**How Many Deaths in Prisons, How Many Inquests? Reflections from the Canadian Association of Elizabeth Fry Societies on the Public Inquest into the Death of Terry Baker**

On the evening of Friday, February 9th, 2024, jurors came to a decision in the Public Inquest into the Death of Terry Baker that Terry’s death was a suicide and put forward 67 recommendations to prevent future deaths in custody.

Yet Terry’s death occurred almost ten years following the widely publicized death of Ashley Smith in the same segregation unit as Terry, and just three years following Ashley Smith’s inquest, which released over 100 recommendations. The majority of recommendations from Ashley Smith’s inquest went unheard by the government.

Terry’s inquest also occurred on the heels of the inquest into the death of Soleiman Faqiri. A Toronto Star report released on February 13th, 2024 states “two months after a coroner’s inquest rules Soleiman Faqiri’s jailhouse death a homicide, the Ontario government has failed to meet the first dozens of recommendations meant to help prevent similar deaths[[1]](#footnote-2).”

The alarming rate of deaths inside of Canadian prisons and penitentiaries have sparked national attention. A collaborative project between civil society and several universities called Tracking Injustice[[2]](#footnote-3) is collecting data and monitoring how many individuals are dying in our institutions.

With one of the primary purposes of public inquests being to put forward recommendations to prevent similar deaths from occurring in the future, it is impossible not to wonder what is going wrong.

Terry Baker was a 30-year-old woman, with debilitating mental health considerations, who died while in a segregation cell at the Grand Valley Institution for Women (GVI), in 2016. The jury determined that Terry Baker died by suicide.

Terry Baker was a woman who had spent nearly half of her life in prison. She was incarcerated as a teenager, essentially ‘growing up’ in a prison setting; a setting that has been repeatedly criticized as inappropriate and harmful for people who are experiencing mental illness. It was the submission of the Canadian Association of Elizabeth Fry Societies (CAEFS) upon Terry’s inquests closing that years of repeated segregation and other security responses to Terry Baker’s mental illness had ultimately led to her death.

Since 1978, CAEFS has worked to address the persistent ways in which women and gender diverse people impacted by criminalization are denied humanity and excluded from the community. CAEFS monitors conditions of confinement in the federal prisons designated for women and supported Terry while she was incarcerated.

The primary reason that CAEFS had sought a homicide verdict in Terry’s death was that, unlike suicide in the community, the Correctional Service of Canada (CSC) is responsible for the lives and wellbeing of incarcerated people. That responsibility must extend to loss of life. The disappointing verdict of suicide places responsibility instead on Terry for her death and ignores the impact that her time in prison and the decisions made by the CSC- such as Terry’s placement in segregation-played in her death.

At the inquest, CAEFS put forward recommendations that spoke to overarching systemic issues that could have led to real change for people like Terry Baker. The elimination of all forms of solitary confinement, the need for independent binding oversight to bring the prison system into compliance with law and policy, and the need for societal responses to mental health crises that focus on the need for therapeutic health care rather than punitive incarceration.

It became clear throughout Terry Baker’s inquest that little had changed in addressing the overarching responses to mental illness both as a societal response and as a prison-specific response. We continue to imprison people with mental illness and to respond to their needs punitively, often placing them in segregation, which we have seen time and again can have fatal consequences.

In order to stop and prevent harm from happening we must focus on the bigger picture. Getting lost in specific recommendations that tinker around the edges of a punitive system is going to continue to reproduce the harms that Terry Baker experienced. Many of the recommendations put forward in the Terry Baker inquest will likely continue to be ignored or implemented through a security focused lens. Systemic change can only happen when broader actions are taken – like those that are proposed in Bill S-230 for example, a Senate bill that has passed third reading.

We want to be shocked that the inquest didn’t result in a homicide verdict, given that the Grand Valley Institution had gone through the inquest process with Ashley Smith and had not instituted most of the recommendations from that jury. However, there was a lack of evidence throughout Terry’s inquest about the broader context within which Terry was incarcerated and her death occurred.

The inquest would have greatly benefited from hearing from more people who knew Terry and people who could provide wider systemic insight into the many issues impacting Canadian penitentiaries designated for women. Ultimately, the witnesses were weighted heavily to staff of the Correctional Service Canada, which shaped both the scope of the inquiry and its outcome.

The process of public inquests is an incredibly important one, especially in that they bring the deaths of people in custody to the public’s attention. However, like so much oversight of the Canadian prison system, recommendations made through inquests are not binding. It has been continually disappointing that more recommendations from Ashley Smith’s inquest weren’t implemented, as many of them could have likely prevented Terry’s death. With Terry’s inquest closed, we must ask ourselves- how many more people with mental illness will perish in Canadian penitentiaries before we truly change things?

Learn more about the Public Inquest into the Death of Terry Baker and about CAEFS @ caefs.ca

1. https://www.thestar.com/news/gta/ontario-misses-deadline-on-first-of-57-soleiman-faqiri-inquest-recommendations/article\_03d37c78-a5e9-11ee-b34a-ef59047e3185.html [↑](#footnote-ref-2)
2. https://trackinginjustice.ca/about-the-project/ [↑](#footnote-ref-3)