HRTO File No. 2017-29710-S

HUMAN RIGHTS TRIBUNAL OF ONTARIO

B E T W E E N :

Ontario Human Rights Commission

Applicant

-and-

Her Majesty the Queen in the Right of Ontario
as represented by the Ministry of the Solicitor General

Respondent

MOTION RE ONTARIO'S NON-COMPLIANCE WITH THE *JAHN v MCSCS* AND *OHRC v ONTARIO* TERMS

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PART I – OVERVIEW

1. Justice David Cole, the Independent Reviewer appointed under the terms of the Human Rights Tribunal of Ontario's 2018 *OHRC v Ontario* Order, has determined that Ontario has failed to comply with the terms of that Order. Contrary to the terms and spirit of the 2018 Order and the 2013 *Jahn v MCSCS* settlement that preceded it, people with mental health disabilities in Ontario's correctional system continue to be warehoused in segregation by the thousands. Courts in this province and across the country have held that such treatment is harmful to the health and well-being of these prisoners.

2. The Tribunal has directed that it will remain seized pending full implementation of the terms of the *Jahn* settlement and its 2018 Order. Accordingly, the Ontario Human Rights Commission (OHRC) now brings this motion to obtain further remedies from this Tribunal to ensure that, after seven long years of policy failures and broken promises, Ontario complies with its legal obligations – and people with mental health disabilities no longer face the harm of segregation every day in prisons across Ontario.

PART II – INTRODUCTION

3. In 2011, Christina Jahn was admitted into Ontario's correctional system and directly into segregation, where she would go on to be held for more than 200 days due to having a mental health disability.

4. Segregation, also known as solitary confinement, is the practice of confining a person to a six by nine foot cell for 22 or more hours a day with little or no human interaction. It has been described as the "most austere and depriving form of incarceration" in Canada,[1] and a "dungeon inside a prison."[2]

5. There is widespread recognition that segregation causes profound and lasting harm, particularly for people with mental health disabilities. The practice is so severe that segregation beyond 15 continuous days is prohibited according to international standards,[3] and has been recognized by courts of appeal in Ontario and British Columbia as unconstitutionally cruel and unusual treatment.[4] Court

[1] Office of the Correctional Investigator, News Release, "Office of the Correctional Investigator Releases Administrative Segregation in Federal Corrections: 10 Year Trends - Federal Corrections Overuses Segregation to Manage Inmates" (28 May 2015).
[2] *Francis v Ontario*, 2020 ONSC 1644 (CanLII) at para 1, [2020] OJ No 1714, appeal as of right to the CA [*Francis*].
[3] *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)*, GA Res 70/175, UNGAOR, 70th Sess, Supp No 106, UN Doc A/Res/70/175, (17 December 2015), Rule 43 [*Mandela Rules*].
[4] *Canadian Civil Liberties Association v Canada*, 2019 ONCA 243 (CanLII) at para 5, [2019] OJ No 1537, appeal to SCC discontinued [*CCLA* CA]; *British Columbia Civil Liberties Association v Canada (Attorney General)*, 2019 BCCA 228 (CanLII), 377 CCC (3d) 420, appeal to SCC discontinued.

decisions across the country have found that segregation subjects people to significant risk of serious psychological harm, that harm can occur after only a few days and for many be permanent, and that the risk of harm is intensified for mentally ill prisoners.[5] In Ontario, the Court of Appeal and the Superior Court of Justice have recognized that people with mental illness should not be placed in segregation.[6] The Superior Court has held that putting people with serious mental illness in segregation for any period is unconstitutional.[7]

6. An Alberta Court considering the use of segregation recently commented that:

> Societal views on what is acceptable treatment or punishment evolve over time. Forced sterilization, residential schools, lobotomies to treat mental disorders, corporal punishment in schools and the death penalty are all examples of treatment once considered acceptable. Segregation ravages the body and the mind. There is growing discomfort over its continued use as a quick solution to complex problems.[8]

7. Back in 2013, it seemed that Ms. Jahn's story of neglect was going to prompt a critical shift in Ontario's use of segregation. At that time, the Government of Ontario entered into a legally binding human rights settlement in which it expressly acknowledged the harm caused by segregation and committed to ensuring that no one with mental illness would be placed in segregation barring undue hardship. The *Jahn* settlement also included a broad range of other measures to ensure that people with mental health disabilities in Ontario's correctional system would receive adequate care, including mental health screening for all prisoners upon admission, individualized treatment plans for those with mental health disabilities, and access to mental health services.[9]

8. Troublingly, almost seven years later, Ontario still remains in breach of these legally binding obligations despite contravention applications; independent reviews; alarming examples of disturbing segregation use; numerous court decisions documenting the *Charter*-violating harm caused by segregation and ongoing failure to implement *Charter*-compliant segregation policies or procedures; and data showing extensive segregation of prisoners with mental health disabilities.

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[5] See *Brazeau v Canada (Attorney General)*, 2020 ONCA 184 (CanLII), [2020] OJ No 1062 [*Brazeau*].
[6] *CCLA* CA*, supra* note 4 at para 66; *Francis, supra* note 2 at para 269.
[7] *Francis, supra* note 2 at para 269.
[8] *R v Prystay*, 2019 ABQB 8 (CanLII) at para 128, [2019] AJ No 7 [*Prystay*].
[9] Schedule A in the matter of *Christina Nadine Jahn v Her Majesty the Queen in Right of Ontario, as Represented by the Minister of Community Safety and Correctional Services* Before the Human Rights Tribunal of Ontario: Public Interest Remedies (24 September 2013) [2013 *Jahn* settlement public interest remedies, Appendix A].

9. In 2017, Ontario's ongoing failure to comply with the requirements of the *Jahn* settlement led the OHRC to commence a contravention application, which resulted in a 2018 Human Rights Tribunal of Ontario (HRTO) Order to achieve operational compliance with the commitments it made in the original *Jahn* settlement (the "2018 Order"). The 2018 Order also included a number of additional requirements designed to ensure that Ontario achieved operational compliance, including the appointment of an Independent Reviewer to monitor and report on Ontario's compliance.[10]

10. It was in this context that on April 24, 2020, the Independent Reviewer, Justice David Cole, released his Final Report.[11] In the Report, Justice Cole finds that Ontario has not complied with the terms of the *Jahn* settlement or the HRTO's 2018 Order.

11. Justice Cole's Final Report establishes not only that Ontario has failed to comply with this Tribunal's Order, but that Ontario's overall approach to *Jahn* has been chronically deficient. Justice Cole emphasizes that "**it cannot be ignored that the ministry's failure to commit itself fully to and implement the various Jahn remedies has now been going on for nearly 6 ½ years**."[12]

12. People with mental health disabilities in Ontario's correctional system continue to be held in segregation by the thousands and fail to receive required mental health services. The Final Report describes that from July 2018 to June 2019, more than 12,000 people were placed in segregation – many repeatedly – and that 46% of them had mental health alerts.[13] Rather than segregation only being used as a last resort for people with mental health disabilities, the Final Report shows that people with mental health alerts, and particularly women, are actually *more likely* to be placed in segregation, and for longer, than people without mental health disabilities.[14] The segregation data reveals that if Ms. Jahn was admitted into an Ontario correctional institution today, she may well again experience the prolonged segregation and inadequate mental health care that her case and the HRTO's 2018 Order should have prevented.

13. The HRTO has directed that it will remain seized pending the full implementation of the 2013 *Jahn* settlement remedies and terms of its 2018 Order.

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[10] *OHRC v Ontario (Community Safety and Correctional Services)*, 2018 HRTO 60 (CanLII) [2018 Order, Appendix B].

[11] Justice David P Cole, Independent Reviewer, Final Report of the Independent Reviewer on the Ontario Ministry of the Solicitor General's Compliance with the 2013 "Jahn Settlement Agreement" and the Terms of the Consent Order of January 16, 2018 Issued by the Human Rights Tribunal of Ontario (25 February 2020) [Final Report, Appendix C] [emphasis in original]. The "Summary of Findings" prepared by the Independent Expert in order to assist the Independent Reviewer in his assessment of Ontario's compliance has been fully adopted into the Final Report.

[12] *Ibid* at 11.

[13] *Ibid* at 17.

[14] *Ibid* at 17–20, Tables 1, 2, 3.

14. In light of the extensive non-compliance findings in Justice Cole's Report, and the long history of Ontario's failure to meet its *Jahn* obligations effectively, additional orders are necessary. To ensure that substantive compliance is finally achieved, these orders must go beyond the strict terms of the settlement and the 2018 Order.

15. Accordingly, the OHRC brings this motion seeking an order to address Ontario's non-compliance by requiring:

a) Strict restrictions on all ongoing segregation use, including time limits and an outright prohibition on segregation for any individuals with mental health alerts; and,
b) Further oversight and accountability measures to promote and monitor Ontario's ongoing compliance.

PART III – HISTORY OF THE *JAHN* PROCEEDINGS

16. A review of the history of the *Jahn* proceedings demonstrates Ontario's ongoing failure to take the steps necessary to achieve substantive compliance with its commitments under the settlement and subsequent Order.

A. 2012: Christina Jahn's human rights application

17. These proceedings began in 2012 when Christina Jahn, a woman with mental health disabilities, addictions, and cancer, filed a human rights application against Ontario's Ministry of Community Safety and Correctional Services (now the Ministry of the Solicitor General). In 2011 and 2012, Ms. Jahn was held in custody at the Ottawa Carleton Detention Centre. She alleged that she was placed in segregation for the entire period of her incarcerations, approximately 210 days, and experienced brutal and humiliating treatment on the basis of her mental health disabilities. She also alleged that women in Ontario's correctional facilities could not access the same level of mental health services as men. While the St. Lawrence Valley Correctional and Treatment Centre, a secure Schedule 1 psychiatric facility, provided treatment to men in custody with mental health disabilities, no equivalent treatment was available for women.

18. The OHRC intervened as a full party in the application to address the systemic issues that led to Ms. Jahn's treatment, and to seek public interest remedies aimed at protecting the *Human Rights Code* (*Code*) rights of all individuals with mental health disabilities in Ontario's correctional system.

B. 2013: The *Jahn v MCSCS* settlement agreement

19. In 2013, Ontario agreed to settle the litigation. Ms. Jahn and the OHRC agreed to resolve the application on the basis of a series of legally binding commitments made by Ontario regarding the use of segregation and treatment of people with mental health disabilities in Ontario's correctional system.

20. In the *Jahn* agreement, Ontario expressly recognizes "that segregation can have an adverse impact on inmates with mental illness" and committed to prohibiting the use of segregation for any individual with mental illness barring undue hardship. Ontario also agreed to a number of other binding public interest remedies, including providing mental health screening for all individuals upon admission, access to mental health services, and a series of internal accountability mechanisms to track and monitor its segregation use.[15]

C. 2015: First Contravention of Settlement Application

21. The 2013 *Jahn* settlement required Ontario to provide all prisoners placed in segregation with a Segregation Handout setting out information about their rights.

