclusion, or medical observation at least once every day, in addition to meeting with individual inmates upon their request. This meeting is not to be accomplished through the food slot under any circumstance, and:

(a) that, on days when the Institutional Head is away, the visit will be conducted by the highest authority and

(b) that any such authority must report in writing to the Institutional Head the findings and outcomes of such visits.

32. That, as a mandatory duty, a mental health professional will visit all inmates in segregation, seclusion, or medical observation at least once every day, in addition to meeting with individual inmates upon their request. This visit will pay particular attention to both the mental and physical health of such inmates, with a focus on assessing the inmate's tolerance to segregation. This meeting is not to be accomplished through the food slot under any circumstance.

33. That a sub-roster team of frontline staff is dedicated to complex high needs female inmates in the segregation unit, with a minimum of one (1) to two (2) consistent staff at all times. Such a team will ensure comprehensive and consistent support for the inmate.

34. That CSC repeal its existing Review of Offender's Segregated Status Working Day Review policies and replace them with five (5) and ten (10) day reviews that are administered by way of consecutive calendar days. This review will focus on the inmate's needs and behaviours with the goal of returning the inmate to the general population.

35. That CSC amend its current policies to ensure that female inmates held in "seclusion" or "mental health observation" are recognized as being on "segregation status" and are therefore entitled to all relevant reviews.

36. That CSC make every effort to ensure that female inmates, including those in segregation or observation cells, have access to, and the opportunity to meet in private with, the RA-IA, Office of the Correctional Investigator, Citizens Advisory Committee, non-governmental organizations and community agencies.

37. That, for the purposes of monitoring and tracking, the Institutional Head will notify the following bodies once any inmate has been placed in segregation or seclusion, and that they will also be responsible for conducting a yearly review.

(a) Women Offender Sector;

(b) Mental Health Services Branch;

(c) Office of the Correctional Investigator;

(d) RHQ – Members of the Regional Complex Mental Health Committee; and

(e) NHQ – Members of the National Complex Mental Health Committee.

RESTRAINTS (PHYSICAL AND/OR CHEMICAL)

WE RECOMMEND:

38. That, in the development of any new policy on the use of restraints, CSC move toward a restraint-free environment by implementing a least restraint policy, and that this recommendation is reflected in CD 843.

39. That the application of restraints must be authorized by a psychiatrist or psychologist, and that this recommendation is reflected in CD 843.

40. That any inmate placed in restraints is given one-on-one therapeutic support for the entire time in restraints, and that this recommendation is reflected in CD 843.

BODY CAVITY SEARCHES

WE RECOMMEND:

41. That body cavity searches for female inmates may only occur in the following circumstances:

a) with the consent of the inmate; or

b) in the absence of consent, only in exceptional circumstances. For greater clarity, exceptional circumstances will only exist when, in the opinion of a physician, there is a risk of death or serious bodily harm to the inmate or another person and the risk cannot be mitigated through any other reasonably available means.

All examinations are to be performed by a licensed medical professional at an external medical facility, in a manner

the external facility is to request that the examination be conducted by a female.

42. That, for the purposes of continuity of care, the institutional psychologist is notified within 24 hours of any body cavity search conducted on a female inmate, including those in treatment facilities.

SELF-INJURIOUS BEHAVIOURS

A. REPORTING OF INCIDENTS

WE RECOMMEND:

43. That all incidents of self-injurious behaviour must be reported as such.

44. That all reports regarding incidents of self-injurious behaviour, incident reports and Officer Statement Observation Reports, must contain a detailed description of the nature of the self-injurious behaviour and a detailed description of any physical injury or changes in physical well-being of the inmate.

45. That all reports regarding incidents of self-injurious behaviour must be forthwith distributed to, and read by the following:

(a) The Warden;

(b) The Chief of Healthcare;

(c) The Chief Psychologist;

(d) Women Offender Sector (for female inmates);

(e) Office of the Correctional Investigator;

(f) RHQ – Members of the Regional Complex Mental Health Committee;

(g) NHQ – Members of the National Complex Mental Health Committee; and

(h) For additional clarity, the duty to read such reports is not delegable, except in circumstances when the responsible officer is on leave, and even then, the responsible officer is to read such reports forthwith upon return to the institution.

46. That following each incident of self-injurious behaviour a Referral for Consultation Form be completed by nursing staff and a copy of the psychology assessment in relation to the incident be appended to this form and this package be forwarded to the institutional psychiatrist. The Chief of Healthcare will be responsible for ensuring this package is also provided to the institutional physician.

B. RESPONSES TO INCIDENTS

WE RECOMMEND:

47. That if frontline staff determine that immediate intervention is required to preserve life, there is no requirement that they seek authorization prior to intervening, or prior to calling 911.

48. That, when an inmate is engaged in self-injurious behaviours, health care staff are on-site, on a 24 hour per day, 7 day per week basis, to support the intervention.

49. That, when an inmate is engaged in self-injurious behaviours, the institutional psychologist are on-call, on a 24 hour per day, 7 day per week basis, for the purposes of supporting the intervention and de-escalating the incident when deemed necessary by frontline staff.

50. That CSC develop a new, separate and distinct model, from the existing Situation Management Model, to address medical emergencies and incidents of self-injurious behaviour.

51. That the Situation Management Model not be resorted to in any perceived medical emergency.

52. That, when reporting a Use of Force intervention to preserve the life of an inmate who has self-harmed, an expedited reporting system will apply. Further, all such incidents should be reviewed, within 48 hours, by:

(a) The Warden;

(b) The Chief of Healthcare;

(c) The Chief Psychologist;

(d) Women Offender Sector (for female inmates);

(e) Office of the Correctional Investigator;

(f) RHQ – Members of the Regional Complex Mental Health Committee; and

(g) NHQ – Members of the National Complex Mental Health Committee.

The review will focus on the mental health needs of the inmate, her behaviour and its lethality, as well as the response of frontline staff, including its appropriateness. It will assist and support the well-being of the inmate, in addition to the efforts of the institution and frontline staff. It will also include strategies to manage the inmate in a safe manner, and encourage staff to exercise good judgment.

53. That CSC policy state that any item used by an inmate for self-injury be classified as contraband.

54. That any inmate engaged in self-injurious behaviour must have a Management Plan in place within 24 hours of the first self-injurious incident, and that plan must address how staff is to respond to self-injurious behaviours.

RESPONSES TO MISCONDUCT BY INMATES WITH MENTAL HEALTH ISSUES

WE RECOMMEND:

55. That, to reduce institutional or criminal charges laid against an inmate, CSC adopts the methods of the St. Lawrence Valley Correctional and Treatment Centre model of care for disruptive or self-injurious behaviours symptomatic of a mental health disorder.

56. That, if a complaint is made to police in regard to alleged misconduct by an inmate with mental health issues, (occurring in the context of an incident of self-injurious behaviour), the Security Intelligence Officer will provide police with complete information. This will include the:

(a) behaviour that is alleged to amount to a criminal offence;

(b) context in which that behaviour occurred; and

(c) circumstances of the incident of self-injurious behaviour.

57. That, if a criminal charge is laid in regard to alleged misconduct by an inmate with mental health issues, (occurring in the context of an incident of self-injurious behaviour), a staff member who was not involved in the incident, and is selected with input from the inmate (preferably a member of her interdisciplinary team), will:

(a) attend any court appearances with the inmate;

(b) advise the prosecutor of his/her presence; and

(c) provide any information that is required by the court to deal appropriately with the charge.

TRANSFERS / ASSIGNMENTS OF HOME INSTITUTIONS

WE RECOMMEND:

58. That female inmates be accommodated in the region most proximate to her family and social supports. This principle is a priority for young adults and/or female inmates with mental health issues and/or self-injurious behaviours.

59. That non-emergency transfers of female inmates with mental health issues and/or self-injurious behaviours will occur only when it is aligned with the clinical needs of the inmate. Non-emergency transfers of female inmates with mental health issues and/or self-injurious behaviours will not occur for reasons related to constraints within the institution, or challenges related to the management of the inmate.

60. That subject to the above, a female inmate may be transferred to an institution or treatment facility so long as that transfer has the approval of clinicians (psychiatrist and/or psychologist) in the sending and receiving institutions. Prior to her discharge a current written plan must be in place for re-integrating the inmate to her home institution.

61. That, in the event a female inmate is transferred away from her home institution, the following measures will address the disadvantages that result from being detained in a location away from home. Such measures may include, but are not limited to:

(a) longer visits from family or support persons chosen by the inmate;

(b) increasing the inmate's access to family or support persons via telephone, videoconference, and/or web-cast, e.g. Skype or Facetime; and

(c) providing the inmate's family or support persons with appropriate access to telephone, videoconference and/or web-cast, when they are unable to visit the inmate due to financial restrictions.

62. That, in the event of a transfer, an inmate's/patient's medical file accompanies her during the transfer to ensure continuity of care.

63. That the receiving Treatment Team will connect with the sending institution's Treatment Team to share best practices, success stories, triggers, and recommendations.

64. That CSC create and implement an electronic medical database to facilitate access to medical information between sending and receiving penitentiaries and treatment facilities.

65. That no transfer occurs on a Friday or holiday given the reduced number of on-site staff at these times.

TRANSITION PROTOCOL FOR YOUNG ADULTS

WE RECOMMEND:

66. That CSC establish separate and distinct programs and services for young adults, that is, 18-21 year olds, within adult institutions which will be geared toward their cultural and developmental needs (e.g. educational, vocational, therapeutic, as appropriate to specific needs and situations).

67. That CSC develop training to prepare staff to recognize and respond to the particular issues faced by a young adults housed in an adult institution.

68. That CSC develop a transition protocol that begins before a young adult is placed in, or transferred to, an adult institution, and which has the following features:

(a) provides clear and structured process for transition which is understood by incarcerated young adults and institutional management and staff;

(b) provides guidance on roles and responsibilities for those involved in the transition process;

(c) provides guidance on identifying needs and sharing information during the transition process; and

(d) helps build relationships between young offender and adult institution in order to support continuation of care.

CONTACT WITH FAMILY FOR YOUNG ADULTS

WE RECOMMEND:

69. That CSC facilitate, support, and document, at minimum, weekly communications by:

(a) increasing the inmate's access to family or support persons via telephone, videoconference, and/or web-cast, e.g. Skype or Facetime; and

(b) providing the inmate's family or support persons with appropriate access to telephone, videoconference and/or web-cast, when they are unable to visit the inmate due to financial restrictions.

70. That CSC streamline the approval process for visits and contact with families and support persons of young

adults. In particular, it will be conducted at a national level such that their families and support persons are not subjected to a repeated approval process at each institution.

71. That health care professionals advise young adults of the benefits of providing consent to disclose health information to their families or support persons.

72. That, at an institutional level, young adults are consulted on an on-going basis to determine if their needs for particular activities and programs are being met.

OVERSIGHT

A. INTERNAL MECHANISMS

WE RECOMMEND:

73. That CSC implement an independent RA-IA for all inmates, regardless of security classification, status, or placement. The institution will be responsible for advising all inmates of the existence of, and their right to contact, the RA-IA.

74. That the RA-IA will be responsible for providing advice, advocacy and support to the inmate with respect to various institutional issues, including:

a) Transition into institutions;

b) Transfers;

c) Security classification, status, or placement;

d) Parole and release eligibility, including escorted and unescorted absences;

e) Temporary absences;

f) Use of restraints – physical and chemical;

g) Seclusion and segregation;

h) Complaints and grievances;

i) Consent to treatment and capacity to consent;

j) Consent to medication, including available alternatives;

k) Consent to disclosure of information; and

l) Institutional and criminal charges.

75. That inmates are protected from reprisals related to contacting the RA-IA and exercising their rights.

B. EXTERNAL MECHANISMS

WE RECOMMEND:

76. That the Citizen Advisory Committee have unrestricted and unannounced access to local CSC-operated institutions at any time and be provided with the opportunity to speak with any female inmate, including those in segregation. These discussions will take place in private, out of hearing of staff.

