COURT OF APPEAL FOR ONTARIO

CITATION: Nelson v. Livermore, 2017 ONCA 712
DATE: 20170913
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2017 ONCA 712 (CanLII)

Doherty, Benotto and Trotter JJ.A.

In the matter of an appeal from a decision of the Consent and Capacity Board, pursuant to the *Mental Health Act*, R.S.O. 1990 c. M7, as amended

And in the matter of Rodney Nelson, a patient at Waypoint Centre for Mental Health Care - Oakridge Site, Penetanguishene, Ontario

BETWEEN

Rodney Nelson

Appellant (Appellant)

and

Dr. Craig Livermore

Respondent (Respondent)

and

Attorney General of Ontario

Intervener (Respondent)

Suzan E. Fraser, for the appellant

Janice Blackburn and Julia Lefebvre, for the respondent Dr. Craig Livermore

Yashoda Ranganathan and Hayley Pitcher, for the respondent Attorney General of Ontario

Heard: April 25, 2017

On appeal from the order of Justice Susan E. Healey of the Superior Court of Justice, dated February 22, 2016, with reasons reported at 2016 ONSC 1262, dismissing an appeal from a decision of the Consent and Capacity Board, dated March 15, 2013.

Trotter J.A.:

A. INTRODUCTION

[1] This appeal involves the application of the involuntary admission provisions of the *Mental Health Act*, R.S.O. 1990, c. M.7 ("MHA") to an incarcerated offender.

[2] In 2005, as the appellant completed a penitentiary sentence, a psychiatrist formed reasonable grounds to believe that the appellant suffered from certain mental disorders (i.e. paraphilia, severe personality disorder, psychotic symptoms) that would likely result in serious bodily harm to another person. The appellant was sent to a psychiatric hospital, where two different psychiatrists assessed him and formed the same opinion about the presence of mental disorders and the risk of harm to others. Despite numerous reviews by the Consent and Capacity Board ("the Board"), the appellant remains detained in a psychiatric hospital.

[3] The Board last reviewed the appellant's status as an involuntary patient at a hearing on March 14, 2013. The appellant's appeal from that decision was dismissed. He now appeals to this court.

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[4] The appellant argues that the Board's decision was unreasonable and that the appeal judge erred in not setting it aside. The appellant contends that he does not have a mental disorder and that the MHA is being used to effectively extend his prison sentence indefinitely, in breach of ss. 7, 9, 11(h), and 12 of the *Canadian Charter of Rights and Freedoms.* He seeks an order for his immediate release under s. 24(1).

[5] I would dismiss the appeal. In short, the appellant has failed to demonstrate that his detention under the MHA in 2005 was motivated by any invidious purpose. In the ensuing years, the Board has confirmed that he has an untreated mental disorder that requires his detention. The appellant has done virtually nothing to address these issues, leading to the Board's last decision, confirming his detention once again.

[6] I agree with the appeal judge that the Board's decision to confirm the appellant's involuntary status was reasonable and free from legal error. I also agree with her conclusion that, because the appellant has failed to demonstrate that his detention (both initial and continued) runs afoul of the MHA, his *Charter* claims must fail.

[7] Before considering these issues in more detail, it is necessary to examine the appellant's criminal and psychiatric history, along with the somewhat complicated procedural history of this case.

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B. THE FACTS

[8] The appellant is 57 years old. He is dangerous. This is clear from his lengthy criminal history. He has committed many violent offences, including sexual offences against women and children. His dangerousness has been confirmed by numerous psychiatric assessments over the years. Since 1990, he has spent most of his time detained, either as a sentenced criminal, or as an involuntary patient in a psychiatric facility.

(1) First Detention in a Psychiatric Facility

[9] In 1999, the appellant was serving an aggregate 14-year prison sentence for armed robbery, sexual assaults, and gross indecency. He served his sentence at Kingston Penitentiary.

[10] As the appellant's sentence came to an end, an application for psychiatric assessment (Form 1) was issued under the MHA. On September 3, 1999, the appellant was transferred to the Penetanguishene Mental Health Centre (Oak Ridge Division), now called Waypoint Centre for Mental Health ("Waypoint"). He was assessed at that hospital and admitted as an involuntary patient (Form 3).

(2) New Criminal Proceedings

[11] On March 17, 2000, the appellant was discharged from Waypoint directly into police custody. He was charged with sexual assault, assault, choking, forcible confinement, and extortion, all against his former female partner. The

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charges dated back to 1990. After a jury trial, the appellant was convicted of common assault only, contrary to s. 266 of the *Criminal Code*, R.S.C. 1985, c. C-46.

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[12] The Crown did not initiate dangerous offender proceedings under Part XXIV of the *Criminal Code*. Indeed, it would have been unable to do so. The dangerous offender provisions are triggered by the commission of a “serious personal injury offence” that carries a maximum sentence of at least 10 years’ imprisonment: see s. 752. The maximum sentence for assault is five years’ imprisonment: see s. 266(a).

[13] The trial judge sentenced the appellant to five years’ imprisonment (less pre-sentence custody): see *R. v. Nelson* (12 June 2001), Sault Ste. Marie, 5963/A0 (Ont. S.C.). In his reasons, at p. 140, the trial judge emphasized the severity of the appellant’s offence:

> In terms of common assault or assault simpliciter, this is the worst case of common assault that I have heard or I am aware of.
>
> Regarding the worst offender, we look at the background of Mr. Nelson. He has a criminal record of 31 convictions between 1976 and 1991. Nine of the convictions are for crimes of violence, including armed robbery, assault and sexual assaults.

The trial judge referred to the appellant’s psychiatric assessments and concluded that he was at a “very high risk to reoffend involving crimes of violence” (at p. 140).

[14] The Crown appealed the appellant's acquittals; the appellant appealed his sentence. Both appeals were dismissed: see *R. v. Nelson*, [2003] O.J. No. 163 (C.A.). In dismissing the sentence appeal, this court affirmed, at paras. 1-2, that the facts of the appellant's case brought it into the category of the most serious simple assault and that the appellant qualified as the worst offender.

(3) Second Detention in a Psychiatric Facility

[15] The circumstances giving rise to this appeal occurred as the appellant's five-year sentence ended. On March 4, 2005, Dr. James Hillen, a psychiatrist at the Regional Treatment Centre of Kingston Penitentiary, completed an application for psychiatric assessment (Form 1). The appellant was transferred to Waypoint on March 10, 2005. This Form 1 is at the core of the appellant's grounds of appeal. He argues that it was used to maintain his custody, and for no legitimate mental health purpose.

[16] To a certain extent, Dr. Hillen's reasons for completing the Form 1 can be evinced from an Institutional Consult Letter ("Consult Letter") he wrote at the time. The document is dated February 24, 2005; however, in it, Dr. Hillen describes events up to March 4, 2005.

[17] The Consult Letter indicates that attempts were made to assess the appellant in 2001 and 2003. However, it states that on both occasions the

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appellant refused to participate in psychological assessments. The document does not indicate who attempted to assess the appellant, and for what purpose.

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[18] In February of 2005, Dr. Hillen reviewed 18 years of the appellant’s psychiatric and psychological records, as well as other records from the Parole Board of Canada and Corrections Canada. Dr. Hillen attempted to meet with the appellant on February 24, 2005, but the appellant refused.

[19] Dr. Hillen then interviewed the appellant’s female parole officer. She reported that the appellant had recently asked her if he could get a condom so they could have sex in her office, and told her that he thought a condom machine had been placed on the unit for this purpose. The officer considered the incident to be “fear-provoking” and suggestive of delusions (i.e. ideas of reference and erotomanic delusions).

[20] Dr. Hillen and a nurse attempted to meet with appellant on March 4, 2005. The appellant refused to be examined, but engaged in some conversation. He denied making sexual statements to his parole officer and denied having any form of mental disturbance. He said that all previous investigations into his sexual well-being were normal.