22. In 2015, a Contravention of Settlement Application was filed alleging that prisoners were not receiving this information. This resulted in a further settlement agreement on December 22, 2015 imposing additional public interest remedies to ensure prisoners in segregation receive information about their rights.[16]

D. 2017: Second Contravention of Settlement Application

23. In April and May 2017 respectively, both the Ombudsman of Ontario[17] and Ontario's Independent Advisor on Corrections Reform, Howard Sapers,[18] released reports showing that Ontario had not complied with the *Jahn* public interest remedies. Ontario publicly accepted the Independent Advisor's findings.[19]

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[15] See 2013 *Jahn* settlement public interest remedies, Appendix A.

[16] *Jahn v Ministry of Community Safety and Correctional Services* 2015 Contravention Application, Settlement Agreement Schedule C: Public Interest Remedies (22 December 2015) [2015 *Jahn v MCSCS* Settlement Agreement Public Interest Remedies]. The public interest remedies in Schedule C are part of the settlement of the first contravention application.

[17] Ombudsman of Ontario, *Out of Oversight: Out of Mind: Investigation into how the Ministry of Community Safety and Correctional Services tracks the admission and placement of segregation inmates, and the adequacy and effectiveness of the review process for such placements* (Toronto: Office of the Ombudsman of Ontario, 2017) [Ombudsman of Ontario, "Out of Oversight: Out of Mind"].

[18] Independent Advisor on Corrections, *Segregation in Ontario, Independent Review of Ontario Corrections* (Toronto: Queen's Printer for Ontario, 2017) [Independent Review of Ontario Corrections].

[19] Ministry of Community Safety and Correctional Services, News Release, "Ontario Taking Action to Reform Correctional System: Province Investing in New Jails in Thunder Bay and Ottawa,

24. Following the release of these reports, in September 2017, the OHRC filed a Contravention of Settlement Application with the HRTO.

E. 2018: The HRTO's *OHRC v Ontario* Order

25. The OHRC and Ontario were able to resolve the 2017 Contravention Application through a further agreement. With the parties' consent, this agreement was issued as an Order by the HRTO in January 2018.[20]

26. The 2018 Order not only required Ontario to comply operationally with the original 2013 *Jahn* public interest remedies, but Ontario also agreed to more prescriptive measures and accountability mechanisms to try and ensure that, this time, it would effectively implement the remedies. This included appointing both an Independent Expert to assist Ontario with implementation, and an Independent Reviewer to monitor and issue an interim and final report on compliance. The Order also provided for compliance timelines that were agreed upon by the parties.

27. The potential financial cost and operational burdens of fully implementing the terms of the Order were within the knowledge of Ontario when it agreed to resolve the Contravention Application and have the terms issued as an order.

28. The HRTO also directed that it would remain seized pending the full implementation of both the 2013 *Jahn v MCSCS* remedies and the additional terms set out in the 2018 Order.[21]

F. 2018–2020: The Independent Expert and Reviewer's Terms

29. Dr. Kelly Hannah-Moffat and the Honourable Justice David Cole were appointed to serve as the Independent Expert and Reviewer, respectively.

30. Dr. Hannah-Moffat is a professor and former director of Criminology and Sociolegal Studies, and a Vice President at the University of Toronto. She has contributed to numerous local, provincial, national, and international committees, inquiries, and commissions about the operation of penal institutions. Multiple Ontario Courts have accepted Dr. Hannah Moffat as an expert on human rights, corrections reform, and the use of segregation and alternatives for prisoners with mental illness.[22]

Modernizing Legislation" (4 May 2017) [News Release, "Ontario Taking Action to Reform Correctional System"].

[20] 2018 HRTO Order, Appendix B.

[21] *Ibid* at para 3.

[22] Ministry of the Solicitor General, "Special Advisors Appointed for Adult Corrections" (5 February 2020) [Ministry of the Solicitor General, "Special Advisors"]; *R v Capay*, 2019 ONSC 535 (CanLII) at paras 191–93, [2019] OJ No 1025 [*Capay*]; *Corporation of the Canadian Civil Liberties Association v Her Majesty the Queen*, 2017 ONSC 7491 (CanLII) at para 239, [2017] OJ No 6592

31. Justice Cole has served on the Ontario Court of Justice for 29 years. Prior to his appointment to the Ontario Court of Justice in 1991, Justice Cole practiced as a defense counsel for 16 years, specializing in legal issues relating to prisoners and parolees.[23]

32. The Independent Expert and Reviewer's terms began in February 2018 and expired on February 28, 2020.

G. 2020: The Independent Reviewer's Final Report

33. The 2018 Order required the Independent Reviewer to prepare a Final Report on Ontario's compliance with both the original *Jahn* terms and additional remedies from the Order, and that a copy be provided to the HRTO.

34. The Final Report issued by Justice Cole includes content from both the Independent Reviewer and Expert, including statements, findings, and recommendations that are made jointly. In addition, a "Summary of Findings" prepared by the Independent Expert in order to assist Justice Cole in his assessment of Ontario's compliance has been fully adopted into the Report.[24]

PART IV – ONTARIO HAS NOT COMPLIED WITH THE TERMS OF THE 2013 *JAHN* SETTLEMENT AND 2018 HRTO ORDER

35. The overarching goal of the *Jahn* settlement and 2018 Order is to protect the human rights of people with mental health disabilities in the correctional system by: (1) ensuring that they are not subject to segregation barring undue hardship; and (2) providing them with access to mental health services. The settlement and Order set out a broad range of measures that Ontario must comply with to achieve its goal.

[*CCLA* Sup Ct], varied, *CCLA* CA, *supra* note 4 at para 75; *Reddock v Canada (Attorney General)*, 2019 ONSC 5053 (CanLII) at paras 260, 296 [2019] OJ No 4450 [*Reddock*].

[23] Ministry of the Solicitor General, "Special Advisors", *ibid*.

[24] Final Report, Appendix C at 15–36.

36. Compliance requires meaningful and effective implementation, including at the operational level.[25] This is squarely addressed by the HRTO's 2018 Order, which expressly requires operational compliance.[26] Addressing the treatment and segregation of prisoners with mental health disabilities cannot be achieved simply through issuing new policies or *pro forma* approaches to implementation.

37. Justice Cole's Final Report shows that Ontario has not complied with many of the essential measures required by the *Jahn* settlement and the HRTO's 2018 Order. As set out below, Ontario has failed to:

A. Implement a system to ensure it is aware of who has a mental health disability;
B. Administer evidence-based, gender responsive mental health screening on admission;
C. Conduct mental health reassessments to screen for individuals who develop mental health disabilities while in custody;
D. Use Treatment/Care plans to ensure that people with mental health disabilities receive appropriate care;
E. Implement a definition of segregation based on conditions of confinement;
F. Accurately track segregation placements;
G. Prohibit segregation for people with mental illness to the point of undue hardship;
H. Meet its segregation review and reporting requirements;
I. Conduct baseline or ongoing health assessments for people in segregation;
J. Collect and release human rights-based data on segregation and restrictive confinement; and
K. Establish effective internal mechanisms to monitor compliance with the terms of the Consent Order.

A. Ontario has not implemented a system to ensure it is aware of who has a mental health disability

38. As noted above, one core feature of the *Jahn* settlement and 2018 Order is to ensure that people with mental illness are not placed in segregation barring undue hardship. Meeting this obligation, and the accompanying accountability and documentation requirements, requires the prompt and consistent identification of those with mental health disabilities.

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[25] See *Ontario Human Rights Commission v Ontario (Correctional Services)*, 2002 CanLII 46519 (ON HRT), 45 CHRR 61 [*McKinnon* 2002] ("In my opinion, the issue is not whether the orders were followed *pro forma*, or whether, as counsel for the Ministry put it, "the four corners of the express orders were met", but (as stated earlier) whether they were carried out in good faith with a view to making them effective" at para 38). Note that the version of the decision provided by the Canadian Human Rights Reporter includes paragraph numbers.

[26] 2018 HRTO Order, Appendix B at A1. The Order repeatedly references not just making policy changes, but also *implementing* the policies and *applying* the definition of segregation.

39. Accordingly, the 2018 Order requires Ontario to ensure that individuals admitted to its correctional institutions with mental health disabilities (including those at risk of suicide or self-harm) have verified mental health alerts. A mental health alert is to "act as an indicator that alternatives to segregation must be considered to the point of undue hardship on account of an individual's mental health disability" (B10).

40. Ontario has not complied with this requirement.

41. The Final Report states that, despite the Ministry revising its policy,

> **…numerous issues remain that prevent compliance with the requirements of the order**, including whether: alerts are actually verified; line staff can expeditiously access the electronic records containing these verifications; and, the fact that the alerts do not currently distinguish between mental or serious mental illness.[27]

42. Compliance audit data from July 2019 showed that only 7 of 24 institutions fully verified their mental health or suicide alerts, with one institution's verification rate being as low as low as 31%.[28] The Final Report states that the results of a further audit in December 2019 indicate that the mental health alert verification rate has not improved.[29] The December 2019 results indicate that only about 77% of mental health alerts were verified overall, and that these rates were as low as 67% and 63% in the Northern and Central regions respectively.[30]

43. The Report also notes that, while mental health alerts are to be recorded and stored in OTIS, Ontario's electronic Offender Tracking Management System, frontline officers are often not able to access OTIS during their shifts, and instead rely on outdated paperwork printed at the time of an individual's admission.[31] This means that although mental health alerts are meant to act as an indicator that an individual cannot be placed in segregation barring undue hardship, they are not always being connected to segregation decisions.

B. Ontario is not administering evidence-based, gender responsive mental health screening on admission

44. Ontario is required to conduct mental health screening for all individuals on admission using an evidence-based, gender responsive screening tool approved by a correctional psychiatrist (PIR2, A1). Such screening is necessary for Ontario to meet its obligations to keep people with mental health disabilities out of

[27] Final Report, Appendix C at 27 [emphasis added].
[28] *Ibid*.
[29] *Ibid.*
[30] *Ibid*.
[31] *Ibid*.

segregation and provide appropriate mental health services. Screening tools must be evidence-based and gender responsive to ensure that they do not have discriminatory impacts on women and non-white people.[32]

45. Ontario has not complied with this requirement. Indeed, the Final Report states that Ontario has not yet even developed a suitable screening tool.