77. That Citizen Advisory Committees are required to publish annual reports, and that CSC facilitate the publication of these reports on their website.

78. That non-governmental organizations, including CAEFS advocates, have broad access to local CSC-operated institutions at any time and be provided with the opportunity to speak with any female inmate, including those in segregation. These discussions will take place in private, out of hearing of staff.

SAFETY AND SECURITY

WE RECOMMEND:

79. That CSC improve the layout of the electronic control panel that opens pod and segregation doors to minimize human error. Specifically, do not have segregation buttons directly beside pod buttons.

ETHICS / WHISTLEBLOWER PROTECTION

WE RECOMMEND:

80. That an enhanced Code of Ethics be created that explicitly applies to all Correctional Service of Canada employees, from the Commissioner down to frontline staff, and that this enhanced Code will:

a) address preservation of life;

b) include provisions with the following language: "staff should be allowed to refuse to follow orders or directions without fear of discipline or reprisal whether they are right or wrong as long as there was an air of reality to the ethical/legal objection";

c) include a provision that affirms the right of all CSC staff members to report an order they believe to be illegal without fear of reprisal;

d) include a provision that addresses the individual accountability of all CSC staff and management, for example:

i. "Prison staff at all levels shall be personally responsible for, and assume the consequences of, their own actions, omissions or orders to subordinates"; and

e) include a provision that addresses the obligation of all CSC staff to respect and protect everyone's right to life, the obligation to ensure the full protection of the health of persons in their custody and the obligation to secure immediate medical attention whenever required.

81. That this enhanced Code of Ethics be taught in CORE and management training. Additionally, refresher courses will be conducted at the institutional level for all CSC staff, contract and otherwise.

82. That all management are responsible, and held accountable, for ensuring that this enhanced Code of Ethics is communicated to their staff.

POLICY DEVELOPMENT

WE RECOMMEND:

83. That inmates who have experienced mental health issues within correctional systems be involved in planning, research, training and policy development with respect to the provision of mental health care for female inmates.

84. That CSC repeal the section dealing with "Involuntary Admission and Treatment" in CD 803, or revise it to conform with community medical practices to ensure equivalency of care for inmates. Specifically, that CSC revise or repeal the requirements that:

a) a physician must assess a patient in-person before providing orders for involuntary medical treatment; and

b) all orders for involuntary health interventions be made in writing.

85. That CSC establish separate and distinct policies for young adults, that is, 18-21 year olds, within adult institutions which will be geared toward their cultural and developmental needs (e.g. educational, vocational, therapeutic, as appropriate to specific needs and situations).

STAFF BURNOUT

WE RECOMMEND:

86. That, upon recognizing burnout in themselves, staff are responsible for raising their concerns to management, and further, that management is responsible for acting upon these concerns and facilitating support.

87. That, to alleviate pressures and avoid staff burnout, the Institutional Head implements mandatory regularly scheduled respite intervals to frontline staff who primarily deal with complex high needs inmates.

TRAINING AND EDUCATION

WE RECOMMEND:

88. That CSC develop training to prepare staff to recognize and respond to the particular issues faced by a young adults housed in an adult penitentiary.

89. That managers and frontline staff who are designated to support high needs female inmates with mental health and/or self-injurious behaviours be offered training in the following areas:

a) fundamentals of mental health issues and self-injurious behaviours;

b) First Aid / CPR (current certifications based on community standards);

c) impacts of segregation on mental health, including that of young adults;

d) trauma-informed care (e.g. post-hostage-taking); and

e) medical distress and its intervention (delivered by an external clinician).

90. That all newly appointed Wardens and Deputy Wardens (whether the positions be on an acting or indeterminate capacity) have weekly mentoring sessions with an experienced mentor. These mentoring sessions will take place for at least one full year to provide the mentee with guidance, advice, and support throughout their first year in their newly appointed position. Ideally, the mentor is located in a region different from the mentee.

91. That CSC provide training and education to staff on restraint minimization and de-escalation techniques, and that any such training includes hearing from persons with lived experience who have directly experienced being placed in restraints.

92. That CSC provide all management and staff with essential refresher training to ensure they maintain the appropriate knowledge and skillsets to fulfill their roles and responsibilities.

AUTHORITY OF THE DEPUTY COMMISSIONER FOR WOMEN

WE RECOMMEND:

93. That the Deputy Commissioner for Women has direct line authority over all matters relating to female inmates. This gives clear authority and accountability to a single body that provides specialized correctional services to female inmates.

94. That the female inmates' institutions be grouped under a reporting structure independent of the Regions.

95. That, in the formation of this new reporting structure, careful consideration is given to the assignment of new positions specifically so that current employee's qualifications, skill sets and competencies are considered for best fit into the newly formed positions.

RESEARCH AND KNOWLEDGE TRANSFER

WE RECOMMEND:

96. That CSC foster working relationships with qualified mental health professionals from academic health sciences organizations (e.g. Centre for Addiction and Mental Health) and research universities. These partnerships will focus on developing treatment strategies and therapeutic practices, as supported by current literature of evidence of effectiveness, specifically for women with mental health illnesses including those engaging in self-injurious behaviour and those in segregation.

97. That CSC revitalize and continue with the research on the emergence of the third group of women who do not respond to psychotherapy or dialectical behavioural therapy.

98. That CSC implement communication structures between units conducting research at National Headquarters (e.g. Research Unit and Women Offender Sector) and local institutions to effectively disseminate information to staff

with health care, mental health staff and senior management.

99. That CSC implement ongoing, internal communication structures between frontline, mental health, and health care staff as well as senior management, to effectively disseminate information. Health care and mental health staff will allocate time to meet and discuss relevant literature, complex cases and effective therapeutic interventions with frontline staff and senior management.

ACCOUNTABILITY

WE RECOMMEND:

100. That an independent, external audit be contracted by the Minister of Public Safety of CSC's compliance with this jury's recommendations. This audit will be conducted in consultation with the Office of the Correctional Investigator, and the results of such audit will be released publicly during the 2016-2017 and 2023-2024 fiscal years.

101. That the Auditor General of Canada conduct a comprehensive audit of the jury's recommendations and that the results of such audit be released publicly in 2019-2020.

VERDICT AND RECOMMENDATIONS

WE RECOMMEND:

102. That this jury's verdict and recommendations regarding the Inquest into the Death of Ashley Smith is posted in writing in every institution and treatment facility operated by the Correctional Service of Canada, in a place accessible to all staff, within thirty (30) days of the receipt of the verdict and recommendations.

103. That an electronic copy of this jury's verdicts and recommendations is made available for the public on the CSC website, for staff's reference on the CSC intranet, and that staff are immediately made aware by management.

104. That the Office of the Correctional Investigator monitor and report publicly, and in writing, on the implementation of the recommendations made by this jury annually for the next 10 years.

Verdict Explanation
Inquest into the Death of
Ashley Smith

Evidence and Argument Heard
January 14, 2013 – December 19, 2013
Coroners Courts, Toronto

Opening comment:

I intend to give a brief synopsis of issues presented at this inquest. I would like to stress that much of this explanation will be my interpretation of both the evidence presented and of the jury's reasoning in making recommendations. The sole purpose of this explanation is to assist the reader in understanding the verdict and recommendations made by the jury. This explanation is not to be considered as actual evidence presented at the inquest and is in no way intended to replace the jury's verdict.

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Summary of the Circumstances of the Death

Ashley Smith was 19 years of age when she died at Saint Mary's General Hospital in Kitchener after being extracted, unresponsive, from segregation cell number one at the Grand Valley Institution for Women, a federal correctional facility. She had been first incarcerated in March 2003, when she was 15 years-old, in youth detention in New Brunswick. Upon reaching the age of 18 and following a transfer hearing heard in the Youth Court in New Brunswick she was transferred in October 2006 to federal custody where she spent the last 11.5 months of her life.

During her federal incarceration she was transferred approximately 9 times between 3 federal institutions, Pinel, St. Thomas and the Central Nova Scotia Correctional Facility. In addition she was sent to the local hospital on 3 occasions on a Form 1 under the Mental Health Act. This took her into four of the five CSC regions of Canada. During almost all of her time in federal custody she was on administrative segregation status and was housed in segregation cells in a suicide smock with little or no cell effects.

At almost all stages of her federal incarceration she demonstrated extreme maladaptive, disruptive and self-harming behaviours. These consisted mainly of self-strangulation with ligatures which she fashioned from clothing and other sources using broken glass she obtained, but which also included head banging, self-mutilation and cutting.

Ms. Smith secreted items for self-harm and for making ligatures on her person in areas which regulations prohibited staff from searching to recover them. These behaviours and the related responses often involved the use of force by staff to recover ligatures and to deal with assaultive behaviours by her on staff. This caused over 150 security incidents to be recorded, most of which generated at least one use of force and/or incident report.

Many of the reported interventions by staff involved the use of physical handling and the use of physical restraints. Occasionally forced injection of medications was used and sometimes there was deployment of OC spray (pepper spray). Ms. Smith generally refused to cooperate with psychological assessments and was certified for involuntary admission on a number of occasions under provincial mental health legislation.

While a full psychiatric assessment was never recorded, she was diagnosed as suffering from borderline and antisocial personality disorders on Axis II of the then current Diagnostic and Statistical Manual for psychiatry. No Axis I major mental disorder such as schizophrenia or psychotic depression was ever diagnosed.

Early in her federal incarceration she completed a few preliminary exercises in dialectical behaviour therapy, the treatment provided for borderline personality by CSC. But shortly after that she withdrew her consent and was never in treatment for these disorders subsequently, nor was she considered treatment-ready. Ms. Smith was from time to time intermittently amenable to taking medications prescribed to her in treatment centres and correctional settings.

While there were, at a few times, some indications that a therapeutic alliance with her might be achieved, there was never enough progress during her short stays at a number of institutions for any significant progress towards this goal which might have eventually led to treatment readiness.

In treatment centres Ms. Smith either refused to consent to assessment and treatment or quickly withdrew any consent she had given. This resulted in discharge and return to correctional care. In none of the psychiatric institutions was a full assessment or any treatment for her disorders recorded.

In one treatment centre she did show some progress toward treatment readiness, but she was allegedly assaulted by a correctional staff member and, in accordance with CSC policy, this required that she be transferred to a different facility. The chief psychologist insisted that she only be transferred to another treatment facility. This was done, but she never subsequently made significant progress toward treatment readiness and her self-harming behaviours became progressively more pervasive and potentially lethal. Despite regular contact with institutional mental health staff in the correctional facilities, no full assessment was ever recorded nor was any plan of mental health treatment implemented.

Ms. Smith's custodial management in correctional institutions was mainly security-focused to protect life and minimize the physical interactions with staff and the uses of force. Consistently, while in custody, Ms. Smith was able to obtain, secrete and use ligatures for self-strangulation and correctional staff were unable to prevent her access to these instruments of self-injury.

On two occasions body cavity searches were conducted at external medical facilities in an attempt to retrieve secreted ligatures or broken glass used for making them, but despite this, her access to and use of ligatures continued.

In the spring of 2007 correctional staff regularly entered her cell to remove ligatures from her neck when they were observed and reports of these actions were approved and commended by supervising corrections staff.

As time went on there were ever more serious instances of self-strangulation with visible physical effects including nosebleeds, broken blood vessels in the face, changes of facial colour to blue and purple, and more severe respiratory distress.

In the fall of 2007, Ms. Smith was transferred on the final occasion to Grand Valley Institution (GVI) in Kitchener. During that period of incarceration staff who entered the cell to remove ligatures were often counselled that they had entered too soon. They were directed to follow the Situation Management Model used in Corrections Canada, which dictated a graduated application of force in response to self-harm. Staff were directed to assess and reassess the situation and to withdraw from the cell as soon as they could see that Ms. Smith was breathing, even when she had tied a ligature around her neck and was in distress.