[21] Dr. Hillen summarized his conclusions in the Consult Letter as follows:

> In my opinion, the patient meets the criteria for completing an Application for Psychiatric Assessment under the Mental Health Act of Ontario under:

- persistent and untreated mental disorder, Paraphilia, complicated by intermittent (possibly continuous but covert) psychotic symptoms, untreated severe Personality Disorder, and persistent attraction to the use of intoxicants;
- persistent risk to the safety of others.

[22] The appellant arrived at Waypoint on March 10, 2005. The next day, Dr. Russell Fleming assessed the appellant and executed a certificate of involuntary admission (Form 3). Dr. Lisa Ramshaw executed certificates of renewal (Form 4s) on March 24, 2005 and April 22, 2005. The Board confirmed the latter Form 4 shortly thereafter.

[23] The Board has reviewed the appellant's involuntary status many times. Each time it has found that he meets the criteria for involuntary commitment.

(4) The *Habeas Corpus* Application

[24] In 2012, prior to the Board's decision that is the subject of this appeal, the appellant challenged his detention (and the Form 1 executed by Dr. Hillen) by way of *habeas corpus*. Representing himself, the appellant argued that his detention amounted to double jeopardy and infringed ss. 7 and 12 of the *Charter*. The application was dismissed: see *Nelson v. Her Majesty the Queen*, 2012 ONSC 1021, 252 C.R.R. (2d) 253. No appeal was taken from this decision.

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C. THE BOARD HEARING AND DECISION

[25] At his most recent Board hearing, the appellant was represented by counsel (not Ms. Fraser); Dr. Livermore, the appellant's attending physician, was not.

[26] The hearing was straightforward. The focus was on whether the appellant continued to meet the statutory criteria for involuntary commitment under s. 20(5) of the MHA. The appellant did not challenge the validity of the Form 1 completed by Dr. Hillen. The appellant's counsel advised the Board that he wished to create a record in support of *Charter* claims to be pursued by the appellant – not before the Board, but at some later date, on appeal. The appellant's counsel told the Board that he "didn't want to get into the case law as to the Board's jurisdiction with respect to that." That issue has since been settled. In *E.S. v. Joannou*, 2017 ONCA 655, this court held that the Board is not a court of competent jurisdiction for the purposes of s. 24(1) of the *Charter*.

[27] Dr. Livermore testified before the Board. He explained that he had been the appellant's attending psychiatrist since August of 2012, long after the completion of the Form 1. He relied upon documentation compiled by others, which was before the Board. Dr. Livermore also prepared a Consent and Capacity Board Summary dated March 13, 2013 ("Summary").

[28] Dr. Livermore was of the view that the appellant continues to suffer from mental disorders. He listed them in his Summary as follows:

> Paraphilia - Sexual sadism and Pedophilia with sexual deviance demonstrated with phallometric testing. History of sexual offenses with a broad victim pool (children, adult males and females) and violent sexual fantasies.
>
> Antisocial Personality Disorder with psychopathy - impulsive, egocentric, manipulative, lack of remorse for victims of prior offences, significant legal history and history of conduct disordered behaviour in childhood and adolescence, PCL-R score of 37/40.

[29] Dr. Livermore referenced the appellant's history of offending, particularly his sexual offending towards children. He was troubled by the appellant's lack of insight into his paraphilias and the wrongfulness of his actions. Dr. Livermore detailed certain behavioural problems exhibited by the appellant while hospitalized, including inappropriate behaviour towards female staff as recently as the year preceding the hearing before the Board. Dr. Livermore described the appellant's steadfast refusal to cooperate with treatment options recommended for him with a view to reducing his risk and paving the way towards fewer restrictions on his liberty, including his possible release into the community under supervision. In particular, Dr. Livermore was of the opinion that the appellant's failure to agree to take sex-drive reducing medication (Lupron) was highly problematic. The appellant had taken this medication for a short period of time in the past, but then refused to continue with it. Dr. Livermore concluded that,

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because of his untreated mental disorders, the appellant poses a high risk to others if released into the community.

[30] The appellant did not testify before the Board. He did not adduce evidence to contradict anything written or said by Dr. Livermore. He simply relied upon two letters from the Mennonite Central Committee Ontario and a brochure regarding its Circle of Support and Accountability, a Federal Corrections sponsored re-integration program. The letters offered to assist the appellant through the Circle of Support if he were deemed suitable for release.

[31] The Board rendered a decision on March 15, 2013. In thorough reasons for that decision, released March 18, 2013, the Board accepted Dr. Livermore's opinion and unanimously confirmed the appellant's involuntary status: see *R.N. (Re)*, 2013 CanLII 33987 (Ont. CCB).

[32] The Board determined that the appellant suffers from a "mental disorder" within the meaning of s. 1 of the MHA. The Board also determined that the appellant's mental disorder is of a nature and quality that would likely result in serious bodily harm to others unless he remained hospitalized. The Board reviewed the appellant's past criminal behaviour and how his conditions prevent him from understanding the wrongfulness of his actions and its impact on others. The Board relied on the following example, at p. 9:

> He was convicted of assaulting his then girlfriend's young daughter, on at least ten (10) occasions and left

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> her with venereal warts in her vagina and has admitted to assaulting other young girls. He could not understand why his girlfriend would not have him back after that event and was of the opinion, at least in 2010, that sex between men and children was not unusual.

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[33] The Board also pointed to the appellant's behaviour while hospitalized, which was sometimes threatening or menacing towards females. The Board observed, at p. 10:

> He is narcissistic and distorts reality…. [H]e is unable to appreciate his past acts were wrong or his fault. He sees himself as a victim of the justice system and does not and cannot take any ownership for any of his past or current actions, behaviours or statements. He is unable to see that others see them differently. He further has no insight as to their [e]ffect on others. His narcissistic traits lead to a distortion of reality and inability to feel emotion or empathy for his victims.

[34] The Board also considered the voluminous material available to it concerning the appellant's dangerousness. At pp. 9-10 of its reasons, the Board stated:

> RN has a score of 37 out of a possible 40 on the Psychopathy Checklist Revised (PCL-R). This tool predicts recidivism, poor community treatment and poor response to treatment. Phallometric testing indicates sexual deviance with a preference for nonsexual violence over consenting adult heterosexual activity, a sexual preference for violent sexual activities against male and female children and coercive sexual activities against male children over consenting adult homosexual activities. At Brockville, further actuarial testing by way of the Static 2002R, which is designed to predict sexual and violent recidivism, place RN in the Moderate-High

> category. This tool suggested RN's rate of recidivism is 2.5 times higher than the average sexual offender.

[35] The Board found that, if released into the community untreated and unsupervised, the appellant's risk of harming others ("particularly young and vulnerable females") is serious and "is likely to happen within a short period of time" (at p. 10).

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D. INITIAL APPEAL PROCEEDINGS

[36] The appellant appealed the Board's decision under s. 48(1) of the MHA and s. 80 of the *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A, which concurrently provide for an appeal to the Superior Court of Justice "on a question of law or fact or both."

[37] The first appeal was argued on December 4 and 5, 2014. Judgment was reserved. On December 23, 2014, this court released its decision in *P.S. v. Ontario*, 2014 ONCA 900, 123 O.R. (3d) 651, holding that the MHA violated s. 7 of the *Charter* because it did not provide the Board with adequate powers to address the needs of long-term detainees. The first appeal judge concluded that *P.S.* rendered the appeal moot: see *Nelson v. Livermore*, 2014 ONSC 7477.

[38] The appellant appealed to this court under s. 134 of the *Courts of Justice Act*, R.S.O. 1990, c. C.43. This court held that it was an error to dismiss the appeal for mootness. The case was remitted to the Superior Court to be heard by another judge: see *Nelson v. Livermore*, 2015 ONCA 688.

