Deaths in Custody

Context

- Between 2003 and 2013, 536 prisoners died in federal penitentiaries.[1]

- The Correctional Service of Canada's (CSC) mortality review process can sometimes take up to 2 years to complete, and although most reveal "questionable diagnostic practices; incomplete medical documentation; quality and content of information sharing between health care providers and correctional staff and; delays and/or lack of appropriate follow-up on treatment recommendations," most CSC prisoner death investigations conclude with the findings:

    1. health care provided was congruent with applicable health care standards and policy,[2] and
    2. "no further action required."[3]

- Almost 1/3 of those who die in prison are people serving life sentences, the majority of whom were still imprisoned, despite being past their full parole eligibility dates at the time of their deaths. [4]

- Research into deaths in prison further reveals that prisoners who are involuntarily transferred die at higher rate than those who are not subject to involuntary transfers. Of the deaths examined by the Correctional Investigator, 20% occurred within 30 days of an involuntary transfer.[5]

- In 66% of the cases reported from 2001-2005, the Boards of Investigation (BOIs) noted shortcomings in the emergency response of the prison personnel, including inadequate emergency responses and improper decontamination of the area surrounding the victim in the immediate aftermath of the incident.[6]

- Deaths in custody have not diminished over time, and the CSC continues to fail to respond effectively to emergency situations within institutions.[7]

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[1] The Correctional Investigator Canada, *Annual Report of the Office of the Correctional Investigator 2013-2014* (Ottawa: Minister of Public Works and Government Services Canada, 2006), at 28, online: The Correctional Investigator of Canada <http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20132014-eng.pdf>.
[2] The Correctional Investigator Canada, *Annual Report of the Office of the Correctional Investigator 2013-2014* (Ottawa: Minister of Public Works and Government Services Canada, 2006), at 38, online: The Correctional Investigator of Canada <http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20132014-eng.pdf>.
[3] The Correctional Investigator Canada, *Annual Report of the Office of the Correctional Investigator 2013-2014* (Ottawa: Minister of Public Works and Government Services Canada, 2006), at 29, online: The Correctional Investigator of Canada <http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20132014-eng.pdf>.
[4] The Correctional Investigator Canada, *Annual Report of the Office of the Correctional Investigator 2013-2014* (Ottawa: Minister of Public Works and Government Services Canada, 2006), at 38, online: The Correctional Investigator of Canada <http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20132014-eng.pdf>, Thomas Gabor, *Deaths in Custody: Final Report* (Ottawa: The Correctional Investigator of Canada, 2007), online: The Correctional Investigator of Canada <http://www.oci-bec.gc.ca/cnt/rpt/oth-aut/oth-aut20070228-eng.aspx>.
[5] Thomas Gabor, *Deaths in Custody: Final Report* (Ottawa: The Correctional Investigator of Canada, 2007), online: The Correctional Investigator of Canada <http://www.oci-bec.gc.ca/cnt/rpt/oth-aut/oth-aut20070228-eng.aspx>.
[6] Thomas Gabor, *Deaths in Custody: Final Report* (Ottawa: The Correctional Investigator of Canada, 2007), online: The Correctional Investigator of Canada <http://www.oci-bec.gc.ca/cnt/rpt/oth-aut/oth-aut20070228-eng.aspx>.
[7] Thomas Gabor, *Deaths in Custody: Final Report* (Ottawa: The Correctional Investigator of Canada, 2007), online: The Correctional Investigator of Canada <http://www.oci-bec.gc.ca/cnt/rpt/oth-aut/oth-aut20070228-eng.aspx>.

Ashley Smith

- In the wee hours of October 19, 2007 Ashley Smith died, isolated, in a segregation cell, at Grand Valley Institution (GVI), the federal prison for women in Kitchener, Ontario. She was transferred up from the youth system less than one year earlier and was only 19 years old when she died.[8]

- On October 18th, 2007, Ashley was on 24-hour suicide watch under direct staff observation. Ashley died of asphyxiation on October 19th; after staff observed her tying a ligature around her neck. Staff claimed managerial direction caused them to fail to respond immediately to her medical distress.[9]

- Ashley was initially jailed for a breach of probation for throwing crab apples at a postal worker whom she believed was withholding welfare cheques from a neighbour.[10] Ashley then accumulated charges while in prison. When she died, she was serving a cumulative sentence of 6 ½ years, and was facing additional sentencing for outstanding prison-generated charges.