These counselling directions became more insistent as time went on during the last admission to Grand Valley and ultimately counselling memoranda were sent to correctional managers in relation to actions of correctional officers. Memoranda from the deputy warden were sharply critical of staff response to Ms. Smith's ligature tying. Specifically, staff were criticized for entering the cell too early and for failing to assess, reassess and withdraw if she was breathing. The managers would sometimes not relay the content of the memos to the identified correctional officers.

Direction was circulated amongst staff and reinforced by training sessions that staff were not to enter the cell while Ms. Smith was still breathing. This direction was reinforced by correctional managers and directions were also given that staff were not to enter the cell without the permission of a correctional manager. On one occasion a correctional manager physically prevented a staff member from entering the cell while Ms. Smith had a ligature in place.

Reports of all these occurrences were sent to Regional Headquarters, National Headquarters and to the Women's Offender Sector at National Headquarters. Summaries of these occurrences were sometimes noted in the SITREPS (situation reports) circulated daily to all senior management of CSC. These reports were either not sufficiently timely or contained insufficient information to be of any effective assistance.

Seven days before her death, on Oct. 12, 2007, Ms. Smith attended in court to answer charges with respect to her previous allegedly assaultive behaviour in relation to interactions with staff attempting to prevent self-harm. She received an additional sentence of 60 days at that time. Upon return to the institution, she was reported to have spoken with correctional officers and a psychologist and indicated her distress at the circumstances stating that she wished to end her life. She also reportedly indicated that she intended to commit suicide during one of the shifts of a particular correctional manager.

An assessment was conducted by the institutional psychologist who advised that she should be placed on high suicide watch and individual observation.
In the early morning hours of October 19th, during the shift of the particular correctional manager noted above (though it is unknown if Ms. Smith knew that), those observation provisions were in place. She indicated that she intended to use

the bathroom facilities in her cell, and while the correctional officer observing her looked away, Ms. Smith tied a ligature around her neck .

When the correctional officer did not hear the toilet flush she resumed her observation and saw Ms. Smith between the bed and the wall with a ligature around her neck and apparently in some distress with labored breathing. The correctional officer left the immediate vicinity of the cell to summon assistance.

There was a delay between this observation and entry of correctional officers into the cell while staff attempted by various measures to determine if she was still breathing. A correctional manager was consulted and eventually the cell was entered and Ms. Smith was recognized as being unresponsive. CPR (cardiopulmonary resuscitation) was started and a correctional manager approved the calling of 911.

Emergency Medical Services attended and continued resuscitation during transfer to St. Mary's General Hospital. Hospital staff continued assessment and resuscitation at the end of which Ms. Smith was declared to be dead.

A coroner was called and a post mortem examination was conducted which concluded that Ms. Smith died from ligature strangulation and positional asphyxia. An inquest was deemed to be mandatory since the deceased had died while an inmate on the premises of a correctional institution.

After a number of preliminary proceedings the inquest was held at Coroner's Court in Toronto with the taking of evidence commencing on January 14, 2013. The inquest consumed 107 days in Coroner's Court and two days during which views were taken of the scene of the incident at Grand Valley Institution in Kitchener and of the mental health treatment unit at St. Thomas Psychiatric Hospital. There were four days of submissions by counsel and the charge to the jury took one day. The jury deliberated for 13 days. The jury heard from 83 witnesses, considered 228 exhibits and delivered its verdict on Dec. 19, 2013. It made 104 recommendations.

Verdict:

Name of deceased: Ashley Smith
Date and time of death: Oct. 19, 2007 at 8:10 a.m.
Place of death: St. Mary's General Hospital, Kitchener
Cause of death: Ligature Strangulation and Positional Asphyxia
By what means: Homicide

Coroner's Comment:
The jury in this inquest returned a verdict of homicide. In determining the answer to the question "By what means?" the jury, as provided in the Coroners Act, may answer natural, accident, suicide, homicide or undetermined.

The jury was instructed that it must find the manner of death or answer the question "By what means?" with a determination of fact. The jury was instructed, in accordance with cases determined in the Supreme Court of Canada that, if it found as a fact that the action or actions of some person or persons materially contributed to the cause of the death, it could find the death to be by means of homicide.

The jury was also instructed that the finding of homicide in a coroner's inquest is a determination of the fact of that material contribution alone and does not carry or convey any finding of intention, foreseeability or criminal responsibility.

The reader should consider the meaning of the verdict in the context of these instructions to the jury as to the applicable law.

Recommendations:

1. That Ashley Smith's experience within the correctional system is taught as a case study to all Correctional Service of Canada management and staff at the institutional, regional and national levels. This case study can demonstrate how the correctional system and federal/provincial health care can collectively fail to provide an identified mentally ill, high risk, high needs inmate with the appropriate care, treatment and support. This case study can also demonstrate the lack of communication, cohesiveness, and accountability of a large organization such as Correctional Service of Canada.

Coroner's Comment:
The Jury felt that CSC should use the experience of this tragic death to learn where the exposed shortcomings were, and in some cases still are, as a means to correct them.

2. That the Ashley Smith case study be designed for all existing and future CSC management and staff, offering a comprehensive understanding and gaps analysis of the practices that occurred leading to this case. This case study will include documents and evidence presented throughout the Ashley Smith Coroner's Inquest, specifically:

- The Jury's Recommendations, December 2013;

- Report to Coroner Investigating the Death of Ashley Smith at Grand Valley Institution for Women (GVI), October 11, 2013, University of Toronto, Professor Kelly Hannah-Moffat (Exhibit 206);

- A Preventable Death, June 20, 2008, Correctional Investigator of Canada (pages 1-30) (Exhibit 22); and

- The Ashley Smith Report, June 2008, Ombudsman and Child and Youth Advocate (excerpts) (Exhibit 6).

Coroner's Comment:
Self-explanatory.

The Provision of Mental Health Care to Federally Sentenced Women

A) Within Penitentiaries

3. That, within 72 hours of admission to any penitentiary or treatment facility, all female inmates will be assessed by a psychologist to determine whether any mental health issues and/or self-injurious behaviours exist.

    a) That, should an inmate be identified as having high needs mental health issues and/or self-injurious behaviours, the Chief of Psychology will notify the Institutional Head, Rights Advisor and Inmate Advocate (RA-IA)*, Women Offender Sector, and the Regional Complex Mental Health Committee in writing within 48 hours of assessment.

    b) That this process of assessment will continue to be conducted on an on-going basis and as required by the inmate.

    c) That the Chief of Psychology implements a plan of effective treatment strategy which will be documented and shared as required.

    *The role of the RA-IA is defined in Recommendations #73-75.

Coroner's Comment:
The jury was concerned that inmates displaying self-harming behaviour be identified very early upon entry to the system. They heard evidence that assessments were sometimes not timely and detailed plans were sometimes not drawn up immediately. They also heard evidence that even when problems were recognized, they were sometimes not communicated to persons in positions of responsibility or, if so communicated, were not recognized as serious or requiring immediate action to obtain professional

help. The jury wanted to make sure that the highest officials, locally, regionally and nationally, be specifically aware of such cases. They felt that early involvement of advocates for the inmate would make it more likely that local and higher officials would take appropriate action to protect the life and improve the circumstances of the inmate who self-harms.

4. That a full range of effective therapeutic interventions are:

   a) individualized to the needs of female inmates considering her self-identified needs, regardless of their security classification, status, or placement;

   b) enhanced to include de-escalation training, and art, music, or pet therapy;

   c) trauma-, age-, and gender-informed, and developmentally appropriate; and

   d) determined and authorized by mental health staff.

Coroner's Comment:
The jury heard extensive evidence from a broad range of experts in both penal and mental health disciplines as to the appropriate range of therapeutic interventions for inmates who self-harm. They wished to emphasize that interventions should consider the self-identified needs of the offender and should not be significantly affected by the security classification, segregation status or placement within the institution of the inmate. The jury also wished to indicate that, based on the evidence, such therapeutic strategies should include enhanced de-escalation training for frontline officers and supervisors. They also felt that programs involving art, music or pets might be helpful to some inmates.

They felt that all intervention should be trauma, age and gender-informed in view of evidence they heard that self-harming offenders are very often victims of prior trauma. They felt that all interventions should be developmentally appropriate based on evidence they heard about the special needs of young persons in prison. They felt that all therapeutic interventions should be devised and authorized by mental-health staff and not by correctional staff.

5. That Correctional Service of Canada (CSC) create a permanent peer support program, with highly trained and qualified peer support workers in each of the women's penitentiaries that:

   (a) is available to all women, including segregated women and regardless of security status, upon their request, 24 hours a day;

   (b) provides training and on-going support for the peers by women-centred psychologists and social workers;

(c) ensures confidentiality between the female inmate and the peer to the greatest extent possible;

(d) can be utilized during an incident of self-injurious behaviour, if requested; and

(e) is offered to women actively engaged in self-injurious behaviour or at risk of engaging in self-injurious behaviour as a therapeutic intervention.

Coroner's Comment:
The jury heard evidence that the correctional services had on occasion, used trained and qualified inmate peers to provide sympathetic listening and a degree of mentorship to other inmates where appropriate. They heard that, while the rules provided for such a peer support system, qualified and trained peer inmates were not available at GVI during Ashley Smith's incarceration there.

The jury heard evidence that this support was not available during self-injurious behaviuor by Ms. Smith and they felt that it should be available in those circumstances. They felt that such peer support should be available to women actively engaging in self-injurious behaviour or at risk of engaging in such behaviour as part of a proper therapeutic intervention.

6. That CSC ensure nursing services are present on-site for inmates on a 24 hour per day, 7 day per week basis, as well as available to staff for consultation.

Coroner's Comment:
The jury heard evidence that nursing services were not available 24 hours per day in the Grand Valley Institution for Women. It was explained that this was considered too expensive.
The jury also heard evidence that there had been a previous inquest into the death of another inmate at Grand Valley Institution for Women and that the jury had recommended that nursing services be available 24 hours per day but that recommendation had not been implemented.

The jury felt that nursing services should be available 24 hours per day not only to provide direct care to inmates when needed, but also to provide advice and help to front-line staff tasked with dealing with difficult medical situations involving both physical and psychiatric ailments.

7. That CSC access community mental health services by developing partnerships with external mental health experts.

Coroner's Comment:
The jury heard evidence that each women's penitentiary has a general medical practitioner and a psychiatrist on contract for varying periods of a few hours per week. The jury felt that in addition to these services, it would be beneficial for some inmates if Corrections Canada built a network of

partnerships with community mental health professionals and teaching hospitals so that their services could be called upon in times of special need.

8. That there be adequate staffing of qualified, mental health care providers with expertise and experience in treating a population with mental health issues, self-injurious behaviours, suicidality, and trauma, at every women's institution to provide services and supports to female inmates. These providers will include:

   (a) Psychiatrists;

   (b) Psychiatric Nurses or Nurses;

   (c) The Chief Psychologist*;

   (d) Psychologists;

   (e) Social Workers;

   (f) Behavioural Counsellors** and/or Recreational Counsellors;

   (g) General Practitioners, and

   (h) Other professional service providers, as required.

   *It is further recommended that, whether working in the position indeterminately or in an acting capacity, the Chief Psychologist must hold a Ph.D. in Clinical Psychology and be a member in good standing of the Ontario College of Psychologists (or provincial equivalent).

   **It is further recommended that behavioural counsellors have qualifications to counsel in behaviour. Otherwise, it is recommended that the title of Behavioural Counsellor is amended to Behavioural Therapy Coordinator.

Coroner's Comment:

The jury heard evidence that on many occasions there were either inadequate numbers of qualified mental health professionals provided for in women's institutions or that positions which were provided for were vacant at many times. The jury felt that a full roster of qualified professionals including specifically psychiatric nurses should be available to inmates at all times. The nurses at GVI had no psychiatric nursing qualifications.