[39] After this court's decision in *P.S.*, the Legislature responded to the constitutional shortcomings of the MHA as identified in the decision. On December 21, 2015, the *Mental Health Statute Law Amendment Act, 2015*, S.O. 2015, c. 36, was proclaimed into force, amending the MHA by giving the Board greater powers to address the needs of long-term detainees. Previously, the Board could only confirm or rescind a patient's involuntary status. Now, under s. 41.1(2) of the MHA, the Board may direct transfers, reduce security levels, adjust privileges, and permit escorted and unescorted passes into the community, among other things. The appellant is entitled to a hearing under this regime. He has refused to participate in the Board process pending the final outcome of his appeal.

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E. SECOND APPEAL PROCEEDINGS

[40] At the second appeal hearing in the Superior Court, the appellant challenged the Board's decision and raised numerous *Charter* arguments in support of his position that he should be released. The appeal judge dismissed the appeal from the Board's decision and rejected the appellant's *Charter* claims. At this stage, I will simply outline the appeal judge's conclusions. A more detailed analysis follows.

[41] The appeal judge reached the following conclusions:

(a) The Board made no error of law in confirming the appellant's involuntary status. The Board's decision was reasonable;

(b) The appellant was not permitted to challenge the conclusions that formed the basis of the Form 1 because Dr. Hillen was not a party to the proceedings. Nevertheless, on the limited record available, Dr. Hillen met the minimal standard under s. 15 of the MHA and the initial detention did not violate s. 7 of the *Charter*;

(c) The execution of a Form 1 at the end of a sentence (psychiatric gating) does not necessarily constitute an unlawful or arbitrary detention. The record did not support the appellant's assertion that the MHA was used for an improper purpose; and

(d) The appellant failed to establish that his *Charter* rights under ss. 7, 9, 11(h) or 12 had been infringed by the process resulting in his initial detention, nor by his continued detention.

[42] The appellant appealed to this court under s. 6(1)(b) of the *Courts of Justice Act*.

F. ISSUES ON APPEAL

(1) Introduction

[43] The appellant challenges the appeal judge's decision to uphold the Board's confirmation of his involuntary status. He attacks the Form 1 that resulted in his initial detention. He invokes the *Charter* to attack his continued detention under the MHA.

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[44] While the appellant's approach is multi-faceted, his arguments coalesce in a single grievance – he is the victim of psychiatric gating (i.e. the use of the MHA to civilly detain an individual at the end of his or her prison sentence). This is at the heart of his challenge to the Board's decision and it drives each of his *Charter* arguments.

[45] All of the appellant's arguments must fail for the same reason – he has failed to establish that his detention runs afoul of the statutory criteria for involuntary commitment, or that the MHA has been used against him for any improper purpose.

[46] Time and again, the Board has confirmed the appellant's status as an involuntary patient. The appellant has done nothing, or next to nothing, to address the chorus of decisions that conclude that, untreated and unwilling to address his underlying mental disorders, he presents a serious risk to others.

[47] I commence with how the appeal judge addressed the Board's decision. I then consider how she handled the appellant's attack on the original Form 1. I will then turn to the appellant's *Charter* arguments.

(2) The Board's Decision

(a) The Role of the Board and the Standard of Review

[48] The Board's decision must be located within the framework of the MHA. In *P.S.*, at paras. 12-18, Sharpe J.A. sets out the applicable statutory framework,

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which I need not repeat as comprehensively here. The appeal judge also provided a detailed account of the procedure under the MHA, at paras. 20- 36.

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[49] Briefly, a Form 1 (under s. 15 of the MHA) permits a physician who examines a person, to make an application for a psychiatric assessment where they have reasonable grounds to believe that the person: has threatened or attempted self-harm, behaved violently towards another causing the person to fear bodily harm, or has shown a lack of competence for self-care; and, is suffering from a mental disorder that will likely result in serious bodily harm to the patient or another. The Form 1 authorizes the detention, restraint and examination of the person at a psychiatric facility for a maximum of 72 hours.

[50] Following the Form 1 assessment, an attending psychiatrist can admit the person involuntarily (under a Form 3) if he or she is satisfied that the criteria for civil committal are present and the person is not suitable for admission as a voluntary patient (ss. 20(1), (5)). A patient's involuntary status may be continued for longer periods if a physician issues a certificate of renewal (a Form 4) (s. 20(4)). Again, this decision is based on the physician's clinical opinion regarding the continued presence of the criteria for involuntary commitment.

[51] Under s. 39(1), an involuntary patient (or someone on the patient's behalf) can apply to the Board to inquire into whether the prerequisites for admission or continuation as an involuntary patient are met. Mandatory reviews are also

required at certain intervals (s. 39(4)). While the statutory framework is somewhat labyrinthine, the role of the Board on these reviews is clear – it must determine whether the involuntary patient suffers from a mental disorder of such a nature or quality that it is likely that he or she will cause serious harm to himself, herself or another person. If the criteria for involuntary commitment are met, the Board "may" confirm the certificate; if not, the Board must rescind it (s. 41). As mentioned above, the newly enacted s. 41.1 provides the Board with broader powers to manage long-term detainees.

[52] The Board is a specialized tribunal. When conducting a review of a patient's continued involuntary status, panels of the Board are comprised of a psychiatrist, a lawyer and a third person who is not a psychiatrist or a lawyer (s. 39(14)). The appropriate standard of review for Board decisions is described in *Starson v. Swayze*, 2003 SCC 32, [2003] 1 S.C.R. 722. The case originated from a decision of the Board, acting under the *Heath Care Consent Act, 1996*. Chief Justice McLachlin, dissenting in the result, agreed with the majority on the applicable standard of review. She held, at para. 5:

> I agree with my colleague Major J. that the Board's interpretation of the law is reviewable on a standard of correctness. On the application of the law to the facts, I agree that the Board's decision is subject to review for reasonableness. The Legislature assigned to the Board the task of hearing the witnesses and assessing evidence. Absent demonstrated unreasonableness, there is no basis for judicial interference with findings of fact or the inferences drawn from the facts. This means

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> that the Board's conclusion must be upheld provided it was among the range of conclusions that could reasonably have been reached on the law and evidence. As Binnie J. states in *R. v. Owen*, 2003 SCC 33 (S.C.C.) (released concurrently), at para. 33: "If the Board's decision is such that it could reasonably be the subject of disagreement among Board members properly informed of the facts and instructed on the applicable law, the court should in general decline to intervene." The fact that the reviewing court would have come to a different conclusion does not suffice to set aside the Board's conclusion.

See also *Gajewski v. Wilkie*, 2014 ONCA 897, 123 O.R. (3d) 481, at para. 33. This is the standard that the appeal judge identified, at paras. 12-17, and applied. She did so correctly in my view.

[53] The appellant argues that the Board erred in finding that he has a mental disorder within the meaning of the MHA. He also argues that, "the Board and, subsequently, the court acted unreasonably by disproportionately relying on historical and hearsay information to the exclusion of the appellant's contemporaneous behaviour." I do not accept either of these arguments.

(b) A Mental Disorder

[54] The appellant contends that he does not have the type of "mental disorder" contemplated by s. 1 of the MHA. He submits that involuntary status under the MHA must be predicated on a "psychotic illness or a mood disorder" that requires "psychiatric care or psychiatric medications."

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[55] In oral argument, Ms. Fraser observed that, in criminal proceedings, the Crown has never suggested that the appellant suffered from a mental disorder that compromised his intent to commit any of his crimes. This, she suggests, should further prevent the Board from relying on the appellant's mental disorders to support his detention as an involuntary patient.

[56] I would reject these arguments. As the appeal judge noted, s. 1 of the MHA defines "mental disorder" in broad terms, as "any disease or disability of the mind." The appeal judge also referenced s. 2 of the *Criminal Code*, which defines a "mental disorder" as "a disease of the mind." To this extent, there is some correspondence between the MHA and the *Criminal Code*.

