CITATION: Barker v. Barker, 2020 ONSC 3746
COURT FILE NO.: 00-CV-199551
DATE: 20200625

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:	
REGINALD BARKER, JEAN-PAUL BELEC, ERIC BETHUNE (formerly Jean-Jacque Berthiaume), JOSEPH BONNER, WILLIAM BRENNAN by the Estate Trustee MAXWELL BRENNAN, STEPHEN CARSON, ROY DALE, MAURICE DESROCHERS by the Estate Trustee LORRAINE DESROCHERS, DONALD EVERINGHAM, JOHN FINLAYSON, TERRY GHETTI, BRUCE HAMILL, ELDON HARDY, WILLIAM HAWBOLDT by the Estate Trustee BARBARA BROCKLEY, DANNY A. JOANISSE, RUSS JOHNSON, STANLEY KIERSTEAD, DENIS LEPAGE, CHRISTIAN MAGEE, DOUGLAS McCAUL, BRIAN FLOYD McINNES, ALLEN McMANN, LEEFORD MILLER, JAMES MOTHERALL by the Estate Trustees DEBORAH KAREN MOROZ and JANE ALEXIS MARION, MICHAEL ROGER PINET, EDWIN SEVELS, SAMUEL FREDERICK CHARLES SHEPHERD and SHAUNA TAYLOR (formerly Vance H. Egglestone) Plaintiffs	*Joel Rochon, Peter Jervis, Golnaz Nayerahmadi, and Adam Babiak*, for the Plaintiffs
– and – ELLIOTT THOMPSON BARKER, GARY J. MAIER and HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO Defendants	*William Black, Sam Rogers, Meghan Bridges, and Bonnie Greenaway*, for the Defendants, Elliot Thompson Barker and Gary J. Maier *Sarah Blake, Ann Christian-Brown, and Meagan Williams*, for the Defendant, Her Majesty the Queen in Right of Ontario **HEARD:** April 29-May 7, May 16-23, May 22-June7, June 17-20, Oct. 3-23, Dec. 2-6, 2019, Jan. 27-31, 2020

E.M. MORGAN J.

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- i) **Pre-Oak Ridge and index offense**
- ii) **Experience in the STU**
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- iv) **Causation and harm**

i) Donald Everingham

- i) **Pre-Oak Ridge and index offense**
- ii) **Experience in the STU**
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j) John Finlayson

- i) **Pre-Oak Ridge and index offense**
- ii) **Experience in the STU**
- iii) **Post-Oak Ridge experience**
- iv) **Causation and harm**

k) Terry Ghetti

- i) **Pre-Oak Ridge and index offense**
- ii) **Experience in the STU**
- iii) **Post-Oak Ridge experience**
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l) Bruce Hamill

- i) **Pre-Oak Ridge and index offense**
- ii) **Experience in the STU**
- iii) **Post-Oak Ridge experience**
- iv) **Causation and harm**

m) Eldon Hardy

- i) **Pre-Oak Ridge and index offense**
- ii) **Experience in the STU**
- iii) **Post-Oak Ridge experience**
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n) William Hawbolt

- i) **Pre-Oak Ridge and index offense**
- ii) **Experience in the STU**
- iii) **Post-Oak Ridge experience**
- iv) **Causation and harm**

o) Danny Joanisse

- i) **Pre-Oak Ridge and index offense**
- ii) **Experience in the STU**
- iii) **Post-Oak Ridge experience**
- iv) **Causation and harm**

p) Russ Johnson

- i) **Pre-Oak Ridge and index offense**
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q) Stanley Kierstead

- i) **Pre-Oak Ridge and index offense**
- ii) **Experience in the STU**
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r) Denis LePage

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s) Christian Magee

- i) **Pre-Oak Ridge and index offense**
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t) Douglas McCaul

- i) **Pre-Oak Ridge and index offense**
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u) Brian McInnes

- i) **Pre-Oak Ridge and index offense**
- ii) **Experience in the STU**
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v) Allen McMann

- i) **Pre-Oak Ridge and index offense**
- ii) **Experience in the STU**
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w) Leeford Miller

- i) **Pre-Oak Ridge and index offense**
- ii) **Experience in the STU**
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- iv) **Causation and harm**

x) James Motherall

- i) **Pre-Oak Ridge and index offense**
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- iii) **Post-Oak Ridge experience**
- iv) **Causation and harm**

y) Michael Pinet

I. Introduction to the claim

[1] The Plaintiffs were patients at the maximum-security Oak Ridge Division of the Mental Health Centre in Penetanguishene, Ontario ("Oak Ridge"), at various times between 1966 and 1983. Oak Ridge was (and its successor still is) a hospital facility for which the provincial Crown is by statute fully responsible.

[2] All of the Plaintiffs were involuntarily admitted to Oak Ridge. Some of those admissions came as a result of Warrants of Remand from the courts, penitentiaries, and reformatories, others pursuant to Warrants of the Lieutenant Governor after having been found not guilty by reason of insanity (in the terminology of that era), and still others were involuntarily committed under the version of the *Mental Health Act* applicable at the time.

[3] The action began its legal life in 2000 as a proposed class action, but has since been reconstituted as an individual action by the 28 named Plaintiffs. In a 2003 ruling that denied certification, Cullity J. identified the three programs at which the claim is specifically aimed: a mind-altering drug regime called Defence Disruptive Therapy ("DDT"), an isolation cell for group

encounters, including hallucinogenic drug encounters, called the Total Encounter Capsule (the "Capsule"), and a strict physical disciplinary regime called the Motivation, Attitude, Participation Program ("MAPP"): *Joanisse v Barker*, 2003 CanLII 25791, at para 3. All three programs were carried out in the Social Therapy Unit ("STU"), a self-contained unit housed within Oak Ridge, primarily although not entirely run by either or both of the personal Defendants, Dr. Elliott Barker and Dr. Gary Maier (together, the "Doctors").

[4] In 2018, the Court of Appeal reversed a summary judgment that had been granted to the Plaintiffs and remitted this action for trial: *Barker v Barker*, 2018 ONCA 255. The Court indicated that the matter was to proceed by "trial or summary trial as deemed appropriate to the Regional Senior Judge for the assignment of a trial judge": *Ibid.*, at para 26. As I indicated in my first trial management conference with counsel, in assigning a trial judge Morawetz RSJ (as he then was) did not pre-determine the trial procedures; rather, he noted the age of the case and emphasized the need to proceed with as little further delay as possible. He accurately stated that, "[a]ll parties recognize that this proceeding should be expedited.": *Barker v Barker*, 2018 ONSC 3998, at para 4, quoting Morawetz RSJ endorsement.

[5] In an effort to expedite matters, the trial has proceeded as a hybrid summary and full trial. Each of the Plaintiffs has testified and been fully cross-examined in court. In addition, each has submitted an affidavit and/or agreed statement of fact which has served as part of their evidence in chief. While the initial plan for the trial was to have the affidavits and agreed statements entirely replace examination-in-chief for each of the Plaintiffs, it quickly became evident that testifying as to their own personal experience of Oak Ridge and the STU programs was an important part of the trial process that could not be entirely replicated by written evidence. Accordingly, each of the Plaintiffs had an opportunity to testify at some length in chief before being cross-examined in full.

[6] Similarly, each of the expert witnesses – 2 on behalf of the Plaintiffs and 7 on behalf of the Defendants – have testified and been fully cross-examined in court. By agreement of the parties, each has submitted his or her expert report and any supplementary or reply reports into evidence and those reports represent part of their evidence in chief. Likewise, a great deal of documentary evidence, including the Plaintiffs' medical records and Dr. Barker's and Dr. Maier's published writings, have been included in the documentary record by consent of the parties. A representative of the Crown, George Kytako, the chief administrator of Penetanguishene from 1986 to 2005, also testified and was cross-examined at trial, and the Defendant, Dr. Maier, testified and was cross-examined as well. Of the Defendants, only Dr. Barker did not testify at trial as he was unable to do so due to health reasons.

[7] The Defendants also called as witnesses two other medical professionals associated with Oak Ridge at the relevant time. The first of those is Dr. Douglas Tate, a psychologist who was the Unit Director of the STU from September 1976 to December 1977 and who still works at Oak Ridge's successor, Waypoint Centre for Mental Health Care ("Waypoint"). The other former member of the Oak Ridge medical staff called by the Defendants is Dr. Vernon Quinsey, who was a staff psychologist at Penetanguishene from 1971-1975 and who in 1975 became the first Director of Research at Oak Ridge.

[8] The trial of this matter has been scheduled in two parts, the first covering all liability, causation, defense and limitation issues, and the second covering quantification of damages. These reasons for judgment cover the first part; the second part is still to be tried. If not for this scheduling accommodation, the trial would not have been able to be scheduled for at least another two years. As it is, the first portion of the trial could not be scheduled to begin until over a year after the initial trial management conference.

[9] The trial was originally set down for 6 weeks but ended up being closer to 10 weeks spread over a number of months. At the first trial management conference, it became clear in canvassing dates with counsel that fashioning a schedule to accommodate the extra time for damages experts to report and testify would have made the task so cumbersome that the trial would have been put off for an excessive amount of time.

[10] Further delay simply would not have been acceptable given the directions by the Court of Appeal and Justice Morawetz. As it is, the case was 19 years old when the trial began, and deals with events that are up to 5 decades old. Four of the 28 Plaintiffs died in the years before the trial commenced and are represented by their estate trustees. In addition, two of the Plaintiffs died during the course of the trial after they had completed their testimony, and two of the Plaintiffs died while the judgment was under reserve. As indicated, Dr. Barker was unable to testify due to age-related health issues. Any further delay would truly have been a case of justice denied.

[11] All three sets of counsel have adapted to the schedule admirably and, in my view, the trial has not been hindered by the inevitable start-and-stop nature of its scheduling. Most importantly, no one was prejudiced by the schedule or by the division of the overall trial schedule into two parts; indeed, I venture to say that the Plaintiffs and both sets of Defendants have all seen the advantage of having the matter proceed sooner rather than later, albeit with non-consecutive weeks and a lengthier gap between the first part of the trial and the second part still to come. I appreciate the fact that all counsel, after some initial difficulty in arriving at a starting date, have been flexible in making themselves available in view of each other's busy schedules.

[12] There are a number of ways to describe the 3 impugned STU programs, depending on one's perspective on them. In fact, it is difficult to describe them without importing some value judgment. In its ruling, the Court of Appeal, at para 2, described the Plaintiffs' participation in the programs in the relatively benign terms favoured by the Defendants: "[t]hey were subjected to intensive therapy programs designed in part by the [Defendant] Dr. Barker for Oak Ridge's Social Therapy Unit which he and the [Defendant] Dr. Maier oversaw".

[13] Elsewhere in its ruling, at para 22, the Court of Appeal described the programs in the relatively strong terms favoured by the Plaintiffs: "[t]he Plaintiffs' claim involves very serious allegations of torture and degradation of human dignity." This more closely reflects the description contained in the Amended Second Fresh as Amended Statement of Claim which asserts, at para 173, that at Oak Ridge the Defendants subjected the Plaintiffs to "inhumane treatment and psychological and physical abuse and…experimentation."

[14] The evidentiary record is voluminous – counsel for the Doctors advise that the data bank of documents, separate from the transcripts of the 38 witnesses that testified at trial, comprises

some 120,000 pages. The programs at Oak Ridge were well documented, and most of the Plaintiffs' Clinical Records from the period in question have been located and have found their way into the evidence. Further, the STU programs were written about and publicized by each of the Doctors, and various television crews and documentary filmmakers were given access to the facility over the years and have produced a video record of what they encountered there. Much of that media coverage is in the evidentiary record as well, and some of the documentary videos were played at trial. I described the extensive evidence and productions in a ruling addressing a mid-trial pleading amendment by the Plaintiffs, and concluded: "It is difficult to imagine a more thorough discovery process": *Barker v Barker*, 2019 ONSC 3015, at para 5.

[15] The fact-finding process has been a lengthy one, but it is well documented in the evidentiary record. With only a few exceptions, the Clinical Records and other evidence establishes which of the 3 programs each of the Plaintiffs experienced, when the programs were used, which of the Doctors or other medical staff were involved in each Plaintiff's treatment, and how each individual Plaintiff responded at the time. The clinical evidence also addresses, with help from expert opinions, the specific impact of the programs on each Plaintiff over the long and short terms.

[16] The central question posed by the Plaintiffs' claim is whether, in subjecting the Plaintiffs to one or more of the 3 STU programs, the Doctors and the Crown breached fiduciary duties owed to them as Oak Ridge patients. To answer this question, it is necessary to explore not only what was done to them in the programs, but why it was done to them. Were the DDT, Capsule, and MAPP professionally acceptable treatment, or were they non-therapeutic and callous experimentation? In other words, how can we characterize the impugned programs that the Plaintiffs were put through in the decade and a half beginning in the mid-1960s: were they medicine or were they abuse?

II. The impugned programs

[17] As indicated, each of the named Plaintiffs testified at trial. Each, as would be expected, has their own story to tell about how they came to Oak Ridge, which, if any, of the 3 programs they experienced there and how they subjectively experienced them. They also each relate what, if any, harm they suffered as a consequence. In fact, it was on the basis that the claim entailed individualized narratives that Cullity J. refused to certify it as a class action.

[18] Justice Cullity viewed the Plaintiffs' experiences as a matter of their own personal histories, and he perceived the causation question as turning on their individual medical pasts and their lifetime trajectories. Most crucially for the central claim of breach of fiduciary duties, he concluded that as between the doctors who ran the programs at issue and the patients who experienced them, he was "not satisfied that degrees of power imbalance and vulnerability can be determined otherwise than on an individual basis": *Joanisse*, at para 49.

[19] Having said all that, the programs themselves can be described as essentially the same for each of the Plaintiffs. They were all patients in the same maximum-security institution, they were each at some point in the STU where the 3 programs in issue were carried out, and they were all or nearly all, patients of either patients Dr. Barker or Dr. Maier or both. Those for whom Drs.

Barker and Maier were not involved in their treatment were treated or directly impacted and caused harm by the work of three other Oak Ridge medical staff mentioned in the Plaintiffs' pleading but not named as Defendants: Dr. Barry Boyd, Dr. Douglas Tate, or Dr. Julia O'Reilly.

[20] The claims here are not based on the theory and design of the impugned STU programs, but rather for their direct, individualized operation by the Defendant on each of the Plaintiffs. However, to best understand the operation of the programs and the impact on each patient, it is helpful to first review the programs at a higher level of generality.

[21] Drs. Barker and Maier published articles describing their psychiatric theories. In addition, Dr. Maier and Dr. Tate testified at trial and described the purpose and operation of the 3 programs first hand. Although Dr. Barker has medical issues that made him unable to testify at trial, his affidavit filed in support of the 2003 certification motion before Cullity J. is in the evidentiary record and also it reviews much of this ground. Finally, a number of experts put forward by both sides testified as to the overall nature, effectiveness, ethics, and rationale for the STU programs.

[22] The STU programs were unique – Dr. Maier himself aggrandized them as the "greatest experiments in psychiatry" while one of the expert witnesses, Dr. Stephen Hucker, diminished them as "a blip in the history of psychiatry". But, either way, they were not like more familiar, and accepted, psychiatric methods. It is worthwhile understanding them in general before delving into their operation on the Oak Ridge patients.

a) History and theory of the STU

[23] Although Oak Ridge/Waypoint is part of a state-run psychiatric hospital, until the 1960s it played what was essentially a custodial function for inmates/patients who were relegated there for life. The institution focused on reducing violence among its population. As described by Dr. Barker, any treatment that was administered consisted for the most part of sedatives, tranquilizers, electro-shock therapy, and in some cases, psychosurgery. Dr. Barker deposed that prior to 1960, the institution was not designed to treat patients and prepare them for a return to the community; rather, "[t]he goal of such treatment was to render patients more manageable and less violent in the hospital setting."

[24] In 1960, Dr. Barry Boyd became Administrator, or Superintendent, of Oak Ridge. During his tenure in this position, which lasted until 1974, the focus of the institution was transformed from custody and security to treatment with a view to eventually releasing patients back into society. The STU was run by Dr. Barker when it first got off the ground in the latter half of the 1960s, followed by Dr. Maier who ran it until taking a year-long leave of absence in 1977-78, during which time Dr. Tate was the STU director. Following Dr. Tate's tenure as head of the STU, Dr. Julia O'Reilly served as STU director from 1978 until its wholesale restructuring in 1983. These 5 individuals – Dr. Barker, Dr. Maier, Dr. Boyd, Dr. Tate, and Dr. O'Reilly – are identified by the Plaintiffs in their pleading as being the agents carrying out the work of the Crown in running the institution and the impugned programs.

[25] Dr. Boyd passed away in 1992. George Kytako, the Crown's main witness at trial, testified that he has reviewed the extensive notes left by Dr. Boyd. He explained that it was Dr. Boyd's

vision to create a program to give patients who previously had no hope of ever being released from custodial care a chance to improve and eventually be released. Dr. Boyd hired Dr. Barker in 1965 to develop the concept of a therapeutic community within the Oak Ridge division in order to accomplish that goal. For his part, Dr. Barker recalled that he and Dr. Boyd were of the view that a shortage of resources meant that traditional psychotherapy was not possible at Oak Ridge. They concluded that a therapeutic community, where patients themselves share decision-making and take responsibility for their own group and individual state of health, would be a feasible form of patient care. Dr. Barker wrote about this approach in his published writings.

[26] The therapeutic community idea itself had been the brainchild of British psychiatrist, Dr. Maxwell Jones. In the late 1940s and early 1950s, Dr. Jones published a number of articles about a therapeutic community he developed at the Henderson Hospital in London. The premise of his project was for the patient community to become its own therapeutic instrument. Patients in the community would interrelate in decision-making and thereby improve their communication abilities, which in turn would help them take responsibility for their own actions. Dr. Jones' ideas were also put into use with incarcerated patients in the U.K., including the Grendon Underwood prison hospital in Buckinghamshire and the Broadmoor maximum-security psychiatric hospital in Berkshire. As discussed below, however, the Oak Ridge programs differed in important respects from the Jones programs.

[27] Dr. Barker combined his interest in Dr. Jones' psychiatric theories with the philosophical literature of, among others, Martin Buber, who believed that violent psychiatric patients had suffered experiences which made them unable to dialogue effectively with others. Dr. Barker then theorized that if, through a therapeutic community, these individuals could learn to communicate effectively, the inappropriate and violent behaviours would dissipate. Dr. Tate testified that under the Barker approach, patients were encouraged to take responsibility for themselves and others primarily by becoming involved in most of the therapeutic activities in the group setting.

[28] The 3 programs at issue in this action were described by Plaintiffs' expert witness, Dr. John Bradford, as "add-ons" to Dr. Jones' original idea of a therapeutic community. In his Supplementary Report dated January 8, 2019, Dr. Bradford notes that one researcher who has traced some of Dr. Barker's personal history has indicated that in 1965, just before his arrival in Oak Ridge, Dr. Barker travelled to Israel to meet with Martin Buber and then proceeded on to China to study character reformation methods employed in prison camps: see Richard Weisman, "Reflections on the Oak Ridge Experiment with Mentally Disordered Offenders: 1965-1968," 18 Int'l J. Law and Psych. 265 (1995).

[29] Counsel for the Plaintiffs submit that it is this unique combination of Buberian philosophy and Maoist methodology that led to Dr. Barker's creation of the STU with its DDT, Capsule, and MAPP programs. In fact, in a 1975 interview with BBC television, introduced into evidence by counsel for the Crown, Dr. Boyd specifically referenced this approach to coercive treatment that was reflective of China's cultural revolution era norms:

> Interviewer: Does it take a bit of brainwashing in order to convince them that they do need the treatment, that they must take the treatment?

> Boyd: We don't like the term brainwashing very much to describe what is happening to our patents, because we think it is the Chinese or someone leading good capitalists away from our system when we think of brainwashing. But, it is no doubt true that many of the techniques that they use in brainwashing are effective and that we are using somewhat similar techniques: the group pressures, the use of drugs, the use of sleep deprivation, some cases fasting; these things help to bring about a change in one's personality structure, which is what we are trying to do with these character disorders.
>
> Interviewer: But that's not brainwashing?
>
> Boyd: We don't use the term.
>
> Interviewer: What do you call it?
>
> Boyd: Well we call it our social therapy unit, we call it milieu therapy, therapeutic community. We stress the use of encounter groups, we talk about defense disrupting drugs.

[30] In 1968, Dr. Barker, along with a co-author, Mike Mason, an Oak Ridge patient who was sent to Penetanguishene having been found not criminally responsible for killing his girlfriend, published a seminal article on the theory behind the STU. That article, "Buber Behind Bars", (1968) 13 Cdn. Psych. Assoc. J. 61, indicates in its opening paragraph that it "will attempt to describe some aspects of an intensive treatment program presently operating in an institution for mentally ill persons…confined by law", and identifies the program as the Intensive Treatment Unit (later re-named the STU) at the Oak Ridge division of Ontario Hospital Penetanguishene. Dr. Barker outlined the following principles as the guideposts of the programs he designed, at p. 71:

> 1) Mental illness is fundamentally a breakdown in the communication between persons.
>
> 2) For a sick person, the most helpful experiences are acts of genuine communication - direct encounters – as defined by Martin Buber, in which each turns to the other in his present and particular being, and addresses him without pretence.
>
> 3) The patient is the principal agent of therapy. He is equipped to help his peers and is better in some ways than the professional whose role is seen as an administratively supportive one creating the space in which direct encounter can occur.
>
> 4) Every event in a total encounter institution should enhance the treatment goals.
>
> 5) The use of force is legitimate in treating patients for illnesses which they do not recognize, in settings where they will be incarcerated until they change.

[31] Dr. Barker goes on in his article to describe the implementation of his dialogic theory in the context of patient-on-patient therapy, as an invasive and brutal experience. In his graphic terminology:

> While a bald report of the activities of a patient committee may suggest the weekend pastimes of Storm Troopers, our explanation would be that a seeming rape is attempted in order to impregnate the patient with ideas that may prevent a further, more subtle, and more menacing rape: the rape that the illness perpetrates upon the patient, and the rape that a sick society perpetrates upon the patient, and the rape that a sick society maintains upon a few of its sicker members.

The "Buber Behind Bars" essay proceeds to describe the then recently-initiated DDT program, at p. 67:

> …30 mg. of methadrine and 1/75 gr. of scopolamine are injected twice a day for four days. Sodium amytal, scopolamine, methadrine, imipramine, and dexadrine were all used either singly or in pairs to reduce defenses... The use of LSD-25 began in February 1967. Concomitantly, efforts were made to reduce the use of tranquilizers to an absolutely necessary minimum.

Dr. Barker makes clear the unpleasant nature of the drug experiences, culminating in "support" by the very patient committees whose "weekend pastimes" were already described in the most violent terms, at p. 68:

> Schematically, then, the program consisted of confrontation, anxiety-arousal, analysis, and support in committees…

Finally, Dr. Barker makes explicit the coercive and authoritarian quality of the experiences he designed, at p. 65:

> Physical force brough the patient to our hospital, physical force maintains him there, and this force will not be lifted until he changes his behaviour in a recognizable way. In our opinion, there is no question that the treatment necessary to produce some remission of the illnesses suffered by most Oak Ridge patients would be impossible on a voluntary basis.

[32] The record establishes, and all sides concur, that from the outset and throughout the relevant time period, the STU had minimal medical staffing. Dr. Barker, and later Drs. Maier and Tate, kept regular business hours on the wards. Dr. Tate testified that the nursing staff had a high patient to staff ratio (3 nurses for 150 patients), and kept one non-medically trained attendant staff on duty during nighttime lockup. Dr. Tate also stated that as a result of their daily interactions with patients, attendant staff came to know individual patients quite well and in his view offered great insight with respect to their behaviour and progress. The 1973 report of the STU, entered into evidence by the Crown, indicates that the attendants were not supervised by professional staff. The attendants were, effectively, security guards.

[33] The STU programs used patients as a replacement for trained therapists, and euphemistically referred to them as teachers. As Dr. Barker indicated in his writings, this was initially prompted by the lack of staff resources, but came to represent a fundamental part of the therapeutic community model of treatment. In "Buber Behind Bars", Dr. Barker opined that the patient is highly effective because it keeps a patient continuously in the therapeutic milieu rather than giving him a periodic hour of professional therapy.

[34] Dr. Barker and Mr. Mason followed up on this idea in another of their published expositions, "The Insane Criminal as Therapist" (1968) 10 Cdn. J. of Corrections 3, at p. 6. They explained that, "Staff are by decree not expected to become involved with patients in discussion or explanation of their feelings and thoughts. Therapy is equated to open and honest dialogue, and is the business of the patients, not the staff – a distinction which has been found both necessary and advantageous in our setting."

[35] To deal with the risk of violence that resulted in removing patients from seclusion or other incarceration-like surroundings and taking them off tranquillizers, Dr Barker introduced the system of patient observers. As described in his article, "LSD in a Coercive Milieu Therapy Program (1977), 22 Cdn Psych. Assoc. J. 311, at p. 312, he also introduced the use of cuffs joining one dangerous patient to another to facilitate both in continuing their therapy. Dr. Tate followed up on this idea in cross-examination, where he agreed that "nine times out of ten" the "teachers" would be psychopaths and that the programs for the most part operated "totally unsupervised by professional staff". He also explained that it was the patients who had the authority to make decisions about placing a patient in restraints or confinement and who controlled the length of time that a co-patient would remain in restraints.

[36] Dr. Barker acknowledged in "The Insane Criminal as Therapist", at p. 5, that with the patient/teacher and patient committee system implementing the STU programs, "[c]onfrontation and communication take place between patients at a relatively intense level." As an example, he elaborated in "Buber Behind Bars", at p. 68, that, "In most settings, it would be considered a heinous crime to tell a suicidal patient that as far as one is concerned, he can go and hang himself… On the [STU]…not caring is a part of reality with which the mentally ill person must learn to come to terms."

[37] Verbally aggressive communications were often combined with patient-on-patient physical enforcement. As Dr. Barker explained, "Our feeling was that force could most usefully be employed in treatment, particularly the treatment of the asocial and antisocial personality disorders; and that as communication approaches a maximum, the permissible use of force also approaches a maximum." At least one of the Defendants' expert witnesses, Dr. Jonathan Freedman, testified that Dr. Barker's approach could be described as one of incentivizing patients to participate in their own and in the group's self-improvement. Dr. Barker himself, however, did not exactly characterize it this way. Rather, he described coercion not as a carrot, but literally as a stick – the "goad to freedom": "Buber Behind Bars", at p. 64.

[38] Dr. Maier, writing 10 years later and reflecting on the first decade of the STU, described the primary lesson learned by watching patients 're-discover' themselves in this way, as "suffering…as the source of re-creativity". As he expressed it rather poetically, "In a culture that

demands one to flee from his pain, where every headache is to be masked by an aspirin, it is hard for one to see the importance of pain in one's life. Be that as it may, the road inward lies on the path through…all of our pain": Gary Maier and T. Hawke, "Penetang: People and Paradox" (1975), p. 8.

[39] The centrality of pain as an instrument of the STU programs was identified in a study commissioned in 1977 by the Ontario Ombudsman's office. Although the STU was described overall as "an exciting program which has the hallmark of being right", the study acknowledged that parts of it represented a "remorseless re-educative experience…capable of abuse": Butler, Long & Rower, "Evaluative Study of the Social Therapy Unit" (Ontario Ombudsman, 1977), pp. 17, 28.

b) Defense Disruptive Therapy

[40] Patients in the DDT program were given high doses of hallucinogens and what Drs. Barker and Maier referred to as "demystifying drugs": "Buber Behind Bars", p. 67; "Penetang: People and Paradox", p. 4. From the 1960s, this type of drug therapy was a cornerstone of Dr. Barker's programs, involving the administering to patients at Oak Ridge mind-altering drugs which he speculated "might free them from the tyranny of their illnesses – and consequently from incarceration – in a shorter time": E.T. Barker, M.H. Mason, J. Wilson, "Defence Disruptive Therapy", (1969) 4 Cdn. Psych. Assoc. J. 355.

[41] Although many (or most) of the DDT patients had a propensity to violently act out, the drug sessions were not necessarily done in the presence of professional staff. Rather, the patients, while drugged, were "observed closely and conscientiously by their fellow patients, and if necessary are secured during the daytime by a locked canvas wrist strap attached to the wrist of unmedicated patients": *Ibid*., p. 356.

[42] It was Dr. Barker's early theory that the use of mind-altering drugs, either alone or in combination with stimulants, could reduce a patient's inhibitions or defences, and that "being handcuffed to another for long periods forces an inescapable interaction: "Buber Behind Bars", p. 67. According to Dr. Barker, this method of chemically reducing patients' mental defences while ensuring that "each member of the community is in a very real sense his 'brother's keeper'", had the additional and necessary advantage of "mak[ing] DDT economically feasible": "Defence Disruptive Therapy", p. 356.

[43] As will be discussed later in these reasons, virtually all of the Plaintiffs who were part of the DDT program testified that they were told that the drug experiences would break down their defences, but none of them were told of the therapeutic benefit of the drugs. Equally, neither Dr. Maier in his testimony nor Drs. Barker and Maier in their respective writings described in any detailed or systematic way a 'rebuilding' process that might follow the disruptive effects of the drugs. It appears that the Doctors had given substantial thought to breaking down their patients' personalities, but neither of them had turned their minds in a serious way to reconstructing them.

[44] In addition to LSD, which is sufficiently unique that it will be discussed separately below, the drugs most used in the DDT program were dexamyl, dexedrine, methedrine, dextro-

amphetamine, amytal, alcohol, tofranil, and scopolamine: *Ibid*., 356-7. Many of the Plaintiffs testified at trial as to the subjective effects of these drug sessions. However, the published clinical observations by the Doctors best describe the effects in an objective way. Dr. Barker was particularly descriptive in his approach to the DDT program, and described the effect of the drug treatments in his article "Defence Disruptive Therapy", p. 357:

> We find that the pulse rate usually rises by the fourth day to a rate of l40-160 when the patient is standing, and it is suspected that this and the occasional hyperventilating and vomiting that occur are mostly due to the extreme anxiety evoked. There is always a reduction in the patient's appetite and he eats little during the period of administration. Sleeping is curtailed or eliminated completely…
>
> The patient experiences…delirious episodes which are accompanied by hallucinations and floridly 'psychotic' behaviour. Contact with 'reality' is highly irregular and recall of events is patchy, the main presenting feature being a general lack of pattern to the sequence of experience and behaviour. Considerable paranoia is exhibited by most patients… However, what seem to be the most useful effects occur during the weeks after drug administration. which appears to be a defence-readjustment period. It has been found that patients experience more anxiety for periods of up to two months following the termination of treatment. They seem less well defended, more sensitive, restless and troubled… Our experience suggests that subsequent courses of DDT increase the degree and duration of the anxiety experienced. We think also that the more prolonged and complete the period of delirium, the more are these delayed effects displayed.

[45] Plaintiffs' expert, Dr. John Bradford, described the effects of the DDT treatment in much the same way, although with a negative rather than a positive perspective on these effects. Echoing the testimony by a number of the Plaintiffs, Dr. Bradford indicated in his Supplementary Report that the DDT drugs could produce "severe psychotic episodes with visual and auditory hallucinations being prominent". He elaborated that the use of amphetamines such as dexamyl, dexedrine and methedrine, could produce "paranoid psychosis", especially in patients diagnosed with schizophrenia. In doing so, he confirmed Dr. Barker's observation that the longer a person is exposed to the DDT experiences, the more protracted are the effects:

> A paranoid psychosis in psychiatric terms is the psychosis that is most likely to lead to physical violence on the spectrum from assault to homicide. This could be the impact in individuals not suffering from a severe mental illness such as Schizophrenia.
>
> In persons suffering from Schizophrenia, all the negative effects are magnified, aggravating the existing condition and leading to severe psychotic episodes of the illness Schizophrenia. Further, in general terms, the longer a person with Schizophrenia remains psychotic, the harder it is to bring the illness into remission and to recovery. In addition, every episode of a psychosis in a person suffering from Schizophrenia also affects the recovery and the length of time prior to going into remission or responding to treatment.

[46] In December 1985, one of the Defendants' current expert witnesses, Dr. Hucker, led a committee of specialists that investigated and published a report on Oak Ridge entitled "Oak Ridge: A Review and an Alternative" (the "1985 Hucker Report"). The 1985 Hucker Report constitutes what was then a recent post-mortem analysis the STU. One of the Hucker committee members, a well-known English psychiatrist, Professor John Gunn, wrote a paper in 2006 based on a lecture he delivered at the Royal College of Psychiatrists' 2005 Annual Meeting. His paper "Abuse of Psychiatry", (2006) 16 Crim. Behaviour & Mental Health 77, which is part of the evidentiary record, refers rather graphically to a visit he made to Oak Ridge some 35 years previously. Writing in praise of the U.K. and E.U. regulatory bodies that carefully govern and put limits on psychiatric treatments, Dr. Gunn relates a first-hand DDT session he observed in the STU:

> North America does not have these advantages. In about 1970, I visited the Oakridge forensic psychiatry unit at Penetanguishene mental hospital in Ontario. At that time they could get few trained staff, but had quite a large number of behaviourally disordered young men (they called them psychopaths) to look after. The part-time psychiatrist in charge decided that he had to use the patients as therapists and had to devise imaginative forms of psychotherapy. His original ideas included handcuffing men together in pairs for long periods, so that they would learn to think of somebody else beside themselves. Another treatment was 'the capsule', a room without furniture, but well heated, in which patients would stay for *days*, in a group, without clothes or other possessions. They were monitored by closed-circuit television and fed through a hatch. This was an experiment in social education. I met one young man rolling on the floor in delirium and was told he was undergoing regression treatment. This meant he had had an injection of scopolamine sufficient to produce delirium and incontinence. He was then expected to recover from these toxic effects whilst in the company of his fellow inmates who would 'look after his bodily needs'. This was 'to correct his adverse childhood by allowing him to be reborn into a caring group' (I am not making this up). I inquired about his diagnosis. I was told he was a 'psychopath' I asked the nature of his offence. I was told that he had repeatedly stolen money from his mother!

[47] Of course, this description, although contained in the record as part of the professional literature about the impugned programs, is, strictly speaking, hearsay, and so does not count as specific evidence of a DDT session. The Plaintiffs' descriptions will fill this role. Having said that, the Defendants' own expert witness, Dr. Hucker, testified that Dr. Gunn is a reliable observer and that he agrees with Dr. Gunn's assessment of the programs. As Dr. Hucker stated under cross-examination by Plaintiffs' counsel:

> Dr. Gunn and I were *ad idem* on how horrified we were at the operation of the program" as described to them in the 1970s. "We all agreed that this is a program that if it had been started when we were reviewing Oak Ridge [1984-85] it would have been closed down. We agreed that this was a 'blip' in the history of psychiatry.

c) LSD

[48] The use of LSD at Oak Ridge was started by Dr. Barker in 1967. Technically, it was part of the DDT program. Dr. Barker wrote that "LSD is as safe to use as other defense disrupting drugs such as amobarbitol (Amytal sodium) or methamphedamine hydrochloride (Methadrine), and patients report undergoing a more intense and beneficial experience after receiving LSD": E.T. Barker, "Treating psychotics with LSD: good results are reported", *Modern Medicine* (March 30, 1978), p. 167. But the drug was so unique, and the sessions occupied such a special place in the life of the STU, that it is logical to discuss it separately as if it were a program in its own right.

[49] In January of 1967, Dr. Barker submitted to Dr. Boyd a proposal for a controlled study of LSD, in which he referred to himself as the "qualified investigator". He proposed including Dr. Boyd as part of the Local Advisory Committee "to supervise the experimental project". Overall, the aim of the proposal was set out by Dr. Barker as an "attempt to evaluate the clinical usefulness of LSD in our intensive treatment war". In much the same language, Dr. Maier, in a November 13, 1975 memo to Dr. Boyd, indicated that he had advised the federal official responsible for licensing LSD access that he planned to "present the findings of our research at the next appropriate scientific meeting either the Ontario Psychiatric Association or better the Canadian Psychiatric Association."

[50] The LSD part of the drug program in the STU for the most part took place in the Capsule, with each patient receiving the drug doing so with a 'dyad', or dialogue partner. Dr. Barker deposed that after the LSD session was over, the patient who took LSD would discuss his experience with his dyad partner. Dr. Maier later created "family groups" in which four patients at a time would prepare for an LSD experience. Each week, one of the preparing patients would receive the LSD with their dyad partner.

[51] The group of patients receiving the LSD would then have a group discussion about their experiences on the drug. Dr. Maier himself was more personally involved in the actual LSD sessions than in other aspects of the three STU programs, and generally administered the drug intravenously to the patients. Plaintiffs testified that he would often be present for portions of their LSD 'trip', and often would be physically present with them when they would "go deep" under the drug's influence.

[52] Dr. Bradford deposed that LSD "induces profound alterations of consciousness, which have been described as mystical experiences". In his own testimony and writings, Dr. Maier concurred with the assessment that this was a mystical type of drug. Dr. Boyd also recognized the association of LSD with eastern theology and mysticism. Interestingly, in a memo dated August 11, 1975, Dr. Boyd tried to warn Dr. Maier that his emphasis of the "mystical" aspects of the DDT program was contrary to current trends in public attitudes, and should be reduced for "political" reasons:

> The introduction of mystical concepts usually associated with oriental religions may well have just as much validity as some treatment modalities in current use in our society. They are difficult to assess scientifically and likely to be misunderstood and not accepted 'politically'. I would ask you to gently de-escalate these aspects of your program unless you can muster more support from the Professional Advisory Committee…

[53] It is evident from Dr. Maier's testimony and his writings that he was a genuine believer in the mind-altering qualities of LSD and the philosophical insights potentially to be gained through the psychedelic experience offered by this drug. In a memo dated July 24, 1975 to the Oak Ridge Professional Advisory Committee, Dr. Maier sought to explain the goals of the LSD portion of the DDT program by appending for the Committee the reading list given to patients in preparation for their LSD sessions. The list contains no medical literature, but was replete with eastern religious texts (*Tibetan Book of the Dead*, *Tao Te Ching*, *The Bhagavad Gita*) as well as the writings of 1960s-70s counterculture authors (Aldous Huxley, Carlos Castaneda, Timothy Leary).

[54] Dr. Maier's memo also contains an insightful, if brief and cryptic interchange between himself and his colleagues on the Professional Advisory Committee. He advises the Committee members that, in his view, "[t]he phenomenology of LSD is very exciting. Understanding these images requires an understanding of the physiology of our senses and even more than that it requires direct experience of these levels of reality within us." He assures the Committee members that the topics and the readings referenced in his memo are also "being read and discussed on F Ward [i.e. in the STU] and are the core of the theoretical/experiential discussion. He then asks his the Committee if it could advise him "in regard to the following practical/theoretical areas", presumably the same areas with which he and the STU patients have been grappling:

> (l) The comparison between the Tonal and Nagual states of reality as described by Castaneda in his four books, and their relationship to the existential world described by Sartre in his book Being and Nothingness. If there is a comparison what are the limits of this? How do these states of reality relate to the Zen term 'no mindedness'?
>
> (2) If for simplicity sake an ecological view of reality implies cultural, personal and intrapersonal levels, how would the terms archetype, mandala, and symbol relate to uniting this reality view?

[55] To say that the query from Dr. Maier would likely have been viewed as obscure is to understate the point quite a bit. The first question on its face attempts to relate Native American notions of consciousness to European philosophical musings over the nature of existence to east Asian concepts of mental focus. In doing so, it could reflect a depth of study that would be beyond the average non-philosophically trained medical professional, to say nothing of the average Oak Ridge patient. Alternatively, it could reflect Dr. Maier's own pop culture fascination with superficially exotic traditions of thought, which he had never studied in any formal or organized philosophical or theological setting.

[56] As a third alternative, the surprising tone of Dr. Maier's ruminations, as expressed to his institution's Professional Advisory Committee, could reflect Dr. Maier's personal commitment to chemically altered states of mind. In fact, in a reflective, confessional article dated August 30, 1973 and published in *The Seventh Circle*, an Oak Ridge newsletter aimed at the patient population, Dr. Maier waxed eloquent about his own recent psychedelic experience:

> I was in a sensitivity group of professionals for one year and learned that I like to power trip as a doctor, that I could play god with patients but please Gary not with peers…

> I took 250 mic's of LSD, supervised in London Victoria Hospital. I experienced the infinite, the mystical and saw the religious questions in my life come to balance…
>
> I learned to hypnotize people in Philadelphia. The different states of consciousness began to come alive for me…
>
> The Native People [in northern Canada] and the community at Esalen in California helped me to accept people without judgment. Suddenly the wholeness of persons blossomed for me. So too the place of our dream life.

[57] According to Dr. Bradford in his Reply Report dated April 28, 2019, Dr. Barker, like Dr. Maier, "did not attempt to ground his ideas in science." More pointedly, in cross-examination, Dr. Hucker characterized the LSD aspect of the STU programs as "bad science". Dr. Maier himself admitted in cross-examination that, at the time that LSD was used in the STU, the "popular view in the medical community was that it was destructive" as it induced psychosis. He also conceded that LSD could have adverse effects, including "severe" hallucinations. At the same time, he insisted in his July 1975 memo to the Professional Advisory Committee that his approach to psychedelics was grounded in "science", although it was not entirely the kind of science in which the Committee members were trained:

> Our contention would be that Eastern and Western science are engaged but the relationship has not been consummated. We would like to preside at the wedding.

[58] An insightful evaluation of Dr. Maier's perspective is provided by one of the Defendants' witnesses, Dr. Vernon Quincey, a former Director of Research at Oak Ridge. In his Report, which is part of the evidentiary record, Dr. Quincey, stated that Drs. Barker and Maier were, in effect, children of the '60s, more 'turned on, tuned in, and dropped out', to use the then-current phrase, than present-day professionalism would countenance:

> Within the STU, and more informally, the perception of risk-benefit ratios was likely influenced by the zeitgeist of the nineteen sixties, a zeitgeist markedly different than that of the present day. The counterculture was influential among younger professional staff and strongly favored the use of mind-altering drugs, such as LSD. LSD trips were widely viewed as facilitating self-discovery. Many patients and some professional staff had, of course, used LSD and other mind-altering substances outside the context of Oak Ridge. The provision of mindaltering substances appeared to be an important selling point of the therapeutic program to the patients (not so much to the attendant staff) and it was clear based on patient requests recorded in Oak Ridge records that mind-altering drug experiences were widely popular among the STU patients.

[59] The use of LSD at Oak Ridge culminated in a mass 'trip' organized by Dr. Maier in which more than two dozen patients were given the drug at once. This led to an eventual rebellion of the attendant staff, for whom security had become intolerably difficult with so many drugged patients populating the institution. As described on the "Remembering Oak Ridge" history website

maintained by Waypoint, the incident took place in 1975 and was a turning point for the use of LSD on the STU:

> The breaking point [of the STU] came in 1975 when Maier orchestrated a mass psychedelic trip on one of the wards. A group of 26 men were each injected with 300 Mcg of LSD-25. Maier's expressed intention was to encourage a collectively shared experience of self-knowing among a group of diagnosed psychopaths and schizophrenics; instead, it heralded the demise of the decade-old program. Shortly after Maier's group experiment, he received a memo from Superintendent Boyd:
>
> > Concern has been expressed by other Unit Directors and the Treatment Department Heads as to the direction of recent developments in treatment… The use of LSD as an experimental and research tool appears to be undergoing some change from the approach originally approved…

d) Total Encounter Capsule

[60] In 1977, Dr. Barker wrote that, "For the last nine years, on a regular basis, groups of naked mental patients have been locked in a small room for periods ranging up to eleven days": Elliott Barker and Alan McLaughlin, "The Total Encounter Capsule", (1977) 22 Cdn. Psych. Assoc. J. 355. The Capsule was a soundproof, windowless, and constantly lit 8' x 10' room, with no furniture and an exposed toilet, where groups of patients had their interactions monitored through closed-circuit television and a one-way mirror by patient observers outside. As Dr. Barker described it in yet another publication, those interactions are bound to be intense: "…from admission to release from the capsule these patients see or hear no one besides themselves and are never further from one another than a few feet": Elliot T. Barker & M.H. Mason, "The Hundred-Day Hate-In: A stubborn attempt at staff-less milieu therapy" (Meeting of the Ontario Psychiatric Association, 5 October 1968), p. 13.

[61] There was no solid food provided to the patients during their Capsule sessions; rather, they were made to ingest food and water from straws protruding through holes in the wall. Patients in the Capsule were subjected to sleep deprivation, were frequently restrained or strapped to each other, and were most often injected with DDT drugs to lower their inhibitions. They were often paired so that patients diagnosed with schizophrenia experiencing a chaotic range of emotions where placed together with patients with antisocial personality disorders – "psychopaths" in Dr. Barker's terminology – experiencing no emotions at all. In this state of forced polarity, they confronted each other, forming what Dr. Barker described in Buberian terms as "genuine dialogue": *Ibid*., p. 355, or as "a friendship bristling with threats": "Buber Behind Bars", p. 69.

[62] It is fair to say that the Capsule was entirely unique to the STU at Oak Ridge. Dr. Bradford, testifying on behalf of the Plaintiffs, made this point emphatically: "It didn't exist before, it doesn't exist afterwards, it didn't exist in the Henderson Hospital, or anywhere else that there was any kind of therapeutic community type setting." Perhaps even more importantly, Dr. Thomas Guthiel, a professor of psychiatry at Harvard University and a Distinguished Life Fellow of the American Psychiatric Association, who testified as an expert for the Defendants, concurred with this view.

In cross-examination, Dr. Guthiel readily agreed that in all of his experience, he has never come across anything quite like the Oak Ridge Capsule:

> Q. Okay. Now, the capsule, you understood the capsule was a constantly lit, windowless room, ten-by-ten?
>
> A. Yes.
>
> Q. With a toilet in the corner?
>
> A. Right.
>
> Q. Men are stripped naked, sometimes drugged, LSD, other drugs, Scopolamine, in they go?
>
> A. Yes.
>
> Q. And they're locked in there and they can't leave for a week, ten days, two weeks?
>
> A. Yes.
>
> Q. And they eat through feeding tubes?
>
> A. Right.
>
> Q. And I think you have been very clear, you've never heard of that being used in a maximum, medium, or any secure mental health facility, before, since, ever?
>
> A. That's correct.

[63] One of the more noteworthy aspects of the Capsule program was the insistence by Dr. Barker and, later, by Dr. Maier, that it would be beneficial for the patients to enter the Capsule entirely nude. Even Dr. Barker conceded that without good explanation, this practice would strike most people as "perverse": "The Total Encounter Capsule", p. 355.

[64] In defense of this practice, Dr. Barker explained that this approach was done partly out of cultural theory prevalent at the time and partly out of safety concerns. He wrote, "[t]his move was prompted partly by the experience of Paul Bindrim, a psychologist working in California, who felt that the uncovering of the private parts of one's body might facilitate the uncovering of the private parts of one's mind, and partly because of our fear that clothing might be used in a dangerous manner": *Ibid*., pp. 356-7.

[65] Dr. Maier confirmed the contemporary counter-culture inspiration for the collective nudity that was part of the Capsule experience. He testified that he had himself visited the Esalen Institute in Big Sur, California prior to coming to Oak Ridge. He explained that, in the then culture of Height Ashbury, he had experienced nude "encounter groups" aimed at mind expanding and maintaining an open consciousness.

[66] Dr. Freedman concurred in his testimony that nude therapy was used in California in some instances in the 1960s, although he conceded that it had been used only by adults who voluntarily participated and not in a secured mental health facility by inmates who had perpetrated acts of extreme violence. As several Plaintiffs testified, the close proximity and nudity exacerbated the fact that some of the patients were older sex offenders and others were minors, some were aggressive and dominant personality types while others were submissive and especially vulnerable personality types.

[67] With these factors in mind, Dr. Bradford was of the view that this innovation was self-evidently inappropriate. As he put it, "it was something that was the brainchild, I believe, of Dr. Barker, and being naked, I mean, if any of us, as people who weren't vulnerable, were locked up for up to 14 days, with naked people, no privacy, but on top of that given drugs such that we're delirious, I think it speaks for itself…"

[68] That said, Dr. Barker reported in a medical journal that "[t]en percent felt the [Capsule] experience was of no particular value and 90 percent felt it was helpful and useful": "The Total Encounter Capsule", p. 357. In giving evidence, Dr. Freedman described the practice of nudity in the Capsule as an innocuous feature, "like a locker room".

[69] By contrast to this, Dr. Graham Turrall, another of the Defendants' expert witnesses, agreed in his testimony that forced nudity would be degrading for anyone. He then commented, however, that this was precisely the point – i.e. it was done for the purpose of allowing mental defenses to become weaker. In other words, degradation of the patient, or an undermining of their personal dignity and sense of self-worth, was not a side effect of the STU programs; it was part of the design.

e) The Motivation, Attitude, and Participation program

[70] The Plaintiffs were unanimous in their testimony that the most harsh and difficult of all of the three impugned programs was the MAPP. Dr. Barker described it in his 2003 affidavit as educational rather than punitive – its purpose was said to be for "re-orienting a group of disruptive patients when they were unwilling or unable to comply with their community rules." In cross-examination at the time, he explained that in order to do this, the disruptive patient was put in the hands of other patients who had experienced disciplinary problems themselves:

> Q. And what was the purpose of the MAP program?
>
> A. …The thinking behind the MAP program was to have a group for those kinds of disruptive patients and to select a patient teacher for the group who had probably been a disrupter himself at some point and knew all of the shenanigans…
>
> Q. I take it one of the overriding objectives of MAPP was to motivate the individual to participate in the programs willingly?
>
> A. Well, so it wouldn't be disruptive for the programs. It would motivate them to want to get better.

[71] A close look at the actual content of the MAPP reveals that the line between conveying a lesson and punishing a non-cooperative patient was so thin as to be invisible. As described by most of the Plaintiffs, and not contested by the Defendants, MAPP began with several days of solitary confinement in an unfurnished cell, where patients sat or slept on a raised cement platform – commonly dubbed a "Barker-bunk" by patients and staff. They had no clothing and could only wear a heavy sack gown – again, commonly dubbed a "baby doll". They were deprived of any outside contact for 3 or 4 days, after which they would be placed in a group setting in which they could earn "privileges" such as wearing clothing or being given a cushion to sit or lie on.

[72] The Ombudsman's 1977 "Evaluative Study", at pp. 15-16, described the central features of the MAPP. The Report indicated that the strict discipline and the 14-day cycle could become an endless circuit for a patient who did not follow instructions to the letter, or at least to the satisfaction of his fellow inmates:

> During the group, he sits on the terrazzo floor with his feet straight out in front of him in the attention position, his fingers are intertwined and he is given a square area of about three square feet in front of him within which he may look. He must respond positively, 'feedback' positively, and participate in the prescribed M.A.P. way. He may use nothing but good English. He may move only four times during a session of about four hours, and then only after being given permission to do so by the 'teacher'…
>
> In order to leave M.A.P., a patient has to have fourteen consecutive perfect days. A perfect day involves: no slips of the tongue, no unauthorized moving, no keeping others waiting, no lack of participation, no disruption, and beyond that, a satisfactory demonstration of motivation, attitude and participation. This means perfect posture, deportment and language. Behaviour, feeling and thinking are all studied by the group and are continually under discussion and observation…

[73] Numerous patients described the requirement to sit motionless for hours on a cold floor to be the most painful part of MAPP. In cross-examination on his 2003 affidavit, Dr. Barker conceded that the MAPP would have been "very unpleasant". Dr. Bradford, testifying at trial, refused to sugar-coat the program, referred to the specific policy of protracted immobility as "positional torture".

[74] For his part, Dr. Maier in cross-examination denied that there was any discomfort in all of this. He did concede, however, that patients were only permitted to move when they got another patient's specific permission. In doing so, he can be heard to accentuate the apparently gratuitous nature of the 'lessons' being taught. As Dr. Maier explained:

> I never heard anybody that felt that they couldn't, uh, eventually get the attention of the teacher so they could make a change in their body posture as though they were sitting there frozen for hours.

[75] It should be noted that several of the Plaintiffs spent time in what Dr. Maier described in his testimony as a precursor to MAPP – the motivation program or MotoPro. Dr. Maier had the

chronology wrong in stating that MotoPro existed only prior to the development of the full MAPP, as the evidence is that it also functioned subsequent to Dr. Maier's departure from Oak Ridge. However, he was correct that the concept of MotoPro was that it would be a somewhat diluted form of MAPP, but with the same punitive, or "motivational" goals in mind.

[76] The evidence establishes that the MotoPro program was really just a version of MAPP, but with an abbreviated name and slightly modified rules – e.g. to be released from the program one had to be on "perfect" behaviour and maintain the requisite physical immobility for 10 consecutive days in MotoPro rather than 14 consecutive days as in MAPP. It is as if some of the participants in the DDT program got slightly lesser dosages of the same drugs, but with similar design and effects, as those in the full dosage DDT program.

[77] Plaintiff Steven Carson described MotoPro as being a mini-MAPP – sitting immobile on a bare terrazzo floor and obeying all rules – but with slightly modified time limits built into the disciplinary rules:

> Q. Sir, did you eventually move to a different program that was similar to MAPP?
>
> A. …You have to earn ten good days, and, ah – ah, they didn't put me in cuffs when I was in MotoPro, they just put me in a safe gown and, ah, – and I had to sit on the floor, and I – like three good days – excuse me, three good days and you earn your, umm, ah – your cushion. And six good days, and you earn your clothes. And then ten days, you're out of the program and back to therapy again.

[78] Plaintiff Douglas McCaul described MotoPro in similar terms in his affidavit:

> While I did manage to avoid MAPP on H Ward, I was subjected to an almost identical program called 'motto pro', or 're-motivation program', or 'mini-MAPP', on G Ward. I was required to sit on the floor with my arms and legs straight out in front of me for hours on end without moving in several sessions per day. If I wanted to move, I was required to wait for permission from the patient designated to monitor the group called a 'teacher'.

[79] Dr. Hucker, testifying on behalf of the Defendants, described MotoPro as the same stress-inducing experience as MAPP. In being cross-examined about the record of Plaintiff Steven Carson's experience in MotoPro, Dr. Hucker confirmed that the effect of the mini-MAPP was essentially the same as that of the full MAPP experience.

> Q. For refusing program? State – he stated he couldn't handle it. And that's a note by someone Fox, dated April 3, 1979?
>
> A. Yes.
>
> Q. And what he couldn't handle, was the stress of being in MAPP, correct?
>
> A. That's how I'd interpret it, yes.

> Q. And then after his transfer to moto-pro or the re-motivation program in F-ward, a clinical note recorded Mr. – 'Mr. Carson was screaming that he could not handle the re-motivation program and he wanted to go back to E-ward.' It states, May 9, 1979, 'F-ward staff report this patient was screaming that he wanted to go back to E-ward because he could not handle the pressure of F-ward.
>
> Again, in a schizophrenic such as Mr. Carson, this would have been extremely stressful anxiety producing, correct?
>
> A. Well, I think it would have been for anybody...

[80] Defendants' expert, Dr. Gutheil, opined in cross-examination that MAPP was a "harsh sanctioning process" that was designed to, and in fact would, create symptoms of psychological distress. The STU's 1973 annual review characterized MAPP as a program of "severe deprivation". This echoed the 1978 Ombudsman's "Evaluative Study", p. 16, which described MAPP as a "remorseless re-educative experience which carries a heavy psychological burden." The Ombudsman's report specifically referred to MAPP as "mental torment": *Ibid*.

[81] Others testified that it was the punishment at the whim of other patients that was the most burdensome aspect of the program. As indicated in the Ombudsman's Report, MAPP was a difficult program to leave. Fourteen days of perfection (or 10 days for mini-MAPP) under its exacting standards, at the whim of other mentally ill patients, was no doubt a difficult test to pass. The Ombudsman's Report also observed that as difficult as it was to get out of MAPP, it was easy to be placed in it. This was apparently equally discretionary and at the whim of other patients. The Ombudsman's "Evaluative Study", p. 15, states:

> Admission is on the basis of behaviour that demonstrates a severe relapse to the members of the Social Therapy Unit. Generally speaking, this is acting out, such as making threatening remarks or striking somebody; or acting in, which is displaying suicidal behaviour. It can be prescribed for undermining (undesirable destructive words or actions). Should a man not mix or talk or generally interact for more than what is thought to be a desirable period of time, he will go to M.A.P., where he will have to interact. There was considerable discrepancy as to whether ordinary criticism or exasperation expressed in the course of group work, or ward committees, would qualify one for this treatment.

[82] And then summing up the point, the Ombudsman's "Evaluative Study", p. 17, concludes:

> Referral to [MAPP] is so flexible as to be capable of abuse and release from it is difficult. Any patient at any stage in his career at Oak Ridge can be sent to it.

III. Informed consent

[83] The issue of informed consent is a contentious one among the parties. Interestingly, it plays out in different ways. Counsel for the Plaintiffs have spent considerable effort establishing that as a matter of medical ethics consent was necessary and was a known feature of medical and

psychiatric care from the earliest days of the impugned programs to the end of the STU era. In this regard, I note that in 1980 the Supreme Court of Canada in *Reibl v Hughes*, [1980] 2 SCR 880, indicated that in order to provide the patient with the requisite informed consent in medical treatment, a doctor must ensure the patient's understanding and in doing so must take into account his or her particular mental and emotional circumstances. I also note that the Court's approach, at 886-7, was based on principles that had in 1980 already been good law several decades:

> It [a physician's duty] is a particular case of the duty which is cast on professional persons in a fiduciary position called upon specifically or by implication to give information or advice to a client intending and entitled to rely on his statements to determine his course: *Nocton v. Lord Ashburton*, [1914] A.C. 932; *Kenny v. Lockwood* [1937] O.R. 142…
>
> The scope of this professional duty of care is defined by the evaluation of a variety of inter-related factors which bear uniquely on each case, factors such as the presence of an emergency requiring immediate treatment; the patient's emotional and intellectual make-up, and his ability to appreciate and cope with the relevant facts; the gravity of the known risks, both in terms of their likelihood and the severity of this realization.

[84] Counsel for the Doctors invest effort in countering that position, explaining that while consent was not strictly required in that era, the essence of the STU was milieu or group therapy and, as such, the patients were in continuous discussion and were thus conversant with the programs in which they participated. Crown counsel, on the other hand, invests considerable portions of their argument to an attempt to demonstrate that formal consent was, in fact, obtained from all patients, including those in the STU programs.

[85] Counsel for the Crown point out that, as a starting point, consent was not required for the Plaintiffs' placement in Oak Ridge. The purpose of involuntary committal to a maximum-security psychiatric hospital was to provide patients with treatment, for the most part as an alternative to incarceration in prison. In support of this, Dr. Tate deposed in his affidavit, "If patients were allowed the final say as to which psychiatric facility held them, or which ward they were lodged in, this would lead to the absurdity of manipulative psychopaths controlling the terms of their own detention and would defeat the purpose of their detention at Oak Ridge."

[86] The DDT and Capsule programs took place in Oak Ridge's G Ward (after an initial assessment on F Ward), while the MAPP was housed separately on H Ward. G Ward was organized by what the Crown describes as a highly structured committee system that "was itself a pro-social therapeutic modality." Within this organizational structure, patients were meant to adapt their behaviour to the STU community's standards, which, in turn, entailed referring specific instances of problematic behaviour to the committee system. Dr. Tate explained that this allowed the patients themselves to investigate, deliberate, and recommend a course of action.

[87] The committee system was summarized by the Ombudsman's "Evaluative Study", at paras 37-41, commencing with a description of the Clarification Committee – the patient committee responsible for investigating any incident of anti-social conduct (in the milieu therapy sense of the

term). As described in this Study, the Clarification Committee's written report would go to the Treatment Committee or the Sanction Committee, which, with the misbehaving patient's participation in the deliberations, would then recommend a course of action.

[88] As the Ombudsman's Study described it, if the Treatment Committee, which like all of the committees was composed of other patients, concluded that the behaviour in question was a symptom of the patient's mental illness, it could recommend a treatment – up to and including specific drugs for a DDT session. And if the Sanction Committee concluded that the behaviour was willful, it could recommend a sanction – up to and including a session in MAPP. The committees' recommendations were to the Staff-Patient Liaison Committee for final approval of the recommended action. It was only at this last stage that non-patients gave some input into the treatment recommended for the patient.

[89] In fact, the notion of patients' "collective responsibility", as the Crown calls the committee system, went beyond responses to misbehaviour. Thus, the Treatment Committee oversaw the progress of all G Ward patients, and was responsible for recommending specific medical treatments. This included recommendations ranging from special group therapy sessions for patients with interpersonal conflicts, specific dyad pairings, various drug treatments, or changes in medication for fellow patients. The Treatment Committee was also relied on to identify and assess patient risk, and to recommend interventions such as cuffs or other restraints. It also prescribed deprivation of items in the cell that were thought unsafe, or imposed continuous peer observation of the patient. The Treatment Committee was also responsible for approving which 'patient-teachers' would observe a patient during DDT sessions.

[90] Dr. Tate in his evidence makes the point that the active participation of patients was essential to the operation of the STU program. That is, the milieu therapy theory and committee structure that went with it required patients to engage socially with their peers, and to confront their problems with open dialogue. The Ombudsman's "Evaluative Study", at pp. 24-25, described patients as having developed an understanding of the STU programs as they progressed through them. According to the Ombudsman, this included them learning about shared responsibility through committee work, and even extended to understanding which DDT drugs they might need for themselves and for others.

[91] Counsel for the Crown contends that even with patient group recommendations and the final approval of professional staff, none of the 3 programs at issue were imposed on a patient without their participation and consent. It is certainly the case that before entering into any of these programs, patients in the STU had the opportunity to observe others in their groups undergoing the same things. Before and after patients underwent DDT, the Capsule, or MAPP, the experience was discussed and planned by the Treatment Committee, and the Staff-Patient Liaison Committee (on G Ward), or at Ward meetings (on F Ward). Further, Dr. Maier deposed in his affidavit that before receiving DDT treatments, patients were often, although not always, made to draft self-reflective letters for review by the patient group and/or professional staff.

[92] The Ombudsman's "Evaluative Study", p. 3, indicated that patients gave consent in writing for DDT and LSD treatments and for Capsule sessions. A number of these consent forms were tendered as exhibits by the Defendants. In cross-examining each Plaintiff and in their final

submissions, counsel for the Crown reviewed in very detailed fashion not only the formal consent forms, but each instruction sheet that the Plaintiffs were given and made to study at the outset of their participation in the various STU programs.

[93] The "Evaluative Study", p. 36, states that as a result of their active participation in the group therapy and committee system, these patients could be said to have been better informed than most general hospital patients. Dr. Maier was particularly keen to point out in testimony that the patients were exceptionally well-informed about the LSD experience. He testified that not only did they each sign a consent form indicating their voluntary participation in the LSD sessions, but that at any point in the pre-LSD preparation process a patient could drop out of the program without penalty.

[94] The view of fully informed consent put forward by the Crown and the Doctors was expressly addressed, and countered, by the 1985 Hucker Report. Appendix C to that Report is a study entitled "Legal Aspects of Living Conditions at Oak Ridge". The study provides a description of the consent obtained or overlooked at Oak Ridge. The "Legal Aspects" study, at p. 153, makes the point that consent at Oak Ridge was inadequately obtained:

> [T]he law has long required that a competent patient's consent to treatment be obtained, and on the whole, this principle applies to psychiatric patients as well as other patients. Even some of the medical personnel at Oak Ridge who were aware of the obligation to obtain consent, have adopted procedures which are unlikely to be found adequate should they ever be challenged in court. One doctor interviewed stated that he gave the patient medication without explanation…and unless they threw it back at him, or refused to take it, the consent of the patient was implied.

[95] Although the patients were apprised of what was being done to them through the committee system, and had an esoteric LSD reading list provided to them by Dr. Maier, the 1985 Hucker Report found that actual informed consent fell short of what was required. In the view of the "Legal Aspects" study, at pp. 153-4, there was "seldom any explanation provided to patients about the nature of the medication which is prescribed to them, its anticipated side effects, its proposed benefits and the detriment which is anticipated would occur should the patient refuse to take the medication." Moreover, the study specifically addressed the question of involuntarily committed patients: "it is particularly important that staff realize that involuntary status does not imply incompetence to consent to treatment and does not remove the legal obligation to seek to obtain the consent of competent patients": *Ibid*., p. 154.

[96] Much as the Defendants' witnesses and counsel at trial insist that consent was actually obtained from patients at Oak Ridge, the contemporaneous evidence shows that the medical staff was aware that it was not obtained. At an inter-unit committee meeting dated June 21, 1977, the minutes of which are in the evidentiary record, this was made explicit in a commentary from Dr. Boyd and a report from Dr. Tate:

> Right for Treatment:

> Dr. Boyd raised this topic for discussion. He stated that we are moving closer and closer to the concept of informed consent. He proposed that we establish a policy to manage patients who are WLGs and who consistently want out of therapy. This policy could be where the patient is relieved of all privileges and left in his room. Involuntary patients who come from corrections could be returned to the referring centre.
>
> Dr. Tate briefly reviewed some of the cases whereby patients have asked to get out of treatment. This request is denied and now the patients have changed and are now more positive towards treatment. Dr. Boyd stated that he has known of a number of patients who, when the going is rough, ask to get out of treatment. However, after they change they are once again positive.
>
> Dr. Boyd suggested that the real issue pertains to group therapy and behaviour modification. If informed consent is required we will experience a great deal of difficulty in the treatment and management of patients.

[97] A similar inter-unit committee was held the following year, and a similar discussion ensued. The minutes of that meeting, dated November 21, 1978, show an interesting difference in views among the Oak Ridge medical staff. They also demonstrate that the medical staff was of the view that a patient under a Warrant of the Lieutenant Governor – i.e. most of the Plaintiffs – could not refuse treatment and thus did not have to consent:

> Application for treatment of patient who refuses to consent can be presented to Review Board. Dr. Quinsey wondered if there was an implied duress. Dr. Stokes felt we might be overly concerned with the matter and we shouldn't be looking for problems…
>
> We are in somewhat different position in Oak Ridge to regional hospitals. According to Ombudsman, WLG does not qualify under this – cannot refuse to be part of therapeutic treatment – WLG is there to be treated and is out of Ombudsman's jurisdiction.

[98] The Ombudsman's "Evaluative Study", at p. 3, noted that "special treatments such as by disinhibiting drugs, e.g., LSD, Sodium Amytal, Ritalin, or Ethyl Alcohol, or, the Capsule, should, and do, require that the Oak Ridge patient be aware of the effects, side-effects, and treatment goals, associated with the drugs, and the special treatment methods employed." Dr. Maier admitted in cross-examination that the materials he had the patients study prior to their psychedelic drug experiences represented the "philosophy underlying the LSD program", and that patients did not review any "peer-reviewed medical literature". For that matter, a perusal of Dr. Maier's LSD reading list reveals that the patients were not exposed to any information coming from sources that could honestly be called medical sources.

[99] The expert evidence at trial generally concurred that the requirement to obtain informed consent from patients was especially critical in the context of experimental treatments with unknown or unclear risks and benefits. Dr. Freedman testified that, in the 1960s and 1970s, mental

health practitioners were required to "get consent, treat [research subjects] with respect, and do no harm in the sense that…you could do things that were unpleasant, but in the long run what you wanted to do is either benefit the people who were involved or do no lasting harm". Further, in cross-examination, Dr. Freedman did not dispute the statement that research review boards throughout North America had, since the early 1960s, focused on "informed consent" of research subjects, and that this focus only increased in the years following that development.

[100] Using similar language, Dr. Guthiel agreed in cross-examination that it was "clearly understood" in the 1960s and 1970s that medical researchers not only had to obtain "informed consent" from research subjects, but that research subjects had to be free to "voluntarily withdraw" at any time from an experiment. Dr. Guthiel explained that, more generally, patients subject to novel or experimental treatments could not be harmed "simply to achieve some scientific result."

[101] For his part, Dr. Bradford opined that "freely given informed consent" was an "absolute requirement" of the impugned programs. It was his view, as stated in his Reply Report, that there be: a) informed consent disclosure of "known risks and benefits", b) the duty to provide consent could not be delegated to a patient's co-patients; and c) these principles were a matter of "broad professional acceptance" during the relevant time frame.

[102] Professor Bernard Dickens, a medical ethicist who testified as expert for the Plaintiffs, stated in his Report dated April 24, 2019 that the *Nuremberg Code* of 1947 and the *Declaration of Helsinki* of 1964 set the "ethical standard which related to the treatment of patients at issue in these proceedings." As he explained it, this standard required that in the case of an "innovative" proposed intervention "without relevant precedent", such as the DDT program in general and the LSD component of that program in particular, it was an ethical requirement to guarantee, *inter alia*, "subjects' adequately informed, freely given consent."

[103] Professor Dickens further acknowledged in his Report that Dr. Barker's or Dr. Maier's influence over the ultimate ability of each patient to be released into society gave him pause – Dr. Maier stated, for example, that it took "a lot longer on average" to be released from Oak Ridge if patients did not "go along with these programs DDT, Capsule, MAP". Professor Dickens ultimately concluded that the necessary level of informed consent was absent from the STU programs.

[104] Professor Dickens also noted in his Report that the patients ought to have had a right of withdrawal, as guaranteed by the *Declaration of Helsinki*. Despite Dr. Maier's admonitions to the contrary with respect to the LSD treatments, it was Professor Dickens' view that "this feature of ethical program design appears absent" from the STU's programs.

[105] In his examination for discovery, Dr. Maier characterized the STU programs as a "principal door to freedom". He conceded that patients who were not participating in the programs could expect to spend a "decade or decades being held in a maximum-security facility". He further stated that patients operated under the understanding that "active participation in the impugned programs…was…necessary to getting a positive recommendation…from the Advisory Review Board."

[106] Along the same lines, Dr. Gutheil agreed in cross-examination that there would be a "huge coercive element with respect to any consent that may have been given to participate" in the impugned programs if STU patients understood that the programs were, effectively, the "road to freedom, and not participating was a dead end." He also conceded that, to the extent that patients were being "coerced as a result of the milieu", this could lead to a "lack of consent".

[107] To put the point as Dr. Freedman put it in his cross-examination, "the people who were incarcerated against their will, they're under great pressure to agree." Indeed, Dr. Freedman in his professional writings has argued by analogy that if the invitation to participate in research "is made by the students' professor, who implies that it may affect their grades, obviously this is undue pressure and does reduce or eliminate the freedom to refuse": R. Abramovich, J.L. Freedman, K. Thoden, C. Nikolich, "Children's capacity to consent to participation in psychological research: Empirical findings" (1991) 62 Child Dev 1100. It stands to reason that if it is coercive to make participation in an experimental treatment or research endeavor a condition for getting an 'A' rather than a 'B' in a class, then it must be highly coercive to make such participation a condition for gaining freedom from a maximum-security state institution.