46. The Final Report describes that the Independent Expert has repeatedly informed Ontario that it needs to undertake a culturally informed and gender-based evaluation of the tools being used in its institutions in order to meet the PIR2 requirements.[33] While Ontario has now advised that it will "consider" completing such an evaluation, the Independent Reviewer and Expert state that they are unable to conclude that there has been compliance:

> As of February 19, 2020, we have been made aware that the Ministry has agreed to consider completing a study to determine whether the Brief Jail Mental Health Screening tool (BJMHS) is sufficiently gender-responsive and culturally informed to meet the needs of Ontario's population. The ministry advises that it is still in the process of determining which of its many tools and forms may need to be assessed. **Thus, on the basis of what has been made available to us as of the date this Final Report is submitted, we are unable to conclude that the Ministry has complied with this aspect of PIR (Public Interest Remedy) #2.**"[34]

C. Ontario is not conducting mental health reassessments to screen for individuals who develop mental health disabilities while in custody

47. Ontario is also required to conduct mental health reassessments using an assessment tool at least once every six months (PIR2, A1, B11(d)). This is to ensure that individuals who develop mental health disabilities while they are in custody are identified.

48. The Final Report concludes that Ontario has not complied with this requirement.[35] Although Ontario has made policy changes, the Final Report states that "Ontario has yet to institute a consistent practice whereby individuals are reassessed at least once every six months".[36]

49. A March 2019 compliance audit of randomly selected cases showed that only 31.7% of people had been reassessed using a reassessment tool, as required.[37] The Final Report makes a point of noting, however, that Ontario

[32] Final Report, Appendix C at 33.
[33] *Ibid* at 10.
[34] *Ibid* [emphasis added].
[35] *Ibid* at 11, 21–22.
[36] *Ibid.*
[37] *Ibid* at 21.

presented its compliance rate as 96.7% based on this same audit.[38] The Final Report expresses concerns with Ontario's approach to assessing its own compliance:

> However, the ministry determined their own compliance rate of 96.7%...because individuals were regularly seen by clinical staff, which they counted as a reassessment, even though a reassessment form was not present in the file...Having a record of appointments with health care staff, however, is deficient in meeting the compliance criteria measured by B-13, which requires the development and operational practice of a standardized reassessment process.[39]

50. The Final Report states that Ontario has provided a summary of results from a further compliance audit, conducted in November-December 2019. Ontario's summary suggests that there may be some improvement, though the compliance rate was still only 81% across the province, and as low as 69% in the Northern Region and 73% in the Central Region.[40] However, the Report explains that Ontario's assessment of its own compliance could not be verified. Despite a request from the Independent Expert, Ontario did not provide the raw data from the compliance audit.[41] Further, the Report notes that the Toronto South Detention Centre was excluded from this recent audit, without explanation.[42] Toronto South is Ontario's largest facility, and has a capacity of 1,650 prisoners.[43]

D. Ontario is not using Treatment/Care plans to ensure that people with mental health disabilities receive appropriate care

51. A second core feature of the *Jahn* settlement and 2018 Order is to establish a regime that ensures that individuals with mental health disabilities are provided with access to tailored mental health services. As part of this feature, Ontario is required to prepare individualized treatment plans, operationally known as care plans,[44] for prisoners with mental health issues. The care plans are to be developed by physicians for individuals with mental illness, and by psychiatrists for

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[38] *Ibid.*
[39] *Ibid*.
[40] *Ibid* at 22.
[41] *Ibid.*
[42] *Ibid* at 21–22.
[43] Ministry of the Solicitor General, "Correctional Services: Facilities – Detention Centres" (20 February 2020), online (web).
[44] This is explained in the Final Report: "While the original wording of the Order states that a "treatment plan" ought to be developed for these individuals, the ministry has labeled this document a "care plan." This is to avoid confusion as there already existed operational clinical documents referred to as "treatment plans" which include medical protocols. The care plan (and *not* the treatment plan), which was meant to fulfill the requirements under PIR (Public Interest Remedy) 4. Therefore, any policies, practices and documents currently used for the clinical purposes (i.e., treatment plan) cannot be said to satisfy these requirements", Final Report, Appendix C at fn 105.

those with major or serious[45] mental illness, and be accessible to all inter-professional team members (PIR4, A1, B11(c)).

52. The Final Report "find[s] Ontario to be non-compliant with the requirement to use care plans to provide individualized and appropriate care to individuals with identified mental illness."[46]

53. The Final Report identifies significant compliance issues with Ontario's use of care plans. Care plans are not in place for the majority of those requiring them.[47] Where care plans do exist, they often lack crucial information that front-line staff require to properly manage highly distressed and *Code*-protected individuals.[48] The Report states that, "pertinent and relevant information and updates about persons in custody are not consistently disseminated to workers on the front lines – those who interact the most with persons in custody and by whom these plans could potentially be utilized most effectively."[49]

54. Further, an understanding of which individuals have mental illness versus major/serious mental illness is necessary to meet the requirement that care plans be developed by physicians or psychiatrists, as appropriate. However, Ontario has not yet implemented definitions of mental illness and serious mental illness, and anticipates that this will only occur within the 2020/2021 fiscal year.[50]

E. Ontario has not implemented a definition of segregation based on conditions of confinement

55. The *Jahn* settlement and 2018 Order set out various restrictions and safeguards for Ontario's segregation use. Meeting these terms requires a clear definition of segregation that is understood and implemented across the correctional system.

56. In 2017, both Ontario's Independent Advisor and the Ombudsman reported that there was no consistent understanding of what amounted to segregation in Ontario's correctional system and, instead, "confusion and disagreement around what segregation actually means."[51]

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[45] See *ibid* at fn 63, "The Consent Order requires the Ministry to define, track and support those with 'mental illness', 'major mental illness' or 'mental health disability.' The ministry has used the terms 'mental illness' and 'serious mental illness' instead to refer to these requirements."
[46] *Ibid* at 28 [emphasis removed from original], 33–34.
[47] *Ibid.*
[48] *Ibid* at 28.
[49] *Ibid* at 50.
[50] *Ibid* at 27.
[51] Independent Review of Ontario Corrections, *supra* note 18 at 27; Ombudsman of Ontario, "Out of Oversight: Out of Mind", supra note 17 at para 6.

57. To address this, the 2018 Order required Ontario to define segregation to cover at least all circumstances in which individuals are physically isolated and confined in a cell for 22 hours or more per day (B1). This definition was to be set out in policy (B2) and govern all of Ontario's *Jahn* and Consent Order obligations (B1, B3).

58. The Final Report states that Ontario has not complied with these requirements:

> ...Ontario has not yet produced clear and consistent policies, procedures, and working definitions of segregation, restrictive confinement, mental health, and associated alerts during the reporting period. Thus, the requirement that Ontario consistently apply the revised definition of segregation has not yet been achieved; as such, **I again join with the Independent Expert when she concludes the ministry is not yet in compliance with B1-B3**.[52]

F. Ontario is not accurately tracking segregation placements

59. Segregation placements are subject to various reporting and review requirements under *Jahn* and the 2018 Order. For these to be triggered at appropriate times and include accurate information about how long an individual has been in segregation, Ontario must be able to accurately track the duration of segregation placements. In 2017 both the Independent Advisor and the Ombudsman found that Ontario was not accurately tracking segregation.[53] To address this, the 2018 Order specifically required Ontario to track both continuous and aggregate segregation placements (B5).

60. The Final Report states that Ontario has not complied with this requirement:

> **...Ontario is not in compliance with the tracking requirements stipulated by the Order. The information and data...provided are inadequate and lack a coherent policy framework**.[54]

61. The Report stresses that Ontario's approach of using a single-minute threshold to determine whether a placement should be tracked as segregation or not is particularly concerning. As described above, circumstances where individuals are physically isolated and confined in a cell for 22 hours or more a day constitute segregation. With Ontario's current tracking approach, an individual who is out of a cell for 121 minutes is considered not to be in segregation, and thus not subject to the various segregation reporting and review requirements.[55]

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[52] Final Report, Appendix C at 11 [emphasis added].
[53] Independent Review of Ontario Corrections, *supra* note 18 at 87–88; Ombudsman of Ontario, "Out of Oversight: Out of Mind", *supra* note 17 at paras 6, 54, 66, 86, 139, 140.
[54] Final Report, Appendix C at 23 [emphasis in original].
[55] *Ibid* at 23.

62. The Report states that this precise minute approach is operationally unrealistic, highly vulnerable to human error, and could produce data that obscures the reality of what prisoners are actually experiencing on the ground:

> ...a 120-minute tracking and review threshold hinges on the ability of a tracking solution to capture the actual conditions of confinement accurately at all times. With the cut-off being at the precise minute, a tracking system that separates those out of cell for 121 minutes or greater is vulnerable to human errors—errors that are highly probable in an unpredictable correctional environment. Frontline officers in several institutions and union representatives have consistently reminded myself and the Independent Reviewer that it is unrealistic to expect the accurate tracking of minutes for every individual's movement, given the nature of their work and current staff complements. **This technology and approach will not ensure compliance with the principles of the Order...let alone the ministry's own policies. It, however, may produce data that appears to demonstrate compliance yet obscures the actual operational practice**.[56]

63. The Report also describes how Ontario's one-minute threshold approach is incongruent with reducing the harm caused by segregation, which is at the very core of the segregation prohibition in the *Jahn* settlement:

> ...individuals who are confined in a cell for extended periods are likely to experience and/or be at risk to similar damaging effects resulting from prolonged isolation...I am not aware of empirical evidence that suggests that harm resulting from segregation can be measured in minutes. Ethically and legally such a sharp distinction is unadvisable, especially if the objective is to reduce and eliminate administrative segregation and limit harm.[57]

G. Ontario is not prohibiting segregation for people with mental illness to the point of undue hardship

64. In the *Jahn* settlement, Ontario expressly recognizes the adverse impact of segregation for people with mental illness. To prevent this harm, the settlement and 2018 Order required that Ontario not use segregation for any individual with mental illness unless it can demonstrate that alternatives to segregation were considered and rejected because they would cause undue hardship (PIR5, PIR6, A1).

65. The 2018 Order specifically tasked the Independent Reviewer with reviewing Ontario's compliance with the terms of the settlement and the Order, and required Ontario to provide its full cooperation and unencumbered access to the information and locations necessary for that review. Despite this, the Final Report states that, "[w]e have not been provided data to indicate whether or not Ontario is considering alternatives to the point of undue hardship", and therefore "cannot

[56] *Ibid* at 24 [emphasis in original].
[57] *Ibid.*

confirm if Ontario is compliant with the terms of the Order or its own policy."[58] In light of Ontario failing to provide this information, the Tribunal must conclude that Ontario has not complied with this aspect of the Order.