[57] In the criminal context, courts have interpreted the term "disease of the mind" broadly. The classic formulation is from *Cooper v. The Queen*, [1980] 1 S.C.R. 1149, in which Dickson J. (as he then was) stated, at p. 1159:

> In summary, one might say that in a legal sense "disease of the mind" embraces any illness, disorder or abnormal condition which impairs the human mind and its functioning, excluding however, self-induced states caused by alcohol or drugs, as well as transitory mental states such as hysteria or concussion. [Emphasis added.]

This broad definition has stood the test of time. Under this umbrella, psychopathy is a disease of the mind: see *R. v. Simpson* (1977), 16 O.R. (2d) 129 (C.A.), at pp. 141-142, referred to with approval in *Cooper*, at pp. 1158-1159.

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[58] The comparison with the criminal law is helpful at the definitional level, but its usefulness ends there. The criminal law is generally concerned with mental disorders that are incapacitating, in the sense of compromising criminal responsibility, or rendering a person unfit to stand trial: see *Criminal Code*, ss. 2, 16, 672.22-672.33). Most often these cases involve disorders that produce psychotic symptoms. Conversely, the MHA is not concerned with blame or censuring an individual for past actions; it is concerned with promoting health and protecting patients and the public at large. Accordingly, disorders that produce the effects relevant to criminal responsibility and fitness are not necessarily required in the civil commitment context. The appeal judge recognized this distinction, at para. 74:

> There is no basis in law, as argued by the appellant, to equate the definition of mental disorder under the MHA to the criminal law analysis of mental disorder, which relates to offence-specific issues such as fitness to stand trial and criminal responsibility.

[59] I agree with this conclusion. There is no reason why mental disorders that do not produce psychotic symptoms are beyond the ambit of the MHA. I note the following cases in which the appellant patients detained under the MHA were diagnosed with pedophilia-paraphilia: *P.S.*; *Starnaman v. Penetanguishene Mental Health Centre* (1995), 24 O.R. (3d) 701 (C.A.); *Penetanguishene Mental Health Centre v. Stock* (1994), 116 D.L.R. (4th) 550 (Ont. Gen. Div.); and *Buccholz v. Allain*, 2015 ONSC 5851.

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[60] The appeal judge determined that there was ample evidence to support Dr. Livermore's conclusion that the appellant suffered from a mental disorder. Moreover, the evidence established that he continues to engage in behaviours consistent with his diagnoses. As the appeal judge concluded, at para. 78:

> I find, therefore, that it was reasonable for the Board to conclude that the appellant, at the time of the hearing, continued to suffer from these diagnoses, each of which constitutes a mental disorder within the meaning of the *MHA*. The diagnoses have repeatedly been confirmed over time, they have gone untreated, and they are diagnoses reached by professionals who have had an opportunity to spend time observing and assessing the appellant.

There is no error in the way the appeal judge dealt with this issue

(c) The Overall Reasonableness of the Board's Decision

[61] The appeal judge did not err in finding that the Board's decision confirming the appellant's involuntary status was reasonable. At para. 81, she stated, "I find that the conclusion reached by the Board that the appellant's release would likely result in serious bodily harm to another person was reasonable on the evidence before it." Responding to the appellant's repeated assertions that he has done nothing wrong in the past and will do nothing wrong if released, the appeal judge stated, at para. 82:

> This evidence, in my view, is sufficient to warrant ongoing detention in the face of the appellant's convictions, the appellant's broad victim pool, the nature of his paraphilia, the nature of his personality disorder,

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> and the chances of recidivism borne out by his test scores. As I suggested to his counsel during argument, there may in fact be individuals for whom long-term detention is the only answer to protection of the public, and the appellant may in fact prove to be one of those individuals.

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[62] In reaching this conclusion, the appeal judge (as did the Board) relied on far more than the appellant's criminal history. Rather, the conclusion was supported by the following evidence: (a) the appellant's test scores on various risk prediction instruments that rated him as being 2.5 times more likely to re-offend than the average sex offender; (b) the results of phallometric testing; (c) the appellant's refusal to take sex-drive reducing medication again; (d) the appellant's refusal to accept behavioural therapies that have been offered to him; (e) the appellant's untreated personality disorder that complicates his ability to control himself; and (f) his personality disorder leads him to place blame on others and renders him unable to appreciate the impact of his behaviour.

[63] The appeal judge found that the Board properly relied upon historical information, as well as information that was more current (i.e. the appellant's attitude towards treatment proposals, his continued lack of insight, and his menacing behaviour towards female staff). Moreover the appellant's complaint about over-reliance on hearsay evidence is misplaced. As this court recognized in *Gajewski*, at para. 40, the Board may admit hearsay evidence: see also *Statutory Powers Procedure Act*, R.S.O. 1990, c. S.22, s. 15; and "Consent and

Capacity Board Rules of Practice", (September 1, 2017), r. 23.1. In *Starson*, Major J., writing for the majority, warned that "the Board must be careful to avoid placing undue emphasis on uncorroborated evidence that lacks sufficient indicia of reliability" (at para. 115). There was no basis upon which the appeal judge could find that the Board erred in its use of hearsay evidence.

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[64] In conclusion, I agree with the appeal judge, at para. 84, that the Board's reasons, "provide a cogent and thorough assessment of the evidence relevant to the issues that it was tasked to decide, and provide no basis for interference from this court".

(3) The Validity of the Form 1

(a) Background

[65] The appellant submits that the Form 1 that triggered his detention is faulty and that every form that proceeded afterwards is invalid. The appellant contends that he should be released on this basis alone.

[66] This submission was not made before the Board. However, the appellant made a similar submission on his *habeas corpus* application: see para. 24, above. The Attorney General argued before the appeal judge that, based on the principle of *res judicata* and the doctrine of laches (in failing to raise this argument over the years), the appellant should be estopped from pursuing it in these proceedings.

[67] I need not consider these preliminary objections in any detail. I agree with the sensible manner in which the appeal judge decided them. As the appeal judge stated, at para. 109:

> In my view, the circumstances of a psychiatric patient who was not represented by counsel on a previous application before the Superior Court of Justice would amount to the type of special circumstances necessary to justify the consideration of issues that could have been raised in an earlier application. With this most vulnerable population, the same standard of reasonable diligence as would apply to other litigants should be significantly relaxed, and the policy reasons surrounding finality in litigation should give way to the policy reasons that offer psychiatric detainees broad access to procedural fairness.

[68] The appeal judge also observed that the judge hearing the *habeas corpus* application misapprehended the holding of this court in *Starnaman*. I will return to the *Starnaman* decision below when discussing psychiatric gating and the *Charter*. For present purposes, this error justifies the trial judge's decision not to apply the principles of *res judicata* to the appellant's detriment.

[69] Although the appellant should not be barred from attacking the Form 1 by *res judicata* or the doctrine of laches, his position is fraught with difficulty for other reasons.

[70] First, Dr. Hillen is not a party to these proceedings. Similarly, even though the Form 1 was completed while the appellant was at Kingston Penitentiary, the Attorney General of Canada is not a party to the proceedings.

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[71] On a more practical level, the materials in the record that bear on this issue are limited. The voluminous documentation relied upon by Dr. Hillen in completing the Form 1 was not before the Board or the appeal judge. The appeal judge determined, at para. 98, that, “[t]he correctness of Dr. Hillen’s conclusion cannot be evaluated in the absence of this evidence”. I agree with this assessment. The Consultation Letter leaves lingering questions on numerous issues, including the circumstances of the attempted assessments of the appellant in 2001 and 2003.