[108] In addition to all of that, the DDT program was attractive to the Oak Ridge patients for non-therapeutic reasons. Dr. Barker in the early days, and Dr. Maier in subsequent years, chose for the program those patients who had already experimented with "illicit chemicals" on the street and who signed up for more: Maier and Tate, "The use of LSD in a therapeutic community", pp. 145-6. Various Plaintiffs testified that the DDT drug experiences corresponded with their street life prior to being sent to Oak Ridge. Shauna Taylor, for example, described herself as having been a full-blown drug addict as well as an alcoholic in her pre-Oak Ridge life, Joseph Bonner indicated that he experimented with street drugs – speed, LSD, marijuana, heroin – when he was 15 years old, Maurice Desrochers had a history of street drugs, and John Finlayson and Donald Everingham were alcoholics.

[109] Perhaps not surprisingly, when Drs. Barker and Maier offered the DDT program, including hallucinogens, methamphetamines, and alcohol, to drug users and alcoholics, they were willing to sign up. As Dr. Barker conceded in his 2003 cross-examination, and as must have been obvious to any observer, "some patients, who have had experience with drugs on the street, might just want a high." To say that they gave their informed consent in any legally cognizable way would today stretch the notion beyond its breaking point. The question that remains is whether it would have done so in the 1960s through to the early 1980s.

[110] Not only the content, but the entire approach to informed consent at Oak Ridge, was strongly criticized in the 1985 Hucker Report, p. 73, which was roughly contemporaneous with the final years of the impugned programs:

> The Committee endorses the viewpoint that no therapy program for mentally competent patients should be imposed without the patient's written consent. However, this approach, though current in contemporary psychiatric-legal thinking, differs appreciably from the traditional treatment ethos at Oak Ridge which was once designated as 'coercive milieu therapy'.

[111] Thirty-four years later, testifying at the present trial, Dr. Hucker changed his view somewhat and indicated that, at least for DDT and the Capsule, the consent standards of the day were met. Counsel for the Doctors submit that Dr. Hucker's later view is in keeping with legal analysis of consent in the context of a facility such as Oak Ridge, which is mandated to provide psychiatric care and treatment to persons suffering from mental health disorders: see *Perez (Litigation Guardian of) v Salvation Army* (1998), 42 OR (3d) 229, at para. 7 (Ont. CA).

[112] Defendants' counsel go on to state that it is of particular importance to take note of section 26 of the *Mental Health Act*, RSO 1967, c. 51 (in force from June 1968 to November 1978), which provided that a patient would be discharged from a psychiatric facility only when he was "no longer in need of the observation, care and treatment provided therein". This arises in the context of the accusation by many of the Plaintiffs that their prospects of release from Oak Ridge was contingent on their participation in the three impugned programs. It is Plaintiffs' counsels' contention that this implicit coercion was built into the Oak Ridge system, and that it effectively vitiated any consent ostensibly given by the Plaintiffs.

[113] As Dr. Maier himself conceded in his affidavit tendered in this trial, this is a difficult issue in a psychiatric hospital populated by involuntary patients.

> First, neither I, nor any other medical staff to my knowledge, ever suggested that a patient should participate in a program because it would help them get released from Oak Ridge…
>
> Second, determining how and what consent to obtain from patients in a custodial mental hospital is a difficult issue. It was particularly unclear during the time I was at Oak Ridge given that the legal and medical communities were still trying to clarify and understand all of the legal and ethical issues that arise when treating patients who are confined against their will.

[114] At trial, Dr. Hucker stated in cross-examination that he continues to agree with the 1985 Hucker Report view that the obligation to obtain consent from patients had been a "long-standing requirement of the common law". When he now states that the informed consent standards of the day were met at Oak Ridge in the 1960s and 1970s, he appears to confuse the standards applicable to regular psychiatric medication and therapy of that era and the rather novel approaches of the DDT and Capsule programs. As noted in the Ombudsman's "Evaluative Study" and referenced above, orthodox anti-psychotic medication and unorthodox DDT drugs such as those used in the STU raise different issues about informed consent.

[115] Dr. Bradford opined in his Report that Drs. Barker and Maier were under an obligation to "provide accepted medical treatments to all patients whether voluntary or involuntary with informed consent." He went on to state that "freely given informed consent" ought to have been an "absolute requirement" of the STU programs. Together with Professor Dickens, he further expressed the view that to the extent that the Doctors were engaged in experimentation going beyond accepted treatment, their obligations were governed by the *Nuremberg Code* and the *Declaration of Helsinki*. These principles, as explained by Professor Dickens in his affidavit, hold:

> When a proposed program is without relevant precedent and innovative…and its potential benefit remains unproven, its ethical introduction requires at least prior approval from a. suitably composed independent research ethics review committee to confirm its methodology, subjects' adequately informed, freely given consent.

[116] In their written submissions, counsel for the Crown argue that the *Nuremberg Code* and *Declaration of Helsinki* are inapplicable here, as those instruments are treaties to which Canada is not bound. This submission misses the principle of medical ethics made by Professor Dickens. These instruments are not cited by Professor Dickens as a source of international legal obligation for Canada as a signing state. Rather, they are cited as an articulation of universally accepted ethical principles applicable to physicians, the essence of which was reiterated in Canadian instruments, including the Canadian Medical Association's *Code of Ethics, 1970*. Moreover, these norms of ethical conduct for experimental medicine are now, and were during the STU era, well recognized at common law: see *Halushka v University of Saskatchewan* (1965), 53 DLR 2nd 436 (Sask CA).

[117] The present claim is not a medical malpractice claim, and so the question of informed consent is not a direct test for liability as it would be in such an action. Rather, the consent question goes to the ethical quality of Dr. Barker's and Dr. Maier, which in turn will inform the analysis of their fiduciary duties to the Plaintiffs. Where experimental medicine is performed on a patient with whom the doctor has a previous and ongoing physician-patient relationship, the ethical obligations on the doctor are even more strict than in the ordinary professional relationship. They certainly involve "full and frank disclosure of all information relevant to free and informed consent": *Stirrett v Cheema*, 2018 ONSC 2595, rev'd on other grounds 2020 ONCA 288.

[118] Dr. Maier agreed in his examination for discovery that, while he was working on the STU, Dr. Boyd, Dr. Barker, and Dr Maier himself all believed that "the treatment or the programs could be applied to [patients] regardless of whether they agreed or disagreed", such that there was "no need to obtain [patients'] consent" for the DDT and Capsule regimes. Given the dramatic form of intervention represented by these programs, Dr. Maier's admission is arresting. As the Court of Appeal has observed, treatments intended to be "mind-altering" are (and always have been) among the most intrusive; they demand scrupulous attention to patient consent: *Fleming v Reid* (1991), 4 OR (3d) 74, at para. 42.

[119] It is little wonder, then, that the 1985 Hucker Report expressed substantial concern over the cavalier approach to informed consent that they found prevailed in the STU. As the Report's authors put it:

> A number of staff, including professional staff, referred to 'the recent change in the law' which now requires them to obtain a competent person's consent to treatment. The Committee was distressed that this area of medical jurisprudence is not clearer to Oak Ridge staff… [U]nconsented treatment on such a patient involving any physical contact is prima facie…would leave a doctor open to a potentially very serious law suit.

[120] The attitude and practice that permeated the STU when it came to the DDT and Capsule programs fell well below the type of informed consent that applicable medical ethical standards require, both then and now.

IV. Research and experimentation

[121] Counsel for the Plaintiffs contend, without qualification, that, "[t]he evidence is overwhelming that the use of Capsule, MAPP and DDT was experimental, and that the Defendants…engaged in human experimentation and poorly structured research." Counsel for the Crown submit, equally without qualification, that "[t]he STU programs, including the adjunct treatments [DDT, Capsule, MAPP] and the methods of control and restraint, were not research experiments. They were innovative treatment."

[122] Counsel for the Doctors take a more sanguine approach, and submit that, "[m]uch ado was made at trial about whether the Capsule, DDT, and MAP Programs were treatment programs, experimental treatment programs, innovative treatment programs, or research experiments. This issue received more attention than it deserved." This observation refers to the fact that sometimes the debate over therapy vs. experimentation gets lost in its own jargon. As counsel for the Doctors point out, the question is whether the 3 programs were, as the Defendants say, aimed at trying to treat the Plaintiffs, or whether the programs were, as the Plaintiffs allege, done for other purposes such as advancing scientific knowledge.

[123] In his Report and his oral testimony, Professor Dickens outlined the basic ethical requirements for medical research that prevailed during the decades in issue. In general, a physician engaged in medical research involving human subjects would be subject to all of the ethical requirements of clinical practice discussed above, plus certain ethical requirements specific to research. In an exchange between Plaintiffs' counsel and Dr. Guthiel in cross-examination, Dr. Guthiel agreed with that basic proposition:

> Q. [Y]ou would agree with me that it was clearly understood in the 60's and 70's, according to the codes of ethics, well understood at the time that any experimentation on human subjects, medical experimentation on human subjects, had to be conducted pursuant to the principles set out in the *Nuremberg Code* and the…
>
> A. Yes.

[124] In his Report, Professor Dickens distilled the ethical obligations of medical researchers from a combination of the *Nuremberg Code* and the *Declaration of Helsinki*. As he explained it, these instruments were, in fact, codifications of ethical principles that were applicable even before the post-war Nuremberg trials. From the *Nuremberg Code*, Professor Dickens cites:

- the voluntary consent of the human subject [art. 1];
- the right of voluntary withdrawal from the experimentation [art. 9];

- the use of scientifically qualified personnel [art. 8];
- the experiment should have sufficient scientific foundation [art. 3]; and
- experiments should not be conducted where there is a basis to believe it will result in death or disabling injury [art. 5].

And from the *Declaration of Helsinki*, Professor Dickens cites:

- the research project must have a favourable benefit-to-risk ratio [Basic Principles, s. 3];
- research that may result in personality change requires special caution [Basic Principles, s. 5];
- the nature, purpose and risk of clinical research must be explained to the subject by the doctor [Non-Therapeutic Clinical Research, s. 2]; and
- the investigator must respect the right of each individual to safeguard his personal integrity, especially if the subject is in a dependent relationship to the investigator [Non-Therapeutic Clinical Research, s. 4a].

[125] In addition, the expert evidence from both Professor Dickens and Dr. Bradford demonstrates that, as a matter of contemporary norms of the 1960s and 1970s, ethical standards would have required any research or experimentation to cease if it became dangerous. They would also have required any research involving minors to be preceded by substitute consent. Of particular concern in the context of Oak Ridge, applicable ethical standards would have required independent oversight for any research where the subjects were in a relationship of dependency with the researcher. In fact, Professor Dickens pointed out in his examination in chief that concerns over inducements to human subjects was sufficiently pronounced during the STU era that research on inmates in prisons was impermissible.

[126] Dr. Gauthiel, called to testify as expert by counsel for the Doctors, agreed that research on human subjects has had to be done in accordance with the *Nuremberg Code* and *Declaration of Helsinki* since the 1960s. He stated that informed consent, availability of voluntary withdrawal, and ‘do no harm’ are the guiding principles of those ethical guidelines.

[127] These universal ethical obligations were recognized as applicable in Canada by the Québec Court of Appeal in *Weiss v Solomon*, [1989] RJQ 731, at para 93:

> La déclaration d’Helsinki exige que tous les risques même potentiels, ce que la déclaration appelle ‘potential hazard’, doivent être divulgués au patient qui accepte de participer au programme de recherche. Cette obligation de divulguer les ‘potential hazard’, tel que le spécifie la déclaration d’Helsinki, devient une obligation impérative de la part du chercheur.

[128] During the course of the STU era, the ethical obligations on researchers were recognized in the medical ethics literature as being very stringent. The U.S. banned medical research using prisoners as subjects in 1976, largely in the wake of debates over the Stateville, Illinois penitentiary malaria experiments that utilized inmates as "reservoirs for the disease and as a food source for the mosquitoes": Nathaniel Comfort, "The prisoner as model organism: malaria research at Statesville Penitentiary", (2009) 40(3) Stud Hist Biomed Sci 190, n 7 and accompanying text.

[129] Writing in the McGill Law Journal in 1981, Professor Margaret Sommerville observed that "if the intervention is non-therapeutic, it is the most exacting standard of disclosure which applies": M. Sommerville, "Structuring the Issues in Informed Consent", (1981) 26 McGill LJ 740, 765. Writing in the University of Toronto Faculty of Law Review in the 1960s, near the dawn of the STU era, Professor Stephen Waddams observed:

> It is clear from this statement of the law that the duty owed by an experiment of to his subject is very high indeed. Evidently, to be safe, an investigator ought to err on the side overstressing the risks of a proposed experiment rather than on the other side. The investigator's good faith is not a defence.
>
> S.M. Waddams, "Medical Experiments on Human Subjects" (1968) 25 UT Fac L Rev 47.

[130] In a memo to Dr. Boyd dated January 25, 1967, Dr. Barker discussed the patients to be included in the STU programs under the title "Therapeutic Community Research Project Selection of Subjects". Dr. Barker referred to the random selection of patients for the impugned programs, which is a hallmark of research, not therapy. Likewise, in a January 30, 1967 letter from Connaught Laboratories regarding Dr. Barker's application to federal authorities for access to LSD, Connaught said, "I believe that his proposals for clinical research are reasonable." For his part, Dr. Barker advised Health and Welfare Canada that he intended to publish the results of his "research" in a "scientific or medical journal".

[131] Similarly, it is worth noting that Dr. Barker's "Total Encounter Capsule" article, published in the peer reviewed journal of the Canadian Psychiatric Association, acknowledged the Donner Foundation as the funder of the Capsule project. That funding was written up in December 1968 pursuant to an application by Dr. Barker for "development and research of the Total Encounter Capsule".

[132] The Penetanguishene Hospital's Clinical Services Committee was under the impression that the drug program was designed as a research project. In its Minutes dated August 6, 1975, under the heading "Terms of Reference", the committee admonished Dr. Maier that he "Must return to more medical treatment orientation rather than mystical retreat, pseudo-religious approach. Of particular importance is the fact that patients can't give informed consent." The Minutes then specifically state: "Valid research is not being carried out on LSD."

[133] It is also clear that Dr. Maier was of the view that the LSD program in particular was a form of research. He and Dr. Tate wrote up their experiences as medical research scholarship, and

submitted them as articles to scholarly journals. I pause here to note that some of the responses they received from editors of those peer reviewed journals are insightful.

[134] A May 14, 1979 letter from the editor of a professional publication to Dr. Maier stated that, "I regret to inform you that the editors of the Journal of Psychedelic Drugs have chosen not to accept your manuscript, 'The F Ward LSD Community', for publication, due to the less than positive response from our Review Board. I have enclosed copies of these evaluations for your information. Both the reviewers have done extensive research with LSD." The reviewer then states in his/her review of Dr. Maier's article: "Overall, this study raises a number of serious ethical and clinical judgment questions. The research findings do not add anything new to the psychedelic drug treatment literature. I cannot recommend that it be published."

[135] In a similar vein, Dr. Tate received a letter dated August 20, 1979 from the editor of the International Journal of Offender Therapy. In it, the reviewer of Dr. Tate's and Dr. Maier's co-authored article states, "If the aggressive behavior or hostility of these patients is relevant to the program, it should have been measured pre-LSD and post-LSD; if not relevant, why not try the program with 'standard' mental patients rather than prisoners, the voluntariness of whose participation is questionable ('a moot point,' according to the authors)?" The professional reviewer goes on to conclude, with a degree of ironic understatement, "In summary, I think that this is an interesting, well-written, descriptive paper without scientific value. It should be published only if the editors would enjoy inciting ethical controversy."

[136] It is more than clear that if the STU programs were research, they were not structured along appropriate lines. In *Stirrett* (SCJ), *supra*, at para 33, the court at first instance indicated that, "Medical research on humans necessarily involves a risk of harm. Greater risk may be tolerated to obtain more valuable outcomes. The decision on whether such research can proceed must be made by bodies independent of the group proposing the research (or principal investigators)." And while the Court of Appeal, having decided the case on other grounds, declined to express an opinion on the correlation of risk to outcomes, it confirmed the requirement that "research involving human subjects…be overseen by a Research Ethics Board": *Stirrett* (CA), at para 10.

[137] There was no such independent oversight of Drs. Barker and Maier in the STU, except by the Penetanguishene oversight committees which were substantially removed from real knowledge of the programs during most of the period in which they were operating. As will be explored later in a patient-by-patient review, Dr. Boyd did have some input with Drs. Barker and Maier, but while he was directly involved with certain of the patients he provided no effective oversight to the treatment of the rest. The oversight committees did ultimately shut down the STU programs many years later, but there was no real independent oversight body which followed the programs as they developed on the ground.

[138] In the 2003 certification motion presided over by Justice Cullity, Dr. Hucker submitted an expert Report (the "2003 Hucker Report) in support of the Doctors. In that Report, he condemned the exaggerated analogies employed by the Plaintiffs with respect to the STU programs. At the same time, he expressed the view that the impugned programs were not truly experimental:

> The STU program at Oak Ridge was not experimental in the way that term is used by the Plaintiffs' expert. The suggestion that the STU program mirrored the experiments of the Nazi doctors tried at Nuremburg is melodramatic… The STU was, at the time, a pioneering effort to provide treatment to these otherwise untreatable patients.

[139] Undisclosed to the Plaintiffs at the time was a 2002 draft report (the "2002 Hucker Rep;ort") which Dr. Hucker wrote for the Doctors but which was replaced by the 2003 Hucker Report and so was never used. In the 2002 Hucker Report, Dr. Hucker also condemned the exaggerated analogies of the Plaintiffs. But beyond that, he opined the opposite of what he ultimately submitted the following year:

> I would agree that this programme, taken in total and individually, was 'experimental'. It was referred to as such by Dr. Barker and Dr. Maier at the time and in various documents referring to this program between themselves and the Ministry of Health. However, the suggestion that the programme mirrored the experiments of the Nazi doctors tried at Nuremberg is melodramatic.

[140] Counsel for the Doctors submits that this contradiction, which counsel for the Plaintiffs considers a form of smoking gun, is really a tempest in a teapot. In their view, the debate is more semantics than substance, and turns on Dr. Hucker's use of quotation marks around the word "experimental". In the Doctors' counsel's submission, in the 2002 Hucker Report, Dr. Hucker used the word "experimental" in the way that Drs. Barker and Maier did – i.e. that the treatments were experimental advancements on existing models of therapeutic communities such as those developed by Maxwell Jones in the U.K. This is a different nuance than the way the Plaintiffs and their counsel use the word to connote human experimentation of the more formal, drug-trial variety.

[141] It may be true that the debate is over language. In any case, the debate is not particularly illuminating for present purposes. Dr. Freedman testified that the impugned programs were "experimental", but they were not research. In much the same way, Dr. Guthiel, in cross-examination, both agreed and disagreed with the "experimental" label put on the STU programs by Plaintiffs' counsel:

> Q. Sir, you describe these programs, and you – I think you refer to them as experimental?
>
> A. Small "e", yes.
>
> Q. Small "e".
>
> A. Yes.
>
> Q. Not large "E" Experiments?
>
> A. Right.

[142] Dr. Guthiel's semantic distinction corresponds with the way in which Dr. Maier used LSD in the STU. In his cross-examination at trial, Dr. Maier confirmed that not only did he report to Dr. Boyd, but that Dr. Boyd also provided hands-on directions on the nature of the more novel parts of the STU programs. Thus, in a memo dated August 11, 1975, Dr. Boyd wrote to Dr. Maier expressing concern about the direction of the LSD sessions, making it obvious that they entailed something more than the strictly therapeutic use of the drug:

> The use of LSD as an experimental and research tool has been undergoing some change from the approach originally approved. I would ask that you would not commit us to further LSD sessions beyond those presently approved until the situation is resolved.

[143] As Professor Dickens explained in re-examination, the ethical tenets of medical research would apply not just to self-declared research projects, but to novel and 'experimental' forms of therapy that departed from the orthodox therapies of the day. Plaintiffs' counsel asked this specific question to Professor Dickens in re-examination:

> Q. [T]o the extent that research programs or therapeutic programs with a research component were in existence in the 60's and 70's, could those programs be conducted without regard to ethical concerns?
>
> A. Well, it's tautological. Not ethically.
>
> Q. And leaving aside tautology, can you elaborate on that?
>
> A. Yes. The – the evolving expectation triggered by Nuremberg, but not originating in Nuremberg, is that there will be ethical perceptions brought to bear.

[144] The evidence shows that the impugned programs were both treatment/therapy and research/experimentation. The DDT, Capsule, and MAPP were used on the Plaintiffs precisely because they were all custodial patients whose antisocial personality disorders or schizophrenia had resulted in acts of criminality and violence. In Dr. Barker's and Dr. Maier's era, these patients had no other hope of relief from their conditions than a novel and experimental therapy that could potentially revolutionize psychiatric medicine in general for these kinds of disorders. The Doctors thus embarked on experimental forms of therapy.

[145] The STU programs in issue were therapeutic/treatment approaches to the Plaintiffs as patients, albeit unproven and ultimately ineffective approaches. They were also experimental research projects, albeit unstructured and haphazard projects. But they were a hybrid of treatment and research nonetheless.

[146] When Plaintiffs' counsel and expert witnesses contend that DDT, Capsule, and MAPP were not treatment or therapy, what they mean is that they were not proper or beneficial treatment/therapy. And when Defendants' counsel and expert witnesses contend that same 3 programs were not research or medical experiments, what they mean is that they were not methodologically sound research or medical experiments.

[147] Without meaning to be blunt, poor treatment is ‘treatment’ and poor research is ‘research’. A hybrid set of programs like DDT, Capsule, and MAPP are required to conform to the ethical standards applicable to both categories. In failing to do so, the programs were conducted in a way that violated the applicable ethical principles.

V. Confinement and restraint

[148] The Plaintiffs argue that solitary confinement was used as punishment for non-compliance with STU rules or disruptive behaviour, and that this practice caused harm. Dr. Maier testified that they were most frequently confined for violently acting out. In this regard, several of the Defendants’ expert witnesses were of the view that short stints in seclusion (the preferred term of the Doctors’ witnesses) is not harmful. Dr. Chaimowitz and Dr. Turrall testified that medical seclusion – i.e. solitary confinement with a therapeutic rather than punitive purpose – is a legitimate part of treatment, while Dr. Bradley Booth indicated that milieu therapy depends on cooperative patients and that excessively disruptive ones need to be removed and confined until they can participate again.

[149] The Plaintiffs, on the other hand, testified that they were frequently confined for a variety of unjustifiable reasons. A number of Plaintiffs (Joseph Bonner, Stanley Kierstead, Shauna Taylor, to name but a few) related, and contemporaneous medical records tend to confirm, that they were placed in confinement for petty misdeeds – e.g. failing to follow group discussions, being confused, making sarcastic remarks, and challenging the authority of patient teachers. They also testified that confinement on the STU typically lasted several days as a precursor to being sent to MAPP, although there is also evidence of it occasionally lasting a longer time.

[150] There are three questions that arise with respect to the allegations regarding solitary confinement: a) what was the nature of the confinement, b) are the Doctors responsible for it, and c) is it properly at issue in this trial?

[151] Counsel for the Plaintiffs summarize the evidence with respect to the confinement policies at Oak Ridge in their written submissions by noting that while confined, “patients were frequently prohibited from speaking to other patients.” Having heard the Plaintiffs’ testimony, this strikes me as a fair one-sentence summary of the nature of the confinement at issue. In cross-examination, Dr. Maier testified that confinement was a recognized form of management for patients who were out of control and potentially assaultive. This was in keeping with Dr. Maier’s evidence respecting the MAPP. Dr. Tate testified that when a patient’s medical records indicate the patient was “confined”, it signifies that he was kept in his room on the ward. Several Plaintiffs confirmed in their testimony that although the rooms were more like jail cells than hospital rooms, they did have a sliding bar door that permitted them to see and communicate with people outside in the corridor.

[152] A number of Plaintiff testified about being confined in so-called “strip rooms”, were different from the patients’ regular rooms. The strip rooms had bed which consisted of a cement slab (a “Barker bunk”), with a mattress added at nighttime. Dr. Quinsey testified that patients were confined to strip rooms if they were at risk of destroying the contents of their own room or otherwise being violent. Even in the strip rooms, where the deprivations were certainly severe, the patients were able to communicate with attendant staff.

[153] The Doctors' counsel points out that with these conditions, the "confinement" or "seclusion" employed in the STU was significantly different than "solitary confinement" or "administrative segregation" as those terms are defined in federal penitentiaries. In *Canadian Civil Liberties Association v Canada (Attorney General)*, 2019 ONCA 243, at para. 1, Benotto JA, on behalf of a unanimous Court of Appeal, indicated that, "[t]he distinguishing feature of solitary confinement is the elimination of meaningful social interaction or stimulus. It has the potential to cause serious harm which could be permanent." The evidence in that case described the only a minimal outlet from an inmate's cell: "The heavy steel door has a small food slot a few feet off the ground. It is often through this food slot that interactions with staff and health personnel take place": *Ibid*., para 20.

[154] Without doubting the severity of the discomfort felt by the Plaintiffs who spent time in confinement at Oak Ridge, the conditions do not compare with those attributed to federal penitentiaries. That is not to say that excessive time in Oak Ridge's version of confinement would not qualify as abusive, especially as Oak Ridge is a hospital setting, not a prison. However, the most significant impact of the 3-day stints in confinement that appear to have been typical of the STU is as a precursor to a 14-day cycle in MAPP (or 10-day cycle in MotoPro) – reminiscent of a 'softening-up' before the main battle. When the confinement period is added to the MAPP period, and the constant threat of MAPP repeating itself along with a new confinement period if the patient so much as moves without permission while in MAPP, the experience becomes all the more intolerable.

[155] There is also evidence in the record of the attendants confining patients to their rooms/cells as punishment for violent or threatened violent actions. Dr. Quincey testified that this was more prevalent in the other Oak Ridge programs than in the STU, since chronically assaultive patients tended to be taken out of the milieu therapy program. However, the punitive use of confinement such as was used more commonly in prisons in the 1960s and 1070s era was not absent from Oak Ridge. Dr. Quincey explained in his examination-in-chief:

> …these decisions to confine patients were made by – by attendant staff, usually, and there was variability amongst the attendant staff in terms of their attitudes towards the patients in their charge. Some of them, a small number, had very negative attitudes towards the patients. They were punitive, and they were essentially not in favour of treatment programs for psychiatric patients, particularly forensic patients.

[156] It is clear from the record that confinement of some kind was part of the reality of Oak Ridge as a maximum-security institution. As the Doctors' counsel point out, it was used before, during, and after the STU programs were in existence, and was not an approach to security that was unique to the STU or, for that matter, to Oak Ridge. It could be ordered by attendants and nurses as well as doctors. While confinement may or may not have been abusive, it is not a particular part of the DDT, Capsule, or MAPP and so is not automatically part of this claim without being specifically pleaded.

[157] It appears that with one exception – Joseph Bonner – the Plaintiffs did not plead that confinement was a distinct factual ground of liability. The causes of action are focused on the three

STU programs, and does not veer into general treatment of patients at Oak Ridge separate and apart from those programs. Paragraph 48 of the Amended Second Fresh as Amended Statement of Claim frames the issues as follows:

> (b) The Experiments
>
> 46. Between 1965 and 1983, the Plaintiffs, together with dozens of fellow inmates, were forced to participate in these discrete mind control/mind altering experiments, which incorporated abuse coupled with psychological and physical torture. The human experimentation initiated and conducted by Barker and Maier, and continued by O'Reilly, was divided into three main programs/experiments in the STU at Oak Ridge, as follows (collectively the 'Experiments'):
>
> (a) Motivation, Attitude, Participation Program ('MAPP');
>
> (b) The Total Encounter Capsule Program (the 'Capsule');
>
> (c) Defence Disruptive Therapy ('DDT').

[158] Counsel for the Doctors points out that no facts concerning the overall nature of solitary confinement are pleaded. Moreover, the Claim does not describe how a finding that a Plaintiff was in solitary confinement – on its own, absent connection to MAPP – would result in liability under a recognized and pleaded cause of action, other than for Joseph Bonner.

[159] As a matter of fact, the Claim does not plead that any Plaintiff except Mr. Bonner even experienced "solitary confinement" while housed at Oak Ridge. Notwithstanding that limitation in the pleading, at trial Allen McMann, Denis LePage, Eldon Hardy, Stanley Kierstead, Stephen Carson and Danny Joanisse, and Shauna Taylor, in addition to Joseph Bonner, all claimed that they had suffered harm due to being in "solitary confinement" for lengthy periods while they were admitted to the STU. Further, Dr. Bradford, who spoke extensively about the harms of solitary confinement in his trial testimony, never mentioned this as an independent wrong done to the Plaintiffs (except Joseph Bonner) in his expert report. It was all raised for the first time at trial as an independent wrong or an independent head of the damages claim.

[160] The Court of Appeal addressed a similar problem in *Kalkinis v Allstate Insurance Co. of Canada* (1998), 41 OR (3d) 528. It concluded that plaintiffs cannot add a new cause of action, or a new factual basis for liability, for the first time at trial:

> The parties, certainly the appellant, were proceeding on the basis that this was an action in contract on an insurance policy. The record had been developed within the confines of the cause of action as pleaded. Accordingly, it was impermissible for the trial judge to entertain an argument founded on totally different legal principles.

[161] It would amount to a reversible error if I were to consider placing liability on the ground of solitary confinement for any of the Plaintiffs except Joseph Bonner for whom it is expressly

pleaded: *Allan v New Mount Sinai Hospital* (1980), 33 OR (2d) 603 at para 1 (Ont CA). Accordingly, I will not consider placement of a Plaintiff in solitary confinement for an extended period of time to be an independent cause of action advanced in this trial, except with respect to the Plaintiff, Joseph Bonner.

[162] That said, the use of confinement in association with MAPP is a factual matter to be taken into account in assessing that program. In this regard, Dr. Bradford's exchange with Plaintiff's counsel in examination-in-chief is instructive:

> Q. Some plaintiffs have testified that if they didn't say the right things in these group sessions, if they stared out the window instead of looking at the other patients in a discussion, if they spoke poorly of another person, that they would be, at the recommendation of the other patients, put into solitary confinement, sometimes naked, sometimes not, as a form of punishment. Do you have an opinion as to whether or not that constituted acceptable medical treatment in a group therapy setting?
>
> A. No, it's not. It's not acceptable medical treatment. It's not acceptable any treatment, as far as I'm concerned.

[163] As for physical restraints, the record is replete with testimony from the Plaintiffs about the use of restraints made of a seatbelt strap type of material. The thinking behind this kind of binding of the hands (and sometimes the feet) was that it would provide a means of keeping a patient in the company of others and in therapy while reducing his risk of violence. According to Dr. Barker, this handcuffing kept the potentially violent patient continuously in the company of others and free to talk with them, rather than being isolated in confinement. Dr. Barker also stated that the patient/observer to whom the bound patient was joined derived the satisfaction of being the helpful party in the relationship: E.T. Barker, M.H. Mason, J. Walls, "Protective Pairings in Treatment Milieux: Handcuffs for Mental Patients" (1968/9), p. 3.

[164] Contrary to this somewhat benevolent-sounding explanation for binding patients by the hands and sometimes the feet, the Plaintiffs described this practice as gratuitous and abusive. Samuel Shepherd's Clinical Record for March 18, 1973 states, "placed on double restraints when he became shut down and appeared to be suppressing a lot of hostility. He later became open with the group and restraints removed." He described the double restraint as seatbelts fastened with a padlock. Shauna Taylor pointed out in her testimony that the MAPP rules, a copy of which is in the Crown's evidence, provide that "[a] person can be placed on restraints for threatening to hurt others (acting out), refusing to attend the program or unpredictability." She testified that non-participation or voicing any complaint about the harsh treatment was considered showing a lack of "motivation" and resulted in restraints.

[165] Several of the Plaintiffs described a method of restraining called the "turkey strap", which was said to be excruciatingly painful. According to Danny Joanisse, who testified as to being turkey strapped on several occasions, it involved seatbelt straps at both the ankles and the wrists, with an extra strap hooked between the ankles and pulled up behind the back and locked in place.

Counsel for the Crown insisted in submissions made at several points during the trial that this never happened and that it is a story made up by the Plaintiffs.

[166] The documentary record does not provide a definitive answer to how invasive the restraints used at Oak Ridge could be. I do note, however, that several of the Plaintiffs' medical documents refer specifically to their being placed in a "T strap". Counsel for the Plaintiffs contend that this is a reference to the notorious "turkey strap", while the counsel for both sets of Defendants contend that it refers to a less severe method of cuffing or restraining. Read in context, the Clinical Records suggest that the "T strap" was only used when regular cuffing did not suffice to restrain a volatile patient. Thus, for example, the Clinical Records for Jean-Paul Belac dated June 22 and 24, 1972, written by hospital personnel, state:

> June 22, 1972 – 'Attacked another patient. Was overpowered by patient security committee and was placed on double restraints.'
>
> June 24, 1972 – 'Slipped out of cuffs and had to be forcibly restrained while T strap was being applied.'

[167] In "Protective Pairings", at p. 3, Dr. Barker wrote, "The ostensible barbarism of procedures which involve direct physical restraint can often obscure their advantages in therapy." On the other hand, Dr. Bradford gave the diametrically opposed view in his examination in chief, stating, in effect, that the use of restraints as described by the Plaintiffs is all barbarism and no therapy.

> Q. In the context of the MAP Program, and in the context of the Social Therapy Unit, do you have an opinion as to whether the use of restraints, cuffs, and we heard about turkey straps, as a form of punishment for comments made that weren't considered appropriate or lack of participation in a group discussion?...
>
> A. No, it's not an acceptable form of medical treatment, and it's – it's – even as far as punishment, it's seriously problematic, and if I understand some aspects to it, there were some people who were probably deliberately paired with individuals that caused them anxiety and distress, so it had a – a kind of a coercive distress, traumatic-inducing component to it as well.

[168] This last point – that restraints were used to intentionally pair domineering with submissive patients – was related most graphically by Danny Joanisse. He testified as to being in the SVU as a small 14-year old boy. He related that his most vivid memory of the STU was having spent several days in the Capsule cuffed to a convicted pedophile murderer named George White. Dr. Hucker, in his testimony at trial, conceded that this would have provoked substantial anxiety and stress, and that it potentially could have caused lifelong harm.

[169] Dr. Barker explained in "Protective Pairings", that the task of choosing the "observer" to whom a patient would be cuffed was delegated by the Doctors to a patient committee. The theory was that an antagonistic observer would have to learn to care for his charge by being bound to him for hours a day, which would thus have a positive effect on both the bound patient and the bound observer. In Dr. Barker's words, at pp. 3-4:

> Patient committees are aware of the potential value of the intense interaction experienced by someone joined to others for sixteen hours a day, and when assigning observers make tactical use of the patient's enemies and friends in an effort to facilitate helpful encounters.

[170] Dr. Hucker, who was produced by the Defendants as an expert witness, conceded in cross-examination that restraints were an integral part of the DDT and Capsule programs as well as the MAPP. In fact, he learned that from Dr. Barker's own writings:

> Q. And Barker made clear in his writings that cuffs were used to control increased risk of homicide and suicide associated with the use of the DDT drugs?
>
> A. Right.
>
> Q. Because the DDT drugs would often induce homicidal or suicidal thoughts?
>
> A. Or it could do, yeah.

[171] The use of restraints is part and parcel of what the Plaintiffs allege was the non-medically indicated, abject cruelty of the 3 impugned programs. The "tactical use" of the patient's enemies in bounding him together with another patient, and the painful contortions into which the other inmates, exercising delegated authority from the Doctors, caused them to be strapped, all factor into the analysis of the DDT, Capsule, and MAPP and its impact on the Plaintiffs.

[172] As Dr. Hucker acknowledged in cross-examination, the use of restraints in this context was, from a medical practitioner's point of view, entirely inappropriate:

> Q. And as a way to mitigate those homicidal or suicidal urges Barker divides this idea of cuffing one patient to another after they have been injected by these DDT drugs?
>
> A. Right.
>
> Q. Would you agree that, all things being equal, that in and of itself is a barbaric action of a – of a psychiatrist?
>
> A. I – I think it was misguided. I don't think that was an appropriate approach.

VI. Plaintiffs' histories and individual causation

[173] As already apparent, much of the evidence in this trial centred on the 3 impugned STU programs and the activities of the Doctors and Oak Ridge as an institution in putting them into operation. That is not to say, however, that the trial presumed that all of the claimants experienced the programs in the same way. This was, first and foremost, a trial of specific claims of damage brought by 28 individual Plaintiffs as a result of treatments they underwent in the 3 programs, which treatments were imposed on them individually by Dr. Barker, Dr. Maier, or one of the other

three named Oak Ridge medical personnel (Drs. Boyd, Tate, or O'Reilly), and caused them specific harms.

[174] Each of the Plaintiffs submitted an affidavit and/or agreed statement of facts and testified at trial, with the exception of several deceased Plaintiffs whose executors testified and whose discovery transcripts or other evidence is in the record. Further, each of the Plaintiffs were the subject of a medical records evaluation by one of the Defendants' several expert witnesses and by Dr. Bradford on behalf of the Plaintiffs.

[175] Overall, there are 4 issues to be considered in reviewing the evidence with respect to each of the Plaintiffs: i) their pre-Oak Ridge background and index offence or reason for having been committed; ii) their experience at Oak Ridge with any of DDT, Capsule, or MAPP; iii) their post-Oak Ridge experience; and iv) an identification of harms that the STU programs might have caused them. A proper review of this evidence requires that the Plaintiffs be considered one at a time.

a) Reginald Barker

[176] Reginald Barker passed away in April 2020, just after the trial had ended but while judgment was still under reserve. There has not yet been an Order to Continue sought with respect to Mr. Barker's claim, and so technically it is stayed. However, Plaintiffs' counsel advised that they would likely be seeking an Order. On the assumption that they will be so instructed, I will review the evidence with respect to Mr. Barker as if the claim were being continued by his estate representative.

[177] Mr. Barker – no relation to the Defendant, Dr. Elliott Barker – spent exactly 10 years in Oak Ridge. He was first admitted to the institution in March 1968 and was finally discharged in March 1978.

i) Pre-Oak Ridge and index offence

[178] Mr. Barker was born in 1946 in Nova Scotia and lived in that province until his teenage years. He deposed in his affidavit that his father was an alcoholic and was violent with his mother, and that his parents separated when he was 14 years old. He did not attend school past grade 6. In a report written about Mr. Barker to an Ontario Review Board in 1990 by Dr. Bradford, it was related that Mr. Barker recalls having some sexual contact with his mother as a young teen and also having coerced a number of younger girls into sexual activity. In his testimony, he described entering the home of a pregnant woman and four children with the intention of killing them when he was 15 years old, but leaving before he could do them any harm.

[179] The family moved to Toronto when Mr. Barker was 16 years old, and his criminal activity and sexual aggression began to escalate. In a March 1968 psychological evaluation, he related that he had several years previously broken into a church and attempted to rape a 77-year old woman at knifepoint. He was remanded to Don Jail, where he reported hearing voices telling him to murder. This resulted in his being committed to Lakeshore Mental Hospital for two months in 1963, where he was diagnosed as a pathological personality, anti-social type.

[180] In a Clinical Record from Lakeshore date March 28, 1963, the examining psychiatrist noted:

> He talked about his auditory hallucinations and stated that he had experienced episodic hallucinations of this kind over the past two years. He stated that these voices urged him to steal and to assault and more recently to kill people, especially women. The most recent development was his statement this morning to one of the female nurses that he was going to kill her and had it planned how he was going to carry out the task. He indicated that the voices told him to kill the nurse and also others… He admitted that his recent assault on a woman which led to his admission here was a planned episode that he had thought out for a week. He stated that he intended to kill her and might have done so if he had not been aware of some passers-by outside the window… He also mentioned some kind of sexual assault or molestation of three boys and three young girls at one time but did not elaborate. He talked about all these things in a very matter of fact manner. He showed no signs of embarrassment or expression of guilt.

[181] Mr. Barker deposed that in 1963, at the age of 16, he was convicted of armed robbery and rape of the 77-year old woman, resulting in a 5-year sentence in Kingston Penitentiary. He was assessed by a psychiatrist on September 5, 1963 and on August 10, 1964, while at the Kingston Penitentiary. The Assessment, which is in the evidentiary record, reported that Mr. Barker continued to be impulsive and aggressive towards women. He was released from Kingston in 1966, and soon afterwards assaulted his 5-year old niece and was admitted to Queen Street Mental Health Institution. Upon discharge from Queen Street in 1967, he was diagnosed with pathological personality, pedophilia with anti-social traits.

[182] On February 20, 1968, Mr. Barker killed a woman at work. Some years later, in July 1986, he reported to a consulting psychiatrist at Penetanguishene that "at that time, she seemed to be like his mother in that she was separated, had a number of children and several lovers and he stated that he then thought that "if I kill this woman, my problem will go away". As a result, he was committed to Oak Ridge at the age of 21 on a Warrant of the Lieutenant Governor. In a Clinical Record dated June 8, 1968, a social worker interviewing Mr. Barker noted that:

> In discussing whether or not he might kill again, patient Barker stated that he just did not know. He recognizes that a number of his upsets this last while have been the result of his thinking about this as well as his feelings of resentment toward his mother and favouritism toward his father after their separation, and his unhappiness with his mother for her transient common-law relationships.

ii) Experience in the STU

[183] Mr. Barker insisted in his testimony that he signed consent forms for sessions in the Capsule and DDT, including LSD sessions, because he was told by the Doctors that it was treatment for his psychiatric condition. In fact, he testified that Dr. Maier had announced to him and a group of patients that LSD was the "cure for psychopathy". As Mr. Barker put it in cross-examination, "If you were a psychopath and you heard this you would have signed up too."

[184] In his affidavit, Mr. Barker deposed that impressing Dr. Barker by participating in the STU programs was his only route to release from Oak Ridge. Having said that, he also testified that Dr. Barker assured him that he would not be forced "to do anything". Mr. Barker then agreed with questions put to him on cross-examination that Dr. Barker treated him with respect and he never actually forced him to do anything against his will. In fact, he stated that he felt that Dr. Barker was particularly friendly to him as they shared the same last name.

[185] The Clinical Records show that Mr. Barker had a total of five DDT sessions in the Capsule, including one LSD session. After his first Capsule session on April 29, 1969, a social worker recorded in the Clinical Record that Mr. Barker "seemed to be in good spirits" and that he "expressed…, as did the rest of the group, a wish to return to the capsule with the same people."

[186] It would seem that Mr. Barker's Capsule session the following month was somewhat less rewarding. The records of May 1969 show that Mr. Barker initially described the experience as "relaxing", but eventually became hostile toward a fellow patient who suggested they stay another two weeks. Mr. Barker threatened to kill someone if he was not let out of the Capsule. The Clinical Records of the session indicate that it was a very uncomfortable l02 F in the Capsule for this session and that the patients were naked on a rubber floor and shared an open toilet. Mr. Barker is recorded as having exclaimed, "You give us no shower, treat us like animals", and then, "Let us out of here, Dr. Barker."

[187] In a lengthy document, a patient observer group documented this May 26, 1969 session in the Capsule hour by hour. The documentation records that Mr. Barker and his several other patients were "screaming to be let out". In their written submissions, counsel for the Doctors point out that Mr. Barker's desperate screams for help were only one incident that day, and that prior to that Mr. Barker was apparently lying in the Capsule trying to sleep. With the greatest of respect, this submission is reminiscent of the apocryphal question 'beside that, Mrs. Lincoln, how was the show?' A half-day that ends with a person screaming in pain and trauma is not an overall quiet day.

[188] Mr. Barker agreed in his testimony that he was informed that the purpose of the Capsule session was to help the patients discover more about themselves, and that the group would collectively decide when to exit the Capsule and when to sleep. The Clinical Record relates that at the time, Mr. Barker attributed his hostility to the feeling he had that one of the patients was rejecting him in favour of another in the Capsule.

[189] Mr. Barker appended to his affidavit a number of Treatment Records from Oak Ridge detailing his DDT treatments:

> Scopolamine and Dexedrine for 2 weeks beginning on September 2, 1969, administered by Dr. Barker;
>
> Dexamyl-Tofranil treatment for 7 weeks beginning in November 1972, authorized by Dr. Maier.

> Alcohol treatment on January 15, 1976 and alcohol-Ritalin on December 6, 1977, both authorized by Dr. Maier.
>
> Sodium Amytal on November 20 and December 10, 1973.
>
> Sodium Amytal on January 7, 8, and 14, 1974.
>
> Sodium Amytal-Ritalin on December 5, 11, and 18, 1975 administered by Dr. Maier.
>
> Sodium Amytal-Ritalin on February 10, 1976, and Ritalin on February 20, 1976, both administered by Dr. Maier.
>
> LSD in the Capsule on April 9, 1976.

[190] In his affidavit, Mr. Barker relates how Scopolamine induced for him a traumatic psychotic episode. He also states that while on Amytal he was psychotic and violent towards other patients, and was put on restraints. Mr. Barker also deposed that Dr. Maier then instructed staff to have the restraints removed as Mr. Barker had apparently calmed down.

[191] According to Mr. Barker himself, however, the drug experiences were what one might call a mixed experience. In December 1969, he wrote an article in *The Seventh Circle* about his experience with Scopolamine, describing all the pain, terror, and other negative effects he experienced with that drug. But he then went on to say:

> The drugs made me aware of my loneliness and my need, my needs to be with people most of the time, more aware of what I have to do to get well; my sensitivities and my insecurities around people and doing things…

[192] In his cross-examination, Mr. Barker conceded that he had requested Amytal treatments, alcohol treatments, and LSD treatments. In a letter to Dr. Maier dated September 12, 1972, he made a request for valium, which Dr. Maier declined to give him. At the same time, Mr. Barker informed Dr. Maier that while he was not willing to try Scopolamine again, he would consider a undergoing a Dexamyl-Tofranil treatment. As for LSD, Mr. Barker was well versed with the literature provided to him by Dr. Maier on the theories of LSD. In the process, he indicated that he could have refused LSD had he not wanted it. However, he testified that he consented to this drug experience because Dr. Maier had declared it to be a cure for psychopathy – an allegation that Dr. Maier in his own testimony flatly denied.

[193] The Clinical Records for Mr. Barker from March 1968 note that he was interested in the programs, had felt that the LSD experience was beneficial and had increased his self-knowledge and helped with his acceptance of himself. However, he also testified that he had trouble writing in the immediate aftermath of the LSD session, and that he saw colours.

[194] The record shows that Mr. Barker wrote a positive letter to the *Barrie Examiner* on January 30, 1976 defending Dr. Maier and the use of LSD at Oak Ridge, explaining that the program was entirely voluntary by the patients. He testified that he and those who signed the letter with him felt

obliged to defend the program in order to curry favour with Dr. Maier. He stated: "All of my peers knew that it was best to sign this letter to show that we were not rabble rousing, we were not challenging the system."

[195] According to the Ward Transfer Slips and his Clinical Records, Mr. Barker was in MAPP on several occasions:

> March 6, 1974 to March 10, 1974. Dr. Maier noted that Mr. Barker was admitted because, in his capacity as MAPP teacher, he had sexually abused another patient in MAPP; and
>
> September 10, 1975 to September 22, 1975. Dr. Maier reported that Mr. Barker was placed in MAPP for being sarcastic, uncooperative, swearing at the area supervisor, and getting romantically involved with a volunteer at Oak Ridge contrary to hospital policy.

[196] Mr. Barker deposed that in March 1974, he was placed in restraints prior to his admission to MAPP, as well as in October 1969 and June 1979. He acknowledged that on those occasions he had been aggressive and hostile. He also explained that he had himself been a 'teacher' in MAPP, and that in that capacity he had to resort to placing restraints on fellow patients and place them in confinement when they were being "unmanageable". At the same time, he acknowledged in cross-examination that in 1973 he had written an article in *The Seventh Circle* stating that cuffs were seldom used on patients because it was rare that they were so upset as to require them.

iii) Post-Oak Ridge experience

[197] Mr. Barker was transferred from Oak Ridge to Lakeshore Psychiatric Hospital on March 15, 1978. On discharge from Oak Ridge, he was diagnosed as having an antisocial personality disorder. This played out in the form of recidivist activity, and on January 14, 1979, Mr. Barker was arrested for breaking into cars while carrying a mask, knife, and screwdriver. In a memo to the Penetanguishene administration, it was noted that Mr. Barker admitted to have been looking for women.

[198] As a consequence of this offense, he returned to maximum-security at Oak Ridge pursuant to a Warrant of the Lieutenant Governor. Upon discharge on October 5, 1984, he was again diagnosed with antisocial personality disorder, and was subsequently transferred to Brockville Psychiatric Hospital where he stayed until June 4, 1986.

[199] When Mr. Barker was discharged from Brockville Psychiatric Hospital he was again diagnosed with personality disorder, psychopathic type. He then returned to Oak Ridge on June 4, 1986, where he remained until April 4, 1989. In a psychiatric evaluation dated April 21, 1987, Mr. Barker is recorded as having reported that he "could not forget what he had done [in killing his female co-worker] although he could still live with himself and he had resolved his problems with his mother. He saw Dr. Barker as having had a positive effect upon him in changing his life by means of various treatments he had received at this hospital."

[200] Mr. Barker verified this in his testimony that this is still his view today:

> Q. Is this the type of thing you would have told to a psychiatrist in the 1980s, that you thought Doctor Barker had changed your life?
>
> A. All I know is that Doctor Barker and I got along okay. He never made me do anything, so I really don't have a beef against him. I have a beef against Doctor Maier.

[201] Mr. Barker was ultimately discharged to the Royal Ottawa Hospital, where he was assessed by Dr. Bradford on a number of occasions for the Board of Review. On August 27, 1990 and again on August 29, 1991, Dr. Bradford stated that Mr. Barker's condition was resistant to treatment. Defendants' counsel point out that on neither occasion did Dr. Bradford make any reference to the impact Oak Ridge might have had on Mr. Barker's rehabilitation, although, of course, that was not exactly the topic of the two Reports. Dr. Bradford also assessed Mr. Barker on January 17 and 22 as well as on February 1 and February 21, 1990. On those occasions Dr. Bradford noted that at Oak Ridge Dr. Barker had diagnosed Mr. Barker as a psychopath, but otherwise his reports are silent on any lingering impact on Mr. Barker of his Oak Ridge experience.

[202] Mr. Barker was never released from custodial psychiatric facilities. When he testified at trial and subsequently passed away, he was a resident of the Providence Care Centre in Kingston, Ontario. Testimony given at an Ontario Review Board hearing in November 2019, in the midst of the present trial, indicates that a high level of supervision was required to manage Mr. Barker, and that the risk of violence that he poses, in particular to women, did not decline with age. The Board concluded that Mr. Barker remained a threat to the safety of the public and maintained the detention order for him to remain in a secure unit of the hospital: *Barker (Re)*, [2019] ORBD No 535.

[203] With all of that, Mr. Barker deposed in his affidavit that he was in a long-term, stable relationship since 1991, and that he had gotten married.

iv) Causation and harm

[204] In cross-examination, Mr. Barker testified that when he left Oak Ridge he was still suffering from mental illness:

> I had a good review board. But when I left the hospital, I was sick. I was very sick. I mean, I had a pretty bad upbringing and I was alone most of my life. Alone to carry thoughts of hurting people and killing people, you now? And when I left hospital, things just went worse…
>
> What was going on inside my head was the fact that I wanted to rape and kill a lot of nurses. That was going on inside my head, and I told him. When I went to the review board… my lawyer said that I had requested far worse than the index offence – the index offence meaning murder, I was going to hurt a lot of people. That's how sick I was.

> That's how sick I was when I left Penetang.

[205] Counsel for the Doctors submit that this description of harm is nothing more than a continuation of the psychological conditions from which Mr. Barker suffered prior to his arrival at Oak Ridge. However, from Mr. Barker's point of view, the prolongation of his mental agony is in itself a form of harm from which he has never recovered. He continued his explanation under examination:

> It's pretty bad when you go into one hospital to get treatment – treat – God damn, I didn't get no fucking treatment… I've been locked up for 50 years; 50 years of my life. All I want to do now is to get out.

[206] In examining his medical records and opining on his condition, Dr. Hucker conceded that it is possible that the use of DDT drugs by Drs. Barker and Maier could have caused the long-term suffering that Mr. Barker describes, although he offered no definitive opinion. He indicated that he had never heard of anything comparable to the drug program at the STU, and that it was so unique that he had nothing with which to compare it and against which to measure its results.

[207] Dr. Hucker indicated that it is likely that at least in the short term, Mr. Barker would have had difficult symptoms as a result of the DDT experiences. In fact, he testified that Drs. Barker and Maier expected short term suffering when they administered the drugs to their patients – that is, they aimed to provoke severe anxiety in the hope that this would prompt introspection and increased self-understanding. Dr. Hucker testified that this is borne out by the fact that in November 1974, Mr. Barker's mother wrote to Dr. Maier asking if her son could get out of the drug program as it was causing him stress. Mr. Barker's early suffering from DDT was also demonstrated in the article he wrote in the patient newsletter in December 1969 entitled "My Drug Treatment". In that article, Mr. Barker described his first weeks of Scopolamine treatment:

> I became quite hostile and shut down… After my second week was over, I was quite sensitive to what people were saying and doing. I was also vulnerable and fragmented. In groups that followed my treatment, I was confused and didn't know what was really happening in them. I was more upset than I usually am or that I used to be. Now I am upset one week and feeling nothing the next, which I find to be a very frustrating experience as to why this happens to me.

[208] Dr. Hucker indicated that this could have been a case of toxic psychosis. He stated that this condition is thought to be completely reversible.

[209] Having said that, it is clear from his ongoing medical records that the traumas suffered at Oak Ridge have had the lingering effect of alienating Mr. Barker from any further psychiatric treatment. A March 16, 1993 Clinical Record at Kingston Psychiatric Hospital indicates: "Overall, Reg talked about his reluctance to get engaged in any group treatment activities. Previously he had stated this was because of his negative experience in Oakridge, Penetanguishene." Similarly, the November 20, 1996 Disposition Orders and Hospital Reports from Kingston Psychiatric Hospital state:

> The impression Mr. Barker left was that he had no interest in becoming involved in treatment, nor could he see any value in doing so. During a brief discussion of this treatment plan with nursing staff, Mr. Barker became angry and remained adamant about not taking any 'therapy', stating that if therapy worked it would have worked at Penetanguishene.

[210] Further, a March 10, 1998 record at Kingston Psychiatric notes that, "Reg wants to consult with Dr. J. Owen with regard to his treatment with LSD and how that impacts upon his psychiatric history." The LSD experience seems to have been on his mind continuously, which Dr. Hucker acknowledged is a common "flashback" experience that is similar in many ways to PTSD. As an example of this continuing stress, Mr. Barker wrote to the CBC Ombudsman on February 23, 1997 complaining about the broadcasting of a show detailing some of the horrors of Penetanguishene. A Kingston Psychiatric Record dated December 24, 1997 states that Mr. Barker reported his feelings about the CBC show to medical staff:

> He spoke of the horrors that took place, and of the experimental drugs that were given to the patients/inmates… Seeing the program brought back many painful memories, which I would prefer to forget. This has caused me a great deal of stress. On several occasions after viewing the film, my current doctor had to increase my antidepressant medication.

[211] Referring to the CBC program, Mr. Barker testified at trial that, "I feel the memories communicating more easily with people before this program. This is in my head all the time now…Penetang made me worse. I was sicker when I left than when I arrived. I feel more socially isolated now, I was a pretty friendly outgoing guy when I went there." He had made similar comments to medical staff at Kingston Psychiatric Hospital at the time of the show's airing. A Clinical Record of December 24, 1997 records Mr. Barker saying that he suffered from viewing the CBC program. The doctor noting the conversation wrote in the medical record:

> [Mr. Barker said] 'It's making it really hard for me to forget the drugs, people, programs…the groups were brutal. I'd thought I'd forgotten everything about Penetang.'
>
> When I asked how I could help he said he was sleeping poorly and experiencing auditory pseudo hallucinations of having his name called aloud when no one was there.

[212] This mulling over the LSD experience continued into the following year. Another Kingston Psychiatric Hospital record dated March 5, 1998 indicates:

> Reg expressed some concern as to whether the LSD effected the 'regression in my head from the index offence of murder to stalking and anger and rage. At Lakehead Psychiatric, I was armed and I was stalking to see how far I would go over the edge.' By that Reg clarified that he meant committing the act of aggravated rape. Reg wants to speak with a professional about the aftereffects of LSD to determine whether it is possible they shifted his brain chemistry.

[213] The lingering fear of further psychiatric treatment apparently never left Mr. Barker. An Assessment Report dated April 12, 2004 states: "Mr. Barker's refusal to engage in treatment largely continued despite the urgings of Dr. Quinsey. He has continued to decline any significant involvement in group therapy, arguing that he did such groups at Penetanguishene. Despite the clear failure of these programs he has not felt any particular need to pursue any concerted efforts at self-improvement."

[214] As a totality, Mr. Barker's post-Oak Ridge records indicate that while many of his mental health issues are a continuation of what he suffered prior to his admission, the STU experience – and in particular the DDT sessions – added substantially to his suffering. It is not just that those therapies failed to improve his mental health in any way; they gave him new types of stress and pain from which he never fully recovered.

[215] In the short term, Mr. Barker's experience at Oak Ridge in the DDT program, and especially with the Scopolamine treatments, caused him great harm in the form of extreme anxiety, trauma, and indignity, and produced no beneficial effect. Over the longer term, the STU programs have caused him harm in the form of LSD flashbacks, continued anger and sleeplessness, the sense of loss of control over his faculties. Drs. Barker and Maier were both directly involved in his treatments.

b) Jean-Paul Belec

[216] Jean-Paul Belec was admitted to Oak Ridge at the age of 21 years in April 1972, pursuant to a Warrant of the Lieutenant-Governor. He remained there until February 6, 1979, when he was released to the Brockville Psychiatric Institute.

i) Pre-Oak Ridge and index offence

[217] Mr. Belec was born on September 26, 1950. His father was an alcoholic who left his mother when he was two years old. He deposed that he was physically abused by his uncle when he was 5 years old and again when he was 15 years old. He was caught shoplifting when he was 14 years old and dropped out of school at 17 years old. A Probation Officer's Psychology Report dated September 26, 1968 indicates that he was a heavy drinker and "a restless young man who seems to have plenty of energy and drive but used it in the wrong direction… He has many positive features as well".

[218] On cross-examination, Mr. Belec related that in his early teens he developed an urge to become a hitman and kill other people. He explained that at that point in his life he began to wonder whether he "could kill another human being without any emotion." He perceived guilt as a weak emotion. In his affidavit, he deposed that he frequently committed minor offences in order to have the opportunity to tell the police about these urges in the hope that they would arrest him so that he would not actually kill anyone.

[219] Prior to his admission to Oak Ridge in his early 20s, Mr. Belec violently attacked two men in Saint John's but was never charged for this crime. He also committed a number of violent attacks on others in addition to auto theft, property damage, and attempted break and enter. A Cumulative

Summary of his personal history prepared at Brockville Regional Psychiatric Centre dated September 25, 1969 indicates that he was institutionalized on numerous occasions prior to being admitted to Oak Ridge. It also indicates that since the age of 14 he has felt guilty about his existence and the burden that he places on his mother, and that "he often wants to strike out and kill."

[220] Mr. Belec's index offence was murder of an elderly man on a street corner in downtown Toronto. The Cumulative Summary relates that he had been suppressing urges to kill until late November 1971, after a day of drinking alcohol:

> He was involved in the gay community from September to December 1971 and during that time he felt the constant urge to kill. This displaced aggression, as he puts it, was discussed quite frequently with the Salvation Army in Toronto and apparently these discussions served to stave off the subject's acting out his urge. However, on November 21st, 1971 the subject approached the Salvation Army again in order to get help with his urge, found them unavailable, returned to his lodging, secured a butcher knife and went to the Yonge Street area of the city looking for a suitable candidate to murder. He decided that he needed someone that no one would miss…

[221] In a personal history compiled of Mr. Belec at the Clarke Institute for Psychiatry in January 1972, it is indicated that several weeks after the murder Mr. Belec apparently again felt an urge to kill, but that this time he had not been drinking and so managed to control himself. He turned himself in to the police and made a statement admitting to the Yonge Street knife attack as well as "another vicious attack he had made on somebody". In January 1972, he underwent a pre-sentence assessment; on cross-examination he stated that at that time he received a provisional diagnosis of personality disorder-sociopathy, borderline state, schizoid personality antisocial traits.

[222] On February 11, 1972, during an assessment at the Clarke Institute, Mr. Belec stated he had "seriously thought of suicide many times, considering slashing, poison and overdose." The Consultation Report completed on that date indicates that Mr. Belec was diagnosed with antisocial personality disorder with the "strong possibility of psychotic breaks under stress or with alcohol as a disinhibiter, alcoholism (probably more related to his depression than to dependency)".

[223] On April 21, 1972, Mr. Belec was found "not guilty on account of insanity" and was committed to Oak Ridge pursuant to a Warrant of the Lieutenant Governor. His Interim History, prepared at the time of his admission to Oak Ridge, indicates that his diagnosis on admission was Borderline State Schizoid Personality and Antisocial Traits.

[224] On cross-examination, Mr. Belec conceded that at the time of his admission he presented with "subtle signs of illness" and demonstrated lack of remorse "for murdering an individual for no reason than feeling like doing so". A Clinical Record prepared shortly after his admission, on May 21, 1972, indicates that Mr. Belec "seems unable to appreciate the seriousness of his situation". It goes on to note, however, that "[o]n the ward he has been friendly and cooperative, especially to those in a position of authority."

ii) Experience in the STU

[225] The Clinical Records at Oak Ridge establish that Mr. Belec experienced frequent violent, murderous urges. He could quickly become a high-risk, dangerous patient who was described in a Ward Transfer Slip dated May 23, 1972 as a "very highly suicidal and homicidal risk." This risk was managed by means of confinement or restraints. In his examination in chief, Mr. Belec testified that while in confinement he was forbidden to speak with other patients, and that if he stood at the door of his cell and attempted to talk to patients or staff he would be given a shot of Nozinan. However, there is no Clinical Record verifying any such Nozinan injections.

[226] Again, on May 23, 1972 it was recorded that he threatened to kill a member of staff and slashed his arm with a pop can because he was suicidal and depressed as a result of being institutionalized. In cross-examination, he indicated that he began to tell staff and other patients when he had homicidal urges in order to be prevented from acting on them. This state of affairs was described in a Clinical Note recorded by a nurse on October 30, 1972, which on cross-examination Mr. Belec confirmed was accurate:

> The patients on G-ward feel Paul represents a risk. Staff agree he has been both homicidal and suicidal tendencies, which he has not overcome. They feel Paul does not know or seem to care why he gets these urges. Paul says the comment concerning his difficulty checking periodic homicidal feelings is true, but realizing that, he tells someone in a suitable check…

[227] While at Oak Ridge, Mr. Belec was subjected to all three of the STU programs in issue.

[228] The Ward Transfer Slips and Clinical Records for Mr. Belec evidence that he was in MAPP on a number of occasions, as follows:

From June 27 to July 13, 1972, Mr. Belec was sent to MAPP for a variety of reasons:

> On June 7, 1972, Mr. Belec stated he had a "desire to kill Dr. Camunias yesterday." On cross-examination Mr. Belec explained that he was angry at the time at Dr. Camunias for suggesting he read the Bible.
>
> On June 13, 1972, Mr. Belec was sent to MAPP because he had taken the "screws out of mop wringer handle so he could kill someone. Spoke about having fulfilled his commitments to God and was now working for the devil. He is going to put on an act to get out of here and then get a machine gun and use it on people."
>
> The Clinical Record of June 24, 1972 notes that a "t-strap" was applied to contain Mr. Belec.

From December 12 to 15, 1974. Mr. Belec was sent to MAPP by Dr. Maier for calling night staff a 'pig'.

[229] The records also show that Mr. Belec was placed in double cuffs on a number of occasions, generally after engaging in violent behaviour or making violent threats. The first use of double cuffs is recorded in the Clinical Record of June 13, 1972, and was prompted by Mr. Belec

threatening to "get a machine gun and use it on people". When asked about this in cross-examination, Mr. Belec stated that attendants had ordered other patients to place him in turkey straps after testing to see if he slipped out of less severe restraints.

[230] Again, the Clinical Records show that Mr. Belec was in the Capsule on the following occasions:

> Approximately June 13-21, 1972;
>
> For a period in January 1973, after signing a Capsule Therapy Contract dated January 23, 1973;
>
> For a period in February 1973, after signing a Capsule Therapy Contract dated February 13, 1973
>
> While in the Capsule in February, 1973, Dr. Maier ordered a Dexamyl treatment to be given in spansule form for a week;
>
> For a period in August 1973, after signing a Capsule Therapy Contract dated August 11, 1973;
>
> September 17 to October 1, 1973;
>
> October 22 to November 5, 1973, after signing a Capsule Therapy Contract dated October 18, 1973;
>
> December 17 to 30, 1973;
>
> February 1 to 3, 1974;
>
> August 8, 1975; and
>
> For an indiscernible period in March, 1976 after signing a Capsule Therapy Contract dated February 26, 1976.

[231] Mr. Belec testified that the Capsule experience was highly uncomfortable due to crowding, lack of hygiene, poor climate control, a strictly liquid diet, and the 24-hour lighting. He also indicated that it was a demeaning because of the forced nudity:

> The whole experience was demeaning as well as many other – other situations. I mean, the – the idea was to – to lower your inhibitions and strip you, you know, literally and figuratively, of – of your defences, right? And – and you could see the transition. When you first go in, you know, everybody's got their legs crossed, and they're protecting their privates, you know, because it's not a natural thing to be exposed like that, you know, especially with men that have questionable backgrounds, you know?

[232] It was Mr. Belec's evidence that the MAPP was a punitive program and that he was coerced into participating in the Capsule and DDT programs. He only "volunteered" because he was goaded to do so, to use Dr. Barker's word. That is, he was convinced by the Doctors that he would derive some benefit in the form of an eventual release from custody.

> Q. And so, the same thing I was coming to with DDT, did you have any ability to say, 'No,' to those...
>
> A. Well...
>
> Q. ...drug programs that you were subjected to?
>
> A. Free choice was – was a myth because what – what they would – would tell you is, 'You can refuse, but you'll never get out,' you know? So, you know, it's – it's kinda being coerced, like...
>
> Q. And in terms of the Capsule – you're in the Capsule 10 times, and you described the...Capsule. Why - why did you volunteer... to go to the – or did you volunteer to go to the Capsule?
>
> A. I – I did volunteer, and I did that on trust of what I was told the benefits would be. And also, I wanted to be looked on as, you know, a champion of – the motivating – or the – you know, the – at the front line of this, you know, breaking therapy, you know?

[233] Mr. Belec's Treatment Records from Oak Ridge record the following DDT treatments:

> Dexedrine on June 12, 1972, ordered by Dr. Barker;
>
> Dexamyl on June 21, 1972, ordered by Dr. Barker;
>
> Dexamyl every day from October 13, 1972 to November 5, 1972, ordered by Dr. Maier;
>
> Dexamyl-Tofranil every day from November 6, 1972 to November 24, 1972, ordered by Dr. Maier;
>
> Dexamyl every day for one week from February 14, 1973, ordered by Dr. Maier;
>
> Dexamyl every day for seven weeks from February 21, 1973, ordered by Dr. Maier;
>
> Scopolamine every day for two weeks from June 5, 1973, ordered by Dr. Maier;
>
> Tofranil for three weeks from September 26, 1973, ordered by Dr. Maier;
>
> Dexamyl-Tofranil for seven weeks from November 2, 1973, ordered by Dr. Maier;

> Dexedrine 15 mg with LSD 275 mcg on January 2, 1974, ordered by Dr. Maier;
>
> One Dexamyl spansule on March 12, 1974, ordered by Dr. Maier;
>
> Sodium Amytal with Methedrine on March 13, 1974, ordered by Dr. Maier;
>
> One Dexedrine spansule on March 13, 1974, ordered by Dr. Maier;
>
> Dexamyl for seven weeks from February 11, 1975, ordered by Dr. Maier;
>
> Sodium Amytal with Ritalin on April 17 and 18, 1975, ordered by Dr. Maier;
>
> Dexedrine 15 mg with LSD 300 mcg on August 8, 1975, ordered by Dr. Maier;
>
> Dexedrine on September 8, 1975, ordered by Dr. Maier;
>
> Sodium Amytal with Ritalin on January 14, 23, 26, 28, and 30, 1976, ordered by Dr. Maier;
>
> Sodium Amytal with Ritalin on February 5 and 19, 1976, ordered by Dr. Maier;
>
> Tofranil daily from March 20 to April 6, 1976, ordered by Dr. Maier;
>
> Scopolamine with Ritalin on three nights per week for three weeks from June 1, 1976, ordered by Dr. Maier; and
>
> Alcohol treatment on July 22, 1976, ordered by Dr. Maier.

[234] Mr. Belec testified that after the first LSD treatment he was "more confused than ever", having experienced "inner turmoil" in which his mind was "conflicted between good and evil". He also testified that he fell into a depression following his second LSD treatment, and in his affidavit deposed that as a result of the LSD sessions he began feeling "electric sensations in my body all the time." Mr. Belec further explained that his depression occurred as the effects of the LSD wore off because he was "looking for answers and all I got was kind of a nihilistic response to everything."

[235] Mr. Belec testified that he underwent a 6-month preparation period for his combined LSD and Capsule treatment, and that this was necessary because he feared taking this drug:

> But there's also – the literature that's provided for you is on eastern religion. I think there was some – some stuff on Huxley and - and people that were familiar with LSD. So, they – they did provide a – some information because I was a little reluctant to even take LSD 'cause I had heard horror stories about LSD.

[236] Mr. Belec acknowledged that the LSD treatment was "voluntary", and that he had vacillated between wanting to go through with it and not wanting to do so. With Dr. Maier's encouragement, he eventually decided that he wanted to proceed with the LSD:

> Q. Doctor Maier in fact told you that LSD was voluntary to take, correct?
>
> A. Right. Although as I expressed this morning, I did have some reluctance and, you know, with some gentle coaxing and encouragement, encouraging me to actually go through with having the – the LSD.