- Despite clearly exhibiting mental health issues, Ashley was never properly assessed, nor was a treatment plan developed for her. In the 11½ months before her death, Ashley was moved 17 times amongst three federal penitentiaries, two treatment facilities, two external hospitals, and one provincial correctional facility. Each transfer eroded her trust in staff and the correctional system, resulted in escalated "acting out" behaviours, and assessments by the Correctional Service that she was increasingly "difficult to manage".[11]

- In the weeks before her death, Ashley spent all of her time in an empty, poorly lit segregation cell, cold, lonely, bored and suicidal; she was therefore also left naked except for a security gown with nothing to do to occupy her time. Her self-injurious and "problematic" behaviours have since been recognized as desperate attempts for human interaction.[12]

- To say Ashley adjusted poorly to imprisonment is a severe understatement. She spent virtually all of her time in segregation in the youth system, and was segregated for the entire time that she was in the custody of the adult provincial and federal systems.[13]

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[8] Bernard Richard, *Ashley Smith: A Report of the New Brunswick Ombudsman and Child and Youth Advocate on the services provided to a youth involved in the youth criminal system*, at 3, (New Brunswick: Office of the Ombudsman and Child and Youth Advocate, 2008), online: Government of New Brunswick <https://www.gnb.ca/0073/PDF/AshleySmith-e.pdf>.

[9] United Nations, *Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment and Punishment*, at 6, online: United Nations <http://www.unhchr.ch/html/menu3/b/hcat39.htm>.

[10] Diana Zlomislic, Donovan Vincent, "Excerpt: The Life and Death of Ashley Smith", *The Toronto Star* (15 December 2013), online: The Toronto Star <http://www.thestar.com/news/canada/2013/12/15/excerpt_the_life_and_death_of_ashley_smith.html>.

[11] Bernard Richard, *Ashley Smith: A Report of the New Brunswick Ombudsman and Child and Youth Advocate on the services provided to a youth involved in the youth criminal system*, at 5-6, (New Brunswick: Office of the Ombudsman and Child and Youth Advocate, 2008), online: Government of New Brunswick <https://www.gnb.ca/0073/PDF/AshleySmith-e.pdf>.

[12] Bernard Richard, *Ashley Smith: A Report of the New Brunswick Ombudsman and Child and Youth Advocate on the services provided to a youth involved in the youth criminal system*, at 7, (New Brunswick: Office of the Ombudsman and Child and Youth Advocate, 2008), online: Government of New Brunswick <https://www.gnb.ca/0073/PDF/AshleySmith-e.pdf>.

[13] Howard Sapers, *A Preventable Death* (Ottawa: Office of the Correctional Investigator, 2008), at 5, online: The Correctional Investigator of Canada <http://www.oci-bec.gc.ca/cnt/rpt/pdf/oth-aut/oth-aut20080620-eng.pdf>.

- The fact that Ashley had been segregated before, and that it had a detrimental effect on Ashley's overall well being, was known by Correctional Services. Despite this information, Ashley was placed on administrative segregation status, and kept there during her entire period of incarceration. This regime is highly restrictive and inhumane.[14]

- At the conclusion of the Inquest, Ashley's death was ruled a homicide, and the jury made 104 recommendations regarding the treatment of prisoners with mental health issues.[15] CSC's response, released one year later, failed to address the recommendations; and notably, amounted only to a promise to contract two treatment beds and examine the possibility of other contracts with provincial/territorial health departments.[16]

Kinew James

- On January 20, 2013, Kinew James, many hours after she first started requesting medical intervention, was deemed "unresponsive" in her cell in the Regional Psychiatric Centre (RPC) in Saskatoon. Kinew was declared dead upon arrival at the hospital. Her mother was told that she had suffered a diabetes-related heart attack.

- Other prisoners at RPC reported that they had repeatedly pressed the emergency call buttons in order to seek medical assistance for Kinew.

- CAEFS will seek standing as an Intervener in the Inquest into the death of Kinew. The date of the inquest has not yet been set.

Suicide and Segregation

- Suicide rates in Canadian prisons are 7 times higher than in the general population.[17]

- 22% of prisoners, who were found to have committed suicide, did so while in segregation.[18]

- Between 1994-95 and 2013-14, 211 federal prisoners committed suicide. Suicide accounts for roughly 20% of all deaths in custody in any given year.[19]

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[14] Howard Sapers, *A Preventable Death* (Ottawa: Office of the Correctional Investigator, 2008), at 6, online: The Correctional Investigator of Canada <http://www.oci-bec.gc.ca/cnt/rpt/pdf/oth-aut/oth-aut20080620-eng.pdf>.
[15] John Carlisle, *Inquest Touching the Death of Ashley Smith: Jury Verdict and Recommendations*, Office of the Chief Coroner (Queen's Printer for Ontario, 2013).
[16] Correction Services Canada (CSC), *Response to the Coroner's Inquest Touching the Death of Ashley Smith*, (Ottawa: December 2014), online: CSC <http://www.csc-scc.gc.ca/publications/005007-9011-eng.shtml#5.1>.
[17] The Correctional Investigator Canada, *Annual Report of the Office of the Correctional Investigator 2013-2014* (Ottawa: Minister of Public Works and Government Services Canada, 2006), at 28, online: The Correctional Investigator of Canada <http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20132014-eng.pdf>.
[18] The Correctional Investigator of Canada, *A Three Year Review of Federal Inmate Suicides (2011-2014)*, at 7, online: The Correctional Investigator of Canada <http://www.oci-bec.gc.ca/cnt/rpt/pdf/oth-aut/oth-aut20140910-eng.pdf>.
[19] The Correctional Investigator of Canada, *A Three Year Review of Federal Inmate Suicides (2011-2014)*, at 3, online: The Correctional Investigator of Canada <http://www.oci-bec.gc.ca/cnt/rpt/pdf/oth-aut/oth-aut20140910-eng.pdf>.