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[72] On occasion, the Board has rescinded a Form 1 when conducting a review of a Form 4. However, these cases generally involve fundamental defects on the face of the Form 1, brought to the Board’s attention at an early review; not substantive challenges years down the road: see, for example, *S.K. (Re)*, 2016 CanLII 38899 (Ont. CCB) (Form 1 rescinded on the basis that it was not signed by a physician when the patient arrived at the psychiatric facility; the Form 1’s rescission invalidated the Form 3 and two Form 4s that followed).

[73] The Board is not specifically empowered to investigate or review the validity of a Form 1. The MHA specifically limits the Board’s authority under s. 39 to reviews of persons under certificates of involuntary admission (Form 3s), or certificates of renewal/continuation (Form 4s/Form 4As). Moreover, reviewing the prerequisites of a Form 1 is not an explicit part of the Board’s mandate when conducting reviews pursuant to s. 39. This is not surprising in light of the

purposes of the civil commitment review process. As Rouleau J.A. said at para. 94 of his reasons in *E.S.*:

> The Board's function is primarily forward-looking and non-adversarial. Nothing in the relevant statutes suggests that the Board is to review and assess prior misconduct. For example, s. 41(1) of the *Mental Health Act* provides that upon an application the Board is to determine whether or not the conditions for involuntary status "continue to be met at the time of the hearing". The issue is not, therefore, whether the original determination was correctly made but rather whether the patient still meets the conditions. The process is more inquisitorial than fault- or blame-based. [Emphasis added.]

These observations are apt in relation to this ground of appeal.

[74] Despite the shortcomings of the record, the appeal judge engaged in a limited review of the Form 1. She refused to determine whether it was completed for an invidious purpose. She examined the record to ensure that there was strict compliance with s. 15 of the MHA, and to ensure that the appellant's rights under s. 7 of the *Charter* where not violated. The appeal judge concluded that the Form 1 was compliant. Assuming that the appeal judge was even required to undertake this task, I agree with her conclusions.

(b) A Proper Examination

[75] The appellant argues that the Form 1 was defective because Dr. Hillen did not examine the appellant. This argument is rooted in the language of s. 15(1) of the MHA, which provides:

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> **15** (1) Where a physician examines a person and has reasonable cause to believe that the person,
>
> (a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;
>
> (b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or
>
> (c) has shown or is showing a lack of competence to care for himself or herself,
>
> and if in addition the physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,
>
> (d) serious bodily harm to the person;
>
> (e) serious bodily harm to another person; or
>
> (f) serious physical impairment of the person,
>
> the physician may make application in the prescribed form for a psychiatric assessment of the person. [Emphasis added.]

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[76] The word "examines" is not defined in MHA. The appellant argues that, given the significant deprivation of liberty that flows from civil commitment, involuntary patients are entitled to an interactive examination with direct contact between the doctor and the patient, and not a decision based on historical records.

[77] The appellant relies on *Dr. X v. Everson*, 2013 ONSC 6134, 4 C.C.L.T. (4th) 205, a decision involving a tort action for false imprisonment, based on an

improper use of the civil commitment process. Addressing the nature of an examination required by the MHA, Reid J. stated, at paras. 94-97:

> It is not surprising that there are safeguards built into the *Act* to prevent misuse of the power of apprehension and detention.
>
> <u>One of the safeguards is the requirement for there to be a personal examination. This means that a doctor cannot proceed with an application based only on third-party evidence. There needs to be direct contact between the doctor and the patient in order for the doctor to come to a proper conclusion or, using the words of Form 1, to make a careful inquiry into all the facts necessary to form an opinion about the nature and quality of the person's mental disorder.</u>
>
> Dealing with the requirement for an examination under the B.C. *Mental Health Act*, Kirkpatrick J.A. of the British Columbia Court of Appeal in *Mullins v. Levy* [2009 BCCA 6, 88 B.C.L.R. (4th) 306] stated as follows [at para. 106]:
>
>> Having regard to the views of the physicians, the purpose of the *Act*, and the interpretation of the word in its ordinary usage in the medical context, in my opinion the term "examination" must be given a broad interpretation so as to be applicable in the myriad of circumstances that confront physicians called upon to make the serious decision to involuntarily commit persons to a psychiatric facility. "Examination", in this context, must mean observing the person, reviewing the patient's chart (if there is one), reviewing the available history and the collateral information, and where possible (in the sense that the person complies) and necessary (in the sense that the information to be gained is not available

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> from other sources) conducting a personal interview with the person to be admitted.
>
> I agree that it is not appropriate to define the nature of an examination too restrictively. It must be appropriate in the circumstances. It is quite possible to imagine a situation where the patient's mental state would make it impossible to have a meaningful conversation as part of an examination. In such a case, an adequate personal examination might well be restricted to direct observation of the patient's behaviour. Conversely, where the observed behaviour is inconclusive, and where there is no impediment to a detailed personal interview, surely it is necessary for a meaningful conversation to occur. [Emphasis added; footnotes omitted.]

[78] The appeal judge held that she was bound by the decision of the British Columbia Court of Appeal in *Mullins*. With respect, she was not. Nevertheless, the analysis in *Mullins* is helpful. The appeal judge applied the approach from that case and concluded that Dr. Hillen complied with the requirements of s. 15(1):

> On the evidence available, Dr. Hillen performed most of the requirements identified in *Mullins* in that he reviewed the appellant's chart, history, and collateral information from an individual who had direct contact with the appellant. It was not possible to interview him due to his lack of cooperation. It was not necessary to do so, given that information about his psychiatric health was available elsewhere. Further given the nature of the appellant's Axis I and Axis II disorders as described by Dr. Hillen in the Institutional Consult Letter, one must question whether it would have been possible to obtain accurate and reliable information directly from the appellant. Finally, in terms of directly observing the appellant, this is a case where the patient's circumstances must dictate the extent to which such

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> personal observation is necessary. The contextual approach referenced in *Mullins* and *Everson* is needed. Specifically, one must question how likely it is that the appellant would have been likely to engage in the predatory, opportunistic, forceful, persistent, and fear-provoking type of coercive behavior that characterized his sex-offending behavior, in Dr. Hillen's presence.

[79] I agree with these conclusions. Section 15 of the MHA is designed to address mental disorders that compromise the safety of the patient or the public at large. The scheme cannot be so easily defeated by the simple failure of an individual to participate in the assessment process. The record indicates that the appellant refused to cooperate with psychiatric assessments in 2001, 2003 and in 2005. As Reid J. noted in the passage quote above, there may be factors, such as a mental disorder itself, that prevent individuals from having meaningful interactions with a physician acting under s. 15. In these circumstances, physicians may need to undertake other measures to evaluate a patient. That is what occurred here. In the face of the appellant's obstinance, Dr. Hillen was thorough in his inquiries and careful in his analysis. He relied upon virtually all information that was available in relation to the appellant, both old and new.

[80] I would add the following observation. To a limited extent, the appellant did engage with Dr. Hillen on the day the Form 1 was executed. As noted in para. 20 above, Dr. Hillen confronted the appellant with information from his parole officer, which the appellant denied. The appellant further denied having any mental health problems in the past. All of this contributed to Dr. Hillen's ultimate

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conclusion that the appellant met the criteria for an application for psychiatric assessment (Form 1) under s. 15 of the MHA.

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(c) A "Triggering Event"

[81] The appellant also argues that it was improper for Dr. Hillen to complete the Form 1 in the absence of a triggering event. This is another way of asserting that the appellant was committed solely on the basis of his criminal past.

[82] This court addressed the need for a triggering event as a precondition to completing a Form 1 in *Starnaman*. Starnaman was a pedophile with a lengthy criminal record. While incarcerated, prison officials found materials in his cell that caused them concern – newspaper clippings and pictures of children, as well as pieces of paper with the names, ages and addresses of single mothers and their children in the Kingston and Toronto areas. Approximately 8 to 9 months later, a psychiatrist completed a Form 1, leading to Starnaman's transfer and involuntary admission to a psychiatric facility. The Board confirmed his involuntary status. His appeal to the Ontario Court of Justice (General Division) was dismissed: see *Starnaman v. Penetanguishene Mental Health Centre*, [1994] O.J. No. 1958.