[237] On cross-examination Mr. Belec agreed that his condition eventually began to improve while on the STU, although he did not attribute this improvement to the impugned programs. Indeed, quite the contrary:

> Q. Now, at this point, Mr. Belec, you're on G-ward and eventually you did make some considerable progress while you were on G-ward, correct?
>
> A. Correct.
>
> Q. And to use your words at your examination for discovery in this case, you 'thrived on G-ward', right?
>
> A. I thrived on G-ward?
>
> Q. Yes.
>
> A. Yes. Once I got off the medication that they put me on, yes, Largactil and Stelazine, once I got off that.
>
> Q. Once you got off that, you did thrive?
>
> A. Right.

[238] According to his Discharge Summary dated February 6, 1979, Mr. Belec was released from Oak Ridge and sent to Brockville Psychiatric Hospital. His discharged was based on the Penetanguishene administration's opinion that he no longer required a maximum-security institutional setting.

iii) Post-Oak Ridge experience

[239] In Mr. Belec's affidavit, he described continuing to feel the LSD sensations years after his discharge from Oak Ridge. Indeed, he described the sensations he felt his immediate post-Oak Ridge years rather vividly:

> From September 1979 to June 1983, I was in Millhaven Correctional, where I was diagnosed with Paranoid Schizophrenia. From June 1983 to November 1983, I was in Joyceville Institution. I told a psychiatrist there, Dr. Carpenter, that I felt electric sensations in my body all the time, and that these and other symptoms were worsened by the earlier drug treatments at Oakridge. I would lose control of my body and that would cause me to act violently.

[240] Four months after he was transferred to Brockville, Mr. Belec stabbed a fellow patient with a pair of scissors. A Clinical Note dated June 4, 1979 indicates that Mr. Belec reported that he had been thinking about killing someone for the past several months, even before leaving Penetanguishene. As with his index offense in 1972, the Clinical Note maintains that, "These thoughts of violence were directed consistently towards males with no family attachments who were judged, by Mr. Belec's standards, to be essentially worthless."

[241] He was charged with attempted murder and following a guilty plea was sentenced to life in prison. Mr. Belec testified that he did not want to pursue what was then called an insanity defence because he did not want to return to Oak Ridge. He told an Advisory Review Board in June 1979 thatat Oak Ridge he "was driven psychotic through drug therapy and other things." As Mr. Belec put it in responding to questions from the Board, "Millhaven is better for me. It's the lesser of two evils, isn't it?"

[242] Mr. Belec was transferred back to Penetanguishene in June 1972, where he stayed until August 1986 when he was sent to the Joyceville Correctional Institute, only to be re-admitted to Oak Ridge in September 1989. In an Ontario Review Board decision dated April 2, 1992, Mr. Belec was described as a dangerous person: "while there was no evidence of delusional thinking there could be no doubt that Mr. Belec is seriously disturbed individual with considerable potential for dangerous and unpredictable behaviour": *Re Belec,* File No. 4594-233/92, p. 6 (Ont Rev Bd).

[243] The Review Board related that in 1990, he was convicted of forcible confinement and aggravated assault of a female member of staff who he had taken hostage with a sharpened metal pipe. In explaining his actions, Mr. Belec sated that he had taken the hostage in order to compel the Lieutenant-Governor "to issue a letter promising not to release any more pedophilic sex offenders from Oak Ridge": *Ibid*., p. 5.

[244] Mr. Belec deposed that he was again released from Oak Ridge on July 6, 2009 and admitted to the Ontario Shores Centre for Mental Health Sciences. In an Ontario Review Board decision dated May 15, 2015, Mr. Belec described as having made significant therapeutic progress and would have been ready for full release into the community; however, in March 2015, while Mr. Belec was on a day pass from the institution, a staff cleaner found in his room a twelve inch chef's knife taped to a metal portion of the bed frame.

[245] Also found in Mr. Belec's room at Ontario Shores was a 4-inch razor blade, several months' worth of the antidepressant Citalopram which Mr. Belec had been hoarding instead of regularly taking, a pair of pliers, some crazy glue and sewing needles and yarn: *Re Belec*, 2015 CarswellOnt 9350, at paras 8-9 (Ont Rev Bd). The Board found him to be a manipulative person, with "a personality disorder that includes psychopathic traits, antisocial traits and narcissistic traits": *Ibid*., at para 24.

[246] In cross-examination at the trial herein, Mr. Belec agreed that he had trained himself to be a "people pleaser", presenting whatever face he intuited that they wanted to see. As he put it:

> [T]he persona that I present is usually to keep myself safe from – from other people, and this was a result of all the treatments that I had at Oakridge that I no longer

> viewed the world as a safe place and - and so therefore, I had to create this - this persona that would - would appease everybody around me...

[247] Needless to say, it is not easy to tell whether this statement itself is but one more example of the "people pleasing" personality that Mr. Belec has donned. In any case, a letter from his criminal defence counsel that is in the trial record indicates that Mr. Belec "entered a plea of guilty to Possession of a Weapon for Purpose Dangerous to the Public Peace on Wednesday, July 15, 2015."

[248] Mr. Belec is currently serving his sentence at Millhaven Institution. He confirmed in cross-examination that his most up-to-date diagnosis is that he suffers from Anxiety Disorder, Major Depressive Disorder in remission, Alcohol Abuse in remission, Personality Disorder, Mixed Type with Antisocial, Schizotypal, Narcissistic and Borderline features, with Obsessive-Compulsive Disorder. He has spent his entire adult life in one institution or another.

iv) Causation and harm

[249] Dr. Booth was the Defendants' expert witness who examined Mr. Belec's records with a view to assessing any harm caused by the Oak Ridge experience. In his testimony he explained that if the question is what is the significance of the experience the patient has had, he looks for signs that there was a distressful situation that really stayed with the patient over time. In that case, it would likely come out in dealings with subsequent psychiatrists or other mental health professionals.

[250] In Dr. Booth's view, the only one of the four Plaintiffs whose post-Oak Ridge records he examined that seemed to pursue the matter was Mr. Belec. Dr. Booth acknowledged that Mr. Belec has long attributed symptoms he continues to suffer to the LSD used at Oak Ridge in the 1970s.

[251] Having said that, Dr. Booth expressed considerable skepticism at Mr. Belec's post-Oak Ridge claims. For example, he doubted the veracity of Mr. Belec's reports of energy surges attributable to the LSD experiences. He also noted that Mr. Belec has intentionally rejected anti-depression medication, which suggests to him that there are no real long-term effects of the STU programs.

[252] On the other hand, Dr. Booth does concede in his Report dated April 2, 2019 that there are expert studies that indicate that "hallucinogen persisting perception disorder ("HPPD") is a known, albeit rare, phenomenon "persisting for months or years after using a psychedelic drug." He also states that he agrees with Dr. Bradford's view that LSD use can cause acute psychosis, although he qualifies this by indicating that "[t]here is no consensus in psychiatry that LSD can trigger schizophrenia and instead might trigger acute, short-lived psychotic experiences related to intoxication with the substance."

[253] Dr. Booth's overall approach is to examine the trajectory that an individual was on earlier in life, take note that they had a blip in their pattern of behaviour (i.e. a violent incident or index offence), and then look at whether the trajectory changed after Oak Ridge. He testified that the

analytic question for him is: are the current symptoms, social adjustment, employability, etc. all part of the problem they would have had absent the impugned Oak Ridge programs?

[254] Dr. Booth opines that Mr. Belec was genetically pre-disposed to alcohol problems. His father was an alcoholic and Mr. Belec's worst offences (although not all of them) were committed while he was inebriated. Dr. Booth also takes note that Mr. Belec had a high violence potential prior to Oak Ridge and that he already showed at a young age a number of mental health issues. With this trajectory in mind, Dr. Booth states that the Oak Ridge program did not change the course of Mr. Belec's life.

[255] In coming to this conclusion, Dr. Booth notes the following factors which tend to support Mr. Belec's claim of harm:

> Mr. Belec voiced distress from the treatments at the time they were administered and appears to have become suicidal a short time afterwards.
>
> Mr. Belec's mother felt the program was worsening her son.
>
> These types of programs have the potential for being psychologically stressful, which has an elevated likelihood of causing harm in psychologically vulnerable individuals.
>
> Mr. Belec has consistently described physical sensations and worsened depression which he attributes to the program.
>
> If the factfinder puts weight on Mr. Belec's report, then he appears to have wanted to avoid returning to Oak Ridge in 1979 due to fears of returning to the program.
>
> Despite mixed feelings and at times advocating for the Oak Ridge programs, Mr. Belec has been seeking out compensation since the early 1980s suggesting that he experienced distress from the programs.

[256] As against these, Dr. Booth indicated that in his view there was "more significant evidence suggesting that although there was a potential for the programs to cause significant harm, Mr. Belec was not significantly harmed by the programs." These factors include:

> Mr. Belec had significant genetic loading for mental health issues and comes from a disrupted environment. He showed behavioral difficulties and alcohol use problems at an early age suggesting likely anxiety and depression prior to the programs.
>
> Mr. Belec had very violent tendencies prior to the program on numerous occasions. It would be a stretch to suggest that the treatments worsened this already high-violenced propensity…
>
> While the medications administered can cause short-term side effects including hallucinations, delusions, emotional dysphoria, anxiety and other problems, these

> primarily incur during intoxication. There is limited evidence to suggest long-term changes in brain function or in worsening psychiatric conditions from limited exposure.
>
> Some evidence would suggest that Mr. Belec may have had some of the somatic energy experiences, depression, anxiety and disorganized thinking prior to exposure to the Oak Ridge program.
>
> …While it is possible that the Oak Ridge program was a stressor causing a relapse of depression and subsequent worsening of depression severity, this occurs routinely in individuals who are not in such programs. Although there is a temporal relationship of his suicidality and emotional distress to worsening in the Oak Ridge program, Mr. Belec had a number of other psychological stressors that could equally have caused or contributed to his mental state.
>
> Despite his voicing depression, anxiety and other issues, Mr. Belec intentionally hoarded antidepressant medications, suggesting that he was not having any long-term effects related to the Oak Ridge program.

[257] With the greatest of respect, the factors listed by Dr. Booth supposedly indicating that there was no harmful effect of the Oak Ridge programs on Mr. Belec simply do not add up to that conclusion. For the most part, Dr. Booth appears to be of the view that a damaged person cannot be more damaged. The fact that Mr. Belec had violent episodes prior to Oak Ridge does not meant that he did not suffer an increase in his inability to control his violent urges after having been subjected to painful and mind-altering substances in inhumane conditions.

[258] Further, the fact that Mr. Belec abused alcohol prior to his admission to Oak Ridge certainly did not make him immune to alcohol abuse at Oak Ridge itself. The notion that one cannot harm an alcoholic by giving him "alcohol treatments" such as those administered to him as part of his DDT is one that simply does not make sense. Indeed, all logic suggests that an alcoholic patient would be far more harmed by being force-fed alcohol in large quantities than a non-alcoholic patient.

[259] Moreover, the "temporal relationship of his suicidality" to the Oak Ridge programs cannot be understated. Mr. Belec was given LSD at Oak Ridge and experienced suicidal thoughts afterwards. To suggest that this type of emotional torment may have just been a coincidence of timing is to deviate from the evidence and, indeed, from what Dr. Booth himself suggests is the all-important trajectory of Mr. Belec's life experiences. While it is true that, as Dr. Booth says, "a number of other psychological stressors that could equally have caused or contributed to his mental state", those stressors in the 1970s when these events occurred would have been the other STU programs. It is difficult to imagine that the DDT drugs combined with non-drug stressors that were somehow even more stressful than, for example, the MAPP. The combination of programs experienced by Mr. Belec in the STU at Oak Ridge doubtless had a cumulative damaging impact on him.

[260] I do take Dr. Booth's point that Mr. Belec's recidivism as a criminal probably has more to do with his pre-existing psychiatric disorders than it does with the several years of hardship he underwent at Oak Ridge. With that, however, it has to be acknowledged that Oak Ridge plays heavily on Mr. Belec's mind years and decades later. Dr. Booth concedes that "if the factfinder puts weight on Mr. Belec's report, he appears to have done everything possible to avoid returning to Oak Ridge. I certainly put weight on that particular assertion by Mr. Booth; after all, given the choice between a hospital and a penitentiary, choosing to serve custodial time in prison speaks volumes about the fear of the hospital setting. Mr. Belec's serious aversion to Oak Ridge is not a product of his manipulative personality. It is real."

[261] It is obvious to me that Mr. Belec suffered substantial psychic pain during and after Oak Ridge, especially as a result of the DDT program and the LSD component thereof. With all of his reading about this drug in the 1970 pop culture books with which he was provided by Dr. Maier, nothing could have prepared him for a mentally disorienting, identity losing, suicide provoking experience that his LSD treatments turned out to be.

[262] The Oak Ridge experiences with DDT, Capsule, and MAPP may not have been the ultimate cause of the Personality Disorder, Mixed Type with Antisocial, Schizotypal, Narcissistic and Borderline features with which he has been diagnosed. But they sure hurt.

[263] The STU experiences caused Mr. Belec acute psychological pain, indignity, and harm in the short term. They also caused him more protracted, if somewhat subdued pain in the long term. Drs. Barker and Maier were directly involved in his treatments.

c) Eric Bethune

[264] Eric Bethune was born Jean-Jacques Berthaume in Montreal in 1948. After committing a rape at knifepoint, he was committed to Oak Ridge as an involuntary patient under the *Mental Health Act* on July 12, 1967. He remained there until discharged on September 2, 1969.

i) Pre-Oak Ridge and index offence

[265] Mr. Bethune deposed in his affidavit that he was given up to foster care by his parents at a young age and that he spent his childhood moving from one foster home to another. He frequently had to spend time in detention centres in between foster homes, which was a frightening experience. He relates that his highest level of education was grade 5, which he attained at the age of 15.

[266] In his affidavit, Mr. Bethune describes moving from job to job in an unstable teenage life. A variety of contemporaneous institutional and medical records indicate that he has suffered from severe depression, fits of rage, and suicidal thoughts since he was 16-years old, although under cross-examination at trial he denied that the diagnosis of depression was accurate. He described himself as a "rebellious child" who was unprepared for adulthood in his later teenage years.

[267] The medical records appended to his affidavit show that in 1965, Mr. Bethune was admitted to the St-Jean-de-Dieu psychiatric hospital. At the age of 17, he was diagnosed with inadequate personality disorder and depressive reaction. Shortly thereafter, he fled St. Jean-de-Dieu and was

charged with attempted rape, which he committed in the course of a home invasion in Winnipeg. He was then admitted to the Philippe Pinel Institute in Montreal on October 12, 1965, where he remained until January 1966. At Philippe Pinel, Mr. Bethune's condition was described in his medical chart:

> The psychological examination displayed a conclusion compatible with a profound obsessional neurosis accompanied with character and behaviour disorders and associated with paranoid elements. As a conclusion, it is our impression in this case the diagnosis of a psychotic process is not to be retained but a severe character neurosis has long developed which might deteriorate, if this patient is not suitably helped.

[268] On June 19, 1967, Mr. Bethune, armed with a knife, broke into the home of a woman who was alone with her two young children, took her to the basement of the house and raped her. He related to his doctors at Whitby Psychiatric Hospital the following month that he struggled with the woman over the knife, and then fled the house and broke into four neighbourig houses. Mr. Bethune was captured and on July 5, 1967 and charged with rape and eight counts of break and enter. He was committed to Whitby on a 60-day Warrant of Remand.

[269] A Clinical Record from Penetanguishene dated August 9, 1967 relates that at Whitby Mr. Bethune was an aggressive patient. He is recorded as having attacked and threatened to kill staff members and as attempting an escape. Medical staff at Whitby ultimately referred him to the Penetanguishene Mental Hospital.

[270] The Clinical Record also indicates that, "He says that he raped many girls varying in age from 14 to a woman over 60, but has only been caught four times. He lived with many females until he tired of them…but he prefers to have relationships against a girl's will, because he feels that this is more satisfactory and he gets a kick out of it."

ii) Experience in the STU

[271] On his Admission Certificate to Oak Ridge dated September 1, 1967, Mr. Bethune was interviewed. The interviewer observed: "[H]e feels he will violently rape other girls in the future as he has in the past, unless he receives treatment." Mr. Bethune testified that he believed at the time, and continues to believe today, that Dr. Barker encouraged him to participate in the STU programs by promising him a reduced sentence. In his affidavit, he deposed that Dr. Barker told him to plead insanity so his detention at Oak Ridge could be extended.

[272] Counsel for the Doctors observes that given Mr. Bethune's history of psychiatric illness prior to Oak Ridge, there is no reason to believe Dr. Barker was incorrect in his belief that the patient was mentally ill. They also point out that there is no documentary evidence supporting Mr. Bethune's assertion that Dr. Barker promised him less jail time in exchange for participating in the STU program.

[273] Nevertheless, Mr. Bethune has long held this belief about being manipulated by Dr. Barker. In an social worker's Oak Ridge Progress Note dated June 18, 1969, Mr. Bethune expressed the same thought:

> Recently it was determined with this patient's consent, that arrangements be made to return him to trial. Although agreeable to this the patient has expressed considerable anxiety as to the verdict of his hearing. He feels that he is not mentally ill and wishes, if convicted, to go to prison. He, however, suspects that Dr. Barker believes him mentally ill and wishes him to plead insanity at his trial and return here for treatment. He gives as a rationale for this suspicion a conversation between himself and Dr. Barker a few months ago, while the patient was on G ward, before his transfer to E. He states that Dr. Barker at this time told the patient that he was mentally ill and required continued treatment.

[274] Mr. Bethune deposed that he did not give his consent to any of the STU treatments because they were not effectively explained to him and in any case the consent forms were in English, a language in which he was not then proficient. He did concede on cross-examination, however, that there were other French speakers at Oak Ridge who could assist with interpretation, and that he generally had someone translate for him when it came to information about medication. In his affidavit, Mr. Bethune reiterated that the medical staff used "fear as a motivation to commit patients to the experiments."

[275] In his affidavit, Mr. Bethune states that he was put in the Capsule several times. But unlike other patients, there do not appear to be any Clinical Records recording that. In testifying in chief, he stated that he recalls being in the Capsule and receiving an injection with some drug that he cannot identify that caused him delirium. He also testified that he was in the Capsule naked with other patients. In cross-examination, he related that at some point he told Dr. Barker that he would not re-enter the Capsule again and refused to do so. Without any medical records documenting these events, there is no corroborating evidence for any of it.

[276] There is no evidence that Mr. Bethune was never sent to MAPP, and in cross-examination he stated that he does not recall being in MAPP. However, the Clinical Records record that he was difficult for the staff to handle and that they implemented security measures to prevent him from acting violently toward staff and other patients. As an example, the Clinical Records from January-March 1968, all written by either a duty nurse or medical attendant, provide:

> Jan. 25, 1968 – This patient was upset today and threatened to punch out windows. He was placed on cuffs and more settled in the evening. His medication is Largoctil Concentrate 100 mgs., q.i.d., Stelazine Concentrate 5 mgs, q.i.d., Cogentin 2 mgs. daily. He has a standing order of Nozinan 50 mgs., q.i.d., p.r.n.
>
> Jan. 26, 1968 – This patient became disturbed when refused privileges by staff. He was confined to Room #10.

> Jan. 27, 1968 – This patient became belligerent, threw six glass stoppers out the window, and one in his hand, threatening anyone to come into his room. He was overpowered and move to Room #2. He was quiet for the rest of the evening.
>
> Jan. 29, 168 – This patient was taken to 'F' Ward during the off-work periods. Attends all ward functions with double cuffs and with observers.
>
> Feb. 9, 1968 – This patient was disturbed. Overpowered and moved to stripped room #2. Given 50 mgs. Nozinan at 1:10 pm. Has no privileges. Must attend all ward functions.
>
> Feb. 10, 1968 – This patient's right hand is swollen. Surgery notified and was checked by surgery staff.
>
> March 26, 1968 – Was put in leg cuffs for attempting to fight with patient Brenner.

[277] Mr. Bethune also testified about his participation in DDT. He testified that he did not know what drugs to expect in this program. As he put it, "There was never mention that we were going to be given ten different drugs or more or possibly LSD…" He indicated that he understood that the purpose of the drug therapy was to "alter your mind and break down your defences so you could, you know, be easily molded back to what society would allegedly accept".

[278] It does not appear from the Clinical Records that Mr. Bethune was ever given LSD. The Clinical Records and Treatment Records record that he was given the following DDT drugs, all prescribed for him by Dr. Barker:

> Sodium Amytal on April 2, 1968.
>
> Dexedrine on February 29, 1968; March 14, 30; April 11, 19, 20, 23, 24, 1968; and May 3, 4, 11, 12, 13, 14, 18, 19, 22, 23, 24, 1968.
>
> Dexamyl spansules on April 1, 28, 1968.
>
> Methedrine on April 2, 16, 17, 30, 1968, May 6, 10, 29, 1968; and June 24, 1968.
>
> Scopolamine on April 2, 4, 1968; and May 10, 29, 1968.

[279] Mr. Bethune claims in his affidavit that his experience with the DDT treatments was very stressful to him, and that it was made worse by being confronted by other patients. Although, as mentioned above, it does not appear from the Clinical Records that Mr. Bethune's DDT sessions actually took place in the Capsule, his description of the personally challenging nature of the sessions conforms with what Doctor Hucker calls "confrontational therapy". Mr. Bethune described the impact of the DDT experience:

> The effect of the drug experimetations has been lasting. I still have nightmares about the delirious episodes I experienced at Oakridge during these drug experimentations. The drug experimentations made me paranoid about everything.

> To make matters worse, these experimentations also involved fellow patients, who were called 'teachers', confronting me about very private matters. These confrontations were often abusive and did not stop until I was able to give them the answer they were looking to hear.

[280] In his Discharge Summary dated September 2, 1969, it is indicated that Mr. Bethune was discharged from Oak Ridge as he was not responding to treatment. It was also determined that he was fit to stand trial. Mr. Bethune's diagnosis on discharge from Oak Ridge was Pathological personality, Antisocial type.

iii) Post-Oak Ridge experience

[281] Mr. Bethune has set out his criminal history in his affidavit. In November 1969, Mr. Bethune was found guilty of the index offence that sent him to Oak Ridge in the first place and sentenced to 4 years in prison. He has had several repeat crimes since that time. In 1985, he was convicted of sexual assault with a weapon and was sentenced to 3 years in prison. In 1989, he was convicted of theft under $1000 and in 1995, he was convicted for criminal harassment. In cross-examination, he indicated that he has never received any psychiatric care since leaving Oak Ridge.

[282] Mr. Bethune's family life has been very stable in recent decades. He lives in Vacouver and is in a long-term relationship with his former wife which has lasted for more than 30 years. He explained in cross-examination that he is committed to looking after his partner now that she is suffering some age-related health problems. He also has had a good relationship with his wife's children, although they have both moved away and are only in limited contact.

[283] Mr. Bethune testified that he made efforts to continue his education in his post-Oak Ride years. He indicated that he began studies at the University of British Columbia at one point, but had to drop out of university because of the lingering negative effects of the DDT treatments on his mind. He testified that he did returned to school in 2010 and completed training as an immigration consultant. He also stated in cross-examination that he now speaks German and Dutch as well as French and English.

iv) Causation and harm

[284] Mr. Bethune was not in MAPP and, given the lack of documentary record of his being in the Capsule, I would conclude that he did not participate in that program either. But he certainly was part of the DDT and received a substantial amount of drugs as part of that program. Although he did not receive LSD, and so was spared the most outlandish aspect of the drug treatments, he received a number of other drugs that are both dangerous and severely stress-inducing. Specifically, he received several doses of Scopolamine and numerous doses of Methedrine.

[285] In "Defense Disrupting Therapy", Dr. Barker wrote that "the joint use of scopolamine and methedrine is probably of greatest value in loosening the rigidly implanted patterns of behavior behind which many patients hide the turmoil of their disorders". On the other hand, Dr. Bradford in his Report advised that "the use of drugs such as Methedrine, Scopolamine, Dexedrine, and Sodium Amytal was against the accepted forms of psychiatric treatment". Dr. Bradford opined

that, "[w]hether these drugs were used singularly or in combination as 'demystifying drugs', in my opinion this was experimental and the potential for harm was extremely significant."

[286] In commenting on the patients that he evaluated, Dr. Booth acknowledged in cross-examination that severe pain is one known side-effect of Scopolamine. As for Methedrine, it is a renowned and dangerous drug which several of the Plaintiffs stated in their testimony that they used on the street prior to admission to Oak Ridge. Clinical Records for Joseph Bonner, for example, indicate that he was under the influence of Methedrine when he committed some of his pre-Oak Ridge crimes, while Stanley Kierstead testified that he was a street drug dealer who manufactured Methedrine.

[287] Dr. Hucker examined Mr. Bethune's records and agrees that the combination of Scopolamine and Mehedrine could be dangerous. In his cross-examination, Dr. Hucker conceded that there probably was no informed consent about these drugs, and that the records indicate that these drugs were by and large recommended by other patients, not by doctors.

[288] Plaintiffs' counsel also called Dr. Hucker's attention to Mr. Bethune's Treatment Records of May 1968, which recorded multiple days in sequence in which he was administered Methedrene, Scopolamine, Dexedrine, and Dexamyl, all of which caused sleep deprivation for 4 consecutive days, followed by another treatment for 3 consecutive days, and then repeated again. Dr. Hucker explained that the overall intention was to induce the disorientation that comes from protracted sleep deprivation, and agreed that in this context the drugs that Mr. Bethune was given amounted to "quite a nasty combination".

[289] Indeed, Dr. Hucker opined that with sleep deprivation, Scopolamine and Methedren would be very anxiety producing. In his words, "You become psychotic after a few days". He then confirmed that a patient would have long term memories of this experience. In a moment of understatement, Dr. Hucker testified: "It would be something they weren't likely to forget."

[290] Mr. Bethune's description of his DDT experiences match Dr. Hucker's description of what he understands Dr. Barker originally intended the drugs to do. That is, they altered his mind and broke down his defenses, causing him to experience not only severe stress but hallucinations, all while being deprived of sleep and while often restrained with canvass straps. Dr Hucker agreed on the witness stand that this treatment was inhumane. He opined, "It would certainly cause an acute toxic state."

[291] Dr. Hucker also conceded that the descriptions by Mr. Bethune of confusion and mental fragility later in life amounted to evidence of longer term harm from the DDT program. He explained that there may be some gaps in Mr. Bethune's memory of these events because the drug treatments may have been too horrible to think about. In fact, that was almost exactly how Mr. Bethune himself had responded to some of the lapses in his recollection of the Oak Ridge drug experiences: "I have a very good memory, but some things you don't want to remember."

[292] While the evidence only supports Mr. Bethune having been in one of the 3 impugned STU programs, that was enough to cause him substantial short term harm and at least some long term harm. The combination of drugs that he was administered, together with sleep deprivation and

frequently being placed in restraints while undergoing these experiences, caused him substantial pain and anguish at the time and have left their mark on him until today. While the DDT program did not cause the criminality that he has occasionally displayed subsequent to his Oak Ridge days – that tendency was present in his personality prior to his admission to Oak Ridge – it did make his ability to achieve a stable life that much more difficult.

[293] Mr. Bethune is fortunate to have a supportive marital relationship and a relatively stable home life in which to recover from his Oak Ridge experiences. But it has taken him the better part of 4 or 5 decades to attain his presently more sanguine state of mind. After all, Dr. Barker went out of his way to break down Mr. Bethune's mental defences, and by all accounts he succeeded. There is no indication in the record that those mental defences were built back up, and as a consequence Mr. Bethune was left in a mentally fragile state and prone to re-living the worst of the DDT episodes. That he has made something of his life in recent years is in spite of, not as a result of, the drug treatments he underwent at Oak Ridge.

[294] The Oak Ridge experience caused Mr. Bethune substantial short-term harm and lingering, although far more mild, long-term harm. Dr. Barker was directly involved in his treatments.

d) Joseph Bonner

[295] According to an Agreed Statement of Facts, Joseph Bonner was in Oak Ridge for less than a year as a 17-year old teenager, from March 24, 1971 to December 25, 1971. His admission was pursuant to a physician's application for involuntary admission under the *Mental Health Act, 1967*.

i) Pre-Oak Ridge and index offence

[296] Mr. Bonner's Agreed Statement, his affidavit, and his testimony at trial relate that he was born in 1954 and had a difficult childhood. His was raised by his mother who was an alcoholic, his father having died when he was 9 years old. He had a Grade 8 education at the time of his admission to Oak Ridge. As a young teenager, Mr. Bonner compiled a record of theft charges. He spent time in the Don Jail, where he was placed in solitary confinement as a result of exhibiting depression and suicidal tendencies. He also spent two months in the Guelph Reformatory when he was 16 years old, where he was abused by other inmates.

[297] A Clinical Record from Queen Street Mental Health Centre dated December 18, 1970 indicates that he had a history with street drugs, including LSD, speed (methamphetamine), cocaine, heroin, and morphine. It also notes that he twice attempted suicide but was caught, once by attempting to hang himself and once by slashing his writs. The doctor examining him at Queen Street concluded the Clinical Record with a rather negative prognosis for Mr. Bonner:

> [T]his is a 17-year old boy who gave indications of emotional problems in his early developmental years. During his early adolescence there were no suitable adult identifying figures, father dying when he was aged nine. Poor impulse controls developed. He has limited education and no vocational training. His problems have not been helped by his mother, who has been unable to meet his emotional needs. His immaturity has contributed to a life style of antisocial behaviour, being easily

> influenced by others in the culture he has chosen to associate with, with resulting drug abuse and dependence. The prognosis at this point in time is poor. He has already suffered a break with reality and a severe depressive state from the mixtures he has injected into himself.

[298] Upon admission to Penetanguishene, his Clinical Record recounts that other institutions have been unable to meet his psychiatric and behavioural needs:

> On March 11, 1971, he was returned to 999 [Queen Street Mental Health] for care because of serious suicida1 thoughts, but again he was impossible to handle and was returned to O.R. Guelph. The youth is a severe personality disorder with a chronic dependency on hard drugs. He is a definite suicidal risk and requires long term treatment with close observation tor the initial period.

[299] Mr. Bonner's Agreed Statement sets out that he was assessed at the Queen Street Mental Health Centre and was thereafter involuntarily committed to Oak Ridge on March 24, 1971, pursuant to a physician's application under the *Mental Health Act, 1967*. The immediate reason for the application, as set out in the Queen Street Re-Admission Note of March 23, 1971, was that Mr. Bonner had advised a psychiatrist that he was intending to commit suicide with an overdose of drugs. In his Agreed Statement, he relates that he was at the time provisionally assessed as having chronic depressive phase and personality disorder, or borderline psychotic state with associated depression due to pronounced drug ingestion.

ii) Experience in the STU

[300] Of the 9 months in total that Mr. Bonner spent at Oak Ridge, he was confined to his room/cell for 6 of them, intermittently. His Clinical Records from March 24, 1971 to December 25, 1971 indicate that he was a difficult patient who experienced drug withdrawals. He was deemed by staff to be abusive and a constant management problem. He was also considered a suicide risk who posed a danger to himself. Mr. Bonner agreed in cross-examination that he had an aversion to therapy at Oak Ridge, and so preferred being in his room. In particular, he explained that he was uncooperative because he disagreed with inmates who were put in charge of evaluating him.

[301] The Clinical Records from Mr. Bonner's time at Oak Ridge record that he was placed in confinement on the following occasions for the following reasons:

> May 15 to May 17, 1971, for breaking ward rules, disrupting groups, and 'acting in a highly subcultural manner'. after a number of warnings. One record indicates: 'Patient is in an acute anxiety state and all symptoms are psychomatic of a chronic addict.'
>
> June 7 to June 21, 1971, intermittently, for what was described as hostile and disruptive behaviour. One record indicates: 'Joe was confined for his overall attitude in the group and for his non-participation. When brought to the front about his reaction to the feedback of the group, he began blaming everyone else for his difficulties and not taking any of the blame for himself.'

> September 26, 1971, in a safe room under observation due to depression as a result of learning he would not return to Oak Ridge after his trial and would go to the street.
>
> October 18 to October 27, 1971, and returned until October 28, for being uncooperative and negative in groups and hostile to a patient acting as group coordinator.
>
> On November 7, 1971, after refusing to participate in a group program.
>
> On December 9, 1971, in a safe room on strip status after a staff member that he was reaching the point of breaking and requesting to go to another ward.

[302] There is some debate as to the meaning of "strip status", which Mr. Bonner testified was a frequent way in which he was confined. In cross-examination, counsel for the Crown suggested to him that this was a relatively safe and comfortable form of confinement. This description was derived from a document which the Crown has found in the Oak Ridge archives. Like many of the 'teaching' documents used as introductory materials at Oak Ridge, it seemed to bear no relationship to reality as described by the Plaintiffs or, indeed, as recorded by staff in the Clinical Records. The archival document was introduced by the Crown as follows:

> Q. Now, this document is called 'Rules and penalties for infractions'. I appreciate that it's – we don't know who the author was and we're not sure the date on the document, but this is in the document collections for Penetang. Have you ever seen this paper before?
>
> A. I've never seen this paper before.

[303] The Crown's document described "strip status" as a form of retreat, complete with therapeutic literature to read, movies to watch, smoking privileges, letter writing materials and postage stamps, and hospital-issued clothing. Mr. Bonner disagreed with virtually everything on the Crown's list of attributes, except for the fact that in strip status he was deprived of his own clothing and made to wear a smock. As Mr. Bonner put it:

> Q. There's some that you disagree with and there's some you agree are part of strip status?
>
> A. I'll – I'll give you the ones I disagree with…
> Wear hospital clothes only. Allow therapeutic literature. Allowed to watch H ward movies and week of promotional movies. Disagree, disagree, disagree. Not allowed to play off ward sports. Well, I'm not allowed to play off ward sports anyway. Allowed smoking materials, stamps, tokens only. I not allowed any smoking or - or any of that stuff in - in - and then therapeutic literature *[indiscernible]*. All of this, I disagree with. The only one I agree with is move to safe room which is – I don't consider a safe room. It's solitary confinement.

[304] Mr. Bonner transferred wards on December 16, 1971 after telling staff that he was going to "crack up". He was discharged from Oak Ridge 10 days later, on December 26, 1971 into the care of his mother, following a visit by his mother who was described by staff as distressed with his condition. Ms. Bonner wrote to Dr. Boyd on December 20, 1971, describing her son as being held in confinement on restraints and indicating that he appeared to have deteriorated from her last visit the previous month. This was investigated and discussed by Drs. Boyd and Barker, after which Mr. Bonner was discharged into his mother's care. The Clinical Record of December 21, 1971 states that a social worker "carefully explained…that he was being released against medical advice".

[305] Counsel for the Doctors makes the point that the confinement of Mr. Bonner was different than solitary confinement as practiced in penitentiaries, especially during the early 1970s era. They point out that he was consistently taken out of his room to participate in groups. While that may be literally correct, Mr. Bonner's response to the group therapy sessions, where he was at the mercy of other inmates suffering from antisocial personality disorders and other psychiatric ills, makes this a distinction without a difference. Mr. Bonner came into Oak Ridge as a depressive youth who had been bullied and driven to several suicide attempts by inmates at the Don Jail and Guelph Reformatory. To put him in confinement only to be removed so that he could be subjected to groups of other psychotic patients dubbed "patient teachers" is not in substance different – indeed, may have been worse – than putting him in solitary confinement all day long.

[306] Mr. Bonner participated briefly in the DDT program. Treatment Records indicate that he received Dexamyl-Tofranil from May 26 to June 7, 1971 at the instruction of Dr. Barker. The record contains an undated, handwritten letter from Mr. Bonner to Dr. Barker requesting an Amytal Methedrine treatment. As previously indicated, Mr. Bonner had experience with Methedrine as a street drug. He specifically requested not being put in the Capsule for this treatment, but volunteered that he would be willing to do it in a group. Mr. Bonner's Agreed Statement indicates that he was in the Capsule for 3 days, October 21-24, 1971.

[307] The record contains no indication that Mr. Bonner was ever in MAPP, although he testified that he recalled being there. In cross-examination, he suggested that his records might be missing this entry:

> Q. During your examination-in-chief, you said that you were in the MAP program?
>
> A. Yes.
>
> Q. And, when I look at your clinical record, there's no mention of the term map.
>
> A. Okay. I didn't have anything referred to map. I wasn't told I was in map, but I do recall being put in a room with four or five inmates and you can't move, is – is that what you're talking about?
>
> Q. And if I – if I told you that in all of the other plaintiff's records where they were in map, the words MAP appear in their clinical records.
>
> A. I guess they didn't put it on mine.

> Q. And they – they don't have it in yours. I want to suggest that you weren't in map.
>
> A. I have to suggest that I was because it's – it's exactly what I was doing. I was sitting on the floor, not being able to move and if you did you were taken out, put into confinement.

[308] It seems unlikely that Mr. Bonner's Clinical Records would have left out his being sent to MAPP. Those records from Oak Ridge are, generally speaking, thorough and detailed with respect to the Plaintiffs' participation in the 3 programs at issue here. It is more likely that Mr. Bonner either heard descriptions of MAPP and has transposed it to himself, or he is describing an ordeal he encountered in a group therapy session that was not, strictly speaking, a MAPP session but borrowed some of the more difficult MAPP elements.

iii) Post-Oak Ridge experience

[309] On December 23, 1971, Dr. Boyd wrote a letter to Mr. Bonner's mother, the crux of which was:

> We feel that your boy ought to receive further treatment in the program at Oak Ridge. We doubt very much if he is going to be able to adjust outside, but it does not appear that he would present a danger to other people. In view of this we are prepared to allow you to take him home against medical advice.

[310] The medical advice was poor advice. After receiving "treatment" that consisted of 6 out of 8 months in confinement in his cell, Mr. Bonner left Oak Ridge and embarked on what by any description has been a successful life.

[311] Mr. Bonner managed to gain employment within the first year following his Oak Ridge experience, and in his testimony related that he has held a number of jobs since that time. His Canada Pension Plan statements were put to him in cross-examination, and they show that he initially earned in the range of $30,000 annually, which by 1994 had increased to $77,221 and $90,000 in 2003. In 2005, he earned $108,000 annually and by 2006 he was earning $162, 825 on an annual basis. Mr. Bonner is now retired and resides in Halton Hills, Ontario. In his affidavit he describes a comfortable and stable home life, living with his common-law partner of more than 20-years. He has never sought any psychological counselling or psychiatric help since his leaving Oak Ridge. He is fortunate that his mother insisted he be released "against medical advice".

iv) Causation and harm

[312] Dr. Bradford reviewed Mr. Bonner's record on behalf of the Plaintiffs. His analysis was summarized in his testimony:

> Mr. Bonner was highly vulnerable in terms of being admitted at 17 years of age and was held in solitary confinement for six months…. His descriptions of lack of trust, paranoid, thinking, mood disturbance, and flashbacks are consistent with what has

> been described by others and were directly caused, in my opinion, by exposure to the programs.

[313] Dr. Turrall examined Mr. Bonner's record on behalf of the Defendants. He opined that Mr. Bonner's participation in STU programs matured him. He testified that Mr. Bonner came to Oak Ridge as a rebellious adolescent who was withdrawn, depressed, and was generally a loner who was abusive to staff. Dr. Turrall opined that he was putting on a "Mr. Tough Guy" performance, which was dealt with by tranquilizing him and keeping him in isolation. This echoed what Dr. Maier had said in cross-examination when asked about the treatment of Mr. Bonner:

> The issue that he had a bad attitude was just his defense to stop us from helping him. There are many ways in which people distance themselves from others. Sometimes they just shut down.

[314] Dr. Maier's view was that forcing Mr. Bonner to participate in the group sessions with the other patients would itself be therapeutic. As it turned out, however, Mr. Bonner was often sent to isolation not because it was thought to medically benefit him, but on the whim of another patient who had been empowered by the doctors to do so. Examples of this were put to Dr. Maier in cross-examination, and he agreed that that was a common occurrence:

> Q. …one of the clinical notes indicated one day he was chastised in the group because he was looking out the window, had his head on his chin and wasn't talking. That would be considered not participating, right?
>
> A. Apparently it was worth noting...
>
> Q. Right...
>
> A. ...and that that would be not participating, correct.
>
> Q. Do you recall that according to the note we look at earlier, this young man spent six months in confinement? …[T]he point is that it appears that the crime that he committed, his sin, was he wasn't actively participating and communicating. He didn't like the group discussion.
>
> A. So, there are many ways that people distance themselves from others. And sometimes they just shut down and not participate.

[315] In his cross-examination, Dr. Quincey also agreed that on the STU it was patients who decided to put other patients in solitary. That said, Dr. Maier conceded that although the directions to send Mr. Bonner frequently came from other patients rather than from medical staff or, for that matter, the attendant staff, the responsibility was that of the Doctors.

> Q. He's in solitary for a week because he's not responding properly and communicating properly in this group session, correct?
>
> A. That's what this note says, yes.

> Q. And of course, the ultimate decision to send him to confinement, was that made by the patient teacher, was that made by one of the other patients or was that made by the physiatrist?
>
> A. It would have been made – there would have been a chain of command with the recommendation that he stay in confinement and ultimately Dr. Barker who would have been – who was the physiatrist would of approved it.

[316] There is today little doubt that placing inmates in solitary confinement can cause harm. One of the Defendants' expert witnesses, Dr. Gary Chaimowitz, submitted affidavits and testified to that effect in the now leading cases of *Canadian Civil Liberties Association v The Queen* (2017), 140 OR (3d) 342 (SCJ) and *Reddock v Canada (Attorney General)*, 2019 ONSC 5053.

[317] In *CCLA*, at paras 247-8, Marrocco, ACJSC accepted that Dr. Chaimowitz is indeed an expert on the issue of confinement, and accepted his evidence "that prolonged administrative segregation poses a serious risk of negative psychological effects." Similarly, Perell, J. confirmed in *Reddock*, at para139, that "the placing of an inmate in in administrative segregation imposes a psychological stress, quite capable of producing serious permanent observable negative mental health effects", and that "the harmful effects of sensory deprivation caused by solitary confinement can occur as early as forty-eight hours after segregation". He also accepted the view that "administrative segregation exacerbates existing mental illness" and that "the practice of keeping an inmate in administrative segregation for a prolonged period is harmful and offside responsible medical opinion".

[318] In his testimony in the present trial, Dr. Chaimowitz argued that while solitary confinement in federal prisons is designed to be punitive, in Oak Ridge it was designed to be therapeutic. Under cross-examination, however, he acknowledged that the two types of confinement were physically very similar. That is, lack of access to the yard or any exercise, which was conceded by Dr. Maier to be the case with confinement at Oak Ridge, is also common to solitary confinement in federal penitentiaries. Likewise, he agreed lack of access to stimuli as described by Mr. Bonner and other patients, and lack of access to treatment, were features of Oak Ridge and are features that cause harm in federal prisons. Dr. Chaimowitz also confirmed that the evidence shows that Drs. Barker and Maier did not visit the Plaintiffs when they were in confinement, which suggests that there was in reality little therapy involved in this arrangement.

[319] The Clinical Records establish beyond any doubt that Mr. Bonner was tormented while in Oak Ridge. In fact, his torment was in a way self-perpetuating, since the more he expressed his anguish the more other non-medically trained patients decided that he should be in confinement. Reading Mr. Bonner's clinical history for those 8 months in 1971 is to read a tale of neglect and irresponsibility by Dr. Barker, Dr. Boyd, and the entire institution. He was subjected to harmful lengths of confinement for the most petty of reasons and at the whim of other patients, with no hope of freeing himself from that cycle.

[320] In the end, it was obvious that his entire Oak Ridge experience was unnecessary. Without having participated in any meaningful therapy at all, and having endured 6 out of 8 months of confinement to his cell, Mr. Bonner was ultimately released "against medical advice". It then

turned out that without the Oak Ridge "therapy" of almost non-stop confinement, he emerged as a stable and successful person. His life trajectory shows not that Oak Ridge helped him through any medical intervention, but that Oak Ridge was so bad for him that the balance of his life improved once it was behind him.

[321] One only has to read the Clinical Records of Mr. Bonner steadily breaking down over his 8 months at Oak Ridge to grasp the extent to which he suffered harm. The fact that he never needed psychiatric help after being released from Oak Ridge is a testament to his mental strength, and to the fact that he should not have been put through the STU in the first place.

[322] Mr. Bonner testified that although he has had a stable life, he continued to suffer anguished effects of the Oak Ridge experience for years afterwards. That is not surprising. Dr. Chaimowitz testified that "extended stays in solitary confinement for people with mental disorders are inherently harmful." He explained that this harm has long lasting effects, much like post-traumatic stress.

[323] Likewise, Dr. Turrall confirmed that individuals could be harmed by the Dexamyl-Tofranil treatments that Mr. Bonner received, and that Mr. Bonner had made complaints about these treatments. He then indicated that it would be speculative to conclude that his life trajectory was altered or would have been different than if he had not been treated at Oak Ridge. As with Mr. Bonner's experience with extended periods of confinement, however, an analysis of the impact of the mistreatment on his life trajectory is only one way of viewing the matter.

[324] One can suffer pain and continued harm and yet have the strength to persevere with life. The Defendants' experts have approached the question of harm by suggesting that either one's life is ruined or it is not, with no alternative possibility. By analogy, if asked whether a person paralyzed as a result of an automobile accident suffered harm, the Defendants' approach would be to only analyze whether she otherwise became successful in business or a profession; it is self-evident, however, that one can be harmed and also have a successful life.

[325] The Oak Ridge experience caused Mr. Bonner intense short-term harm and continued, long-term harm in the form of ongoing stress, notwithstanding that he has managed to lead a subsequently successful life. Drs. Barker and Boyd were directly involved in his treatments and with his extended confinement.

e) William Brennan

[326] William Brennan was born in 1954 and died on October 11, 2018, prior to the commencement of trial. His affidavit from an earlier stage of this action is part of the record, and his partner, Kristie Miller, testified on his behalf at trial. Mr. Brennan was committed to Oak Ridge once on a 30-day warrant of remand during which he did not participate in the STU Programs, and again for 3 years – from June 12, 1974 to September 2, 1977 – where he experienced DDT, Capsule, and MAPP.

i) Pre-Oak Ridge and index offence

[327] Mr. Brennan was born and raised in Wisconsin, where he had a somewhat troubled childhood. He deposed that he was a rebellious youth and was often in trouble with authority figures, especially his father who was a strict disciplinarian. He dropped out of school before finishing high school, although he later completed a high school equivalency certificate and some university courses while serving time in prison. According to an FBI report in the evidentiary record, Mr. Brennan had a criminal history prior to his admission to Oak Ridge that included charges of disorderly conduct, theft, driving under the influence, and eluding a police officer.

[328] In 1973, at the age of 18, Mr. Brennan was travelling by car through Canada when he was arrested and charged with two counts rape, one count of attempted rape, and kidnapping (which was eventually withdrawn). In his Penetanguishene Clinical Record dated September 21, 1973, it is recorded that he had sexual relations with two female hitchhikers he had picked up. He claimed that he did not force them to have sex, but that they had seen a starter pistol he had in his possession and were scared of him. He also admitted to having committed several previous rapes without having been caught.

[329] On August 31, 1973, Mr. Brennan was sent to Oak Ridge for a 30-day assessment on a Warrant of Remand. His Admission Record of that date indicates that he was diagnosed with dangerous antisocial personality disorder, but was found fit to stand trial and was returned to court and eventually convicted of the rapes. On June 12, 1974, Mr. Brennan was involuntarily committed and was returned to Oak Ridge from Kingston Penitentiary.

ii) Experience in the STU

[330] At Oak Ridge, he was diagnosed with personality disorder, being immature and anti-social. A Clinical Record from June 1974 indicates that he was "sarcastic toward staff, admits he has an authority problem which he has to curb". Two months later, in a Clinical Record from August 1974, he is said to be "[n]ot responding to treatment on ward, disruptive in group". Medical staff notes that, "sanctioning this patient has little effect on him… Talked to him about going to MAPP for motivation… When returned to group on restraints he was upset and started struggling. He was placed on a t-strap."

[331] In his affidavit, Mr. Brennan deposed that he had consented to drug treatments because he believed that there was no alternative if he were to get himself out of Oak Ridge. His Treatment Records reflect that he received a number of DDT treatments:

> Dexamyl-Tofranil on February 12, 1975, for seven weeks on orders of Dr. Maier. In his examination for discovery, Mr. Brennan stated that Dexamyl, then a popular street stimulant, 'is not a bad drug.' He spoke positively about the experience in a handwritten Special Treatment Report dated February 13, 1975.
>
> Sodium Amytal-Ritalin on February 10, 1975 and February 22, 1977, on orders of Dr. Maier. The Bedside Nursing Notes indicate that he spent considerable time crying during this drug session, and in discovery Mr. Brennan stated that his first Amytal-Ritalin treatment prompted a bout of depression and suicidal thoughts. It also earned him a renewed warning from staff about his poor behaviour and

> attitude. His final session was recorded on a Bedside Nursing Note as having caused 'a lot of turmoil', although a nurse also recorded that Mr. Brennan asserted that the 'treatment went well' and that he wanted another one. In discovery he said that he enjoyed the feeling that the Amytal-Ritalin drug combination induced.
>
> Dexedrine on August 24 and 26, 1975 and September 7, 1975, on orders from Dr. Maier who had special access to this drug from the federal Ministry of Health for this.
>
> LSD (300 milligrams) on August 24, 1975 while in the Capsule, administered by Dr. Maier. The LSD 'Program Contract' signed by Mr. Brennan is for a 4-day session in the Capsule, from August 24, 1975 to August 28, 1975.

[332] In his examination for discovery, Mr. Brennan said that he could recall reading the literature he was given in preparation for the LSD session. He also indicated that Dr. Maier was closely involved in the LSD preparatory stage during the summer of 1975:

> Q. Do you remember being at an LSD group meeting?
>
> A. …that's all we did that whole summer was talk about LSD and hypnotisms. And Maier used to come in and hypnotize us and we used to do om every day.
>
> Q. Like the chant?
>
> A. Yeah.

[333] Mr. Brennan also recounted in discovery that his "partner guide" was fellow patient Terry Ghetti, who is also a Plaintiff in this action. Mr. Brennan testified that having been partnered with Mr. Ghetti was a terrifying experience for him. Mr. Ghetti was known to Mr. Brennan as having killed a fellow inmate with his bare hands several years previously in the Don Jail, a story which Mr. Ghetti himself confirmed in his own testimony at trial. As Mr. Brennan put it:

> Q. I see your name paired with Mr. Ghetti. Would that be Terry Ghetti?
>
> A. That would be one badass Terry Ghetti.
>
> Q**.** Were you partnered with him?
>
> A. Yeah. …The only thing I remember about Ghetti was I made him laugh or something like that and he almost killed me. I swear to God he was going to kill me.
>
> Q. Why do you say that?
>
> A. Because I wasn't afraid of him anymore after the LSD, but then he kind of brought me back to where I was, you know. It's kind of hard to explain.

Q. Did he do something to you?

A. Yeah, he came right up and he kind of grabbed me and was about ready to kill me.

Q. Just to get this on the record –

A. If I didn't shut up, at that moment he was going to kill me, I swear he would have.

Q. How was he going to do it?

A. Didn't matter. He did it at the Don jail in a shower room.

Q. Did he have your hands around your neck or something?

A. He was about to, yeah.

[334] The Ward Transfer Slips indicate that Mr. Brennan was placed in MAPP on three occasions:

> From August 30, 1974 to September 23, 1974. The Bedside Nursing Notes indicate that attendant staff sent him to MAPP after he was disruptive and 'continually looking for loopholes to buck the system'.
>
> From April 7 to April 14, 1975. Bedside Nursing Notes record that he was sent to MAPP by Dr. Maier due to 'game playing and rank attitude'.
>
> From May 20 to June 19, 1975. Bedside Nursing Notes record that he was sent to MAPP for having 'neglected his duties and general attitude'.

[335] In discovery, Mr. Brennan confirmed that patients would spend two or three days in confinement before entering the MAPP group. He described the MAPP sessions as a total loss of liberty and privileges, lengthy group therapy while sitting immobile on a bare floor in a hospital smock until the requisite number of days on good behaviour had passed and privileges were gradually regained:

Q. And so how would you earn your privileges back?

A. Well, you would start out sitting with your back straight against the wall and your feet straight out. And one of the ways you would earn privileges back is by not changing that position. If you changed that position, then you would have to go another so often for days or whatever. And then you'd have to have a good attitude. And which means that you couldn't be mad at anybody at all. You'd have to be very subservient and just kind of go along with the program. If you did that

> long enough, then they would give you your clothes, seems to me. And then they would give you a cushion to sit on.

[336] Mr. Brennan's belief, which is generally reflected in the Bedside Nursing Notes and Clinical Records, was that patients and guards made many of the decisions to send patients to MAPP. and that Dr. Maier was often at odds with the staff on various issues and so may not have been able to override a staff decision to send someone to MAPP. That said, the records also show Dr. Maier himself occasionally authorizing a MAPP session.

[337] In his own testimony, Dr. Maier indicated that for the most part it was the attendant staff, not the Doctors or medical staff, who sent patients to MAPP. This, however, belies Dr. Barker's and Dr. Maier's supposed belief, supported by the opinion of Dr. Chaimowitz, that MAPP was therapeutic rather than punitive. Attendant staff were security guards. Either MAPP was a security-oriented punishment disguised as therapy, or it was a therapeutic program improperly delegated by the Doctors to security staff. In any case, it was, as Dr. Bradford described it, a tortuous program that supposedly was part of the patients' therapy but was punitive in its very nature and its administration.

[338] In his affidavit, Mr. Brennan described being restrained and confined while at Oak Ridge. He stated that while restraints were usually used to calm patients down, but that in MAPP they were used as punishment. He testified to being in confinement from September 2 to September 12, 1973, and again on September 10, 1974. He also recalled being placed in a so-called turkey strap and confined for two weeks in August 1974. The Clinical Notes in this respect refer to Mr. Brennan being placed in a "t-strap", which counsel for the Defendants states is a different type of restraint than what the Plaintiffs refer to as a turkey strap, but which is more restrictive than an ordinary handcuff or leg iron.

iii) Post-Oak Ridge experience

[339] Mr. Brennan's Discharge Summary from Penetanguishene dated February 9, 1977 indicates that he was no longer in need of a maximum-security hospital, and recommended that he be transferred to St. Thomas Psychiatric Hospital. His final diagnosis reads: "Bizarre Ideation, Psychopathic Personality, Depression, Phobias, Obsessions and Compulsions, Hypochondriasis, Paranoid Tendencies, Hysteria and Hypomania. The following year he was granted parole and returned to the United States.

[340] The decades following his discharge were not easy ones for Mr. Brennan. In 1979, he was charged with rape in the U.S. and served 3 years of a 5-year sentenced. His American criminal record provided to counsel by the FBI shows that Mr. Brennan was again charged with rape in 1983. It also discloses that he was charged with driving under the influence and eluding a police officer in the 1990s. Mr. Brennan indicated during discoveries that this latter incident prompted him to seek counselling.

> Q. The one in the mid '90s, what caused you to seek out counseling at that time?

A. That was because of the DUI and the eluding an officer. It was a recommendation by my attorney before I went to court to have some counseling. And then, you know, the judge said usually people come up in front of me and then they go to counseling, but I'm glad you went first.

Q. So as I understand it, it was sort of a condition of dealing with those charges?

A. It wasn't a condition, it was a voluntary way to show that I took it seriously.

Q. So it was motivated by the charges you were facing at the time?

A. Correct.

[341] Mr. Brennan and Ms. Miller met in 1987. They have two children. Ms. Miller earned income and Mr. Brennan stayed home to raise the children. As of his examination for discovery in 2016, Mr. Brennan had not worked for approximately 18 years. As he explained it:

Q. And what's the reason that you're not working?

A. Most of the jobs that I had I couldn't hang onto and I finally just sort of gave up.

Q. Why couldn't you hang onto them?

A. A combination of not getting along well enough and drinking, sometimes that was the problem, that's about it.

iv) Causation and harm

[342] Dr. Hucker examined Mr. Brennan's life history and medical records. He opined that there is no evidence he suffered long-term psychological harm from his time in the STU.

[343] That said, he acknowledged that Mr. Brennan was in MAPP for a cumulative 60 days. He also acknowledged that Mr. Brennan was in MAPP for a large number of days, and that MAPP was a punitive program that was associated with periods of confinement, all of which would have been a degrading and inhumane experience:

Q. And the evidence suggests that Mr. Brennan was exposed to a very large number of days in the MAP program, right?

A. Right.

Q. And based on your won description of what would be inhumane treatment, being in confinement for a period of over 24 hours would be considered inhumane?

A. Yes, except in exceptional circumstances, yeah.

Q. Right. And – and the MAP program itself, I think you agreed earlier, that was a very punitive program?

A. Yes, it was.

Q. And it was shocking for you to have learned about it when you first learned about what was involved in that?

A. I can't remember when I first learned about it.

Q. Well, when you – when you first became aware of it, you were shocked and horrified of what had happened

A. Well, I can't separate MAP from the rest of the program, because I learned about it all at the same time. Yeah, no, it was – it was something as I had expected it to be and it was clearly excessive, but that wasn't the – that wasn't the attitude I came to it with.

Q. Sir, you – you mentioned yesterday that you – you were shocked and horrified about what had happened at Oak Ridge within the context of the STU, right?

A. Yes, sometimes I was, yes.

[344] It yet another exchange on cross-examination, Dr. Hucker was reminded that Mr. Brennan said in discovery that he wanted to kill himself after receiving the Sodium Amytal-Ritalin treatment. Mr. Brennan had testified that the withdrawal from these drugs was traumatic for him, and that it stuck with him as a bad memory for a very long time. In response, Dr. Hucker agreed that suicidal ideation and depression are foreseeable results of coming down from these drug treatments. As a result, Dr. Hucker agreed that Mr. Brennan suffered harm at the time, and that several decades later there was still a "memory of the harm".

Q. Well, he was suicidal at the time, right?

A. No argument.

Q. No argument. And he had very vivid memories according to his discovery transcript of feeling very suicidal at the time following these injections, right? And that stuck with him for a long period of time.

A. Yeah. It's a very bad memory.

Q. Right. And these are anticipated side effects to taking the DDT drug cocktail?

A. Not that it would be long-lasting, but it certainly would occur in the short term.

Q. The fact that there would be suicidal ideation...
A. Yeah.

Q. ...immediately following the withdrawal.

A. Part of the depression that goes with the coming down from being on an amphetamine.

Q. Right. And being artificially induced into suicide – suicidality means he became depressed?

A. Sure.

Q. Because suicidal ideation is a major symptom of depression?

A. Correct.

Q. So, they harmed him at the time, right?

A. That's not unreasonable.

Q. And those harms continued according to the evidence of Mr. Brennan?

A. Not the same kind, it's a memory of the harm.

[345] Mr. Brennan deposed in his affidavit and stated in discovery, and Ms. Miller confirmed from her point of view, that these bad, vivid memories prevented him from carry on a productive work life. While he was fortunate during the last 2 decades of his life to settle down in a supportive family situation with Ms. Miller, it is equally clear that he never was able to escape the psychological impact of Oak Ridge.

[346] Ms. Miller testified that for the entire time she knew him, Mr. Brennan had a mistrust of doctors and was paranoid – moving his family from place to place and home schooling his children. She stated in her testimony that Mr. Brennan was chronically concerned that his children not be mistreated by their peers the way he was. In cross-examining Dr. Hucker, counsel for the Plaintiffs suggested that these paranoiac and attitudes and manifestations of anxiety this could be a result of the programs he experienced in Oak Ridge. Dr. Hucker agreed.

Q. And that – that she says happened because of what he experienced at Oak Ridge?

A. Yes, I get that.

Q. Right? And so, those were the ongoing symptoms, ongoing elements of harm that Christie Miller observed in her husband over a long period of time?

A. It could be related to that, yes.

[347] In other words, the Defendants' own expert concedes that Mr. Brennan suffered harm. He suffered it contemporaneously in the form of induced depression and suicidal ideation, and he suffered it on an ongoing basis as paranoia and anxiety in raising his children. He also suffered harm in the form of long lasting, vivid memories that had triggered suicidal thoughts. Although Dr. Hucker was reluctant to say so in so many words, it is obvious from his testimony that memory of past harm is itself a form of harm.

[348] Dr. Hucker opined in his Report that, based on Mr. Brennan's history and complaints, it is unlikely that his life would have been different had he not participated in the STU programs. He stated that it is unlikely that Mr. Brennan was psychologically or physically harmed in any lasting way by the Oak Ridge experiences.

[349] What Dr. Hucker acknowledges, but then leaves out of his conclusion, is that the STU programs caused Mr. Brennan pain. The Oak Ridge experiences were not the original cause of his alcoholism and other psychiatric problems, but they were a supervening cause and increased his suffering substantially both contemporaneously and in the long term. His suffering certainly passes the compensability threshold of "serious and prolonged" psychological upset: *Saadati v Moorhead*, [2017] 1 SCR 543, at para 37.

[350] The STU treatments caused Mr. Brennan considerable short-term emotional harm and indignity as well as long-term mental anguish and harm. Dr. Maier was directly involved in his treatments.

f) Stephen Carson

[351] Stephen Carson was involuntarily committed to Oak Ridge on January 30, 1979 on a 30-day Warrant of Remand after he assaulted his brother. That short term committal was then extended to January 29, 1980 by involuntary committal under the *Mental Health Act* pending his trial.

i) Pre-Oak Ridge and index offence

[352] Mr. Carson deposed in his affidavit that he stopped attending school was he was 15-years old and had completed Grade 8, two credits of Grade 9, and a few more advanced high school credits. His parents were alcoholics. He related that he began drinking heavily in his early teens and also used street drugs such as LSD, Phencyclidine (PCP), and marijuana. He also deposed that he had a good relationship with his parents and siblings until he was diagnosed with schizophrenia as a teenager.

[353] In terms of pre-Oak Ridge criminal history, Mr. Carson had convictions for mischief to private property, causing a disturbance, assault with intent to resist arrest, and common assault. He deposed in his affidavit that this anti-social behaviour was a result of his then undiagnosed schizophrenia and lack of needed medical care. On cross-examination, Mr. Carson testified that schizophrenia made him hear voices and he believed that people were out to get him, leading him to commit numerous assaults both before and after his time in Oak Ridge. He deposed that these symptoms only ceased when he began taking medication in 1997.

[354] In July 1978, Mr. Carson was charged with assault causing bodily harm after fracturing his father's rib with a pipe. He was committed to Metropolitan Toronto Forensic Service for an assessment on July 4, 1978. In his preliminary assessment dated July 4, 1978, Mr. Carson was described as having "ambivalent thought processes, questionable auditory hallucinations and some autistic thinking." It was recommended that he be remanded for a more complete assessment. On August 15, 1978, he was transferred to the Queen Street Mental Health Centre where he stayed until November 9, 1978.

[355] The Discharge Summary from Queen Street indicates that Mr. Carson was diagnosed with "adolescent maladjustment". The diagnosis also contains the comment that, "Present psychological testing revealed intellectual functioning in the superior range. His full scale I.Q. score was 122 (average 80-110)." It was noted that Mr. Carson had not kept up with scheduled treatment sessions at Queen Street, and that he exhibited assaultive behaviour and "had difficulties with explosiveness". In cross-examination, Mr. Carson chalked this behaviour up to his undiagnosed schizophrenia:

> Q. …Do you remember being advised that you had difficulties with explosiveness, at this time?
>
> A. No, I wasn't explosive. I – what do you mean by explosive?
>
> Q. Would you get angry with people quite quickly?
>
> A. Umm, yeah, I – I kinda did, you know, because I didn't know I was schizophrenic, and they didn't know I was schizophrenic, and people come on and they talk to you like everything's –- there's nothing wrong, eh, and – and they – and you don't know what's wrong with ya, and what can you say, you know. You just come on and you say, look, you know, leave me alone. I don't know.

[356] Mr. Carson deposed that on January 30, 1979, at the age of 20, he was committed involuntarily to Oak Ridge on a Warrant of Remand for assessment after he assaulted his brother. On February 9, 1979, Dr. Fleming, a staff physician at Oak Ridge, certified him as an involuntary patient under the *Mental Health* Act. In his Assessment, Dr. Fleming noted that Mr. Carson was unpredictable and could potentially cause serious bodily harm to others. The following week, on February 13, 1979, another staff physician, Dr. Camunias, admitted Mr. Carson under a Certificate of Involuntary Admission. The Certificate notes that Mr. Carson was "emotionally inappropriate, tangential in speech having phobias of losing control, obviously psychotic". It goes on to state that he "has very little insight into his condition, and his judgment is impaired."

[357] Mr. Carson's status was assessed and reviewed a number of times by the Ontario Review Board while he was held involuntarily at Oak Ridge. There are numerous Review Board decisions and orders in Mr. Carson's file indicating that he had applied to the Review Board to challenge the periodic renewals of his status, and that his parents had retained a lawyer to represent him for this purpose.

ii) Experience in the STU

[358] Mr. Carson testified that the only personal contact with Dr. Barker that he could specifically recall was seeing him in the corridor at Oak Ridge. Dr. Maier was not at Oak Ridge during Mr. Carson's time there. The Clinical Records show that Mr. Carson's medical care was looked after for the most part by Dr. de Lucas and Dr. Watson, neither of whom are Defendants or otherwise named in the Plaintiffs' pleading.

[359] The Clinical Records do show that Dr. Barker approved Mr. Carson's renewed certification on March 27, 1979. Likewise, the Physician's Orders record that Dr. Barker performed Mr. Carson's May 1979 treatment/medication review.

[360] Mr. Carson was never in the Capsule during his year at Oak Ridge. According to the Beside Nursing Notes from 1979-1980, he was given the antipsychotic drug Trilafon and was prescribed other medications such as Cogentin, Largactil, and Nosanine. He never received LSD or any of the other mind-altering drugs entailed in the DDT program.

[361] Mr. Carson's claim relating to the STU programs relates to the time he spent in MAPP. The Bedside Nursing Notes in the record indicate that he was in MAPP for one session, from March 15, 1979 to April 9, 1979. He was also in Moto-Pro, a modified form of MAPP, commencing May 8, 1979. Mr. Carson testified that Moto-Pro was less strictly disciplined than MAPP, and that the requirement of adherence to the rules in order to earn a release was reduced to 10 days rather than 14. He described Moto-Pro as being unpleasant, but a relatively more tolerable alternative to MAPP:

> Q. Sir, did you eventually move to a different program that was similar to MAPP?
>
> A. Yeah. I went to the motivation program, they call it MotoPro. That's – that's to get you motivated again to attend regular therapy groups. They could – they could see I couldn't handle the MAP Program, so they put me in MotoPro, and there you have to earn – it's something like MAPP, but only not as strict.

[362] The Clinical Records show a number of occasions on which Mr. Carson was acting in an uncontrolled or violent manner and was put on restraints or sent to confinement. In his testimony in chief, he asserted that he spent either 2 months or 6 weeks in solitary confinement, but the records do not support any stretch of confinement that lasted longer than a few days. The Clinical Records record that Mr. Carson was confined intermittently when he would refuse to participate in groups and/or when his behaviour was otherwise difficult for staff to control.

[363] Perhaps more significantly, Mr. Carson's own description of the nature of his confinement is distinctly different than solitary confinement as that term is more typically used in a prison setting. His description is one of a lonely cell, but not of the sensory and other deprivations associated with solitary confinement.

> Q. … did you also spend time just in solitary confinement?
>
> A. I was in the solitary confinement, just – they give you a safe gown and they put you in one of those little rooms.

Q. How big was the window in that room?

A. Ah, so...

Q. Sorry, the window in the door?

A. The window on the door was about six-by six inches, and, ah, it had a latch on it that could slide open so you could talk to the doctors or whoever, the staff, whoever might come by, the nurse with your medication, and, ah, they had a window in the back of the room that led to the outside, eh. If you needed fresh air, they had that.

[364] In Mr. Carson's Mental Status Report dated August 31, 1979, Dr. de Lucas diagnosed Mr. Carson with "Schizophrenia, Undifferentiated Type". The Report notes that Mr. Carson's family members were in the process of having the criminal case against him dismissed. Interestingly, Dr. de Lucas observes, "He is looking forward to having the charges dropped and to being treated as a medical patient." The statement comes as close as one can to an acknowledgment that Oak Ridge, at least for Mr. Carson, was a form of custodial warehouse more than a treatment facility.

[365] Mr. Carson was discharged from Penetanguishene on January 29, 1980 into his parents' care. His family withdrew the criminal charges against him, and in a decision dated January 24, 1980, the Ontario Board of Review concluded that he no longer met the conditions for involuntary commitment under the *Mental Health Act*. His Discharge Summary indicates that his release was contrary to the advice of Dr. de Lucas, who diagnosed Mr. Carson with "borderline syndrome" and recommended that he continue to take Largactil and make follow-up appointments at the Queen Street Mental Health Centre.

iii) Post-Oak Ridge experience

[366] Mr. Carson admitted on cross-examination that he did not follow up as an outpatient at Queen Street or any other medical facility and did not take medication. After Oak Ridge he went off the Largactil and all other medications that he had been prescribed, and reverted to heavy drinking and criminal misconduct:

Q. And you mentioned this in your examination in-chief, but Dr. DeLucas had prescribed you Largactil, correct?

A. Yeah, Largactil, yes.

Q. And you understood that was a treatment, an anti-psychotic medication used to treat schizophrenics?

A. Yeah. Yeah, I did, yeah.

> Q. And you stopped taking that medication after you were discharged from Oak Ridge, correct?
>
> A. Yeah, I did. Yeah, I stopped taking the medication. I didn't have any money to pay for it, and –- and he gave me a prescription, and I was supposed to take it to the doctor, and get it renewed, but maybe my parents would have paid for it, I don't know, but, ah, I – I went off it. I turned to alcohol again, and I – I kinda – I messed it up.

[367] Despite being seen by several doctors in the interim, Mr. Carson conceded in cross-examination that he did not take any medications to address his schizophrenia until 1997. At that time, a doctor prescribed him Olanzapine, which Mr. Carson indicates in his affidavit effectively manages his illness. He stated in cross-examination that it is this medication that allows him to at least function properly. It has apparently also put an end to his criminality. Mr. Carson's last criminal charge was in 1998, within a year of his starting on Olanzapine, and according to his affidavit consisted of assault, uttering threats, and criminal harassment.

iv) Causation and harm

[368] Dr. Bradford, who examined Mr. Carson's records on behalf of the Plaintiffs, testified that as a schizophrenic if Mr. Carson were exposed to the programs at Oak Ridge and were not given anti-psychotic drugs, it would have caused psychiatric harm. However, the records show that he was given Lorgactil and Nosanine, which were the anti-psychotic drugs available in that era. He was never provided with DDT drugs, and Dr. Bradford's evidence indicates that there likely would have been a protective effect by the anti-psychotic drugs that would have eased the MAPP/Moto-Pro experience.