They further recommended that there be behavioural counsellors, but that this job title should be used only if the persons employed were properly qualified to counsel regarding behaviour. The jury had heard evidence that while persons were employed at the time of this death who

were called behavioural counsellors, they had no qualifications to counsel with respect to behaviour.

9. That CSC expand the scope and terms of psychiatrists' contracts to enable them to fulfill their duties in a meaningful way.

Coroner's Comment:
The jury heard evidence that, while the Correctional Service of Canada had qualified psychiatrists on contract, they generally were retained for only a few hours per week giving them little opportunity to provide special attention to difficult and complex cases.

10. That all staff providing mental health care will report to, and be accountable to, health care, not security, and that the therapeutic relationship should not be compromised by the assignment of security-focused assessments.

Coroner's Comment:
The jury heard evidence that at the time of the death some mental health professionals, the psychologists, in the women's institutions reported to correctional management. The jury also heard that psychologists, reporting as they did, were often assigned to conduct assessments where the result of the assessment would, for various purposes, be reported to correctional management and might determine the privileges or conditions of confinement enjoyed by the inmate.

The jury felt that all health professionals should report in the healthcare line of supervision and that, to facilitate the development and maintenance of a good of therapeutic relationship, such health professionals should not be assigned to conduct assessments, the content of which, might have correctional or security consequences for the inmate.

11. That CSC organize and fund secondments for nursing staff to psychiatric wards of local Schedule 1 hospitals, or other specialized mental health institutions. These secondments are to be of sufficient length and completed with regularity. This will ensure the continual improvement of their knowledge and skills in the provision of mental health care, services and supports to female inmates, and their knowledge of community nursing practices and standards generally.

Coroner's Comment:
The jury heard evidence about, and observed by videotape, the practice of nurses in women's correctional facilities. They also heard from nurses who provided care to Ashley Smith.

The jury felt that it was very important for nurses in such facilities to be able to continuously improve their professional skills, to provide care at community standards and to maintain their independent responsibilities as health professionals distinct from any role of a correctional nature.

The jury heard evidence about the practice in other systems and felt that the above goals would be best achieved by having nurses from the correctional institutions regularly, and for a significant period of time, undertake secondments in community psychiatric hospitals where they could maintain their awareness of community practice standards , improve their skills in managing mentally ill self-harming women, and maintain professional relationships which would foster attitudes toward their roles consistent with their responsibility as nurses.

12. That the decision to disclose information to security by a mental health care provider should be governed by the applicable legislation, and professional and ethical standards, bearing in mind that reporting may affect the therapeutic relationship. The decision to disclose must also take into account the paramount duty of CSC to ensure the safety of the inmate. Service providers should be encouraged to consult with their professional governing bodies or colleagues when determining the necessity of disclosure.

Coroner's Comment:

The jury heard that it was very difficult to establish a therapeutic relationship with Ashley Smith and with some other self-harming inmates. The jury also heard that some mental health providers employed by CSC to care for inmates reported directly to and shared health information with security staff. The jury believed that sharing patient care information with security staff without the consent of the inmate would potentially harm the therapeutic relationship or make it more difficult to establish such a relationship.

The evidence in this case indicated that security staff did not have the information they needed to keep Ashley Smith safe. This recommendation recognizes the difficult decision mental health care staff sometimes need to make regarding disclosure of confidential information, and seeks to achieve a balance.

13. That CSC create an institutional social worker position or positions whose responsibility will include working in consultation with local Canadian Association of Elizabeth Fry Societies, and other community groups, to identify, coordinate and access available community services, including mental health services and supports. The mandate of this position would include the dissemination of information regarding the availability of, and assistance with connecting to, such services and supports to female inmates and to staff (including contract-based clinicians).

Coroner's Comment:

The jury heard evidence that community groups including The Canadian Association of Elizabeth Fry Societies knew of and had access to community resources which might be useful in the management of mentally ill and self-harming female inmates. The jury felt that the inmates and the professionals providing care to them could benefit from this information.

14. That CSC be required to provide all contract physicians with copies of Commissioner's Directives, including revisions to Commissioner's Directives, that govern their practice within the penitentiary.

Coroner's Comment:
The jury heard evidence that some contract physicians working in women's institutions had never had access to the commissioner's directives governing their practice.

B) Alternatives to Penitentiary

15. That female inmates with serious mental health issues and/or self-injurious behaviours serve their federal terms of imprisonment in a federally-operated treatment facility, not a security-focused, prison-like environment.

Coroner's Comment:
The jury heard consistent expert evidence to the effect that female inmates with serious mental health issues or with self-injurious behaviours could not be effectively managed in prison environments. Having heard the evidence respecting the care of Ashley Smith in both prisons and mental health facilities, the jury believed that inmates like her in the system should not be housed in prisons but rather should be cared for in treatment facilities with a therapeutic focus and scheme of management.

16. That female inmates who have been identified as having serious mental health issues and/or self-injurious behaviours be promptly transferred to such a facility as soon as reasonably practicable.

Coroner's Comment:
Having heard the evidence respecting the care of Ashley Smith the jury perceived that there was a clear and present danger that the management of female inmates in similar circumstances in prisons might result in yet another death and thus they felt that any such inmates entering or currently incarcerated in prisons operated by the Correctional Service of Canada should immediately be transferred to therapeutic facilities as described in recommendation 15.

17. That such a facility or facilities be made available at least on a regional basis, and particularly in Ontario. It is urged that more than one federally-operated treatment facility is available for high risk, high needs women in the event that a major conflict occurs between the inmate and staff. Furthermore, and specifically, that existing male federally-operated treatment facilities be adapted to accommodate a wing for female inmates.

Coroner's Comment:
The jury heard evidence of the importance of housing female inmates in a facility located close to their home so that they could receive the support of their families .They also heard that only two facilities were available for the housing of federally sentenced female offenders with problems similar to those

experienced by Ashley Smith. The jury felt that there should be a federally operated treatment facility for high-risk, high-needs women in each region of Canada.

The jury also heard that when serious problems arise such as an assault on the inmate by a member of correctional staff it was the policy of Corrections Canada that the inmate must be moved to a different institution. In view of this the jury felt that there should be sufficient federally operated treatment facilities for high-risk, high-needs women so that the occurrence of such an event would not compromise the potential for treatment of the inmate by requiring them to be transferred to a prison rather than a treatment facility.

The jury also heard evidence that there might be an insufficient number of women like Ashley Smith to justify the construction of standalone facilities or the negotiation of bed space at provincially owned and operated facilities in some or all regions. The jury felt that the need might be accommodated by adapting existing facilities for men to accommodate a wing for female inmates.

18. That CSC negotiate arrangements with provincial health care facilities to provide long-term treatment to female inmates who chronically engage in self-injurious behaviour or display other serious mental health problems. Further:

    a) that the Government of Canada sufficiently and sustainably funds the CSC to enter into such agreements;

    b) that this will include any and all capital and operating costs associated with the establishment of such facilities, and that the accommodation and treatment of female inmates therein will be the responsibility of CSC;

    c) that the focus of such a facility be on the preparation for treatment of, and treatment of, the inmate; and

    d) that a female inmate with mental health issues and/or self-injurious behaviour who is not consenting, and/or withdraws consent, to treatment remain in a pre-contemplative therapeutic environment for the purpose of allowing health care professionals to seek her consent to treatment.

Coroner's Comment:
The jury heard evidence of arrangements between Corrections Canada and certain provincial mental health facilities, but noted that these arrangements, with the exception of those at Pinel Institution in Quebec, were only for assessment and not for long-term treatment of female inmates who might require it. The jury heard about an arrangement for long-term treatment of men at St. Lawrence Valley Institution for men.

The jury felt that there should be arrangements between Corrections Canada and outside treatment

facilities for such long-term treatment as might be required by federally sentenced women and that, in view of their status as federally sentenced women, the Government of Canada should be financially responsible for all costs associated with such accommodation. The jury also heard evidence that some inmates withdraw their consent to treatment, as Ashley Smith did, while housed in treatment facilities outside the prison. The jury heard evidence that this requires the inmate to be discharged from the treatment facility and returned to prison.

The jury heard evidence that a better strategy would be to retain the inmate in a therapeutic facility to afford staff the opportunity to encourage the inmate to again consent to treatment as well as affording the inmate the opportunity to reconsider the matter. The jury believed that inmates who withdraw their consent while in a treatment facility should continue to be housed in a treatment facility as long as staff believes it appropriate to permit an opportunity for consent to be renewed.

19. That decision-making with respect to the clinical management and interventions of inmates with mental health issues are made by clinicians in consultation with the inmate, rather than by security management and staff.

Coroner's Comment:
The jury heard evidence that decisions respecting the management of mentally ill female inmates were often made by, or in consultation with, security staff or management. Such decisions might be based on factors not related to the best interests of the inmate or with incomplete knowledge of the mental health issues that had implications for appropriate management and interventions. The jury also heard that the role of psychology in the management of Ashley Smith was strongly influenced by security concerns.

20. That a treatment facility has the capacity to be designated as the home facility of a female inmate serving her sentence therein.

Coroner's Comment:
The jury heard evidence that normally a treatment facility could not be designated as the home institution of a mentally ill female inmate. Because of this, if an inmate were temporarily in the community and problems occurred, the inmate could not be returned to the treatment facility, but could only be returned to a prison.

The jury heard that a better strategy would be to make the treatment facility the inmate's home institution so that, in the event of such an occurrence, the inmate could be returned directly to the treatment facility. The jury heard that this had already been done in one exceptional case and felt that this should be possible in all cases.

21. That such a facility in Ontario, or a part thereof, be designated as a Schedule 1 facility under the Ontario Mental Health Act.

Coroner's Comment:
The jury heard evidence that, in Ontario, a mentally ill patient could only be detained for assessment in a Schedule 1 mental health facility. They also heard evidence that community treatment orders could only be made for patients who were resident at the time in such a facility. The jury felt that such activities might be necessary in respect of federally sentenced female inmates with mental health challenges and thus they felt that any such treatment facility in Ontario should be a Schedule 1 mental health facility.

22. That inmates in such facilities must have access to an independent patient advocate system, equivalent to the advocacy system to be provided to inmates in penitentiaries, pursuant to these recommendations, including the newly adopted RA-IA (see Recommendations #73-75).

Coroner's Comment:
The jury later, at recommendations 73-75, made recommendations for the adoption of an advocacy system for inmates in federal women's penitentiaries. The jury wished it to be clear that such an advocacy system ought to be in place both within the prisons themselves and also in the treatment facilities recommended in the immediately foregoing recommendations.

Management of Complex High-Needs Female Inmates

23. That a Treatment Team is created at the institutional level to support high needs female inmates with a consistent and dedicated team of qualified health professionals, which will include psychiatrists, psychologists and general practitioners, and that such a team:

(a) meet during the psychiatrist's regular visits at the institution in order to provide on-going, timely, and regular care to inmates;

(b) support the inmate regardless of her security classification, status, or placement within the institution;

(c) seek input from the inmate about the efficacy of her therapeutic relationships and interventions on an on-going basis;

(d) seek input from frontline staff assigned to support the inmate with mental health care needs; and

(e) develop management plans for the purposes of therapeutic intervention and preventative measures. This plan will take into account the inmate's past experiences of trauma, and the potentially traumatic effects of being incarcerated, segregated and/or restrained, and further, that such management plans are developmentally-appropriate, and age- and gender-informed.

Coroner's Comment:
The jury heard evidence that the care provided to Ashley Smith was often the result of a team effort by correctional and health care staff. They also heard evidence that not all relevant staff either from the correctional or health care sides were always involved.

The jury felt that the arrangements for the care team should not be ad hoc, but should be formally organized. The jury heard that the team meetings rarely involved the psychiatrist who was only present in the institution for a few hours per week. The jury felt that these meetings should include the psychiatrists.