[83] In dismissing Starnaman's further appeal, this court observed that neither the Board nor the appeal judge were concerned with whether s. 15 of the MHA had been complied with; instead, both were focused on whether the criteria for

involuntary admission in ss. 20 and 39 were met. Moreover, the court stated at p. 705:

> Second, assuming that a “triggering” event during the period of incarceration was necessary, it is our view that the discovery, in the appellant's cell, of the material referred to above, considered in light of his particular sexual deviancy and his prior *modus operandi*, amounted to a “triggering event”. In rejecting this ground of appeal, we specifically refrain from deciding whether a s. 15 application can be made in circumstances where the conduct prior to incarceration provides the only basis for the application.

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[84] In this case, the appeal judge recognized that *Starnaman* is inconclusive on the requirement for a triggering event. Nevertheless, she rejected this ground of appeal. Referring to the appellant’s comments to his parole officer, the appeal judge held, at para. 123:

> However, if such a triggering event is required, the events as relayed by the appellant’s parole officer to Dr. Hillen, as outlined in Dr. Hillen’s Institutional Consult Letter, would be sufficient. In my view, the events illustrate the extent to which the appellant’s illnesses cause him to be unable to appreciate the social inappropriateness of his conduct, conduct which has repeatedly throughout his life crossed the line into criminality.

I agree with this conclusion.

[85] I would also add that the wording of s. 15 of the MHA does not prevent a physician from completing a Form 1 in the absence of a triggering event. The

temporal requirements of the section are clear. Section 15 required Dr. Hillen to have reasonable grounds to believe that the appellant:

> has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her
>
> [and]
>
> …… the person is apparently suffering from mental disorder of a nature or quality that likely will result in,
>
> (e) serious bodily harm to another person. [Emphasis added.]

[86] To preclude recourse to s. 15 until a triggering event of the type contemplated in the appellant's submissions (i.e., further offending) would seriously compromise the protective aims of the MHA. Moreover, as the appeal judge recognized, at para. 99, "one must question how likely it is that the appellant would have been likely to engage in the predatory, opportunistic, forceful, persistent, and fear-provoking type of coercive behavior that characterized his sex-offending behavior, in Dr. Hillen's presence."

[87] I would dismiss this ground of appeal.

(4) The Appellant's *Charter* Claims

(a) Psychiatric Gating

[88] The appellant argues that his rights under ss. 7, 9, 11(h), and 12 of the *Charter* have been infringed by the timing and purpose of his involuntary

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admission in March of 2005, and his continued detention since. He submits that he was detained under the MHA not *as* his sentence was coming to an end, but *because* it was coming to an end. The appellant argues that the MHA was used for an improper purpose and he is the victim of psychiatric gating.

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[89] The appellant in *Starnaman* advanced a similar claim. This court refused to pronounce on the legality of psychiatric gating in general, stating, at p. 704:

> Counsel's submissions on behalf of the appellant raise issues specific to this record as well as broader concerns referable to the role of the civil commitment process and its relationship to the criminal process. We are satisfied, however, that the appeal can and should be disposed of only by reference to the specific issues raised herein; the broader questions cannot be properly addressed on this record. [Emphasis added.]

This court also rejected Starnaman's narrower claim that the MHA had been used as a disguised attempt to prolong his detention beyond his sentence, or that it amounted to a *de facto* dangerous offender application.

[90] In *P.S.*, at paras. 97-99, this court confirmed that *Starnaman* did not resolve, once and for all, the legality of psychiatric gating. There, the court found that the powers of the Board to deal with long-term involuntary patients were inadequate and violated s. 7 of the *Charter*. The legality of psychiatric gating was not a live issue in the case. While Sharpe J.A. noted that the practice has attracted some critical academic attention, he refused to comment on the issue. He stated, at para. 100:

> However, the appellant has not squarely challenged the constitutionality of gating in this proceeding and accordingly I make no comment on that issue.

[91] On his *habeas corpus* application, the appellant argued he was the victim of psychiatric gating. The application judge held, at para. 17:

> The constitutionality of civil committal following a criminal sentence has been upheld by the Ontario Court of Appeal. *Starnaman* is a complete answer to the complaints of the applicant of psychiatric gating and double jeopardy. The application should be dismissed.

[92] I agree with the appeal judge, at para. 113, that the application judge was mistaken. This court has yet to pronounce on the legality of the general practice of psychiatric gating. Ms. Fraser for the appellant does not ask us to so. Instead, she argues that the practice is highly suspect, but not unconstitutional *per se*. She submits that the appellant's circumstances must be carefully scrutinized for complete procedural and substantive compliance with the MHA. She asserts that when the record is subjected to this scrutiny, it reveals that the appellant's rights under ss. 7, 9, 11(h), and 12 of the *Charter* were, and continue to be, violated by his detention under the MHA.

[93] The appeal judge applied this rigorous level of scrutiny through the lens of the *Charter*. Her findings of fact or mixed fact and law cannot be dislodged absent a "palpable and overriding error"; questions of law are subject to the correctness standard: see *Housen v. Nikolaisen*, 2002 SCC 33, [2002] 2 S.C.R. 235. I can find no error in her analysis.

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[94] As observed earlier in these reasons, the record does not support the proposition that the MHA was used for an improper purpose. If it is determined that s. 15 was complied with, the appellant's *Charter* claims largely falter. As the appeal judge stated, at para. 121:

> Accordingly, the fact that an individual becomes the subject of a Form 1 at the end of his penal sentence does not automatically result in an unlawful deprivation of liberty or an arbitrary detention. Those arguments would only be engaged if the record showed that the statutory requirements for the execution of the Form 1 were not met, which is not the case with the appellant.

[95] The appellant's arguments operate on the assumption that, as a sentenced offender, he was somehow immune from the reach of the MHA. This is not the case. Any individual, at any point in time, is potentially subject to s. 15 of the MHA. This includes individuals serving custodial sentences, or subject to other forms of involuntary detention. As Klowak J. stated in *Stock*, at p. 552, "one must simply look at the criteria in the *Mental Health Act* itself to determine whether or not involuntary detention is justified, and it matters not where the person confined has been resident, provided the required criteria are met."

[96] When a Form 1 is completed as an individual completes a sentence, suspicions may arise. As described above, at paras. 9-15, the appellant has been subjected to the civil commitment process twice, both times at the end of a custodial sentence. Little is known about the circumstances of the first Form 1 and the appellant's subsequent hospitalization, other than that he was

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discharged from Waypoint directly into police custody to face criminal charges that dated back many years. The propriety of how the MHA was used at that time is not before us. However, it is a contextual factor that reinforces the need to carefully scrutinize the appellant's present circumstances to ensure that there has been strict compliance with the MHA.

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[97] The appellant places great emphasis on the timing of Dr. Hillen's completion of the Form 1. However, this event must be viewed in light of the fact that efforts were made to assess the appellant much earlier in his sentence, in 2001 and 2003.

[98] With these observations in mind, I consider the appellant's arguments under the *Charter*.

(b) Fundamental Justice (s. 7)

<u>Introduction</u>

[99] There can be no doubt that the appellant's liberty interests are engaged by virtue of his detention under the MHA. The respondents do not suggest otherwise. The critical issue is whether the deprivation of his liberty is in accordance with the principles of fundamental justice.