[369] Dr. Hucker examined Mr. Carson's records on behalf of the Defendants. He noted that Mr. Carson had a hard time enduring having to relate closely with others and did not know how to participate in group sessions. He explained that schizophrenics are very "inward", and that the MAPP would have been particularly difficult. He also opined that solitary confinement would have been very damaging to someone like Mr. Carson.

[370] As indicated above, the record establishes that what Mr. Carson called confinement was not the entirely isolating form of incarceration usually associated with that term, and that although his liberty was restricted he continued to have interpersonal contact and interactions with attendant and medical staff. He had open windows and bars on his room through which he could communicate with whoever was nearby. This experience would have been confining, but does not conform to the description of psychiatrically damaging forms of solitary confinement.

[371] The same can probably be said of Mr. Carson's time in Moto-Pro. It was not an enjoyable time, but it was described by him as tolerable. In fact, it was imposed on him as an alternative to the much harsher regime of MAPP. The Moto-Pro experience did Mr. Carson no therapeutic good; at the same time, it appears to have caused little lingering harm.

[372] As for Mr. Carson's stint in MAPP, that was undoubtedly difficult for him. In fact, it was so difficult that he was never subjected to it again. While it caused him contemporaneous harm, it is difficult to say that this one occasion caused him ongoing harm. Mr. Carson commented that, "I have bad dreams every now and then about jail and, Penetanguishene, every now and then not too often. It's been like forty years, so, you know, you gradually forget about it after a while. Dr. Hucker's response, which I accept as a logical one, is that this is a description of fading memories, not a sign of long-term harm.

[373] I am compelled to note that Mr. Carson was a schizophrenic when he entered Oak Ridge and was correctly diagnosed as such by the medical staff there. He was given appropriate medication for that ailment, which helped him get through the difficult discipline of the Oak Ridge experience. He was not subjected to any course of DDT drugs, and the only drugs which he was given at Oak Ridge were those appropriately used in the late 1970s for treating schizophrenia.

[374] Mr. Carson ceased taking his prescribed medications when the Ontario Review Board released him, and his illness continued to plague him for another 2 decades until he again started taking appropriate medications. It does not appear that Oak Ridge, unpleasant as it may have been for him, caused Mr. Carson any long-term harm.

[375] The only harm that can be linked to Oak Ridge in Mr. Carson's case is the pain he undoubtedly suffered during his one stint in MAPP. Dr. Hucker acknowledged that the MAPP experience was a wrongful one, and a painful one, for Mr. Carson to have been put through:

> Q. MAP would not have been appropriate?
>
> A. No.
>
> Q. In fact, for someone who's a schizophrenic, that would have been very, very difficult for them to endure?
>
> A. I think I've said that already, yes.
>
> Q. And it would have been harmful to them at the time?
>
> A. At the time. Yes, sure.

[376] Oak Ridge as an institution failed to treat Mr. Carson as a medical patient and rather treated him as if he were in a custodial, prison setting. The MAPP/MotoPro programs were not therapeutic, but rather were punitive and physically and emotionally hurtful. This experience caused Mr. Carson to suffer contemporaneous, short-term harm, although it did not cause him long-term harm. Dr. Barker was involved in his treatment in an oversight and supervisory role.

g) Roy Dale

[377] Several months after having deliberately shot himself in order to be admitted to psychiatric care, Roy Dale was sent to Oak Ridge for assessment and stayed there for a month, from October-November 1972. He was sent there again 2 years later, on November 4, 1975, on a 30-day Warrant

of Remand for setting fire to a hotel and restaurant while on an alcoholic binge. He was found not guilty of the arson by reason of insanity was again committed to Oak Ridge on February 19, 1976. He remained there for nearly 3 years, until his release on January 9, 1979.

i) Pre-Oak Ridge and index offence

[378] Mr. Dale deposed in his affidavit that his parents divorced when he was a young child, and that he has 8 half-siblings. He related that he had a hard childhood, moving between foster care homes starting at the age of 7, and attending somewhere around 12 different public schools. At the age of 14, he was sent to a series of training schools, where he described being abused both physically and sexually. The stint in training schools lasted until he was 16, at which point he went to a public high school for a short time before dropping out after grade 10. Mr. Dale also indicated that he started drinking heavily at 16 years old and considers himself to be an alcoholic.

[379] In the affidavit, he goes on to depose that he got married in 1971 at the age of 19 and had a child who had cerebral palsy. The marriage lasted until 1976 when he got divorced. While he was in Oak Ridge his daughter was taken away by Child Services and, sadly, she later passed away. Mr. Dale stated that this was a very difficult time for him. The following year he shot himself in the hand in an effort to call attention to his mental illness and get himself admitted to a psychiatric hospital. In an Out Patient Consultation Report dated March 2, 1972 from a doctor at Goderich Psychiatric Hospital, Mr. Dale was described as "a rather thin little fellow who feels that he has very bad nerves." He was diagnosed with personality disorder, uncontrollable rages and depression.

[380] Several months later, in September 1972, Mr. Dale set fire to a number of properties, including several owned by his wife's family. He was charged with three counts of arson, although, as indicated in another Goderich out-patient Report dated September 19, 1972, he was never convicted of the charges. However, the assessing physician concluded that, "I considered that there was enough presenting evidence, substantiating the fact that this young man is a potential threat to the lives and property of others and to himself…and advised that arrangements should be made forthwith to have him transferred to the Penetanguishene Hospital."

[381] From Goderich, Mr. Dale was involuntarily committed to Oak Ridge for one month for a psychiatric assessment. In his affidavit and his testimony in chief, he alleged that during this month-long assessment he was strangled unconscious by attendant staff as a punishment for making noise, and that he was double-cuffed and put in MAPP for six days where he was placed in a turkey-strap by another patient. He stated that he recalls MAPP being torturous.

[382] In cross-examination he conceded that the records do not corroborate these allegations, but insisted that they did take place. At the same time, he also agreed that in this initial admission to Oak Ridge he did not participate in any of the other STU programs:

> Q. Mr. Dale, you told His Honour earlier that you were in MAPP the first time you went to Oak Ridge?
>
> A. Yes.

Q. You're aware that there is no indication in your records that you were in MAPP, correct?

A. Yes. They didn't put a lot of things into the record, believe me.

Q. During your first admission to Oak Ridge in 1972, you were not in the capsule, correct?

A. That – that's correct.

Q. And you were not given any defence disruptive therapy or drugs, correct?

A. That's correct.

[383] Mr. Dale spent just over a month in May-June 1974 as an involuntary patient at Hamilton Psychiatric Hospital for assessment following arson charges again being laid against him for a number of fires started in and around St. Catharine's. Under cross-examination, he explained that he had gone on a "rampage" after consuming a large amount of alcohol. In a Hamilton report dated June 1, 1974, he was diagnosed with episodic excessive drinking, alcohol abuse, depressive neurosis (reactive depression), and personality disorder, sociopathy (antisocial). He was ultimately sentenced to 15 months on the arson charges.

[384] In October 1975, after drinking heavily for a week, Mr. Dale set fire to a hotel and a restaurant in Guelph, Ontario. As described in his cross-examination:

Q. And again, to use your language during the discovery, you decided that you wanted to cure everyone in Guelph of alcoholism and you would do that by setting the hotels that sold alcohol on fire, correct?

A. Yes.

Q. Several people were injured and one firefighter was killed, correct?

A. I knew that a fireman was killed, I didn't know anybody else was injured.

[385] He deposed that he was charged with arson and remanded to Guelph County Jail following this incident. In November 1975, he was then re-committed to Oak Ridge for a month on a Warrant for Remand. In his Oak Ridge Admission Form dated November 4, 1975, Mr. Dale filled in the answer to the question "Do you feel that you are mentally ill?" with the response: "I feel that there is something wrong. I set fires for seemingly no motive and at the time do not feel there is anything wrong or unjust about doing that…"

[386] During this second admission to Oak Ridge, Dr. Fleming diagnosed him with personality disorder, antisocial, alcohol abuse, and latent schizophrenia, but found him fit to stand trial. As a result, Mr. Dale was discharged from Oak Ridge after a month and returned to face criminal charges for the arson.

[387] None of Mr. Dale's claims relate to his treatment at Oak Ridge for his month-long stay in November-December 1975:

> Q. During this second assessment at Oak Ridge, you did not receive any medication, correct?
>
> A. Correct.
>
> Q. You were not in the MAP program, correct?
>
> A. Correct.
>
> Q. And you were not in capsule?
>
> A. No.
>
> Q. And fair to say, you have no complaints against Doctor Barker or Doctor Maier with respect to this second admission to Oak Ridge, correct?... This second admission we're talking about right now.
>
> A. Oh, for the assessment?
>
> Q. Yes.
>
> A. I'd have to answer that, no.
>
> Q. You have no complaints, right?
>
> A. No.

[388] Mr. Dale was eventually found not guilty by reason of insanity in relation to the arson charges. At the age of 23, he was again involuntarily committed to Oak Ridge on February 19, 1976. For this third committal, he stayed for 3 years pursuant to a Warrant of the Lieutenant-Governor, from February 1976 to January 1979. He was 23 years old at the time. In his Admission Form dated February 19, 1976, he answered the question "How do you feel about being here?" with the response: "I feel it was the right decision of the Court and feel I can benefit tremendously from a stay here. It is too bad this happened and that I am here, but will make the best of it."

ii) Experience in the STU

[389] Mr. Dale was generally perceived as a positive ward member. He had a good rapport with the Oak Ridge staff. On August 9, 1976, Dr. Tate reported that Mr. Dale had "put an honest effort into the program". In his affidavit, Mr. Dale deposed that he only spoke positively about the STU programs and consented to participating in them in an effort to avoid punishment and obtain an earlier release.

[390] In fact, Mr. Dale was such a cooperative patient that he was given a job working in the front office of Oak Ridge. He deposed that he was the only patient during his time at Oak Ridge permitted to leave the building to do some gardening and to pick up litter on the grounds of the building. On cross-examination, Mr. Dale agreed that he knew the rules and did not break them, which spared him some of the more drastic aspects of the STU programs:

> Q. Do you recall staff and physicians at Oak Ridge believing that you were one of the most reliable patient observers?
>
> A. Yes. …
>
> Q. So, you did not get sent to MAPP, correct?
>
> A. That's right.
>
> Q. You did not receive an LSD treatment during your third admission, correct?
>
> A. No, I didn't. No.
>
> Q. In fact, you never received LSD at Oak Ridge?
>
> A. Not at all.

[391] Mr. Dale did receive a number of DDT treatments, as evidenced by the Bedside Nursing Note and a series of Special Treatment Reports in the record:

> Sodium Amytal-Ritalin on June 4, 1976, administered by Dr. Maier – Mr. Dale testified that during this treatment the security team held him down while Dr. Maier injected the drugs into his vein. He described it as traumatic for him: "I went psychotic on it, I actually thought I was a – a Viking in a – on a Viking ship. It – it just made me totally psychotic at the time." However, the Special Treatment Report of June 4, 1979 makes note of the session but contains no mention of a psychotic episode.
>
> Ritalin administered through an IV for a 3-week stretch commencing August 9, 1976.
>
> Scopolamine for 3 weeks in August-September 1976, administered intramuscularly by Dr. Maier. Mr. Dale deposed that he was handcuffed to two other patient helpers and that the drug induced a psychotic episode and caused him to feel like ants were crawling under his skin. Counsel for the Defendants submit that he there is no contemporaneous report indicating any such discomfort and that in the Special Treatment Report of September 16, 1976, Dr. Tate referred to it as a "good treatment" and a security attendant noted that it was "probably one of the better treatments we have seen in quite some time". On the other hand, the same Report indicates that he was indeed distressed, even if trying to be cooperative: "Co-operative; coped with uncomfortable situation; extremely vulnerable as indicated by excessive emotional turmoil" and that he "experienced a physical and mental breakdown".

Dexamyl-Tofranil in pill form for 7 weeks beginning September 14, 1976, prescribed by Dr. Maier after receiving authorization from the federal Health Protection Branch. In a Clinical Record dated December 5, 1976, Dr. Tate reported that Mr. Dale showed significant improvement as a result of the DDT treatments:

> Dale is very happy with the results of the treatment. He says he will no longer sit back in the shadows and not be heard. He had a very poor self-image prior to the treatment but now feels he is worth something. He is happier with himself than he has ever been before. The staff feel the treatment was beneficial for Dale because he is expressing his feelings more openly and honestly now.

On cross-examination, Mr. Dale denied this was the case, and explained that he was only saying and displaying the attitude that he thought would benefit him with Dr. Maier:

> Q. …Stopping there, sir, that was true at the time?
>
> A. You, you have to understand that – I called it parroting, it's like a parrot, you learn from what Maiers *[sic]* wanted you to be saying and – and through the Milieu and that – you learn all these different words to use like, half – half of that – was what I said in order to make them happy and they thought that I was doing very well in the program.

Alcohol, 15 oz. on March 1, 1978. Mr. Dale testified that he thought this was initiated by Dr. Maier, but the medical records do not show Dr. Maier having been involved in this decision. A Special Event note dated February 28, 1978 indicates that although it was ultimately signed off on by Dr. Levinskas, the treatment itself was initiated by other patients. In fact, it was also other patients who, following this alcohol treatment in a Special Treatment Report dated March 8, 1978, recommended that Mr. Dale 'needs no further drug treatments and is ready to leave the hospital.' In initiating the alcohol treatment, the patients in Mr. Dale's group recorded in this report that they did so because they were curious to see the effects of alcohol on an alcoholic who had committed serious crimes while under the influence:

> We, Tribe III recommend that Roy receive an alcohol drug treatment. We would like to see the effects on himself emotionally when under the influence of alcohol as he commit *[sic]* his crimes while under the influence. Roy wants to get into past feelings around his family to find out if he has come to a healthy resolve *[sic]* of such.

[392] Until today, Mr. Dale cannot fathom the beneficial purpose of the DDT program. That is, he understands the negative side of the treatments – i.e. to break down the patient – but saw no evidence of a positive side in building the patient back up. As he put it in his examination in chief:

Q. And DDT, what's that stand for?

A. Defence Disruptive Therapy.

Q. And what was the purpose of defence disruptive therapy as you understood it?

A. Oh, again, his idea was that the – by giving you these – it was total experiment, there's no proof that it ever worked – but his idea was that by giving the drugs and making you crazier, it would break you down and...

Q. And after you're broken down, what was the plan?

A. I can't honestly tell you there was any plan after that. That's the thing that always puzzled me, but that was the idea, it was – it was supposed to – break down your defences to get at the true you and bring that out like, I – I have...no other explanation for it.

[393] Mr. Dale was in the Capsule for some period of time between March 29, 1976 to April 20, 1976, although the records are unclear of the precise dates. He was also in the Capsule for a period of time between November 15, 1976 and November 29, 1976. Like all other Plaintiffs who testified about being in the Capsule, he was naked in close proximity with other patients.

Q. And how many other individuals were with you at the time?

A. There –- I think when I was in there was four other individuals – a total of five of us in there.

Q. And were you clothed?

A. No, he put us in naked.

Q. And what was the purpose of that?

A. In his idea, he believed that these clothes that we're wearing now hide part of our personality and we had to be more open to each other and – and more open – with our feelings towards each other and that.

Q. And how did it make you feel when you're in the capsule?

A. Totally like, degraded, humiliated.

[394] In his affidavit, Mr. Dale deposed that Dr. Maier at some point put him in a large common room called the sunroom with 29 other patients, and that they were made to stay there for a month without showers and only an open toilet. He called this experience the "100 Day Hate In". There is no evidence in any of the Clinical Records that this large a number of patients were placed in the sunroom without interruption for 30 days. When this was put to him in cross-examination, Mr. Dale surmised that the records must be missing this information in error:

Q. There there's some indication in the records – that you took part in group therapy during the day in the sunroom during that time, but there's no indication that you were kept there or that it lasted for a period of 30 days.

A. Well, that's wrong then.

[395] Mr. Dale's memories are clearly confused, at least on this point. The name referenced by Mr. Dale mimics a paper written by Dr. Barker and Mr. Mason, "The Hundred-Day Hate-In: A stubborn attempt at staff-less milieu therapy". It was presented by Dr. Barker to the Fall meeting of the Ontario Psychiatric Association on October 5, 1968, some 8 years prior to Mr. Dale's arrival at Oak Ridge.

[396] Mr. Dale was discharged from Oak Ridge on January 9, 1979 to the London Psychiatric Hospital, which was also a custodial facility but a less secure one. His Discharge Summary indicates that he was discharged without medication. Dr. Barker gave him a final diagnosis of personality disorder, anti-social with alcohol abuse.

iii) Post-Oak Ridge experience

[397] On August 22, 1980, Mr. Dale was discharged from London Psychiatric Hospital, and a year later, on August 7, 1981, Warrant of the Lieutenant Governor was vacated. He testified that although he has not had the kind of severe psychiatric problems that he had as a young man, he still suffers from depression and anxiety. On May 30, 2007, he was assessed for Workers' Compensation by the WSIB Appeals Tribunal and was diagnosed with "major depressive disorder".

[398] That said, since leaving Oak Ridge in January 1979, Mr. Dale has been a stable, successful person. He deposed in his affidavit that he has not drunk alcohol since leaving Oak Ridge. He also acknowledged in cross-examination that his past criminality has not recurred. He has achieved a productive education that has kept him gainfully employed.

Q. You have not committed any other acts of arson, correct?

A. Correct.

Q. You have not been admitted to any psychiatric institutions since then, correct?

A. Correct.

Q. And you're not currently on any psychiatric medication?

A. Correct.

Q. Now, sir, I understand you attended college after you went to Oak Ridge, correct?

A. That's correct.

Q. You became a licenced paramedic?

A. Yes.

Q. That was through Conestoga College?

A. Yes.

Q. You also became a licenced child and youth worker?

A. That's correct.

Q. And that was with a program through Niagara College, correct?

A. Yes, three-year program at Niagara College.

Q. You also became a licenced auctioneer?

A. That's correct.

Q. And a licenced real estate agent?

A. Correct.

[399] Mr. Dale has been married three times and divorced twice. He has four children. On cross-examination he confirmed he remains on good terms with three of his children, although he rarely speaks with his eldest daughter. His youngest daughter helps him take care of his house. He remains on friendly terms with his ex-wives. Sadly, his third wife passed away from cancer.

iv) Causation and harm

[400] Dr. Hucker, who examined Dr. Dale record as expert for the Defendants, stated in cross-examination that it is at least possible that his present-day depression is related to the Oak Ridge experience and treatment. Mr. Dale testified that the STU often gave him feelings of being "degraded and humiliated" – so much so that he will not go to a psychiatrist and thinks he suffered a form of PTSD (although this cannot be confirmed because he refuses go to a psychiatrist). Although Dr. Hucker was reluctant to give this point away on cross-examination, he ultimately had to concede what appears to me to be the obvious possibility of ongoing harm:

Q. Okay. And it may be that this major depressive disorder was related to the horrific experiences Mr. Dale suffered at Oak Ridge, at least in part.

A. Well, it may be I can't say. I – I would have to read the rest of the report to find out, but it's certainly possible, yeah.

[401] While Dr. Hucker could not definitively say that the Oak Ridge experiences are lingering with Mr. Dale, he was clear that Mr. Dale's description of many of the events described as having taken place there would be degrading and, to use his word, "barbaric". In cross-examination, it

was pointed out to Dr. Hucker that Mr. Dale was in the Capsule for 8 days in total. The Clinical Records also show that in the course of the DDT program, Mr. Dale underwent in August 1976 a 3-week regime of Scopolamine and Ritalin and was sleep deprived for those 3 weeks. Dr. Hucker conceded this is stressful and harmful, at least contemporaneously if not thereafter.

[402] It was also put to Dr. Hucker that Mr. Dale testified that he was "choked out" by a guard early in his time at Oak Ridge, and that he had been turkey strapped and dropped up and down on his knees. Dr. Hucker agreed that this was cruel and not therapeutic. In cross-examination, he opined, "If they [doctors] became aware of this and did nothing about it, it would be inexcusable." He commented that the Doctors should have foreseen the abusive conduct by the 'patient-teachers'. He agreed with Plaintiffs' counsel that abuse was almost inevitable when you create a program whose goal is to break people down with degradation and humiliation, and then put inmates in charge of other inmates.

[403] Dr. Hucker did not seek to justify the abuse infected by other patients placed by the Doctors in positions of authority, nor did he seek to justify the ill-informed DDT and MAPP recommendations that the patients made for each other. He did say, however, that he understood the Doctors were delegating their authority because they had too much on their plate and not enough staff.

[404] That said, Dr. Bradford was clear that understaffing is not a reason to substitute non-medically trained patients for medical decision makers:

> Q. One of the issues that comes up in the material was that there was a lack of resources and a lack of funding for Oak Ridge, and that this was one of the reasons that patients were used to administer the programs, recommend drugs, recommend punishments, observe people in the – on these drug programs, et cetera. In your opinion, is that an acceptable justification, according to the medical standards of the day?
>
> A. No. My opinion is, was when I was in hospital administration, on various Boards and things like that, lack of resources is not an excuse for not providing care, for not providing the right care. So, there is a responsibility in hospital administration, in my opinion, and from my experience is that if you don't have the resources to complete a procedure or a certain amount of treatment, then you don't offer it, because of the risk and dangers are enhanced. So, if the argument here is that there were hundreds of patients and very few doctors, so this was okay, in my opinion it wasn't okay. What would have been okay would be to say, we don't have the resources, we can't manage this patient population and we need extra staffing, and to go to the Ministry of Health, or the Government of Ontario at the time, and ask for help, not to go on – not to say we're doing this because we don't have resources. That's not an excuse for not providing acceptable care. It wasn't an excuse then, it's not an excuse today.

[405] Mr. Dale did his best during his time at Oak Ridge to cooperate with the STU programs. He was rewarded for this cooperation with certain privileges, including being permitted to work

in the front office and outdoors on the grounds of the building. At the same time, he clearly suffered during his DDT and Capsule experiences. The Clinical Records consistently describe him as being highly sensitive to the drug treatments and experiencing mental breakdowns while under the influence of DDT drugs, in particular Scopolamine. Mr. Dale testified that although he was indeed broken down by the DDGT treatments, as the contemporaneous records note, there was never any attempt to build him back up. Indeed, the contemporaneous records suggest that there was no counselling or other treatment aimed at a reconstructing of personality after the drug-induced breakdowns.

[406] That Mr. Dale has been stable since leaving Oak Ridge is to his credit. He has gone from being a problematic and violent alcoholic to not having had a drink in nearly 4 decades. And this is not a result of the treatment he received at Oak Ridge; in fact, quite the opposite. Dr. Maier was so cavalier with his imposition of DDT treatments that he prescribed substantial doses of alcohol to an alcoholic. In a moment of understatement, Dr. Hucker expressed the view that for Mr. Dale this was "ill advised". He elaborated that "you would usually recommend abstention rather than measured treatment."

[407] Mr. Dale started his journey to Oak Ridge by shooting himself in the arm in a cry for help. What he received was not help, but numerous shots of DDT drugs that caused him severe psychic pain. The fact that Mr. Dale was a troubled youth did not make him a ready test subject for treatments that were designed to break him down but had no component designed to re-build him. He had to do the latter step himself.

[408] Mr. Dale exhibited strength of character and managed to make it through the DDT and Capsule ordeals keeping his good behaviour intact, which paid off for him in the short term with special benefits that most patients could not access. His strong character also paid off for him in the longer term by allowing him to quit alcohol consumption even after it was foisted on him by Dr. Maier. He managed to eventually achieve a comfortable home and work life, with the exception of some lingering bouts of depression and anxiety.

[409] In short, Mr. Dale suffered harm by being induced into painful psychotic episodes in the guise of DDT treatment. He also suffered harm by being degraded and humiliated when he was placed naked in a crowded Capsule with other naked men. And he suffered considerable harm in having to consume large quantities of alcohol to satisfy the whimsical curiosity of other patients as to how he would handle it, with the authority for this and other oppressive medical decisions being improperly delegated to patients by Dr. Maier and Oak Ridge as an institution.

[410] All of this contemporaneous, short term harm has lingered in the form of ongoing depression and anxiety, which has arisen intermittently in his post-Oak Ridge life. His treatment at Oak Ridge caused Mr. Dale intense short-term harm and more subtle, intermittent long-term harm. Dr. Maier was directly involved in his treatments.

h) Maurice Desrochers

[411] Maurice Desrochers died in a house fire while visiting friends on June 22, 2006. His sister, Lorraine Desrochers, brings this claim on behalf of his Estate. Mr. Desrocher's Clinical Records

from Oak Ridge are in the evidentiary record, and Ms. Desrochers was examined for discovery in her brother's place as executor of his Estate.

[412] Mr. Desrochers was committed to Oak Ridge on September 15, 1980 at the age of 18, having been found not guilty by reason of insanity for killing his mother and shooting and wounding his father. He remained there until January 2, 1985. His time at Oak Ridge was after Drs. Barker and Maier had already left. Dr. Julia O'Reilly was the STU Director during his stay there. The Capsule had been dismantled by that time, and the DDT treatments had ended. His claim herein, commenced by his sister in 2006, relates solely to his stints in MAPP.

i) Pre-Oak Ridge and index offence

[413] Lorraine Desrochers testified that she and her brother had a difficult home life as children. Their mother suffered from heart disease and their father had pernicious anemia as well as anger management problems. Ms. Desrochers was removed from the family by the Children's Aid Society when she was 14 years old. Her brother started using drugs and drinking alcohol early in life, including glue sniffing at 9 years old. He was bullied and taunted in school, and dropped out at the age of 16 without finishing high school.

[414] On February 27, 1980, at the age of 17, Mr. Desrochers purchased ten rounds of .303 calibre bullets for his rifle at a sporting goods store in Toronto. According to a Psycho-Social Assessment done by a social worker at Penetanguishene on December 2, 1980, Mr. Desrochers took the rifle and ammunition the following day and, under the influence of a mix of drugs and alcohol and experiencing "really violent visions", stood at his parents' bedroom door and fired his rifle three times. He hit his mother with two shots and his father with one. He then fled the house, stopped a taxi and told the driver to take him to a police station. Mr. Desrocher's mother was pronounced dead on arrival at the hospital, while his father survived after undergoing emergency surgery to amputate his left arm.

[415] A doctor that examined Mr. Desrochers at the police station on February 29, 1980 observed that he was unstable, volatile, notably depressed, and suicidal. On the following day, March 1, 1980, Mr. Desrochers attempted suicide while in custody and was put under close observation. Six months later, on September 9, 1980, Mr. Desrochers was found not guilty by reason of insanity for the murder of his mother and the attempted murder of his father.

ii) Experience in the STU

[416] In a Questionnaire about her brother completed by Ms. Desrochers at Penetanguishene on October 27, 1980, Ms. Desrocher took wrote of her perspective on her brother's behaviour and mood at the time. She described Mr. Desrochers as "really belligerent", observing that he "seemed scornful & cynical all the time but never said much". She also stated that was "either really quiet 'or he would just flare up' for little or no reason".

[417] Mr. Desrocher's Clinical Record dated February 18, 1981 states that after a period of confinement, he was sent to MAPP on February 16, 1981 for displaying a negative attitude. The Record indicates that while in MAPP he was "evasive and playing games" and therefore "placed

on restraints". The Clinical Records recording Mr. Desrochers being sent to this stint in MAPP are all signed by Dr. J. O'Reilly.

[418] Over the next several months he remained in MAPP, with the Clinical Records recording that he was frequently uncooperative and displaying a "manipulative, smart-alek attitude". In a note on his Clinical Record dated April 8, 1981, it was noted: "Chief complaint – gastric distress whenever he is under stress".

[419] The Clinical Records of May 1981 disclose that Mr. Desrochers was considered to lack insight and motivation for self-improvement in MAPP. He was ultimately removed from MAPP without completing the program. He continued to suffer from gastrointestinal problems. It is apparent that the stress of 50 days in MAPP did not help the digestive issues that he was experiencing prior to being placed in that program. The Clinical Records show that Dr. O'Reilly conducted a post-MAPP interview with Mr. Desrochers on May 27, 1981, concluding "Patient to remain in present program." She reached a similar conclusion in an interview with Mr. Desrochers a month later, as documented in his Clinical Record dated June 24, 1981.

[420] Dr. O'Reilly met with Mr. Desrochers on August 12, 1981, and reported on his progress in his Clinical Record of that date. A week later, on August 18, 1981, he was sent to MAPP again because he "continued to talk about drugs and previous habits" and for "showing a negative attitude toward the program and policies". A Clinical Record dated August 28, 1981 indicates that he was apparently putting more effort into the MAPP group therapy but was not able to accept feedback from other patients. As on the previous stay in MAPP, Mr. Desrochers was consistently recorded as lacking insight and maturity. His sister, who had visited him in Oak Ridge with her father, testified that the MAPP program was not kind to Mr. Desrochers:

> Q. And what was – what was your impression – of his – his thoughts – or experiences in MAPP?
>
> A. Well, that he was angry about it, that he felt that the other patients or whatever had bullied him.

[421] The Clinical Records indicate that he was in MAPP at least a month from mid-August 1981 to mid-September 1981. It seems that each time Mr. Desrochers was put in MAPP he was unable to accomplish the 14 perfect days it would have taken to end the session, and as a consequence it had to be repeated. A Clinical Record of November 25, 1981 states that, "Maurice said he would like to go to 'E' Ward. The patient has spent a considerable amount of time in the Motivation, Attitude, Participation Program."

[422] Dr. O'Reilly conducted a Patient Management Meeting with Mr. Desrochers on December 5, 1980 which is thoroughly documented in the Clinical Record. The Records show that she followed this up with interviews and a review of his condition on a nearly monthly basis through to January 1982, when she increased her sessions with him to a weekly or bi-weekly basis until another substantive Patient Management on May 25, 1982 documented in the Clinical Record. The Records show that Dr. O'Reilly continued the periodic visits through 1983 and 1984. On

September 6, 1984, she recorded in his Clinical Record that he had been appointed a "patient-teacher".

[423] On November 14, 1984, Dr. O'Reilly reported that Mr. Desrochers was "doing quite well", and on December 6, 1984 she wrote in his Clinical Record that, "On the whole he's reached his maximum of improvement." Dr. O'Reilly completed Mr. Desrocher's Discharge Statement dated January 2, 1985, in which she states that he "functions very well when he is put in a position of some little authority. He needs to improve his feelings of self-worth." In the Discharge Statement, Dr. O'Reilly also indicates that his diagnosis at that point: "Personality Disorder, Antisocial, Drug Abuse".

iii) Post-Oak Ridge experience

[424] Ms. Desrochers testified that Mr. Desrochers was discharged to North Bay Regional Hospital on January 2, 1985, and that he remained there until 1993. According to Lorraine Desrochers, the time in North Bay was not as disturbing to Mr. Desrochers as the time at Oak Ridge.

> Q. And without telling us what he said about his time at Oak Ridge, what was your impressions based on your discussions with him of the impact of Oak Ridge on him.
>
> A. Well, it upset him, it made him angry and – yeah. …
>
> Q. And – and did your brother – have the same reactions when he would speak about North Bay as he did...
>
> A. No.
>
> Q. ...about Oak Ridge?
>
> A. No, he didn't.

[425] Having said that, Dr. Hucker conceded in cross-examination that Mr. Desrochers attempted suicide at least once after leaving Oak Ridge. The change of venue could not change the underlying causes of his pain.

iv) Causation and harm

[426] In his Supplementary Report, Dr. Bradford opined that Mr. Desrochers' psychiatric condition made him particularly susceptible to being harmed by the stress of MAPP:

> In my opinion Mr. Desrochers was vulnerable because he suffered from Schizophrenia and the programs in MAPP were traumatizing and had a negative effect on individuals suffering from Schizophrenia… He most likely suffered harm as a result of his exposure at Oak Ridge.

[427] Dr. Hucker also examined Mr. Desrochers' records. He agreed in cross-examination that there was no therapeutic benefit to the time Mr. Desrochers spent in MAPP. It was his view that with his documented gastric syndrome, MAPP would have been a very bad place to be. Dr. Hucker's view was that exposure to MAPP for a person with this syndrome was "ill advised" and an untherapeutic thing to do. In fact, Dr. Hucker acknowledged that MAPP was a form of punishment, and an inhumane form at that.

> Q. And so, if someone with a predisposition with a gastric condition, this would be a very bad place to find yourself?
>
> A. It may be entirely attributable to it as well.
>
> Q. And he had been in MAP for over 40 days straight when he made this complaint...
>
> A. Uh-hmm.
>
> Q. ...right? In April 1981?
>
> A. Yeah. That's when it was.
>
> Q. Okay. And that – using your 24-hour confinement as a yardstick for whether or not something is humane or inhumane, being placed as – as a very young person in MAP for over 50 days straight, that would be very inhumane?
>
> A. Yes, I think so.
>
> Q. It would be degrading?
>
> A. Certainly inhumane, yeah.

[428] While Mr. Desrochers arrived too late to participate in all of the STU treatment programs, he did get placed in the harshest one of all. That is not to say that he was despondent every day for the nearly 5 years he spent at Oak Ridge. Indeed, Dr. Hucker pointed out that in letter dated March 31, 1981, Mr. Desrochers said pointedly, "I have no complaints about the program." He used this as an example of Mr. Desrochers feeling well disposed toward his experiences.

[429] Dr. Hucker may be right that, at least on a periodic basis, Mr. Desrochers was inclined to tolerate the Oak Ridge experience. On the other hand, this letter is written in the midst of Mr. Desrochers' lengthy, 3-month stint in MAPP, when the Clinical Records on a consistent basis describe his condition as unable to tolerate the program, both mentally and physically. In cross-examination, Plaintiffs' counsel suggested, and Dr. Hucker agreed, that Mr. Desrochers may have written the letter in order to pander for his release from MAPP:

> Q. Because without displaying this level of positivity, there was virtually no chance that you were going to get a positive recommendation from one of the – the psychiatrists?

A. That's what people said, yes.

Q. And that's the clear unequivocal evidence in this case, correct?

A. In this one, yeah.

[430] As Dr. Hucker says, it was inhumane to treat Mr. Desrochers with a program like MAPP. As a psychiatrist, Dr. Hucker characterized the program as "untherapeutic", and as a physician he described it as a program to which a patient with Mr. Desrochers' gastric problems never should have been exposed. Moreover, as Dr. Bradford said, a patient like Mr. Desrochers, diagnosed by Oak Ridge as schizophrenic, is especially vulnerable and especially prone to suffering great psychic pain in a stressful program like MAPP.

[431] Oak Ridge and the MAPP did not cause Mr. Desrochers to be a very broken, mentally ill man. He was all of that when he entered Oak Ridge after having killed his mother and maiming his father. It also is not the cause of his being suicidal; again, he attempted suicide both before and after experiencing MAPP. But for Mr. Desrochers, time spent in MAPP was time spent suffering badly. He was a vulnerable young man who, having been bullied as a youth, was again bullied by the very institution that was supposed to help him.

[432] Oak Ridge exposed Mr. Desrochers to patients who caused him to relive the experience of being bullied, it put him under stress that either caused or greatly exacerbated his gastrointestinal problems, and it prompted him into a lingering sense of anger that, according to his sister, stayed with him the rest of his days. Mr. Desrochers deserved a secure custodial environment and therapeutic care. He did not deserve to have suffering and indignities inflicted on him.

[433] Not all of his troubles emanated from Oak Ridge, but Oak Ridge certainly caused Mr. Desrochers intense short-term pain and a certain amount of long-term harm. Dr. O'Reilly was directly involved with his treatment.

i) Donald Everingham

[434] Donald Everingham was first committed to Oak Ridge from March 7, 1975 to May 3, 1975, when he was 29 years old, for an assessment after being charged with the violent rape of an 8-year old girl. He was re-admitted to Oak Ridge 5 months later, on October 17, 1975, after having committed another violent sexual assault for which he was found not guilty by reason of insanity. He remained at Oak Ridge and its successor institution, Waypoint, until March 28, 2012.

i) Pre-Oak Ridge and index offence

[435] Mr. Everingham was born on March 25, 1946. His mother died during his birth and his father remarried when he was three years old, leaving him in the care of his maternal grandmother who blamed him for his mother's death. Mr. Everingham deposed that his grandmother was both verbally and physically abusive, and that she never let him forget that he had caused his mother's death.

[436] That said, his home life as a young child was a mixture of positive and negative. He testified that he was enrolled as a student at the Royal Conservatory of Music and was a child prodigy on piano who at a young age performed at the Royal Alexander theatre.

[437] Mr. Everingham testified that he began drinking alcohol when he was 12-years old, smoked 4 to 5 packs of cigarettes a day, and took drugs such as marijuana, speed, and acid (LSD). When he was 15-years old he was accused of molesting two young girls, and he dropped out of school at 17-years old. He gave evidence that during this time he was abusing substances on a daily basis:

> Q. How heavily were you drinking, before?
>
> A. Well, to get the work, which about six, seven miles I would drink a mickey. In work I would drink a 26er, and after work I'd drink a mickey. But, I'd also be doing drugs.
>
> Q. Okay. So you were on the extreme level of the alcoholic spectrum?
>
> A. Yes.
>
> Q. And you're a drug addict, as well?
>
> A. Yes.

[438] According to a 1975 Case History prepared at Penetanguishene, Mr. Everingham was not a stranger to the criminal justice system in the years prior to his admission to Oak Ridge. In 1967, he was convicted of criminal negligence and was sent for assessment to the Clarke Institute. There it was noted that psychiatric treatment was recommended although it might not be successful. In 1969, he was charged with dangerous driving and possession of a rifle and was committed to the Clarke Institute on a Warrant of Remand for a fitness assessment. He was found to be fit to stand trial, but was diagnosed with antisocial personality disorder and his prognosis was not positive.

[439] Mr. Everingham's pre-Oak Ridge criminal history did not stop there. He deposed in his affidavit that it also includes charges for break and enter, theft, indecent assault, and a number of driving offences.

[440] The Penetanguishene Case History relates that on May 5, 1975, Mr. Everingham was convicted on charges of rape, attempted murder, and forcible seizure resulting from an incident in which he abducted an 8-year old girl, raped her, tied a sock around her throat and abandoned her in a ditch. He was ultimately sentenced to life in prison. The record indicates that it was a particularly brutal assault, and that the young girl only survived because the sock was loosened by a rain storm that occurred on the night of the attack. Mr. Everingham was committed to Oak Ridge from March 7, 1975 to May 3, 1975 for an assessment. He did not participate in the STU programs during this 2-month period.

[441] Dr. Fleming assessed Mr. Everingham and summarized his findings in a Pre-Sentence Report dated May 2, 1975, a copy of which is in the evidentiary record before me. Interestingly,

in that Report it is recommended that although Mr. Everingham suffers from a "serious mental disorder" he will likely not benefit from institutionalization at Oak Ridge:

> Mr. Everingham, in my opinion, presents a very serious potential for further dangerous behaviour. He has expressed an interest in returning to Penetanguishene for treatment. Unfortunately, he presents pathology of a very severe and long-standing type so that only a lengthy period of involvement could bring any hope for improvement and even then the prognosis is poor. After considerable discussion with our treatment team and in view of our rather limited resources it was felt that Mr. Everingham is not presently a suitable candidate for long-term treatment in this facility.

[442] Having said all of that, Dr. Fleming was also of the view that at some point in the future Mr. Everingham should be subjected to therapy at Oak Ridge. It is obvious that Dr. Fleming recognized Mr. Everingham's need for treatment but was skeptical that Oak Ridge could provide what he needed and did not want to recommend that he be set up to fail. In a Clinical Record dated April 3, 1975, Dr. Fleming wrote:

> I would regard this man as one of the most severe antisocial personality disorders I have ever encountered. He is indeed extremely dangerous and should be confined for an extended period for the protection of the public, is my personal opinion. That he ought to have been found not guilty by reason of insanity such is the depth of his pathology.

[443] In the meantime, Mr. Everingham was also put on trial for an incident that occurred the previous year in which he attacked a 17-year old girl at the Royal York Hotel. He was charged with indecent assault and assault causing bodily harm. The Case History narrates that that on the night of this incident he went to his aunt's house, consumed a substantial amount of alcohol and smoked hash, and threatened to kill his aunt if she got up from the floor where she was sitting. He then told her that he wanted to kill three more people and that "he liked to watch their eyes pop out."

[444] It is also reported in the Case History that he told his landlady when he returned to his own apartment that, "I now know that I am two people. Do you know what the other person is like? He hates me, he is a killer and he wants to take me over completely and he is doing it more often now… I have done nothing but the other one has killed." The social worker who interviewed Mr. Everingham and authored the Case History observed that at the time of the interview "he has no feelings about the whole affair and it does not perturb him that he could possibly have done similar crimes without remembering them."

[445] Mr. Everingham was found not guilty by reason of insanity on the charges with respect to the 17-year old victim. Despite Dr. Fleming's pessimism about the potential for successful treatment, Mr. Everingham apparently chose to go to Oak Ridge instead of prison in hopes of curing his violent behaviour. He testified that he was in desperate need of treatment.

> Q. Now, when you arrived in Oakridge both for the assessment and the longer-term, in March and October of 1975, did you make it known to professional staff that – well, tell me what you made known to the professional staff in relation to your desire to seek treatment?
>
> A. I wanted treatment. I was given an opportunity by my lawyer at that time, (a) you can go to prison and you will probably stay there until, well, my parole date was 1987, September 7th - no, 1985, September 7th, sorry. And – or, you can go to Oakridge and get a cure because if you get out from the penitentiary, you'll probably re-commit. Or, you can go to Oakridge and probably never, ever re-commit and get out within five to seven years. And I said, 'Yeah, send me to Oakridge.' I realized I was so bad some of the stuff I was doing was just right – you – there's no – no words in the – no words to describe what I did. None.

[446] Mr. Everingham was re-admitted to Oak Ridge on October 17, 1975 and was placed in the STU.

ii) Experience in the STU

[447] The 3 impugned programs were active in the STU when Mr. Everingham arrived in October 1975, and he participated in all of them.

[448] The Bedside Nursing Notes for Mr. Everingham, together with the Capsule Therapy Contracts in the record, indicate that he was in the Capsule on 5 separate occasions:

> February 16-8, 1976. A signed Capsule Therapy contract is in the record. Mr. Everingham amended it so that his admission was for only two days and so that the word 'unclothed' is changed to 'clothed'.
>
> February 26 - March 9, 1976. A signed Capsule Therapy contract is in the record. Mr. Everingham amended it so that the word 'unclothed' is changed to 'clothed'.
>
> March 29 - April 1, 1976. A signed and unamended Capsule Therapy contract is in the record.
>
> June 7-10, 1976. A signed Capsule Therapy contract is in the record. The Bedside Nursing Notes for this Capsule session indicated that it was intended to be for 'possibly' two weeks, but it appears to have lasted for only 3 days.
>
> June 17, 1977, for two weeks. A signed and unamended Capsule Therapy contract is in the record. The record is unclear as to the specific entry and exit dates.

[449] Mr. Everingham testified that the Capsule was for him a very negative experience. The Bedside Nursing Notes do not record any acute distress suffered by him during the Capsule sessions; in fact, the Clinical Record of July 11, 1977 refers to Mr. Everingham's participation in the Capsule program as: "trying to get more into his feelings he says, with very little success." Nevertheless, he testified at trial that he objected to the very purpose of the program:

> Q. Right. Okay. And tell me about the anything in relation to sensory deprivation?
>
> A. Yeah. When you - when you come out of there and you see people and they've got clothes on, it's a total shock. What they do is absolutely - I did mention brainwashing and that's what they were doing, they were trying to brainwash you into - I don't know what. But it was not - to me, it was a bad, bad, bad experience. It was really bad.

[450] Mr. Everingham's evidence was that although he volunteered for the Capsule, this was not a sincere gesture on his part. As he explained it in cross-examination, his willingness to subject himself to this program was premised on the fear that he would otherwise be sent to MAPP. At the same time, he conceded that he consented to the Capsule as for a number of reasons:

> Q. And the first time you went it was because you were interested in going and hoping to become less defensive as a result of experiencing the Capsule, right?
>
> A. And to get off the ward.
>
> Q. Because, generally speaking, you preferred going to the Capsule over doing ward work, didn't you?
>
> A. No. I preferred going to Capsule rather than being punished. If you sign a contract in the Capsule you can't be punished. But that was wrong, we were punished.

[451] Mr. Everingham's Treatment Records at Oak Ridge show that as part of the DDT program, he received Dexamy-Tofranil treatments and alcohol treatments, as follows:

> Dexamyl-Tofranil, for six weeks beginning in September 1976. Dr. Maier received authorization for these drugs from the federal Ministry of Health.
>
> Alcohol on December 13, 1976.

[452] Mr. Everingham deposed that his DDT experience was limited due to a chronic heart condition. He explained that the Dexamyl-Tofranil regime was stopped after four days because he began to experience heart problems. Counsel for the Doctors submits that there is no documentary evidence that supports this, but in fact there is. A Clinical Record dated October 17, 1976 indicates that Mr. Everingham had a Dexamyl-Tofranil treatment but that a "scopolamine treatment…eventually had to be denied because of cardiac insufficiency." In a Penetanguishene Hospital Report to the Ontario Review Board dated August 4, 1988 reviewing Mr. Everingham's history, it is recorded that "drug treatment…had to be denied because of a heart problem. He took part in an alcohol treatment, but this also caused physical problems."

[453] There is a considerable difference of opinion between the parties as to what occurred during Mr. Everingham's single alcohol treatment. Mr. Everingham testified that the session ended in a serious physical altercation and that he was put on restraints.

[454] The Plaintiffs state that Mr. Everingham was involved in a physical altercation with other patients and that he complained to the Ombudsman's office about his "exposure to alcohol." Mr. Everingham testified that he was placed in double restraints while on the alcohol treatment:

> Q. And moving to the DDT/Alcohol program, you've described the level of alcoholism that you suffered from. Were you subjected to alcohol as part of the DDT?
>
> A. Yes. I was.
>
> Q. Tell us about that.
>
> A. You have to – you're put in a room similar to the capsule, like the floor, and it had VS and VH audio and video tapes, and that was done – my alcohol was done by a fellow patient, BA, I'll just initial him. They were not getting - after I drank the 26oz, they weren't getting anywhere with me, I would answer their simple questions, so they sent, quote unquote, 'Heavies' in there. And they started to shove me back and forth…
>
> So, after they pushed me back and forth, I went for D's throat and I said, 'Oh, what am I doing? This is wrong.' And one guy was diving at me so I hit him. Got up and kicked Currie (ph) because he was the second-toughest guy, and I was just dancing around until I was grabbed by the ankle and I went down and they all piled on me, and I ended up on the floor with a bloody nose.
>
> And then the staff came in with a wet rag and ran it in my face, and I was screaming because that was what my grandmother did. I was – I lost it. And they put me on double restraints and about an hour and a half later they took the double restraints off and said I was on full status.

[455] The Clinical Record of December 13, 1976, written by Dr. Tate, records the incident in a distinctly different way:

> Don had an alcohol treatment in Studio F with five patient observers today. While having his treatment he bumped his nose when he attempted to run from the studio and fell on the mats. No apparent damage resulted. An accident report was made out. In the evening he scratched his wrists while on supportive restraints and threatened to write the Ombudsman about the way he is being treated. He later complained of chest pains and difficulty in breathing and appeared to be flushed. He was examined by Mr. G. Gignac R.N. and was given Nozinan I.M. a 2210 hours on orders of Dr. Call.

[456] I note that Dr. Tate concedes that Mr. Everingham was put on restraints, which would be an odd reaction of staff to an accidental bumping of the nose. I also note that Dr. Tate records Mr. Everingham reacting to a stressful situation with chest pains, which seems to corroborate the evidence that he had heart problems which limited the DDT to which medical staff felt he should

be exposed. Whatever the truth – that is, whether there was a fight among patients undergoing alcohol treatments in the Capsule or Mr. Everingham tried running and bumped his nose – the evidence is that an injury occurred when Mr. Everingham, an alcoholic, was given an alcohol treatment.

[457] Mr. Everingham conceded in his testimony that he initially volunteered for LSD treatment as part of Dr. Maier's program but subsequently sought to be removed. As a result, he did not receive LSD. According to Mr. Everingham, he thought better of it and contacted an activist with the Church of Scientology who worked with the Citizens Commission on Human Rights to prevent the treatment. The church then initiated a public campaign against the use of LSD at Oak Ridge.

[458] In response to the Scientology campaign, Dr. Maier encouraged Reginald Barker to write, and the other STU patients to sign, a supportive letter to the editor of the *Barrie Examiner* praising the LSD program. For his part, Mr. Everingham stated he chose not to add his name to the list of patients signing the letter:

> Q. Your name is not on the list?
>
> A. No, it was not.
>
> Q. And so you knew about the letter, you chose not to sign it?
>
> A. That's right.
>
> Q. Okay.
>
> A. I knew what LSD can do.
>
> Q. Because you had already experienced it on the street?
>
> A. Yes.

[459] Defendants' counsel submit that Mr. Everingham's withdrawal from the LSD program without sanction is consistent with Dr. Maier's evidence that patients could withdraw from the program. The timing and context of this incident, however, is crucial to understanding it. Having prompted a very public anti-LSD campaign in the press, and an effort by Dr. Maier to counter that campaign, the response to Mr. Everingham's request to withdraw from the LSD program might well have elicited a more benevolent answer than otherwise. It is difficult to fathom that Dr. Maier would have compelled a patient in those circumstances to continue with LSD against his will or in light of a change of mind on pursuing the treatment.

[460] Bedside Nursing Notes indicate that Mr. Everingham underwent MAPP on one occasion, from December 15, 1978 to January 19, 1979. He is recorded in the Clinical Record of December 14, 1978 as having been sent to MAPP as a result of his having abused his position as a "runner" – a sort of in-house courier – by delivering a Christmas card to a friend on another ward. Counsel for the Plaintiffs pose this as a graphic illustration of the petty and arbitrary discipline meted out and resulting in sessions in MAPP.

[461] While in MAPP, Mr. Everingham apparently suffered an upset stomach and was removed intermittently to receive medical attention for that condition. His MAPP session ended on January 19, 1979 after he called a lawyer to complain that he believed he was unjustifiably sent there. The Bedside Nursing Notes also record that he was interviewed by the Ombudsman on January 31, 1979 in this regard.

[462] Mr. Everingham also testified that after subduing an aggressive patient with just one hand, he was asked to join the patients' security committee. He indicated that he responded positively to this, stating that "I don't mind because I'm not going to, you know, kick or hit anybody." However, he was unable to continue on the security committee for very long because it required him to remove his glasses, without which he was unable to see properly.

iii) Post-Oak Ridge experience

[463] As previously indicated, Mr. Everingham remained at Oak Ridge and its successor institution until 2012, when he was transferred to Brockville Mental Health Centre where he resides until today. In the years between the end of the STU program and 2012, he made numerous applications to be transferred to a medium security facility. He was also assessed on numerous occasions by various physicians in preparation for his Parole or Review Board hearings. His Oak Ridge file is therefore rather voluminous.

[464] On September 14, 1982, Mr. Everingham wrote to the National Parole Board and requested that he not be sent to Kingston Penitentiary. He stated in his letter that during his time at Oak Ridge he had greatly improved and did not want to risk setting himself back. In his pitch to avoid penitentiary time, he praised the effectiveness of the Oak Ridge programs:

> I am quite frankly worried as to what would happen if I was to be transferred to Kingston first instead of to Toronto Queen Street Mental Health Centre. I have just spent the last 8 years in the Oak Ridge Division M.H.C. and have since that time, made all of the necessary changes to be eligible for a transfer. If I had to do all of this over again in Kingston, I firmly believe that it would be a detriment to my Mental Health. Your system is geared totally different from the present system that I am now in.

[465] Several years later, in an assessment performed at the Clarke Institute on April 17, 1989, Mr. Everingham was described as having a long history of antisocial behaviour. The Assessment Report noted that he had benefitted from progress in some areas since his admission to Oak Ridge.

[466] At the same time, the physician who had performed the assessment expressed the opinion that the sincerity of Mr. Everingham's praise of the progress he had made at Oak Ridge was questionable. He indicated that this was especially the case given his recorded refusals to participate in activities on the ward and in therapy programs.

[467] Mr. Everingham was assessed by Dr. Bradford and a colleague in 2013 for the purposes of preparing a Report to be submitted to the Ontario Review Board on November 6, 2013. His diagnosis as set out in this Report indicated that his condition had not changed substantially over

the years at Oak Ridge: paraphilia, sexual sadism, pedophilia, polysubstance abuse, and antisocial personality disorder. Despite having aged out of his ability to inflict as much physical violence as he had in the past, Dr. Bradford was still of the view that Mr. Everingham represented a risk to the public:

> Mr. Everingham continues to pose a significant risk to the safety of the public. This is due to the severity of his index offences, his diagnoses of sexual sadism and antisocial personality disorder, his elevated score on the psychopathy checklist, and recent violence over the last year.
>
> Despite the incidence of violence towards a co-patient, the treatment team is still recommending 1:4 staff accompanied privileges on grounds and into the community of Brockville. A change from staff escorted to staff accompanied privileges would not introduce much additional risk given Mr. Everingham's mobility problems. He would be, in my opinion, at low risk for elopement. His risk of sexual violence is greatly reduced on the injectable antiandrogen medication.

[468] In more recent years, Mr. Everingham has pursued litigation regarding computer use, privacy issues, and the terms of his admission to Brockville Mental Health Centre. The Court of Appeal took note that, "the appellant's treatment team considers that he continues to be a high risk for future sexual violence despite his advanced age": *Re Everingham*, 2014 ONCA 743**,** at para 7.

[469] The Court went on to observe that the continued restrictions on his liberty were consistent with the recommendation of his long-standing treatment team at Waypoint. The medical records reviewed by the Court indicated that a "'cautious progression', with escorted privileges, be adopted with respect to the appellant's reintegration into the community": *Ibid*., at para 46.

iv) Causation and harm

[470] Dr. Bradford testified that during his years at Oak Ridge, Mr. Everingham was traumatized by the STU programs and as a result developed a distrust of doctors and the mental health system, which likely delayed his rehabilitation and transfer out of Oak Ridge for many decades. Dr. Bradford was also highly critical of the decision to give Mr. Everingham an alcohol treatment given his history of sexual violence aggravated by alcohol consumption. It is Dr. Bradford's view that the alcohol treatment likely slowed down Mr. Everingham's recovery and rehabilitation.

[471] By contrast, Dr. Turrall, who examined his medical history on behalf of the Defendants, opined that Mr. Everingham suffered no adverse effect or harm from the treatment he received at Oak Ridge. Although Dr. Turrall concedes that the records show that Mr. Everingham did complain once about being put in MAPP, he states that overall he consented to everything done to him. As he put it in his Report, "Mr. Everingham has significant psychological problems before being sent to Oak Ridge, and he participated in the programs willingly." In his Report, Dr. Turrall also commented on the alcohol treatment: "Although I agree that giving someone with Mr. Everingham's background alcohol should not be done, I do not agree that it harmed him."

[472] Mr. Everingham has long been diagnosed with psychopathy or antisocial personality disorder. As Dr. Booth has said with respect to several of the other Plaintiffs, pathological lying is one of the diagnostic criteria for this type of disorder, and must, in a setting where credibility is at issue, be taken into account. Dr. Turrall testified that in reviewing the record he could see that there were significant differences between Mr. Everingham's description of events in his affidavit and in his evidence on discovery. According to Dr. Turrall, this tendency, with spontaneous responses at discovery sometimes downplaying the STU experiences and statements in the affidavit playing up those same experiences, is a manifestation of a manipulative personality disorder and intent to deceive.

[473] Dr. Booth also opined in his Report that psychopaths, a category of disorder in which Mr. Everingham's diagnosis fits, have poorly developed emotions and are less likely to develop depression or anxiety or be impacted by mind-altering DDT drugs. In his reply, Dr. Bradford accused Dr. Booth of significantly overstating the point. He commented that, "Certain of the Defendants' expert[s]…suggest that psychopaths are wholly or partially immune from experiencing psychiatric harm as a result of the coercive, abusive, and humiliating experiences in the Capsule, DDT and MAPP programs."

[474] For his part, Dr. Booth testified that Dr. Bradford's critique is itself an overstatement and mischaracterization of his point. In Dr. Booth's view, persons with this type of diagnosis are not immune to the ill effects of these programs, but they are clearly less vulnerable. As he explained it, people with high scores on the Psychopathy Check List have very low scores on anxiety and depression and have a form of "emotional immunity".

[475] The record at trial leaves little doubt that Mr. Everingham is very intelligent and highly aware of his situation. He is one of the very few Plaintiffs who, for example, had the presence of mind to add the word "clothed" to the Capsule consent form before he signed it. That said, the evidence also goes a long way to establish that he is a manipulative individual. For example, in the Bedside Nursing Notes of January 7, 1979 that documented Mr. Everingham's session in MAPP, it is noted: "c/o feeling nauseated and vomiting. Staff feels this could be self-inflicted. RN notified."

[476] On a larger scale, it is easy to observe that in his affidavit Mr. Everingham is as critical of the Oak Ridge experience as one could be. By contrast, in his submissions to the National Parole Board and the Ontario Review Board he is as effusive in praise of the Oak Ridge program as one can be. So, for example, in his 1982 letter to the National Parole Board, he states:

> I firmly believe that the present system that I am now in is the BEST REHABILITATION SYSTEM EVER TO RUN IN ANY CANADIAN INSTITUTION. Second to none in the world. And to change the positiveness, and environment of cultures that I would have to face in Kingston would definitely be a hard thing to do [emphasis in the original].

[477] Having said that, in paragraph 4 of his affidavit, he states:

> While at Oakridge, instead of treatment, I was subjected to experimental programs that have left me psychologically and emotionally scarred. I have tried my best to forget what happened to me there, because every time I think back to it there is a tightening in my chest. I remember how abusive the behaviour of the staff and fellow patients was. Those recollections still exacerbate my feelings of anger and trigger my impulses toward violence.

[478] In his testimony, he described Oak Ridge as a "bad, bad, bad experience" and a "brainwashing experience" where he had feelings of distrust and none of his expressions were genuine. In a Clinical Record of October 17, 1976, he is quoted as saying that "he has made an honest trusting friendship and that this is a very real accomplishment for him."

[479] In a similar way, he testified at trial that instead of treatment, he received more abuse than he ever thought possible:

> A. I received more abuse than I ever thought possible. It was the most horrific time… At night when you wake up, you just hit the wall, and it's automatic, you don't – you don't – you don't it's not planned.
>
> Q. What do you mean, hit the wall?
>
> A. You hit the wall with your fist.

[480] On the other hand, at his discovery in 2013 he said he has "pretty well tried to forget everything."

> Q. When did you feel like you had moved on?
>
> A. Oh about ten years ago, eleven years ago, you can't carry this crap with you…

[481] It is also apparent from the record that in the Capsule and groups with other patients he was a domineering participant rather than a submissive one. Mr. Everingham's own description of the melee that took place during his alcohol treatment on December 13, 1976, in which he single-handedly took on a group of "heavies", illustrates that. Likewise, the fact that he was asked to be a member of the security committee for his ability to subdue other patients speaks to his general lack of vulnerability to his fellow patients.

[482] It is perhaps not surprising that Mr. Everingham played a domineering role in the Capsule and other group encounter venues. It conforms with Dr. Barker's original theory that domineering psychopathic patients would be paired in the STU experiences with vulnerable schizophrenic patients. Dr. Barker wrote about this explicitly in "Buber Behind Bars", p. 63:

> What perhaps may reassure those unaccustomed to thinking in these terms is the fact that the short-comings of patient therapists tend to be ruled out in groups, where pathologies cancel and reciprocate one another. To give a very crude example, a schizophrenic will object to the slick solution to a problem adeptly fleshed out by

> a psychopath. The psychopath will point with some justice to the woolliness and diffuse idealism of the schizophrenic.

[483] In his testimony, it was apparent that Mr. Everingham was rather proud of his dominant "teacher" role vis-à-vis the more submissive and vulnerable patients. And while some of the Plaintiffs testified that being grouped with other patients who were "teachers", and who had no professional training but had been given authority over them, was the most oppressive part of the STU, for Mr. Everingham it was the part that was most satisfying:

> A. The psychotics on that ward, they were teachers. I was the coordinator of the teachers. I was a teacher first, and the became a coordinator of teachers. I was at the sunroom for two and a half years – well, I think about two years with BA another patient. We enjoyed it. We tried to help them. We tried to relieve their anxieties…we tried to bring them down from where they were to a more stable level. No staff. And you also – no – no pro staff, just the patients helping patients. And there wasn't too many patients that could do that.
>
> Q. Okay. When you were in the role of teacher is it fair to say that you never abused another patient?
>
> A. I only had one fight with one patient when he attacked me.

[484] Given the harshness of the MAPP and the nature of the drug experiences in the DDT, it is difficult to say that anyone who went through them at all was not somehow harmed. Mr. Everingham did not complain about the programs at the time, but his reactions – losing his temper, lashing out at other patients, either experiencing or feigning stomach problems, etc. – is evidence that he suffered from these programs even if he did not realize it at the time. In some ways, although he did not express his upset in words, he wore his short-term pain on his sleeve.

[485] As for longer term harm, that is more difficult to perceive in Mr. Everingham's case. He came into Oak Ridge a very dangerous, violent, and volatile person with an antisocial personality disorder and a diagnosis as a sexual predator, and he left with roughly the same disorders and diagnosis. His mental illness was such that while it did not make him immune to the immediate pain caused by the programs, it armed him against much long term impact.

[486] Dr. Turrall noted in his Report on Mr. Everingham that in an early assessment of him it was observed that "since age 13 he caused a lot of trouble, stating that he was a 'hell raiser'". He also noted that as recently as 2015, he could still be described in similar fashion. At his 2015 Ontario Review Board hearing, the Board's conclusion reflected the same general personality he has exhibited since his early teens:

> Mr. Everingham suffers from major mental illnesses: sexual sadism, pedophilia, heterosexual type and poly-substance abuse. He also has access to diagnosis of antisocial personality disorder. While at Penetanguishene, he became an active advocate to change the programs that he had experienced, contacted his former lawyers, patient advocate at Penetanguishene, the Ministry of Health and the

> ombudsman of Ontario. He also participated in the various therapies offered to him hoping that some of these therapies would be of assistance to improving his mental health.

[487] As Dr. Booth points out, psychiatrists generally tend to consider personality disorder to be in a different category than other types of mental illness. Other disorders – schizophrenia, for example – are "states", and are understood as "temporary changes from baseline induced by 'precipitating factors'". A personality disorder, however, is considered a "trait which is inflexible, developed at a young age and does not vary much over a lifetime." This latter description applies to Mr. Everingham's diagnosis and appears to conform to the medical records recording his behaviour and diagnoses over the years.

[488] Accordingly, while for Mr. Everingham there is certainly proof of short-term suffering and harm contemporaneous with his actual experiences in the three STU programs during the 1970s, the evidence of long term harm outlasting the immediate impact of those programs is weak. Such evidence as there is of long-term harm or a lingering effect of the STU programs is based on Mr. Everingham's own testimony, which is contradictory in many areas and not particularly credible.

[489] The suggestion of long-term harm is also based on Dr. Bradford's observation that Mr. Everingham has a notable distrust of psychiatry and psychotherapy. But Dr. Bradford does not explain how and why this is a result of the STU experience as opposed to any of the other experiences with psychiatric treatment Mr. Everingham has undergone over the 4 decades that he has been institutionalized. Indeed, I note that in the early 1990s Mr. Everingham sued Oak Ridge about another program – the Behavioural Management Program – that was used later in the 1980s. In Mr. Everingham's description in his examination-in-chief, that program was at least as damaging as the STU programs, if not more so:

> Q. And I understand that there was also lawsuit you were involved with in relation to something called the Behavioural Management Program?
>
> A. Yes. I believe I – one of them I stepped out of.
>
> Q. Okay. But just before we get to that, what was that suit in relation to, briefly, do you recall?
>
> A. The abuses that were going on inside called the behaviour program. It – to make this short so that people may try to understand this, what I did was horrendous. What they were doing to us was worse. They figured they had an absolute clear ticket to do whatever they wanted with us, to abuse us, to do anything they wished. And they had the government behind them. It was – it was insane.

[490] The treatments he received at Oak Ridge caused Mr. Everingham short-term harm in the form of physical discomfort and endangering him by placing him without proper supervision in intense situations where he was prone to getting into fights with other patients. Dr. Tate and Dr. Maier were directly involved in his treatments.

[491] There is insufficient evidence to establish that the Oak Ridge experience caused him the long-term harm that he claims.

j) John Finlayson

[492] John Finlayson passed away in June 2020, after the trial had ended and while judgment was under reserve. There has not yet been an Order to Continue sought with respect to Mr. Barker's claim, and so technically it is stayed. On the assumption that Plaintiffs' counsel will ultimately obtain an Order to Continue, I will review the evidence with respect to Mr. Finlayson as if the claim were being continued by his estate representative.

[493] Mr. Finlayson was committed to Oak Ridge on March 18, 1974 on a Warrant of the Lieutenant Governor after being found not guilty by reason of insanity for the murder of a young boy in a Toronto hotel. He remained in Oak Ridge until January 30, 1979, when he was discharged to Brockville Psychiatric Hospital.

i) Pre-Oak Ridge and index offence

[494] Mr. Finlayson related in his affidavit that he was born in 1936 and grew up in a poor family of Scottish immigrants. He dropped out of school after grade 8. His father was a chronic alcoholic who, when intoxicated, was aggressive towards Mr. Finlayson and his mother. A psychiatric assessment dated February 26, 1974 done at the Clarke Institute in Toronto records that he was apparently sexually assaulted by an older man when he was 7 or 8 years old, and that a few years later, at the age of 10, he engaged in some sexual game playing with his younger sister with whom he slept in the same bed.

[495] In his affidavit, Mr. Finlayson also states that he was hit by a car when he was 7 years old. He seems to believe that this accident caused a lesion on his left temporal lobe, but a electroencephalograph performed at the Clarke Institute in 1973 did not indicate the presence of any lesion or structural abnormality in the brain.

[496] The Clarke Institute report also narrates that when he was a teenager he tried to renew his sexual relationship with his sister, and that he became aggressive toward her when she declined the invitation. Once he nearly strangled her and another time he hit her on the head with a wrench, rendering her unconscious.

[497] As Mr. Finlayson told it in his affidavit and testimony at trial, he started drinking heavily as a youth and by the time he was 22 years old had become a serious alcoholic, much like his father. He testified that his drinking caused him to lose his job, broke up his marriage, and caused his wife to leave with his young son who he believes was eventually taken away by the Children's Aid Society and put up for adoption. These events sent him spiraling into bouts of depression, anger, and aggression.

[498] Mr. Finlayson deposed that in 1961 he was charged with possession of a dangerous weapon, and in 1963 he was charged with assault causing bodily harm and sentenced to 6 months in custody for attempting to strangle the 4-year old son of a friend he was visiting. He was charged with assault causing bodily harm and given a 6-month sentence. In 1968, he was sentenced to

another 6 months after being convicted of indecent assault on two young girls. He testified that he was always intoxicated when committing criminal acts. According to the Clarke Institute report, he spent 5 months, from August to December 1969, at an alcoholism treatment clinic. In terms of an early diagnosis, the report states:

> Psychological tests were carried out at the Clarke Institute on September 13th, 1973 and on several days subsequently. They revealed a man of high average to bright normal intelligence who showed a high level of fearfulness and anxiety. There were indications of extreme emotional instability in a submissive, sombre, apprehensive and inhibited individual. There was considerable confusion about sexual orientation with strong tendencies towards immaturity, dependency, depressive features and a general inadequacy. The diagnostic impression of the psychological report stated that, although there were no clear indications of psychotic tendencies, the personality must be considered so pathological that his behaviour may, at times, become quite disordered and out of conscious control.

[499] A number of other criminal offences ensued. In 1971, Mr. Finlayson was convicted of assault and threatening after striking a young woman he was seeing and threatening the wife of the superintendent of an apartment he was thinking of renting. As a consequence, he spent a month in jail. In 1972-73, he was again admitted to an alcoholism rehab centre where he stayed sober for the duration of his stay. Upon discharge, he immediately began drinking heavily. On July 26, 1973, he went to the supermarket and met a young boy who helped him carry groceries back to the hotel where he was staying. The Clarke Institute report states:

> He tried to obtain a cab in vain and he remembers the walk back to the hotel, accompanied by the boy, as the clearest memory in an otherwise confused period. Back at the hotel in his room, he assumes he made advances to the boy, which were rejected. He remembers grabbing him around the neck and holding him tight, recalls him becoming limp but did not think he was dead. He denies any recollection of committing sodomy or biting the boy on the buttocks. But he does recall pulling a blanket over the boy up to his chest and then leaving the hotel. Thereafter, events are blacked out…

[500] A letter dated March 21, 1974 from a Crown attorney to medical staff at Penetanguishene sets out that Mr. Finlayson was assessed by three different psychiatrists. It concludes: "All three agreed that the prisoner was a most dangerous man." Mr. Finlayson was found not guilty by reason of insanity and committed to Oak Ridge on a Warrant of the Lieutenant Governor.

ii) Experience in the STU

[501] In his initial Clinical Record at Penetanguishene, dated March 22, 1974, Dr. Camunias summarized his impression and diagnosis of Mr. Finlayson as follows:

> He tends to cover up his problems with alcohol and was always running away from his problems. He now impresses one that he seems to be taking a hard look at

> himself and he may be realizing that he has no way of getting away from his present situation. He has come to the end of the road, so to speak.
>
> DIAGNOSIS
>
> Personality disorder; sexual deviation, pedophile, dangerous under the influence of alcohol – he can turn into (a viscous beast) a dangerous person to susceptible children.

[502] Mr. Finlayson was a well-behaved patient who cooperated with authority at Oak Ridge. He stated in cross-examination that he was never in MAPP or restrained or placed in cuffs. He understood that MAPP was punishment, not therapy, and explained that he had never been sent to MAPP because, as he put it, "if you obeyed the rules you don't go to MAPP".

> Q. You were a well-behaved patient while you were at Oak Ridge, right?
>
> A. I'm a well-behaved person everywhere, on the street, if you keep me away from alcohol.
>
> Q. You were never sent to the MAP Program, correct?
>
> A. That's right.
>
> Q. And you were never sent to MottoPro?
>
> A. One of the fellas said to me in the dining room, he said, Why don't you ever go to MAPP? And I looked at him, and I didn't have an answer ready, a ready answer, because it seemed to me if you obey the rules, you don't return to MAPP.