The jury heard evidence that care sometimes could not be offered to those who were placed in segregation.

The jury heard evidence that input from the inmate\patient was sometimes not sought where a proper interview was difficult to do because of placement in segregation.

The jury heard evidence that valuable information potentially available from frontline security staff was often not received by the treatment team.

The jury heard evidence that treatment plans developed often failed to give any clear instruction for interventions or preventative measures and failed to clearly direct frontline staff.

24. That the selection of the frontline staff assigned to a female inmate will consider:

    (a) the skill and interest of the frontline staff;

    (b) the wishes of the inmate; and

    (c) input from the Treatment Team.

Coroner's Comment:
The jury heard evidence that the rapport between front line staff and the inmate could be an important factor in the development of treatment readiness for female inmates with mental health challenges.

The jury heard evidence that some of the front line staff in Ashley Smith's case were very talented at relating to her and interested in doing so while other officer's talents lay elsewhere.

In view of the critical importance of developing a therapeutic alliance the jury felt that the input of the treatment team was also critical.

25. That CSC maintain a roster of external psychologists and psychiatrists to provide a second

opinion regarding treatment, services and/or recommendations when challenging behaviours are identified.

Coroner's Comment:
The jury heard evidence that from time to time there were very difficult inmates to deal with in relation to serious mental health challenges. While the jury believed that there should be very capable and experienced psychologists and psychiatrists employed and on contract, the jury also felt that a roster of external consultants able to be contacted in a timely manner should be maintained to provide support to treatment staff with particularly difficult cases.

26. That an external and independent review be conducted of the Regional and National Complex Mental Health Committees to determine their efficacy, and identify opportunities for improvements.

Coroner's Comment:
The jury heard evidence of the development of regional and national Complex Mental Health Care committees after Ashley Smith's death and heard something of their intended process. The jury was uncertain as to the appropriateness or likely effectiveness of the described processes and, in view of the evidence they heard regarding the problematic responses of regional and national headquarters in the case of Ms. Smith, they recommended that an external and independent review be conducted to determine whether these mechanisms were effective and to identify opportunities for improvement.

Segregation and Seclusion

27. That, in accordance with the Recommendations of the United Nations Special Rapporteur's 2011 Interim Report on Solitary Confinement, indefinite solitary confinement should be abolished.

Coroner's Comment:
The jury heard evidence about the report of the United Nations Special Rapporteur on solitary confinement. The jury agreed with the conclusion of that report that indefinite segregation was inappropriate for the confinement of any inmate and thus they recommended that such confinement be abolished. The evidence heard by the jury (apart from the UN report) in relation to long term segregation was in the context of management of mentally ill, self-harming women. They heard nothing, for example, about the use of administrative segregation for the purposes of protective custody.

28. That there should be an absolute prohibition on the practice of placing female inmates in conditions of long-term segregation, clinical seclusion, isolation, or observation. Long-term should be defined as any period in excess of 15 days.

Coroner's Comment:
The jury heard evidence about the effect of long term segregation in Ashley Smith's case and heard expert evidence concerning the negative effects of long-term segregation in general. The jury concluded that long term segregation was not an appropriate method for managing female inmates with serious mental health challenges.

29. That until segregation and seclusion is abolished in all CSC-operated penitentiaries and treatment facilities:

a) CSC restricts the use of segregation and seclusion to fifteen (15) consecutive days, that is, no more than 360 hours, in an uninterrupted period;

b) That a mandatory period outside of segregation or seclusion of five (5) consecutive days, that is, no less than 120 consecutive hours, be in effect after any period of segregation or seclusion;

c) That an inmate may not be placed into segregation or seclusion for more than 60 days in a calendar year; and

d) That in the event an inmate is transferred to an alternative institution or treatment facility, the calculation of consecutive days continues and does not constitute a "break" from segregation or seclusion.

Coroner's Comment:
Same comment as above.
The jury heard evidence that in Ashley Smith's case Corrections Canada had treated transfers as an interruption in confinement in segregation and thus had taken the position that certain time-based mandatory reviews of that status need not take place, particularly the review at 60 days requiring higher level review.. The jury was concerned therefore, in relation to recommendation 28, that the manner of calculating the 15-day limitation set out be very clearly defined. It must be explicit that transfers to other institutions or treatment facilities should not be deemed to be interruptions in segregation for the purpose of avoiding rules or prohibitions against long term segregation.

30. That conditions of segregation be the least restrictive as possible for inmates and determined on a case by case basis – female inmates in segregation should, as much as possible, have access to programs, activities, and facilities and have contact with other inmates, staff, visitors, and non-governmental organizations, such as CAEFS.

Coroner's Comment:
The jury heard evidence concerning conditions of Ms. Smith's confinement while in segregation for the protection of her life. The jury understood that restrictions on her cell effects were considered necessary for such protection. The jury also heard expert evidence concerning the effects of long-term segregation and recommended that where such segregation was deemed to be necessary, the

restriction on cell effects, participation in programming and access to staff, visitors and nongovernmental organizations should be the least restrictive possible.

The jury heard evidence that on at least one occasion access to assistance from The Canadian Association of Elizabeth Fry Societies (CAEFS) was perceived to have been denied because of segregated status.

31. That, as a mandatory duty, the Institutional Head will visit all inmates in segregation, seclusion, or medical observation at least once every day, in addition to meeting with individual inmates upon their request. This meeting is not to be accomplished through the food slot under any circumstance, and:

(a) that, on days when the Institutional Head is away, the visit will be conducted by the highest authority; and

(b) that any such authority must report in writing to the Institutional Head the findings and outcomes of such visits.

Coroner's Comment:
The jury heard evidence that at the time of Ashley Smith's confinement it was required that the institutional head visit all inmates in segregation at least weekly. The jury also heard evidence that, variously, either what was actually occurring in the segregation unit was unknown to the institutional head or, having received reports of what was going on, the institutional head failed to appreciate the importance and potential lethality of the situation.

The jury felt that considering the potential consequences of mismanaged segregation for the protection of life, the institutional head should be required to take much more aggressive steps to become aware of and appreciate all aspects of the management of such inmates in segregation.

The jury heard evidence of the difficulty of having meaningful communication with an inmate through the food slot.

32. That, as a mandatory duty, a mental health professional will visit all inmates in segregation, seclusion, or medical observation at least once every day, in addition to meeting with individual inmates upon their request. This visit will pay particular attention to both the mental and physical health of such inmates, with a focus on assessing the inmate's tolerance to segregation. This meeting is not to be accomplished through the food slot under any circumstance.

Coroner's Comment:
The jury heard evidence of the deleterious effects of segregation particularly on inmates with serious mental health challenges. The jury therefore felt that a mental health professional should visit and assess such inmates on a very frequent basis. The jury heard evidence that a proper mental health

assessment was very difficult or impossible to conduct through a food slot.

33. That a sub-roster team of frontline staff is dedicated to complex high needs female inmates in the segregation unit, with a minimum of one (1) to two (2) consistent staff at all times. Such a team will ensure comprehensive and consistent support for the inmate.

Coroner's Comment:
The jury heard expert evidence of the importance of consistency of personnel and approach in the management of complex high-needs female inmates in segregation. The jury also heard evidence of the difficulties in providing such consistency in the management of Ms. Smith.
The jury recommended that the provision of consistent frontline support to such inmates be a requirement.

34. That CSC repeal its existing Review of Offender's Segregated Status Working Day Review policies and replace them with five (5) and ten (10) day reviews that are administered by way of consecutive calendar days. This review will focus on the inmate's needs and behaviours with the goal of returning the inmate to the general population.

Coroner's Comment:
The jury heard evidence of the system of review of segregated status in place at the time of Ms. Smith's incarceration. They heard that the times for the mandated reviews of such status were predicated on numbers of working days in segregation (either 5, 30 or 60 days) and that this sometimes resulted in the reviews being held after the intended time period had expired due to weekends and holidays. The jury felt that the mandated time periods for review should be shorter and should be based on calendar days to prevent such delays from compromising the inmate's vital interest in a timely review.
The jury also felt that such reviews should be meaningful, carefully documented and should be required to focus on the goal of returning the inmate to the general population.

35. That CSC amend its current policies to ensure that female inmates held in "seclusion" or "mental health observation" are recognized as being on "segregation status" and are therefore entitled to all relevant reviews.

Coroner's Comment:
The jury heard evidence that inmates held in the forms of segregation they identified might not be seen as entitled to all required reviews of segregation status.

36. That CSC make every effort to ensure that female inmates, including those in segregation or observation cells, have access to, and the opportunity to meet in private with, the RA-IA, Office of the Correctional Investigator, Citizens Advisory Committee, non-governmental organizations and community agencies.

Coroner's Comment:

The jury heard evidence that on occasion Ms. Smith was not able to meet with the advocates who might have drawn concerns about her circumstances and about her management to the attention of senior officials of Corrections Canada who, as the evidence later demonstrated, did not know what they ought to have known about those circumstances.

37. That, for the purposes of monitoring and tracking, the Institutional Head will notify the following bodies once any inmate has been placed in segregation or seclusion, and that they will also be responsible for conducting a yearly review.

(a) Women Offender Sector;

(b) Mental Health Services Branch;

(c) Office of the Correctional Investigator;

(d) RHQ – Members of the Regional Complex Mental Health Committee; and

(e) NHQ – Members of the National Complex Mental Health Committee.

Coroner's Comment:

The jury heard evidence that, while information regarding the circumstances and the problems in management of Ms. Smith was reported through the chain of command in Corrections Canada, senior officials were not aware of that information or could not appreciate its significance. In particular, the Women's Offender Sector and the Mental Health Services Branch were unaware of or did not appreciate the significance of the reported information. The jury wished to be certain that senior officials at National Headquarters and in particular in the Women's Offender Sector and the Mental Health Services Branch would receive this information directly from the institutional head in a manner which would be traceable, timely and accountable.

The jury also felt that the required awareness and accountability would be assisted by such information being correctly reported by the institutional head in an accountable manner to the Office of the Correctional Investigator and to the newly established Regional and National Complex Mental Health Committees. The jury felt that this information should be reported directly to the members of those committees so that they could decide whether they needed to meet. This they felt was necessary in light of the infrequent or ad hoc nature of the meetings revealed in the evidence.

Restraints (Physical and/or Chemical)

38. That, in the development of any new policy on the use of restraints, CSC move toward a restraint-

free environment by implementing a least restraint policy, and that this recommendation is reflected in CD 843.

Coroner's Comment:
The jury heard evidence concerning the use of physical restraints, such as Pinel restraints, in the management of Ashley Smith. They also heard expert evidence concerning the effectiveness of the use of physical restraints for the management of persons like her and regarding the policies respecting the use of restraints in other jurisdictions and settings.

The jury recommended that CSC move to a restraint-free environment and establish a policy minimizing the use of restraints in these circumstances. The jury understood that such a policy could be effective only if contained in a commissioner's directive. The jury understood that normal day–to-day use of things such as handcuffs would need to continue.

39. That the application of restraints must be authorized by a psychiatrist or psychologist, and that this recommendation is reflected in CD 843.

Coroner's Comment:
The jury heard evidence about the use of physical restraints in the management of Ashley Smith. The jury felt that, in view of the serious implications for the therapeutic relationship and the need to carefully consider risks and benefits on a continual basis, physical restraints should only be applied on the order of a mental health professional.

40. That any inmate placed in restraints is given one-on-one therapeutic support for the entire time in restraints, and that this recommendation is reflected in CD 843.

Coroner's Comment:
Same comment as above.
In view of the serious implications for the therapeutic relationship and the significant potential for harm, the jury felt that continuous therapeutic support while in restraints is essential and should be required by commissioner's directive.