66. As is described in more detail below, Ontario's failure to comply with this requirement is confirmed by: its failure to satisfy steps that are necessary for compliance; data showing extensive, continued use of segregation for people with mental health disabilities; and, the Superior Court of Justice's findings in *Francis v Ontario* that "Ontario was frequently non-compliant with its own policy requirement to consider alternatives to administrative segregation to the point of undue hardship."[59]

i. Awareness of people with mental illness and what constitutes segregation is necessary for compliance

67. Compliance with this requirement is dependent both on having awareness of who has mental health disabilities and implementing a clear definition of what constitutes segregation. As outlined above, the Final Report finds that Ontario has not complied with either of those requirements (see sections 'A' and 'E' under Part IV). Without having these fundamental elements in place, it is not possible for Ontario to be complying with the requirement to prohibit segregation for those with mental illness barring undue hardship.

ii. Alternatives to segregation are not being considered adequately – or at all

68. The Report identifies circumstances where alternatives to segregation are not being considered adequately – or at all. This is evident from an analysis of Ontario's segregation documentation:

> **The latest versions of the 30-day and 60-day reports (dated January 2019 and provided to me on November 10, 2019), continue to show that alternative housing placements are not adequately considered, nor are alternative management strategies documented. For example, some individuals with an 'active mental health alert' are not identified as having 'Code-related needs,' and remain in prolonged and continuous segregation.**[60]

69. The Final Report also describes how alternatives are not being considered in circumstances where individuals themselves request segregation. Ontario's most recent data shows that a person's own request is currently the primary reason for segregation, and that these prisoners are highly likely to have mental health disabilities: of the 7,627 placements that were associated with inmate's own

[58] *Ibid* at 21.
[59] *Francis, supra* note 2 at para 269.
[60] Final Report, Appendix C at 26 [emphasis in original].

request between July 1, 2018 and June 30, 2019, 5,305 placements (69.6%) were for people who had a mental health alert, suicide risk alert, and/or suicide watch alert on file.[61]

70. The Final Report stresses that segregation requests are made when an individual perceives that there is no other way for them to be safe, and "must not be conflated with the individual requesting conditions of confinement that expose them to potentially permanent psychological damage."[62] While the Final Report recommends that these individuals should not be in segregation, but separately and safely housed elsewhere,[63] in reality they are sometimes placed in segregation without alternatives being considered at all:

> Policy dictates that requests to be kept in conditions that constitute segregation are to be considered on an individual basis by the superintendent or designate. Furthermore, PSMI (Placement of Special Management Inmates) policy is clear that such requests should only be approved as a last resort after all other placements and strategies have been considered and rejected. However, the Independent Expert and I have both been told by some Institutional Admissions Officers in different facilities that they are of the view that if a newly admitted prisoner requests to be segregated, they have "no option" but to accede to that request. Perhaps more needs to be done to educate staff on the rules surrounding alternative placement options to try and limit reliance on this designation.[64]

iii. Ontario has not taken sufficient steps to implement or utilize alternatives

71. The Final Report also reveals that Ontario has not taken sufficient steps to implement or utilize alternatives to segregation. Despite the fact that Ontario has developed draft policies for alternatives to segregation that would appear to address the needs of all types of individuals currently being held in segregation (albeit in a form of restrictive confinement), this has not resulted in those actual alternatives being operationally realized:

> Ontario has designated specialized placements that can accommodate individuals who would otherwise fall into the categories of 'own request' or protective custody; however, it is my view joined by the Independent Reviewer that these remain underutilized. At present, **Ontario has not identified a type of individuals currently housed in administrative segregation but [*sic*] cannot be accommodated within its 2019 specialized placement framework**.[65]

72. The Report states that "The introduction of specialized care placements was meant to reduce its use of segregation, yet I have not been provided with evidence to demonstrate that this has occurred, especially for those suffering from mental

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[61] *Ibid* at 20–21, fn 72.
[62] *Ibid* at 21.
[63] *Ibid.*
[64] *Ibid* at 52.
[65] *Ibid* at 21 [emphasis added].

health issues."[66] Indeed, the revised *Placement of Special Management Inmates* policy, which officially sets out the requirement to consider alternatives to the point of undue hardship and the specialized care placements is still only in draft form, and will not be in place until "sometime in 2020".[67]

iv. The high numbers of people in segregation with mental health alerts indicate that alternatives are not being considered to the point of undue hardship

73. Finally, the numbers speak for themselves. The data shows extensive use of segregation for people with mental health alerts, indicating that Ontario is not complying with the requirement to consider all alternatives to the point of undue hardship before resorting to segregation.

74. The most recent data, which is on Ontario's segregation use from July 1, 2018 to June 30, 2019, not only reveals that huge numbers of people with mental health alerts are in segregation, but that segregation is actually being used disproportionately for this vulnerable group:

- **Almost half of the individuals placed in segregation had mental health alerts:** Of the 12,059 individuals placed in segregation, 46% (5,558 people) had a mental health alert.[68]
- **People with mental health alerts are disproportionately placed in segregation, and women in segregation are more likely to have a mental health alert than men:** 44% of the men (4459 people) and 58% of the women (1099 people) placed in segregation had mental health alerts, compared to 28% of men and 46% of women in the overall custody population.[69] Of those in segregation, women prisoners had a higher incidence of mental health, suicide risk and suicide watch alerts than men.[70]
- **People with mental health alerts are more likely to be held in prolonged segregation**: While most individuals are in segregation for less than 30 continuous days and less than 60 aggregate days, the proportion of individuals with mental health and suicide risk alerts is higher for those in prolonged segregation:
    - For segregation placements of 30 continuous days or longer (1969 placements), 63.9% were for people with mental health alerts, and 47.6% for those with a suicide alert.[71]
    - For segregation placements of 365 continuous days or longer (19 placements), 73.7% of the individuals had a mental health alert, and 52.6% had a suicide alert.[72]

[66] *Ibid* at fn 72.
[67] *Ibid* at 40.
[68] *Ibid* at 17.
[69] *Ibid.*
[70] *Ibid* at 17, 20 (Table 1).
[71] *Ibid* at 17.
[72] *Ibid* at 17–18 (Tables 2, 3).

- Of people who were segregated for over 60 aggregate days (1091 individuals), 65.4% had a mental health alert, and 49.1% had a suicide alert. [73]

- **People who are placed in segregation repeatedly are more likely to have a mental health alert:** Whereas 39.8% of individuals placed in segregation a single time had a mental health alert, this increases to 76.7% of those placed in segregation 11 or more times having a mental health alert.[74]

75. The Final Report concludes that:

> ...**prolonged segregation (15 days or longer) remains a routine practice for individuals with mental health and/or suicide risk alerts on file.** These individuals also tend to have a high number of aggregate segregation days, and repeated segregation placements.[75]

76. Given the extent to which people with mental health alerts are being subjected to segregation, the data alone indicates that Ontario is not complying with the requirement to consider alternatives to the point of undue hardship before placing any individual with mental illness in segregation. This is especially true given that undue hardship is a high threshold, as Ontario has acknowledged in its own policies.[76]

77. These numbers are also a sobering reminder of the significant daily effect Ontario's non-compliance has on the rights and lives of individuals with mental health disabilities in Ontario's correctional facilities.

v. Ontario was found to be non-compliant with the requirement to prohibit segregation to the point of undue hardship in Francis v Ontario

78. In its April 2020 *Francis v Ontario* decision, the Superior Court of Justice found that, "Ontario was frequently non-compliant with its own policy requirement to consider alternatives to administrative segregation to the point of undue hardship."[77]

79. *Francis v Ontario* was a class action seeking damages for a class of people who were held in prolonged segregation (over 15 days) in Ontario, as well as a subclass of those who were held in segregation for any duration while suffering from a defined list of conditions amounting to "serious mental illness". The entire

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[73] *Ibid* at 17, 18–19 (Tables 4, 5).
[74] *Ibid* at 19 (Tables 6, 7).
[75] *Ibid* at 20 [emphasis in original].
[76] Ministry of Community Safety and Correctional Services, "Undue Hardship: Providing Accommodation Short of Undue Hardship" (2015), cited in Independent Review of Ontario Corrections, *supra* note 18 at Appendix B.
[77] *Francis, supra* note 2 at para 269.

class period post-dates the *Jahn* settlement, and the 2018 Order by at least eight months. Many members of the class, and all members of the subclass, are people who the *Jahn* settlement and 2018 Order were to have protected from segregation. The Court held that the use of segregation beyond 15 straight days violated the s. 12 *Charter* right of all class members to be free from cruel and unusual treatment, and that any use of segregation for prisoners with a serious mental illness violated the *Charter* s. 12 rights of that subclass.

80. In reaching its conclusion, the Court made key findings about Ontario's habitual use of segregation for people with mental health disabilities, and its failure to consider alternatives to the point of undue hardship prior to these placements. The Court found that Ontario:

- continued to "habitually" place prisoners with mental health disabilities in segregation,
- continued to "habitually" fail to comply with accepted standards or even its own written policies,
- continued to place prisoners in segregation contrary to its own policy directives (including putting prisoners with mental health disabilities in segregation rather than in a clinical environment where they may receive treatment), and, to reiterate,
- was "frequently non-compliant with its own policy requirement to consider alternatives to administrative segregation to the point of undue hardship."[78]

H. Ontario is not meeting its 5-day, 30-day and 60-day segregation review and reporting requirements

81. The *Jahn* settlement and 2018 Order impose a series of accountability mechanisms for Ontario's segregation use. First, Ontario must review the circumstances of individuals with mental health disabilities in segregation at least once every five days, and document what alternatives have been considered to the point of undue hardship (PIR6, A1). Second, all segregation placements of 30 continuous and 60 aggregate days for individuals with mental illness must be reported to the Minister (now the Solicitor General) and Assistant Deputy Minister (Institutional Services). These reports must detail the circumstances of each individual's segregation placement, the undue hardship analysis undertaken, and set out the evidence relied upon in determining that no alternative placement was available (PIR5, PIR6, A1, B14).

82. These mechanisms are meant to safeguard against individuals with mental illness being placed or remaining in segregation in the absence of undue hardship.