[503] The Clinical Records and Treatment Records for Mr. Finlayson indicate that he received the following DDT treatments:

> Dexamyl-Tofranil for a 7-week treatment from November 25, 1974 to January 13, 1975, on the orders of Dr. Maier;
>
> Sodium Amytal and Ritalin on March 13, 1975, on the orders of Dr. Maier; and
>
> Dexedrine on July 21, 23, and September 7, 1975.

[504] The Clinical Records do not contain any indication of complaints or trauma experienced by Mr. Finlayson during these treatments. That said, he had documented difficulties during the extended Dexamyl-Tofranil treatment. The Special Treatment Report of January 13, 1975 documents that during the course of the drug treatment he was "Aggressive and outspoken. Very over-sensitive. Inappropriate emotions at times. Went through numerous mood swings."

[505] Defendants' counsel submit that Mr. Finlayson's response to this treatment was overall a positive one; however, what the Special Treatment Report shows is that studying his difficulties

in controlling his moods was positive for the others participating with him and observing him, but not for Mr. Finlayson himself:

> The group feels that they benefitted insofar as getting a more extensive picture of John's emotional make-up.

[506] In his testimony in chief, Mr. Finlayson indicated that the treatments were not especially helpful to him. When pressed, he testified that the aggression that came out during the drug treatments may have had one positive impact on his personality:

> Q. Can you tell the court what benefit you obtained from taking all these drugs, including the LSD, when you were at Oak Ridge?
>
> A. Well, the only one I can put my finger on, it's obvious, ah, I'm more aggressive, well, assertive, you know, I'm more assertive than I was before.

[507] In addition to the DDT sessions listed above, the records show that Mr. Finlayson was in the Capsule from July 21, 1975 to July 25, 1975 for a 4-day LSD treatment, and was administered 300 mg of LSD. The Special Treatment Report of August 22, 1975 that records this session is signed by Dr. Maier. The LSD Program Contract dated June 26, 1975 and signed by Mr. Finlayson states that while undergoing this treatment in the Capsule he was to have pajamas to wear, was to be restricted to a liquid diet, was to have music of his choice playing, and was to have no visitors. According to Mr. Finlayson, however, the experience did not work out entirely that way.

> Q. Were you clothed a – sorry, were you clothed at the time they injected you, or were you naked?
>
> A. Oh, no, I was naked. I had to take off my clothes. But, what was I gonna say? They – it was – what spoiled it for me was John Richmond, my partner, playing John Denver's music, right. Now, I liked John, he was one of my favourites, but that's how my trip turned out.
>
> Q. So, you were listening to John Denver albums during your LSD trip?
>
> A. Oh, yes, and then for weeks before…
>
> Q. You had a placid trip on LSD, right?
>
> A. A what?
>
> Q. A very placid trip?
>
> A. Oh, yeah. But, it was that damn music that was playing that a – that did it. I – I wouldn't have -- it might be very, very different if I would have had no music. Umm, that's what I was feeling –feeling, when I went into the – the LSD. Once John played John Denver, oh, geez, I was walking in grass, and was – there was trucks on the highway. There was, ah, something else, but I can't put a memory. I

> remember the grass. It was a very placid trip, and it was that damn music that did it.

[508] The Consent form and Clinical Records make it clear that Mr. Finlayson agreed to the LSD treatment prior to its being administered. His explanation for having so agreed and signing the Consent is similar to that of several other Plaintiffs – that is, his agreement was more strategic than sincere:

> Q. I see. And tell us about the LSD program, as best as you can remember it?
>
> A. Well, the LSD Program, I don't think I wasn't given a long explanation of it, but I'm not stupid, I – I may be lacking in whatever, but I'm not stupid. The way it was presented to me, there was a strong hope of getting out within a, whatever, a short time, right. So, umm, I signed up for it.
>
> Q. Well, just to come back to the strong hope, who – who told you that you would have hope of getting out if you participated?
>
> A. It was – it was Dr. Maiers *[sic]* because Dr. – the other doctor wasn't as personable as Dr. Maiers was.
>
> Q. What did Dr. Maier tell you about LSD and you leaving the institution?
>
> A. Well, he – I can't remember his exact words, but I I know for a fact that he presented it as a – something dear to his heart, and he wanted this – this done, and I'm not a dumb person, I'm reasonably intelligent, and I put two and two together that he wanted this program for him, and if I supported him, I was working on his good side; if I refused, I'd probably be locked up there for five, ten years.

[509] Following the LSD session, Mr. Finlayson wrote a page of reflections on the treatment, which forms part of his Oak Ridge medical file. In these reflections, he says generally positive things about the experience:

> Most of the former hurt within me seems to have been successfully resolved because of my LSD trip and now and then when I think about the emotional feelings I have after the trip, and in the capsule, I am convinced that this was natural considering the intense feelings of hurt experienced during the trip itself. I cannot think of anything else to add to this narration of my trip, except to say, from that time to this I have greatly benefitted from my LSD experience.

[510] But when asked about his response to the LSD, he gave the same explanation as he gave with respect to his consent to it in the first place:

> Q. You told nurses at Oak Ridge that you saw positive changes in yourself after the LSD, right?

> A. Well, as I said, from the beginning, even when it was first discussed, I thought going along with the program, going along with the doctor would hasten my – so, I would say stuff like that. It – it's far from the truth.

[511] With all of that, Mr. Finlayson confirmed in cross-examination what he had said a number of years previously in his examination for discovery:

> Q. Do you think the LSD did cause you permanent damage?
>
> A. No, I think a – I don't know for sure, I don't think so…

[512] In cross-examination, Mr. Finlayson acknowledged that he was one of the numerous Oak Ridge patients that had signed the letter to the editor of the *Barrie Examiner* written by Reginald Barker in support of the LSD program. The published letter was dated January 30, 1976, putting it about 6 months after Mr. Finlayson's own LSD treatment. As with the rest of the DDT program, his explanation for signing the letter was that it was not a sincere act on his part: "But again, I didn't want to be out of step with the doctors. I could hardly hope to get out if – if I blocked the doctor."

[513] Mr. Finlayson was discharged from Oak Ridge to Brockville Psychiatric Hospital on January 30, 1979, after the treatment team concluded that he no longer required a maximum-security setting. His Discharge Summary records his diagnosis on discharge as: "Personality Disorder; Sexual Deviation; pedophile, dangerous under the influence of alcohol".

iii) Post-Oak Ridge experience

[514] On January 13, 1989, Mr. Finlayson was charged with aggravated sexual assault, wounding, break and enter, and a number of other offences. The incident took place while he was still in Brockville but was out on privileges in the community. He somehow obtained a knife, although it is unclear how this came about, entered a woman's apartment, sexually assaulted her at knifepoint and then stabbed her. He was remanded back to Penetanguishene for an assessment, which took place on March 20, 1989.

[515] The Consultation and Assessment Report notes that he was asked by a physician about his thought process, to which he responded: "When you're as drunk as I was, how can you know what's on your mind!" It also notes that he had ceased taking the anti-androgen medication that had been prescribed for him. Indeed, in a more recent assessment dated June 11, 2014 done in preparation for an Ontario Review Board hearing, it was noted that Mr. Finlayson blamed the anti-androgen medication for his frustration in that it "robbed him of the ability to have an essentially normal relationship with an appropriate female."

[516] For the sexual assault and break and enter charges, Mr. Finlayson was found not guilty by reason of insanity. He was subsequently admitted to Kingston Psychiatric Hospital. He deposed that he is now 80 years old and resides at Providence Care Mental Health Services in Kingston, Ontario. In his affidavit, he describes his psychiatric condition as follows:

> At various points in my life, doctors have variously described my illness as unspecified personality disorder, immature personality, chronic alcoholism, substance abuse, sexual sadism, obsessive compulsive personality disorder, having premorbid narcissistic and antisocial features, and paraphilia. While the diagnoses changed from one to another, I seem to have never been psychologically healthy.

iv) Causation and harm

[517] In his Supplemental Report dated January 8, 2019, Dr. Bradford acknowledged that Mr. Finlayson "had a number of very serious problems prior to his initial admission to Oak Ridge in 1974." That said, he also noted that, "He is one of those individuals who violently recidivated after receiving the 'treatment' at Oak Ridge. Given this set of circumstances, in my opinion, he has been seriously harmed by the programs at Oak Ridge".

[518] The problem with Dr. Bradford's analysis of Mr. Finlayson, however, is not so much what he says about the patient but what he fails to say or apparently take into account. This was brought out pointedly when he was cross-examined on his Supplemental Report:

> Q. The other striking thing about your report, Dr. Bradford, is that there is no mention of Mr. Finlayson's problems with alcohol, as I read it, and take a moment to confirm that's the case.
>
> A. Right. I mean, although extensively that has been part of the reason why he ended up in the system. So, ...
>
> Q. Right.
>
> A. ... I didn't repeat all of that, because it's well-known. But, he had pathological intoxication, diagnosed I think in Toronto, and confirmed by myself.
>
> Q. Yeah. He was, we've heard, a prodigious drinker, wasn't he?
>
> A. Well, he was a prodigious drinker, but he also had pathological intoxication as a particular problem. So, I didn't repeat it in the report, but that's a specific condition.
>
> Q. And it's an important condition, as is his alcohol intake, to take into account in a fair assessment of Mr. Finlayson, isn't it, sir?
>
> A. Right. So, what it's a – the sort of – what's behind it is that there are certain people who, when they consume alcohol, because of a brain defect, have an abnormal reaction. So, again, it's a kind of a vulnerability issue that he suffered from. So, what it's –- the sort of – what's behind it is that there are certain people who, when they consume alcohol, because of a brain defect, have an abnormal reaction. So, again, it's a kind of a vulnerability issue that he suffered from.

[519] There is no getting around this omission in Dr. Bradford's analysis, just as there is no getting around the central role played by alcohol in Mr. Finlayson's criminal behaviour over the years. But what is most important is that Dr. Bradford ultimately acknowledges that the condition is a life-long one. The only way to address it is for Mr. Finlayson not to drink.

> Q. He got into serious difficulty when he drank, both before and after, right?
>
> A. Right. So, he would have this condition for the rest of his life, and technically should never consume alcohol in any form.
>
> Q. Right. And that, I suggest to you, is actually the main feature to explain Mr. Finlayson's abhorrent behaviour, both before and after Oak Ridge, that is the underlying pathology, the susceptibility in particular to alcohol, and a propensity to drink prodigiously, which gets him into trouble?
>
> A. Right… That would be with him for the rest of his life…

[520] Dr. Turrall examined Mr. Finlayson's record on behalf of the Defendants and agreed that his violet recidivism was attributed to alcohol consumption. He was of the view that the DDT and Capsule programs in which Mr. Finlayson was involved may have been humiliating – in particular, he referenced the nudity and protracted stay in the Capsule. He also agreed with Dr. Bradford that the DDT treatments which Mr. Finlayson received that involved amphetamines and other stimulant drugs, such as Dexedrine and Ritalin, were dangerous and potentially addictive; but he pointed out that the records do not show that they were a problem for Mr. Finlayson.

[521] Mr. Finlayson himself has not only never voiced any strong complaint about the DDT and Capsule programs, but has on various occasions expressed the view that they improved his state of mind. Thus, for example, in a 1989 report from Brockville Psychiatric Hospital, written just after his most dramatic instance of recidivism, a doctor noted:

> Mr. Finlayson claims that with the various treatment programs he underwent in the Mental Health Centre, Penetanguishene, he has gained a lot of confidence in himself and has been able to relate to both men and women in an appropriate adult manner.

[522] Despite Dr. Bradford now opining that Mr. Finlayson's recidivism is related to his long incarceration, this is not mentioned in any of the several reports that he did with respect to Mr. Finlayson prior to the present litigation. Mr. Finlayson's problem, which is self-evident in all of his records – both medical records and criminal records – is drink. Given that Dr. Bradford left this out of the equation in opining on Mr. Finlayson, the better view is that of Dr. Turrall. Mr. Finlayson's long-term problems were caused by factors which pre-dated his admission to Oak Ridge, and which were triggered after he left Oak Ridge by his renewed use of alcohol in precisely the same way as he had done his whole life.

[523] The DDT and Capsule, including the LSD experience, which Mr. Finlayson underwent at Oak Ridge in the 1970s were undoubtedly degrading. They did him no good, were not

therapeutically beneficial, and he should not have been exposed to them. But they do not appear to have been traumatic for him. Even the LSD treatment was, in his words, not too severe but rather too "placid". His main complaint was that, with John Denver music in the background, it was almost distractingly pleasant:

> A. And what could I say, John Denver is – is a, well it depends what you want your trip to be… But, if you – you want to really find out what's – who John Finlayson is, then you don't need music, you don't want music, you just want the acid in your – you know.

[524] The DDT and Capsule programs administered to him by Dr. Maier caused Mr. Finlayson short-term harm in the sense that he was degraded and was used for the potential benefit of other patients. It appears from the evidence, however, that the experiences did not, even in the short term, cause him a painful breakdown or trauma. Dr. Maier was directly involved in Mr. Finlayson's treatments, and, in particular, with his DDT experiences.

[525] Further, the evidence does not support the DDT and Capsule programs having caused him long term harm. He came out of Oak Ridge essentially the same person he was when he went in.

k) Terry Ghetti

[526] Terry Ghetti was committed to Oak Ridge on December 5, 1973, when he was 28-years old, after having, *inter alia*, raped and murdered a 77-year old woman and killed a fellow inmate while on remand at the Don Jail. He has been diagnosed with psychopathy and anti-social personality disorder. He resides at Waypoint until today.

i) Pre-Oak Ridge and index offence

[527] Mr. Ghetti's childhood and youth were sad, troubled, and ultimately filled with crime and violence. As he narrated it at trial, until he was put up for adoption at 7 years old he lived with his mother and step-father in a difficult home, illustrated by the fact that his step-father once locked him in a closet for 2 days. He was sent to a series of reform schools in the United States, where by the age of 15 he had already been arrested for armed robbery and was using marijuana, cocaine, and heroin.

[528] At 17, after attempting to run away from one of the reform institutions, he was described by the Deputy Superintendent in his report as having threatened to kill staff and inciting a riot and mass escape. The report, dated June 21, 1962 and entitled "Boys Training School Summary for the Court", concluded that Mr. Ghetti was intelligent, but dangerous:

> Personality: Terry has tested to have a full scale I.Q. of 122. He has little capacity for depth relationship, is emotionally deprived and hostile to authority. There is indication of psychosis or mental illness.

[529] From 1962 to 1967, Mr. Ghetti was transferred from one mental hospital in the state of Michigan to another. In 1967, he was sent to Iona State Hospital where in an Interim Social History

he was described as a "homicidal patient". He remained there until 1969, when he was deported to Canada.

[530] Mr. Ghetti was first committed to Oak Ridge for a 3-month stay and assessment on May 28, 1969, when he was 23 years old. He was discharged to the community on September 12, 1969. His Clinical Records from this first commitment document him as being diagnosed with personality disorder and paranoid personality. With that, however, he was reported to be functioning well in the ward, and there is no record of any violence or other aggressive conduct during this time.

[531] On August 25, 1969, a social worker observed in the Clinical Record that Mr. Ghetti "thinks he has gained benefit in that he feels he has more control over himself and when faced with a problem and confronted he is more ready to talk about his situations." At trial, Mr. Ghetti testified that he was made a 'patient-teacher' during this first stay at Oak Ridge. He does not complain about anything that transpired during this admission; further, neither Dr. Barker nor Dr. Maier appear to have treated him during this time.

[532] Within a month of being released from Oak Ridge, Mr. Ghetti was involved in an armed robbery. A couple of months later, in December 1969, he was arrested again in Detroit for drug trafficking and theft. He was found incompetent to stand trial and was returned to Ionia State Hospital on June 19, 1970, where an Interim Social History report dated July 9, 1970 indicates that he had been using alcohol, methamphetamine, and barbiturates. It also observes that Mr. Ghetti related that he enjoyed the short Penetanguishene experience and had benefitted from the group therapy experience.

[533] At Iona, he was diagnosed with schizophrenia, schizo-affective type. Under cross-examination, Mr. Ghetti denied that the record from Iona – presumably including both the diagnosis and the praise he was said to have expressed toward Oak Ridge – was accurate. He commented that Iona at the time was not a place whose records can be relied on:

> A. I'm not – this is a place they used to – I think these guys would just write anything down. I've agreed with a lot of things here today, this isn't one of 'em, eh. Like – but what – if it was, it would have had to have been an offhand statement, which here is laced into the context of some free-booting mental patient crook kind of a guy wannabe, you know.

[534] In September 1971, Mr. Ghetti was found competent to stand trial in Michigan, and in December 1971 he was re-committed to Oak Ridge for assessment pursuant to the *Mental Health Act* for after being again deported from the United States. In a letter dated December 13, 1971, Dr. Boyd explained to Mr. Ghetti that he would be assessed for 30 days; subsequently, on January 2, 1972, Mr. Ghetti's involuntary certificate was renewed for a further period of two months. A Review Note dated February 18, 1972 stated that further evaluation was required to determine Mr. Ghetti's treatability; at the same time, Dr. Barker wrote that Mr. Ghetti was "not likely to respond to treatment here" and predicted Mr. Ghetti "will be in trouble again—maybe serious".

[535] Notwithstanding these assessments, the Ontario Board of Review found on February 26, 1972 that Mr. Ghetti did not suffer from mental disorder requiring hospitalization, or that he was a danger to his own safety or the safety of others. He was discharged against Dr. Barker's advice on March 1, 1972. His Discharge Summary records that, "It is generally felt that patient will continually be in trouble on the street due to his basic personality – especially if on drugs."

[536] It did not take long before this prediction came to pass. In June 1972, Mr. Ghetti became a suspect in a rape and murder, for which he was eventually convicted. The events of the crime were later described in an Interim History report at Oak Ridge dated November 26, 1973 as a particularly brutal attack. It was noted that an autopsy of the elderly victim found "five fractured ribs on the left side of the body, a lacerated spleen, the left upper and lower jaw were fractured, the skull was fractured, a blunt or flat surface injury to the left side of the head and many bruised areas on the chest, head and hands."

[537] Mr. Ghetti has at various times denied that he committed this offence. He did so in a Psychiatric Report dated March 28, 1973 done at Oak Ridge, he did so again in a Psychiatric Report dated October 31, 1973 done in anticipation of a trial on other charges then pending, and he did so again at trial. Counsel for the Doctors points out that despite these denials, there is reference in a number of Oak Ridge medical documents to Mr. Ghetti confessing to the rape and murder. For example, in a Clinical Record dated April 24, 1979, a social worker wrote: "Patient Ghetti reaffirmed an earlier admission which he had made in MAPP, that he had raped and killed a 77-year old woman."

[538] Much testimony was devoted during the course of the trial to whether MAPP was a punitive program or merely a very harsh disciplinary program. Dr. Bradford, for example, described the strict immobility that was enforced in MAPP as "positional torture", while Dr. Chaimowitz characterized the pain that would ensure from this regime as an unintended side effect of what was otherwise behavioural therapy. None of the expert witnesses, however, suggested that MAPP would be an appropriate venue for extracting confessions from patients. To rely on a patient's confession disgorged under the physically rigorous and painful conditions in MAPP would be to rely on a human rights violation of the first order.

[539] In *R v Oickle*, [2000] 2 SCR 3, at para 27, the Supreme Court of Canada reiterated a longstanding view of confessions that emanate from a coercive environment: "[I]n *Hobbins v The Queen*, [1982] 1 SCR 553, at 556-57, Laskin C.J. noted that in determining the voluntariness of a confession, courts should be alert to the coercive effect of an "atmosphere of oppression". Whether or not one sees the MAPP as a form of torture, see *Barker v Barker*, 2017 ONSC 3397, at para 15, its atmosphere was admittedly designed to be an oppressive one where pain was inflicted and, as Dr. Chaimowitz delicately put it, "some liberties were taken away from people."

[540] The legal proceedings over the attack on the elderly woman were protracted. In the meantime, Mr. Ghetti embarked on a series of violent incidents. The Interim History of November 1972 indicates that on June 26, 1972, Mr. Ghetti assaulted a potential witness to the killing, breaking the man's right ankle and cheekbone and lacerating his forehead. He was sentenced to 9 months in Guelph Correctional Centre. Then, on October 20, 1972, he received an additional sentence of six months for assaulting a guard at Guelph and breaking his jaw. He was transferred

to the Millbrook Correctional Centre on October 27, 1972, where he was involved in a series of fights with other inmates.

[541] On November 14, 1972, a psychometrist at Millbrook interviewed Mr. Ghetti and reported: "I strongly think that Mr. Ghetti should definitely be placed in a setting like the Penetang Psychiatric Institute in which there is an intensive treatment program including psychiatric staff." Three days later, at his own request, Mr. Ghetti was committed to Oak Ridge from Millbrook. He stayed for under 2 weeks and was discharged on November 28, 1972. The Mental Status Report issued upon discharge diagnosed Mr. Ghetti with personality disorder with anti-social trends. The Report further commented that, "He has poor insight into his behaviour. His psychopathic behaviour is unchanged. His lifestyle would always be taking advantage of the unwary, innocent."

[542] In anticipation of the trial on charges of rape and murder of the elderly woman, Mr. Ghetti was assessed on March 28, 1973 and October 31, 1973. The psychiatrist who assessed him diagnosed him as "psychopathic personality, aggressive type", and noted that even in the assessment where Mr. Ghetti was attempting to be cooperative, his aggressive demeanor was on display. That aggression manifested again on October 22, 1973, while awaiting trial in the Don Jail. According to the Interim History report dated November 26, 1973, Mr. Ghetti punched another inmate in the head, apparently for walking in front of him, and the inmate died as a result of that one punch. Mr. Ghetti was charged with manslaughter.

[543] He was again assessed in respect of this charge. The Psychiatric Report dated October 31, 1973 states that during this time Mr. Ghetti was using drugs and had what seemed to be delusional episodes:

> He was making frequent use of LSD, and during those periods of time had experienced a great sense of power, describing in detail his ability to carry out Oriental defensive arts such as Kung-fu. He goes into great detail as to how he can control his body. He states that he felt people were aware of his power, and that they were influenced in their behaviour to him. During this period of time, he describes having a number of people under his influence, whom he refers to as slaves. He appears to be making specific reference to some homosexual people who carried out some of his orders because they were afraid of him. I cannot be sure that this represents delusional thinking, as I am sure people would be terrified of him. However, it does represent a complete lack of appreciation of the effect of his behaviour on others, and he is totally lacking in conscience in this regard.

[544] On November 30, 1973, Mr. Ghetti was found fit to stand trial and was returned to court. He was subsequently found not guilty by reason of insanity for the manslaughter of the Don Jail inmate as well as for the rape and murder of the elderly woman.

[545] Under cross-examination at trial, Mr. Ghetti agreed that he chose to plead 'insanity' because he preferred to go to Oak Ridge rather than to a penitentiary. He was re-admitted to Oak Ridge on December 5, 1973, and was ultimately committed to Oak Ridge pursuant to a Warrant of the Lieutenant Governor.

ii) Experience in the STU

[546] The Treatment Records and Bedside Nursing Notes indicate that Mr. Ghetti received the following DDT treatments:

> Dexedrine on August 24 and 26, 1975, authorized by Dr. Maier with the permission of the Health Protection Branch.
>
> Dexedrine on September 7, 1975, authorized by Dr. Maier.
>
> Sodium Amytal-Ritalin on September 26, 1975, administered intravenously by Dr. Maier. This is the only record of a Sodium Amytal-Ritalin treatment, although Mr. Ghetti deposed that he was filmed having a treatment in December 1974 and that he was humiliated when he watched the video playback.
>
> LSD 25 on August 26, 1975, administered intravenously by Dr. Maier. This is the only record of a LSD treatment, although Mr. Ghetti deposed in his affidavit that he received it twice.
>
> Dexamyl-Tofranil on January 24, 1975 to March 1975 (7 weeks), authorized by Dr. Maier with the permission of the Health Protection Branch.
>
> Dexamyl-Tofranil on October 28, 1975 to November 17, 1975 (2 weeks), authorized by Dr. Maier with the permission of the Health Protection Branch.
>
> Dexamyl-Tofranil December 2, 1975 (for 2 weeks), authorized by Dr. Maier with the permission of the Health Protection Branch.
>
> Dexamyl-Tofranil on September 1, 1977 (for 7 weeks).

[547] On cross-examination it was put to Mr. Ghetti that he had agreed to all of these treatments. His response was that it was all fabricated: "Everything I said was a lie, you know. I'm going along with the system, and I mean like really doing it with a – a lot of zeal."

[548] Despite this explanation, there are numerous documented instances in which it is recorded that Mr. Ghetti requested DDT treatments: April 4, 1973 participation in the LSD program, August 1, 1974 hyoscine hydrobromide treatment, November 7, 1978 Amytal-Ritalin treatments and Scopolamine, undated letter for Scopolamine, March 20, 1975 Dexamyl-Tofranil regime. Moreover, on August 29, 1975, following his LSD treatment, Mr. Ghetti himself wrote in a Special Treatment Report that "the treatment was of great benefit to me."

[549] During his examination in chief, Mr. Ghetti recalled consenting to the LSD treatment and stated that he did so in order to avoid otherwise boring group therapy. As for the reading material that Dr. Maier gave them as a version of informed consent about the effects of LSD, Mr. Ghetti made it clear that he and other patients did not have to read the pop culture books on hallucinogenic drugs as they already knew about these substances. Mr. Ghetti, according to his pre-Oak Ridge medical reports, had extensive street experience with LSD:

> Q. Sir, going to the DDT Program, when you were given all these drugs, and others were as well, did you consent to these treatments?
>
> A. Yeah. Yeah, I did. Like, for the two LSD, I –- you –- you can probably find the paper in there somewhere, unless they lost it.
>
> Q. Okay. And do you know why you went along with this?
>
> A. Because otherwise I'd be downstairs on 'G' Ward, or in the other case, 'F' Ward, and I'd be with that regular humdrum program, and I couldn't stand listening to guys that had no education telling guys that were, you know, educated to the point where they won awards, being told by a third Grader that, you know …
>
> Q. But, you didn't get the LSD right away, you spent the entire summer, this is the summer of 1975, preparing for your LSD?
>
> A. Ah, that – yeah, you didn't necessarily have to be preparing. You – ostensibly, you had to – you should be doing something, you know, showing an interest in how it works and stuff like that, and stuff that most guys – a lot of guys already knew.

[550] Mr. Ghetti likewise stated in cross-examination that he consented to sessions in the Capsule because he "would do anything to get out of the regular everyday therapy stuff on the ward". The Clinical Records show that he was in the Capsule from March 11 to March 25, 1974, and that he has signed a Capsule therapy contract for this session in which he chose which patients with whom he wanted to go into the Capsule.

[551] He also stated in cross-examination that Dr. Maier had explained to him that the Capsule was based in part on what was being practiced in Esselon, California. Mr. Ghetti testified that he was aware that in the Capsule the patients would be enclosed in a windowless and soundproof room, fed a liquid diet, naked, and that observers would be present and the session would be videotaped. Following his Capsule session, he wrote in a Special Treatment Report dated April 15, 1974, that, "[I] do believe I've gained much more flexibility. I don't think the capsule itself meant much."

[552] Mr. Ghetti's behaviour on the ward was often difficult for staff to manage The Clinical Records contain numerous instances of him being described as aggressive. The Bedside Nursing Notes of July 17, 1975 record him as being "rather hostile", the Bedside Nursing Notes of May 15, 1975 describe him as being "angry", and the Bedside Nursing Notes of October 14, 1974 describe him as expressing his "disgust". Mr. Ghetti confirmed on cross-examination that he could be a threatening figure to the other patients. Reading from a Clinical Record dated July 17, 1975, counsel for the Crown put to him his inclination toward hostility to other patients:

> Q. … I have to start at the top. 'Came across with a rather hostile and non-receptive attitude to patients Singer, Mark, and Belec, all, when they were feeding back to

> him about a word that was', something, 'from the ward that he was using. Settled down later after ward meeting.' So, there is another example, and it gives you a couple of patients that you were hostile and non-receptive in your attitude towards feedback from Paul Belec, for example?
>
> A. I don't doubt it, yeah.

[553] Counsel for the Defendants submit that it was this hostility from an already volatile patient that required Mr. Ghetti to be sanctioned by being placed in MAPP. For his part, however, Mr. Ghetti perceives that he was placed in MAPP for trivial reasons not related to any violence or threat of violence. He testified that he would be sent to MAPP if he disagreed with the program, or if he complained to the Ombudsman's office, or if he criticized the STU programs to any outside investigators. He also expressed his view that he was frequently punished by being made to write essays praising MAPP.

[554] Defendants' counsel say that these allegations are untrue. They particularly take issue with the allegation that Mr. Ghetti was punished for complaining to the Ombudsman. They cite a Clinical Record dated January 26, 1976 written by Dr. Maier as evidence that counters Mr. Ghetti's allegation. Dr. Maier wrote:

> On the 23rd of January prior to the ward meeting, Terry impressed the following view of his tome with an unusual amount of conviction and with a mild threat. He related to me how he had a great dislike for the MAP program and how he had passed this on to the representatives of the Ombudsman liberally. While this is all quite acceptable, there was a level of potential challenge of his which concerned me. At the ward meeting that followed, his attitude continued to be questionable and I became more seriously concerned about his power in the community. As a result of this, on the 24th of January I asked Terry to write me three one thousand word essays on the following topics: 1) How the MAP Program is a Help to Me 2) How MAP is an Aid to the Community 3) How I Will Support the Next Person who is offered the MAP Program…

[555] Mr. Ghetti was not happy to have to write positive essays on a topic such as MAPP. His essays, which are part of the exhibits in the record, are replete with surprising praise for the way that MAPP makes him feel; at one point he went so far as to write that, "Sometimes I've felt that I would request to go to MAPP when I felt very negative and had friends on the ward. It would give me a chance to gather my wits and/or examine my conscience."

[556] It is interesting to see Mr. Ghetti, who has been diagnosed as a highly manipulative psychopathic personality with little in the way of conscience, expounding on the thoughtfulness of those who put him in the program. Presumably, this was what he thought Dr. Maier would want to hear. He concludes that MAPP, described by other patients as well as expert witnesses as the most physically tortuous of experiences, is "something like Yoga or the practice of Zen…" One need not be a particularly strong cynic to conclude that Mr. Ghetti was evidently a careful reader of the 1960s counter-culture literature which Dr. Maier clearly favoured.

[557] On the other hand, Mr. Ghetti was not loathe to engage in some criticism of MAPP, albeit in milder form than many of the Plaintiffs did in their testimony. In one of his letters he writes, in perhaps a moment of admirable understatement, that "there were some things I disagreed with in MAPP, such as sitting rigidly still…" Others have described this aspect of the program as the most painful, with patients having to sit frozen in one position for hours on end and only shifting their sitting position when teacher-patient appointed for this task gives them permission. Mr. Ghetti's expression of "disagreement" with the disciplinary rigours of MAPP is a testament to both his physical endurance and his strength of will.

[558] The Clinical Records and Bedside Nursing Notes indicate that Mr. Ghetti was in MAPP on the following occasions:

> October 18 to November 4, 1974, as a result of his refusal to participate in the program.
>
> January 3, 1975 to January 8, 1975, as a result of having a negative attitude and refusing to take part in the program.
>
> September 29, 1978 to January 17, 1979, on the order of Dr. Barker as a result of his being sarcastic and threatening to lay charges against Dr. Barker.
>
> April 9, 1979 to May 10, 1979, as a result of flicking a cigarette at another patient and then cursing at the Treatment Committee during the meeting held to discuss the issue.
>
> March 27, 1980 to April 11, 1980, on the orders of nine professional staff members for being arrogant and sarcastic toward other patients and staff.
>
> June 2, 1981 to June 22, 1981, after having threatened to make staff "pay", sexually acting out with other patients, threatening a patient with harm to his family, ad giving other patients cigarettes while in MAPP.
>
> October 5, 1981 to October 9, 1981, after informing Mr. Egglestone [Shauna Taylor] he would "knock Vance's head off." A Clinical Record dated October 6, 1981 reports:
>
> > Terry reported to staff that he was feeling a lot of anger with an urge to kill other patients on G Ward. He also stated that G Ward patients treated him like an animal. Terry was interviewed by Dr. Moreau whereupon he stated that if the MAPP teacher gave him a hard time he would 'ring his fucking neck.'

[559] Most of Mr. Ghetti's complaints about his time in the STU are aimed at Dr. Maier. In his testimony he confirmed what he had aid in discovery – that he did not have "specific complaints against Dr. Barker", because from his point of view Dr. Barker "wasn't a major player". As for Dr. Maier, he described him as evil but silver tongued:

> Q. And indeed, you don't have any specific complaints about Dr. Maier either?
>
> A. Oh yeah, I do, because he was – he was like the – he was the leader. He was – he was like Hitler. But, he had a – a BA in English, he could express himself so flawlessly that he could get out of things.

[560] On July 21, 1982, Mr. Ghetti wrote to a member of federal Parliament, and although by this time Dr. Maier was long gone from Oak Ridge, he sung his praises in his letter:

> The most effective man ever to direct therapy here was Dr. Gary Maier. Staff whined and cried and lied until they finally got him dismissed. The shrewish, provincial-minded bumpkins were absolutely terrified at Gary's personal effectiveness with every man jack of us.

[561] Mr. Ghetti is obviously of two minds about Dr. Maier and his involvement with him in the STU programs. In one conflicted sentence, he expressed not only his distaste for other people, but his simultaneous admiration and disdain for Dr. Maier and the programs with which he was involved:

> He was such a verbal genius. And on the one hand I liked him, but like he sent me to MAPP several – well, several times. He had me sent down to 'G' Ward because I didn't want other people reading my books. I didn't wanna read theirs, and I didn't want 'em readin' mine.

iii) Post-Oak Ridge experience

[562] Mr. Ghetti has never left Oak Ridge, and he continues to live at Waypoint as a psychiatric patient requiring maximum security. The Doctors' counsel point out that he has continued to change his story about murdering the 77-year-old woman: at times he admits to it and at times he denies it. These vacillating perspectives on his own past were noted in an assessment done for the Ontario Review Board on May 5, 1984, where it is observed: "Terry Ghetti is a 38-year-old man whose entire life has been characterized by emotional deprivation, impulsive behaviour, and aggressive acting out. There has been little maturation in his basic personality structure since childhood despite involvement in Penetanguishene Mental Health Centre programs for over ten years."

[563] An Administrator's Report to the Ontario Review Board dated August 26, 2009 concluded that Mr. Ghetti continued to be too dangerous to transfer to a medium security institution. The report summarized his ongoing situation as being one not likely to change:

> Mr. Ghetti's score on the Violence Risk Appraisal Guide (VRAG) places him in the highest of nine categories. 100% of mentally disordered offenders within this category reoffend within an average of seven years of their release. His score on the Psychopathy Checklist – Revised is 35 out of a possible 40. Mr. Ghetti's diagnosis of Antisocial Personality Disorder has a poor prognosis…

> Mr. Ghetti continues to hold antisocial values and has chosen not to adopt healthier coping strategies which could enable him to live a fuller life while also increasing the safety of others.

[564] Interestingly, Mr. Ghetti himself has indicated that he does not wish to move from Waypoint, as he would likely not be granted the privileges at another institution that he has over time achieved in his present situation. The point is not so much that he is given any preference by staff who have come to know him, but rather that the maximum-security setting is the one best suited for him. As the August 2019 Administrator's Report explains it:

> [T]he highly structured and supervised setting of Oak Ridge enables Mr. Ghetti to enjoy a degree of freedom that would not be available to him in a less secure setting. His risk to the public, including vulnerable co-patients, is much too great to allow him unsupervised privileges of any sort in a less secure hospital. It is the opinion of the Clinical Team that the unique resources of Oak Ridge allows Mr. Ghetti a quality of life that would not be available to him elsewhere, and that a detention order at Oak Ridge is the least onerous and least restrictive setting for him.

iv) Causation and harm

[565] Dr. Bradford opined that Mr. Ghetti's MAPP and DDT participation left him angry and bitter at the mental health system, and caused him to develop a persecution complex. Mr. Ghetti himself echoes this evaluation, and traces his present state of perpetual anger to the treatments he received while in the STU. In cross-examination at trial he was asked about his reaction to certain specific DDT treatments, but his response was broader than that and is a generally revealing one. In his answer, Mr. Ghetti described his own overall self-assessment decades after the DDT treatments ended:

> Q. You have suffered no lasting impact, in your view, from the Dexamyl-Tofranil treatment you experienced, correct?
>
> A. …I became bitter and I answered questions like this and give them what they want and move along, while I see in front of me a thing that doesn't work and I was becoming embittered more and more all the time. So, if you think that my bitterness is trivial, you need to read some reports on me, eh, because they caused me to be as bitter as I am now. When I first came in here in '69, I was a healthy kid at twenty-six. I liked everybody. But, when I came here I learned to hate everybody.

[566] Dr. Bradford's assessment that the impugned STU programs made Mr. Ghetti an angry and anti-social person therefore matches Mr. Ghetti's own assessment that while prior to his admission to Oak Ridge he was a friendly and sociable individual, during his time in the STU he became bitter and hateful. I am compelled to say, however, that neither assessment reflects reality.

[567] Dr. Turrall, who examined Mr. Ghetti's records on behalf of the Defendants, concludes that Mr. Ghetti was not harmed by the impugned STU programs. He opined that Mr. Ghetti was

on a particularly negative trajectory when he entered Oak Ridge and that that trajectory did not change as a result of his experiences in the 3 programs.

[568] Mr. Ghetti's self-assessment reflects, to put the matter delicately, delusions as to his pre-Oak Ridge state of mind. It is hard to believe that a person with as violent a history as Mr. Ghetti, with a record of multiple homicides, sexual assault, and assaults causing bodily injury, who spoke freely about enslaving weaker individuals to do his bidding, truly was someone who "liked everybody". Indeed, in a June 2, 1962 report from a school in the United States prepared for one of Mr. Getti's early court proceedings, it was specifically noted that he was, even then, hostile and incapable of meaningful social relationships. The report, and Mr. Ghetti's response to it when asked about it in cross-examination, says much about his pre-Oak Ridge personality:

> Q. Under 'personality', which is Roman Numeral 1V, it won't surprise any of us to know that you were tested to have a relatively high IQ, but it says you have little capacity for depth in relationships, you were emotionally deprived, and hostile to authority. Agree?
>
> A. I agree with that, as big as I can. I – I – people, pllffttt, who needs 'em?

[569] Dr. Bradford, for his part, is simply uninformed about Mr. Ghetti. Indeed, he said so himself in cross-examination:

> Q. Let's go ahead to Mr. Ghetti. Going back to your report, and it's the bottom of page 46 is where it starts. I am going to paraphrase, so again pay attention to make sure I don't mis-state anything, doctor, but you say that Mr. Ghetti, as a result of his experience at Oak Ridge was left angry and had persecutory beliefs regarding the mental health system, right?
>
> A. Yes.
>
> Q. Did you consider, Dr. Bradford, the extent to which Mr. Ghetti was angry, defiant towards any structured systems or programs before his Oak Ridge experience?
>
> A. No, not directly. I mean, I was concentrating on what he was saying from Oak Ridge in his affidavit, right.

[570] Insofar as the DDT treatments are concerned, Mr. Ghetti does not say that he was vulnerable to them. He concedes that he had street experience with LSD and wanted more of it when he learned it was available at Oak Ridge. He explained that he had no need to read the books about hallucinogenic experience that Dr. Maier offered, since he already knew more than he could learn about them in group therapy. In cross-examination, he ridiculed the pop culture philosophy sessions prompted by Dr. Maier's reading list: "There were tons of books about LSD around. But there was no intelligent instructions or discussions. You would sit around with uneducated people who would talk nonsense."

[571] Mr. Ghetti's real complaint about being harmed by the DDT program is that he was made to observe others who were vulnerable and who suffered from the drug experience. He testified, "I am built of all of these abuses I saw inflicted on others. I am made out of it." And yet, Mr. Ghetti was hardly a sympathetic audience to his fellow patients whom he saw being abused in the STU programs. Indeed, he readily admitted in cross-examination by counsel for the Crown that he was himself one of the abusers:

> Q. …It appears that a lot of patients are very insecure about feeding back on this patient?
>
> A. They were insecure about feeding back on a lot of guys that would beat their heads in.
>
> Q. And you were one of those guys?
>
> A. Yeah. So, what's that got to do with this?

[572] As for his reactions to being placed in MAPP, Mr. Ghetti has never really complained about that program despite its being what even the Defendants' expert witnesses concede was a harsh environment. For the most part, Mr. Ghetti's primary complaint is not that he suffered in MAPP, but that other patients who were suffering in MAPP were annoying to him. As he explained at trial, "Usually the cleverest guys got out of MAPP quickly… There's some unfortunate guy stumbling around with real mental illness, he doesn't know what he's doing but he's being punished constantly 'cause he's a scapegoat."

[573] In a Special Treatment Report of December 10, 1974, Mr. Ghetti described the patients who were obviously suffering in the program as having gone "off on schizophrenic tangents". In expressing this view, he fully exhibited Dr. Barker's observation in "Buber Behind Bars", p. 63, that a psychopath in a close encounter with a schizophrenic will typically bridle at the "wooliness" of the latter's thinking.

[574] As for himself, Mr. Ghetti testified that he has a tough enough outer layer of psyche that nothing could really do him harm:

> Q. …Not a lot is going to turn on it, Mr. Ghetti, I suspect, because you would say that the MAP Program did not have any negative impact on you, did it?
>
> A. I was already braced up. I – I'm trying to answer your question as directly as possible. I was always braced up against everything I saw.

[575] Indeed, the entire milieu therapy approach, with its patient 'democracy' and committee system, was manipulated in Mr. Ghetti's hands. He testified that he was on the Security Committee, and in that capacity wanted to let everyone out of their cells. Likewise, he was on the Clarification Committee, where he brought to bear his antisocial personality disorder on the 'adjudication' of the conduct of other patients. He was also on the Staff-Patient Liaison Committee, where he testified expansively that, "I ran the whole ward. The Staff loved me. They

didn't have anything to do." He was also proud to advise the court that in his 'teacher' capacity he had the chance to recommend drug treatments for other patients, presumably bringing to bear his own extensive experience both in Oak Ridge and before his arrival.

[576] With all that they did not break him down, it is also accurate to say of the STU programs that they were not therapeutically beneficial to Mr. Ghetti. Having been placed in MAPP on numerous occasions, he was doubtless hurt by a program designed to hurt. While Mr. Ghetti has a tough exterior and seemingly impenetrable mental defenses, he is not immune to pain. Indeed, in a single sentence of his testimony at trial, he framed the entire debate between the experts about whether patients with psychopathic personalities are truly harmed by experiences aimed at breaking down mental defenses like those in the STU programs: "Because a guy is tough it doesn't mean he's not effected by it."

[577] The medical records on Mr. Ghetti, from his earliest encounters with institutional life up until his present-day evaluations, establish that he was a domineering and violent individual suffering from an antisocial personality disorder as a young man, and that he remains so today. He proved as much with his answers and demeanor in court. For example, when cross-examined about his criminal record, Mr. Ghetti revealed that he continues to harbour the same attitudes that he has displayed his entire life:

> Q: You were convicted of break and enter and armed robbery?
>
> A: I would never do a break and enter. Armed robbery yes.
>
> Q: Not break and enter?
>
> A: It's a lowly crime.

[578] Mr. Ghetti neither improved as a result of his STU experience nor deteriorated as a result. Counsel for the Doctors submit that his trajectory was not changed by the impugned STU programs, and that analysis is borne out by the evidence. I cannot conclude that the 3 programs in issue here caused Mr. Ghetti long-term harm.

[579] At the same time, it is difficult to conclude that the DDT and MAPP experiences did not cause some short-term harm. Mr. Ghetti had a street drug problem prior to Oak Ridge, and instead of treating it the Doctors exposed him to more of the same drugs. Mr. Ghetti also had an anger management and violence control problem prior to Oak Ridge, and instead of treating it the Doctors placed him in positions of authority and close physical proximity to weaker, more vulnerable people. They did not create his problems or cure them, but they made him live them at a stage when he should have been free of them. Because Mr. Ghetti tends always to be the victimizer rather than the victim in his encounters does not mean that he is not thereby harmed.

[580] As reviewed earlier, an August 25, 1969 Clinical Record indicates that he felt that on his previous stay at Oak Ridge he had benefitted from milieu therapy. This was prior to his having been in the STU or experiencing the DDT or MAPP programs. It does note that he had been made a 'teacher-patient' during that brief stay, and had enjoyed the position of authority. This authority

was later augmented under the influence of DDT drugs and in MAPP, to the point where Mr. Ghetti experienced the surge of aggression that he had experienced during his violent crimes.

[581] Mr. Ghetti was placed him in a supposedly therapeutic program which instead of helping him to overcome his urges, actually augmented them for the short term. This was harmful to him, even if he did not experience it as pain. He certainly experienced it as frustration, as illustrated in this exasperated exchange with Crown counsel in cross-examination.

> Q. And it was the patients who were disruptive in the group therapy who got sent to MAPP?
>
> A. That's not always true…
>
> Q. And you got sent to MAPP for intimidating other patients, they were afraid of you?
>
> A. I don't remember which incident that is. Like, I'm ...
>
> Q. Could we go to page ...
>
> A. I'm sure it happened...

[582] On other occasions it was the DDT program that was used by the Doctors as a control mechanism for Mr. Ghetti. As he put it in cross-examination: "[e]very time I had an argument with Maier, he put me on seven weeks of Dexamyl." He was aggressive and uncooperative toward Dr. Maier and others, and was responded to with what could be described as an amped-up application of the harshest STU programs.

[583] Mr. Ghetti may not have felt the same kind of pain that many other patients felt from these programs, but they did augment his sense of frustration and feelings that the world was against him. He did not deserve that. The STU programs to which he was subjected by Dr. Barker and, especially, Dr. Maier, who was directly involved with his treatments, caused him perhaps not intense harm, but some degree of indignity and harm in the short term.

l) Bruce Hamill

[584] Bruce Hamill passed away in May 2019, just after completing his testimony at trial. There has not yet been an Order to Continue sought with respect to Mr. Hamill's claim, and so technically it is stayed. However, Plaintiffs' counsel advised during the course of the trial that they would likely be seeking an Order. On the assumption that they will be so instructed, I will review the evidence with respect to Mr. Hamill as if the claim were being continued by his estate representative.

[585] Mr. Hamill suffered from a brain injury at birth and was a lifelong volatile personality. On January 17, 1978, at 21-years old, he was found not guilty by reason of insanity for the murder of his neighbour, who he stabbed 36 times. He was committed to Oak Ridge 3 days later on a Warrant

of the Lieutenant Governor. He remained at Oak Ridge for the next two years until his discharge to Brockville Psychiatric Hospital on December 9, 1980.

i) Pre-Oak Ridge and index offence

[586] Mr. Hamill deposed in his affidavit that he was born on November 27, 1956 and that at birth his skull was fractured from the use of forceps. He suffered from temporal lobe epilepsy, which in a June 30, 1977 assessment letter from Royal Ottawa Hospital was identified as a cause or contributing factor to his personality disorder and tendency to aggression.

[587] In his affidavit, Mr. Hamill stated that he was a slow learner as a child, and had difficulties speaking full sentences until the age of 5 or 6. In *Re Hamill*, 2010 CarswellOnt 8389, the Ontario Review Board decision of 2010 described his mental condition as a youth:

> Mr. Hamill quit school following completion of grade 11 at age 19 years. He was referred by his high school to the Oshawa General Hospital for psychiatric assessment. He had earlier reported extreme irritability beginning at age 15, resulting in frequent fights. The diagnosis was temporal lobe dysfunction associated with explosive personality.

[588] In a Case History dated April 4, 1977, a social worker at Penetanguishene recorded an interview with Mr. Hamill in which he indicated that he had attacked a woman living next door to his family home after she had an argument with his mother. The woman's dead body was found by the police in her home with 36 stab wounds. The knife used for the stabbings was dismantled, with the blade, handle, and guard found in different parts of Mr. Hamill's house and garbage. Mr. Hamill was charged with first degree murder and was sent to Penetanguishene for a 60-day assessment on a warrant of remand.

[589] At the time of this first admission to Oak Ridge, Mr. Hamill was observed to be suffering from paranoia and was considered a suicide risk. He was observed hitting his head on the wall and sink, was extremely depressed, and paranoid. In a Clinical Record dated March 6, 1977, Dr. Tate wrote:

> Bruce was observed banging his head against the sink and crying, he refused to discuss his problems with staff but later said he wanted to see his parents. Patient is too disturbed to attend programme, suicidal status remains.

[590] In his examination in chief, Mr. Hamill confirmed this assessment. He testified that he was in an unpredictable and explosive state:

> Q. …And, how were you feeling yourself? You mentioned suicidal. Tell us about whether you had any feelings of depression when you first arrived.
>
> A. I was very depressed because the Ottawa Police did not inform me of Oak Ridge, or did my lawyer… When I came here, there was a time bomb ready to happen.

[591] On April 29, 1977, Mr. Hamill was assessed and found fit to stand trial. At the same time, he was diagnosed with personality disorder, immature and explosive, and possible temporal lobe epilepsy.

[592] Mr. Hamill was also assessed by a neurologist on July 6, 1977 at the request of the Royal Ottawa Hospital. The Assessment Report observed "the presence of an old frontal depressed fracture, potential epileptiform changes in the left temporal region…" It also recorded that Mr. Hamill often fantasizes about being aggressed against, which in turn prompts him to react aggressively.

> His aggressive behaviour seems to be of two types. The simple straight forward type is an immediate reaction to being touched, pushed, bumped into, or any similar accident. The second more complex one consists of the above described [fantasizing] process. It begins gently and gradually builds up so that so that when he is ready to explode he develops a cold sweat all over his body, his hands are sweaty, he has a tingling sensation inside, his mouth is dry, he urinates frequently, occasionally he has chest pains, rarely he gets white spots in front of his eyes, he is unable to relax and feels very weak. His head feels weird and he is extremely restless. As this reaches a climax he 'goes in' and attacks somebody. Usually this individual has been the object of his 'imaginary' process.

[593] On August 29, 1977, after a number of violent incidents while in custody, Mr. Hamill was committed to Oak Ridge for another 60-day assessment on a new warrant of remand. A Clinical Record from the date of this admission notes that he arrived from the Ottawa jail with a black eye and abrasions. Mr. Hamill reported at the time that these injuries resulted from a violent incident with police at the Ottawa jail, and that he had acted in self-defence.

[594] In a Clinical Record dated October 29,1977, it was reported that Mr. Hamill had become agitated and said that a staff member "grabbed him by the arm for no reason." The Record concludes that Mr. Hamill "is very unpredictable and should be closely observed." He was asked about this Report on cross-examination, and agreed that he was considered unpredictable but qualified that answer:

> Q. Do you remember being considered to be very unpredictable during your time at Oak Ridge?
>
> A. Not by my buddies, the inmates at Oak Ridge. It was by the goons and by the coppers and by the inmates who were – I didn't like. They predicted everything as supposedly before I even said it.

[595] On January 17, 1978, at the age of 21 years, Mr. Hamill was found not guilty by reason of insanity for the stabbing death of his neighbour. He was committed to Oak Ridge on January 20, 1978 on a Warrant of the Lieutenant Governor and remained there for nearly 3 years, until December 9, 1980.

ii) Experience in the STU

[596] Clinical Records document that Mr. Hamill was sent to MAPP frequently. Although Mr. Hamill insisted in his testimony that this punitive regime was imposed on him for trivial reasons or because of his depression, the Records state that he was sent to MAPP primarily because of his dangerous and aggressive behaviour. They also show that Mr. Hamill was placed on restraints and often sent to MAPP because he was extremely volatile. Although he consistently stated in his testimony that he only acted in self-defense, the contemporaneous records document that on numerous occasions he spontaneously launched physical attacks on other patients.

[597] Mr. Hamill was sent to MAPP for the first time from November 28, 1977 to December 19, 1977. This followed several months of notations in his medical records that he was alternately emotional and crying in his room or angry in group sessions. The Beside Nursing Note of November 28, 1977 states: "Put into MAP program by Dr. Maier. Patient not doing what little work he was given too well. Non-caring attitude. Patient became very angry with Dr. Maier." In cross-examination, Mr. Hamill testified that he resented being made to working without pay; he also stated that this was the one time he remembered being sent to MAPP by Dr. Maier himself.

[598] According to a written Incident Report, on February 14, 1978, Mr. Hamill was put in MAPP after he struck a "security" team of two other patients in the face who had responded to a security call against him. This followed several weeks of notations in the Clinical Records documenting Mr. Hamill's increasing paranoia. On January 27, 1978, the Clinical Record states: "Ward staff report that Bruce is paranoid around other patients on the ward… While being walked up the corridor by other security members he screamed and started struggle." On February 4, 1978, the Clinical Record states: "The ward staff report that Bruce attempted an attack on patient Dennis Ireland, making a lot of accusations about Ireland hitting and mishandling other patients."

[599] In cross-examination, Mr. Hamill was questioned about the February 14, 1978 incident. He explained that the security team, as the two other patients who approached him were called, could not be trusted:

> Q. …On February 14th, 1978, according to this note, you attacked two patients, Dave Albertson and Kevin Wildon, do you remember that?
>
> A. Vaguely, yes.
>
> Q. Do you remember why you attacked them?
>
> A. They were the head – they were the goons on a – on the ward – on – on the range. I didn't want anything to do with them.
>
> Q. And, after you attacked them you were transferred to the MAP program, correct?
>
> A. After receiving Nozinan they carried me upstairs.

[600] On February 18, 1978, while in MAPP, Mr. Hamill slashed his neck while shaving. The Accident and Injury Report of that date describes the wound as a laceration and "superficial injury", with little bleeding, which was examined, cleaned and dressed by nursing staff. Mr. Hamill

was restrained on the spot by attendant staff and the "patient teachers" present with him. He described this in his trial testimony as an attempted suicide:

> Q. Yeah. Do you recall getting Nozinan on that occasion?
>
> A. Yes, I do.
>
> Q. And, I see that this is in relation to your neck being slashed.
>
> A. I *[indiscernible]* to commit suicide in MAP program when in the shave room because I – I wasn't – I wanted a way out. I didn't think I was ever making it out of Oak Ridge and I didn't like the treatment I was receiving I considered to be next to nothing, and I felt it to be a hostile, hateful building and I wanted out.

[601] The Clinical Record of May 15, 1978 records that Mr. Hamill was again sent to MAPP for acting out with other patients. He remained there until July 10, 1978. Dr. Tate wrote in is Clinical Record: "My impression of Bruce is that he is a very emotional and impulsive and insecure individual who trusts others very little." The Notes of the observers of his MAPP session indicated that from May 29 to June27 he was an "acting out risk, intimidating, threatening group and teachers, physically acting out several times, suicidal thoughts, homicidal thoughts, totally unpredictable." At the bottom of the Notes page, where the patient himself is asked to write his response to MAPP and to indicate any mistreatment that he received, Mr. Hamill scratched: "No complaints".

[602] Dr. Tate wrote in Mr. Hamill's Clinical Record during his MAPP session that Mr. Hamill "is a very emotional and impulsive and insecure individual who trusts others very little. He seems to respond to any kind of insecurity or threat by becoming verbally and physically hostile." Counsel for the Doctors submit that these observations adhere to the theory of MAPP espoused by Dr. Maier. In making this point, they make reference to Dr. Maier's evidence that MAPP was designed to settle down disruptive patients in order to teach them appropriate conduct that would allow them to return to Ward activities. Counsel for the Plaintiffs submit that Mr. Hamill was sent to MAPP because of his conduct which was a manifestation of his suicidality. They further contend that this demonstrates that MAPP was not only a punitive rather than therapeutic regime, but that if it was conceived as therapeutic by the Doctors it was entirely inappropriate and an abuse of their position as physicians.

[603] Plaintiffs' counsel's viewpoint is for the most part borne out by the Clinical Records. On June 15, 1978, for example, the Clinical Record describes Mr. Hamill's MAPP session as follows:

> The MAPP teacher reports attending groups on restraints and doing fair in program. Is very unpredictable, uses the slightest aggravation as an excuse to start yelling and trying to act out in groups. Attempts to shut others down when they get onto his situation […] Stated that he hated himself and has felt suicidal for the past week or so, had thoughts of punching out the windows in his room and to cut his throat while shaving. Says we can't stop him from committing suicide of he decides to do so […] MAP is the ideal place for

> Bruce as long as he is experiencing these suicidal urges. He needs to learn to express himself more spontaneously and in a more appropriate manner than he does now.

[604] On January 10, 1979, Mr. Hamill was put in MAPP for having struck another patient without warning while being placed in restraints, presumably by the patient that he struck. He stayed in MAPP for 20 days, until January 30, 1978. The Clinical Record states that "the patient is noted for this type of behaviour and is considered a very dangerous, unpredictable person". Staff making these notes appear not to have ever discerned Mr. Hamill's pattern of lashing out with resentment against the physical authority over him that had been delegated to other patients. According to Mr. Hamill's narration of his experiences, this type of incident – striking back at a patient who was on a "security team" or who was charged with placing him in restraints – was not unpredictable.

[605] From February 6, 1979 to February 21, 1979, Mr. Hamill was in MAPP when a patient member of the "clarification committee" accused him of violating hospital rules by attempting to secretly pass a note to another patient's visitors. Dr. Maier testified that although note-passing may not be a serious matter in many environments, it is a serious issue in a maximum-security facility due to the custodial nature of institution and the patient population, who may be planning on escape.

[606] In his affidavit, Mr. Hamill deposed that he agreed to participate in DDT because he was told it would be good for his treatment. He was given Amytal Ritalin on one occasion on February 3, 1978, on the orders of Dr. Maier. No other DDT treatments appear in his Clinical Records. On a number of occasions he was given non-DDT drugs such as Tegretol, Mysoline, Persol Forte, and Neuleptil as medication against seizures, as well as Nozinan as a sedative.

iii) Post-Oak Ridge experience

[607] In December 1980, Mr. Hamill was transferred to Brockville Psychiatric Hospital. On June 1, 1981, he was assessed there in preparation for an Ontario Review Board hearing. The Assessment Report concluded that Mr. Hamill was not quite ready to spend time in the community, and that it was important to keep him on anticonvulsant drugs as "his behaviour becomes markedly different when his medication is discontinued". The Report also suggests that Mr. Hamill was only partially cognizant of his own behavioural issues, and although he had some ability to articulate his experiences at Oak Ridge, he had only limited self-awareness.

> He described his early experiences at Penetang and some of the tensions and stress that he underwent at that time. He explained that the first couple of years were very difficult for him but that there was then a change in his thinking and he realized although he still felt periodically angry that he had to learn to control his feelings. He claims that for the past twenty-eight months there have been no overt physical assaults on anyone although at times he states he has felt angry and frustrated.

[608] On March 2, 1983, Mr. Hamill was transferred to the Royal Ottawa Hospital where he was permitted community privileges. During his time in Ottawa he was seen on several occasions by

Dr. Bradford, who reported on June 3, 1983 that Mr. Hamill appeared to have stabilized. In his Report of January 9, 2019, Dr. Bradford also stated that "the clear delineation of right temporal lobe atrophy by CAT scan, neurophysiological testing and left temporal lobe epilepsy by electroencephalography has been defined".

[609] Unfortunately, Mr. Hamill was not as stable as had been thought – at least, not while ceasing to take his medications. On July 13, 1991, he travelled to Brockville Psychiatric Hospital to meet another patient who was on a day pass. An Ontario Review Board ruling dated January 20, 1993 sets out that *en route* to Brockville he purchased a knife and hatchet with which he and the friend who he met sexually assaulted and killed another Brockville patient. Mr. Hamill was eventually found not criminally responsible for this offence and was admitted to the Royal Ottawa Hospital. The January 1993 Review Board decision summarizes Dr. Bradford's evidence with respect to Mr. Hamill:

> Dr. Bradford testified that the accused ceased to take his prescribed medication prior to the commission of first degree murder, which indicates his potential dangerousness. Dr. Bradford also observed that the lack of remorse of the accused for the offence is less than he would have expected from the accused in the circumstances.

[610] Dr. Bradford's evidence at the Review Board was put to Mr. Hamill in cross-examination in the present trial. He responded to it in a perhaps surprisingly matter-of-fact way:

> Q. And that prescribed med a – medication was the Tegretol, correct? You went off it and then you were accused and found NCR of committing a first-degree murder, correct?
>
> A. I thought I'd take a vacation on it and see how I'd do without it.
>
> Q. …And, Doctor Bradford testified that he observed a lack of remorse of the accused for the offences less than he would have expected from the accused in the circumstances. Do you remember not being as remorseful as you would expect about the person who was killed, Mr. Hamill?
>
> A. That's temporal lobe epilepsy. That's part of it, just part – part of the illness if you wanted to stay on this.

[611] The 2010 Review Board decision referenced earlier concluded, at para 31, that Mr. Hamill was to remain in Oak Ridge as he represented an ongoing danger to the public:

> It is clear from the evidence that Mr. Hamill presents a very significant risk of danger to the public, given the history of two murders while in an untreated psychotic state. Given his resistance to therapeutic treatment and his complete absence of insight… the least onerous and least restrictive disposition is continued detention at the Oak Ridge Division of Mental Health Centre, Penetanguishene with the added privilege of staff escorted hospital and grounds. In arriving at this

> disposition, the Board has taken into account the need to protect the public from dangerous persons…

[612] As already indicated, Mr. Hamill was still residing at Waypoint when he testified at trial and at the time of his death.

iv) Causation and harm

[613] In Dr. Bradford's Expert Report dated January 8, 2019, he opined that Mr. Hamill's lifelong "deep distrust" of the medical system was caused by his experiences in Oak Ridge. He also indicated that Mr. Hamill "remains one of the very few not guilty by reason of insanity patients that have ever recidivated with a second homicide." The suggestion is that this, too, is causally linked to the Oak Ridge treatments he received. This conforms with a Penetanguishene Consultation Report dated April 2, 1993, in which a forensic psychiatrist observed that Mr. Hamill "specifically attributes many of his difficulties to having been here before, and having been mistreated by an ineffectual, harsh, and occasionally destructive system."

[614] The Doctors' counsel submit that Dr. Bradford's conclusion, like Mr. Hamill's own self-assessment, is highly unlikely. I am compelled to agree.

[615] Taking all of the evidence of Mr. Hamill's medical history into account, it is not possible to say that anything done to him or not done to him at Oak Ridge caused Mr. Hamill's explosive violence. That was a result of his underlying mental illness which, the doctors examining him in the past (including Dr. Bradford himself) concluded, was likely a result of a brain injury that he sustained at birth.

[616] Indeed, in his reporting letter of June 3, 1983, Dr. Bradford observed that Mr. Hamill was on his prescribed medication and under Dr. Bradford's own care and doing well working in the community as a dishwasher. There is nothing in the reporting letter to suggest that while on his medication Mr. Hamill had an otherwise "deep distrust" of the medical system or of psychiatrists. The same can be said of a reporting letter that Dr. Bradford wrote in 1986, where he described Mr. Hamill as "highly motivated" and recommends vacating his Lieutenant Governor's warrant. There is no suggestion that Mr. Hamill has any aversion to the medical system as long as he is taking his anti-convulsant medication.

[617] The STU programs, and in particular the MAPP since that was the one to which he was primarily exposed, neither improved nor worsened Mr. Hamill's condition in the long term. Physically, Mr. Hamill has complained that the rigorous bodily restrictions of the MAPP have caused him arthritic pain in his knees and back, but in an environment where his every move was medically recorded there is no medical evidence to support that claim. Psychiatrically, he was prescribed the appropriate anti-convulsant medication. This was not, of course, part of the DDT or the other impugned STU programs. These medicines kept Mr. Hamill's condition under control, but nothing else is demonstrated to have impacted on his long-term propensity to go violently out of control.

[618] Turning to the question of short-term harm, in Mr. Hamill's Clinical Record dated March 14, 1978, it is observed that, "Bruce was crying and upset. He said he couldn't cope with the MAP program…" Moreover, as reviewed above, Mr. Hamill not only reported suicidal thoughts at the time he was in MAPP, he actually attempted suicide while shaving. Dr. Chaimowitz, who examined Mr. Hamill's medical records on behalf of the Defendants, responded to this in his testimony by saying that the self-inflicted neck wound was only a superficial laceration, but he does not seem to take into account that the attendants interfered with Mr. Hamill's cutting himself before he could complete the task.

[619] Dr. Chaimowitz opines that there is no evidence that Mr. Hamill suffered any harm as a result of the MAPP or DDT programs. That is not an accurate assessment of the evidence. The Clinical Records are filled with objective, reliable descriptions of the mental suffering to which Mr. Hamill was put in MAPP, and that contemporaneous suffering constitutes harm. Certainly, if nothing else (although there is a lot else), cutting one's own neck with a razor is an indication of the immediate pain caused by MAPP, even if MAPP was not a cause of long-term harm.

[620] Sadly, from the moment of birth Mr. Hamill appears destined to have lived a frustrated, angry, volatile, and violent life. While it was possible to control the symptoms of his brain injury and resulting mental illness with anti-convulsant medication, there was little any medical intervention could have accomplished if he stopped taking his medicine. He had long-term brain damage when he entered the STU at Oak Ridge, and he had the same long-term brain damage when he left 3 years later.

[621] That does not mean, however, that he deserved to be abused by his doctors and subjected to torment by other patients in the STU programs. The MAPP, in particular, caused him tremendous stress, anxiety, depression, indignity, and, had attendants not been present to intervene while he was shaving one day, could have caused him his life.

[622] This harm and personal suffering was inflicted on him, and directly caused by, the STU programs to which he was subjected from 1978 to 1980. Drs. Tate and Maier were directly involved in his treatments. The harm was short-term rather than long-term, but it was real and was caused by the Defendants.

m) Eldon Hardy

[623] In an Agreed Statement of Facts, it is related that Eldon Hardy was at Oak Ridge and the STU from June 19, 1972 to March 23, 1977 pursuant to a Warrant of the Lieutenant Governor. He had been found Not Guilty By Reason of Insanity on charges of buggery and indecent assault on a boy under 16 years of age. His Penetanguishene Discharge Summary of March 23, 1977 states that his diagnosis was: "Personality Disorder, Sexual deviation, Homosexual, Pedophilia". For a number of offences and infractions reviewed below, he subsequently spent roughly 4 years at Oak Ridge within the time frame covered by this litigation.

i) Pre-Oak Ridge and index offence

[624] An Initial Report on Mr. Hardy from Kingston Penitentiary dated August 6, 1968 indicates that his father was physically abusive to him as a child, and that as a youth he suffered sexual abuse at the hands of a number of adults. He stated in cross-examination that he began drinking alcohol at the age of 16, at the same time that he was sent to St. John's Training School in Uxbridge, Ontario, after being charged in juvenile court for theft.

[625] Mr. Hardy's Case History documented at Penetanguishene on August 17, 1972, records that he had a number of criminal convictions early in life. He was convicted of breaking and entering in March 1965, and during the course of the next few years had several convictions in a row for indecent assault on young boys for which he served sentences at Millbrook Correctional Institution. In 1966, he was convicted of an indecent assault on a 12-year old boy and received a 5-year sentence which he served in Kingston Penitentiary. In the Penetanguishene Case History it is noted that he admitted to being a heavy drinker during this time, and attributed much of his aggressive conduct to consumption of alcohol:

> He stated that when he was drinking he experienced an uncontrollable urge for sexual relations with males and it was more than he could handle. The patient also said that when he was not drinking, he usually had a fight with himself, but did control himself most of the time. While at Kingston Penitentiary, Mr. Hardy attempted suicide and was sent to the psychiatric ward. On the psychiatric ward, Mr. Hardy suffered a broken cheekbone in an incident...

[626] In cross-examination at trial, Mr. Hardy related that while at Kingston Penitentiary he attempted suicide and was sent to the psychiatric ward. There he got into a scuffle with an inmate who he says was raping him, and in the ensuing fight he suffered a broken cheekbone. The doctor at the penitentiary refused to repair his face with plastic surgery, stating that Mr. Hardy was too aggressive and that he did not want to treat a patient who had to be brought to him in leg irons and handcuffs. Mr. Hardy sued the doctor and settled with him a year or so later, although at trial he stated that he was not happy with the amount of the settlement. Mr. Hardy also made it clear in cross-examination that he had developed a bitter view of the physician as a result of this incident:

> Q. Fair to say you developed hatred for the doctor that you felt failed to treat you at Kingston Pen?
>
> A. Yeah, I was very unhappy, so much so that at one point, when I got out of the penitentiary, I was drinking and got ruminating about things, and I grabbed a knife and I took a taxi or something to the doctor's house, and I was gonna go hurt him. And he – I remember he opened up the curtain of his – his window, a front window or something, saw me, and he wouldn't answer the door, so I turned around and went home. It was kind of bizarre, but that's – yeah, I was that upset with the doctor.

[627] At trial, Mr. Hardy told of having lived through a riot at Kingston Penitentiary in which sex offenders were violently targeted by other inmates. In cross-examination, he became emotionally upset and characterized the riot as "trauma". He testified that he has never gotten over the images that persist with him of that prison riot:

> A. I tried to talk about the horrible experiences I had during that riot, but never enough that I could get rid of the terrible things in my head, and I still suffer a lot of nightmares about that…

[628] Mr. Hardy was discharged from Kingston Penitentiary on December 21, 1971. Three months later, on March 20, 1972, he was charged with indecent assault on a man. He was admitted to Oak Ridge for an assessment on March 31, 1972 pursuant to a Warrant of Remand. The Clinical Record of his admission to Oak Ridge states that he "been charged with buggery on one [name redacted], a 10-year old child. He committed the act several times threatening the boy with a knife." It goes on to indicate that he had already spent several uncomfortable months at Kingston Penitentiary due to the nature of his offense. He was diagnosed with "personality disorder – sexual deviation, homosexual, pedophilia."

[629] This first admission to Oak Ridge does not appear to have been eventful for Mr. Hardy. He did not participate in the STU programs for this relatively short stay. He was discharged from Oak Ridge into the custody of the Hamilton city police on April 26, 1972.

[630] Mr. Hardy returned to Oak Ridge on June 19, 1972 pursuant to a Warrant of the Lieutenant Governor after he was found Not Guilty By Reason of Insanity on charges of buggery and indecent assault on a boy under 16 years of age. He stayed there for roughly 5 years, and was discharged on March 23, 1977. At that time his diagnoses remained unchanged from the time of his initial Oak Ridge assessment.

ii) Experience in the STU

[631] According to his Agreed Statement of Facts and his Clinical Records, while in the STU Mr. Hardy was in the MAPP on the following dates:

> September 21 – November 8, 1972, after several weeks of verbally aggressive and threatening behaviour toward staff and patients;
>
> October 22 – November 5, 1973, for being very sarcastic toward staff at a ward meeting;
>
> December 25, 1973 – January 2, 1974, for making an implied threat to a staff member;
>
> June 21-28, 1974, after yelling at staff and acting hostile and paranoid;
>
> July 9 – August 11, 1975, for acting paranoid around and hassling a patient-teacher. During this month-long MAPP session, Mr. Hardy was noted to become aggressive toward staff when confronted;
>
> July 23 – August 13, 1976, as a result of a conflict between Mr. Hardy and a staff member that felt unable to correct or manage him.