Body Cavity Searches

41. That body cavity searches for female inmates may only occur in the following circumstances:

a) With the consent of the inmate; or

b) In the absence of consent, only in exceptional circumstances. For greater clarity, exceptional circumstances will only exist when, in the opinion of a physician, there is a

risk of death or serious bodily harm to the inmate or another person and the risk cannot be mitigated through any other reasonably available means.

All examinations are to be performed by a licensed medical professional at an external medical facility, in a manner most compatible with the inherent dignity of the inmate. Correctional Service of Canada staff escorting the inmate to the external facility is to request that the examination be conducted by a female.

Coroner's Comment:
The jury heard evidence that at the time of Ashley Smith's confinement body cavity searches could be conducted only on the direction of the institutional head and with the consent of the inmate. Having heard the evidence of the circumstances surrounding such searches as conducted in her case, the jury acknowledged that there might be exceptional circumstances when a physician perceived that the risk of death or serious bodily harm could not be averted by any other means. Where such circumstances were found to exist by a physician, the jury recommended the manner in which the examination should be conducted.

42. That, for the purposes of continuity of care, the institutional psychologist is notified within 24 hours of any body cavity search conducted on a female inmate, including those in treatment facilities.

Coroner's Comment:
Self-explanatory.

Self-Injurious Behaviours

A) Reporting Of Incidents

43. That all incidents of self-injurious behaviour must be reported as such.

Coroner's Comment:
The jury heard evidence of occasions during Ms. Smith's confinement when incidents of her self-injurious behaviour were reported through the chain of command of Corrections Canada and were categorized as other than self-harming behaviour. Categories such as "damage to government property" were substituted for self-harming behaviour.

The jury felt that there was the potential for a repetitive pattern of self-harming behaviour requiring vigorous intervention to protect life being unrecognized or unappreciated due to miscategorization.

44. That all reports regarding incidents of self-injurious behaviour, incident reports and Officer Statement Observation Reports, must contain a detailed description of the nature of the self-

injurious behaviour and a detailed description of any physical injury or changes in physical well-being of the inmate.

Coroner's Comment:
The jury heard evidence that various reports provided to regional and national reviewers by staff of the correctional facility failed to result in a realization on the part of the reviewers of how serious and potentially lethal the self-harming behaviours exhibited by Ms. Smith were. While the evidence showed that often reports were given which clearly described changes in facial colour, nosebleeds and a description of serious distress following ligature use, the serious nature of the situation was either not noticed or not appreciated by those who reviewed the reports.

The jury felt that all such reports should very explicitly describe apparent injury or change in the physical well-being of the inmate in a manner more likely to be appreciated by those reviewing reports and responsible for an appropriate response.

45. That all reports regarding incidents of self-injurious behaviour must be forthwith distributed to, and read by the following:

(a) The Warden;

(b) The Chief of Healthcare;

(c) The Chief Psychologist;

(d) Women Offender Sector (for female inmates);

(e) Office of the Correctional Investigator;

(f) RHQ – Members of the Regional Complex Mental Health Committee;

(g) NHQ – Members of the National Complex Mental Health Committee; and

(h) For additional clarity, the duty to read such reports is not delegable, except in circumstances when the responsible officer is on leave, and even then, the responsible officer is to read such reports forthwith upon return to the institution.

Coroner's Comment:
The jury heard evidence that the reports of self-injurious behaviour contained in incident reports either did not come to the attention of, or were not read or appreciated, by those responsible for protecting Ashley Smith's life. The jury felt that to increase the likelihood of an appropriate response to potentially lethal self-harming behaviour senior officials of Corrections Canada responsible and accountable for an appropriate response should be tasked with a non-delegable duty to read each and

every one of those reports.

To make it more likely that this would occur effectively, the jury felt that those reports should also be circulated to and read by the Office of the Correctional Investigator and the members of the Regional Complex Mental Health Committee and the National Complex Mental Health Committee.

46. That following each incident of self-injurious behaviour a ***Referral for Consultation Form*** be completed by nursing staff and a copy of the psychology assessment in relation to the incident be appended to this form and this package be forwarded to the institutional psychiatrist. The Chief of Healthcare will be responsible for ensuring this package is also provided to the institutional physician.

Coroner's Comment:
The jury heard evidence that information concerning incidents of self-harming behaviour might not come to the attention of either the institutional general physician or psychiatrist. If they came to the attention of the physician and psychiatrist at all, it was a considerable time after the occurrence because those physicians attended the institution only episodically and because there was no mechanism in place for them to receive such information.

The jury felt that a medical evaluation of all such incidents should occur at the earliest appropriate time and therefore reports of all such incidents should immediately be forwarded to the physician staff so that they would have timely notice and would be in a position to determine an appropriate medical and psychiatric response.

B) Responses To Incidents

47. That if frontline staff determine that immediate intervention is required to preserve life, there is no requirement that they seek authorization prior to intervening, or prior to calling 911.

Coroner's Comment:
The jury heard evidence that in Ms. Smith's case there were explicit instructions that front-line staff were not to enter the cell to respond to a perceived emergency without first receiving permission to do so from the correctional manager. They heard evidence that explicit permission was also required for the officer with access to the telephone to dial 911.

The jury felt that the unnecessary delay imposed by such requirements ought not to occur and thus recommended that any such requirements be eliminated.

48. That, when an inmate is engaged in self-injurious behaviours, health care staff are on-site, on a 24 hour per day, 7 day per week basis, to support the intervention.

Coroner's Comment:
The jury heard evidence that front-line staff and managers were unable to accurately assess the nature and potential lethality of Ashley Smith's self-harming behaviours. In view of the potential consequences of misapprehension of the health-care implications of the situation, the jury felt that healthcare personnel should be present on site at all times when such behaviours were occurring or might be anticipated.

49. That, when an inmate is engaged in self-injurious behaviours, the institutional psychologist are on-call, on a 24 hour per day, 7 day per week basis, for the purposes of supporting the intervention and de-escalating the incident when deemed necessary by frontline staff.

Coroner's Comment:
Same comment as for recommendation 48. The jury felt that in complex and difficult cases the support of professional staff to preserve life is essential and should be required to be present on the site.

50. That CSC develop a new, separate and distinct model, from the existing Situation Management Model, to address medical emergencies and incidents of self-injurious behaviour.

Coroner's Comment:
The jury heard evidence that the situation management model used by Corrections Canada was not designed for interventions in medical emergencies. The jury felt that strict compliance with the existing situation management model was incompatible with an appropriate response to a medical emergency. The Commissioner of Corrections gave evidence that the appropriate response to the tying of ligatures by an inmate around her neck would be to immediately remove the ligatures.

The jury also heard evidence that subsequent directives given about this could be interpreted as inconsistent with the commissioner's approach and as more consistent with the prior situation management model. In light of the potential confusion, and of the potentially lethal consequences of any such confusion, the jury recommended that an entirely new management model designed exclusively to regulate response to a medical emergency involving self-injurious behaviour be developed and implemented.

51. That the Situation Management Model not be resorted to in any perceived medical emergency.

Coroner's Comment:
Same comment as for recommendation number 50 above.

52. That, when reporting a Use of Force intervention to preserve the life of an inmate who has self-harmed an expedited reporting system will apply. Further, all such incidents should be reviewed, within 48 hours, by:

(a) The Warden;

(b) The Chief of Healthcare;

(c) The Chief Psychologist;

(d) Women Offender Sector (for female inmates);

(e) Office of the Correctional Investigator;

(f) RHQ – Members of the Regional Complex Mental Health Committee; and

(g) NHQ – Members of the National Complex Mental Health Committee.

The review will focus on the mental health needs of the inmate, her behaviour and its lethality, as well as the response of frontline staff, including its appropriateness. It will assist and support the well-being of the inmate, in addition to the efforts of the institution and frontline staff. It will also include strategies to manage the inmate in a safe manner, and encourage staff to exercise good judgment.

Coroner's Comment:
The jury heard evidence that at times there was a lack of immediate awareness or appreciation by senior staff of the correctional institution of the seriousness of incidents of self-harming behaviour or of the inappropriateness of the frontline response in Ms. Smith's case. The jury wanted every such incident to be reviewed in detail by senior staff immediately and thus recommended that an expedited reporting system be put in place. To make it more likely that such a system would be effective, the jury recommended that these expedited reports also be made immediately to regional and national bodies which could help and provide advice and support.

The jury was particularly concerned that these incidents be immediately reviewed so that complex mental health needs and potentially lethal situations be immediately identified so that the inmate's needs could be served and the front-line staff supported.

The jury recognized that, in the end, the good judgment of front-line staff would be the inmate's best protection in the immediate situation and they felt that front-line staff should be encouraged and supported to exercise such good judgment.

53. That CSC policy state that any item used by an inmate for self-injury be classified as contraband.

Coroner's Comment:
The jury felt that all objects used by an inmate for self-injury should be classified in such a manner

that they could immediately be removed by a front-line officer when seen.

54. That any inmate engaged in self-injurious behaviour must have a Management Plan in place within 24 hours of the first self-injurious incident, and that plan must address how staff is to respond to self-injurious behaviours.

Coroner's Comment:
The jury heard evidence that there were management plans put in place in respect of Ms. Smith, but that they were not always in place immediately and that they did not include any explicit instructions to front-line staff as to how they were to respond to these self-injurious behaviours. The jury felt that a management plan should be put in place very quickly in the face of self-injurious behaviour and that, in particular, the plans should contain explicit instructions as to how front-line staff were to respond to these behaviours.

Responses to Misconduct By Inmates With Mental Health Issues

55. That, to reduce institutional or criminal charges laid against an inmate, CSC adopts the methods of the St. Lawrence Valley Correctional and Treatment Centre model of care for disruptive or self-injurious behaviours symptomatic of a mental health disorder.

Coroner's Comment:
The jury heard evidence that most of the sentence being served by Ms. Smith resulted from the laying of criminal charges in relation to her behaviours while incarcerated. The additional sentences imposed in relation to these charges did not affect her behaviour in a positive way.

The jury heard expert evidence as to the approach adopted in the Saint Lawrence Valley Correctional and Treatment Centre for male inmates with mental health challenges. This approach involved seeking a resolution to inmate misbehaviours as part of the therapeutic program rather than by the use of criminal charges.

56. That, if a complaint is made to police in regard to alleged misconduct by an inmate with mental health issues, (occurring in the context of an incident of self-injurious behaviour), the Security Intelligence Officer will provide police with complete information. This will include the:

(a) behaviour that is alleged to amount to a criminal offence;

(b) context in which that behaviour occurred; and

(c) circumstances of the incident of self-injurious behaviour.

Coroner's Comment:

The jury heard evidence that from time to time staff members elected to contact the police regarding the conduct of Ms. Smith during incidents when staff were restraining her to prevent self-harm. The jury was concerned that police investigating such complaints and the court ultimately dealing with them might not be aware of the circumstances in which the alleged conduct had occurred. This approach they felt, might make it more difficult for the police or the court to determine an appropriate response.

57. That, if a criminal charge is laid in regard to alleged misconduct by an inmate with mental health issues, (occurring in the context of an incident of self-injurious behaviour), a staff member who was not involved in the incident, and is selected with input from the inmate (preferably a member of her interdisciplinary team), will:

(a) attend any court appearances with the inmate;

(b) advise the prosecutor of his/her presence; and

(c) provide any information that is required by the court to deal appropriately with the charge.

Coroner's Comment:
Same comment as for recommendation 56 above. The jury wished to be certain that the court dealing with any such incident would have access to information about the circumstances in which the alleged offenses occurred. The jury believed that this might make it more likely that the court would be able to reach an appropriate disposition. The jury understood that this function might be served by an outside advocate, but wished to be certain that, should this not occur, the necessary information would still likely be made available to the court.

Transfers/Assignments of Home Institutions

58. That female inmates be accommodated in the region most proximate to her family and social supports. This principle is a priority for young adults and/or female inmates with mental health issues and/or self-injurious behaviours.