[78] *Ibid.*

83. The Final Report states that Ontario is not in compliance with these review and reporting requirements.[79]

84. The Final Report describes how the issues with tracking segregation frustrate the review process: "Since Ontario has not instituted a break in segregation that is qualitatively different from segregation itself, the segregation clock and timing of these reviews may not occur at the intended five, 10 and 14-day markers".[80]

85. The Final Report also states that the segregation reports lack required information, particularly regarding what alternatives to segregation have been considered:

> My Interim Report commented on the lack of detail in these reports in detail, particularly that the 30-day consecutive and 60-day aggregate segregation reviews did not contain meaningful documentation regarding accommodation or undue hardship. Since that time, I have not been provided with evidence of improvement. **The latest versions of the 30-day and 60-day reports (dated January 2019 and provided to me on November 10, 2019), continue to show that alternative housing placements are not adequately considered, nor are alternative management strategies documented. For example, some individuals with an 'active mental health alert' are not identified as having 'Code-related needs,' and remain in prolonged and continuous segregation. As such, Ontario has not complied with the requirements of this schedule item**.[81]

86. Further, the Final Report notes that, "without sufficient resources for restructuring, alternatives and associated frontline supports, these regional-level reviews will likely remain pro-forma exercises."[82]

These concerns with Ontario's internal segregation review process are confirmed by the Ontario Superior Court of Justice in its *R v Capay* decision. *Capay* concerned the experience of Adam Capay, a young, Indigenous man with serious mental health disabilities held in prolonged segregation in Ontario's correctional system. The Court considered extensive evidence on Ontario's internal segregation accountability mechanisms, which included the *Jahn* requirements. The Court found that it was "obvious that the segregation review process in the case of the accused was meaningless at the institutional and regional levels."[83] The Court reflected on the systemic nature of the problems with Ontario's correctional system, finding that the misconduct in the case before it was "not isolated" and that the "inadequacy and ineffectiveness of the segregation review

[79] Final Report, Appendix C at 10–11.
[80] *Ibid* at 11.
[81] *Ibid* at 25–26 [emphasis in original].
[82] *Ibid* at 26.
[83] *Capay, supra* note 22 at para 386.

process in Ontario has been a long standing and ongoing problem." [84] Ultimately, the Court held that Ontario's treatment of Mr. Capay was so egregious that it violated his *Charter* rights and merited granting a stay of Mr. Capay's first degree murder charges – the most drastic remedy that a court can grant.

I. Ontario is not conducting baseline or ongoing health assessments for people in segregation

87. If an individual with mental health issues is placed in segregation, Ontario is required to provide a baseline health assessment and ongoing health assessments prior to every 5-day segregation review. These assessments must be conducted by a physician. For those with a major or serious mental illness, the assessments must be done by a psychiatrist (PIR7, A1). These assessments are critical for monitoring whether and how an individual's mental health is affected by being in segregation.

88. The Final Report indicates that Ontario has not complied with this requirement.[85]

89. As outlined above, Ontario has failed to take steps to ensure that it has the information necessary to meet this requirement. First, without accurately being able to track segregation placements, Ontario cannot ensure that these health assessments are conducted at the required times. Second, an understanding of which individuals have mental illness versus major/serious mental illness is necessary in order to ensure that the health assessments are conducted by physicians or psychiatrists, as appropriate. However, Ontario has not yet implemented such definitions, and anticipates that this will only occur within the 2020/2021 fiscal year.[86]

[84] *Ibid* at para 532.
[85] See Final Report, Appendix C at fn 96 ("As stated in my Interim Report: "Ontario has not demonstrated province-wide operational changes compliant with its requirements under Public Interest Remedies 4 and 7, which outline specific care requirements for those assessed as experiencing serious mental illness").
[86] *Ibid* at 27.

90. Further, the Final Report indicates that Ontario's policies do not reflect that these assessments *must* be conducted by physicians or psychiatrists. Instead, it appears that Ontario's policies allow the assessments to be done by any mental health provider, and that having them done by a physician or psychiatrist is just preferable:

> Special attention is paid throughout the new policies both to limit and to guide when those with mental illness may (and sometimes may not) be placed "in conditions that constitute segregation". Particularly germane to my mandate are various detailed provisions that direct **early and ongoing consultation with and input from a "mental health provider" (preferably a physician or psychiatrist where available)**.[87]

J. Ontario is not meeting its obligations to collect and release human rights-based data on segregation and restrictive confinement

91. Ontario is required to annually release data on: a) its use of segregation and restrictive confinement (B15, B17), and b) the proportion of individuals in the overall correctional population with mental health disabilities and breakdown of the correctional population based on sex/gender (B16). Such data is essential not only for Ontario itself to assess whether it is meeting its *Code* and *Jahn* obligations, but also for public accountability.

92. The Final Report states that Ontario has not complied with the human rights data collection and reporting requirements.[88]

93. The Report sets out extensive issues regarding the Ontario's data collection and release, including that:

- Since "Ontario has not yet produced clear and consistent policies, procedures, and **working** definitions of segregation, restrictive confinement, mental health, and associated alerts during the reporting period...it is hard to accurately and consistently determine how segregation and restrictive confinement are used for men, women, and non-binary individuals, as well as for those with mental health concerns."[89]
- The issues with Ontario's segregation tracking affect the accuracy of segregation placements durations; and
- The data needs to be further disaggregated based on further human rights factors in order to allow for meaningful analysis.[90]

[87] *Ibid* at 41 [emphasis added].
[88] *Ibid* at 11.
[89] *Ibid* at 22.
[90] *Ibid* at 23.

K. Ontario has not established effective internal mechanisms to monitor compliance with the terms of the Consent Order

94. Ontario is required to establish internal mechanisms to monitor the implementation of and ongoing compliance with the 2018 Order requirements (A11, B20).

95. Based on the information in the Final Report, Ontario has not effectively complied with this requirement.

96. The Report explains that, to be effective, the accountability and oversight system must be able to promote systemic changes regarding Ontario's use of segregation:

> An effective accountability and oversight system should promote systemic changes so that segregation is at least minimized, if not completely phased out in the long-term. In the short-term, this system must ensure that segregation is not used for those with identified mental health conditions, nor that its use is discriminatory on the basis of Code-related factors. An effective oversight system can then be premised on an in-depth examination of patterns and drivers of segregation.[91]

97. While the Report acknowledges that Ontario has established an Oversight and Accountability Unit, it concludes that "the Unit's oversight capacity is fundamentally limited".[92] It explains that "the scope and power of this Unit is severely limited and siloed"[93] and that "its oversight role is constrained to conducting baseline and compliance audits, with little ability to address the systemic or institutional-based concerns."[94] The issues with Ontario's ability to internally monitor effectively are so significant that the Final Report concludes that only an official charged with professional oversight of corrections, such as an Inspector General, would sufficiently be able to hold Ontario accountable:

> Simply put, only an official charged with continuing professional oversight of provincial corrections is going to be in any position "to hold the ministry's feet to the fire", especially, as we have regrettably found, a ministry that seems very resistant to change. As previously stated, 6 1/2 years have now elapsed since the initial Jahn settlement, and, as the contents of both the Interim Report and these Final Reports repeatedly disclose, SolGen (Ministry of the Solicitor General) is still far from complying with the need for fundamental changes revealed by the Capay case and the various Jahn settlements.[95]

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[91] *Ibid* at 13.
[92] *Ibid* at 29.
[93] *Ibid* at 13, 29.
[94] *Ibid*.
[95] *Ibid* at 15.

PART V – ONTARIO'S OVERALL APPROACH TO IMPLEMENTING *JAHN* HAS BEEN DEFICIENT

98. Ontario's non-compliance with the specific terms outlined above must be viewed in the context of its long history of failing to implement the *Jahn* remedies effectively.

99. From the outset, Ontario's conduct relating to *Jahn* has been characterized by inattentiveness, delay, a failure to operationalize change, incompetence, and even resistance. Moreover, Ontario has repeatedly been made aware of the deficiencies with its approach to *Jahn*. The OHRC, Independent Advisor on Corrections Reform, the Ontario Superior Court of Justice on multiple occasions, and now also the Independent Reviewer and Expert, have all identified Ontario's failure to implement the *Jahn* remedies effectively.

A. The OHRC has consistently expressed concern about Ontario's compliance

100. Almost since the outset of the *Jahn* settlement process, the OHRC has repeatedly expressed concern to Ontario through correspondence, submissions to government, meetings—and even previous contravention proceedings—that the *Jahn* terms are not being effectively implemented.[96] These ongoing concerns also led the OHRC to seek segregation data and start conducting tours of Ontario's correctional facilities as part of its efforts to monitor conditions on the ground.

[96] See, for example, OHRC, "Submission of the OHRC to the Ministry of Community Safety and Correctional Services Provincial Segregation Review" (29 February 2016); OHRC, "Supplementary Submission of the Ontario Human Rights Commission to the Ministry of Community Safety and Correctional Services' Provincial Segregation Review October 2016" (18 October 2016); OHRC, "Re: MCSCS Corrections Reform – Findings from Tour of Kenora Jail" (28 February 2017); OHRC, "Letter to the Ministry of Community Safety and Correctional Services re: Findings from Tour of Vanier Centre for Women" (7 January 2019). OHRC, "Letter to the Minister of Community Safety and Correctional Services: An action plan to end segregation in Ontario" (21 February 2019); OHRC, "Letter to Solicitor General Jones – Elgin Middlesex Detention Centre" (17 May 2019); OHRC, "Letter to Solicitor General Jones re: Hamilton Wentworth Detention Centre" (1 August 2019); OHRC, "Submission of the Ontario Human Rights Commission to the Ministry of the Solicitor General on the proposed amendments to the segregation provisions in Regulation 778 under the *Ministry of Correctional Services Act*" (24 September 2019); OHRC, "OHRC and corrections workers call for dedicated funding to address crisis in Ontario corrections" (21 January 2020); OHRC & OPSEU Corrections Management-Employee Relations Committee, "Joint submission to Ontario's consultation on the 2020 budget: Necessary investments in Ontario's correctional system" (21 January 2020); OHRC, "Report on conditions of confinement at Toronto South Detention Centre" (30 March 2020).

B. 2017: Ontario's Independent Advisor on Corrections Reform

101. In 2017, Ontario's Independent Advisor on Corrections Reform, Howard Sapers, released his report on Ontario's use of segregation, revealing that Ontario had not been complying with the *Jahn* requirements.[97] The Independent Advisor, whose findings were accepted by Ontario,[98] specifically addressed the deficiencies in Ontario's approach to the systemic transformation required by *Jahn*:

> For nine months after the settlement agreement there was no Ministry lead assigned to work on the government's response. When a team was finally assembled in the summer of 2014, they were already significantly behind schedule. They scrambled to complete the in-depth policy reviews and reforms, systemic reports, inmate rights guides, enhanced mental health services, additional segregation reporting and develop and deliver the Ministry-wide mental health training.
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> [...]
>
> ...A stressed management team and insufficient policy, evaluation and analytic capacity have resulted in organizational coordination issues and strategic planning gaps.
>
> [...]
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> The practice of placing mentally ill inmates in segregation was squarely addressed by the *Jahn* settlement. As reviewed above, in September 2015 the Ministry overhauled its segregation policies, mandating mental health screening upon admission, ongoing mental health assessments, the development of Care Plans and Treatment Plans, and regular assessments by physicians for segregated inmates with mental illness...
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> …
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> Our review has found that these policies have simply not translated into operational practices across the system. The best available data show that, between October 2015 and December 2016, the percentage of segregated individuals with suicide risk and mental health alerts increased. Most institutions are still regularly segregating individuals with mental illness for weeks or months at a time. Those detained who are suicidal, requiring medical observation or who self-harm continue to be routinely segregated.