[632] Under cross-examination, Mr. Hardy indicated that he was sent to MAPP on different occasions for being "sarcastic and mouthy" to staff, threatening patient-teachers, and on one occasion documented in the Bedside Nursing Notes, biting another patient. He also recalled being placed on restraints after calling security on himself and acting unruly in a ward meeting after he had shared, as he put it, a "batch of brew" in an episode in which "half the ward was running around drunk." There is no indication in Mr. Hardy's Clinical Records or Bedside Nursing Notes which individual staff member at Oak Ridge sent him to MAPP each time.

[633] Mr. Hardy was, however, under the care of Drs. Barker and Maier at different times during his years on the STU. Mr. Hardy was introduced to the STU in a letter dated April 19, 1972 from the head of the Psychiatric Unit at Kingston Penitentiary to Dr. Barker. The record also contains a substantial amount of correspondence and reports by Dr. Maier dealing with Mr. Hardy's condition. In one exchange of letters dated May 1974 between Dr. Maier and Mr. Hardy's father, Dr. Maier reports to Mr. Hardy's parents on his condition and encourages the parents to visit their son. Dr. Maier signs this correspondence: "Dr. G.J. Maier, MD, Unit Director – Social Therapy Unit". In other correspondence, Mr. Hardy or a lawyer on his behalf writes to Dr. Maier complaining of his treatment or of one or more incidents in the STU.

[634] According to the Treatment Records and the Agreed Statement of Fact, Mr. Hardy was given DDT treatments as follows:

> Scopolamine for three weeks beginning February 5, 1973, by order of Dr. Maier;
>
> Dexedrine, on a twice-weekly basis, together the Scopolamine treatment in February 1973;
>
> LSD, cycles of 5 days on and 2 days off, through January-February 1974;
>
> Dexedrine on February 15, 1974, by order of Dr. Maier;
>
> Amytal-Methedrine on March 13, 1974, ordered and administered intravenously by Dr. Maier;
>
> Dexedrine on March 12 and 13, 1974, by order of Dr. Maier with the authorization from the Federal Ministry of Health;
>
> Amytal-Ritalin on May 27, 1974, by order of Dr. Maier; and
>
> Dexedrine in January 1975.

[635] On January 18, 1974, Mr. Hardy wrote a note to Dr. Maier complaining of the pain he experienced in his Scopolamine treatment and asking that this drug be eliminated from his DDT. Dr. Maier did not pay any immediate heed to this correspondence. A month later, however, in a patient newsletter dated February 22, 1973, it is reported that Mr. Hardy was on his last week of Scopolamine treatment. The records do not indicate any repeat Scopolamine treatment after this 2-month ordeal.

[636] In the same letter in which he complained about the Scopolamine, Mr. Hardy told Dr. Maier that "the idea of a ten day LSD sounds good" and indicated that he was "willing to go through that with an Amytal follow-up". In a Treatment Record dated February 14, 1974, it is noted that Mr. Hardy was disappointed with the lack of strong effect on him of his initial LSD treatments. The LSD doses had proceeded on a 5-days on, 2-days off cycle, ending with an extra-large dosage of 475 mc of LSD on February 15, 1974 in the Capsule.

[637] All orders for LSD were made by Dr. Maier, and Dr. Maier met with Mr. Hardy in advance of his treatment with LSD in the Capsule. Dr. Maier administered the 475 mcg dose in the Capsule. This session lasted for 4 days and took place entirely in the Capsule. The Special Treatment Report dated February 28, 1974 that reports on this final LSD session do not record any particular distress experienced by Mr. Hardy. The records also show that Mr. Hardy was one of the patients who signed the letter to the *Barrie Examiner* newspaper on January 30, 1976 which defended the use of LSD at Oak Ridge. In cross-examination at trial, Mr. Hardy claimed he did not recall signing the letter and stated that he must have "blindly signed it".

[638] In a Clinical Record dated March 13, 1974, Dr. Maier wrote that, following his Amytal-Methedrine treatment, Mr. Hardy had reached "a stage that he could get into his negative feelings at some length." This was shortly after completing the LSD treatment, when Mr. Hardy wrote a conflicted letter to Dr. Maier dated February 19, 1974. In his letter, Mr. Hardy complained about the cancellation of certain programs and expressed his personal disappointment in Dr. Maier; at the same time, Mr. Hardy expressed praise to Dr. Maier for the "concern you showed me during my LSD."

[639] The Agreed Statement of Facts sets out that on March 23, 1977, Mr. Hardy was sent to St. Thomas Psychiatric Hospital to assist staff at that facility with setting up a Social Therapy Unit of their own. He was sent back to Oak Ridge on April 27, 1977 after assaulting a staff member at St. Thomas and being convicted of assault causing bodily harm. He remained in Oak Ridge for another 3 years, until April 1, 1980, when again he was transferred to St. Thomas. His re-admission to Oak Ridge interview was conducted by Dr. Tate, who summarized this interview in a Clinical Record entry dated May 8, 1977:

> Eldon was interviewed in the office today by the professional team….We then attempted to discuss the difficulties that Eldon encountered at St. Thomas which resulted in his being transferred back here. He stated that this was only due to the fact that he had asked not to remain as a teacher in their program. We attempted to point out to Eldon that he had had severe interpersonal difficulties, both with the staff and the other Oak Ridge patients, as well as the female patients on the Forensic Unit in St. Thomas. We pointed out that this was very important [sic] factor in his adjustment, both in St. Thomas and a regional setting in the future. Eldon was very threatened by this issue and refused to discuss the matter at all, claiming that we were threatening him and that he had a legal problem that he would take up with his lawyers and the Ombudsman.

[640] Mr. Hardy received an alcohol treatment on May 26, 1977 which, according to a Clinical Record of that date, he requested himself. Like several other hard-drinking Plaintiffs, Oak Ridge

obliged his craving for alcohol. The Record observes that during this session he revealed a great deal of "paranoia about the system and his hatred for figures in authority". The Agreed Statement of Fact also records that Mr. Hardy was in MAPP on one occasion during this 3-year admission. That took place in December 1979, at a time when neither Dr. Barker nor Dr. Maier were at Oak Ridge.

[641] A month and a half after arriving for the second time at St. Thomas, Mr. Hardy was again sent back to Oak Ridge on May 27, 1980. The Transfer-In Note dated June 5, 1980 indicates that he was transferred for meeting with a female patient after midnight. He remained at Oak Ridge this time until October 6, 1981, when he was discharged to Metropolitan Toronto Forensic Services. His diagnosis at the time of discharge was: Personality Disorder with Paranoid and Antisocial Features and Homosexual Pedophilia."

[642] During this final admission to Oak Ridge, Mr. Hardy was, according to the Agreed Statement of Fact, in the MAPP from November 14 to November 17, 1980 and again for some period time in April 1981. A social worker's note dated April 9, 1981 indicates that he had made accusations against staff that they did not like, and that he sent to MAPP on the basis of "a conjoint decision by patient peers, ward and members of clinical staff."

iii) Post-Oak Ridge experience

[643] Mr. Hardy has never managed to spend any substantial amount of time outside of institutions and in the community. The Agreed Statement of Fact relates that on September 21, 1982 he was transferred to Queen Street Mental Health Centre. He shortly afterward began living in the community, but in 1985 was convicted of 2 charges of assault. He was then returned to Queen Street Mental Health Centre until December 1, 1986.

[644] A month after his discharge from Queen Street, on January 23, 1987, Mr. Hardy was re-admitted to Oak Ridge. Except for a month-long assessment at the Royal Ottawa Hospital from January 11, 1991 to February 20, 1991, he remained at Oak Ridge for 5 years, until January 29, 1992. Following his discharge, he has vacillated between the Royal Ottawa Hospital, the Kingston Psychiatric Hospital, and the Brockville Mental Health Centre. The Agreed Statement states that he fled from the Royal Ottawa Hospital in 2001. He was then re-admitted to the Royal Ottawa and stayed there until he was discharged in 2008. Within a year, in 2009, he was returned to the Royal Ottawa when he was charged with a sexual assault and ultimately designated as a dangerous offender.

[645] Mr. Hardy currently resides at the Brockville Mental Health Centre. His Brockville Hospital Report dated August 15, 2018 indicates that his current diagnosis is multi-faceted. It lists his mental disorders as: major neurocognitive disorder due to frontal lobe degeneration, paraphilia, paraphilia sexual sadism, alcohol dependence, psychotic disorder, antisocial personality disorder, and paranoid personality disorder. The Report states that Pedophilia" and "Sexual Sadism" are "in remission". Mr. Hardy stated in cross-examination that a feature of his paranoid personality disorder is that he is suspicious of those around him. Indeed, he seemed to demonstrate that tendency in his answer to the cross-examination questions:

> Q. One feature of your diagnosis of personality disorder is that you're typically paranoid of the people around you, is that fair?
>
> A. Well I suppose it's splitting hairs a bit, but paranoia could mean that there's – I think there's people out to harm me, who aren't harming me or are going to harm me, not particularly, no. I generally know when somebody means harm to me, and yes, I get suspicious of them.

[646] He then traced the source of this now deep-seated suspicion and described its lingering effect:

> Q. Do you agree with me that you get paranoid of the people generally around you or no?
>
> A. Not generally, no, in the sense that I meant it here, like - yes, what I'm saying is the doctors *[indiscernible]* caused me harm. And I was paranoid of them in that sense, because they - they - they - they caused me harm and I was afraid anytime they wanted me to do anything, I was gonna get more harm. So I was suspicious of them. And patients, I got suspicious of because they were forced to do with each other what they were told to do or they'd get in trouble.
>
> Q. And today, Mr. Hardy, you continue to be paranoid of the people around you, even in the Brockville Centre, correct?
>
> A. With good - good reason I have suspicions, yes, to be concerned about harm to me, yes.
>
> Q. You also today find it difficult to trust authority?
>
> A. Yeah.

iv) Causation and harm

[647] Mr. Hardy complains that he suffered greatly due to the MAPP experiences and the periods in confinement that went along with MAPP. Counsel for the Plaintiffs emphasize that he was frequently punished with MAPP sessions for exhibiting the psychiatric disorder which he was in Oak Ridge to have treated. For example, the Clinical Record dated July 24, 1976 and signed by Dr. Tate states that, "During the past month Eldon went from a position of positivity to a state of argumentative negativity, which culminated in his transfer to MAPP." This punishment for mood swings and depression that were part of his illness but were seen as misbehaviour was very frustrating and harmful to Mr. Hardy.

[648] Dr. Chaimowitz, who examined the medical file of Mr. Hardy on behalf of the Defendants, agreed that solitary confinement can be a version of torture if enough time is spent there. Indeed, he deposed as much in his affidavit dated September 1, 2017 filed in *Reddock v Attorney General of Canada*, Court File No. CV-17-570771-00CP. There he indicated that, in fact, young people and those suffering a prior mental illness are more susceptible to the detrimental effects of

confinement. He also opined that seclusion can reactivate past trauma. His opinion in *Reddock* was that under those circumstances, confinement "may cause serious trauma and lead to deterioration in mental health."

[649] Dr. Bradford testified that a review of Mr. Hardy's records indicates that he was traumatized by his Capsule and DDT experiences as well. That is more difficult to discern in the medical records, as there is little evidence that Mr. Hardy had a difficult time with the DDT drugs, with the exception of Scopolamine. Dr. Bradford indicates, however, that the drug treatments contributed to Mr. Hardy's paranoia.

[650] In a Report dated January 25, 1991 by Dr. Bradford following an assessment of Mr. Hardy he performed at the time at the Royal Ottawa Hospital, it is noted that, "he discussed in detail with me his Scopolamine treatment. This occurred in 1973/74…" The Report then goes on to describe this particularly harsh DDT treatment:

> The objective was that the person would become confused, they would create an anticholinergic effect, cause the effects on the heart and as bradycardia, the central nervous system effects or drowsiness, irritability and disorientation is an acute toxic psychosis…He describes that person who went through the treatment became confused and hallucinated and became very frightened.

[651] Dr. Bradford noted in his testimony that he had also examined Mr. Hardy at the Royal Ottawa Hospital in March 1991. In a March 20, 1991 Report submitted to the Review Board for one of its periodic considerations of Mr. Hardy's condition, Dr. Bradford thoroughly reviewed Mr. Hardy's sexual history, including the series of sexual assaults on young males in the mid-1960s when he was in his 20s. Dr. Bradford also mentioned in that Report the 1971 riot at Kingston Penitentiary when Mr. Hardy and other pedophiles were targeted by other inmates. These were identified as contributing events in Mr. Hardy's paranoia and other psychiatric conditions. They all pre-date his first admission to Oak Ridge.

[652] That said, Dr. Chaimowitz conceded that the DDT sessions, and in particular the Scopolamine, could have fostered severe anxiety and paranoia. In cross-examination, Dr. Chaimowitz was asked about a January 31, 1991 Clinical Record of Mr. Hardy from the Royal Ottawa Hospital. That Record observes:

> Tense, agitated, angry at times, clearly suspicious man. He seems to possibly have a core truth to his poor handling at Penetang, particular with regards to Scopolamine, LSD, and MAPP and possibly had some complaints against the union. Whether they are secondary elaboration in a paranoid delusional sense at this time is still difficult to evaluate. He is hallucinating at this time and he is fully oriented.

[653] Dr. Chaimowitz dismissed this Record as showing nothing but the ramblings of a delusional man. But, of course, that is Plaintiffs' counsel's very point about Mr. Hardy. While he may have been a sexual predator long before his arrival at Oak Ridge, his delusions, anxiety, and paranoia seem to stem from the very treatments he received in the STU. And what's more, the

Royal Ottawa Clinical Records provide concrete evidence that Mr. Hardy complained of this harm on multiple occasions since Oak Ridge and well before this litigation commenced.

[654] As indicated, Dr. Chaimowitz agreed with Plaintiffs' counsel that the design of the DDT program was to provoke anxiety in an effort to break down the patients' defenses, and that the drugs used by Drs. Barker and Maier in this program could produce months-long anxiety attacks. He also agreed that Mr. Hardy was reporting this prolonged anxiety for years, although he testified that he cannot know for sure where the reported 1990s anxiety really came from. He testified, "I do not believe his distrust and paranoia come from these events. They come from somewhere else."

[655] I find it surprising that Dr. Chaimowitz takes this position. Dr. Bradford testified that being abused by his psychiatrist could retraumatize someone like Mr. Hardy, and certainly could cause him lingering anxiety about authority figures. Dr. Chaimowitz' retort to Dr. Bradford's view is to say that although what Mr. Hardy went through was unpleasant and he didn't like it, it didn't cause any more harm. Given Dr. Chaimowitz' known views in previous cases where he gave expert evidence for the other side – i.e. for the prisoner claiming abuse rather than for the authority figure accused of abuse – this assessment of Mr. Hardy's experiences with MAPP and the associated periods of confinement, coupled with his experiences with Scopolamine and other mind altering drugs, is difficult to credit.

[656] I have no hesitation in concluding that Mr. Hardy suffered while in MAPP. Virtually everyone who went into that program did; it was designed to produce suffering. In this respect, Dr. Barker, who designed the program, admitted Mr. Hardy to it and assessed him, and, Dr. Maier, who was directly involoved in his STU treatments and who sent him to MAPP on numerous occasions, caused Mr. Hardy short-term harm.

[657] The same can be said of the DDT program. Mr. Hardy may have enjoyed some of the drug and alcohol experiences, but that does not mean that they did not harm him. And he was certainly harmed in the short term by the painful month in 1973 that he spent on Scopolamine ordered by Dr. Maier. He complained of pain during the session, but was forced to finish the lengthy session before he could terminate further Scopolamine treatments.

[658] In addition to causing him short term harm, the MAPP and DDT programs caused him long term anxiety and paranoia. He may have had some of these syndromes prior to Oak Ridge, but the evidence shows that the time he spent in the STU augmented them and prevented them from fading with time. Dr. Chaimowitz agreed with Dr. Bradford that this is a likely effect of the drug experiences, confinement, and "positional torture" as Dr. Bradford called MAPP, and there is no reason to think that it is not what is driving Mr. Hardy's continued anxiety and paranoia.

[659] The Doctors, and the Crown as responsible for Oak Ridge, therefore caused Mr. Hardy both short-term mental anguish and long-term mental harm in the form of ongoing anxiety and paranoia disorders.

n) William Hawboldt

[660] William Hawboldt passed away after he was examined for discovery in this action. His sister and litigation guardian, Barbara Brockley, continues his claim on his behalf.

[661] The criminal court verdict in the record indicates that on September 2, 1975, Mr. Hawboldt was found not guilty by reason of insanity of the charges of attempted murder and arson and was committed to Oak Ridge pursuant to a Warrant of the Lieutenant Governor. He was re-admitted to Oak Ridge (having been there previously for an assessment) and remained there until January 9, 1981.

i) Pre-Oak Ridge and index offence

[662] In his affidavit, Mr. Hawboldt describes a very difficult childhood in which he and his siblings were terrified of his father. When he was nine years old, his father murdered his mother and then committed suicide. Thereafter, Mr. Hawboldt was separated from his siblings and moved from living with various friends and relatives to a variety of boarding houses. He deposes that due to the instability of his life after the loss of his parents he was unable to stay in school beyond grade 8. At 17 years old he joined the army.

[663] While he was in the army, Mr. Hawboldt suffered a serious brain injury as a result of an automobile accident in which two passengers died. His affidavit relates that following the accident, he experienced occasional bouts of depression, cognitive issues, and lapses of memory. He also describes how his personality changed after the accident. He was ultimately discharged from the army after stealing a razor from another person.

[664] After leaving the army, Mr. Hawbolt embarked on a series of aggressive and self-destructive acts. He narrates in his affidavit that in October 1962, he took an overdose of drugs in an attempt to commit suicide, and was admitted to Lakeshore Psychiatric Hospital. Then, in July 1963, his landlady, with whom he was in a romantic relationship, asked him to leave and in response Mr. Hawbolt threatened to kill her and himself. He was committed as an involuntary patient to Whitby Psychiatric Hospital. Two months later, in September 1963, he was admitted to Victoria General Hospital in Halifax after again attempting suicide.

[665] Over the next decade, Mr. Hawboldt was admitted to Queen Street Mental Health twice – once for exposing himself to some young children and another time when he complained of suicidal thoughts. He was also admitted to the Clarke Institute when, as he tells it in his affidavit, “the police found me crawling around in a field on my hands and knees.” Over the course of these years he was also convicted of assault following an attack on a Toronto Transit Commission streetcar driver.

[666] A Case History taken at Oak Ridge on March 17, 1975 describes the events which led to Mr. Hawboldt’s admission there. It appears that Mr. Hawboldt became involved in an argument with his landlord in which he alleged the landlord had kicked his dog. The argument eventually lead Mr. Hawboldt to move out of the basement apartment of the house. A week later, he set fire to the house; in the process, he intentionally poured inflammatory material at the entrance of the house in an effort to block their exit from the building. The Case History concludes: “Police feel that it was sheer luck that no one was killed or injured as a result of this arson.”

[667] Mr. Hawboldt was arrested and committed to Oak Ridge on January 31, 1975 on a Warrant of Remand. He remained there for nearly 2 months, until March 21, 1975. On February 3 and 25, 1975, Mr. Hawboldt underwent a psychological examination in which the examining doctor observed that his interpersonal relationships "have generally been perceived as unsatisfactory and he suggests that he holds hostile feelings toward others… William appears to experience considerable interpersonal difficulties and subsequently attempts to remain aloof from his environment."

[668] Dr. Fleming conducted a Mental Status examination of Mr. Hawboldt on March 19, 1975. He concluded that although Mr. Hawboldt's prognosis was "probably guarded", he was fit to stand trial. Dr. Fleming observed that, "indications are that he is an accomplished liar but I would doubt if he has much insight into his tendency toward impulsive and aggressive behaviour. Certainly he would appear to have some impairment of judgment if the recent behaviour is any indication."

[669] The records do not indicate that Mr. Hawboldt received any treatment during this admission, which was strictly devoted to observation and assessment of him. He did not receive DDT drugs, did not stay in the Capsule, and was not sent to MAPP. On September 2, 1975, he was found not guilty by reason of insanity of the charges of attempted murder and arson, and was subsequently committed to Oak Ridge pursuant to a Warrant of the Lieutenant Governor where he remained for nearly 5 ½ years.

ii) Experience in the STU

[670] Mr. Hawboldt's Clinical Records from Oak Ridge show that he had an intense dislike of the milieu therapy and the STU in general, and that he asked to transfer to a different ward on several occasions. The Records also show that at times he had extreme hostility toward the STU staff and experienced suicidal and homicidal thoughts. A Clinical Record dated March 1, 1978 reports that he had compiled a list of professional staff and others at Oak Ridge that he wanted to kill.

[671] It appears that he was relatively content with his lot at Penetanguishene on those few occasions when he was permitted to join a different ward and did not have to take part in the group sessions. In fact, the record contains a note written by Mr. Hawboldt dated February 9-10, 1981 – i.e after he had already left Oak Ridge for St. Thomas Psychiatric Hospital, entitled, "Reasons Why I Want to Go Back to Penetang", in which he complained that St. Thomas had similar group therapy sessions that he so disliked on the STU.

[672] There is no record of Mr. Hawboldt ever having been in the Capsule. The Clinical Records show that he was in MAPP on two occasions:

> July 24 – August 21, 1978, for lying to staff about communicating to a patient on a different ward during yard time.
>
> November 9-24, 1978, by 'ward staff' for undermining staff and 'being very devious in his behaviour.'

[673] The records show that Mr. Hawboldt was under the psychiatric care of Dr. Maier, who was responsible for his participation in the STU. In the context of this participation, he was sent to MAPP on two occasions, albeit by other staff members each time. It is clear that Mr. Hawboldt experienced extreme discomfort in MAPP and considered it to be tortuous treatment. In November 1975, he wrote to a physician at Oak Ridge to express his feelings about MAPP:

> As I foresaw, I will have problems here. The main problem I am having is of the physical nature. I have been feeling like giving up because of the pain. I thought that barbaric treatment of the body went out in the dark ages. I believe I should be punished, but under the circumstances of my age, I am not up to this. Mind you, I'll try, but only because I have to no matter what I say or do. … So far I haven't made matters any better for myself, as I have broken one of the rules. … this will probably set me back from a 14 day projected stay … As you recall from my interview with you, plus my conference, I have no faith in this hospital in wanting to give me any help in regards to treatments.

[674] His complaints about the physical hardship in MAPP were accompanied in the same letter about his lack of trust in the STU programs overall:

> I have no faith in this hospital in wanting to give me any help in regards to treatments (scopolamine, dexamyl, etc). Therefore, I only see fit in asking for a transfer to E ward. My ward supervisor was so far out of touch of where I was in wanting treatments, he didn't even know I've talked about it. I'd only have to go back to the [illegible] sunroom in January to show you how much people wanted to offer me any help. Maybe, its best that I didn't get the treatments anyway! It only would have prolonged my stay in therapy. Here in MAP, I'm having an even harder time because of restrictions of speech. Somehow, I just can't seem to communicate as well, or as confidentially. If I make it out, it might do something for my self-esteem, because I haven't felt I could make it. The teachers have been fair so far.

[675] Treatment Records show that although Mr. Hawboldt was never given LSD while at Oak Ridge, he was in the DDT program. The Treatment Records document him participating in 3 DDT sessions, all of which were ordered by Dr. Maier:

> Amytal-Ritalin on November 20, 1975
>
> Alcohol-Ritalin on November 15, 1977
>
> Alcohol-Ritalin on December 30, 1977

[676] None of the records from these dates show Mr. Hawboldt reporting any special distress related to the DDT treatment sessions. A Special Treatment Report dated November 28, 1977 indicates that his defenses had not been broken down during his DDT sessions and that he still needed to improve social interactions. The staff portion of the Record suggests that Mr. Hawboldt was in need of further drug sessions.

iii) Post-Oak Ridge experience

[677] The record indicates that Mr. Hawboldt remained institutionalized for at least two decades after leaving Oak Ridge. He was committed to St. Thomas Psychiatric Hospital until August 5, 1983, when, according to a Transfer Note in his medical file, he moved to Queen Street Mental Health Centre. In his affidavit dated March 6, 2017, he relates that he was committed to Oak Ridge again on February 23, 1984 and was discharged on June 29, 1984, once again back to Queen Street. He was then apparently committed to Oak Ridge yet again on August 8, 1984 and remained there until May, 1990, when he was discharged to Brockville Psychiatric Hospital.

[678] He recounts in his affidavit that on October 29, 1992, he was discharged from Brockville to live in the community. He was residing at a home for the elderly in Brockville at the time he swore his affidavit and remained there until his death.

iv) Causation and harm

[679] In his Report dated January 8, 2019, Dr. Bradford opines that Mr. Hawboldt was "highly vulnerable" because of the childhood trauma of his father killing his mother then committing suicide and the brain injury he sustained in the motor vehicle accident at 19 years of age. It is certainly believable that both of those incidents would have had a life-long impact on him. Whether they made him vulnerable to additional harm or had already caused all of the harm that Mr. Hawboldt continued to suffer later in life is a matter of conjecture.

[680] Dr. Bradford's Report appears to be a tad sloppy when it comes to Mr. Hawboldt's history. He states that at Oak Ridge Mr. Hawboldt "suffered serious harm" as a result of his exposure to "the MAPP, DDT and Capsule programs"; however, as already indicated, there is no evidence that Mr. Hawboldt was ever in the Capsule. Furthermore, Dr. Bradford states in his Report that "Mr. Hawboldt reported that he had been diagnosed with schizophrenia", and concludes from this that he had heightened vulnerability to DDT drugs and to the strenuous experience of the MAPP. A review of his own records indicates that Mr. Hawboldt's diagnosis is not schizophrenia. As can be seen on the Penetanguishene Report dated August 24, 1989, his diagnosis is, and has been since he was first diagnosed, "Personality Disorder, Immature, Inadequate and Antisocial".

[681] Dr. Bradford mentions in his Report that Mr. Hawboldt claimed he continued to have nightmares in the 1990s tracing back to his time in Oak Ridge, and that it was Mr. Hawboldt's view that the reason he could not hold down a steady job due was that he had ongoing stress from the Oak Ridge experiences. What Dr. Bradford does do is to adopt or expressly agree with Mr. Hawboldt's self-analysis of the source of his later problems. Dr. Bradford's Report therefore does not contain an actual opinion that Mr. Hawboldt's later-in-life suffering was caused by the treatment he received at Oak Ridge.

[682] Dr. Booth reviewed Mr. Hawboldt's records and discovery transcript and concluded that, contrary to Dr. Bradford's view, Mr. Hawboldt likely did not suffer ongoing harm due to his exposure to the STU Programs. Dr. Booth opines in his Report dated April 2, 2019 that Mr. Hawboldt's psychiatric disorders can be explained entirely by his early, pre-Oak Ridge life experiences, including his parents' murder-suicide and his automobile accident. Dr. Booth points out that Mr. Hawboldt had been diagnosed as having an unstable personality, with a tendency to paranoia and significant psychopathy prior to his time at Oak Ridge.

[683] At trial, Dr. Booth explained that in his view, Mr. Hawboldt's long-term complaints were not a result of the STU programs:

> Q. Do you recall that he testified that he had recurring nightmares two or three times a month, right up to the present?
>
> A. Yes, he did testify that.
>
> Q. Okay. And recurrent nightmares about a traumatic experience is a sign of PTSD, isn't it?
>
> A. Yes, it is.
>
> Q. And that's a sign of continuing psychological harm?
>
> A. That is a sign.
>
> Q. And you have no reason to believe that he isn't suffering recurring nightmares two or three times a month about Oak Ridge?
>
> A. I would disagree with that strongly. This is a gentleman who isn't, in any of these letters, expressing horrific experiences. So, yes, he underwent the MAP Program, he underwent time in the capsule, but these letters aren't about that. These letters are, people are mistreating me because they want to talk – get me to change my opinion and act a different way. The other reason that I didn't put weight on his current testimony is he had been seen by many other individuals since the time of the Oak Ridge program, and he had never complained to any of them around nightmares and flashbacks.
>
> Q. Okay.
>
> A. And that's such a rich piece of that PTSD diagnosis, that, again, it just isn't conceivable that somebody would go for that many years and not complain about those symptoms when given the opportunity recurrently.

[684] There is insufficient evidence to support Dr. Bradford's view, which is itself based at least in part on incorrect facts, that the STU programs caused Mr. Hawboldt long-term harm. Considering that he had only 3 DDT treatments and was in MAPP only twice, the nightmares and stresses he suffered later in life were more likely to have been caused by the several traumas of his early life than by the relatively few painful incidents he suffered at Oak Ridge.

[685] Having said that, Mr. Hawboldt did suffer because of the DDT and MAPP programs, and said so at the time. The pressure of having to open up to other patients, including under the influence of a combination of stimulants and alcohol, caused him such strain and undermined his personal dignity to the extent that it prompted suicidal thoughts. And the MAPP was so painful to him that he complained chronically that he needed to be removed from the STU.

[686] Dr. Maier was directly involved in Mr. Hawboldt's treatments, which caused him short-term harm while he was at Oak Ridge.

o) Danny Joanisse

[687] Danny Joanisse passed away during the course of the trial, after completing his testimony at trial. There has not yet been an Order to Continue sought with respect to Mr. Joanisse's claim, and so technically it is stayed. However, Plaintiffs' counsel advised that they would likely be seeking an Order. On the assumption that they will be so instructed, I will review the evidence with respect to Mr. Joanisse as if the claim were being continued by his estate representative.

[688] Mr. Joanisse had a very difficult childhood. He conceded when testifying at trial that he had spent much of his life dealing with the "demons" left by his treatment at St. John's Training School, where he was repeatedly physically and sexually abused. By the time he was admitted to Oak Ridge in May 1971, he had attempted suicide several times and had slashed himself with a knife. He remained in institutions most of his life, and was in and out of Oak Ridge until the mid-2000's.

i) Pre-Oak Ridge and index offence

[689] Mr. Joanisse was born on May 28, 1956. In his affidavit, he relates that his parents were musicians who moved around a lot. He was physically small and had health issues, including a number of seizures. He also states that he was a slow learner and had a difficult time in school, and never managed to go beyond grade 5.

[690] In his pre-teen years he started engaging in relatively petty criminal offences. He testified at trial that a series of thefts and break and enter charges resulted in him eventually being put in foster care and being made a ward of Children's Aid Society at the age of 13. He deposed in his affidavit that when he was 13-years old he was sent to the Hamilton Psychiatric Hospital on a Warrant of Remand for a 30-day assessment. The Administrator's Report from Hamilton sets out his diagnosis as "character disorder with antisocial features, and possible organic deficits of unknown etiology." In January 1970, at the age of 14, he was sent to St. John's Training School.

[691] Mr. Joanisse deposed that at St. John's he experienced assorted physical abuses, including being beaten with sawed off goalie sticks as a form of punishment. He further deposed that he was repeatedly sexually abused by a Christian Brother working at the school. Out of despair and frustration, he began to self-harm by cutting his wrists and constantly trying to run away from the school. In cross-examination he estimated that he had gone AWOL from the training school roughly 30 times, and that during his time there he had attempted suicide and slashed his wrists numerous times.

[692] It is unclear whether Mr. Joanisse ever disclosed to Dr. Barker or Dr. Maier that he had been sexually abused at St. John's. In cross-examination he stated that he could not recall whether he discussed this with them. The earliest indication of this in the record is a letter he wrote to Dr. Barker dated June 26, 1991, in which he asked if he could return to Oak Ridge. The contemporaneous Clinical Records written during the period covered by this litigation make

mention of his very troubled youth, but do not mention the sexual abuse he experienced while at training school.

[693] When he was 15 years old, Mr. Joanisse was involuntarily committed to Oak Ridge pursuant to the *Mental Health Act*. He remained there for nearly a year, from May 25, 1971 to March 1, 1972. In his affidavit, Mr. Joanisse described his memories of his first admission to Oak Ridge:

> The day I entered Oakridge was one of the scariest days of my life. I had just been transferred from a place where I was repeatedly sexually abused to an institution which housed adult males who had committed serious violent crimes, including rape and murder. I was physically small, even for my age, let alone among the other patients, and I just wanted to go back home. I cried uncontrollably and asked for my father. During this stay at Oakridge, my parents separated and I blamed myself for breaking up the family.

[694] An Interim History dated June 30, 1971 written at Penetanguishene indicates that his parents consented "to give to Danny Joanisse any form of medical or psychiatric treatment that will be for his benefit for any period of time as may be needed, thirty days or more". His Clinical Record of May 27, 1971 notes that he was admitted to Oak Ridge due to his "depressive state (plus intensive anxiety) and several suicidal attempts. His Clinical Record from 2 days later, on May 29, 1971, states that he was experiencing auditory hallucinations and thought he heard his father calling his name. In response, he was place on stripped status.

[695] A Clinical Record dated June 2, 1971 states that, "It would appear that he becomes psychotic under stress on occasion." It likewise records that Mr. Joanisse had been suicidal while he was at St. John's Training School.

[696] Counsel for the Doctors points out that the Clinical Records reveal that at times Mr. Joanisse wanted to be in the STU, and at others he sought to be placed in a less onerous unit. In his testimony, Mr. Joanisse denies that he consented to any of the treatment programs he underwent while on the STU. However, when presented with the records that demonstrate that he vacillated on the subject, he conceded that he often requested to go back to the STU at those times when he was out of it.

[697] In a note inserted into his Clinical Record dated February 8, 1972, written on behalf of unnamed patients and attendant staff, it was reported:

> This is the pattern Danny's stay in the hospital followed, he would feel insecure and rejected by the rigors of the programmes he was in; then manipulate to remove himself from this situation…
>
> He still projects insecurity and we believe he would have difficulty in a training school atmosphere.

[698] During this initial time in Oak Ridge, Mr. Joanisse was not in MAPP at all. The Bedside Nursing Notes show that he was in the Capsule for one evening on October 6, 1971 and again for

5 days, from October 9-14, 1971, on Dr. Barker's orders. He testified that while in the Capsule he was naked and handcuffed to a co-patient who was known to be a child abuser, and that yet another patient in the Capsule at the time threatened to kill him. Mr. Joanisse also testified that when the second patient was removed he continued to hallucinate that he was there. As the Doctors' counsel point out, there is nothing in the Clinical Records to corroborate this testimony.

[699] Likewise, Dr. Maier was unable to confirm that Mr. Joanisse expressed fear of anything when he was in the Capsule. At the same time, he confirmed, in an almost flippant way, that placing a vulnerable and naked 15-year-old in the Capsule with older criminals was indeed done and was an unusual approach to therapy:

> Q. Okay and this nude therapy, that was not recognized psychiatric therapy for schizophrenics or personality disorders or psychopaths.
>
> A. Yeah, there were other places in the country that, uh, were advancing nude therapy but I don't remember if it was specifically for people with schizophrenia or not.
>
> Q. And certainly, there was no suggestion that you take a young teenager like Danny Joanisse or Pinet or McMann and cuff them naked in the Capsule with people that were sex offenders or murderers or mafia hitmen. That had never been done anywhere.
>
> A. That was part of the novelty of it.

[700] In addition to two sessions naked in the capsule, the Treatment Records disclose that Mr. Joanisse was given the following DDT treatments during his initial stay at Oak Ridge:

> Sodium Amytal and Methedrine on August 11 and 16, 1971, ordered by Dr. Barker;
>
> Dexedrine on September 8, 1971, ordered by Dr. Barker;
>
> Dexamyl on June 10, 1971, and October 10, 11, 12, 13, 29, 1971, ordered by Dr. Barker; and
>
> Tofranil on October 29, 1971, ordered by Dr. Barker.

[701] By decision of the Review Board dated February 26, 1972, Mr. Joanisse was discharged from Oak Ridge. He testified that this was contrary to the advice expressed at the time by Dr. Barker. He was sent back to St. John's, where the sexual abuse that he had previously experienced started again. He further testified that this recurrence of abuse so upset him that he began to lash out in different directions. An Interim History produced at Penetanguishene on May 4, 1972 indicates that he cut himself with a knife a number of times in the aftermath of being returned to St. John's, and that he ultimately obtained a large butcher knife and stabbed another boy with whom he was on an outing from the residence. He also lacerated his own left hand, resulting in his loss of several fingers.

[702] His description of the incident in a Clinical Record at Penetanguishene dated April 21, 1972 indicates that he was at the time in a dissociative state of mind. As he put it to the assessing physician, “I have to find out why I did it.”.

[703] Mr. Joanisse was charged with attempted murder. On March 26, 1972, he was committed to Oak Ridge on a Warrant of the Lieutenant Governor. On September 24, 1973, he was found not guilty by reason of insanity for attempted murder.

ii) Experience in the STU

[704] With this second committal, Mr. Joanisse was again placed in the STU program. His Medication Sheet indicates that as part of the DDT program, he was given an Alcohol-Ritalin treatment May 19, 1972. A signed Consent form for this treatment is in the record.

[705] The May 19, 1972 Alcohol-Ritalin treatment is the only DDT session contained in Mr. Joanisse’s Oak Ridge records for this admission. Despite the absence of documentation, Mr. Joanisse provided in the course of his examination-in-chief the following rather detailed description of a frightening course of Scopolamine treatments:

> Q. And I understand that at some point injections were involved, somebody called it DDT.
>
> A. Yes, it was called…
>
> Q. Can you tell us whether you had experienced any injections and what the circumstances were?
>
> A. Circumstances at the time, I was on turkey strap, I was in the psychotic sunroom, I was yelling and screaming, I was in pain for one, and all they were trying to do they’ve realized that 25 Noz (ph) wasn’t working again, so they’d come down with a – a shot, it was usually three shots of Scopolamine, they can - the most they can give somebody. They gave me one shot, they come back to give me a second, I was gone, like I mean I was hallucinating, I didn’t know where the hell I was, I things in the – it was very was hallucinating, like seeing - you know, seeing - like the hallway, like the corridor, it was just brutal, you know, and - I mean who in their right mind, you know, that’s – that's brutal treatment for one. I was exposed to high-risk sexually abused, you John’s for instance, offenders at know, I lost this is just that age, I was already – I mean the people in St. the – if you follow, it'll lead to the – I lost the trust, you know.

[706] It is difficult to know what to make of this narrative of an alleged undocumented DDT experience. There is likewise no documentation of Mr. Joanisse having been in a turkey strap or “T-strap”, as the more elaborate form restraint is sometimes referred to in the Oak Ridge records. Elsewhere in his testimony, Mr. Joanisse made frequent reference to the Clinical Records, and did not suggest that they were unreliable or missing any information. That said, the testimony about this session was exceptionally vivid – whatever happened, the fear and the dissociative mental

state were ‘real’ in Mr. Joanisse’s mind. Indeed, he seemed to re-experience the episode while on the witness stand some 47 years later.

[707] During his time in Oak Ridge, Mr. Joanisse’s Clinical Records show that he was continuously disturbed. On May 24, 1972, the Clinical Records state that, contrary to the advice of other staff physicians, Dr. Barker ordered him back into the STU after a break of some time. On September 11, 1972, he is reported to have cut his own arms and had to be taken to surgery. On November 9, 1972, he was reported to be suicidal after being approached for sexual reasons by another patient. His distressed behaviour was apparent and documented regardless of which unit of Oak Ridge he was placed in. That said, at the outset he held out great hopes that the STU would be the place to resolve his psychiatric and behavioural issues. On December 21, 1972, the Clinical Record contains the report of an interview with a social worker:

> Dan would like to go to the Social Therapy Unit as he believes there are people there his age who have done similar things as himself and who might be able to tell him why he stabbed the boy. He thought if he knew why he did it he might think twice before doing it again…

[708] Although he seems to have had limited DDT sessions during this admission, the Clinical Records show that Mr. Joanesse was in the MAPP a number of times. For the most part, this punitive program was imposed on him for reasons beyond his control – i.e. that were patently a result of his mental disorder:

> September 1-28, 1972, after it was noted he was a suicide risk and would also act manipulatively.
>
> April 18-24, 1975, after Mr. Joanisse refused to work in the kitchen, as reported by Dr. Maier. Dr. Maier then reported he was returned to a work assignment because he was not able to function in MAPP.
>
> On May 5, 1977, Mr. Joanisse reportedly had lost 17 pounds “in the last few months”. This is a week following a Clinical Record dated April 25, 1977 which reports that staff had caught him trying to tie his belt through the upper bars of his cell window, presumably in an effort to hang himself.
>
> May 25 to July 3, 1977, after Mr. Joanisse tried to stab fellow patient William Brennan with a pen.
>
> On July 7, 1977, Dr. Tate reported that Mr. Joanisse asked to return to MAPP because he did not want to participate in therapy.
>
> December 20, 1977 to February 20, 1978, after Mr. Joanisse continued to engage in manipulative behaviour and demonstrated a negative attitude. The record contains a MAPP Report completed at the end of this 2-month stint. That Report notes that Mr. Joanesse had been confined and had cut his own arms 11 times and that he was put in restraints 18 times. At the end of the Report, Mr. Joanesse himself handwrote: “Being in MAPP, I was not mistreated whatsoever”.

> March 22 to April 19, 1978, after refusing to participate in group therapy, sulking, and expressing homicidal and suicidal thoughts.
>
> June 22, 1978 to June 30, 1978, for sexually acting out. In the initial Clinical Record from this MAPP stint dated June 22, 1978, it is noted that: "The MAPP teacher reports patient presently confined. Was transferred from Ward on June 20 and placed in confinement for customary three days." An attendant further stated in his Clinical Record that "though Danny has stated he wants to work his way out of the program there is still a doubt due to the way he behaved during his last trip to MAPP, only time will tell."

[709] On January 30, 1979, Mr. Joanesse was discharged from Oak Ridge to Brockville Psychiatric Hospital. Within 3 months, on April 25, 1979, he ran away from Brockville. A chronology of Mr. Joanesse's admissions to mental institutions was prepared at Penetanguishene on January 27, 1993. It indicates that after turning himself in at Brockville he was then sent to the St. Thomas Psychiatric Hospital for several days and then transferred back to Oak Ridge on May 9, 1979 on a Warrant of the Lieutenant Governor.

[710] Mr. Joanesse remained at Oak Ridge until December 3, 1980, when he was transferred to St. Thomas Psychiatric Hospital. There is no record that he was involved with the STU programs during that time. Likewise, the Clinical Records do not indicate any contact with Drs. Barker or Maier during this admission.

[711] Mr. Joanisse was transferred to St. Thomas Psychiatric Hospital from December 3, 1980 to April 9, 1981. He was returned to Oak Ridge on April 9, 1981 to January 28, 1982, after he made repeated requests to return. The St. Thomas Discharge Summary of April 9, 1981 states that Mr. Joanisse "wrote to the Administration requesting transfer to Penetang, apparently threatening to 'raise hell' on the ward if he were kept here."

[712] During this next admission, the Ward Transfer Slips indicate that the only experience that Mr. Joanisse had with the STU programs in issue here was one session in MAPP, from September 4 to 13, 1981. In a handwritten letter dated September 13, 1981 and addressed "Dear Dr. and Leo" without specifying which doctor, Mr. Joanesse wrote: "I want to let you know I am dealing with my problems in the MAP program. I did not think I could work my way out, but I can when I put my mind to it." The letter then expresses a plea not to be sent back to the STU.

[713] This letter represents a distinct change of heart from earlier correspondence written by Mr. Joanesse. In a letter to Dr. Barker dated April 22, 1979, written while he was in Brockville, he indicated that he thought it would be best for him to return to the STU. In fact, he seemed to be longing for a reprise of the DDT program and another Alcohol-Ritalin. As he put it in his own words:

> To be honest with you I really need a good drinking drunk to get things out of my mind and just let things go, that's if it happens that I go back. It will do me a lot of good to get drunk, the first drunk was good in some ways but I did not get really into things as what I want to do. Well Dr. Barker let me know what you think.

iii) Post-Oak Ridge experience

[714] In cross-examination, Mr. Joanisse conceded that he often requested to go back to Oak Ridge and the STU after being transferred out. He explained that after a while it was the only thing that he knew and with which he had a sense of familiarity and comfort:

> Q. And I'm gonna suggest to you, Mr. Joanisse, that in fact, during the 1990's and indeed all the way through to – sorry, during the 1970's and all the way through to the 1990's, you constantly expressed the wish to be at Penetang when it was operating, in – sorry, be at Penetang, and in this STU, the Social Therapy Unit, when it was operating? Do you agree with that?
>
> A. When they transferred me from one institution to another, I would go back, that was my security blanket. That's all I knew, not realizing, you know...

[715] On January 28, 1982, Mr. Joanisse was returned to St. Thomas Psychiatric Hospital, where he remained until September 6, 1983. He again requested to be sent back to Oak Ridge, and was uncooperative until they agreed to do so. In fact, a memo from the Administrator of St. Thomas to Penetanguishe dated August 31, 1983 states that, "He is threatening to harm himself or others and this week destroyed a television set." Ten years later, in 1993, he was in St. Thomas again and manipulated his way back to Oak Ridge. He deposed in his affidavit that this was done through committing yet another criminal assault:

> In 1993, I asked another patient at St. Thomas to set me up for assault. I never actually assaulted him, but I wanted to return to Oakridge because I was not comfortable at St. Thomas. I was convicted of assault in 1994, and was given six months' probation.

[716] In a Penetanguishene Hospital Report to the Review Board dated November 20, 2008, his subsequent history of transfers between institutions is set out:

> On September 6, 1983, he was transferred back to Oak Ridge from the Elgin-Middlesex Detention Centre, where he had been since tried to escape from St. Thomas. During this time, on March 23, 1993, he was convicted of uttering false messages and bomb threats to what he thought was St. John's Training School.
>
> On September 22, 1994, he was transferred to the Guelph Assessment and Treatment Unit after running away from Oak Ridge and igniting gas pumps in the vicinity of St. John's Training School.
>
> On December 12, 1994, he returned to Oak Ridge from December 12, 1994 after threatening to harm himself if he was not sent back. He describes this rather vividly in his affidavit filed in this proceeding: 'On November 24, 1994, while detained at G.A.T.U., I swallowed a lens from my broken glasses and one of my denture plates. On December 12, 1994, I was transferred back to Oakridge. I preferred the familiarity of Oakridge to the new environment of G.A.T.U.'

> On March 6, 1997, he was transferred to Kingston Psychiatric Hospital.
>
> On June 16, 1999, he was transferred back to Oak Ridge.
>
> On October 17, 2005, he was transferred to St. Joseph's Health Care Hamilton. During this time he took an unauthorized leave and tried to return to Oak Ridge, resulting in his official transfer.
>
> On December 18, 2006, he transferred back to Oak Ridge After taking an unauthorized leave from St. Joseph's in an attempt to return himself to Oak Ridge.
>
> On February 8, 2008, he was returned to St. Joseph's.
>
> On August 12, 2008, he again ran away from St. Joseph's and was held at Oak Ridge until February 10, 2009.
>
> On February 10, 2009, he returned to St. Joseph's until being absolutely discharged on November 10, 2011.

[717] In his affidavit, Mr. Joanisse deposed that he underwent Dialectical Behaviour Therapy at St. Joseph's, and that this was the psychiatric treatment that he needed to "be a productive member of society" and to overcome his anxiety and other disorders. His Discharge Summary from St. Joseph's states that his final diagnosis was "Personality Disorder Not Otherwise Specified (borderline and self-defeating traits), Anxiety Disorder Not Otherwise Specified (institutional-induced social anxiety), and Alcohol Abuse (in remission)."

iv) Causation and harm

[718] Dr. Bradford examined Mr. Joanisse's affidavit and other written records on behalf of the Plaintiffs, but did not have an opportunity to examine him in person. Based on this documentary review, Dr. Bradford opined in his Supplementary Report dated January 8, 2019:

> Mr. Joanisse arrived at Oak Ridge at a young age directly from training school. In my opinion, his vulnerability was increased by the fact that he was the victim of sexual abuse by the Christian Brothers at the training school that he attended. He was of borderline intelligence, which may have affected his ability to understand the programs and consent, apart from any proper steps taken by the responsible physicians to obtain free and informed consent. Despite this, he reported being coerced to participate in the programs and his experiences were very similar to what is described by others. He was involved in the Capsule, Mapp, and DDT programs. Given his vulnerability and his extended and extensive exposure to these programs, in my opinion, Mr. Joanisse was severely harmed by the programs at Oak Ridge.

[719] Dr. Turrall also examined Mr. Joanisse's records and testimony. He opined that Mr. Joanisse was a damaged person prior to Oak Ridge, having already been diagnosed with an anti-social personality disorder. It was Dr. Turrall's view that the damage caused to him as a child and early adolescent, especially at the hands of abusive authority figures at training school, was not

further adversely effected by Oak Ridge. Dr. Turrall testified that as a young man Mr. Joanisse had to be kept safe, and at that time there was no other place in society for him other than training schools. According to Dr. Turrall, considering that the alternative was to stay in the abusive training school environment, being admitted to Oak Ridge was a positive development for him.

[720] The view expressed by Dr. Turrall can only be read as dismissive of Mr. Joanisse's subjective experience of having been sent to Oak Ridge as a diminutive 15-year old. He deposed in his affidavit:

> I was just a kid when I was involuntarily transferred from St. John's to Oakridge on May 27, 1971. I was scared to walk into a maximum security institution for the criminally insane, and to live among high risk offenders.
>
> I told the staff and professionals at Oakridge about the sexual abuse that I experienced at St. John's. No one seemed to believe what I said and I was offered no counselling or treatment.

[721] As Dr. Bradford points out, Mr. Joanisse's young age, his diminished intellectual capacity, his history of sexual abuse, and his mental disorder all combined to make him an extremely vulnerable patient at Oak Ridge. None of this appears to have been taken into account in the treatment he received there. Although he had issues with alcohol, his documented DDT sessions involved Ritalin and alcohol, and he continued to crave a return to these alcohol "treatments", in which an entire bottle of whiskey would be consumed, for years afterwards. Further, no accommodation appears to have been made for his young age. He was placed in group sessions, in the Capsule, and in MAPP with older patients who themselves had been admitted to Oak Ridge for acts of violence and sex offences.

[722] The MAPP sessions would have been particularly onerous for a teenager or young adult who was small and physically frail. As a result, Mr. Joanisse was repeatedly confined, restrained, and punished. When he deposes that he was fearful of the institutional environment and of his fellow patients, it is entirely credible. Even his trial testimony reminiscing about the Oak Ridge years was delivered with what were obvious, intermittent flights of paranoid delusions. Being consistently sent to the sordid and harshly disciplined environment of MAPP appears to be a triggering experience even several decades later.

[723] It is, of course, accurate to say, as Dr. Turrall did, that Mr. Joanisse was already mentally ill when he arrived at Oak Ridge. But that does not mean that he could not be harmed any further; quite the contrary. Again, knowing from Clinical Records and from Dr. Barker's own writings that MAPP involved sitting stationary for extended periods of time, that Mr. Joanisse was frequently restrained and that the form of restrained practiced in the STU was to bind one patient to another, and that the Capsule involved close quarters and nudity, the description in Mr. Joanisse's affidavit sounds entirely credible and accurate:

> I still remember the horror of being 'cuffed' to and dragged around by another naked patient in the Capsule. I remember adult men sitting on my legs for hours at a time when I dared to move in MAPP. These so-called 'treatments' were barbaric

> and had no therapeutic effect on me. They did not provide me with the education and therapy I needed to manage my anger and to socialize with others. They were just another form of humiliation, degradation and abuse. I believe that these programs worsened my mistrust of authority figures and delayed by decades my reintegration into society.

[724] The Doctors, under whose care Mr. Joanisse was entrusted, together with Oak Ridge as an institution, certainly caused him short-term harm by putting him through physically and psychically painful experiences in the guise of therapy. Any consent that he gave was artificial and meaningless to him; he was too young and too emotionally and intellectually frail to give effective consent to harsh and novel treatments such as the STU programs.

[725] Moreover, to say that a young boy who has already suffered abuse cannot be harmed by further abuse is simply wrong. Mr. Joanisse was harmed by having to endure the Capsule, MAPP, and DDT programs. They hurt him and degraded him, causing pain and indignity.

[726] Drs. Barker, Maier, and Tate were all directly involved in Mr. Joanisse's treatments in the STU programs. These treatments caused him long-term harm as well. He entered Oak Ridge as a 15-year old with a mental disorder that could have been dealt with benevolently so that, even if there was no cure, there would not be further infliction of harm. Instead, he was humiliated, degraded, and deprived of any sense of security other than constantly craving a return to the very institution that had so mishandled him.

[727] I have little hesitation accepting Mr. Joanisse's statement that the treatment he received in the 3 STU programs at issue prevented him from reintegrating into society up until the last decade of his life. He was in mental agony when he arrived at Oak Ridge as a youth, and the treatments imposed on him by the Doctors and the institution augmented that agony in the short-term and prolonged his paranoia, anxiety, and mental anguish in the long-term.

p) Russ Johnson

[728] Dr. Bradford, who testified as an expert on behalf of the Plaintiffs, conceded in his testimony that Russ Johnson is one of Canada's most notorious and prolific sexual offenders and serial killers:

> Q. And Mr. Johnson, in particular, was a sort of infamous – one of the first known infamous serial killers in this country, right?
>
> A. Yes.
>
> Q. He killed a number of women, and raped a large number more?
>
> A. Yes. There was seven homicides.

[729] Mr. Johnson concedes all of this himself. For example, in cross-examination counsel for the Doctors drew his attention to an Administrator's Report from Penetanguishene submitted to the Review Board. Reading from the Report, counsel asked:

> Q. 'While the statistical risk appraisal guide placed Mr. Johnson in the middle of nine categories for risk of violent recidivism, his history of serial murder, attempt murder and sexual assault on 17 victims indicates that he has the potential for very dangerous behaviour.'
>
> And I take it you don't disagree with that assessment?
>
> A. I do not.

[730] Mr. Johnson's index offence was the rape and murder of 7 women and sexually attacking 11 others. He was found not guilty by reason of insanity and was admitted to Oak Ridge pursuant to a Warrant of a Lieutenant Governor on November 18, 1977. He remains at Waypoint until today.

i) Pre-Oak Ridge and index offence

[731] In his affidavit, Mr. Johnson deposed that he had a difficult childhood marked by emotional turmoil. His father abused his mother, who was diagnosed as a schizophrenic and institutionalized when he was 17 years old. The household, and especially his mother, was staunchly Catholic, and the topic of sex was utterly taboo. Mr. Johnson indicated that he was shamed for having sexual thoughts, and repressed all sexual expression for fear of being criticized and punished by his parents.

[732] At the age of 16, Mr. Johnson was arrested and charged with theft of women's undergarments from clothes lines, which he would then wear as a means toward self-gratification. In a Discharge Summary from London Psychiatric Hospital dated May 22, 1969, it is recorded that at this time he began experiencing bouts of depression and was hospitalized for that disorder at the age of 22. He was married at the age of 20, which in turn seems to have prompted aggressive conduct when he became suspicious that his wife was disloyal to him. He conceded as much in cross-examination:

> Q. And, the paragraph we're looking at indicates that you had become extremely depressed, resulting from your inability to cope with your relationship with your wife and your inability to resolve sexual and aggressive impulses which had been present since you were 14 years of age, that you parted with your wife on one occasion and that at that time you were feeling suicidal, right?
>
> A. The aggressive impulses weren't present at 14. They became apparent in my late teens when I married and was – started to find my wife was – my first wife, Linda, was unfaithful.

[733] In fact, at the time he was hospitalized for the first time on May 22, 1969, he had just committed his first violent attack – a sexual assault and murder. In cross-examination he admitted:

> Q. Because, by May the 12th of 1969, you had in fact already committed a violent rape, hadn't you, sir?
>
> A. Before going to Doctor Nugent, I had, yes.

> Q. Yeah. And in fact, it was the day before, May 11th, 1969 when you had committed that first violent rape.
>
> A. A day or so before, yes. I went to Doctor Barry (ph) and we went to Saint Joe's Hospital and they sent me to Doctor Nguyen (ph). Yes.
>
> Q. And we can come to the description if we need to, but essentially you had entered a woman's apartment through a window and raped and strangled her.
>
> A. Yes.

[734] He also indicated that in the 8 years between that first attack and his admission to Oak Ridge, he had frequent suicidal thoughts and that he had, in fact, attempted suicide.

> Q. And, I understand that you had suicidal thoughts before going to Oak Ridge and during that period from 1969 to 77?
>
> A. Yes, as a matter of fact, prior to the police confession and being questioned by the police, I had made attempts and plans to commit suicide.
>
> Q. And you attempted suicide twice and the details of that are in Exhibit A of your affidavit in a letter from Doctor Barker to Doctor Boyd dated November 8, 1978…
>
> Q. And Doctor Barker is explaining [referencing a letter from Dr. Barker to Dr. Boyd dated November 8th, 1978] that the patient stated he's thought seriously about committing suicide on several occasions. He said he attempted to kill himself by slashing his wrist.
>
> A. Yes.
>
> Q. And so, when you first arrived at Oak Ridge, what was your mental state?
>
> A. I was extremely depressed, remorseful. I was suicidal.

[735] Mr. Johnson was admitted to Oak Ridge on August 2, 1977 on a 60-day Warrant of Remand. He was re-admitted on September 30, 1977 on a second 60-day Warrant of Remand. He was not in any of the STU programs during his first admission. His Discharge Summary dated January 12, 1978 indicates that during his second 60-day admission, he was given one Alcohol-Ritalin treatment on November 1, 1977. He did not receive any other drug treatments under the DDT program during this admission, and was not in the Capsule or MAPP.

[736] In January 1978, Mr. Johnson was tried on 3 counts of murder in relation to crimes he had committed between 1969 and 1977. In his affidavit he relates that on February 1, 1978, he was found not guilty by reason of insanity and was ordered to be detained by Warrant of the Lieutenant Governor at either Oak Ridge or the London-Middlesex Detention Centre. The following day, on

February 2, 1978, he was re-committed to Oak Ridge. His Oak Ridge Admission Form is filled out in his own handwriting, and reads:

> I attacked one girl in 1969 nearly killing her and I killed a girl in 1974 and one in 1977. Was picked up and charged with two counts of murder and one count of attempted murder.
>
> I feel that this is probably the only place I can get some help for whatever is wrong.

[737] As he explained in his examination in chief, the 3 murders were only the tip of the iceberg in terms of his violent activity over the course of the previous 8 years.

> Q. And shortly before that [his first admission to Oak Ridge on August 2, 1977], I understand that you'd gone to the police station and made a confession.
>
> A. Yes, however I – it's a little inaccurate, I'll say it that way. The police were questioning me on an offence and I went and answered their questions, and they were releasing me, and after releasing me out the back door, I had second thoughts and I returned and made a confession.
>
> Q. And, what was the nature of that confession?
>
> A. It involved 17 offences over a seven-year period where I had gone into apartments and – and attacked females when they were sleeping and seven died.
>
> Q. And I understand that at the time you were known in the area as the 'bedroom strangler'.
>
> A. I think that – that came out, that started happening during trial.

[738] The details of Mr. Johnson's 17 known offences are described in an Oak Ridge Administrator's Report to the Ontario Review Board dated March 23, 2010:

> The victims of the murders were usually found without any signs of violence in their beds in natural sleeping positions. The cause of death could not always be determined. From the accounts of the women attacked, they stated that they would wake up finding the patient on top of them and in most cases choking them, usually into unconsciousness. Some, but not all of these women, were sexually attacked. The mode of access to these women was to enter their apartments either through unlocked windows, balcony doors or by slipping the lock on the doors inside.

[739] In a report dated November 22, 2003 prepared for Mr. Johnson's lawyer to present to the Review Board, Dr. Bradford observed that the crimes were premeditated and well organized:

> The level and degree of organization is supported by the fact that subsequent to his arrest and his confession to the police he was able to take them back to the various apartment buildings where the homicides occurred over the previous eight years.

> He was able to take them through a detailed account as to the different apartments themselves and his points of entry and whether he committed a homicide or another sexual attack. He was able to identify woman *[sic]* as victims when autopsy had identified the cause of death as natural causes. All of this is strongly indicative of him being organized, and thinking clearly at the time of these attacks.

[740] Although a number of the victims' bodies were later found in a relatively undisturbed state, that is not true for all of them. In *Re Johnson*, [2010] ORBD No 2304, the Review Board, a complete list of Mr. Johnson's victims is provided with a brief description of each how each victim was found and what is known of the incident. Some of the descriptions are as macabre as one can imagine. Going over this list with counsel during cross-examination in the present trial, Mr. Johnson did not hesitate in confirming the worst of the descriptions:

> Q. It returns to a rape, and then a murder. Some of the – I'm not gonna touch on it in detail, but some of the incidents included some evidence of necrophilia, right?
>
> A. Yes. The last one, I think.
>
> Q. Indeed, in the last item on page 4 that we're looking at now, there was a – you cut a partial hole into the chest wall of one of your victims, right?
>
> A. Yes.
>
> Q. And as I understand it from reading elsewhere it as some attempt by you to literally enter the victim as it were?
>
> A. Yeah. I thought at the time I could do that.

ii) Experience in the STU

[741] Mr. Johnson was never in the Capsule during his time in the STU and did not receive LSD. He did, however, receive the following drug treatments as part of the DDT program during this third admission:

> Amytal-Ritalin on September 8, 1978, administered by Dr. Barker according to a note in the record dated September 8, 1978.
>
> Dexamyl-Tofranil for 6 weeks beginning January 26, 1979, requested by Dr. Barker in a letter dated December 15, 1978 and approved by Health and Welfare Canada in a letter dated January 12, 1979.

[742] A Bedside Nursing Note dated February 15, 1979 states that during the DDT session, "Feelings of anger and hate towards his past and especially his mother, began to come to the surface today. He states that he is experiencing a lot of fear around his underlying feelings and the reality of them." Counsel for the Doctors characterizes this as a beneficial exercise. Mr. Johnson, on the other hand, describes it as a painfully distorting and frightening experience:

> Q. So, what was your experience like on Dexamyl-Tofranil for seven weeks?
>
> A. Well, Dexamyl-Tofranil turned out to be a drug that – Dexamyl would in – increase your – your hyperness and you become – like speed. Tofranil would magnify your feelings, whether they be positive or negative, and now that they got you racing, the – these feelings would – would magnify and – so, I – I dreamt in colour and was scared all the time. I didn't understand what was happening. They were telling me I was supposed to say certain things and have certain feelings that I didn't know anything about, and when I told them I didn't know about them, they would tell me – confront me and coerce me and say that – that I was withholding, that I wasn't telling the truth, that I had to feel these things.

[743] Mr. Johnson testified that he was put in restraints a number of times, often for losing control of his emotions during group therapy sessions. He also stated that he was placed on the security committee against his wishes. He testified that he did not want to have to secure or subdue another inmate acting out, as he had no desire to "hurt anybody". He also indicated that he found strip searching other patients to be a degrading experience.

[744] Having said that, in a Clinical Record dated October 10, 1979, it is recorded that Mr. Johnson "stated that he feels he has made a lot of gains in the two years he has been in therapy." In cross-examination, Mr. Johnson confirmed the veracity of that statement:

> Q. Mr. Johnson, the statement that you felt like you had made a lot of gains in the last two years in therapy, was a true statement, wasn't it?
>
> A. Well, in context, of course, I started two years earlier and I wasn't as confused as I was when I first came in. I started learning the system, yes.
>
> Q. Right. And as a result of that, it was fair to say that you felt you had improved in therapy?
>
> A. Yeah. I'd improved over those years. Yes.

[745] The Ward Transfer Slips indicate that during this third admission, Mr. Johnson was in MAPP from July 4-24, 1978. The Bedside Nursing Note of July 4, 1978 reports that Mr. Johnson was sent to MAPP for discussing another patient's treatment situation, for convincing another that he would be given Nozinan, and for being generally "devious, gamey, lying in the coordination meeting."

[746] The Clinical Records do not indicate that Mr. Johnson expressed any particular complaints about the MAPP experience. In a note dated July 13, 1978, an STU staff member stated that he "[displayed] a very good attitude toward the program and seems to want to gain as much as he can from his stay in MAPP." A similar note dated July 25, 1978, just after the MAPP session concluded, states that since being in MAPP Mr. Johnson "says that he feels he has a much better understanding of how to relate and present himself as he has worked on this in some depth."

iii) Post-Oak Ridge experience

[747] The record contains an assessment of Mr. Johnson done for the Review Board by Dr. Bradford dated May 6, 1985. At that time, Dr. Bradford diagnosed him with "psychosexual disorder, personality disorder, paraphilia, sexual deviation, lust murder, necrophilia, fetishism, and voyeurism". Dr. Bradford also measured Mr. Johnson's sexual impulses when he was given alcohol, and observed that alcohol has a disinhibiting effect on him. At the time, Dr. Bradford recommended anti-androgen treatment to reduce Mr. Johnson's sex drive and to attempt to address his necrosadistic tendencies.

[748] In a decision dated December 3, 2007, the Review Board approved Mr. Johnson's request for a 6-month trial period at the medium security facility at Brockville Mental Health Centre under the supervision of Dr. Bradford. A condition of the approval was that Mr. Johnson give informed consent and take sex drive reducing medication. This was done despite that fact that the Review Board acknowledged, at paragraph 14 of its reasons for decision, the expert opinion of Dr. Hucker that there was no certainty that the medication would effectively control his behaviour or that the safety of females that Mr. Johnson might encounter at Brockville could be guaranteed.

[749] Although the 6-month trial appears to have proceeded without incident, the Review Board has not been willing to make the transfer to a medium security facility permanent. Dr. Hucker opined in the 2001 decision referenced above that Mr. Johnson presents in a relatively calm and reassuring manner, that over time the vigilance of the institution would doubtless subside. That would present a dangerous situation if Mr. Johnson were at that point housed in an institution with potential victims present. The Review Board's conclusion, at paragraph 72 of its reported decision, is definitive as to the lack of any realistic prospect for Mr. Johnson to be removed from a maximum-security hospital:

> We agree that the evidence adduced before the Board clearly established that the test for significant threat continues to be met. Mr. Johnson has a history of committing sexual offences of the most serious nature, including sexual homicides, described by Dr. Bradford as 'lust murder ... the most serious of all the sadistic sexual acts.' He suffers from a constellation of diagnoses that are highly resistive to treatment and which carry a poor prognosis. There is little evidence that sexual sadism is amenable to change or that any effective treatment currently exists to modify those behaviours that arise from Mr. Johnson's personality structure.

iv) Causation and harm

[750] In his Supplementary Report dated January 8, 2019, Dr. Bradford acknowledges that he has a history of examining Mr. Johnson and that he has long recognized that Mr. Johnson is a troubled and potentially violent person. He concedes that the threat posed to the public if Mr. Johnson were to be released from a maximum-security institution results from disorders which he suffers from an early age. With all of that, Dr. Bradford is also convinced that the exposure to MAPP and DDT at Oak Ridge harmed Mr. Johnson in significant ways.

[751] As Dr. Bradford put it in his Supplementary Report:

> Mr. Johnson is well-known to me and his very serious problems related to sexual violence antedated his introduction to Oak Ridge and are not related to any of the programs that he went through at Oak Ridge. His ongoing detention at Waypoint is related to the perceived level of risk to the public at large based on his very serious problem with sexual deviation. Mr. Johnson functions quite well at the present time. Nonetheless, in my opinion, his exposure to the programs resulted in harm to him.

[752] Dr. Bradford goes on in his Supplementary Report to opine that the reason Mr. Johnson has never been transferred from Oak Ridge to the less secure facility at Brockville is due to what he terms a "treatment impasse". That is, it is Dr. Bradford's view that the Oak Ridge psychiatric staff has been unable to make inroads in terms of Mr. Johnson's self-understanding of his issues is that they have never been able to establish the requisite level of trust. This lack of trust in his psychiatrists, according to Dr. Bradford, is the primary reason he has not been able to leave the maximum-security environment of Penetanguishene for an environment which would permit him more liberties:

> Mr. Johnson has been repeatedly blocked by Oak Ridge and subsequently Waypoint for transfer and part of the concern relates to him not being completely committed to treatment in that facility. This treatment impasse is related to the experiences he had in the programs at Oak Ridge, which directly contributed to his long-term incarceration at that facility.

[753] Dr. Turrall examined Mr. Johnson's records on behalf of the Defendants, and came to a contrary conclusion. He observed that Review Board and psychiatric assessment reports over the years have consistently concluded that Mr. Johnson lacks insight into himself and the causes of his sexually sadistic conduct. He opined in his Report of 2019 that, "[g]iven his extraordinarily violent history, that [i.e. his lack of insight] would be sufficient to prevent his release from a maximum security hospital." In similar fashion, the Court of Appeal noted in *R v Johnson*, 2012 ONCA328, at para 2, that even Mr. Johnson "conceded that he remains a significant risk to the safety of the public."

[754] In Dr. Turrall's view, when it comes to assessing whether to transfer him to a less secure facility, the public safety risk overshadows any question of Mr. Johnson's progress, or lack thereof, in achieving self-awareness:

> Prior to his admission to Oak Ridge, Mr. Johnson had attacked at least 17 women and killed 7 of them. As noted by Dr. Bradford' Mr. Johnson had been diagnosed as sexually sadistic… [T]he reason Mr. Johnson has not been transferred to a medium security facility is concern about public safety. He was transferred to Brockville for assessment for 6 months, but on a ward with no female patients, a situation that evidently can only be accommodated at Brockville on a temporary basis. Given Mr. Johnson's very serious criminal history, it is not surprising he has never been released from Oak Ridge. His experiences in MAPP and with the DDT program more than 40 years ago are not the reason he remains at Oak Ridge.

[755] It is difficult to argue with Dr. Turrall's view that whatever the MAPP and DDT programs did or did not do, they did not change the trajectory for the worse. Mr. Johnson was, after all, a patient who started out as a sexually sadistic and prolific serial killer with necrophiliac inclinations. His trajectory was likely never going to be headed toward anything but a lifetime in maximum security. The Supreme Court of Canada has noted that in considering whether release to a less secure environment is warranted, "the liberty interest of an NCR accused should be a major preoccupation of the Review Board", but only "within the outer boundaries defined by public safety": *Pinet v St. Thomas Psychiatric Hospital*, [2004] 1 SCR 528, at para 19.