- Of prisoners who suicide, 58% had a history of psychological problems; 60% had prior suicide attempts; more than one-third had a history of self-harm; 85% had difficulties with past substance abuse.[20]

- De-briefing is offered to staff members following prisoner suicide, but not necessarily to prisoners.[21]

- CSC policy prohibits the use of segregation to manage suicide risk. However, CSC persistently continues to utilize this dangerous practice of long-term segregation of prisoners with mental health issues, elevated suicide risk and/or risk of self-injury.[22]

- CSC is increasingly separating prisoners from the general prison population by isolating them in special units, as well as in segregation. In 2013-2014, prisoners were placed in segregation 8,328 times; and, on any given day, there are an average of 850 prisoners in administrative segregation in Canadian penitentiaries. This is a 6.4% increase in the last five years.[23]

- Segregation is both a status and a place. For instance, maximum security and mental health units in prisons for women are isolated from the general population of prisoners and the women in those units have limited access to recreation, programs and services.

- The experiences of isolated prisoners has been compared to those documented by prisoners of war: small rooms, bare neutral coloured walls, lights on 24 hours a day, and the provision of minimum amenities (i.e. a toilet, a sink, a bed (and sometimes a desk) – all secured to the walls or floor, respectively).[24]

- Studies identify such detrimental effects of prolonged segregation, as insomnia, anxiety, panic, withdrawal, hypersensitivity, ruminations, cognitive dysfunctions, hallucinations, loss of control, irritability, aggression, rage, paranoia, hopelessness, lethargy, depression, a sense of impending emotional breakdown, self-mutilation, and suicidal ideation and behaviour.[25] Indeed, many of these are the behaviours Ashley Smith exhibited, and for which she was "punished". And, as the evidence at the inquest revealed, some developed while she was in segregation; others were exacerbated by the conditions of her confinement.[26]

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[20] The Correctional Investigator of Canada, *A Three Year Review of Federal Inmate Suicides (2011-2014)*, at 10, online: The Correctional Investigator of Canada <http://www.oci-bec.gc.ca/cnt/rpt/pdf/oth-aut/oth-aut20140910-eng.pdf>.

[21] The Correctional Investigator of Canada, *A Three Year Review of Federal Inmate Suicides (2011-2014)*, at 15, online: The Correctional Investigator of Canada <http://www.oci-bec.gc.ca/cnt/rpt/pdf/oth-aut/oth-aut20140910-eng.pdf>.

[22] The Correctional Investigator of Canada, *A Three Year Review of Federal Inmate Suicides (2011-2014)*, at 4, online: The Correctional Investigator of Canada <http://www.oci-bec.gc.ca/cnt/rpt/pdf/oth-aut/oth-aut20140910-eng.pdf>.

[23] The Correctional Investigator Canada, *Annual Report of the Office of the Correctional Investigator 2013-2014* (Ottawa: Minister of Public Works and Government Services Canada, 2006), at 32, online: The Correctional Investigator of Canada <http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20132014-eng.pdf>.

[24] Atul Gawande, "Hellhole", *The New Yorker* (30 March 30, 2009), online: The New Yorker <http://www.newyorker.com/reporting/2009/03/30/090330fa_fact_gawande>.

[25] Howard Sapers, *A Preventable Death* (Ottawa: Office of the Correctional Investigator, 2008), at 42, online: The Correctional Investigator of Canada <http://www.oci-bec.gc.ca/cnt/rpt/pdf/oth-aut/oth-aut20080620-eng.pdf>.

[26] The Correctional Investigator of Canada (2008), *Ashley Smith: A Preventable Death*, pp 5-7, online: The Correctional Investigator of Canada <http://www.oci-bec.gc.ca/cnt/rpt/pdf/oth-aut/oth-aut20080620-eng.pdf>.

- In 2011, the UN Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, recommended that segregation be abolished for youth and prisoners with mental health issues, and that no prisoners should ever be segregated for more than 15 days. Indeed, the UN considers prolonged periods of segregation as torture.[27]

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[27] United Nations, *Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment and Punishment*, online: United Nations <http://www.unhchr.ch/html/menu3/b/hcat39.htm>.

2006), online: The Correctional Investigator of Canada <http://www.oci-bec.gc.ca/cnt/rpt/pdf/annrpt/annrpt20132014-eng.pdf>.

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