HOW CANADA'S PRISONS KILLED ASHLEY SMITH:

A NATIONAL CRIME AND SHAME

by Don Weitz

Editorial note: This paper is a substantially revised version of my original article titled "How Canada's Prison System Killed Ashley Smith: A Case Report on Canada's War Against Rebellious Youth"; it was first published in *Voices*, newsletter of the Psychiatric Survivor Archives Toronto, vol.4 no.3 (October) 2013; also published as a blog at the website below with the title "How Canada's Prisons killed Ashley Smith: a national crime and shame," on December 14, 2013, http://www.madinamerica.com/2013/12/canadas-prisons-killed-ashley-smith-national-crime-shame.

This is a critical report about imprisonment of one young woman, Ashley Smith, her being diagnosed "mentally ill" and her death in a women's prison, and the inquest which ended in Toronto in early December 2013.

Born in 1988 Moncton, New Brunswick and adopted as a young child, Ashley was a very troubled and rebellious teenager. By the time she was 13, she was getting into trouble in school, she frequently refused to attend or dropped out. On one occasion, Ashley was charged with the crime, actually a childish prank of "throwing crabapples at a postal worker." For this so-called crime, Ashley was convicted and sentenced to detention in New Brunswick Youth Centre where she was frequently punished and segregated, thrown in solitary confinement for roughly three consecutive years. The detention staff, and later CSC guards ("correctional officers"), and correctional managers and wardens labeled Ashley's youth rebelliousness "acting out"; prison psychologists and psychiatrists psychiatized Ashley, labeled her defiant behavior a "mental health issue", a thinly disguised term for "mental illness." In the New Brunswick youth jail, the staff severely punished Ashley for being "non-compliant"; they punished her by throwing her into segregation (solitary confinement) for resisting staff orders and institutional rules.

Apparently, there is no official record of any detention or prison staff or health professional trying to understand Ashley's resistance to authority as youth rebellion, no attempt to understand her "acting out" as expressions of and attempts to struggle with a serious identity crisis, which is very common in youth. Ashley was basically trying to find herself, trying to discover whom she was by asserting herself, stubbornly standing her ground. When she turned 18 in 2006, Ashley was forcibly transferred from New Brunswick's youth detention facility to the Nova Institution for Women in Nova Scotia, one of several federal prisons run by CSC. She lasted about a month before she was transferred to another prison in Joliet, Quebec.

From 2006 to 2007, the last 11 to 12 months of Ashley's life, CSC managers had transferred Ashley to a total of 9 prisons and psychoprisons; in virtually every prison she was segregated and physically restrained her as an "acting out", "difficult" or disruptive inmate – the psychologists and psychiatrists were complicit in labeling and stigmatizing Ashley as a "borderline personality disorder", another unscientific psychiatric grab bag diagnosis commonly applied to girls and women who self-harm. By this time, Ashley was frequently tying cloth ligatures around her neck, sometimes using glass, which she often hid on her body, to cut off pieces from a prison "suicide gown." In various prisons and psychoprisons (psychiatric institutions), Ashley was constantly locked up in a segregation cell, frequently tied up in 4-point restraints and once tied up for hours in a torturous wooden device called "restraint chair." Prison guards entered her cell almost daily to forcibly cut the ligatures she tied around her neck, sometimes they assaulted her (officially recorded as "use of force incidents"). After an internal investigation at Saskatchewan's Regional Psychiatric Centre in Saskatoon, a correctional manager was charged with assault but not

convicted, he died shortly thereafter.

Ashley frequently lashed out while trying to assert and protect herself from daily “interventions” or uses of force by the guards. More alarming, she was becoming increasingly desperate and suicidal. Ashley flatly refused to consent to CSC’s proposed treatment plan of “intensive intervention”, such as “dialectical behavior therapy”, a euphemism for behavior modification based on rewards and punishments such as removing “privileges” -- actually violating prisoner’s human rights. She was constantly locked up in segregation with no peers or prisoners to talk with and sometimes denied the “privilege” of pen and paper to write.

During the last 11-12 months of her life, CSC not only locked up Ashley in segregation (without appeal) but also forcibly transferred her 17 times to 9 different institutions in 5 different provinces. These institutional transfers, solitary confinement cells and physical assaults must have caused her incredible anxiety, fear, and trauma. While on “suicide watch” in September and October in Grand Valley Institution (GVI), a maximum-security federal prison for women in Kitchener, Ontario, Ashley was tying a cloth ligature cloth around her neck almost daily. Finally, while wearing a “suicide gown” in a segregation cell, Ashley choked herself to death on October 19, 2007 in GVI – several guards just watched, refusing to enter her cell. Ashley was 19.