[756] I cannot conclude that the STU programs did Mr. Russell long-term harm. He may have formed a certain distrust of psychiatric care, as Dr. Bradford suggests, but this has not changed his situation in any material way. Dr. Turrall states in his Report that, "Although Mr. Johnson may not look fondly on his time in the treatment programs, I see no evidence that it caused him any lasting harm or changed the course of his life in any way." I likewise see no such evidence.

[757] As indicated for several other of the Plaintiffs, just because Mr. Johnson was destined to remain at Penetanguishene for the rest of his life does not mean that he should be made to suffer more than necessary. In terms of short-term harm, Mr. Johnson complains that he was caused excessive discomfort and insecurity by being subjected to the MAPP and the DDT program.

[758] Dr. Turrall states that this does not accord with the Clinical Records or with Mr. Johnson's own descriptions of the program. In particular, Mr. Johnson did not seem to be phased by the MAPP, with all of its physical and psychological challenges. He was, in fact, ultimately put on the security committee as a patient who could control others when they were in highly pressured situations. That kind of pressure did not seem to cause him any particular grief.

[759] On the other hand, Mr. Johnson did testify about excessive discomfort when it came to the Dexamyl-Tofranil treatments that he received for weeks on end in 1978. These treatments, ordered by Dr. Barker, were designed to be disorienting and, according to Mr. Johnson, they more than fulfilled that expectation. He described the sensation as one of continuous fear and panic at his own loss of control.

[760] The experts all concede that the DDT treatments, which were meant to "break down" the patients' defenses, ultimately contained no corresponding "building up" stage and did the patients no good. In Mr. Johnson's case, they provided no insight into the source or reasons for his disorder, as evidenced by the later reports of the Review Board. All they seem to have done was to inflict emotional pain on him for the duration of the treatments, and instill lingering fears in his mind for at least some time thereafter.

[761] Although Mr. Johnson did not suffer as badly as some of the more vulnerable Plaintiffs, I find that the STU experience – and the DDT program in particular – caused him some short-term harm. Dr. Barker and, to an extent, Dr. Maier, were directly involved with his STU treatments. They put him through a drug experience for no therapeutic benefit, which had the effect of causing him a measure of psychic pain in 1978. This may not have impacted on him in the long term, but it harmed him to some degree while he was in the STU programs.

q) Stanley Kierstead

[762] For a period of a 14 months, from June 3, 1969 to August 25, 1970, when he was 16-17 years old, Stanley Kierstead was committed to Oak Ridge as an involuntary patient under the *Mental Health Act*. Following his release, Mr. Kierstead married, obtained a university education, and enjoyed a successful career. There is no documentary evidence of his having been in any of the three STU programs. His complaint at trial revolves around his having been held an inordinate amount of time in confinement, although this was never actually pleaded on his behalf.

i) Pre-Oak Ridge and index offence

[763] Mr. Kierstead testified that he had a troubled childhood. He moved back and forth from foster care homes to his mother who lived an unstable life:

> Q. Do you remember for a period of time, going back to live with your mother after she re-married?
>
> A. I did that a number of times. It got so bad that the Children's Aid Society eventually told my mother that I had died so that she wouldn't come around looking for me anymore.
>
> Q. It's because you had a difficult time when you were living with your mother, correct?
>
> A. It – yes and no. Sometimes we had great times together me and her, and then sometimes I was tied up and thrown in a closet for two or three days while she went off with some trick she was turning because that's what my mother did on the side, I guess.

[764] An undated, early psychiatric Consultation Report in the record indicates that there was "a history of mental illness, cruelty, etc. in Stanley's family. He…had a history of lying, stealing, biting, jealousy, wandering around all night and running away… At one time he tried to put out the dog's eyes by pushing sticks into its eyes and has threatened young children with razor blades." The Consultation Report recommended that he be sent to Training School or to Rideau Regional Hospital School in Smith Falls. He was ultimately admitted to hospital in Smith Falls after stealing a newspaper from a newsstand.

[765] On October 16, 1967, Mr. Kierstead was remanded to the Kingston Psychiatric Hospital for 60 days after he was charged with a break and enter at a restaurant. According to a later Report from Sprucedale Training School in Hagersville, he was sentenced to 6 months at Bowmanvile Training School, from which he was eventually transferred to Sprucedale. In a Psychiatric Report dated January 13, 1969, a staff psychiatrist at Sprucedale expressed concern that Mr. Kierstead had behaved aggressively while at the training school and that he might seek revenge against people at the school after his release. In cross-examination, Mr. Kierstead conceded that there was a "better than even chance" that he would have done so.

[766] The Psychiatric Report assessed that Mr. Kierstead was potentially homicidal and that the "only treatment situation which I know of which might do justice to this youngster is the Penetanguishene Psychiatric Hospital, Oakridge Division." The Physician's Application for Involuntary Admission dated Jun 12, 1969, observes that Mr. Kierstead perceived "nothing abnormal about the beatings which he has administered to students here at Training School, seems to have every intention to 'pay back' a couple of people with beatings when he returns to the community."

[767] On Jun 13, 1969, at the age of 16, Mr. Kierstead was admitted to Oak Ridge as an involuntary patient pursuant to a certificate under the *Mental Health Act*. The Clinical Record of that date indicates that he was admitted by Dr. Barker. A letter from Kingston Psychiatric Hospital to Dr. Boyd dated 4 days later, June 17, 1969, indicates that Dr. Boyd had made the arrangements for Mr. Kierstead's transfer from Kingston and admission to Oak Ridge.

ii) Experience in the STU

[768] Mr. Kierstead testified that he was in the Capsule on several occasions with 5 other unnamed patients. In his testimony, he could not recall if he was nude or wearing a "baby doll" sack. H said that he recalled some sexual acting out in the Capsule, and that the toilet was just a bucket on the floor.

[769] In his affidavit, Mr. Kierstead also states, "While at Oakridge I was put into MAPP however I do not remember what the program consisted of." As indicated, the Clinical Records do not show that he was ever in MAPP; however, he goes on in his affidavit to describe his experience of solitary confinement in a way that is more reminiscent of MAPP than of confinement arrangements at Oak Ridge: a "cell with a hole in the floor for a toilet, a cement bed and a blanket. I wore a suicide gown while in solitary confinement." Given that MAPP was typically preceded and punctuated by stints in confinement, it is plausible that Mr. Kierstead was expressing fear of MAPP but in reality it was solitary confinement, and not MAPP, that was imposed on him.

[770] Finally, Mr. Kierstead testified that he was in the DDT program, and that he received both LSD and Scopolamine. In fact, unlike all of the other patients, he said that he received both of these drugs together and swallowed them at the same time. He was particularly vague on the details of this experience, and indicated that he only really knew this from second hand information conveyed to him by other patients.

> Q. And you say in your affidavit, you were told by other patients that you received LSD and Scopolamine while in the capsule and that you believed that to be true.
>
> A. Well, they knew more than I did. I just assumed they were telling me the truth.
>
> Q. But you don't remember any medical staff telling you, you'd received LSD?
>
> A. Oh, no. I don't remember the medical staff telling me anything that was relevant to what's going on in my life at the time.

> Q. And you don't remember any medical staff telling you you were receiving Scopolamine?
>
> A. No.
>
> Q. And as I understand it, your recollection is you received Scopolamine and LSD at the same time in one cup, correct?
>
> A. I can remember the little cup of orange juice and – and handed it to me and told to drink and right after, I walked through the doors of the box there and they closed it behind us. I have no idea what was in that cup 'cause I didn't do a chemical analysis of what – the liquid. Sorry.

[771] Counsel for the Doctors point out that in all of the Clinical Records, Bedside Nursing Notes, and Treatment Records from his time in Oak Ridge, there is no documentary evidence of Mr. Kierstead participating in any of the 3 impugned STU programs. Nowhere in his medical file does it show that he was in MAPP, the DDT program, or the Capsule.

[772] This discrepancy between his memory and his medical documentation is possibly due to the fact that he made a conscious effort over the years to erase his memory of Penetanguishene:

> Q. Do you remember being assessed for your safety status?
>
> A. Not really.
>
> Q. Earlier you mentioned – oh, sorry, sir.
>
> A. I…I spent 50 years trying to forget anything to do with Penetanguishene. I mean, I've done a pretty good effort of it up until nowadays because all this crap is now bringing all that back up. But something like that, I wouldn't – I wouldn't have a clue, or remember it, if at all. It had no real bearing on my life. It was something that may or may not have happened, but it didn't have bearing on what I was doing.
>
> Q. So you...
>
> A. And that's the bottom line, is that's why I don't remember this stuff.
>
> Q. So you tried not to remember your time at Penetang?
>
> A. Oh, God, yes.
>
> Q. And so today there's much of your time at Penetang you can't remember?
>
> A. Oh, God, yes.

[773] Counsel for the Doctors submit that Mr. Kierstead's account of his supposedly undocumented MAPP, DDT, and Capsule experiences is not reliable. I would have to agree that

with his loss of memories, he appears to have adopted, perhaps unconsciously, the narratives of other patients as his own. LSD and Scopolamine were not administered simultaneously; to do so would not be within the parameters for those drugs described by Drs. Barker and Maier in their writings about DDT, and would have been contrary even to the descriptions of experimentation adopted by the Doctors' staunchest critics. Further, there is no indication anywhere in the record that Clinical Records were somehow deleted or not made with respect to Mr. Kierstead in the same way that they were made and are available for all of the other Plaintiffs.

[774] What the Clinical Records do show is that Mr. Kierstead adamantly refused to participate in the DDT program. In a Clinical Record dated July 31, 1969, a social worker noted this unequivocal refusal:

> In an incident yesterday during the feedback of his small group, Stanley became very hostile, and expressed what could be described as warding off feedback. An example of this was when he was asked about a future drug treatment, by another patient Brian Smith, telling Brian to 'fuck off'. He also stated, "I don't want my mind fucked with" and 'Nobody gives me drugs to fuck up my mind'. He was met with by the patient Crisis Committee, at the request of Eric Young, Ward Moderator. When being questioned by the Crisis Committee, Stanley seemed more calm and expressed the same feelings toward drugs, in a less hostile manner. He also expressed insecurities about talking in large crowds. He was assessed as being no risk…
>
> Agreed by: Stanley Kierstead [signed]

[775] One can, of course, argue, as Plaintiffs' counsel do, that the Consents obtained from the Plaintiffs for LSD treatments and other forms of DDT and Capsule participation were not properly informed and are therefore not meaningful. One can also argue, as Plaintiffs' counsel do, that the policy of Drs. Barker and Maier to not allow a patient to opt out of the DDT program once they had started it was wrongful. But neither of those situations apply to Mr. Kierstead. There is no other instance in the record of DDT drugs being administered over the express objection of a patient from the outset. Under the circumstances, Mr. Kierstead's account of these experiences is not possible to accept as reliable.

[776] Although there is no reliable evidence as to his actual participation in the 3 specific STU programs at issue here, there is certainly evidence in Mr. Kierstead's Clinical Records that demonstrates that his time in Oak Ridge was a difficult one. He was frequently placed in confinement and restrained, often for seemingly arbitrary reasons or for reasons that reflected the very diagnosis that brought him to Penetanguishene for treatment in the first place. Although, again, Mr. Kierstead's current memory of the details of these periods of confinement and restraint is not always accurate, there are documented accounts showing that these experiences permeated his 14 months at Oak Ridge.

[777] Mr. Kierstead also experienced danger at Oak Ridge and was himself a source of danger. Thus, for example, the Clinical Records note that on July 31, 1969, he was aggressive and hostile to other patients in his group. On August 5, 1969, the Clinical Records record him as being

"sadistic" toward another patient. A Review Note dated August 8, 1969 states that he has "frequent marked conflict with his fellow patients." On August 14, 1969, a Clinical Record establishes that he is fearful of others in his group therapy sessions to the point that he would not participate.

[778] The list of incidents that reflect the fear and loathing that Mr. Keirstead suffered at Oak Ridge goes on and on. A Clinical Record of December 16, 1969 relates that a handwritten diary was found in his cell in which he expressed anger and suicidal thoughts, and on December 19, 1969 he was sent to sleep in the "safe room" for fear that he was about to hurt himself. On January 19, 1970, a nurse recorded that he had threatened to kill another patient and himself if he was not discharged from Oak Ridge. On April 16, 1970, the Clinical Record states that Mr. Kierstead attempted to sell a shiv to another patient. And in Mr. Kierstead's affidavit dated February 28, 2017, he deposed that he was cuffed to other patients on at least one occasion, on December 18, 1969, which he found degrading and frightening.

[779] A review of the Clinical Records reveals that many of these and other similar incidents that occurred with remarkable frequency led to confinement or threats of confinement. This, in turn, created a cycle of fear, in which anticipation of confinement led to him acting in a way which threatened further confinement. As he relates it in his affidavit, when admitted to Oak Ridge, Mr. Kierstead was "only 16 years old with a Grade 10 education…[and] diagnosed with a personality disorder as being immature and anti-social". He was unable to handle the stress of Oak Ridge, and is of the view that his Oak Ridge time "was the biggest downfall of my life."

[780] Although Mr. Kierstead deposed in his affidavit that he was primarily under the care of Dr. Barker, the Clinical Records show a number of different physicians tending to his treatments. The Oak Ridge administrative records from the same period also show that, for the most part, Mr. Kierstead's personal affairs were looked after directly by Dr. Boyd. A letter from Kingston Psychiatric Hospital to Dr. Boyd dated June 17, 1969 provides Dr. Boyd with Mr. Kierstead's "History, Mental Status, and Discharge Letter". An exchange of letters between Dr. Boyd and the principal of Mr. Kierstead's former school in Hagersville shows Dr. Boyd advising as to visitation possibilities for Mr. Kierstead.

[781] The administrative file is voluminous and it is not possible in these reasons to recite every document. But it is clear that Dr. Boyd was well apprised of Mr. Kierstead's status and issues at Oak Ridge. A letter dated February 17, 1970 from Oak Ridge, signed under Dr. Boyd's position as "Superintendent" by an assistant, shows Dr. Boyd making arrangements with Legal Aid Ontario for Mr. Kierstead's upcoming Ontario Review Board hearing. A letter dated July 24, 1970 from the Chair of the Review Board to Dr. Boyd advised that Mr. Kierstead was not to be discharged. A memorandum to Dr. Boyd dated August 17, 1970 summarizes Mr. Kierstead's status and diagnosis, and assesses that Mr. Kierstead "has no real interest in therapy."

[782] Mr. Kierstead complains of excessive confinement during his time at Oak Ridge. He states in his affidavit that the longest stretch of time that he was confined was 53 consecutive days. However, the Clinical Records show that the longest stretch of confinement that Mr. Kierstead endured was from February 2, 1970, where the Clinical Records note that he was confined for using sarcastic and degrading language toward fellow patients, until February 25, 1970, where the Clinical Records note that he was transferred to E Ward where he participated in work assignments.

I will take it that Mr. Kierstead's memory is slightly faulty on this point, and that the lengthiest time he endured in confinement was 23 days, as documented in the Clinical Record, rather than 53 days.

[783] Considering that the Court of Appeal has determined that for administrative segregation, which Plaintiffs' counsel submit is the prison equivalent to confinement at Oak Ridge, a duration of more than 15 days constitutes cruel and unusual punishment, 23 days in confinement more than suffices to make Mr. Kierstead's point that he suffered greatly from the experience: *CCLA v Canada (Attorney General)*, 2019 ONCA 243.

[784] I note in passing that the Court of Appeal's ruling was made in a case where the judge at first instance took note of expert evidence by Dr. Gary Chaimowitz, one of the Defendants' experts in the present case: "Dr. Chaimowitz, the Head of Forensic Psychiatry at St. Joseph's Healthcare in Hamilton and a Professor in the Department of Psychiatry and Behavioural Sciences at McMaster University offered evidence filed by the applicant that solitary confinement for more than 15 days posed a serious risk of psychological harm": *CCLA v Canada (Attorney General)* (2017), 140 OR (3d) 342, at para 124 (SCJ).

[785] It is the Defendant's position that confinement at Oak Ridge is less lonely than in a prison setting, and unlike in prison, is implemented for therapeutic rather than punitive purposes. However, Mr. Kierstead's recounting of the experience, supported by the relevant Clinical Records, demonstrates the contrary to be true. The Clinical Records document that Mr. Kierstead was confined numerous times for trivial matters and in punitive conditions:

> July 7, 1969 – 'Stanley was recently released from confinement for snickering about the upset of a fellow patient in the ward meeting.'
>
> August 14, 1969 – 'Stan was confined on a number of occasions, for laughing inappropriately at another patient while in discussion, being disruptive at meetings, and generally making what is described as a nuisance of himself.'
>
> February 2, 1970 – 'confined for continuously using sarcastic, degrading remarks when referring to fellow patients'.

[786] Mr. Kierstead was discharged from Oak Ridge on August 25, 1970, and was sent to the Kingston Psychiatric Hospital. In a Memorandum to Dr. Boyd dated August 17, 1970, his final diagnosis is described as: "Personality disorder, immature and antisocial." Six months later, Mr. Kierstead was discharged into the community. Although he engaged in some subsequent criminal activity, he has never been in a psychiatric hospital again.

iii) Post-Oak Ridge experience

[787] Mr. Kierstead's criminal record reveals that after leaving Oak Ridge, he was convicted of a number of offences including assault, theft, and the careless use of firearms in 1971-1975, and 1988. He also testified that in the years following his discharge from Oak Ridge, he was taking "pretty well every street drug known to man at the time". In his affidavit, Mr. Kierstead described his personal life as follows:

> I believe that I have between six to 14 children all from different relationships and I am not in contact with any of them. I have been married three times. My personal relationships were negative after Oakridge because I did not trust people anymore… In 1988 I met my current wife and we have been together ever since.

[788] Mr. Kierstead also deposed that he embraced education in order to overcome the stigma of having been a patient at Oak Ridge. He obtained a BA in history, a welding license, a teacher's certificate in welding, and a mechanical and electrical engineering degree from Durham College. He ultimately pursued a career as a welding manager, at which he has, according to his affidavit, earned a "decent living" since the late 1980s.

iv) Causation and harm

[789] Mr. Kierstead's records were examined on behalf of the Defendants by Dr. Dominique Bourget, a staff psychiatrist at the Royal Ottawa Hospital and an Associate Professor at University of Ottawa. Her approach to assessing whether or not the years at Oak Ridge caused discernable harm, as she explained it in her testimony, is to consider all pieces of information available about the person in an effort to get a better sense of the life of the patient and their functioning in their adult life.

[790] Dr. Bourget observed that Mr. Kierstead was already diagnosed with a severe personality disorder prior to entering Oak Ridge, and that he had a chronic condition which one would expect to persist. In Dr. Bourget's view, there is no evidence that his condition worsened as a result of his stay at Oak Ridge. She opined that his later drug use was a manifestation of his pre-existing personality disorder and criminal lifestyle, and that his propensity for violence in the years following his discharge from Oak Ridge was also a result of his pre-existing condition and long-time anti-social behaviour.

[791] According to Dr. Bourget, if Mr. Kierstead was really caused extensive and long-lasting harm at Oak Ridge, one would expect to find a psychiatric diagnosis somewhere during the subsequent decades. She testified that Mr. Kierstead was followed for many years by his family doctor, who at one point did refer him to a psychiatric assessment at the request of a Workers Compensation Board. It turns out, however, that after Oak Ridge he was never diagnosed with any mental disorder. She stated that from his records, the only ailment which Mr. Kierstead has suffered since leaving Oak Ridge is a chronic pain disorder not related to the Oak Ridge years.

[792] In forming her opinion, Dr. Bourget took note of the fact that Mr. Kierstead has achieved a university education and has been successfully employed for several decades. In her opinion, his life would not have been different had he not been at Oak Ridge.

[793] Dr. Bradford examined Mr. Kierstead's records on behalf of the Plaintiffs, but his examination was marred by a reliance on some of the mistaken information in Mr. Kierstead's affidavit with respect to participation in the DDT, Capsule, and MAPP.

[794] Dr. Bradford also described the harms that can be caused by extended confinement in a cell. According to Dr. Bradford, "[s]olitary confinement is not only one of the oldest prison

practices, but with the exception of the death penalty, it has been described as 'the most extreme penalty which can legally be imposed on prisoners'. Confining an individual to a cell for all or nearly all of the day with minimal environmental stimulation and limited opportunity for social interaction can, and historically has, caused severe psychiatric harm." [citations omitted]

[795] Dr. Bradford went on to state that, "the serious psychiatric harms caused by solitary confinement had been documented well before the Oak Ridge programs were designed or implemented." He testified that it is understood in the psychiatric community, and accepted not only by Ontario courts but by the United Nations, that solitary confinement is not just punishment, it is torture.

[796] Although Dr. Bourget was not convinced that Mr. Kierstead suffered any long-term harm as a result of Oak Ridge, she did concede in cross-examination that one must take into account that Mr. Kierstead was 16 years old when admitted to Oak Ridge, and that he was often placed in solitary for arbitrary or petty reasons. She also conceded that Mr. Kierstead sometimes experienced suicidal thoughts while at Oak Ridge, as documented in his contemporaneous diary. The records do not show that he had been suicidal prior to his arrival there.

[797] Dr. Chaimowitz, the expert on solitary confinement whose evidence was accepted in the *CCLA* case, testified at trial that confinement in the federal penitentiary system entails up to 22 hours a day in the cell and 1 or 2 hours outdoors. Prisoners in confinement are generally permitted to shower daily, and their cells are described as "spartan" and are furnished with a thin matrass, toilet, sink, and sometimes a window. Confined prisoners are typically visited daily by nurses in order to assess the risk of self-harm. They are also given an opportunity for periodic visits by legal counsel and religious advisors.

[798] Several of the Defendants' experts, including Dr. Chaimowitz, contend that the conditions of confinement at Oak Ridge are substantially different than what is found, and has been labeled "cruel and unusual", in penitentiaries. According to Mr. Kierstead's evidence and that of several other of the Plaintiffs, however, the two situations are not all that different. In fact, the description of confinement at Oak Ridge is remarkably similar to Dr. Chaimowitz' description of confinement in prisons. Shauna Taylor, for example, testified that she has experienced confinement in both a federal penitentiary and at Oak Ridge and found them to be nearly identical.

[799] In Oak Ridge, there are small cells with a metal door. Confined patients are given the opportunity to shower every 3 to 7 days, their cells are constantly lit, the mattress are removed from their beds in daytime so that they have to sit on bare concrete, there is no temperature control, the toilets could not be flushed from inside the cells, there is no running water in sink, no access to pictures or personal items, and no access to books other than religious books. If confinement in a penitentiary for more than 15 days constitutes torture under the United Nations' and the Court of Appeal's standards, then so does confinement for more than 15 days at Oak Ridge.

[800] I tend to agree with Dr. Bourget that the trajectory of Mr. Kierstead's post-Oak Ridge life has been a positive one and there is little evidence of a downward curve following his discharge from Oak Ridge. His stable marriage and employment speak to a lack of long-term harm that can be attributed to the Oak Ridge experience.

[801] That said, Mr. Kierstead was in confinement more than he could stand. The Clinical Records show that he disliked the experience intensely, and that his response to being confined on a number of occasions prompted staff to record that he appeared suicidal. Dr. Booth opined that this kind of stress can lead to anxiety and depression and cognitive and perceptual impairment, and the longer an individual is exposed the more likely this is. Indeed, this may well explain the perceptual confusions evidenced in Mr. Kierstead's testimony, in which he transposed his experiences with stress in confinement with those of other patients and their stresses in the MAPP.

[802] According to Dr. Booth, confinement can cause severe psychiatric harm. Mr. Kierstead was in Oak Ridge as a teenager of 16 years old, and was very vulnerable to the fears and stresses that this treatment placed on him. It is a testament to his strength that he has not suffered from this in the long term.

[803] Mr. Kierstead interacted with Dr. Barker at Oak Ridge. He deposed in his affidavit that, in fact, he liked Dr. Barker when he first met him. He also was consistently monitored by Dr. Boyd, who can be seen in the Oak Ridge documentary record to have taken responsibility for his time there. There is, however, little evidence from Mr. Kierstead himself that he had a personal relationship with the Superintendent. Nevertheless, Dr. Boyd and Dr. Barker were involved in his treatment at Oak Ridge.

[804] There is no doubt that Mr. Kierstead was emotionally pained while at Oak Ridge, and that he spent more time in confinement than more modern studies have indicated are tolerable. And although the evidence does not establish that he was in any of the 3 impugned STU programs, he has vivid, but false recollections of those programs that suggest that he is being truthful when he says that he feared them. In particular, he feared being placed in confinement in a way which is reminiscent of MAPP and suggests that the stress under which he operated at Oak Ridge prompted him to anticipate MAPP-like treatment.

[805] The evidence does not establish that Mr. Kierstead actually experienced any of the Capsule, DDT, or MAPP. Nevertheless, the specter of these programs caused him harm. As a teenager he was made to endure fear and stress by the threat of being sent to MAPP, or being placed in the Capsule – both of which he continues to fantasize about in the form of false recollections. The existence of MAPP in the stressful environment of the STU sufficed to inflict on him psychic harm; the fear of MAPP is a harm caused by MAPP. These assaultive fears, made operational for him by Dr. Boyd and Dr. Barker, caused Mr. Kierstead to endure a certain amount of short-term pain.

r) Denis LePage

[806] In 1966, Denis LePage was convicted of manslaughter after killing his aunt with a rolling pin. He served 8.5 years in Kingston Penitentiary before being paroled on January 17, 1975. Within a year and a half of his release, he was convicted of sexual assault of three young boys and sentenced to another 21 months. Shortly after his release from that custody, on September 6, 1977, he was charged with possession of a firearm with which he was stalking a female therapist. He was ultimately found not guilty by reason of insanity and was committed to Oak Ridge on a

Warrant of the Lieutenant Governor on January 20, 1978, where he remained until discharged in 1982.

i) Pre-Oak Ridge and index offence

[807] On January 17, 1966, in the wake of the death of his aunt, Mr. LePage was committed to Oak Ridge for the first time on a 30-day warrant. The Clinical Records from this brief admission do not show that he was any of the Capsule, DDT or MAPP at this time. According to the Clinical Record dated February 3, 1966, he was prepared for a Sodium Amytal treatment, but ultimately opted out of it for fear of self-incrimination. Counsel for the Doctors highlights this as an indication that the DDT program was indeed consent-based, and not imposed on unwilling patients.

[808] Mr. LePage was found fit to stand trial, and was discharged from this 30-day admission on February 13, 1966. His Mental Status Report to the court dated January 27, 1966 describes him as a person "who did not appear to have normal comprehension". It also observed that he was "felt to be highly manipulative…lied easily and without conscience…to serve his own ends."

[809] As indicated above, he was convicted of manslaughter in the death of his aunt. The incident is related in a Clinical Record compiled by Dr. Barker and a social worker dated November 7, 1977.

> On January 4, 1966, Denis is alleged to have killed his aunt with a rolling pin. He telephoned police and got into a police car himself and asked them to take him to the station. He was disturbed and distraught at the time. He remembered being in a fight but was not sure with whom or what the fight was about. He had what appeared to be spots of blood on his forehead and in his hands. He was examined at the Carleton County Jail by Dr. Catterson, who felt that the amnesia was genuine and was most likely hysterical in nature and, because Denis described having experienced a déjà vu phenomenon, recommended further assessment, specifically to investigate the possibility of epilepsy.

[810] In 1976, Mr. LePage let three adolescent boys into his home and showed them pornographic films. His affidavit relates that he was convicted of sexual assault and served time at the Guelph Assessment and Treatment Unit and the Rideau Correctional Centre. The Oak Ridge Clinical Record of November 7, 1977 states that at Guelph, Mr. LePage was assessed as having anxiety, depression, or depression in schizoid personality, and that he was considered a threat to female staff after he "fixed his designs" on a female therapist. He was then transferred to the more secure Millbrook Correctional Centre. The Clinical Record reports that he continued to harbour threats against the therapist, stating in the presence of a correctional officer: "I'll get her".

[811] After being released from Millbrook in 1977, Mr. LePage became dangerously preoccupied with the same female therapist from Guelph, who he blamed for having had him transferred to Millbrook. He eventually acquired a firearm, a set of handcuffs, and a model gun, and waited for her near her home with two hand-drawn pictures depicting a young woman's head and a young child crying. He deposes in his affidavit that he was arrested for possession of a dangerous weapon and he pleaded not guilty, all in an effort to compel the therapist to testify in a new trial.

[812] On September 19, 1977, Mr. LePage was again committed to Oak Ridge for assessment, this time on a 60-day Warrant of Remand as he awaited trial on the dangerous weapon charge. He was assessed by Dr. Barker, whose Report dated November 16, 1977 states that Mr. LePage was diagnosed with a Borderline Personality as well as "elements of a Schizoid or even Schizophrenic illness." Counsel for the Plaintiffs rely on this early diagnosis, and in particular the mention of schizophrenia, as indicative of Mr. LePage's extreme vulnerability. Counsel for the Defendants note that Mr. LePage's later assessments do not all repeat this particular diagnosis, and submit that he was not as vulnerable as Dr. Barker's tentative assessment at this early stage might suggest.

[813] Mr. LePage was discharged from Oak Ridge on November 15, 1977. During this 60-day admission, there are no Clinical Records indicating that he had any exposure to the DDT, Capsule, or MAPP. In writing his Discharge Summary, Dr. Barker referenced Mr. LePage's diagnosis as: "Borderline Personality or Pseudopsychopathic Schizophrenia". The next day, November 16, 1977, Dr. Barker wrote an evaluation to the Provincial Court indicating that, despite being fit to stand trial, Mr. LePage "suffers from a disease of the mind which, at the time of commission of the alleged offence, rendered him unable to appreciate the nature and quality of his acts."

[814] On January 20, 1978, Mr. LePage was committed to Oak Ridge on a Warrant of the Lieutenant Governor after having been found not guilty by reason of insanity with respect to the possession of a dangerous weapon charge. In a Clinical Record dated February 17, 1978, it is indicated that he was found in his holding cell of the courtroom hanging by his belt in an apparent suicide attempt. He was resuscitated and sent to Ottawa General Hospital for an examination, after which he was again sent to Oak Ridge.

[815] On cross-examination at trial, Mr. LePage denied the accuracy of this version of events:

> Q. And, in fact, sir, as a result of that, perhaps I understand that your view is that you having been found hanging by your belt was just an opinion?
>
> A. You're not allowed a belt in the police station. They took my belt away here, in this courtroom. It has been history since the beginning of time, even on the first time I went to jail. They take your shoelaces, they take your belt, and they take your money, they take everything that could cause harm to anybody or yourself. So, they really, they're not doing their job right, or they were doing it right and nothing – they were doing it right. I didn't even have a belt.

ii) Experience in the STU

[816] The Clinical Records indicate that Mr. LePage was resistant to taking medication early in his stay at Oak Ridge, despite the conclusion of medical staff that he was dangerous without medication. During cross-examination, he confirmed that he had resisted medication, explaining that, "they were trying to get rid of me one way or another and, in my view, like a zombie on medication, well they succeeded."

[817] This course of events is described by Dr. O'Reilly in Mr. LePage's eventual Discharge Summary from Oak Ridge dated February 4, 1982:

> During his initial stay in this hospital, Mr. LePage was resistive to any program of treatment and refused medication. In order to treat this man, who was becoming increasingly difficult to manage and physically violent, he was Civilly Committed and permission from the Central Ontario Board was sought to treat him. This was granted. Mr. Lepage responded well to the program of therapy and he functioned extraordinarily on the G ward therapeutic program. At the patient's request he was subsequently transferred to the E ward vocational therapy where he continued to do reasonably well.

[818] Mr. LePage testified that in November 1980, while he was confined to his cell the water to his cell was intentionally shut off and he had to drink out of the toilet. However, in cross-examination he stated that there was a faulty plumbing valve and that the water had been gurgling at night, causing staff to shut it off. Mr. LePage also testified that in yet another occasion the water was shut off for several days because, at a time when he had lost a substantial amount of weight, it was thought that he may have been disposing of his food in the toilet. This suspicion is noted in Mr. LePage's Clinical Record dated October 13, 1980: "H ward staff report patient is eating very little and is suspected of flushing his food down the toilet. He has been moved to a room where this can be monitored."

[819] The Clinical Records do not show Mr. LePage as having participated in either the DDT program or the Capsule. They do, however, record that he was put in MAPP on a number of occasions:

> April 5 to May 19, 1978, for having challenged the 'patient-teachers'. The Clinical Records record him as being alternately "spaced out most of the time" or "sarcastic and abusive toward the teachers";
>
> June 8, 1978 to December 6, 1978, in MotoPro, which was similar to MAPP but required 10 rather than 14 days of good behaviour;
>
> December 5, 1978 to December 27, 1978, for acting irresponsibly and for 'displaying a rank and negative attitude';
>
> April 2, 1980 to November 7, 1980, for 84 days. A Conference Report dated September 18, 1980 states that he refused to 'work his way out of MAPP' and demanded to see a lawyer.

[820] Mr. LePage also complained in his testimony that during the course of his time at Oak Ridge, he was placed in confinement for an inordinate amount of time, much of it in association with sessions in MAPP. He testified that confinement essentially meant spending all day alone in his cell wearing a "baby doll" smock and sitting on a hard cement floor which was freezing cold in the winter and very hot in the summer.

[821] In their factum, counsel for the Doctors reply that, "The records indicate that Mr. LePage preferred confinement to having to participate in the MAPP group therapy, and was 'happy' while

there." This assessment is, in turn, directly supported by Clinical Records dated November 9 and 13, 1977:

> Denis has been quiet in confinement and sleeps the majority of the time. His mood is good and he appears to be enjoying his lockup. He has not asked to be taken out of confinement. Staff note that he has no interest in returning to the groups at this time.
>
> Denis continues to be in confinement and is quiet there. He is presenting no problems and his mood is satisfactory. Staff notes that he is happy in confinement and wants nothing to do with the program.

[822] Needless to say, to be "happy in confinement" when the alternative is the "positional torture", as Dr. Bradford described it, of MAPP, is only a very tenuous definition of happiness. In Mr. LePage's case, the extensive use of MAPP and the attendant use of confinement were part of a single continuum of punitive approaches. They were designed to quell the behaviour of a troubled and difficult patient. His inability to cope with MAPP was evident to the staff, but they nevertheless persisted with the program. The Clinical Record of April 9, 1978, for example, states: "It appears that he will be up here a long time and it is questionable as to whether he can actually earn his way out of MAPP."

[823] It is clear from his testimony that MAPP had a negative effect on his cognitive abilities. In the midst of his April 1978 stint in MAPP, a nurse commented in his Clinical Record that the patient-teachers view Mr. LePage as acting as if he is "delusional and paranoid", and that he "will not face reality". Mr. LePage confirmed these effects in his testimony at trial:

> Q. And what did it do to your mind, that very lengthy time in seclusion and in the MAP Program?
>
> A. Well, what it did to my mind is that it interfered with my thyroid condition, hypertension, ah, and the fact that I couldn't understand what was going on, because when they medicate you, they scramble your mind and you might be talking common sense but to the patient that's medicated, it's all jumbled up.

[824] Once Mr. LePage started taking his medication more diligently, his delusions and other symptoms began to subside. Dr. O'Reilly renewed his certification on January 5, 1981, indicating on his Clinical Record of that date that he was showing a "great improvement on treatment with Largactil and Persitan." From that point until his discharge a year later, Dr. O'Reilly interviewed and reported on him roughly every two weeks. These reports were for the most part positive and stressed the improvements Mr. LePage had made, although there were exceptions. For example, on April 6, 1981, Dr. O'Reilly noted in his Clinical Record that he had been given a "severe warning" about trying to sell goods to other patients on his ward. Further, on June 15, 1981, Dr. O'Reilly noted in his Record that Mr. LePage displayed nervousness and anxiety.

[825] On August 25, 1981, Dr. O'Reilly wrote in the Clinical Record that she was contemplating a reduction in dosage of Largactil for Mr. LePage. With the approach of an Ontario Review Board

hearing in late 1981, Dr. Boyd sought to interview Mr. LePage in order to provide the Board with the necessary report. On November 3, 1981, Dr. O'Reilly noted in Mr. LePage's Clinical Record that he "refused to speak with Dr. Boyd". She wrote that the same thing occurred on November 10, 1981. On that date, Dr. O'Reilly recorded in the Clinical Record that Mr. LePage harbored a bitter resentment toward Dr. Boyd:

> …[T]his patient again refused to be interviewed by Dr. Boyd. After discussing the reasons with Dr. Boyd, he told him to 'f… off', 'I don't want anymore to do with you.'

[826] On January 6, 1982, Dr. O'Reilly observed that Mr. LePage had told attendant staff that the "first thing that he will do when he gets out, is to buy a shot gun to protect himself against people who would be after his money." The following week, on January 14, 1982, Dr. O'Reilly adjusted the dosages of Mr. LePage's medication.

iii) Post-Oak Ridge experience

[827] Mr. LePage was discharged from Oak Ridge to Brockville Psychiatric Hospital on February 4, 1982. Dr. O'Reilly indicated in his Discharge Summary that he still had a diagnosis of "Schizophrenia, Paranoid Type". He attempted to escape from the medium-security unit at Brockville on July 11, 1983 and was returned to Oak Ridge. In a Psychiatric Report dated October 20, 1986, it is indicated that medication had started to change his mental condition:

> The diagnosis is that of Paranoid Schizophrenic in Partial Remission. The prognosis may be considered fair while his is on his present regime of medication; it would likely be a more guarded one if he did not continue on his medication.

[828] Psychiatrists, review boards, and courts have over the decades commented that Mr. LePage remains a very difficult and potentially violent individual. This view was summarized by the Ontario Court of Appeal in *R v Lepage*, [2006] OJ No 4486:

> The Board noted that the following summary of the expert evidence taken from the previous year's Board Reasons continued to apply:
>
> > There has been no variation in the opinion of the many clinicians who have opined on Mr. LePage's file and his diagnosis and the prospects of successful treatment of the accused's major mental disorder. Dr. Malcolmson stated that Mr. LePage has no insight into his illness. Further, the doctor noted with alarm that the index offence is in the doctor's words 'mild' when compared with the observed research that Mr. LePage continues to expend in preparation for the perpetration of threats of death, threats of violence and intimidation that continues routinely at Oak Ridge by this accused. In the doctor's view Mr. LePage's serious intention to physically harm staff and co-patients by death threats is very real. The doctor could detect no prospect that the accused will ever change with respect to this type of disturbing misconduct.

> …In his oral submissions to the court, the appellant took issue with the Hospital's suggestion recorded in the 1997 and 1998 dispositions of the Board that his refusal to participate in therapeutic programs is because he has always denied having a mental illness. He stated that he acknowledged he was mentally ill in a letter dated July 14, 1987 to the unit director.

[829] In 2007, a psychiatrist at the Royal Ottawa Mental Health Centre changed Mr. LePage's diagnosis and abandoned the schizophrenia conclusion that Dr. Barker had come to early in Mr. LePage's admission to the STU. In a Report dated June 3, 2007, he was diagnosed with obsessive compulsive disorder, antisocial personality disorder, narcissistic and paranoid traits. The Report notes that Mr. LePage had been describing the STU program of years earlier:

> Concerning psychiatric treatment, Mr. LePage has been treated in various experimental programs at Oakridge for the past 29 years. He indicated that he has refused day programs consisting of LSD and Scopolamine. He said as a result of that he was placed into a program which he believes was aimed to convince him to comply with treatment with medications.

[830] Mr. LePage was assessed by Dr. Hucker in 2009 for the purpose of recommending whether he could be transferred to a medium security facility. In his Report dated April 30, 2009, Dr. Hucker recommended against a transfer, emphasizing the difficulty of managing Mr. LePage as a patient and the risk he posed to staff and to the public:

> The Hospital Record is replete with examples of Mr. LePage's consistent tendency to threaten personal violence towards both staff and co-patients…
>
> Finally, it should be mentioned that hospital staff and various consultants have uniformly regarded Mr. LePage as presenting a very high risk to both members of the general public and to staff and other patients. As Dr. M. Menuck put it, 'only the identity of his next victim(s) and the timing of his next attack are in question.'

[831] Mr. LePage has remained institutionalized at Waypoint. In *Re LePage*, 2011 CarswellOnt 6160, the Ontario Review Board states that he remains threatening and violent. His latest diagnosis, as found at para 62 of this decision, confirmed the addition of obsessive compulsive disorder, and indicated that this was accompanied by a "query Asperger's disorder".

iv) Causation and harm

[832] In an article entitled "Psychiatric Effects of Solitary Confinement", 22 Wash. U. J. Law & Policy 325, 348 (2006), which is referred to in Dr. Bradford's Report, the author, Dr. Stuart Grassian of New York University, observes that people with personality disorders and psychopathic functioning are particularly "at risk for severe psychopathologic reactions to such isolation." In cross-examination, Drs. Bradford and Booth both stated that they agree with this analysis. Dr. Chaimowitz, to whom it was also put in cross-examination, testified that he does not

necessarily agree, although he conceded that the more stable you are the better you will be able to withstand trauma the more emotionally disturbed you are the more you may be traumatized.

[833] In Dr. Chaimowitz' view, people with "dependent histrionic, borderline personalities" will struggle with the stresses of confinement more than most other people. He also agreed that confinement can exacerbate pre-existing mental conditions. In cross-examination, Dr. Chaimowitz stated without hesitation that a revolving door confinement environment increases stress, and that the unpredictable and arbitrary use of confinement as a punishment is anxiety inducing.

[834] It is therefore difficult to understand why, in Dr. Chaimowitz' opinion submitted on behalf of the Doctors, it is stated that Mr. LePage did not suffer harm as a result of his time in MAPP. The Clinical Records and Ward Transfer Slips show that he was altogether 219 days in MAPP, including 84 days in confinement. He testified that it induced extreme anxiety. Given that he had what Dr. Barker thought was a schizoid effective disorder, and others later conceded was a form of paranoia and obsessive compulsive disorder, it is hard to believe that Mr. LePage did not only suffer harm due to this treatment, but suffered a substantial amount of psychological harm and mental pain.

[835] In his Supplementary Report, Dr. Bradford indicated that he had reviewed Mr. LePage's documentation and medical records and understands that he has had "multiple psychiatric diagnoses including Obsessive-Compulsive Disorder, Schizophrenia, and Antisocial Traits as well as a possibility of Asperger's Syndrome." He then goes on to state that with this in his background, "Mr. LePage was harmed by his exposure to MAPP." Mr. LePage's pre-existing disorders made him particularly vulnerable to the oppressive environment and associated stretches of time in confinement that characterized his MAPP experience.

[836] It is understandable that Mr. LePage has never managed to transfer out of a maximum-security institution. Instead of beneficial therapy he was treated in a punitive way at Oak Ridge. Dr. Barker was very much involved with his admission and his diagnoses, and his entry into the STU, while Dr. O'Reilly took over involvement in Mr. LePage's treatment in later years. Having diagnosed him as schizophrenic – even if the designation was then changed by others before still later being brought back by Dr. O'Reilly – Dr. Barker was certainly aware of Mr. LePage's frailties and susceptibility to the traumatic impositions of the MAPP.

[837] Mr. LePage suffered both short-term and long-term harm due to the STU programs. He endured an intolerable level of contemporaneous mental stress being placed repeatedly in MAPP and confining him in association with that program, thereby replacing therapy with harsh punishment. These experiences also imposed on him longer term harm by exacerbating his inability to grasp the reality of his situation and increasing his aversion to the medications he required in order to control his mental disorder. Dr. Barker and Dr. O'Reilly were directly involved with his treatments, with oversight by Dr. Boyd.

[838] But for the oppressive STU experience from 1978 to 1982, the trajectory of Mr. LePage's life may well have been improved. His index offence was not one which would have kept him incarcerated for more than a few years, but the harm he suffered at Oak Ridge likely prevented him from achieving the liberty he may have otherwise achieved.

s) Christian Magee

[839] Christian Magee was first committed to Oak Ridge on June 25, 1976, for the rape and murder of a 15-year old girl. In total, he has sexually assaulted five women, murdering three of them. Except for a brief period of several months, he has resided at Oak Ridge and Waypoint ever since his first admission.

i) Pre-Oak Ridge and index offence

[840] Mr. Magee deposed in his affidavit that he had a difficult childhood, with an abusive father and a violently abusive older brother. The highest level of schooling he achieved was grade 8, and he stopped attending school at the age of 16. His parents separated when he was 20 years old and his mother passed away shortly thereafter. A Mental Status report from Penetanguishene dated July 26, 1978 indicates that he started drinking heavily around the age of 22. Further, he got married at around that time and had two children. The Mental Status report relates Mr. Magee's perception that the marriage was plagued with sexual disagreements, with his spouse not wanting to have frequent relations and leaving him sexually frustrated.

[841] Mr. Magee was first committed to Oak Ridge from June 25, 1976 to August 20, 1976 on a Warrant of Remand for a 60-day assessment after being charged with the rape and murder of a teenage girl that occurred on June 15, 1976. He was assessed by Dr. Barker, who found him fit to stand trial. The Discharge Summary dated August 20, 1976 provides Dr. Barker's diagnosis: "Pathological Personality, Antisocial Type". Dr. Barker's Report to the court dated August 18, 1976, provides a more descriptive assessment of Mr. Magee:

> A number of psychological tests were given, including the MMPI, the WAIS, the Sacks Completion Test, and Rorschach Test. A review of the personality tests to date suggest that Mr. Magee is a rebellious and restless individual who is potentially very aggressive and impulsive in his actions. He has a low frustration tolerance, but at the time of testing was relatively well-controlled. In unstructured situations, he tends to be anxious, but he is able to overcome this anxiety quickly. He is manipulative and experiences some sexual confusion and has a high potential for aggressive acting out.

[842] Although he was initially committed for assessment in respect of a single murder charge, he was eventually found to have committed 5 sexual assaults, resulting in the deaths of 3 of the victims. These events are described in some detail in a Review Board decision dated November 5, 2012 reported as *Re Magee*, [2012] ORBD 2117:

> On June 15, 1976 Mr. Magee enticed a 15 year old girl to accept a ride in his truck. He then strangled her, stabbed her in the throat and chest area, cut her across the abdomen above her vagina, and raped her. Until his appeal from his conviction for first degree murder was dismissed in 1979, Mr. Magee denied any involvement in these crimes. At that time, he informed the authorities of his commission of additional offences, namely, two further murders, a rape and a

sexual assault perpetrated during the period between March 1974 to November 1975.

The first of these additional offences, involve the murder of a 19 year old girl, who Mr. Magee grabbed on March 2, 1974 when she was on her way home after shopping at a variety store and purchasing a pizza. Mr. Magee appears to have made sexual demands and, when the victim refused and struggled, he slashed her throat with a knife (nearly severing her head from her body) and then sexually assaulted and robbed her.

The next offence took place on June 20, 1975. The female victim was returning home from a local library when Mr. Magee came up behind her, grabbed her around her throat, and ordered her to remove her clothes. When she refused, he tightened his grip around her throat, strangling her until she passed out. After she recovered consciousness, it was discovered that her vagina had been injured and it appeared that she had been sexually assaulted.

The third offence, another murder, occurred on October 20, 1975. On this occasion Mr. Magee strangled a 19 year old female acquaintance and knifed her in the throat. Although the victim's underwear was removed, no signs of a sexual attack were later detected. Mr. Magee acknowledged that he went to the victim's home and, on gaining entry, grabbed her and forced her to the floor for the purpose of having sex. He claimed that he did not carry through with this act, but admitted that he had no control over what he was doing and that he strangled the victim, first with his hand and then with a shoe lace, which he tied around her throat. He then stabbed her in the throat with a knife.

The last index offence took place on November 3, 1975. It involved the rape of a 14 year old female hitchhiker who accepted a ride from Mr. Magee. Mr. Magee struck the victim in the face, tore her clothes off, had forced intercourse with her causing lacerations to her vagina, strangled her until she lost consciousness, and hit her on the head with a pop bottle. She was later found naked and semi-conscious on the road. She sustained a fractured skull, amongst other injuries.

[843] While still awaiting trial for the murder of the 15-year old girl, Mr. Magee was again committed to Oak Ridge for a 60-day assessment on March 1, 1977. The Discharge Summary dated May 10, 1977 indicates that this time he was assessed by Dr. Levinskas and Dr. Tate, with a final diagnosis of: “Pathological Personality – antisocial type”. He was then returned to jail to await trial. On October 11, 1977, he was found not guilty by reason of insanity for murder of the 15-year old girl.

[844] On December 1, 1977, at the age of 29, Mr. Magee was re-committed to Oak Ridge pursuant to a Warrant of the Lieutenant Governor. The Bedside Nursing Notes indicate that on May 3, 1979, within a week of the dismissal of his appeal against conviction, he was sent to MAPP by Dr. Barker. The following week, two detectives were apparently called in to interview him. The Bedside Nursing Note of May 11, 1979, written while Mr. Magee was still in MAPP, states

that he confessed to two detectives who had been called in to interview him that he committed the other two murders and sexual assaults.

[845] Mr. Magee was ultimately tried and found not guilty by reason of insanity for two counts of murder and rape and one count of indecent assault. On February 26, 1980, he was again committed to Oak Ridge for these acts pursuant to a Warrant of the Lieutenant Governor. His Mental Status Report dated December 16, 1977 states that he maintained his innocence of the offences for which he had been charged, although he did concede that there was something wrong with him and that he was willing to submit to treatment. His diagnosis at this stage was noted in the Mental Status Report as: "Personality Disorder with Antisocial Features".

ii) Experience in the STU

[846] Mr. Magee deposed that he was given Sodium-Amytal in preparation for an interview for assessment purposes by Dr. Barker, which took place on August 5, 1976. Dr. Barker was apparently cognizant of the legal pitfalls of administering a drug treatment that eliminates free will to an accused facing trial, and in cross-examination Mr. Magee confirmed that medical staff consulted with his lawyer before this took place.

[847] Prior to this Sodium-Amytal session, Dr. Barker met with Mr. Magee to discuss the matter and to confront him on his dishonesty in reporting his thoughts and actions. In a Clinical Record dated July 30, 1976, Dr. Barker documented that after this conversation Mr. Magee himself requested the Sodium Amytal treatment:

> It seems completely impossible for him to give a straight, honest answer to almost any question. I confronted him about this with regard to his evasiveness over problems he was having in his marriage. His position initially was that if he is found guilty in Court, he would like to come here for treatment rather than go to prison. I pointed out that we have to establish whether or not he requires treatment here before his Court appearance and he agreed that we might use Sodium Amytal to assist us in understanding his problems, particularly his sexual ones which he states he has difficulty talking about. I pointed out that he might in fact talk about the offences for which he is charged under this drug and that he should be aware of that and that we would seek consent from his lawyer in that regard. He seems quite willing, stating that if he did these offences, he would like to find out and therefore would like to have Sodium Amytal.

[848] In addition, the Clinical Records reflect that Mr. Magee received an Alcohol-Ritalin treatment on March 9, 1978, and that he signed a written Consent for this treatment. In examination-in-chief, he insisted that Dr. Maier recommended to him a number of times that he take an Alcohol-Ritalin treatment in order to break down his mental defences, but that Mr. Magee resisted this as much as he could. In his testimony, Mr. Magee alleged that he had two alcohol treatments, but the March 1978 session is the only one that is recorded in his Clinical Records. On being pressed in cross-examination, he conceded that he was relying solely on his memory.

[849] There is no evidence that Mr. Magee received an alcohol treatment in December 1977 or any time other than in March 1978. In cross-examination, Mr. Magee hesitatingly conceded that his memory could be faulty on this point:

> Q. So, if there's only records of one alcohol treatment, you're not able to help us with when the other –- if another one occurred or when it occurred?
>
> A. Well, I'm 99 per cent sure that there's more than one.
>
> Q. But, again, you don't know when...
>
> A. No.
>
> Q. ... or where it occurred?
>
> A. No. And just – if the notes say that there's only one, then I have to, ah, give way to – unless notes got lost. I – I personally feel that there was more than one. I know that – I know there's at least two, but – and it could be three. But, ah...

[850] In a Clinical Record dated March 10, 1978, a nurse noted that medical staff wanted Mr. Magee to undergo further Alcohol-Ritalin treatments but were aware that this might impact on his still pending appeal. His lawyer then wrote a letter to the Oak Ridge administration on March 29, 1978 withdrawing Mr. Magee's consent for "certain therapy…particularly with respect to the administration of drugs." By reply letter dated April 6, 1978, Dr. Tate confirmed that the consent was withdrawn and that Mr. Magee would be transferred to another ward for "a less intense program".

[851] Although in testimony Mr. Magee thought that he had been in MAPP at least 5 times, the Clinical Records indicate that he was in either MAPP or Moto-Pro, on 4 occasions:

> March 14, 1978 to April 9, 1978, intermittently, for displaying a 'lack of interest in the program' on the order of professional staff.
>
> May 3 to May 31, 1979 on the orders of Dr. Barker, who recorded that this was at the request of Mr. Magee. In a Clinical Record dated May 3, 1979, Dr. Barker attended a meeting in which Mr. Magee stated that he would be 'prepared to go to MAPP'. The Record states that, 'He is wondering about appealing again', and relates that, 'It was noted the hospital was in accord with the court and jurors who sentenced him, however the patient maintained he did not commit the crime.' As indicated above, Mr. Magee then entered MAPP, police detectives visited him there, and he confessed to several additional crimes.
>
> December 21, 1979 to February 18, 1980, for manipulating the rules and making a telephone call on the 'grounds of a so-called emergency'. This stint in MAPP was briefly interrupted a number of times for Mr. Magee to attend his preliminary inquiry and criminal trial.

> September 28 to October 19, 1982, for attempting to manipulate other patients and trying to 'railroad' them into MAPP, and for fantasizing about having sex with the kitchen workers.

[852] In both his affidavit and his testimony in chief, Mr. Magee alleged that he suffered considerable abuse by the patient-teachers, particularly while in MAPP and MotoPro. He recounted an incident in Moto-Pro in March-April 1978 wherein other patients held him down and one of them took a cigarette lighter to his chest and burned off his right nipple. He also claimed this other patient would shove his hands up Mr. Magee's 'baby doll' smock with the lighter onto his testicles. In his affidavit, Mr. Magee stated that staff did nothing to intervene on these occasions. On the witness stand, Mr. Magee was insistent that he had been abused in this way, and offered to remove his shirt to show the court the scar on his chest.

[853] The Clinical Records do not record any of these events, nor do they contain any record of a contemporaneous complaint about them by Mr. Magee. They also do not appear to contain any observation by any physician of Mr. Magee suffering a visible injury to the chest. However, the Clinical Records from March 21 through to April 9, 1978 do relate that Mr. Magee had negative reactions to his fellow patients in MotoPro, that he expressed feelings of anger and frustration, and that he was "not accepting feedback from other patients, states that he is right and they are wrong." Other than these general observations, the Records for these dates are sparse on details of Mr. Magee's interactions with other patients.

[854] Mr. Magee never participated in the Capsule program as a patient, although he testified that he was in the Capsule as an observer. He described the Capsule accurately as being continuously lit with bright lights, with straws through the walls for meals and water, and housing a program in which patients confronted each other during the treatment. His time in the Capsule is not recorded in Mr. Magee's Clinical Records, but that is because he did not undergo any treatment there. As the Doctors' counsel point out, the Capsule was dismantled in 1979 and Mr. Magee's lengthy admission (other than for an assessment) came in 1978. Accordingly, any exposure of Mr. Magee to the Capsule would necessarily have been limited.

iii) Post-Oak Ridge experience

[855] Mr. Magee continues to live at Waypoint, and has never been released to a less-than-maximum security institution. With the passing of years, he has managed to improve his basic schooling and literacy levels, but has not been able to overcome his impulse to criminality. At trial, he expressed disagreement with this assessment, although he seemed to confuse his having achieved further education with having achieved psychological stability.

> Q. Mr. Magee, can I just go to your affidavit. I'll do this very quickly. Your affidavit, behind Tab 1-A – and actually, let me – before we go there, let me just put it to you, sir, you understand that the consensus view of most of your treating psychiatrists is that you are untreatable, correct?
>
> A. Ah, I understand that, that's their viewpoint. I know that I've made a lot of changes over the years. But, to say that I'm not treatable is unbelievable, because I

> know the changes that I've made today, from the day that I walked through this building is tremendous. The danger that I was back then is entirely different than now. I know that I'm not a danger now, and I know that the changes that I made, that low self-esteem, self-worth, ah, depression, ah, the anxieties, the – ah, everything that was going through my head back then, where now I have a lot more self esteem, self-worth. I – I feel good about myself. am proud about I can now read, and – not very – I still have a lot of problems with spelling, but I feel comfortable. Ah, I don't need to feel ashamed about it. I'm halfway through writin' a novel. I've gotta write a test on Thursday for my Grade 12 Science, and then I got one more course and I'll have my Grade 12.

[856] As reported in 2012 in *Re Magee*, *supra*, at para 51, Dr. Bradford commented on Mr. Magee's educational and cognitive shortcomings, concluding that the lack of insight demonstrated at trial has been an unchanging characteristic:

> Dr. Bradford accepted that Mr. Magee had a limited education and accepted the possibility that the lack of insight and lack of judgment may arise because of his cognitive limitations. Dr. Bradford noted however, that whatever the cause there is still a profound lack of judgment and a profound lack of insight.

[857] As noted by the Review Board and by counsel for the Doctors in their written submissions, until today Mr. Magee does not seem to recognize the gravity of his violent conduct. At para 87 of its judgment, the Review Board relates that in speaking with medical staff, he had commented that the Board should focus on his accomplishments instead of on his "little mistake" – referring to his index offense of rape and murder.

[858] This unchanged mindset has led the experts who have examined him, including Plaintiffs' expert, Dr. Bradford, to conclude that Mr. Magee remains a serious danger to the public. The Review Board summarized this finding in its 2012 decision, at paras 34-36:

> Dr. Bradford repeated his opinion that Mr. Magee's prospects of rehabilitation remain 'extremely bleak' and that he does not realistically see that prognosis change at any time over the next four or five years.
>
> In response to questions from Crown Counsel, Dr, Bradford accepted that Mr. Magee's risk really flows from a constellation of significant diagnoses.
>
> Dr. Bradford accepted that Mr. Magee represents a serial sexually motivated sadistic murderer. Mr. Magee represents an extremely high risk of danger to members of the public. Dr Bradford made the point that were Mr. Magee to reoffend, the outcome of such re-offence would either be a homicide or an extremely severe sexual attack.

[859] Mr. Magee's current diagnosis, as set out by the Review Board at para 22, is much the same as it has been for 4 decades: "Sexual Sadism, Transvestite Fetishism, Antisocial Personality Disorder, and Narcissistic Personality Disorder."

iv) Causation and harm

[860] In his Supplementary Report filed in this trial, Dr. Bradford opines that Mr. Magee was harmed by the STU programs he experienced in the late 1970s and early 1980s, but he provides little in the way of detail or explanation. By contrast, Dr. Bourget, who examined Mr. Magee's records on behalf of the Defendants, opines in her Report dated March 20, 2019 that he is unlikely to have been caused any harm by these programs.

[861] Dr. Bourget testified that Mr. Magee "may have had some unpleasant experiences, but to say that on the long term he suffered severe mental anguish or severe problems, I think we do not have the evidence for this, and there's no evidence of seeking treatment for those, either." In her Report, she concludes that Mr. Magee's life trajectory was not changed by his STU experiences – in effect, he was a damaged and volatile person when he arrived at Oak Ridge, and remains the same damaged and volatile person today.

> By the time that Mr. Magee was admitted to Oak Ridge, he had already committed a series of very serious offences that justified a long-term detention, especially considering his high risk of reoffence due to a severe paraphilia (sexual sadism) and antisocial personality disorder. These, in their own rights, would have most likely alienated him from his family, especially given the fact that he continued to entertain sexual fantasies concerning his daughter. His dangerosity and high risk of recidivism would also have compromised his successful reintegration in the society…
>
> Under these circumstances, whether or not Mr. Magee had undergone the treatment programs, his current life would be very similar to what it is at the present time, with continued hospitalization in Oak Ridge.

[862] On one hand, it is hard to disagree with Dr. Bourget that Mr. Magee is for the most part mentally unchanged since the time of his first admission to Oak Ridge. The Review Board and every psychiatrist who has assessed him, including Dr. Bradford, has reached that conclusion. But that is not the real question. Rather, the question in terms of long-term harm is whether the STU programs that he experienced caused him prolonged anxiety or psychological pain or significantly contributed to his inability to change.

[863] In cross-examining Dr. Bourget, counsel for the Plaintiffs took issue with her minimalistic description of Mr. Magee's experience of MAPP as "unpleasant" and her dismissal of his allegations that they were anxiety producing. Counsel pointed out that this characterization was at odds with the way in which Mr. Magee himself described the experience. In response, Dr. Bourget emphasized that the contemporaneous records do not disclose any vehement complaints by Mr. Magee, and then she explained her view by again stressing the life trajectory perspective: "Mr. Magee also stated that he had learned to cope and that he was not always feeling anxious and that the anxiety was not – was not, you know, impacting significantly on his day-to-day life."

[864] While Mr. Magee may not have had the right vocabulary or mindset to voice his complaints at the time, there is no doubt that his MAPP sessions had a serious impact on him. For one thing,

in May of 1979, Dr. Barker ordered him into MAPP and then the institution arranged for two detectives to visit him and take the confession that the experience prompted him to make. He was subsequently charged and tried for the very crimes to which he had confessed.

[865] The record before me does not indicate whether in that pre-*Charter* era the court took account of the "positional torture", to use Dr. Bradford's expression about MAPP, under which those confessions were produced. It is undeniable, however, that today they would not have been admissible and could not have formed the basis of a prosecution or trial. Significantly, the reason for that is that we understand that the confession is a product of the intense duress and is therefore not reliable as being a truthful product of free will: *R v Hart*, [2014] 2 SCR 544, at para 192. It is also understood, of course, that, whether it is the positional variety or takes some other form, "torture is so abhorrent that it will almost always be disproportionate to interests on the other side of the balance, even security interests": *Suresh v Canada (Minister of Citizenship and Immigration)*, [2002] 1 SCR 3, at para 76.

[866] Mr. Magee has continuously denied having committed the offenses with which he was charged and for which he was found NCR. It is not the role of this court in this trial to revisit those trials or the accuracy of their findings. However, the fact that he confessed to several offenses while in MAPP, and that he did not continue to stand by those confessions once out of MAPP, suggests that the MAPP experience amounted to more than just a minor "unpleasant experience", as Dr. Bourget characterized it. Indeed, when asked in cross-examinations about his confessions, he described the experience as a particularly stressful one:

> Q. And before we get there, you have mentioned this a few times, and I just want to confirm. When you made your further confessions to further crime, that was done while you were in MAPP, correct?
>
> A. That's correct. That was when I was depressed, ah I – I wanted to give up. I didn't see any light at the end of the tunnel. Everything was hopeless. It didn't matter, it couldn't get any worse, so I might as well get everything off my chest and – and – it ain't gonna make things worse. You don't got nothin' to prove. You ain't got nothin' to lose. So, you might as well get everything out.

[867] Whether or not the depression and anxiety described by Mr. Magee has had a long-term effect, there is little doubt that the confessions have lingered with him. The factual background of the offenses to which he confessed to the two detectives who interviewed him in MAPP are related to each psychiatric expert and adjudicative body to consider his situation.

[868] By way of example, in *Mental Health Centre, Penetanguishene v Magee* (2006), 80 OR (3d) 436, paras 8-13, the Court of Appeal commenced its judgment dismissing Mr. Magee's request to be transferred to a medium security institution with an account of each of his offenses. This included his 1976 index offense of rape and murder as well as the other murders and sexual assaults to which he later confessed. The Court grounded its reversal of a finding in Mr. Magee's favour on the basis of the confessed offenses: "In this case, the Review Board's disposition effectively calls for the detention of a serial murderer and sexual offender on a locked ward not currently designed to house such offenders": *Ibid.*, at para 97.

[869] The MAPP experience and the confessions that it produced have become a part of Mr. Magee's background that he cannot now escape. The confessions may or may not have been truthful, but their effect has been extremely negative for Mr. Magee. MAPP had no discernable therapeutic effect; and but for this essentially punitive experience, his institutionalization, or his subsequent treatment within Oak Ridge/Waypoint, would likely have followed a different path.

[870] Dr. Barker and Dr. Tate were directly involved in Mr. Magee's treatments. I find that subjecting Mr. Magee to MAPP caused him short-term pain and anxiety. This put him in a physically and emotionally stressful environment which he was not equipped to handle. I find that his having been subjected to MAPP also caused him long-term harm in that it forced a confession of unknown veracity out of him. This had a contributing effect to his having to be kept housed under maximum security for the past 4 decades.

t) Douglas McCaul

[871] In his affidavit, Douglas McCaul relates that there were complications at his birth and that as a result he suffered brain damage. He then suffered further trauma when at 3 years old he fell from a bunk and incurred a skull fractured skull and a loss of hearing. In his affidavit, he deposes: "I have since been diagnosed with Personality Change due to a general medical condition, Cerebral Trauma and Cerebral Ischemic Disease."

[872] Mr. McCaul's Clinical Record from Penetanguishene dated April 15, 1976 indicates that he was committed to Oak Ridge pursuant to a Warrant of the Lieutenant Governor when he was in his mid-20s, and stayed for just over 4 years, from December 17, 1976 to January 23, 1981. He had killed a woman, buried her, and returned later to the site and committed an indecent act with the body.

i) Pre-Oak Ridge and index offence

[873] In a Pre-Sentence Report dated June 4, 1973, it is reported that at a young age Mr. McCaul began to run away from his father's violent home. When he was 12-years old he became involved in small-time crime and was convicted of theft, for which he was sentenced to 6 months at St. John's Training School where he was sexually abused and beaten. According to his own affidavit, he ran away from St. John's several times, and when caught had his sentence extended.

[874] On cross-examination by counsel for the Crown, Mr. McCaul conceded that the effect of these early experiences lingered with him in a negative way:

> Q. And so, your experiences at both the St. John's Training School, and the foster home, those were traumatic experiences for you. Is that correct?
>
> A. I felt they were…
>
> Q. And this resulted in a lack of trust, your being unable to trust others?
>
> A. I wouldn't trust anybody at that point.

[875] In a Report dated May 12, 1983 from St. Thomas Psychiatric Hospital, the assessing physician notes that, "Mr. McCaul reported that at age 14 he engaged in homosexual prostitution, and experienced a physical beating from a customer so he gave it up." The same Report states that Mr. McCaul admitted that at the age of 14 he assaulted a 12-year old boy by enticing him into a quiet area and threatening him by holding a sharp can opener to his chest until the boy was coerced into fondling him. When that was done, Mr. McCaul then beat the young boy with a wire tied to a stick until the child screamed and Mr. McCaul let him go.

[876] At age 16, Mr. McCaul was released from St. John's and was placed in the custody of a foster home in Toronto. He deposed that in this setting he was again physically and sexually abused, and has conceded that this experience was also traumatic. He soon left the foster home to live on his own. Mr. McCaul states in his affidavit that he only completed school up to Grade 5, and that before he arrived at Oak Ridge at the age of 23 he was functionally illiterate.

[877] In his affidavit, Mr. McCaul places the blame for his later criminal behaviour on his youthful traumas and broken childhood. He deposes:

> I believe that the sexual abuse I suffered played a significant role in my criminal behaviour. I did not understand how to express my anger in an appropriate fashion, I did not have a social support network, and by eighteen years old I had developed a serious drinking problem.

[878] In January 1976, Mr. McCaul was charged with the murder of a 22-year old woman who had herself run away form a psychiatric institution. His Clinical Record of April 15, 1976 relates that Mr. McCaul reported having been drinking heavily during the attack on the woman, had little or no memory of the event, and had suffered a number of alcohol-induced blackouts. The description of the incident provided in this Clinical Record, which is summarized from the contemporary Police Report, is graphic:

> The Police Report advises that on Sunday morning, February 8, 1976, the body of a female person was found in a leaf-trough…
>
> A post-mortem examination was performed on the body and resulted in the findings that she had died as a result of a very severe beating to the upper portion of her body. She had sustained fractures of the jaw, ribs, and of the clavicle. There were indications of boot or shoe marks which revealed the outline of the sole and heel on her chest and lower abdomen. She was also strangled.

[879] The May 12, 1983 St. Thomas Report contains further a narration by Mr. McCaul about the February 1976 attack. In that Report, the disturbing follow-up perpetrated by Mr. McCaul is described:

> …Mr. McCaul recalls that he tore off his 25-year old victim's clothes at the time of his beating her to death. When she was down on the ground, he had the 'thought of having sex with her', but when he realized she wasn't breathing, he panicked and proceeded to get rid of her body. He went back a week later specifically for

> sex, at which time he 'thinks' he 'tried'. He stated he was at the body site probably two or three hours before leaving.

[880] Mr. McCaul was committed to Oak Ridge on March 1, 1976 pursuant to a Warrant of Remand for a 60-day psychiatric assessment. In the April 15, 1976 Clinical Record, it is reported that he experienced suicidal thoughts and that he related to staff that in the past he had tried to hang himself on one occasion. The Discharge Summary dated April 29, 1976 states that he was fit to stand trial, indicates Mr. McCaul's diagnosis as: "Personality Disorder, Inadequate and Antisocial plus Alcohol Abuse."

[881] After being found not guilty by reason of insanity, Mr. McCaul was re-committed to Oak Ridge on December 17, 1976 pursuant to a Warrant of the Lieutenant Governor. He remained there for 4 years, until his discharge to St. Thomas Psychiatric Hospital on January 23, 1981.

ii) Experience in the STU

[882] In his affidavit, Mr. McCaul deposes that he was in the Capsule, and that he went there on the recommendation of other patients. The affidavit states that, "I knew that I could not decline to participate, because I would have been sent to MAPP." Mr. McCaul then provides a rather fulsome description of the Capsule, much of which is reminiscent of what other Plaintiffs had said of this program:

> The Capsule room and experience was meant to replicate a womb. We were naked on the floor with a rubber mat floor and padded walls, and we were fed through straws to replicate an umbilical cord. The room was lit twenty-four hours per day, which resulted in severe sleep deprivation and disorientation.
>
> …Four patients were ultimately selected by the patients on the ward to go into the Capsule with me, and they were told to confront me and provoke my anger. At one point, in order to heighten the confrontation, I was 'cuffed' by special restraints, made out of seatbelt material, to another patient.

[883] There is no Clinical Record or other evidence in Mr. McCaul's medical file documenting his having spent any time in the Capsule. In March 2008, Dr. Bradford wrote a lengthy, 26-page assessment of Mr. McCaul for the Review Board for which he interviewed Mr. McCaul and reviewed his entire history, including his files from the Oak Ridge years. Dr. Bradford's assessment letter does mention that drugs were administered to Mr. McCaul as part of the DDT program, but nowhere is there any mention of the Capsule. In cross-examination, Mr. McCaul conceded that he could not recall ever telling anyone prior to this litigation that he had been in the Capsule.