Coroner's Comment:
Self-explanatory. The jury heard expert evidence of the importance of family, community or appropriate other social supports to female inmates and in particular to those who were young or who had mental health challenges.

59. That non-emergency transfers of female inmates with mental health issues and/or self-injurious behaviours will occur only when it is aligned with the clinical needs of the inmate. Non-

emergency transfers of female inmates with mental health issues and/or self-injurious behaviours will not occur for reasons related to constraints within the institution, or challenges related to the management of the inmate.

Coroner's Comment:
The jury heard evidence that some of the transfers of Ms. Smith from institution to institution and from region to region were not explicitly designed to enhance her therapeutic interests, but were decided upon because of difficulties with staffing and facilities within institutions.

60. That subject to the above, a female inmate may be transferred to an institution or treatment facility so long as that transfer has the approval of clinicians (psychiatrist and/or psychologist) in the sending and receiving institutions. Prior to her discharge a current written plan must be in place for re-integrating the inmate to her home institution.

Coroner's Comment:
The jury heard evidence that some of the transfers of Ms. Smith from institution to institution were made based on consultation between institutional heads or with senior management of Corrections Canada. They heard evidence that these decisions were sometimes not considered appropriate by treating health professionals.

The jury also heard evidence that, while the general policy was to return an inmate to her home institution after discharge from an alternate placement, this did not always occur.

61. That, in the event a female inmate is transferred away from her home institution, the following measures will address the disadvantages that result from being detained in a location away from home. Such measures may include, but are not limited to:

(a) longer visits from family or support persons chosen by the inmate;

(b) increasing the inmate's access to family or support persons via telephone, videoconference, and/or web-cast, e.g. Skype or Facetime; and

(c) providing the inmate's family or support persons with appropriate access to telephone, videoconference and/or web-cast, when they are unable to visit the inmate due to financial restrictions.

Coroner's Comment:
Self-explanatory. The jury heard expert evidence of the importance of housing female inmates close to their supports and felt that, where this was not possible, everything that could be done to maintain those supports should be done.

62. That, in the event of a transfer, an inmate's/patient's medical file accompanies her during the transfer to ensure continuity of care.

Coroner's Comment:
The jury heard evidence that on some occasions inmates' medical files were not transferred to a new institution in a timely manner accompanying the inmate. The jury felt that it was very important that this vital information should accompany the inmate.

63. That the receiving Treatment Team will connect with the sending institution's Treatment Team to share best practices, success stories, triggers, and recommendations.

Coroner's Comment:
The jury heard evidence that full information regarding matters they referred to was not always effectively transferred from institution to institution on the occasion of inmate transfer.

64. That CSC create and implement an electronic medical database to facilitate access to medical information between sending and receiving penitentiaries and treatment facilities.

Coroner's Comment:
The jury heard evidence that the Electronic Medical Record is used in almost all large medical institutions in Canada. Given the huge size and wide geographical coverage of the correctional health care institution across Canada, the jury felt that corrections should introduce an Electronic Medical Record to maintain the community standard of care and protect the safety of its inmates.

65. That no transfer occurs on a Friday or holiday given the reduced number of on-site staff at these times.

Coroner's Comment:
The jury heard evidence of the negative effects of transferring Ashley Smith on the eve of a long weekend. Given the evidence they heard regarding the difficulty caused by low staffing on weekends and holidays, the jury could see no benefit and heard evidence of considerable harm and potential for harm caused by such transfers.

Transition Protocol For Young Adults

66. That CSC establish separate and distinct programs and services for young adults, that is, 18-21 year olds, within adult institutions which will be geared toward their cultural and developmental needs (e.g. educational, vocational, therapeutic, as appropriate to specific needs and situations).

Coroner's Comment:

The jury heard expert evidence that the needs of young adults were quite different from those in older age groups. The jury heard evidence of the difficulty in meeting Ashley Smith's programming needs and felt that specific programs should be put in place for young adults.

67. That CSC develop training to prepare staff to recognize and respond to the particular issues faced by a young adults (sic) housed in an adult institution.

Coroner's Comment:
The jury heard expert evidence that young persons (variably defined as persons between 18 and 20, 21 or 24) needed special attention and programs when housed in an adult correctional facility.

68. That CSC develop a transition protocol that begins before a young adult is placed in, or transferred to, an adult institution, and which has the following features:

(a) provides clear and structured process for transition which is understood by incarcerated young adults and institutional management and staff;

(b) provides guidance on roles and responsibilities for those involved in the transition process;

(c) provides guidance on identifying needs and sharing information during the transition process; and

(d) helps build relationships between young offender and adult institution in order to support continuation of care.

Coroner's Comment:
The jury heard expert evidence regarding the special needs of young adults at the time of transfer or entry into federal custody. They also heard expert evidence regarding procedures followed in other jurisdictions.

Contact with Family for Young Adults

69. That CSC facilitate, support, and document, at minimum, weekly communications by:

(a) increasing the inmate's access to family or support persons via telephone, videoconference, and/or web-cast, e.g. Skype or Facetime; and

(b) providing the inmate's family or support persons with appropriate access to telephone, videoconference and/or web-cast, when they are unable to visit the inmate due to financial restrictions.

Coroner's Comment:
The jury heard expert evidence of the beneficial effect of family or other personal support for federally sentenced women particularly when they are housed far from their homes. The jury also heard about the beneficial effect on Ashley Smith's condition of family conversations.

The jury heard further evidence regarding the difficulties in arranging family visitation for Ms. Smith. The jury heard about alternate schemes relying on technology which could economically improve this situation for women like her.

70. That CSC streamline the approval process for visits and contact with families and support persons of young adults. In particular, it will be conducted at a national level such that their families and support persons are not subjected to a repeated approval process at each institution.

Coroner's Comment:
The jury heard evidence of the difficulties Ashley Smith's family encountered in attempting to visit her. The jury heard that the process of security clearance to permit family visits was lengthy and had to be repeated over again for every new institution to which she was transferred.

71. That health care professionals advise young adults of the benefits of providing consent to disclose health information to their families or support persons.

Coroner's Comment:
The jury heard evidence that there was sometimes difficulty in healthcare staff providing access to important medical information concerning a young inmate to her family because the inmate refused to provide consent for disclosure of that information . The jury heard expert evidence that inmate consent was required and could not be insisted upon by CSC. The jury felt that health care staff could still inform inmates of the benefits of providing consent in the hope that they might reconsider their refusal.

72. That, at an institutional level, young adults are consulted on an on-going basis to determine if their needs for particular activities and programs are being met.

Coroner's Comment:
Self-explanatory.

Oversight

A) Internal Mechanisms

73. That CSC implement an independent RA-IA for all inmates, regardless of security classification, status, or placement. The institution will be responsible for advising all inmates of the existence of, and their right to contact, the RA-IA.

Coroner's Comment:

The jury heard evidence that, despite being incarcerated, inmates enjoyed a number of important rights under relevant legislation. The jury saw in evidence a number of occasions upon which Ashley Smith appeared to have exercised some of those rights as well as a number of occasions upon which she attempted unsuccessfully to do so. There was also considerable evidence that she did not understand her rights, and or lacked independent advice as to the implications of exercising her rights in a particular manner. CSC staff are not in a position to provide independent advice that reflects the best interests of the inmate. The jury heard evidence of a number of occasions upon which, for various reasons, her rights under legislation were not accorded to her.

The jury felt that it was important that inmate's human and statutory rights be respected and they felt that an independent "rights advisor" or institutional advocate should be put in place in the federal women's penitentiary system to be certain that inmates are advised of their rights at all times.

74. That the RA-IA will be responsible for providing advice, advocacy and support to the inmate with respect to various institutional issues, including:

a) Transition into institutions;

b) Transfers;

c) Security classification, status, or placement;

d) Parole and release eligibility, including escorted and unescorted absences;

e) Temporary absences;

f) Use of restraints – physical and chemical;

g) Seclusion and segregation;

h) Complaints and grievances;

i) Consent to treatment and capacity to consent;

j) Consent to medication, including available alternatives;

k) Consent to disclosure of information; and

l) Institutional and criminal charges.

Coroner's Comment:
The jury drew on the evidence they heard respecting difficulty in the management of Ms. Smith's case to define the circumstances in which the "rights advisor" or institutional advocate should provide the listed services to inmates.

75. That inmates are protected from reprisals related to contacting the RA-IA and exercising their rights.

Coroner's Comment:
The jury heard evidence that inmates sometimes fear reprisal from attempts on their part to exercise rights.

B) External Mechanisms

76. That the Citizen Advisory Committee have unrestricted and unannounced access to local CSC-operated institutions at any time and be provided with the opportunity to speak with any female inmate, including those in segregation. These discussions will take place in private, out of hearing of staff.

Coroner's Comment:
The jury heard evidence that each woman's penitentiary has a Citizen Advisory Committee made up of representatives of the community in which the institution is located. They heard evidence that this group of persons has access to the institution from time to time, speaks with inmates and makes recommendations to the institutional head. The jury heard that from time to time access could not be provided to the Committee for various reasons including security concerns. The jury understood that there might be valid security concerns, but also felt that at times when that was the case the advice of the Citizen's Advisory Committee might be most needed.

As recommended in recommendation 75 above, the jury wanted interviews with inmates to be private from security staff. The jury understood that there might be security concerns, but wanted them to be resolved in a manner which would permit visits to be conducted in that way.

77. That Citizen Advisory Committees are required to publish annual reports, and that CSC facilitate the publication of these reports on their website.

Coroner's Comment:
The jury felt that for maximum effectiveness each Citizen's Advisory Committee should publish an annual report. This, they felt, would properly account to the public for its function and would increase public confidence in the correctional system. The jury understood that there might be some difficulty in the publication of a report coming from a volunteer citizen group and thus recommended that

Corrections Canada provide support for this function and publish the reports on its public web site.

78. That non-governmental organizations, including Canadian Assosc. of Elizabeth Fry Society advocates, have broad access to local CSC-operated institutions at any time and be provided with the opportunity to speak with any female inmate, including those in segregation. These discussions will take place in private, out of hearing of staff.

Coroner's Comment:
The jury heard evidence of the important advocacy work done by local and national nongovernmental organizations such as the Canadian Association of Elizabeth Fry Societies. The jury also heard evidence that on occasion such organizations did not have success in gaining access to Ashley Smith for these purposes.

For reasons paralleling those given in recommendation 76, the jury wanted those interviews to be conducted out of the hearing of security staff. It was recognized that there might be security concerns and the jury wanted those to be resolved in a manner which would permit the interviews to be conducted in the manner they recommend.

79. That CSC improve the layout of the electronic control panel that opens pod and segregation doors to minimize human error. Specifically, do not have segregation buttons directly beside pod buttons.

Coroner's Comment:
The jury heard evidence concerning numerous design defects in segregation cells which contributed to Ashley Smith's potential to self-harm. In particular, the jury heard evidence of the harm done to her by human error related to the unfortunate poor design of a control panel which operated the locks on the cell doors in the secure unit. The buttons activating the cell doors in the segregation unit were so placed in relation to the buttons operating the doors on the pods that errors could easily be, and frequently were, made by staff members in activating the wrong button in response to a request.

The jury heard evidence that on two occasions human errors in relation to this control panel resulted in inadvertent releases of Ms. Smith from her segregation cell and permitted her to obtain materials with which she could self-harm. The jury believed that amongst the many other defects in cell design they heard about, this particular defect in the control panel should immediately be remedied by its redesign and replacement.