In January 2013, almost 6 years later, the coroner’s inquest into Ashley‘s death began after CSC delayed the start of the inquest for over a year by withholding prison videos and audio clips of physical assault, pepper-spraying, physical restraints including a torture device called “restraint chair”, forced drugging and other

dehumanizing and incriminating evidence of guard brutality inflicted on Ashley. Thanks to Coroner John Carlisle, the graphic and disturbing videos were eventually screened in court. According to independent reports by Federal Correctional Investigator Howard Sapers, during the final twelve months of her life, Ashley was “shuttled through nine different institutions across five provinces before landing in Kitchener and spent most of that time in a segregated cell wearing nothing but a padded suicide gown.” (1,2) These institutional moves occurred about every 3-4 weeks or sometimes after a few days -- a series of institution-initiated traumas instigated by prison wardens and correctional managers who couldn’t control and obviously wanted to get rid of “inmate Ashley.” The many frequent transfers also undermined any possibility of “continuity of care”; they were traumatic, a form of torture since Ashley always ended up in a segregation cell in every prison and psychoprison during four years of imprisonment up to and including her death.

These transfers included the following prisons and psychoprisons: Grand Valley Institution for Women in Kitchener, Ontario; Institut Philippe-Pinel Mental Health Unit for Women in Montreal; Nova Institution for Women, a CSC prison in Truro, Nova Scotia; Joliette Institution, a CSC prison in Quebec; St. Thomas Psychiatric Hospital in St.Thomas, Ontario; Grand Valley Hospital; and Regional Psychiatric Centre in Saskatoon, Saskatchewan. (3)

According to the inquest testimony of several correctional officers and senior management staff at GVI and CSC’s Regional Headquarters, Ashley frequently tried to choke herself while “her face was blue or

purple.” To escape detection, she sometimes hid the cloth ligature and/or a piece of glass inside her body. On one occasion, GVI forcibly transferred Ashley to St. Thomas Psychiatric Hospital where medical or mental health staff forcibly strip-searched her, looking for but failed to find any glass in her body.

Correctional managers’ orders to many prison guards frequently undermined CSCs stated policy and principle of “preserving life” of the prisoners. For example, several orders issued to correctional officers as email messages by GVI’s Acting Warden Cindy Berry and Deputy Warden Joanna Pauline were confusing, contradictory, and maddening—such as “don’t enter [Ashley’s cell] while she’s still breathing, walking or talking”, even though her face sometimes turned “blue or purple” and/or she was gasping for breath. At the same time, guards were ordered to enter her cell if Ashley was in “medical distress”, a key term that was vaguely defined by correctional managers and frequently misinterpreted by many guards. However, when some concerned guards disobeyed or ignored Warden Cindy Berry’s “don’t enter” command by entering Ashley’s cell while she was breathing and cutting the ligature around her neck, Berry criticized them for their “excessive use of force.” At the inquest, Berry testified that correctional officers were supposedly trained to “use their judgment or common sense” in recognizing prisoners who showed signs of “medical distress”, in immanent harm or death, such as turning blue or purple and gasping for breath. Some guards were understandably confused and hesitated to enter to enter the cell even when Ashley was lying on the cell floor barely breathing; at the same time, some guards believed Ashley just “wanted more attention” or was being “manipulative.” By September 2007, approximately 6 weeks before her death, Ashley was overtly suicidal, she was making several daily attempts to strangle herself with a cloth ligature in plain

view of correction officers, and the knowledge of GVI's wardens. Nevertheless, some guards played a 'waiting game'—they deliberately waited or hesitated minutes to enter the cell while Ashley's face turned blue or purple.

At the inquest, Elizabeth Fry Society Executive Director Kim Pate, who visited Ashley a number of times in 2007, testified that on September 24, 2007, approximately 3 weeks before she died, Ashley filed two written complaints of guard abuses addressed to GVI Warden Cindy Berry but they were never delivered; they were found in a box months after her death. Pate also testified that Ashley should not have been kept in segregation for long periods; instead she should have been hospitalized and offered "peer support" in prison and the community. However, community alternatives to youth detention centres and "mental health treatment" in prisons - such as women-centered 24/7 crisis centres, healing houses, and safe supportive houses for abused and traumatized women – were virtually nonexistent in CSC and never seriously discussed during the entire inquest. If CSC staff had offered peer support to Ashley and if she had consented, Ashley would probably be alive today.