[100] The appellant relies generally on the articulation of the principles of fundamental justice in *Canada (Attorney General) v. Bedford*, 2013 SCC 72,

[2013] 3 S.C.R. 1101. In particular, he relies on para. 123, in which the Chief Justice stated:

> All three principles — arbitrariness, overbreadth, and gross disproportionality — compare the rights infringement caused by the law with the objective of the law, not with the law's effectiveness. That is, they do not look to how well the law achieves its object, or to how much of the population the law benefits. They do not consider ancillary benefits to the general population. Furthermore, none of the principles measure the percentage of the population that is negatively impacted. The analysis is qualitative, not quantitative. The question under s. 7 is whether *anyone's* life, liberty or security of the person has been denied by a law that is inherently bad; a grossly disproportionate, overbroad, or arbitrary effect on one person is sufficient to establish a breach of s. 7. [Emphasis in original.]

See also *Carter v. Canada (Attorney General)*, 2015 SCC 5, [2015] 1 S.C.R. 331, at paras. 83-90.

[101] The appellant argues that the appeal judge erred in failing to place the burden on the state to show that the appellant was detained for a non-punitive purpose. The general rule, dating back to the early *Charter* decision in *R. v. Collins*, [1987] 1 S.C.R. 265, is that the person asserting an infringement must bear the burden of proof on a balance of probabilities, both in terms of the substantive right, and any consequential remedy under s. 24. This rule applies to those rights, such as s. 7, that are qualified by their own terms: see *R. v. Malmo-Levine*, 2003 SCC 74, [2003] 3 S.C.R. 571, at para. 97.

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[102] Aside from the special circumstances in which the Crown bears the burden of justifying warrantless searches under s. 8 of the *Charter* (see e.g. *Collins*, at pp. 277-278), fairness may sometimes dictate the reversal of the usual burden of legal persuasion. However, these circumstances are restricted to "those relatively rare cases where the party who would normally bear the burden of proof has no reasonable prospect of being able to discharge that burden, and the opposing party is in a position to prove or disprove the relevant facts": see *Peart v. Peel Regional Police Services Board*, [2006] O.J. No. 4457 (C.A.), at para. 149.

[103] This is not such a case. The appellant adduced no evidence to support his claim that Dr. Hillen or others involved in his civil committal perverted the purposes of MHA. A relaxation of the burden of proof is not a matter of convenience; it is a matter of necessity. Such necessity is absent on this record.

Arbitrariness and Gross Disproportionality

[104] The appellant argues that his detention is arbitrary because there is a disconnect between the objects of the MHA and its effect on him as an individual. He also argues that his detention is grossly disproportionate because of his lengthy detention without a triggering mental health event (and on the basis of past criminal conduct and diagnoses).

[105] In *Bedford*, the Chief Justice explained the concept of arbitrariness under s. 7 in following terms, at para. 111:

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> Arbitrariness asks whether there is a direct connection between the purpose of the law and the impugned effect on the individual, in the sense that the effect on the individual bears some relation to the law's purpose. There must be a rational connection between the object of the measure that causes the s. 7 deprivation, and the limits it imposes on life, liberty, or security of the person.... A law that imposes limits on these interests in a way that bears *no connection* to its objective arbitrarily impinges on those interests. [Emphasis in original; reference omitted.]

[106] In *Carter*, the Court wrote, at para. 83, "[a]n arbitrary law is one that is not capable of fulfilling its objective. It exacts a constitutional price in terms of rights, without furthering the public good that is said to be the object of the law."

[107] The focus on this appeal is not the validity of the MHA, but the appellant's treatment under the law. I agree with the appeal judge's conclusion that the appellant's treatment under the MHA is not arbitrary.

[108] As this court held in *Thompson v. Ontario (Attorney General)*, 2016 ONCA 676, 134 O.R. (3d) 255, the MHA has the dual purpose of promoting health and protecting the public. The appeal judge found that the appellant was not detained for any improper purpose. He was, and continues to be, detained because he has a mental disorder that will likely result in serious bodily harm to another, which he lacks insight into, refuses to receive treatment for, and resists all attempts to manage. On this record, the MHA was used in a manner that is consistent with its purposes. There is no disconnection between the law's purpose and its effect on the appellant.

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[109] The Chief Justice explained the concept of gross disproportionality in s. 7 in *Bedford*, at para. 120:

> Gross disproportionality asks a different question from arbitrariness and overbreadth. It targets the second fundamental evil: the law's effects on life, liberty or security of the person are so grossly disproportionate to its purposes that they cannot rationally be supported. The rule against gross disproportionality only applies in extreme cases where the seriousness of the deprivation is totally out of sync with the objective of the measure. [emphasis added]

[110] In *Carter*, the Supreme Court elaborated on this concept, and its limitations as a principle of fundamental justice, at para. 89:

> The inquiry into gross disproportionality compares the law's purpose, "taken at face value", with its negative effects on the rights of the claimant, and asks if this impact is completely out of sync with the object of the law (*Bedford*, at para. 125). The standard is high: the law's object and its impact may be incommensurate without reaching the standard for *gross* disproportionality (*Bedford*, at para. 120; *Suresh v. Canada (Minister of Citizenship & Immigration)*, 2002 SCC 1, [2002] 1 S.C.R. 3 (S.C.C.), at para. 47).

[111] I agree with the appeal judge that the appellant has failed to establish that his deprivation of liberty has been grossly disproportionate. As she recognized, at para. 133, the appellant's detention is necessary to achieve the public protection function of the MHA. The restrictions placed on him, while onerous, are not grossly disproportionate given the importance of protecting public safety and the dire consequences of a mistake.

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Abuse of Process

[112] The appellant argues that his detention is an abuse of process because the MHA is being used in place of the dangerous offender provisions in Part XXIV of the *Criminal Code*. The appellant asserts that Parliament "intended to foreclose the pursuit of an indeterminate sentence for habitual offenders outside of that regime." The appellant also claims that his detention under the MHA violates the principle of collateral estoppel by giving rise to "contradictory rulings on the same evidence." By this claim, the appellant submits that detention under the MHA amounts to an end run around this court's decision upholding his five-year criminal sentence. I would reject both of these arguments.

[113] First, as addressed earlier in these reasons, the appellant's present detention is not an "indeterminate sentence." His detention under the MHA has no penal or punitive purpose. I will elaborate on this theme below, when addressing the appellant's double jeopardy argument.

[114] Secondly, this argument repeats the appellant's more general contention that the provisions of the MHA were used against him for an invidious purpose. This contention has already been rejected for lack of evidence.

[115] Finally, the collateral estoppel argument is completely without merit. This court did not reduce the appellant's sentence; it confirmed that the appellant should receive the maximum sentence for his offending. The subsequent

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decision, taken by other parties, to invoke the MHA did not in any way contradict or undermine this court's decision to dismiss his appeal.

Failure of the State to Follow the Law

[116] The appellant submits that s. 7 of the *Charter* has been infringed because the state acted unlawfully in failing to release the appellant from Kingston Penitentiary at warrant expiry, and by failing to follow the requirements of the MHA. This replicates the unmeritorious psychiatric gating argument. Moreover, the casual use of the expression "the State" glosses over the important fact that the appellant was under the control of the Federal government when he was imprisoned at Kingston Penitentiary. As I have already noted, the Attorney General of Canada is not a party to these proceedings.

Lack of Hearing to Consider Substantive Rights

[117] The appellant argues that his detention violates s. 7 of the *Charter* because the MHA fails to provide him with an adequate basis upon which to assert his rights. The appellant points to s. 70.1 of the *Health Care Consent Act, 1996*, which provides that, "[t]he Board shall not inquire into or make a decision concerning the constitutional validity of a provision of an Act or a regulation." Moreover, at the time of the oral hearing into this matter, the issue of whether the Board may exercise s. 24(1) jurisdiction was left unresolved in *P.S.*, at paras. 190-192. As noted above, *E.S.* has since resolved this issue.

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[118] The essence of this aspect of the appellant's s. 7 claim is that the Board, "even with the amended powers, lacks the robust power necessary to provide meaningful process of ongoing review that takes into account the context and circumstances of the individual case." In more transparent terms, the appellant complains that the Board's is powerless to examine the validity of his Form 1.