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[97] Independent Review of Ontario Corrections, *supra* note 18. On November 8, 2016, Ontario announced that it had appointed Howard Sapers as an Independent Advisor on Corrections Reform to review its use of segregation. His terms of reference requires that he provide an interim report regarding segregation, including consideration of the *Jahn* remedies, and a final report to inform Ontario's approach to long-term correctional reform. See Ministry of Community Safety and Correctional Services, News Release, "Ontario Appoints Independent Advisor on Corrections: Advisor to Review Use of Segregation in Province's Corrections System" (8 November 2016). His interim report was released to the public on May 4, 2017. See News Release, "Ontario Taking Action to Reform Correctional System", *supra* note 19.

[98] News Release, "Ontario Taking Action to Reform Correctional System", *supra* note 19.

> There are many barriers to translating the vision that emerged after the *Jahn* settlement into an operational reality. The policies were updated in September 2015, but no implementation supports were offered to institutional managers or frontline staff at that time. Ministry-wide training on mental illness and human rights obligations, originally intended to accompany the new policy rollout, was delayed for over a year. Institutions were not provided with any additional resources or space to fulfill their obligations to provide the required treatment, services and modifications to conditions of confinement. At some institutions, Superintendents that received the policy update copied and pasted the new directions into memos that were circulated to staff via email, with only limited follow-up or direction.
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> At every institution there are managers and frontline staff doing excellent work to appropriately provide care within a secure custody setting [...] The individual staff doing these things do so because it is the right, humane thing to do – not because it is an operational norm. In fact, in many instances it would have been easier for staff to keep their head down and follow the routine procedures. Many we spoke to would like to do more, but feel they are handcuffed by staffing shortages, resource limitations and the prevailing ethos within their workplace.
>
> Transformational change cannot be achieved by simply writing new corporate policies. In this context, it is not surprising that the systemic issues identified by the *Jahn* settlement remain.[99]

C. 2019: The *R v Capay* decision

102. In January 2019, the Ontario Superior Court's *R v Capay* decision also highlighted systemic failures with Ontario's conduct regarding the *Jahn* requirements.

103. As noted above, *Capay* concerned the experience of Adam Capay, a young, Indigenous man with serious mental health disabilities held in prolonged segregation in Ontario's correctional system. Mr. Capay's troubling circumstances first came to light in 2016 after the OHRC's then Chief Commissioner, Renu Mandhane, toured the Thunder Bay Jail, where Mr. Capay was held. During the tour the Chief Commissioner met Mr. Capay, learned that he had been in continuous segregation for more than four years, and that this was the case despite having apparent mental health disabilities.

104. Though the *Jahn* requirements were supposed to be in place during Mr. Capay's custody and were reflected in various Ministry policies, the Court, found "a disturbing pattern of disregard for policy, procedure, and inmates' rights within

[99] Independent Review of Ontario Corrections, *supra* note 18 at 54, 55, 66–68.

the Ontario correctional system."[100] The Court further noted that, despite the Ministry's failures, the record "fails to establish that any of the correctional officials involved in decision making or the review of decision making in regard to the accused's prolonged segregation have suffered any consequences despite the disturbing lack of compliance with provincial law and policy."[101]

105. The Court's decision also highlighted significant judicial concerns about the attitude of Ministry officials in ensuring that individuals like Mr. Capay are kept out of segregation. In remarking on the evidence provided by Ministry officials (including the Thunder Bay Jail's Health Care Manager, Superintendent, and the Deputy Director of Ontario's Northern Region Institutional Services), Justice Fregeau stated:

> In listening to the evidence on this application, I was disturbed by the contrast in the demeanour of the expert witnesses on the one hand and the Ministry witnesses on the other. As previously noted, all experts were demonstrably appalled by the state's treatment of the accused over the span of four and one-half years. By contrast, with the exception of Mr. Lundy, I did not observe a single note of contrition or regret during the testimony of the correctional witnesses who were largely responsible for detaining the accused in segregation under abhorrent conditions for four and one-half years.[102]

D. 2020: The *Francis v Ontario* decision

106. Ontario's deficient approach to implementing the reforms necessary to comply with the *Jahn* settlement and 2018 Order, or to otherwise protect prisoners with mental health disabilities from the harms of segregation, were further identified by the Superior Court of Justice in *Francis v Ontario.*[103]

107. As noted above, *Francis v Ontario* was a class action seeking damages for a class of persons who were held in prolonged segregation (longer than 15 days) at any time between April 20, 2015 and September 18, 2018. It also included a subclass of individuals who were held in segregation for any duration while suffering from a defined list of conditions amounting to "serious mental illness". The plaintiff class alleged that Ontario's use of segregation breached their *Charter* rights under ss. 7 and 12 and sought damages under s. 24 of the *Charter*.

108. The entire class period post-dates the *Jahn* settlement, and by at least eight months post-dates the 2018 Order. Many members of the class, including all of the members of the subclass, are people who the *Jahn* settlement and 2018 Order should have protected from segregation.

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[100] *Capay*, *supra* note 22 at para 516.
[101] *Ibid* at para 519.
[102] *Ibid* at para 520.
[103] *Francis, supra* note 2.

109. The Court held that the use of segregation beyond 15 straight days violated the s. 12 *Charter* right of all class members to be free from cruel and unusual treatment, and that any use of segregation for prisoners with a serious mental illness violated the *Charter* s. 12 rights of that subclass.

110. In reaching its conclusion, the Court relied upon the 15,000-page evidentiary record before it – which included the Independent Expert's reports – to make a number of key findings regarding the state of Ontario's knowledge about the harm caused by segregation, and its continuing failure to take action to remedy that harm. The Court's findings included that Ontario:

- knew that there was a worldwide consensus that solitary confinement should never be used for certain inmates, including the seriously mentally ill,
- knew that there was a worldwide consensus that prolonged solitary confinement was contrary to what the United Nations had set as the *Standard Minimum Rules for the Treatment of Prisoners* (the revised Mandela Rules),
- knew precisely what it was doing with respect to the use of administrative segregation,
- knew what other jurisdictions were doing with respect to the use of administrative segregation in their correctional institutions and with respect to the treatment of the mentally ill.
- knew about the development of alternatives to administrative segregation and about prison reform developments to ensure the humane treatment of inmates, and
- knew about the tragic incidents associated with prolonged solitary confinement.[104]

111. And yet, despite this knowledge, the Court found that Ontario:

- continued to "habitually" place prisoners with mental health disabilities in segregation,
- continued to "habitually" fail to comply with accepted standards or even its own written policies,
- continued to place prisoners in segregation contrary to its own policy directives (including putting prisoners with mental health disabilities in segregation rather than in a clinical environment where they may receive treatment), and
- was "frequently non-compliant with its own policy requirement to consider alternatives to administrative segregation to the point of undue hardship."[105]

[104] *Ibid* at para 269.
[105] *Ibid.*

112. The Court in *Francis* further commented on Ontario's failure to take prompt steps to ensure compliance with the *Jahn* settlement, the 2018 Order, or the recommendations from independent reviews, finding that:

- Ontario was very slow to respond to the growing international recognition and expert consensus that the use of solitary confinement should be prohibited for mentally ill prisoners and that it should never be used as a substitute for appropriate mental health care.
- Ontario was very and unduly slow to respond to the reports of Justice Arbour and others that indeterminate prolonged administrative segregation does not conform to legal standards…
- …Ontario was very and unduly slow to reform its policies and practices with respect to the use of administrative segregation particularly with respect to the mentally ill, and
- Notwithstanding that it had acknowledged that prolonged periods of solitary confinement can have serious and detrimental effects on a prisoner's mental health, Ontario was very and unduly slow in responding to the consensus that prolonged administrative segregation should be prohibited including the recommendation of Ontario's Ombudsman that segregation for more than 15 days be prohibited.[106]

113. In awarding damages to remedy Ontario's *Charter* breaches, the Court reviewed Ontario's conduct over the past 30 years – including its failure to properly implement the *Jahn* settlement[107] – and concluded that Ontario's conduct was "clearly wrong" on an individual and systemic basis,[108] and that Ontario was, "willfully blind to the harm it knew it was causing"[109]:

> Ontario knew about the problems associated with administrative segregation for decades and some of the signal and significant events of the history of administrative segregation occurred in penitentiaries and prisons located in Ontario. As early as 1992, Ontario's policies recognized that segregation should be avoided wherever possible with more humane options to be preferred. **With the first Jahn Settlement in 2013, Ontario has tried to reform its use of administrative segregation, but it has been dilatory in doing so** and its negligence and breaches of the standard of care have been habitual, continual, and continuous. Ontario has fallen short in fulfilling the promises or undertakings it made, to do better and to reform its practices particularly its treatment of mentally ill inmates. It has promised to reform its correctional institutions, but it has fallen short in carrying out its promises.[110]

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[106] *Ibid.*
[107] *Ibid* at para 581.
[108] *Ibid* at para 583.
[109] *Ibid* at para 593.
[110] *Ibid* at para 581 [emphasis added].

E. 2020: The Independent Reviewer's Final Report

114. As is now set out yet again in the Independent Reviewer's Final Report, Ontario's approach to its *Jahn* obligations continues to be deficient.

115. In a joint statement, the Independent Reviewer and Expert make a point of stressing that Ontario has consistently failed to commit to meeting its legal obligations under *Jahn* and the Order:

> ...**the ministry's failure to commit itself fully to and implement the various Jahn remedies has now been going on for nearly 6 1/2 years**. For numerous senior officials (corporate and field) to continually rationalize the ministry's lack of substantive response to the Jahn litigation with phrases such as "it takes a lot of effort to turn a big ship around", or "things are different now as we have new managers and structures in place", or "we have to await political direction, which takes time" is simply inadequate, given the gravity of the issues involved.[111]

116. The Report also identifies problems with how Ontario has undertaken the correctional policy reform required by *Jahn*.