Two weeks before her death at GVI, Ashley became more depressed and overtly suicidal; she made several daily suicide attempts, especially after she was charged and convicted of physically assaulting some guards, and after a judge sentenced her to 6 additional months. At this time, Ashley believed she was about to be paroled, but her hopes for release or parole were dashed, her spirit crushed by the judge's ruling. On October 19, 2007 while on 'suicide watch' wearing a "padded suicide gown" in a GVI segregation cell, Ashley strangled herself to death with another ligature tied around her neck, while several guards stood outside her cell and watched her

die. The guards refused to enter her cell; they were following Warden Cindy Berry's order, "don't enter if she's breathing." They hadn't noticed that Ashley had stopped breathing for several minutes.

Ashley's parents want to launch a public inquiry or lawsuit because of compelling video and other evidence of criminal and medical negligence and inhumane treatment - such as indefinite solitary confinement in segregation cells, 4-point restraints and "the restraint chair", forced drugging, lack of "mental health" care, strip searches, physical assaults by prison guards and the complicity of prison managers and wardens. Also worth noting was CSC's systemic failure to share critical information among all levels of management; as a result there were huge information gaps and decision delays on 'hi-risk' prisoners like Ashley. Control and "use of force" were the orders of the day. According to the testimony of a former senior mental health manager at CSC's National Headquarters, guards were involved in "150 use of force" incidents involving Ashley, "43%" happened a few weeks before her death. "Use of force" incident reports about Ashley, and probably many other prisoners, were not widely accessible and shared by most prison managers. Apparently, Ashley's frequent use of ligatures was never understood as existential cries for help by correctional managers and other prison officials, including senior staff at CSC's Regional and National Headquarters.

Obviously, It's time for an independent and thorough public investigation into all federal and provincial prisons, as well as youth assessment and detention centres, especially those that use segregation and physical restraint as punishment. The jury recommendations, no matter how well intentioned, may not be enough to arouse national public concern and government action,

despite extensive media coverage of this inquest. Recommendations of the Coroner's Jury should be released sometime in December; they should make maddening reading, especially those that promote the discredited medical model including "mental health treatment" and "mental illness." During the inquest, health professionals and lawyers who frequently repeated unscientific and stigmatizing psychiatric diagnoses such as "personality disorder" and "borderline personality disorder" as medical-scientific facts were never challenged. A psychiatrist who briefly interviewed Ashley at the Pinel psychoprison ("mental health unit") in Montreal had diagnosed her with the "anti-social behaviour disorder" label. It's also significant that CSC's mental health professionals as well as most of the inquest lawyers didn't try to deconstruct "mental disorder" or "mental illness" as attempts to cope with personal life crises. Together with psychiatrists and other mental health professional witnesses, they failed to understand that "mental health treatment" in prisons really means fraudulent psychiatric diagnoses, forced drugging, physical restraints, daily degradation and humiliation.

Ashley's suicide, like many other prisoner deaths, was not accidental, it was predictable and preventable. There will probably be no verdict of homicide in the Coroner Jury's report and recommendations expected at the end of the inquest this December.

The Harper government's "get tough on crime" policy that legislates building more prisons, overcrowding ("double-bunking"), mandatory and longer prison sentences have undoubtedly contributed to the epidemic of self-harm, suicide and violence in virtually all federal prisons in Canada. What's needed is not "prison reform" but prison abolition and community alternatives which were denied Ashley and many of her sister prisoners. There are and will be many other Ashley

Smiths - a national shame and crime.

Notes

1. Howard Sappers. Report of Correctional Investigator Howard Sapers and CSC National Board of Investigation into the Death of an Inmate [Ashley Smith] at Grand Valley Institution for Women on October 19, 2007 (February 2008). http://www.oci-bec.gc.ca/rpt/oth-aut/oth-aut20080620-eng.aspx

2. "Ashley Smith Case: Secrecy surrounds suicide case," *The Toronto Star*, September 3, 2010.

3. Thanks to Child and Youth Advocate Lee Tustin and lawyer Richard Macklin for this information. Personal Communication, September 30, 2013.

Recommended Reading:

Louise Armstrong (1993) *And They Call It Help: Psychiatric Policing of American Children*. New York: Addison-Wesley Publishing Co.

Peter R. Breggin & Ginger Ross Breggin (1994) *The War Against Children.* New York: St. Martin's Press,

Brenda A. LeFrancois (2012). The pursuit of meaningful collaborative consultation, and the need to do better. In CRAN (Ed.). *Children's Rights Academic Network Final Report* – 4th Annual General Meeting. Ottawa: Landon Pearson Resource Centre for the Study of Childhood and

Children's Rights.

Don Weitz. "We still lock up children." *Toronto Life*. (May) 1976.

An expose of solitary confinement ("the digger") in Ontario's "reform institutions" - its criminal youth justice system.