[119] The appellant's claim under this heading is, in reality, an attack on the constitutional validity of the MHA, and especially the Board's role in this scheme. This broad constitutional claim has not been formally asserted in this litigation and I would not give it consideration.

[120] Before leaving this ground of appeal, I observe that an involuntary patient in the appellant's circumstances is not powerless to assert *Charter* rights. Although the Board's powers are curtailed by s. 70.1 of the *Health Care Consent Act, 1996*, and by *E.S.*, the *Charter* still has a role to play. As Rouleau J.A. recognized in *E.S.*, at para. 97, an appellant may combine an appeal from a Board's decision with an originating application to the Superior Court seeking *Charter* remedies. This occurred in this case.

[121] Moreover, the Board must act in a manner that balances *Charter* values. As Rouleau J.A. recognized in *E.S.*, at para. 99:

> The Board's decisions often have a direct impact on fundamental *Charter* rights, such as the right not to be detained and the right to control one's body. See *Gligorevic v. McMaster*, 2012 ONCA 115, 109 O.R.

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> (3d) 321, at para. 60. In deciding issues of detention and consent to treatment, the Board is often engaged in balancing *Charter* rights, such as those under s. 7 of the *Charter*, against the objectives of the statutes which the Board is mandated to apply. This balancing reflects the Board's obligation to exercise its discretion in a *Charter*-compliant way. Thus, while the Board does not have s. 24(1) *Charter* jurisdiction, it is not precluded from considering the impact of its decisions on *Charter* rights.

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(c) Arbitrary Detention (s. 9)

[122] In addition to his s. 7 claim based on arbitrariness, the appellant argues that he was arbitrarily detained under s. 9. This argument can be readily disposed of. In *R. v. Mann*, 2004 SCC 52, [2004] 3 S.C.R. 59, Iacobucci J. held at para. 20, "[i]t is well recognized that a lawful detention is not "arbitrary" within the meaning of that provision." The appeal judge, at para. 120, correctly found that the appellant's detention was lawful under the MHA. This conclusion is determinative of this *Charter* claim.

(d) Double Jeopardy (s. 11(h))

[123] The appeal judge correctly dismissed the appellant's claim under s. 11(h) of the *Charter*, which provides:

> **11.** Any person charged with an offence has the right
>
> …
>
> **(h)** if finally acquitted of the offence, not to be tried for it again and, if finally found guilty and punished for the offence, not to be tried or punished for it again....

[124] Section 11(h) is inapplicable for the simple reason that the appellant is not being punished twice for the same offence. As the Supreme Court held in *R. v. Rodgers*, 2006 SCC 15, [2006] 1 S.C.R. 554, at para. 63:

> As a general rule, it seems to me that the consequence will constitute a punishment when it forms part of the arsenal of sanctions to which an accused may be liable in respect of a particular offence and the sanction is one imposed in furtherance of the purpose and principles of sentencing.

See also see *Canada (Attorney General) v. Whaling*, 2014 SCC 20, [2014] 1 S.C.R. 392, at para. 52.

[125] As the introductory words of s. 718 of the *Criminal Code* provide, "The fundamental purpose of sentencing is to protect society and to contribute, along with crime prevention initiatives, to respect for the law and the maintenance of a just, peaceful and safe society by imposing just sanctions…." This purpose is achieved through the various objectives of sentencing, including denunciation, deterrence and rehabilitation. It is sometimes necessary to achieve these goals with sanctions of indefinite incarceration or long-term supervision: see *Criminal Code*, Part XXIV. These are true punitive or penal measures.

[126] Not all detention authorized by the *Criminal Code* is punitive in nature. For example, persons found not criminally responsible or unfit to stand trial may be detained for lengthy periods of time. However, there is no punitive or penal purpose associated with detention on either of these two bases: see *Winko v.*

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B.C. (Forensic Psychiatric Institute), [1999] 2 S.C.R. 625, at paras. 30, 40-43; and *R. v. Demers*, 2004 SCC 46, [2004] 2 S.C.R. 489, at para. 36.

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[127] Protection of society is recognized as one of the legitimate aims of mental health legislation. Detention in a hospital is sometimes necessary for this purpose. However, it can hardly be considered punitive or penal in nature. There is no censure or blame involved in detaining an individual under the MHA.

[128] In *Thompson*, this court considered the constitutionality of amendments to the MHA brought about by the enactment of *Brian's Law (Mental Health Legislative Reform), 2000*, S.O. 2000, c. 9. In characterizing the purpose of the legislation, Sharpe J.A. stated the following, at para. 51:

> I agree with the Attorney General that to the extent the legislation does have a public safety purpose, that purpose cannot be viewed in isolation. It must be seen as part and parcel of an integrated scheme that promotes both improved treatment and public safety. The legislation does not rest upon unproven stereotypes or assumptions about mental health and violence. Its dual purpose of promoting health and public safety is achieved through a carefully balanced scheme that requires a highly specific and individualized assessment of the individual's mental health history, treatment needs and the risk that individual poses to him or herself and the public at large. [Emphasis added.]

[129] The fact that the *Criminal Code* and *MHA* both promote public safety through detention does not imbue the latter with a punitive or penal purpose. This overlap does not engage s. 11(h). Moreover, as the trial judge found, it has not

been established that the MHA was used for punitive or penal purposes against the appellant.

(e) Cruel and Unusual Treatment (s. 12)

[130] The appellant argues that his lengthy and continued detention reaches the standard of gross disproportionality in s. 12 of the *Charter*. He claims that his detention has been so excessive that it is an outrage to the standards of decency, and that Canadians would find it abhorrent and intolerable: see *R. v. Ferguson*, 2008 SCC 6, [2008] 1 S.C.R. 96, at para. 14; and *R. v. Nur*, 2015 SCC 15, [2015] 1 S.C.R. 773, at para. 39. I agree with the appeal judge that there is no s. 12 infringement.

[131] The appellant likens his circumstances to the situation in *Charkaoui v. Canada (Citizenship and Immigration)*, 2007 SCC 9, [2007] 1 S.C.R. 350, in which the Court stated, at para. 98:

> [I]t has been recognized that indefinite detention in circumstances where the detainee has no hope of release or recourse to a legal process to procure his or her release may cause psychological stress and therefore constitute cruel and unusual treatment.

[132] The comparison is inapt. The record demonstrates that the appellant has had many formal hearings before the Board, each providing the opportunity for his release from detention. Each time, the Board has found that the appellant continues to meet the conditions for involuntary commitment.

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[133] I accept that it is unrealistic to think that the appellant's diagnoses will ever change. However, the existence of a mental disorder is only one of the conditions for involuntary commitment under the MHA. Another key element is the impact of the disorder on a person's risk to himself or herself, and others. Except for a brief period of time when the appellant took Lupron, he has done very little to address his risk to others. As noted above, at para. 29, Dr. Livermore has evaluated the appellant with a view to the possibility of lowering his level of security and, perhaps, releasing him into the community. However, this will not occur until the appellant cooperates with, and shows progress from, the treatment plan that his attending psychiatrist has developed to make his risk manageable in the community. As Klowak J. stated in *Stock*, at p. 555, "[a]lthough this man can, theoretically, be detained indefinitely unless he voluntarily agrees to treatment, his own control of that treatment gives him a large measure of control over the timing of his own eventual release." The appellant stands in a similar position.

[134] Since the appellant's last appearance before the Board, the MHA as been amended to provide the Board with powers to more effectively address the circumstances of long-term detainees such as the appellant: see s. 41.1. The appellant has not had the benefit of a hearing in these new circumstances.

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G. DISPOSITION

[135] I would dismiss the appeal. The respondents do not seek their costs of this appeal. Accordingly, I would make no order.

Released: “DD SEP 13 2017”

“G.T. Trotter J.A.”
“I agree. Doherty J.A.”
“I agree. M.L. Benotto J.A.”

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