117. First, the Report describes how Ontario's policy development is motivated more by what "can be complied with" and will not "reflect negatively on the ministry" than a commitment to meeting Ontario's legal and human rights obligations:

> Our experience is that all too many draft policy documents we have seen reflect piecemeal "policies that can be complied with" rather than policies that are consistent with federal and provincial legislation and case law. Indeed, we have both been expressly told on several occasions that some policy developers are reluctant to propose policy changes "if they might reflect negatively on the ministry". Given the reality which led to the establishment of this investigation and review, this is simply unacceptable and needs to be addressed forthwith by senior correctional management.[112]

118. Second, the Final Report also points to a systemically inadequate policy development process that is not evidence-based, and is improperly staffed by officials with a "glaring lack of field experience".[113] Moreover, when officials with apparent experience were involved, many were found to have outdated knowledge, leading to the Independent Reviewer and Independent Expert encountering "graphic examples where advice provided by such "experts" is simply wrong or substantially outdated."[114] While the Independent Reviewer and Independent Expert did remark on efforts to consult with Superintendents and other "field" personnel prior to adopting policies, they conclude that such consultation is of limited value and report that Ontario has failed to take decisive

[111] Final Report, Appendix C at 11–12 [emphasis in original].
[112] *Ibid* at 14.
[113] *Ibid*.
[114] *Ibid*.

or fully-informed steps to meet their obligations, noting that they have "experienced too many recurrent examples where "field experts" seem quite unwilling to "think outside the box" and pursue evidence-based practices that have been shown to work in other jurisdictions."[115]

119. Third, the Independent Expert further explains that Ontario's approach to segregation reform has been uncoordinated and lacks a cohesive policy framework. She explains that her conclusion that Ontario remains non-compliant "is principally based on Ontario not being able to produce **a cohesive** policy framework required to operationalize and implement the terms of the Consent Order, nor the incumbent PIR (Public Interest Remedy)s."[116]

120. Finally, and most troublingly, the Final Report also reveals that Ontario's behavior has been resistant, uncooperative, and even misleading. The Independent Reviewer and Expert set out in detail how they not only faced "considerable resistance" accessing relevant information, but that requested documents were actually withheld and only disclosed at the eleventh hour in response to anticipated criticisms of Ontario in the Final Report.[117]

121. For example, at the outset of their mandates, the Independent Reviewer and Expert sought "any and all scans that had been done of legislation, policies and procedures in other jurisdictions, in both Canada and other countries".[118] They explain that their repeated requests for this information were met with resistance.[119]

122. Based on the limited documentation they eventually received, the Independent Reviewer and Expert concluded that Ontario had not made sufficient efforts to conduct cross-jurisdictional research. They then dedicated considerable time and resources to conducting such research themselves, and made efforts to share information with Ontario, though they note that Ontario was not receptive.[120]

123. In a draft of the Final Report, the Independent Reviewer and Expert set out their views that Ontario had not undertaken the cross-jurisdictional research necessary to make evidence-based policy decisions. However, shortly after providing the draft report to Ontario for review, Ontario responded by indicating that it had, in fact, been in possession of relevant materials that were not disclosed throughout the duration of their terms. The Independent Reviewer and Expert describe these events, and conclude that, despite their repeated requests:

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[115] *Ibid*.
[116] *Ibid* at 17.
[117] *Ibid* at 12.
[118] *Ibid.*
[119] *Ibid*.
[120] *Ibid*.

- It is clear that the ministry has been in possession of numerous comprehensive scans prior to, and throughout the entire duration of our respective mandates.
- It is obvious that these have only been disclosed in anticipation of what we might be documenting in the Final Report.
- Since we have only been given “a few” or “some” of these materials, we are unable to discern exactly what other materials are in the ministry’s possession.
- No explanation has been offered at any point to explain or offer a rationale why these (and any other) jurisdictional scans have not been previously shared with us.
- The ministry has made no admission of wrongdoing, nor has any apology been offered. This takes on particular salience when we recall how much of our research assistants’ time (as well as taxpayer fiscal contribution) was wasted by having to duplicate that which was already in the ministry’s possession - materials that could so easily have been disclosed in a timely fashion.
- This inevitably makes us somewhat dubious about other areas identified where the ministry has claimed not to have materials which we sought.[121]

124. All of these reports and court decisions demonstrate that Ontario’s overall approach to implementing its obligations has been deficient and ineffective from the outset. They also demonstrate that Ontario has continuously failed to meet its obligations despite being repeatedly being made aware of its failings.

125. These chronic and persistent deficiencies in Ontario’s approach and internal capacity to implement the *Jahn* and 2018 Order terms demonstrate that broader remedial action is necessary to effectively and substantively ensure Ontario’s compliance.

PART VI – ONTARIO’S CONDUCT DEMONSTRATES THAT A BROADER ORDER IS NECESSARY TO COMPEL COMPLIANCE

126. Ontario has now failed to comply with its legal obligations under *Jahn* for almost seven years. This non-compliance has persisted in the face of contravention applications, independent reviews, disturbing examples of segregation use, data showing extensive segregation of prisoners with mental health disabilities, and even the 2018 Order requiring compliance.

[121] *Ibid*.

127. Further, the evidence before the Tribunal also shows that Ontario's overall approach to implementing the *Jahn* and 2018 Order obligations has been chronically deficient. Ontario's efforts have been delayed, uncoordinated, not evidence-based and without allocating the resources needed to achieve meaningful implementation.

128. In this context, an order from the Tribunal simply reiterating and ordering compliance with the terms will not be enough to spur Ontario into action and ensure effective implementation. Indeed, ordering compliance already occurred as part of the 2018 Order, and was not sufficient.

129. Instead, if the full promise of the *Jahn* settlement and 2018 Order is to be realized, an order imposing additional and more stringent requirements is now warranted. In order to ensure effective implementation, the Tribunal should now make an order for the following:

a) Strict restrictions on all ongoing segregation use; and
b) Further oversight and accountability measures to promote and monitor Ontario's ongoing compliance.

To ensure compliance, the Tribunal can impose new terms using its broad remedial powers.

130. The HRTO has the broad remedial authority to take innovative action to ensure Ontario's compliance with the *Jahn* settlement and 2018 Order. This authority is based on the case law regarding the Tribunal's powers when it remains seized of a matter following an order,[122] as well as its ability to remedy contraventions of settlements under s. 45.9 (8) of the *Code.*[123]

131. In both circumstances, the Tribunal has the authority to impose new obligations to ensure compliance, beyond simply restating the original terms of an order or settlement.

132. In the *McKinnon v Ontario* decisions, which were affirmed by the Court of Appeal, the Tribunal (then called the Board of Inquiry), concluded that it retained the authority to impose additional terms in the event of non-compliance. Like the present case, the *McKinnon* decisions involved the Ministry's chronic failure to comply with the terms of a human rights order relating to systemic discrimination in Ontario's correctional system. In its 2007 decision in that case (which followed orders in 1998 and 2002), the Tribunal confirmed its broad authority to order remedies that ensure compliance.[124]

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[122] See *McKinnon v Ontario (Correctional Services)*, 2007 HRTO 4 (CanLII), 59 CHRR 89 [*McKinnon* 2007].
[123] See *Aiken v Ottawa Police Services Board*, 2017 HRTO 178 (CanLII), [*Aiken* 2017]; *Aiken v Ottawa Police Services Board*, 2019 HRTO 934 (CanLII), [*Aiken* 2019].
[124] *McKinnon* 2007, *supra* note 122 at para 43.

133. The scope of the Tribunal's authority to go beyond the original terms and impose new obligations and innovative remedial action has also been recognized in the context of remedying settlement contraventions. Where there has been a breach of settlement, the Tribunal has confirmed the broad scope of its power under s. 45.9(8) of the *Code* to make "any order that it considers appropriate to remedy the contravention". [125]

A. Strict restrictions on all ongoing segregation use ensures compliance

134. Ontario has failed to comply with one of the core elements of *Jahn* and 2018 Order: the requirement to consider alternatives to the point of undue hardship before placing anyone with mental health disabilities in segregation.

135. To ensure Ontario's compliance with this requirement going forward, the Tribunal should now impose stricter restrictions on Ontario's segregation use, including:

> 1) a full prohibition of segregation for those with mental health disabilities; and
> 2) strict limits restricting any segregation to no more than 15 continuous days and 60 aggregate days in a calendar year.

i. Fully prohibiting segregation for people with mental health disabilities is necessary because Ontario is unable to conduct meaningful undue hardship analyses

136. At no point since Ontario made the commitment to prohibit segregation for people with mental health disabilities barring undue hardship has it ever demonstrated the ability to meaningfully conduct undue hardship assessments. Instead, every review of Ontario's segregation practices since 2013 has confirmed that undue hardship assessments prior to segregation placements are either *pro forma*, or not conducted at all. As set out above, the Final Report describes circumstances where alternatives to segregation are not being considered adequately – or at all – for people with mental health alerts.

137. Further, as mentioned above, in its April 2020 *Francis v Ontario* decision, the Ontario Superior Court found that "Ontario was frequently non-compliant with its own policy requirement to consider alternatives to administrative segregation to the point of undue hardship."[126]

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[125] *Saunders v Toronto Standard Condominium Corp No 1571*, 2010 HRTO 2516 (CanLII) at para 39 [*Saunders*]. See also *AW v Ottawa International Soccer Club*, 2011 HRTO 915 (CanLII) [*AW*] (The HRTO added on a requirement for the Respondent to hire an external consultant to deliver training at paras 25–26); *Salimi v Toronto Community Housing Corporation*, 2013 HRTO 66 (CanLII) at para 46 [*Salimi*].

[126] *Francis*, *supra* note 2 at para 269.

138. Given that, over all this time, Ontario has not shown it is able to ensure that alternatives are considered to the point of undue hardship prior to placing an individual with mental health disabilities in segregation, the Tribunal should now ensure Ontario's compliance with this requirement by ordering that segregation be prohibited altogether for this group.

ii. Strict time limits on all segregation use are needed because Ontario is not able to accurately identify people with mental health disabilities

139. The evidence before the Tribunal also shows that Ontario is not accurately identifying the people in its custody who have mental health disabilities and should not be subject to segregation. As a result, ordering stricter time limits on all segregation placements is needed to mitigate the extent to which any person with a mental health disability that Ontario has failed to properly identify would experience segregation in contravention of *Jahn* or the 2018 Order.

iii. Stricter limits on segregation are further warranted by the harm of any non-compliance and Ontario's constitutional obligations

140. As any ongoing non-compliance with this requirement will result in serious and irremediable harm to prisoners with mental health disabilities, imposing strict limits to ensure compliance as soon as possible is justified.

141. These harms have been recognized by the courts in Ontario, and issuing an order prohibiting segregation for people with mental health disabilities and imposing a time limit on all segregation placements is consistent with the government's constitutional obligations. The *Francis v Ontario* and *CCLA v Canada* decisions establish that it is unconstitutional to place persons with serious mental illness in segregation at all, and to place anyone in segregation for more than 15 days.[127]

142. Finally, such restrictions are also in line with the content in the Final Report, which describes the harm caused by segregation; and urges Ontario to shift its practices in light of the evidence of harm, recognized standards, and example of other jurisdictions to severely restrict or altogether eliminate segregation:

> ...[Segregation] should be prohibited for those with serious and/or identified mental and physical disabilities. One of the known harms of segregation include negative mental health effects. Any sustained use of segregation, then, will produce the very issues that the Consent Order sought to remedy. Succinctly, the CSRA (Correctional Services and Reintegration Act, 2018)

[127] *Francis*, *supra* note 2 at paras 313–15; *CCLA* CA, *supra* note 4 at para 150.