Ethics/Whistleblower Protection

80. That an enhanced Code of Ethics be created that explicitly applies to all Correctional Service of Canada employees, from the Commissioner down to frontline staff, and that this enhanced Code will:

a) address preservation of life;

b) include provisions with the following language: "staff should be allowed to refuse to follow orders or directions without fear of discipline or reprisal whether they are right or wrong as long as there was an air of reality to the ethical/legal objection";

c) include a provision that affirms the right of all CSC staff members to report an order they believe to be illegal without fear of reprisal;

d) include a provision that addresses the individual accountability of all CSC staff and management, for example:

"Prison staff at all levels shall be personally responsible for, and assume the consequences of, their own actions, omissions or orders to subordinates"; and

e) include a provision that addresses the obligation of all CSC staff to respect and protect everyone's right to life, the obligation to ensure the full protection of the health of persons in their custody and the obligation to secure immediate medical attention whenever required.

Coroner's Comment:
The jury heard evidence about the lack of specific direction for CSC staff on a number of matters they referred to and felt that, in view of the potential uncertainty in the mind of many CSC staff as to their ethical obligations and as to the manner in which they should conduct themselves to uphold those obligations, a new ethical code should be prepared and promulgated in the terms the jury set out.

81. That this enhanced Code of Ethics be taught in CORE and management training. Additionally, refresher courses will be conducted at the institutional level for all CSC staff, contract and otherwise.

Coroner's Comment:
CORE Training is the basic training received by every Corrections Canada front line staff member when they first enter the service.

82. That all management are responsible, and held accountable, for ensuring that this enhanced Code of Ethics is communicated to their staff.

Coroner's Comment:
Self-explanatory.

Policy Development

83. That inmates who have experienced mental health issues within correctional systems be involved in planning, research, training and policy development with respect to the provision of mental health care for female inmates.

Coroner's Comment:
Self-explanatory. The jury felt that the input of inmates with similar experiences could not help but be beneficial in planning.

84. That CSC repeal the section dealing with "Involuntary Admission and Treatment" in CD 803, or revise it to conform with community medical practices to ensure equivalency of care for inmates. Specifically, that CSC revise or repeal the requirements that:

a) a physician must assess a patient in-person before providing orders for involuntary medical treatment; and

b) all orders for involuntary health interventions be made in writing.

Coroner's Comment:
The jury heard evidence that after Ashley Smith's death a commissioner's directive was given that required a physician to assess a patient in person before providing orders for involuntary medical treatment and give the orders for such treatment in writing. The jury heard expert evidence that this was not the standard of care in the community and would not be practical. They heard that it would result, instead, in delays or denial of necessary treatment for some inmates.

85. That CSC establish separate and distinct policies for young adults, that is, 18-21 year olds, within adult institutions which will be geared toward their cultural and developmental needs (e.g. educational, vocational, therapeutic, as appropriate to specific needs and situations).

Coroner's Comment:
The jury heard expert evidence that younger adults require specific programming and approaches which are significantly different from those required for adult offenders.

Staff Burnout

86. That, upon recognizing burnout in themselves, staff are responsible for raising their concerns to management, and further, that management is responsible for acting upon these concerns and facilitating support.

Coroner's Comment:
The jury heard evidence of the considerable difficulties encountered by staff in managing Ashley

Smith's care caused by the extreme stress of working daily in the segregation environment. This was often compounded by extended and unanticipated overtime shifts with an extremely challenging inmate who suffered from mental health issues. The jury felt that these staff burnout issues must be addressed for the safety both of staff and of inmates. This could only be done effectively if staff undertook the responsibility to identify their needs and management undertook the responsibility of responding appropriately to them.

87. That, to alleviate pressures and avoid staff burnout, the Institutional Head implements mandatory regularly scheduled respite intervals to frontline staff who primarily deal with complex high needs inmates.

Coroner's Comment:
As above, the jury heard evidence of the extreme stress of working in the segregation unit in circumstances similar to Ms. Smith's case.

Training and Education

88. That CSC develop training to prepare staff to recognize and respond to the particular issues faced by a young adults housed in an adult penitentiary.

Coroner's Comment:
As above, the jury recognized from the expert evidence it heard that young adults have special needs.

89. That managers and frontline staff who are designated to support high needs female inmates with mental health and/or self-injurious behaviours be offered training in the following areas:

a) fundamentals of mental health issues and self-injurious behaviours;

b) First Aid / CPR (current certifications based on community standards);

c) impacts of segregation on mental health, including that of young adults;

d) trauma-informed care (e.g. post-hostage-taking); and

e) medical distress and its intervention (delivered by an external clinician).

Coroner's Comment:
The jury heard evidence of the care received by Ashley Smith during her federal sentence. They also heard from the front-line workers and managers who cared for her. They heard of the training received by such staff and concluded from the evidence concerning the problems with Ms. Smith's care that there were additional training requirements for those tasked with the care of young female

inmates with serious mental health challenges.

90. That all newly appointed Wardens and Deputy Wardens (whether the positions be on an acting or indeterminate capacity) have weekly mentoring sessions with an experienced mentor. These mentoring sessions will take place for at least one full year to provide the mentee with guidance, advice, and support throughout their first year in their newly appointed position. Ideally, the mentor is located in a region different from the mentee.

Coroner's Comment:
The jury heard evidence that the acting warden of Grand Valley Institution to which Ms. Smith was admitted in the fall of 2007 had almost no experience either as a warden or in the management of a women's facility or women offenders.

91. That CSC provide training and education to staff on restraint minimization and de-escalation techniques, and that any such training includes hearing from persons with lived experience who have directly experienced being placed in restraints.

Coroner's Comment:
The jury heard expert evidence on the use of physical restraints for the management of lethal self-harming behaviour. The jury accepted that minimization of restraint use and the use of alternate de-escalation techniques would sometimes present better possibilities of benefit. They felt staff should receive training in these matters and that such training would be most effective if it included user experience.

92. That CSC provide all management and staff with essential refresher training to ensure they maintain the appropriate knowledge and skillsets to fulfill their roles and responsibilities.

Coroner's Comment:
Self-explanatory.

Authority of the Deputy Commissioner for Women

93. That the Deputy Commissioner for Women has direct line authority over all matters relating to female inmates. This gives clear authority and accountability to a single body that provides specialized correctional services to female inmates.

Coroner's Comment:
The jury heard evidence that there had been considerable thought within CSC as to whether the Women's Offender Sector should have line authority in the management of women's institutions. They heard that the Arbour Commission had recommended this approach and that this had been supported by other outside reviews. However, Corrections Canada had decided that the sector would

act as a centre of knowledge and in an advisory capacity only.

The jury heard that the sector did carry out a number of line responsibilities in respect of transfers and other matters. The jury considered the evidence they had heard about the effectiveness of women's institutions reporting through regional headquarters in Ashley Smith's case and they determined that, in view of what they learned about the management of Ms. Smith, this was not a satisfactory or safe way of operating women's institutions.

94. That the female inmates' institutions be grouped under a reporting structure independent of the Regions.

Coroner's Comment:
Same as above.

95. That, in the formation of this new reporting structure, careful consideration is given to the assignment of new positions specifically so that current employee's qualifications, skill sets and competencies are considered for best fit into the newly formed positions.

Coroner's Comment:
The jury heard evidence of a number of situations in which key positions requiring specialized knowledge or experience were filled with persons who did not possess any such experience or skills. The jury was concerned, for example, to hear that an individual was appointed as manager of intensive intervention strategies who had no knowledge of mental health matters or experience in managing those with mental health challenges. The jury wished to emphasize that in the creation of a new management structure, care should be taken to appoint persons to positions of responsibility requiring skills and/or experience, only if they have the necessary qualifications.

Research and Knowledge Transfer

96. That CSC foster working relationships with qualified mental health professionals from academic health sciences organizations (e.g. Centre for Addiction and Mental Health) and research universities. These partnerships will focus on developing treatment strategies and therapeutic practices, as supported by current literature of evidence of effectiveness, specifically for women with mental health illnesses including those engaging in self-injurious behaviour and those in segregation.

Coroner's Comment:
The jury heard evidence that important research relating to the management of self-harming behaviour was conducted in university centres.

97. That CSC revitalize and continue with the research on the emergence of the third group of

women who do not respond to psychotherapy or dialectical behavioural therapy.

Coroner's Comment:
The jury heard evidence that Corrections Canada relied almost entirely on dialectical behaviour therapy for the management of borderline personality disorder and self-harming behaviour. The jury also heard evidence that Corrections Canada had recognized the emergence of a group of inmates suffering from these disorders who do not respond to dialectical behaviour therapy. The jury observed evidence that Ms. Smith may have been a member of that group.

98. That CSC implement communication structures between units conducting research at National Headquarters (e.g. Research Unit and Women Offender Sector) and local institutions to effectively disseminate information to staff through regular institutional visits. Research staff will share relevant literature on effective therapeutic interventions with health care, mental health staff and senior management.

Coroner's Comment:
The jury heard evidence that there is substantial research activity being conducted in Corrections Canada at national headquarters with original research and review of the literature. The jury appreciated from the evidence that awareness of the contents of the literature was not disseminated in an organized, efficient or effective way to regional and local institutions within the service, resulting in lost opportunities for learning from in-house research.

99. That CSC implement ongoing, internal communication structures between frontline, mental health, and health care staff as well as senior management, to effectively disseminate information. Health care and mental health staff will allocate time to meet and discuss relevant literature, complex cases and effective therapeutic interventions with frontline staff and senior management.

Coroner's Comment:
The jury heard evidence that healthcare staff and mental health care practitioners within the service did not hold regular educational events or create opportunities to share best practices. The jury felt that regular such events should be held similar to grand rounds and national meetings in the civilian health care sector.

Accountability

100. That an independent, external audit be contracted by the Minister of Public Safety of CSC's compliance with this jury's recommendations. This audit will be conducted in consultation with the Office of the Correctional Investigator, and the results of such audit will be released publicly during the 2016-2017 and 2023-2024 fiscal years.

101. That the Auditor General of Canada conduct a comprehensive audit of the jury's recommendations and that the results of such audit be released publicly in 2019-2020.

Coroner's Comment:
The jury heard evidence that CSC's rate of compliance with recommendations of inquest juries generally was very low. At least one recommendation of a coroner's jury in respect of a death prior to Ashley Smith's in the institution where she later died had not been complied with. The jury also heard evidence from the commissioner of CSC that compliance with its recommendations might be conditioned by a number of factors including cost.

The jury felt that compliance with its recommendations should be measured and reported publicly. If there were reasons not to comply with some of the recommendations it considered important, officials making such decisions should be publicly accountable for the decision not to comply. Accordingly, the jury recommended audits of compliance by outside auditors.

Verdict and Recommendations

102. That this jury's verdict and recommendations regarding the Inquest into the Death of Ashley Smith is posted in writing in every institution and treatment facility operated by the Correctional Service of Canada, in a place accessible to all staff, within thirty (30) days of the receipt of the verdict and recommendations.

103. That an electronic copy of this jury's verdicts and recommendations is made available for the public on the CSC website, for staff's reference on the CSC intranet, and that staff are immediately made aware by management.

Coroner's Comment:
The jury felt that it was important that the story of Ashley Smith's management and passing be used as a learning tool within the Canadian federal corrections system. They felt that this could best start by making the findings of the jury available to all staff. The jury felt that staff might be able to implement the letter or the spirit of a number of recommendations in a practical way immediately.

104. That the Office of the Correctional Investigator monitor and report publicly, and in writing, on the implementation of the recommendations made by this jury annually for the next 10 years.

Coroner's Comment:
Same comment as for recommendations 100 and 101 above.

Closing comment:

In closing, I would like to stress once again that this document was prepared solely for the purpose of assisting interested parties in understanding the jury verdict. It is worth repeating that this is not the verdict. Likewise, many of the comments regarding the evidence are my personal recollections of the same and are not put forth as actual evidence. If any party feels that I made a gross error in my recollection of the evidence, it would be greatly appreciated if it could be brought to my attention so that any error can be corrected.

Respectfully submitted,

X

John R. Carlisle, M.D., LL.B., FCLM
Coroner, Province of Ontario

April 7, 2014