> as legislated requires the elimination of the practice of segregating mentally ill persons. Ideally, Ontario will follow other national and international jurisdictions and severely restrict, with a view to eliminating, the practice of administrative segregation.[128]

B. Further oversight and accountability measures are necessary to promote and monitor Ontario's ongoing compliance

143. The evidence before the Tribunal not only shows Ontario's non-compliance with specific *Jahn* and 2018 Order requirements, but also highlights the weaknesses of Ontario's overall approach to implementation. Ontario has failed to take effective action despite years of clear knowledge of these issues from independent reports, findings in legal decisions, input from the Independent Expert and Reviewer, and ongoing concerns raised by the OHRC.

144. When, as is the case here, an institution demonstrates an ongoing inability to modify its conduct, accountability and oversight measures are integral to promoting effective implementation going forward. The fact that Ontario failed to comply with the *Jahn* settlement and the 2018 Order despite the built-in accountability and oversight measures of the 2018 Order underscores the need for even stronger such measures to be imposed now.

145. Requiring accountability and oversight to promote compliance as soon as possible is also justified in light of the harmful consequences of non-compliance for people with mental health disabilities. Every additional day that Ontario fails to comply is another day that a person with a mental health disability may be suffering the profound and permanent harm of segregation. In other instances, people are not receiving the mental health services that should be available to them.

146. In these circumstances, the HRTO's order should include the following oversight and accountability measures:

i. Implementation plan and financial accountability

147. Ontario can only achieve compliance if adequate resources are allocated and spent to support meaningful implementation of the Tribunal's orders.

148. In order to ensure that this occurs, the Tribunal should order Ontario to develop an Implementation Plan that includes costing and budget allocation.

149. To provide accountability regarding whether the necessary resources are actually allocated and spent, the Implementation Plan should independently reviewed, and there should also be ongoing evaluation of Ontario's resource allocation and expenditure.

[128] Final Report, Appendix C at 17.

ii. Continuing to work with the Independent Expert

150. The 2018 Order required that Ontario work with an Independent Expert on implementation. As compliance has not yet been achieved, Ontario should continue to work with the Independent Expert. The HRTO's order should include provisions to ensure that the Independent Expert is enabled to be as effective as possible in her role.

151. Ontario's approach to implementation, as described in the Final Report, underscores the importance of the Independent Expert's ongoing involvement. As set out above, the Final Report states that Ontario's policy development process has not been evidence-based, was uncoordinated, and was conducted by staff lacking sufficient experience. Howard Sapers, Ontario's former Independent Advisor on Corrections Reform, also noted the insufficient policy, evaluation and analytic capacity in Ontario's approach to *Jahn* implementation.

152. Having Ontario continue to work with the Independent Expert aligns with the Tribunal's approach in other cases where respondents were required to work with experts to ensure that systemic remedies were effectively implemented.[129]

iii. Appointing an Independent Monitor

153. Given Ontario's years-long inability to implement the *Jahn* and 2018 Order terms, or to monitor its own compliance, appointing an Independent Monitor to provide oversight of Ontario's compliance is appropriate.

154. The Tribunal has the authority to appoint a monitor to oversee the implementation of its orders, and has done so in other cases involving systemic remedies and the continuing failures of respondents to meet their obligations. In the *McKinnon* proceedings, after finding that Ontario had not complied with its previous 1998 order, the Board of Inquiry ordered in 2002 that a committee be established to monitor compliance with its orders.[130]

155. In its *Lepofsky v Toronto Transit Commission* decisions, the Tribunal also appointed an independent monitor to oversee the implementation of its orders and provide ongoing reporting to the Tribunal, at the Toronto Transit Commission's expense.[131]

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[129] See, for example, *McKinnon* 2007, *supra* note 122; *AW, supra* note 125.

[130] *McKinnon* 2002, *supra* note 25 (The Board ordered: "9. (a) That within thirty days of this decision a committee to be called the "Compliance Committee", the membership of which is to be approved by the parties, be established at the Centre for the purpose of monitoring compliance with these orders in that facility; and (b) that the Superintendent of the Centre provide the said Compliance Committee with monthly progress reports until these orders are fully implemented" at para 312).

[131] *Lepofsky v Toronto Transit Commission*, 2005 HRTO 21 (CanLII) at para 2, [*Lepofsky* 2005]; *Lepofsky v TTC*, 2007 HRTO 23 (CanLII) at para 14, [*Lepofsky* 2007].

156. Like the *McKinnon* and *Lepofsky* proceedings, this case involves systemic remedies and a long history of Ontario failing to meet its obligations, and is one in which an order for independent monitoring is appropriate.

157. The need for independent oversight is also supported by the evidence that Ontario is not able to effectively monitor its own compliance or its use of segregation. The Final Report describes Ontario's internal monitoring mechanisms as "fundamentally limited" and concludes that only an official charged with professional oversight of corrections would be able to hold Ontario accountable.[132] Similarly, courts, experts, and oversight bodies have all described Ontario's internal segregation review processes as inadequate.[133]

158. The deficiencies in Ontario's internal oversight and monitoring systems demonstrate the need for independent monitoring to ensure meaningful implementation and compliance going forward.

iv. Public accountability

159. Ensuring that information about Ontario's implementation efforts and compliance is reported publicly is also an important aspect of ensuring compliance by holding Ontario publicly accountable for its efforts. Accordingly, the Tribunal's order should require publication of information relating to the government's resource allocation, reports on Ontario's compliance with the terms of the *Jahn* settlement and subsequent orders, and correctional policies developed relating to the *Jahn* requirements.

160. The *Jahn* settlement and the 2018 Order include public interest remedies providing important protections for individuals in Ontario's correctional system. It is essential that people, especially those as vulnerable and invisible as prisoners with mental health disabilities, can access information about Ontario's obligations regarding their treatment while in custody and be able to assert their rights. Public information on Ontario's obligations, and whether it is meeting them, also allows for Ontario to be held accountable through means other than non-compliance motions before the Tribunal.

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[132] Final Report, Appendix C at 13, 15, 29.

[133] *Francis, supra* note 2 at para 269, *Capay supra* note 22 at para 521, Independent Review of Ontario Corrections, *supra* note 18 at para 124, Ombudsman of Ontario, "Out of Oversight, Out of Mind", *supra* note 17 at 82–83; Ombudsman of Ontario, "Annual Report: 2019-2020" (Toronto: Office of the Ombudsman of Ontario, 2020) at 35–36.

PART VII – ORDER BEING SOUGHT

161. In order to address Ontario's non-compliance to date, and to promote compliance going forward, the OHRC is seeking an order for the following:

1. For clarity, the terms of the *Jahn v MCSCS* settlement and 2018 *OHRC v Ontario* Order continue to apply.

Strict restrictions on all ongoing use of segregation

2. Ontario will prohibit segregation for any individuals with a mental health disability, who should have verified mental health alerts in accordance with Schedule B, paragraph 10 of the 2018 *OHRC v Ontario* Order.

3. Ontario will prohibit all segregation placements exceeding:
    a. 15 consecutive days; and
    b. 60 aggregate days in the most recent 365-day period.

Further oversight, monitoring and accountability measures

Implementation plan and financial accountability

4. Ontario will prepare an Implementation Plan, which includes costing and budget allocation, for how the terms of *Jahn* and related HRTO orders will be achieved. The Implementation Plan will be provided to the Independent Expert, Independent Monitor, OHRC and Tribunal.

5. Ontario shall:
    a. Arrange for an independent analysis of the Implementation Plan;
    b. Establish quarterly independent monitoring and evaluation of its budget allocation and expenditure relating to the Implementation Plan; and
    c. Publicly post and provide the independent analysis of the Implementation Plan and quarterly budget evaluations to the Independent Expert, Independent Monitor, OHRC and Tribunal.

Continuing to work with the Independent Expert

6. Ontario shall continue to work with the Independent Expert appointed pursuant to the HRTO's 2018 Order to assist with reaching full implementation of the *Jahn* terms and HRTO's orders.

7. The Independent Expert will be able to report directly to the Deputy Solicitor General Correctional Services and the Independent Monitor.

8. Ontario shall provide the Independent Expert with full cooperation and unencumbered access to the information, locations and people (including the parties, and external experts and stakeholders) the Independent Expert deems necessary to assist Ontario with achieving compliance.

9. If the Independent Expert experiences impediments in conflict with this Order, she will report her concerns in writing to the parties, Independent Monitor, and HRTO.

10. The Independent Expert will be a compellable witness and materials produced by the Independent Expert may be relied upon as evidence in any subsequent proceeding.

Establishing Independent Monitor of Corrections

11. Ontario shall appoint an Independent Monitor of Correctional Services who is fully independent of the Ministry and who shall, consistent with the role of the Inspector General contemplated by the *Correctional Services and Reintegration Act*:

    a. Monitor, inspect, investigate and audit the Ministry to ensure that correctional services employees comply with the *Jahn* settlement terms and related HRTO orders, the laws and regulations governing Ontario corrections, and the Ministry correctional policies and procedures;

    b. Issue directions to the Minister or correctional services employees if they are not in compliance;

    c. Report in writing to the Minister any non-compliance with directions made under (b);

    d. Receive complaints from prisoners;

    e. Report on the treatment of prisoners and on conditions in correctional institutions;

    f. Review and report on the use of segregation, restrictive confinement and lockdowns in correctional institutions;

    g. Develop, maintain and manage records and conduct analyses regarding correctional services employees' compliance with the *Jahn* settlement terms and related HRTO orders, the laws and regulations governing Ontario corrections, or a Ministry correctional policy or procedure;

    h. Make recommendations about Ministry correctional policies and procedures;

    i. Inform the public about the Independent Monitor's duties and activities and the Ministry's compliance with *Jahn* settlement terms and related HRTO orders, the laws and regulations governing Ontario corrections, or a Ministry correctional policy or procedures; and

j. Submit an annual report to the Minister, a copy of which will also be provided to the HRTO and OHRC.

12. The Independent Monitor may appoint such employees as the Monitor considers necessary to carry out these functions.

13. Ontario shall provide the Independent Monitor with full cooperation and unencumbered access to the information, locations and people the Independent Monitor deems necessary.

14. The Independent Monitor will be able to make public statements with respect to the correctional system.

15. The Independent Monitor will be a compellable witness and materials produced by the Independent Monitor may be relied upon as evidence in any subsequent proceeding.

16. If the Independent Monitor experiences impediments in conflict with this Order, the Independent Monitor will report these concerns in writing to the parties and HRTO.

Independent review of segregation placements

17. The Independent Monitor will review all segregation placements of five or more consecutive days and will have the power to order a prisoner's removal from conditions of confinement amounting to segregation if they determine that ongoing segregation is unreasonable in the circumstances.

Publicly posting relevant policies and ADM Directives

18. Ontario will publicly post all policies and ADM Directives. If doing so raises any security or confidentiality issues, a determination regarding possible redaction will be made by the HRTO.

HRTO will remain seized

19. The HRTO shall continue to remain seized of this matter pending full implementation of the *Jahn* settlement terms and related HRTO orders.

20. Ontario shall comply with such other remedies as the OHRC may request and that the HRTO may order.