[884] This discrepancy was put to Mr. McCaul in cross-examination. His response demonstrates a misunderstanding about the frequency with which the Capsule program was used:

> Q. So, Dr. Bradford, in his report, did not relay your experiences in the capsule. I guess that he didn't just – I guess we can ask him why he didn't include it, but it's your evidence that you did tell him about the capsule experience?

> A. I'm pretty sure I did. Every – every – like as far as almost every – every program, everybody, whether you're on 'G' Ward, 'H' Ward, whatever, you're in the system. Everybody went into the capsule at one point.

[885] It is not, in fact, the case that every patient in the STU at Oak Ridge during the relevant period was put in the Capsule. Mr. McCaul appears to have taken a generic description of the Capsule program gleaned from other patients – including its design to replicate a "womb" and other things that would have come from knowledge about the program but not from direct experience of it – and transposed it in his mind to his own experience. He also testified that he was on several occasions an observer of treatments given to other patients, which may have added to his confusion as to what he experienced himself and what was experienced by others.

[886] The Bedside Nursing Notes indicate that on August 30, 1977, Mr. McCaul admitted during a group session that he had committed the murder of the 25-year old woman. This is his first recorded admission of responsibility for that offense, as up until then he had always denied it despite knowing every possible detail about it. He then also revealed to the group that when he was 17 years old he had, unknown to anyone else, murdered an elderly man. A description of this confession is contained in Mr. McCaul's January 23, 1981 Admission Report from St. Thomas Psychiatric Hospital:

> During his long stay at Penetang, Doug confessed to a second murder which occurred when he was 17-years of age. He had a bitter argument with his father over his father's refusal to permit him to use the family car. In his anger he wandered through a schoolyard with the idea he would rob someone. As he passed a man who was unknown to him he stabbed him in the back 12 times and ran.

[887] Interestingly, Mr. McCaul has never been charged with this second murder. The Admission Report states: "By his account, his confession has been reviewed by the Crown and his lawyer tells him he is immune from prosecution." There is no further explanation for the fact that a prosecution has never been commenced. The confession did, however, have one concrete outcome, as he indicated in cross-examination: it propelled Mr. McCaul into the DDT program.

> Q. And as I understand it, it was after your second confession that your group recommended to you that you receive a drug treatment. Is that correct?
>
> A. Yes, sir.

[888] Mr. McCaul indicated in his cross-examination that he signed a Consent for the drug treatments, but that he did so under stress and in a mentally fragile state after having admitted his crimes. He also indicated that although the DDT was authorized by Dr. Maier, the explanations that formed the basis of his consent to the program came from other patients and not from any medically trained person. A Clinical Record dated December 1977 states:

> Doug comments, …I felt I was put under pressure to have a drug treatment, I kept putting it off because I felt they were not necessary… [A]t this time I was very

> emotional, more than I was when admitting to the other one...the group said I should consider a drug treatment, and I did consider one.

[889] The treatment that Mr. McCaul eventually received was an Alcohol-Ritalin treatment. On cross-examination, he was asked about his consent to this treatment:

> Q. And, as I understand it, you were authorizing Dr. Maier, or his designate, to administer Alcohol Ritalin to you, and you were signing that you understood the reason for the administration of this treatment, its advantage, and possible complications, which have been explained to me. And that's true, Dr. Maier did meet with you and discuss the treatment?
>
> A. He may have approved the alcohol treatment, but he wasn't there.
>
> Q. I understand he may not have been there when the actual treatment was taking place, but you agree that he spoke with you in advance and explained its advantages and potential complications?
>
> A. No, he didn't. The group did…
>
> Q. So, you're saying this form is inaccurate, Dr. Maier did not meet with you?
>
> A. The alcohol treatment was recommended by the Treatment Committee. So, they write up a req and they send it to Dr. – well, they send – they give it to the staff, the staff gives it to the doctor, and he – he writes an order.

[890] On December 7, 1977, Mr. McCaul was injected intramuscularly with 20 mg of Ritalin and was then given 25 oz of alcohol to drink. The Clinical Record of that date reports that Mr. McCaul went into convulsions and was administered to by Dr. Maier and a nurse. In his testimony at trial, Mr. McCaul elaborated that during the DDT session several patients had provoked him by shoving and hitting him, that he had reacted violently, and that during the ensuing struggle he hit his head which caused him to go into convulsions. Despite the convulsions, the December 1977 Clinical Record quotes Mr. McCaul as telling a nurse: "I was told I expressed my real self in this treatment… I do plan on having more drug treatments in the future."

[891] This supposedly positive attitude is contradicted by Mr. McCaul in his affidavit. There he deposes:

> After my first Alcohol-Ritalin experience, I did not want to do another because I was afraid that the same thing would happen. The patients on my ward, however, believed that I should do another 'treatment'. I did not bother objecting because I knew I could be overridden by the group, and I believed that I would be placed in MAPP if I was seen to be showing a negative attitude.

[892] Despite the bad experience of the first Alcohol-Ritalin treatment, Mr. McCaul was given another similar dose of Ritalin and Alcohol on March 10, 1978. That DDT session was no better, and perhaps even more painful, than the previous one. The Clinical Record documents this:

> The ward staff report that Doug was given an alcohol treatment which finished at 1400 hours. At 1425 hours Doug went into what appeared to be convulsions. The doctors and nurses were notified and in attendance at this time. He was given 150 mgs Dilintan I.V. by Dr. Fleming at 1440 hours. In the p.m. Doug was still having convulsions and was given another 100 mgs of Dilintan I.M. Shortly after this injection he became more lucid and talkative. In the course of this conversation he mentioned feelings he had about having sex with a corpse four days after he had killed her. During the night Doug was violently ill at 0115 hours. He was vomiting, weak, shivering and began convulsing again at 0130 hours. He was given 10 mgs of Valium I.M. Doug had a further convulsion at 1225 hours and was very frightened. Later he went to sleep with no further difficulty. The patient is to have no more alcohol treatments.

[893] Mr. McCaul was in Moto-Pro on one 6-week occasion, from May 30, 1978 to July 18, 1978. The Clinical Record of May 30, 1978 states: "The ward staff report that Douglas was placed in the Remotivation Program because of his lack of motivation and participation. He became very emotional and unpredictable and was assessed double restraints."

[894] Mr. McCaul deposed that this was a "mini-MAPP", lasting for a period of 10 days. In his description, he had to sit without moving unless given permission, and if he did move he would be sanctioned. Mr. McCaul alleged that while in Moto-Pro he was turkey strapped, but that this would only last for seven or eight minutes. Mr. McCaul described the pain of this type of restraint as being extremely painful, and said that you could not walk while so bound.

[895] The Clinical Records of his time in Moto-Pro say nothing of being turkey strapped. However, the Clinical Record dated June 17, 1978 states that Mr. McCall reported to a nurse: "In Moto-Pro, I have been lying and playing games and this led me to threatening Ward members." Despite this moment of apparent honesty, the Clinical Record of October 4, 1978 written by Dr. Barker comments that Mr. McCall is, overall, "[a] rather unreliable historian."

iii) Post-Oak Ridge experience

[896] On January 23, 1981, Mr. McCaul was transferred to St. Thomas Psychiatric Hospital. His Discharge Summary provides that his diagnosis was: "Personality Disorder, Inadequate with Antisocial Features, plus Sexual Deviation.

[897] While at St. Thomas, he was anxious to return to Oak Ridge. Indeed, he wrote in a handwritten note dated June 2, 1988 that he had "threatened to castrate myself to return to Penetang". In his testimony in chief, he explained that he felt this way "because they still had MAPP program. All the stuff that Penetang abolished St. Thomas decided to hang – to keep. And so I decided to fight the system."

[898] On January 14, 2009, Mr. McCaul was transferred to the Brockville Mental Health Centre. More recently, on June 6, 2019, he was granted a conditional discharge by the Review Board. His most recent diagnosis, as recorded on the Brockville Discharge Summary, is: "Personality Change due to a general medical condition (Cerebral Trauma and Cerebral Ischemic Disease), Sexual

Disorders – Transvestic Fetishism, Sexual Disorders – Sexual Sadism, Substance Use Disorder, Alcohol Dependence (in remission), and Antisocial Personality Disorder."

iv) Causation and harm

[899] A Pre-Sentence Report dated June 4, 1973 relating to a theft charge committed when Mr. McCaul was 19 years old states that he was "drinking on each occasion which he was involved in the offenses shown on his record." His Clinical Record of April 15, 1976, written during his initial assessment at Oak Ridge, documents that Mr. McCaul suffered alcohol blackouts on the day of his index offense, and that he had been drinking so heavily that day that he had little memory of it.

[900] Mr. McCaul's very first diagnosis from his initial assessment at Oak Ridge dated April 29, 1976, identified one of his problems as alcohol abuse. Virtually every assessment and diagnosis of Mr. McCaul done over the past 45 years has mentioned alcoholism as a disorder from which he suffers (or, as in his final diagnosis, which he suffered in the past and is now in remission), and which has been instrumental to his criminality.

[901] With this background, was Mr. McCaul's consent to alcohol treatments at Oak Ridge truly a willful consent, and did Dr. Maier's authorization of those alcohol treatments cause Mr. McCaul harm? To ask these questions is to answer them. Mr. McCaul's participation in the DDT program was precisely what he should not have done in a hospital setting.

[902] That said, Dr. Bourget, who examined Mr. McCaul's records on behalf of the Defendants, was dismissive of the harm this treatment may have caused. In cross-examination she expressed the view that, in effect, once a person has a disorder – whether sexual deviation or alcohol abuse – more sexual abuse or alcohol cannot hurt him:

> Q. In your opinion, to the extent that Mr. McCaul participated in any of the STU programs at issue in this case, did those programs more likely than not cause harm to him?
>
> A. I think that the – the programs did not cause further long-lasting harm impacting on his current life. I think that the problems were there before Mr. McCaul entered Oak Ridge… He also had a history of a sexual disorder prior to Oak Ridge, so I don't think that the experience in Oak Ridge worsened any of his conditions… In terms of addiction, Mr. McCaul had a pre-existing history of alcohol abuse and of drinking beer and experiencing blackouts. And the offence, the murder that he committed of this young woman was committed while he was intoxicated. I found no evidence that he developed a drug addiction, specifically because of the treatment he underwent at Oak Ridge.

[903] Mr. McCaul suffered severe convulsions each time he was force-fed large quantities of alcohol at Oak Ridge. As already observed with respect to Jean-Paul Belec, an alcoholic patient seems more likely to be harmed by consuming entire bottles of alcohol than another patient with no experience of alcohol abuse. And as for Mr. McCaul's supposed informed consent obtained by Dr. Maier, one can only recall Dr. Barker's observation, also noted earlier in these reasons, that a

patient with the experience of excessive drug or alcohol use on the street "might just want a high" when offered their favored substance.

[904] Accordingly, I cannot accept Dr. Bourget's analysis. Either Dr. Maier did not read Mr. McCaul's file before authorizing his alcohol treatments, or he read the file and did not care. The DDT program caused Mr. McCaul short-term harm in terms of convulsions, physical pain and mental anguish during the treatments. He had to be resuscitated and then calmed with Valium just to survive the ordeal.

[905] The time he spent in mini-MAPP also was harmful in the short-term. Mr. McCaul found the physical and harsh disciplinary aspects to be extremely painful. And while he was confused about having been in the Capsule, it is altogether possible that he mistook some of the events that he underwent in the Moto-Pro for events that happened in the Capsule. In fact, some of his testimony that was supposedly about the Capsule described other patients holding him in immobile positions and other MAPP-like experiences.

[906] Dr. Barker was obviously aware from an oversight perspective of what these programs were doing to Mr. McCaul, and can be seen commenting on his performance in the Clinical Records. He did nothing to improve Mr. McCaul's lot in the STU and oversaw his supposed therapy of suffering.

[907] The DDT program and the mini-MAPP both also caused Mr. McCaul long-term harm. He consistently complained of being targeted for violence by other patients during his time at Oak Ridge, which he primarily attributed to his having been known as a homosexual and transvestite. The intense environment of the Moto-Pro exacerbated these issues for him, and the insecurities of being the victimized patient were exacerbated by having been given alcohol in quantities that made him convulse and require medical attention.

[908] These insecurities were made more profound by the DDT and mini-MAPP, and extended well beyond the end of his STU period. For example, an assessment done at St. Thomas dated May 12, 1987 notes that Mr. McCaul "impresses as a lost soul who does not know which way to turn... Awareness of his helplessness seems to generate considerable hostility."

[909] As Dr. Bradford points out in summary, Mr. McCaul suffers from sexual and general identity disorders, fetishism, alcohol dependence issues, anti-social personality, heart disease and diabetes (which, according to Dr. Bradford, are associated with trauma). These ailments plagued him all his life, and existed before, during, and after Oak Ridge. But it is evident that they should not have been compounded by the "therapy" he received in the STU.

[910] Through sheer longevity, Mr. McCaul has managed very recently to be released into the community after 4 ½ decades of custodial living. Had his existing disorders not been aggravated by the STU programs, he would likely have reached that stage sooner.

[911] Dr. Maier and Dr. Barker were directly involved in Mr. McCaul's treatments, which in turn caused him both long-term and short-term harm.

u) Brian McInnes

[912] After twice being sent to Penetanguishene for assessments when he was 16 and 17-years old, Brian McInnes spent a 6-month stint in Oak Ridge as an involuntary patient from April 30, 1976 to November 9, 1976, at the age of 18. On his Physician's Application for Involuntary Admission dated April 29, 1976, he was described as a "potentially dangerous psychopath" with violent fantasies.

i) Pre-Oak Ridge and index offence

[913] Mr. McInnes was born in Kirkland Lake, Ontario in 1958. He deposed in his affidavit that he had a difficult childhood, with an alcoholic father who abused him both physically and emotionally. He relates in his affidavit that he was bullied throughout his school years and dropped out after grade 7. He also deposed that, "I did not hold any jobs before my time at Oakridge, other than a two-month stint as a dishwasher in 1974. I believe I lost that job due to my dependence on alcohol; I had started drinking around the age of 10 or 11."

[914] He confirmed in cross-examination that he was also sexually abused by his nephew from the age of 7 until his early teens, which traumatized him and continues to this day to have a significant impact on his life. In an Initial Report dated August 1, 1974 on Family and Social Situation by a Probation and After-Care Officer, it is related that he was sent to the Cecil Fraser Youth Centre in Sudbury, and that he was frequently caught "lying, stealing and running away". It was there that he apparently had his first encounter with the criminal justice system, as he explains in his affidavit:

> I was bullied by the other youth there. I was out on a day pass and did not want to return, so I threatened the Cecil Fraser staff with a gun when they came to pick me up, and made them drive me down the highway. The police came and I was charged with possession of a weapon, kidnapping and seizure of a government vehicle. This was my first brush with the law.

[915] After this incident, Mr. McInnes was sent to a maximum-security youth facility called the Hillcrest Training School. In his testimony, he described his time there, and his teenage years in general, as riddled with anxiety:

> Q. Okay, and could you just describe that to me? What was the anxiety like in your teens?
>
> A. Well it was – it was – it was fairly – fairly – fairly strong anxiety because I was always subject to bullies in school, and [by] the other inmates. I guess they weren't called inmates in the training school, but by the other people in there, so at that point, I used to try to put on a face of rubato [*sic*], 'yeah, watch out, I'll give you the...' play the tough guy, and try to back these people away from harassing me.
>
> Q. And, you did that because you were very anxious, and in fact, from time to time, you were on medication because of your anxiety?
>
> A. I believe that I was on some medication, yeah.

[916] Mr. McInnes then commenced a series of assessments, as one institution after another found him very difficult to deal with. Hillcrest sent him to Oak Ridge as an involuntary patient for a month-long assessment starting December 5, 1974, when he was 16-years old. Dr. Maier assessed him, and recorded in his Discharge Summary dated January 7, 1975 as having "Personality Disorder Immature with Explosive Features".

[917] Six months later, in June 1975, Mr. McInnes was sent for another 30-day assessment to North Eastern Regional Mental Health Centre. He testified that while in that facility, he set a fire in a washroom and escaped in a stolen car before engaging in a high-speed police chase.

[918] On the recommendation of the Director of Clinical Programs at the hospital, he was remanded by court Order back to Oak Ridge on June 26, 1975. There, he underwent a 60-day assessment and was found fit to stand trial for the automobile theft. He was ultimately convicted and sent to serve a custodial sentence at Guelph Assessment and Treatment Unit.

[919] According to a Medical Report dated January 15, 1976, while at Guelph, Mr. McInnes assaulted another inmate by placing a metal lock in a sock and hitting him in the head with it. The record contains a letter in which the Director of Guelph wrote directly to Dr. Maier to arrange Mr. McInnes' transfer back to Oak Ridge. A Physician's Application for Involuntary Admission dated April 29, 1976 indicates that at Guelph, Mr. McInnes was diagnosed as having a sociopathic personality disorder, and as a "potentially dangerous psychopath" with violent fantasies.

[920] Mr. McInnes was re-admitted to Oak Ridge as an involuntary patient from April 30, 1976 to November 9, 1976. He was 18 years old at the time, and was placed in the STU having committed no offense more serious than theft and an assault, both of which took place in the context of a troubled teenager being held in a difficult custodial situation. In an Interim History dated On May 31, 1976, it is indicated that he was diagnosed with "Immature Personality With Explosive Features".

ii) Experience in the STU

[921] Like several of the other Plaintiffs, Mr. McInnes testified that he took part in the DDT and Capsule programs, when the Clinical Records from his time at Oak Ridge contain no indication that he participated in either program. He likewise testified that he was frightened of having been cuffed to other prisoners while in the Capsule, as he knew that they had committed violent offenses and he felt vulnerable to them.

[922] As counsel for the Doctors point out in argument, it is unlikely that Oak Ridge, with its extensive recording and preserving of Clinical Records, would have failed to record drug treatments administered to Mr. McInnes. For reasons that are somewhat inexplicable, Mr. McInnes said at trial that he had been given Scopolamine, Nozinan, and LSD, when his Clinical Records do not contain any mention of those drugs. Likewise, the Bedside Nursing Notes contain no indication that Mr. McInnes was in the Capsule. As Dr. Tate said in cross-examination, "[Those] significant events…should be mentioned in the clinical notes."

[923] There is nothing to indicate that any records have inexplicably gone missing from Penetanguishene. As Dr. Maier testified, the STU programs were intended to be well documented for further study and use. Although there are details of each patient's experiences that are inevitably left out, the Clinical Records provide a running narrative of the most important events and contemporaneous observations. Dr. Maier's categorical assertion of this is credible in the circumstances:

> Q. Okay. It has been suggested along the way I think that certain of the clinical notes which should or would have been in place have gone missing. Was there ever any practice that you observed of removing notes from a chart?
>
> A. Never.

[924] Mr. McInnes' assertions about being in the Capsule and DDT programs are not reliable. What is credible, in view of his psychiatric history, is that he was frightened and intimidated by other patients he encountered in the STU. Moreover, the Ward Transfer Slips and Clinical Records do indicate that he spent time in MAPP, which he might have confused for the Capsule. These are possible explanations. While it is not believable that he had undocumented Capsule and DDT experiences, it is certainly understandable that these fearful fantasies reflect the genuine intimidation and fear that Mr. McInnes experienced in Oak Ridge.

[925] The Clinical Records show that Mr. McInnes was in MAPP for a month-long stint, from June 14, 1976 until July 19, 1976. In a Clinical Record dated June 13, 1976, the day before his MAPP session began, Dr. Maier wrote:

> Brian stated out in the airing court to patient John Zuzack, that he was going to get a gun brought in and he would get out of hear *[sic]*. He was assessed by Central Committee and will be confined until this matter is clarified.

[926] On cross-examination, Mr. McInnes acknowledged that this threat, which harked back to his violent conduct the previous year at North Eastern Regional Mental Health Centre, was the reason he was sent to MAPP. The experience in MAPP was neither easy nor pleasant for Mr. McInnes. The Clinical Records show that he was restrained frequently during his month-long MAPP session:

> On June 19, 1976, the Clinical Record states that he 'became very upset in groups, threatening to kill patient McCallum Fred. Placed on restraints due to his emotional state.'
>
> Later on June 19, 1976, the Clinical Record indicates that he remained on restraints and was 'threatening teachers and staff. Pt states that he is going to show everyone how tough he is at first chance'.
>
> On June 21, 1976, Dr. Maier wrote in Mr. McInnes' Clinical Record: 'Brian was confined for his negative attitude towards the program. He is a liar. He displays

> some hostility and negativity towards the MAP teachers. He is presently attending group on restraints.'
>
> On June 26, 1976, Dr. Tate wrote in Mr. McInnes' Clinical Record: 'Brian was placed on restraints for his negative attitude and also for being defiant and provoking other MAPPees with statements like, 'there is nothing you MAPPees can do to change me'. He says he feels the program is a joke and that he does not want to make any changes.' Dr. Maier testified that when someone says that they are special and cannot be changed, it plays to the 'Con Code', and that "we had our radar out for that" and would send or keep the person in MAPP.
>
> From June 26 to June 28, 1976, the Bedside Nursing Notes report that Mr. McInnes was 'threatening teachers, very negative attitude, put on restraints because of his unpredictable nature… Out to MAPP group on restraints as he is considered an acting out risk.'

[927] Mr. McInnes testified that the reason for his having to be restrained so often in MAPP was indeed his acting out, which itself was a product of his continuous fear of other patients (or 'teachers') while in that program:

> Q. So, I just want to talk about some of the times you were restrained in the MAP program. Do you remember being put on restraints while you were in MAPP?
>
> A. I most certainly do, yeah. They used to call it cuffs, but it wasn't like cuffs like police use, it was like seat belt material and they had padlocks.
>
> Q. So according to...
>
> A. And MAPP teachers who were psychotic killers had the keys to the padlocks. Not a very good system.

[928] On November 9, 1976, Mr. McInnes was discharged to the custody of his father. The diagnosis on his Discharge Summary of that date is: "Personality Disorder with Antisocial Features". The form is signed by Dr. Boyd, and states: "We do not feel Brian is in need of maximum security at this time."

iii) Post-Oak Ridge experience

[929] Mr. McInnes' testimony highlighted his continued suffering from anxiety-related disorders well after his departure from Oak Ridge. Thus, for example, while the Clinical Records may not show that he was given DDT drugs while in the STU, he admitted in cross-examination that a decade after his release he was indulging to excess:

> Q. I understand you drank heavily until 1988 or 1989?
>
> A. Yes, that's correct, yeah.

Q. And as I understand, when I say 'drink heavily', you were drinking, you said, whiskey from the bottle. You were drinking about a bottle of whiskey a day?

A. Oh, yes, indeed that's true, yeah.

Q. And I understand in the 1980s you experimented with magic mushrooms and LSD?

A. I did, yeah.

Q. And I have it as on approximately 12 occasions, is that – is that – is that, about right?

A. Yeah, probably. Yeah for it wasn't – I didn't do LSD very often. I did it a few times and I had some bad trips from it and I didn't – didn't – didn't care for that.

[930] In fact, for years after Oak Ridge, Mr. McInnes' everyday activities were heavily punctuated by seemingly uncontrollable, compulsive behaviours.

Q. …And at that time [1990], at Lakehead, you were, according to the records, drinking 40 to 50 cups of coffee a day. Is that right?

A. Yeah, that's about right, yeah. When I gave up booze, I – I – I started drinking coffee at the same amount that I drank the booze. I still drink a lot of coffee. I don't drink that much, but I still drink a lot of coffee though.

Q. And you were smoking two to three packs a day?

A. Yeah, that's correct.

Q. And you've done that since, as I understand it, young childhood?

A. Oh yeah, for sure, yeah. I believe I was 10 when it started.

[931] Moreover, Mr. McInnes continued to engage in criminal conduct, most of which appears to have involved non-violent offenses. As an illustration, the evidentiary record contains a February 14, 1991 letter from a probation officer to Penetanguishene requesting prior medical records. This correspondence indicates that Mr. McInnes had just been released after serving a 9-month sentence for theft over $1,000. It was part of an ongoing pattern for Mr. McInnes through the 1980s and, more sporadically, the 1990s. He testified that it is only in the past 20 years he has managed to curtail his criminal behaviour.

Q. We don't need to go to it, but as you acknowledge, you had a lengthy criminal record after your time at Oakridge?

A. I had yeah, I most certainly do, yeah.

> Q. And you were arrested throughout the 70s, 80s and early 90s, correct?
>
> A. That's correct, yeah.
>
> Q. But relatively, you have not been arrested then, except for one occasion in 1998, correct?
>
> A. Nineteen – yeah 1999, I had – I had – I had a charge and prior to that, I was released in early 1990 from jail and other than 1999 I had no charges in the 90s.

[932] Although Mr. McInnes has managed to overcome the worst of his substance dependencies and compulsive behaviours, those psychological problems have had a lasting impact on his economic and social well-being. Specifically, in cross-examination he testified that the lingering issues have prevented him from having been productively employed over the past several decades.

> Q. But your lengthy criminal record interfered with your ability to obtain employment, correct?
>
> A. Yeah, that and the panic – and anxiety disorder, yeah…
>
> Q. And, understand – fair to say, your alcoholism prior to 1998, or excuse me 1988, interfered with your ability to obtain employment, correct?
>
> A. Yeah, more than likely, yeah, although I did manage to obtain employment back then but – I had the worse time obtaining employment after I quit drinking when then panic and anxiety kicked in….

[933] The documentary record of Mr. McInnes' life after his discharge from Oak Ridge is relatively sparse. But his testimony in respect of his struggles with substance abuse, alcohol, tobacco, and caffein, is entirely credible. Further, his assessment of the impact of these struggles on his behaviour, including his criminality and his employability, is logical and likewise credible. Mr. McInnes may be misremembering some of the events of his Oak Ridge years, but his evidence of craving a bottle or whiskey or 50 cups of coffee and 3 packs of cigarettes a day paints an arresting portrait of an anxiety-ridden and partly dysfunctional person.

iv) Causation and harm

[934] In his Supplementary Report, Dr. Bradford opined: "Mr. McInnes was admitted as a teenager to Oak Ridge. In my opinion, this alone increased his vulnerability to the traumatizing effects of the programs." He then went on to elaborate on the lingering impact of Mr. McInnes' relatively short time in Oak Ridge and relatively limited exposure to the STU programs:

> The subsequent difficulties of panic, anxiety disorders and alcoholism could have been caused or worsened by his experiences at Oak Ridge. He went as an involuntary patient as a teenager and it appears that his involuntary status was most

> likely on the basis of him suffering from a personality disorder or, in the terms of Oak Ridge, being a psychopath. This is borne out by his problems with ongoing anxiety and substance abuse. This persisted and required further hospitalization. It likely affected his marriage and his social interaction as well as his ability to maintain employment. Although his exposure was relatively brief, in my opinion he was harmed as a result of his exposure to the programs at Oak Ridge.

[935] Dr. Turrall reviewed Mr. McInnes' file for the Defendants. He indicates that Mr. McInnes was still in his teens when he was admitted to Oak Ridge, and that as an antisocial personality the prognosis was, as he put it, "very slim that he would change". According to Dr. Turrall, despite that poor prognosis, the Oak Ridge programs were designed to help people like Mr. McInnes by loosening their defenses and allowing the individual to understand what had happened to them. In that way, they could then experience emotional growth.

[936] Although Dr. Turrall was willing to acknowledge the young and vulnerable age that Mr. McInnes was at the time of his admission, he explained that in the mid-1970s the only alternative would have been the far worse training schools run by the Ministry of Correctional Services. In that way, Dr. Turrall explained in his testimony, Mr. McInnes was kept safe from abuse by being at Oak Ridge. Accordingly, while Oak Ridge may or may not have actually helped him, in Dr. Turrall's opinion it did not do him any harm.

[937] Dr. Maier played a direct and important role in Mr. McInnes' treatment in the STU, as evidenced in the Clinical Records and elsewhere in the documentary record. Mr. McInnes testified that he dealt with Dr. Barker as well, but that is a more contentious question. His admission to Oak Ridge came at a time when Dr. Barker was for the most part assigned to a different unit at Penetanguishene and played little or no role in the STU. Mr. McInnes' Clinical Records do not appear to contain notations by Dr. Barker, and so Dr. Barker's alleged involvement with him may be another confusion in Mr. McInnes' mind.

[938] In any case, Oak Ridge and Dr. Maier caused Mr. McInnes short-term harm by forcing a vulnerable young teenager to spend time in MAPP. The Clinical Records indicate that the reason he was put in MAPP was, essentially, for acting his age – being sarcastic and disrespectful of authority. He was also frightened, as any teenager would be if some minor thefts and running away from training school had got them institutionalized and thrown into MAPP with older, hardened patients who had committed rapes and murders. The agitation, anxiety, and affront to his personal dignity that he felt during those sessions is palpable in his lashing out in anger and his somewhat juvenile cynicism aimed at the program, as recorded in the Clinical Records.

[939] Oak Ridge and Dr. Maier also caused Mr. McInnes long-term harm in the form of significantly increased anxiety. Mr. McInnes came to Oak Ridge a young, vulnerable, abused and troubled youth. When he was discharged he was a complex package of anxiety and nervous obsessions, drinking alcohol and then coffee extremely heavily, and consuming cigarettes in large quantities.

[940] While it is difficult to say that his relatively short Oak Ridge experience also caused him to engage in his later criminality, the record does establish that the STU, and specifically his

experience in MAPP, hurt him when he went through it and accelerated his anxiety-related instability, thereby contributing to his inability to live a happy and economically stable life.

v) Allen McMann

[941] Allen McMann was born in 1959 and had a very abusive childhood. At the age of 5 he was considered unmanageable and sent by his family for psychiatric assessment. A physician's Treatment Summary dated September 1966 diagnosed as being a "neurotic type." He was first admitted to Oak Ridge on September 29, 1975 and remained there until discharged on January 26, 1978.

i) Pre-Oak Ridge and index offence

[942] Mr. McMann had a very oppressive childhood. According to an Agreed Statement of Facts, he was beaten and emotionally abused by his father, and sexually assaulted by an aunt from the age of 3 or 4. He was known as a behavioural problem and a bully in school, and was sent for a psychiatric evaluation when he was 10 years old. In an Emergency Psychiatric Report dated February 28, 1973, it was reported that was "very unco-operative and difficult to involve in the educational and social process". The Report concludes:

> In essence, we are presented with a severely disturbed boy in terms of his overall behaviour, distractibility, inability to accept limits and socialize with his peer group. It is quite evident that ongoing care is going to be needed here…

[943] A Discharge Summary dated May 22, 1974 from Thistletown Regional Health Centre indicates that Mr. McInnes suffered serious deprivations in the wake of his parents' separation. The physician who authored the Summary stated that he was "appalled by the bitter struggle between Allen's estranged parents…through gross manipulation of all people relevant to this family." He had been placed in Thistletown for 2 months for an assessment. The final diagnosis upon discharge was: "Neurotic Behaviour Disorder of Adolescence", with a prognosis of "Poor".

[944] After his discharge from Thistletown, Mr. McMann was sent to live with a foster family, which, as he indicated in cross-examination, turned out to be a physically abusive environment. He was then sent to St. John's Training School, but was removed and made a ward of the Hillcrest Training School on November 29, 1974. A Psychiatrist Report of that same date indicated that St. John's had removed him after "constant AWOLs and charged with Car Theft." The Agreed Statement of Facts further sets out that in 1975 he was convicted of breaking and entering and given a suspended sentence and two years of probation. He was then made a ward of the Hillcrest Training School.

[945] A Psychiatric Report from Hillcrest dated May 28, 1975 indicates that even the strict environment of a training school did not result in a tempering of Mr. McMann's volatile personality:

> During a lengthy interview Allen stated that he considers everyone here to be 'stupid'. He hates all the boys, and has not a good word to say about any of the staff who have tried, individually and collectively, very hard to help this boy. Allen

> blames everyone but himself for all his problems… I am not too hopeful that Allen will co-operate with any psycho-therapeutic programme, but I feel that we have no alternative at this point in his life. In my opinion Allen is suffering from a well established and serious Behaviour Disorder of long standing. His instability to function becomes more marked as time goes on.

[946] In his testimony at trial, Mr. McMann did his best to deflect responsibility for his conduct. He stated that far from being the instigator of friction among his classmates, he was assaulted and put into solitary confinement. He also very much blamed his father for causing him to deteriorate:

> Q. There's a reference in the second to last paragraph [of the Hillcrest Psychiatric Report] about the unstable family history and the fact that your father has a history of repeated hospitalization for depressive episodes…
>
> A. In Hillcrest, in the holding centre after I escaped from Hillcrest or the Don Jail. My father beat any sense out – I mean, I didn't take boxing, I didn't take Marshall Arts *[sic]*, I mean I played hockey. I was big for my age and I was mouthy. But my father was the most manipulative person you could ever come up against.

ii) Experience in the STU

[947] The Agreed Statement sets out that on September 29, 1975, at the age of 16 and with a grade 8 education, Mr. McMann was admitted to Oak Ridge for an assessment pursuant to a certificate under the *Mental Health* Act. Dr. Maier wrote several Clinical Notes throughout the months of October-November 1975 which suggest the harshness of Oak Ridge on a 16-year old who has committed no serious crime.

> October 1, 1975 – Allen is doing well in groups. He was given a final warning today for talking in the shower room. He seems to find it incredible that he is certified mentally ill.
>
> October 13, 1975 – Allen is breaking numerous ward rules. He has a noncaring attitude and as a result was confined. He became upset and was whistling, yelling, and banging his door. He was given 50mg of Nozinan I.M. by Miss Farrow R.N. on orders of Dr. Maier. He attempted to kick the nurse when needles was given *[sic]*. He later apologized to everyone for his behaviour.
>
> October 18, 1975 – Allan has been doing fairly well in groups. He appears to have become adjusted to the functioning of the ward (H). Staff comment that Allan seems to have improved since coming out of confinement and is friendly and cooperative.
>
> October 25, 1975 – Allen participates well in groups. He seems to becoming a little too relaxed for his own good. He needs checking as he will hang

> himself if given enough rope. Staff comment that he is a little immature and acts before thinking.
>
> November 20, 1975 – Allen was transferred to the MAP program in the morning for his overall non-caring attitude around a patient who was talking escape and also telling them about his thoughts of escape when he was visiting with his mother.
>
> November 20, 1975 – Allen is in the MAP program at this time. He is argumentative, rigid, unreceptive, and irresponsible. He was recently confined for being negative and running down the hospital and programs. He is gamey. He tries to shut down others in groups.

[948] Staff continually had a hard time managing Mr. McMann. A Clinical Record dated June 10, 1077, authored by a social worker, indicated that the STU might not have been the right place for him after all and that the Activity Treatment Unit ("ATU") might have been preferable:

> The Social Therapy Unit requested that Mr. McMann be assessed for a transfer to the Activity Treatment Unit. The reason for the request centered around the fact that he had been in MAPP on eight different occasions and that the programs on the STU had just not been able to change his deviant behaviour.

[949] In his testimony-in-chief, Dr. Tate explained that the ATU was not an appropriate place for a patient like Mr. McMann. It was designed for a patient demographic that was distinctly different from Mr. McMann:

> …The thing about the ATU patients is they tended to be of subnormal intelligence. Some had brain injuries. Some of them were new Canadians who didn't speak English very well. Some of them were very -- they had learning disabilities. So, some of them were quite primitive, and that's why the program there was a very simple behaviour modification and working in the shops. And I think they thought somebody bright and intelligent and manipulative, like Allen McMann, would completely disrupt their program. And then they also mentioned they were worried about the morale, the effect it would have on the morale of their attendant staff, to have somebody that difficult all of a sudden one of their responsibilities. They just thought it was a bad idea. So they didn't accept him.

[950] In fact, however, in August-September 1977 Mr. McMann did, in fact, get sent to the ATU and spent 30 days there. His description of this experience is graphic, and portrays a punishing institution that is barely recognizable as a medical facility:

> Q. And I understand you spent some time on the activity unit, or the ATU?
>
> A. I was – I was threatened because of my immature behaviour - there was no violent behaviour. Because of my immature behaviour I was threatened with the ATU…

> D-ward [i.e. the ATU] smelled like faeces and urine the whole time I was there. I think I was there for 30 days and I was sent there for punishment. The people who were there were later explained to me, they were born and they either like epileptic. I mean, if you look at pictures of the holocaust that's the physical condition they were in.

[951] The Clinical Records and Agreed Statement document that Mr. McMann was in MAPP on numerous occasions:

> November 20 to December 31, 1975, as indicated above, for having a 'non-caring attitude around a patient who was talking escape…'
>
> March 22 to May 3, 1976, after receiving news that his parents were divorcing and was reported by Dr. Maier as becoming 'quite aggressive' and suicidal.
>
> May 28, 1976, with a sanction to write a 1,000-word essay. Dr. Maier explained in testimony that he was witnessing a 'process of a patient who is decompensating, not caring, not following the rules, not responsive to the ways that the program or the board would try to include him.'
>
> May 31 to June 16, 1976, after Dr. Maier noted that he was 'transferred to MAP program because of his negative attitude and lack of trust in patients on G-ward.'
>
> September 8 to October 25, 1976, after Dr. Maier noted that he was watching while other patients sexually acted out. In the Clinical Record of September 20, 1976, Dr. Maier comments that Mr. McMann was removed from MAPP and put into confinement and that he was still lying about situations and is unreceptive to feedback. On September 21, 1976, Dr. Maier records in the Clinical Record that, 'Allen was laughing inappropriately and talking to persons unknown. He remains in confinement…'
>
> January 13 to January 31, 1977, after continuing to resist the group therapy program and aggravate other patients. The Clinical Record records that Mr. McMann physically hit members of the security team when he was transferred to MAPP.
>
> February 8 to March 28, 1977, after being reported as having a poor attitude.
>
> April 14 to May 20, 1977, after Dr. Tate reported that Mr. McMann was showing 'disruptive behaviour and a lack of respect'.
>
> June 7 to August 31, 1977, after making a 'hangman's noose with the toilet paper' and displaying a 'non caring attitude'.
>
> June 23, 1977, the Clinical Record states: 'Allen is again in MAPP for sexually acting out in the Capsule. He is making no progress, being totally negative, arrogant, mouthy and nasty. He is confined most of the time.

> August 13, 1977, after swearing and throwing food on the floor due to being upset at his father's visit and receiving the news that his father was marrying his former school teacher.
>
> October 26 to November 21, 1977, after being caught sending letters to patient David Lariviere with whom he testified he had a sexual relationship and for threatening another patient. In an unusual bit of documentation, Mr. McMann was made to sign a form stating: 'I was never ever mistreated in any way, shape, or form by the either of the two MAPP teachers.'

[952] When an attendant staff member denied Mr. McMann's request to give to his mother, who was visiting Oak Ridge, a package of writings by patients, Mr. McMann tried to pass the papers to his mother himself. These documents are in the evidentiary record and described the difficulty Mr. McMann was having in MAPP. Specifically, Reginald Barker wrote descriptions of the course of other patients through MAPP. One document, entitled "Motivation, Attitude, Participation", is a patient essay on the intended purpose and the efficacy of the MAPP program, and articulates Dr. Barker's idea that MAPP was developed as a last resort and as an alternative to traditional and punitive measures.

[953] Dr. Tate and Dr. Maier testified that there was a security rule prohibiting passing items to visitors, ostensibly to prevent the dissemination of escape plans. However, the notion that a patient's mother would be involved in what would effectively be a prison break seems somewhat implausible. Rather, it is evident that the Doctors and Oak Ridge staff were anxious not to have a full, patient-written description of the oppressive MAPP conditions divulged to family and the public.

[954] Mr. McMann testified in his examination-in-chief that he only agreed to the DDT and Capsule programs in order to demonstrate his cooperation and to avoid being sent to MAPP. The Agreed Statement of Facts, Bedside Nursing Notes, and Clinical Records document that he was in the Capsule on the following 4 occasions:

> January 5, 1976, for a single day for having an altercation with another patient.
>
> Multiple days in the first 2 weeks of March 1976, after signing a standard Capsule Therapy Contract dated February 26, 1976 that provided that the duration of the treatment would be at the discretion of staff, he could not communicate with anyone outside the Capsule, he would receive a liquid diet, protective cuffs could be used as necessary, he would not have music or showers, and that he could be clothed.
>
> May 31, 1977 - June 7, 1977, after signing a standard Capsule Therapy Contract dated May 27, 1977. He also wrote a letter requesting to go in with a number of other patients that he wanted to get to know better. In an Incident Report dated June 7, 1977, Dr. Tate characterized this Capsule experience in very negative terms: 'Allen was punkish and negative, sarcastic and totally incorrigible throughout the group and used sarcasm as well as open verbal attacks against [omitted] whenever he tried to initiate any kind of positive and hopefully therapeutic interactions. Allen

> has spent his time in sexual foreplay fondling and kissing as well as two instances of sexually acting out with [an older] patient…' Dr. Tate testified that Mr. McMann was sent to MAPP as a result, but that the older patient was not as he had remained calm. Thereafter, Mr. McMann began writing letters of affection to the older patient.
>
> July 12, 1977, for a single day.

[955] The name of the older patient omitted from the above-mentioned Incident Report was Dave Lariviere, who has elsewhere in the trial been described as a seasoned 'hit man' for organized crime. In a Clinical Record dated November 7, 1977, Dr. Maier wrote that Mr. McMann and Mr. Lariviere need to be "irrevocably separated", and that "[f]or over a year these two patients have been pathologically involved with one another." In a reversal of the intuitive understanding that an older, hardened criminal might be manipulated by a teenager whose worse offense was automobile theft, Dr. Maier recorded: "It was felt that Dave has very complex feelings for Al, and that Al is completely using Dave for favors."

[956] There is little doubt that the Oak Ridge medical staff, including Dr. Maier, was aware of the fact that Mr. McMann and Mr. Lariviere had been coupled in the Capsule. In cross-examination, Dr. Tate confirmed that it was a known fact which was only taken seriously when it was the subject of complaints by others:

> Q. Right. Now do you remember an individual by the name of Allen McMann?
>
> A. Yes, I do.
>
> Q. And he too got to spend time in the Capsule?
>
> A. He did.
>
> Q. And he gave evidence about his time in the capsule. Your Honour, this is a transcription of the examination in-chief of Allen McMann dated May 6, 2019 at 3:05 p.m. and it begins, 'David Lariviere had been' – page 45 of the record – 'David Lariviere had been there a few years before me. I don't know how he knew where the blind spots were, but he wanted me to masturbate him.'
>
> A. Hm hmm.
>
> Q. 'So he goes into a position. We were all nude there, and this was either before or after my 17th birthday.'
>
> A. Hm hmm.
>
> Q. Question, 'You spent your 17th birthday in the Capsule?' 'Yeah.'
>
> A. Yeah, I remember.

Q. Do you remember this incident with...

A. Yeah, they were pulled out because of that, pulled out of the Capsule.

Q. Were you aware of the fact that David Lariviere was a very powerful crime figure in Montreal and had worked apparently for the Montreal crime organizations?

A. Wouldn't surprise me but that – you know, we had lots of people like that.

Q. Okay, and David Lariviere in particular was one of those powerful people that was seen as very potent within Oak Ridge, correct?

A. I don't think so. He would – he would be in the middle echelon. I think Allen McMann was capable of creating more waves than David Lariviere.

Q. Okay, well Al just turned 17 at the time.

A. Yeah.

Q. So he was a boy. David Lariviere had worked allegedly as a hit man for the mafia in Montreal, correct?

A. I don't – I don't know that. I just know that he killed a couple of people. I don't remember how he got there.

Q. I see, and so you became aware of this sexual activity in the Capsule?

A. Yeah.

[957] Mr. McMahon received a number of DDT treatments while at Oak Ridge. He testified that he was never offered LSD and the Clinical Records make no mention of any LSD treatments for Mr. McMann. The Special Treatment Records and Agreed Statement of Facts set out the following DDT sessions:

> Sodium Amytal-Ritalin on December 1, 1975, January 15 and 22, 1976 by order of Dr. Maier.
>
> Sodium Amytal treatment on January 28, 1976 by order of Dr. Maier. Dr. Maier reported that it helped Mr. McMann explored the impact his family had on him. On cross-examination Mr. McMann stated that there was "no exploration" but that he talked about how guilty he felt for his parents' separation.
>
> Alcohol on October 13, 1977.
>
> Alcohol-Ritalin on November 3, 1977. On his Treatment Report, Mr. McMann wrote that he 'got to see how guilt ridden I finally am and how defensive I am

> around my inner most sensitive thoughts and feelings.' It is not clear which doctor ordered this treatment.
>
> Dexamyl in November 1977, approved by Health and Welfare Canada on November 7, 1977 at the request of Dr. Boyd**.**

[958] The Clinical Record of November 13, 1977 states that Mr. McMann "has displayed more maturity than in earlier MAPP trips, and has made deliberate efforts to behave within the rules… If his performance continues as such, he would be eligible for transfer on November 20, 1977." The Agreed Statement of Facts and Discharge Summary indicate that Dr. Maier diagnosed Mr. McMann with "Personality Disorder with Anti-Social Features" on his release from Oak Ridge on January 26, 1978. Dr. Maier prescribed no medication for Mr. McMann on his discharge.

iii) Post-Oak Ridge experience

[959] Mr. McMann testified that upon release from Oak Ridge, he took the advice of some of the patients he had met there and sought unconventional employment:

> Q. Now, as you told His Honour a moment ago, that in addition to the sporadic conventional work that you and I talked about, you worked as a male prostitute on the streets...
>
> A. Yes.
>
> Q. ...for a number of years following your release from Penetang?
>
> A. Yes, it was suggested when I was in Penetang, by one of the patients, that I could employ myself in that, as being – to be employed. That – that's how crazy that place was. You should consider that I was in there, in that condition and that I thought it was a great idea, to be a prostitute, and I find it humiliating, but I have to be honest, that that's what I thought. That's how far-gone I was before I got out.

[960] In a Psychiatric Report done at the Clarke Institute dated October 11, 1984, it is relayed that in the years after leaving Oak Ridge Mr. McMann committed a litany of criminal offenses. He was convicted of breaking and entering and theft in 1978 and 1979, escaping prison in 1979, mischief in 1980 and 1984, and aggravated sexual assault in 1984 for which he served six years in Millhaven Penitentiary. The Psychiatric Report stresses his "maladaptive sexual attitudes" and "deviant sexual behaviour":

> He maintained that he was aware from an early age that his father was a sex offender. He described his father as also deriving sexual satisfaction from punishing him and he himself got to enjoy this as well and he liked to get punished. He maintained that he was led into homosexual activity when he went to training school as a child.

[961] Mr. McMann had a difficult time at Millhaven, and is reported to have been suicidal while incarcerated. In a Treatment Report dated May 30,1988, his treating psychiatrist wrote a detailed history of Mr. McMann's post-Oak Ridge psychiatric problems:

> His time at Penetang did little to improve his attitude or behaviour, although afterwards he remained free of convictions from 1978 to 1982. During this time period, he became a male prostitute and developed sexual problems (most importantly ejaculatory incompetence) which resulted in a number of difficulties in sexual relationships. His self-respect deteriorated and concomitantly his use of street drugs escalated. From 1982 to 1984 he continued his destructive behaviour…
>
> He was coerced into sexual interaction at the age of 5 by aunt… He remained a 'virgin' until his late teens, and again was involved with an older and unattractive woman who seduced him. The sexual contact was not satisfying and did not encourage him to continue sexual contact. Homosexual behaviour predominated during his early to mid-20s, but he met a woman in 1983 and his relationship with her continued during his incarceration. Subsequent to his incarceration, he told her to seek out relationships with others and she did. Although his attempted suicide using scissors occurred when that relationship ended, it was due to accumulated problems. The end of the relationship was the last straw in a series of depressive episodes.
>
> When Al McMann felt sufficiently depressed and did not have access to street drugs (alcohol, grass, amphetamines, valium) he considered suicide as a viable alternative to his lifestyle.

[962] Mr. McMann was released from Millhaven in 1990. He testified that following his release he again turned to street drugs, and became addicted to crack cocaine. He has since that time been sporadically employed in relatively menial jobs in factories and as a window cleaner, but for the most part has subsisted on welfare. His Criminal Record dated February 23, 2016 sets out that in 2008 he was convicted of uttering threats resulting in probation, and in 2011 he was convicted of assault for which he was given a suspended sentence.

[963] In his affidavit dated February 27, 2017, Mr. McMann says that he continues to experience symptoms of what he describes as "post-traumatic stress disorder". According to Mr. McMann, the passage of several decades has not eased the mental anguish that he attributes to his Oak Ridge years. He deposes, "As time passed, I continued to have debilitating feelings of anger and fear related to my experiences at Oakridge."

iv) Causation and harm

[964] In reviewing Mr. McMann's record in his Supplementary Report, Dr. Bradford stressed the young age, susceptibility to sexual invitation, and repetitive punishments that characterized Mr. McMann's time at Oak Ridge. He concludes that these experiences – encompassing the MAPP, DDT, and Capsule programs – led Mr. McMann to eventual substance abuse and increased

criminality. This includes an escalation of his offenses to sexual assault, which is a significant leap from the theft and property crimes in which he was previously engaged.

[965] It is Dr. Bradford's view that Mr. McMann was harmed at Oak Ridge, particularly because the STU programs were ill-suited for someone of his age, background, and personality traits:

> [H]e reports that he arrived at Oak Ridge at age 16 and was coerced or forced into participating in the programs. He states that he did not know that any of the 'treatments' were experimental…
>
> Given the nature of his experiences and his extreme age vulnerability, in my opinion, Mr. McMann was harmed by the programs. Mr. McMann was vulnerable going to Oak Ridge at 16 years of age. He has had a history of childhood abuse, including sexual abuse, which enhanced his vulnerability…
>
> Since his release, he has struggled with substance abuse. He was also found guilty of aggravated sexual assault in 1984, after his release from Oak Ridge, which is significant compared to his non-violent criminal history.

[966] The humiliation that Mr. McMann experienced at Oak Ridge is palpable until today, and manifested in his response to cross-examination questions. Counsel for the Crown reviewed for him a series of Oak Ridge patient newsletters, one of which criticized him for his behaviour as a member of the "Sanctions Committee" – a form of patient-populated tribunal in which murderers imposed sanctions on petty thieves, 16 year-olds sat in judgment of mature adults, and patients with different forms of personality disorders imposed rules and punishments on each other. One exchange at trial serves to highlight the lingering emotions of a teenager confronted with this difficult environment:

> Q. Seventh circle, I think you said yesterday, Seventh Circle is something you were familiar with…
> And the top of the page, Allen McMann again made the grade of pains in the neck, by getting another referral for eating snacks while on strip status on the 18th. This took place late last night while sitting in sanctions committee. What a place to be breaking a sanction.
> So, this newsletter is noting that you were on the sanctions committee at the time that you ate a snack when you weren't supposed to.
>
> A. You've got to be kidding. I was sexually assaulted and you're bringing up something about snacks?
>
> Q. I appreciate you don't like my questions but...
>
> A. No, their – their a – their obscene. I mean you're asking me about snacks.
>
> Q. I'm asking…

A. Okay.

Q. I'm asking you about sanctions committee. This document suggests you were on the sanctions committee. Do you disagree that you were on the sanctions committee?

A. Well, I guess I was.

Q. Okay, and do you remember sitting on the sanctions committee?

A. No.

Q. So, you don't remember anything that happened in the sanctions committee?

A. I guess I was eating snacks.

[967] Counsel for the Crown had, of course, every right to ask the question about snacks. She was attempting to establish that Mr. McMann was not punished gratuitously at Oak Ridge, but rather was punished because he had breached the strict rules.

[968] Mr. McMann had, of course, every right to bridle at the question about snacks. It evoked for him the extreme disproportion of the oppression imposed on him at Oak Ridge – and reminded him that his treatment as a misbehaving schoolboy who stole an automobile was placed by Dr. Maier and the Oak Ridge staff as being on par with that of Canada's most prolific serial killers and sexual predators.

[969] For Mr. McMann, the most extreme manifestation of this degrading treatment was the constantly revolving door of MAPP. Between the ages of 16 and 18, he was repeatedly subjected to this punitive regime for talking back to patients and staff, being sarcastic, being insincere and uncaring about the program he was in, being sexually adventurous, and for occasionally being caught with contraband – i.e. for acting a rambunctious 16 to 18-year old.

[970] The intense humiliation of MAPP was followed by the Capsule, where Mr. McMann was naked and in very close quarters with Mr. Lariviere, a prison-hardened, seasoned killer who was several decades older than him. Then, the fact that from this oppressive coupling in the Capsule came an emotional bond formed between Mr. McMann and Mr. Lariviere was itself considered a manifestation of pathology. In other words, Mr. McMann was "treated" by the institution with punishment for being insensitive, and then "treated" by the institution with punishment for being sensitive – a seemingly perfect storm for an emotional teenager.

[971] In examining his records for the Defendants, Dr. Bourget came to the opposite conclusion as Dr. Bradford. She testified that, as she saw it, Mr. McMann already had severe behaviour disorder prior to his arrival at Oak Ridge. She said that the records establish that he could not function in the institutional settings he was placed in during his teenage years, and demonstrated that he already suffered from depression, anxiety, and anti-social disorder. According to Dr. Bourget, Mr. McMann's life would not have been much different had he not been in Oak Ridge.

[972] I cannot agree with Dr. Bourget's opinion, and the evidence does not support it. What the evidentiary record establishes is that Oak Ridge caused Mr. McMann long-term harm by taking a vulnerable and emotionally confused teenager and creating an angry, substance-dependent, and sometimes violent adult. Oak Ridge did change the trajectory of Mr. McMann's life, and the change was distinctly for the worse. Teenagers can mature out of their sarcasm, disrespect for authority, and even their small-time crimes; but a teenager placed consistently in MAPP or stripped naked and placed in an enclosed capsule with killers several decades older are not going to mature in the same way. As Dr. Bradford observed about Mr. McMann, such a teenager will mature from an admittedly irresponsible youth to a violent offender.

[973] The record establishes that Oak Ridge also caused Mr. McMann sort-term harm. They caused him short-term harm by punishing him multiple times in the physically and mentally punishing MAPP despite there being no therapeutic value to that punishment; and by placing him in a precarious situation with hardened criminals in the Capsule. Mr. McMann expressed fright and emotional turmoil in response to these experiences, and these responses pained him in a way that constitutes actionable harm.

[974] In October 1975, in the midst of his first assessment at Oak Ridge, Mr. McMann wrote a letter to Dr. Maier expressing a desire to speak with him one-on-one about his condition. Dr. Maier never answered this letter, and never appears to have focused at all on Mr. McMann as an individual patient. In his testimony, Mr. McMann was asked about this letter and Dr. Maier's lack of response, and in the course of his answer described his relationship with the Doctor as follows:

> Q. So the letter indicates that Doctor Maier received and filed the letter. Did Doctor Maier ever come to speak with you after that?
>
> A. He would come on his rounds, either with Doctor Barker, other nurses, the guards, but he never mentioned that letter, ever, the whole time I was there. He never acknowledged it and no other guards, nurses, patients ever acknowledged that I had written that letter. And I don't think I – I brought it up with anybody.
>
> Q. So you never had a private meeting with Doctor Maier about your treatment?
>
> A. No… When I first met him, when he came down the hallway, the first thing that he asked me the first time I met him, the other staff and himself came into the room and I was sitting on the bed. He sat down to the left of me. I have a habit of picking at my fingers, dry skin, and the first question he asked me was, 'When you arrived here one of the guards, a Mr. Nankoveldt (ph) told me...' and this is Maier speaking, Nankoveldt had told Maier that I was a shit disturber. Those are the words that Maier said to me. And Doctor Maier asked me, 'Do you know why Mr. Nankoveldt would say that?' And I said, no.
>
> Q. Did Doctor Barker ever come to see you?

> A. He – he'd be there on the rounds, but I never spoke to him. They were both dressed quite differently. One was in a suit, the other one was dressed quite liberally.

[975] Mr. McMann's experience of both Dr. Maier and Dr. Barker was of being one more undifferentiated cog in the large STU wheel. Although Dr. Maier was much more instrumentally involved in his MAPP, Capsule, and other therapies, Dr. Barker was Dr. Maier's senior and supervisor, and, much like Dr. Maier, entirely ignored his medical responsibilities toward Mr. McMann. Neither Doctor related to Mr. McMann properly as a patient under their actual care, and both treated him as part of an institution which they were attending to for purposes other than the individual treatment of Mr. McMann. Their treatment of him caused harm to his sense of emotional well-being and personal dignity.

[976] Dr. Maier was directly involved in Mr. McMann's treatments during his time in the STU. Dr. Maier in an immediate sense, and Drs. Barker and Boyd in a supervisory sense, together with the Crown, caused Mr. McMann the short and long-term harm he has suffered.

w) Leeford Miller

[977] In 1977, at the age of 23, Leeford Miller was charged with first degree murder and was admitted to Oak Ridge. Despite his recollection to the contrary, the Clinical Records do not record Mr. Miller ever participating in the DDT program, ever receiving LSD at Oak Ridge, and ever being in the Capsule. However, the Clinical Records do establish that he spent time in the Moto-Pro, or mini-MAPP. Mr. Miller was repatriated to his native Jamaica in 2003. He testified and was cross-examined at trial by video link.

i) Pre-Oak Ridge and index offence

[978] Mr. Miller was born in Jamaica in 1954. His parents relocated to England without him shortly after his birth; he testified that for the first 10 years of his life he was raised by an abusive and neglectful aunt. He joined his parents in the U.K. when he was 10 years old. In cross-examination, he indicated that his parents were very strict disciplinarians, and that he has suffered depression since childhood.

[979] At the age 15 he moved with his family to Canada. He completed grade 9, but then moved out of his parents' home and was unable to complete grade 10 while trying to support himself. He stated in his testimony that around that time he had begun drinking alcohol on a regular basis and using LSD, MDA, mescaline, marijuana, and heroin. He also indicated that he had started dealing relatively small amounts of street drugs.

[980] In his testimony at trial, Mr. Miller described that also at this time he suffered from anxiety, and that he had the feeling that police were following him and causing him to lose jobs. As a result of these depressive and anxious feelings, he tried to commit suicide at the age of 20. In his affidavit, he deposed that in 1976 he voluntarily admitted himself to the Royal Ottawa Hospital, where he was diagnosed as a paranoid schizophrenic.

[981] In a Penetanguishene Case History dated September 12, 1977, it is documented that Mr. Miller was first committed to Oak Ridge on a Warrant of Remand at the age of 23, having been arrested and charged with first degree murder in the death of his girlfriend's cousin. He testified that he had gone to her house to speak with her after their relationship ended, bringing with him a loaded firearm. The cousin came to the door, and Mr. Miller shot him and took two children hostage before eventually surrendering himself to the police.

[982] Mr. Miller was committed to Oak Ridge for assessment on August 4, 1977. The Psychological Examination Report dated August 18, 1977 written by Dr. Barker states that Mr. Miller continued to suffer from anxiety and depression:

> A review of the personality test data reveals that he is a very depressed individual who experiences a very high level of anxiety. He is very suspicious of others and appears to be quite confused to the point of having fixed false beliefs. He reports experiencing auditory hallucinations and has difficulty concentrating. Also noted were tendencies suggesting obsessive features in his personality as well as considerable rebelliousness.

[983] Dr. Barker diagnosed Mr. Miller with schizophrenia and depression and recommended that he return to Oak Ridge for further assessment. Dr. Barker appears to have remained engaged with Mr. Miller's case; the record contains a handwritten letter from Mr. Miller to Dr. Barker dated September 2, 1977, in which Mr. Miller expresses the fears that he constantly suffers and that are a product of his mental disorder.

[984] Mr. Miller was re-committed to Oak Ridge for another 60 days on September 27, 1977, at which time he was treated with anti-psychotic medication as well as Stelazine and Cogentin to treat schizophrenia. In cross-examination, Mr. Miller agreed that he was not given any DDT-type drugs during these short-term admissions, and was not in the Capsule or MAPP. In his Clinical Record dated November 27, 1977, at the end of this 60-day assessment, Dr. Barker wrote that Mr. Miller was "spaced out" and occasionally suicidal.

[985] On June 6, 1978, Mr. Miller was re-admitted to Oak Ridge on a Lieutenant Governor's Warrant after being found not guilty by reason of insanity for the murder of his girlfriend's cousin. He remained at Oak Ridge for 5 years. A Psychologist's Report dated October 26, 1983 indicates that on October 13, 1983 he was discharged from Penetanguishene and transferred to Whitby Psychiatric Hospital.

ii) Experience in the STU

[986] The Bedside Nursing Notes indicate that Mr. Miller was placed in Moto-Pro on two occasions, both times for somewhere over 1 month. The reasons for the transfer were not to curb aggressive or violent behaviour, but rather to punish a lack of enthusiasm for the STU program:

> July 19 to August 24, 1978, after having 'shown no self-motivation, doesn't get into any depth about his crime. Does not take his situation seriously. Thinks it's all a joke. Has been given numerous opportunities to improve his behaviour and

> discuss his problems.' On July 2, 1978, the Bedside Nursing Notes record Mr. Miller as agitated and 'breaking rules and policies in the remotivation program'. On August 1, 1978, he was admonished for 'no participation, lack of interest.' On August 2, 1978, the Notes record that he was 'Very vague, answers all questions with a yes or no.'
>
> October 3, 1978 to November 21, 1978, for being 'unmotivated, evasive and unreceptive to feedback'. On October 16, 1978, the Bedside Nursing Notes record that Mr. Miller 'Could do a lot better in the remotivation program, but chooses not to. Shows no interest.' On November 10, 1978, the Notes observe, 'Seems very nervous and defensive and is not feeding any of this back to his group.' On November 14, 1978, the Notes provide that he 'Lost a day today, displayed a placative attitude, showed little concern to help himself or others.'

[987] The mini-MAPP only seems to have increased Mr. Miller's anxiety and did not particularly motivate him. The Bedside Nursing Notes of December 6, 1978, several weeks after his release from MotoPro, indicate that he "appears a little anxious and unsure of himself. Sleeping on risk status". These symptoms continued for some time after his MAPP experience. For example, 3 months later, on March 23, 1979, the Bedside Nursing Notes record: "Patient becomes paranoid, thought Ward was out to get him, placed on double restraints. Patient sleeping on risk status."

[988] Indeed, Mr. Miller testified at trial that he was humiliated and tormented by the MAPP experience. Unlike with respect to some other matters, Mr. Miller's memory of mini-MAPP was vivid and detailed:

> Q. And where were you sitting while you were in the MAPP room?
>
> A. You're on a – a concrete floor. It's a terrazzo – a terrazzo floor. Well, one was in the shower room, and that's terrazzo floor.
>
> Q. And were you ever restrained or cuffed while you were sitting in this floor?
>
> A. Yes.
>
> Q. And describe to His Honour what that was like?
>
> A. Well, you're – you're tied up on a – I mean, you're cuffed up on a – on the floor, and you've got no clothing, expect for this gown. It was very, very humiliating, and – and just – you're just tormented. You're tormented, you're humiliated, outside of everything. It's like the world threw you away some place. It's like you're just hiding away in the middle of nowhere.
>
> Q. And how were you cuffed?
>
> A. Ah, sometimes they cuff just the feet and your – your hands.
>
> Q. You can show His Honour. You can put your hands up.

> A. Because your hands are cuffed together and your feet are cuffed together. Sometimes your hands are cuffed, and then cuffed to your –- and then cuffed to your waist. So, both hands are cuffed to your waist, and your feet are tied together too.
>
> Q. And were there rules for the MAP program?
>
> A. There were rules. Ah, I can't recall the rules now but there were rules…
>
> Q. Okay. And what does that mean, you don't gain your days? Can you explain to His Honour what you meant.
>
> A. When you – you gain a day by doing what you're told and participating well in the group, and having a good attitude and you – you will gain a day. If you don't participate to the teacher's satisfaction, you don't get them days, and you could – you could stay there a long, long, long time.

[989] Dr. Barker made sporadic notations in Mr. Miller's Clinical Records, indicating that he was overseeing the medications. Mr. Miller testified that he was given Stelazine, which caused his tongue to swell, and Cogentin, which was given to counteract this effect. He contends in his affidavit that these drugs were part of the DDT program and that they caused severe panic attacks. However, Stelazine and Cogentin were not, in fact, DDT drugs; as counsel for the Doctors point out, they were standard anti-psychotic medications of the day.

[990] The Medication and Treatment Records for Mr. Miller do not contain any DDT drugs. These Records also indicate that he stopped receiving Stelazine and Cogentin on or about July 12, 1979.

[991] In mid-1981, Dr. O'Reilly took over responsibility for Mr. Miller's medication and progress. On July 6, 1981, she recorded in his Clinical Record that "this patient impresses as a personality disorder with psychopathic traits. He is showing little change." She likewise reported no change in December 1981, and on February 25, 1982 recorded in his Clinical Record that he was confined and on "indefinite strip status" for manipulating fellow patients.

[992] Dr. O'Reilly likewise noted on June 28, 1982 that Mr. Miller was again on strip status for refusing to work. On October 21, 1982, Dr. O'Reilly observed in the Clinical Record that, "It was the opinion of the treatment team that this patient should be deported to Jamaica. He shows no remorse toward his crime whatsoever."

iii) Post-Oak Ridge experience

[993] After being discharged from Oak Ridge, Mr. Miller was transferred a number of times between Whitby Psychiatric Hospital, North Bay Psychiatric Hospital, and Kingston Psychiatric Hospital. During this time, Mr. Miller was volatile and had a difficult time getting along. He

testified about a number of incidents that ultimately resulted in his being sent back to Oak Ridge on May 14, 1984 with a diagnosis of personality disorder.

> Q. And you were involved in some violent incidents at some of those institutions, correct?
>
> A. Yes.
>
> Q. For example, at – when you were at Whitby, in 1983, you attacked a patient and bit his nose?
>
> A. Well, that's on the record, but it's actually the patient attacked me and he was bigger than I am, and I had to bite him to – I had to bite him, that's the only thing I could do.
>
> Q. So, you agree that the biting happened, but it was in self-defence, in your view?
>
> MR. JERVIS: Was it in self-defence?
>
> A. Yes.
>
> Q. Okay. You also threatened a female patient and a female nurse with violence while you were at Whitby?
>
> A. I just wanted her to leave my room, because I was just going in my bed, so I asked her to leave, and she wouldn't leave. I cursed her out, and she left eventually, when I was getting upset. I didn't actually say any threatening things. I just said, Don't get in my room. There's nothing to explain to her.

[994] In July of 1989, he was charged with assault with a weapon. He was eventually convicted of assault and served 21 months in Quinte Detention Centre and Millbrook. He returned to the Kingston Psychiatric Hospital on February 8, 1992 and deposed that around this time he got married. on June 24, 1992, after another assault charge, he was returned to Oak Ridge yet again. His Discharge Summary from Oak Ridge dated April 13, 2004 sets out his diagnosis as: "Personality Disorder, Antisocial and Narcissistic Features".

[995] After his 2004 discharge from Oak Ridge, Mr. Miller was deported to Jamaica. He currently lives in a family property he inherited and makes efforts to operate as a guest house. As he described it at trial, however, his Oak Ridge reputation precedes him and he has a difficult time attracting guests:

> Q. Now, sir, you left Oak Ridge, and you now live in Jamaica by yourself. Can you explain to His Honour, why do you live by yourself?
>
> A. Well, I find that people – I don't once you have been in a program like that, you're institutionalized in a psychiatric institution, people, you know, look at you different, and, ah, they pass gossip about you around – around to other people. So,

> you start getting pressure from people. Like, you just have to isolate yourself because you can't get along with them, and like, there's nothing you can do to get along with them. You just have to go along with whatever they think of you.

iv) Causation and harm

[996] Dr. Booth examined Mr. Miller's records and testified that no harm was done to Mr. Miller at Oak Ridge:

> Miller's primary problem appears to be of an unstable personality disorder. This would have not been caused or aggravated by the experiences in Oak Ridge... On the whole, Mr. Miller's psychiatric presentation and difficulties can be explained entirely outside of the Oak Ridge program exposure.

[997] In coming to the conclusion that there is no evidence of psychological harm in Mr. Miller's file, Dr. Booth observes that, in fact, Mr. Miller wrote several letters of complaint about his treatment in Oak Ridge over the years. He notes that these had to do with allegations of racial discrimination and various specific incidents of mistreatment by staff at Oak Ridge, but made no mention of MotoPro or MAPP. According to Dr. Booth, this demonstrates that Mr. Miller was obviously capable of voicing his complaints, and that the fact that he did not do so with respect to his mini-MAPP must say something about these complaints.

[998] That said, Dr. Booth conceded in his cross-examination that Mr. Miller's evidence was that he was constantly terrified that they would put him back in MAPP (or MotoPro). He agreed that if this is found to be believable, this fear could be a symptom of psychological stress. Likewise, Dr. Booth acknowledged that Mr. Miller reports continuing nightmares since his time at Oak Ridge. Again, Dr. Booth testified that if found credible, this could possibly be a sign of ongoing psychological trauma resulting from Oak Ridge.

[999] Dr. Bradford, who examined Mr. Miller's file on behalf of the Plaintiffs, notes in his Supplementary Report that the STU program to which he was exposed was therapeutically useless and frightening to a person with his mental disorder:

> Mr. Miller's complaint from the time of his initial admission to Oak Ridge was that his diagnosis of Schizophrenia was ignored… [and that] the MAPP program was…an 'extended detention' [with] no therapist in the room, no communication with anybody from outside, and…run by fellow patients called MAPP 'teachers'.

[1000] Furthermore, in terms of whether he voiced any contemporaneous complaints about this program, Dr. Bradford observes that Mr. Miller cannot be faulted for not knowing what to complain about:

> He also describes that he did not receive treatment for his principal psychiatric condition which was Schizophrenia and he 'was not in a position to appreciate the duties and responsibilities of the doctors and other staff members in the hospital owed to me.'

[1001] Dr. Bradford then concludes with the opinion that, “Mr. Miller had a traumatic childhood and was therefore vulnerable to the effects of trauma subsequently in his life. This vulnerability was made worse because of his exposure to the MAP program.”

[1002] The evidence in the record supports Dr. Bradford’s view and does not support Dr. Booth’s view. The fact that Mr. Miller did not express a specific complaint about MAPP or Moto-Pro in the same way that he did about mistreatment by staff at Oak Ridge is not indicative of a lack of harm being suffered. There is a significant difference between complaining about discrimination or mistreatment by staff and complaining about an authorized program which has been explained as being therapeutic. A patient suffering from schizophrenia will doubtless understand the wrongfulness of a beating by a guard or an undeserved punishment; that same patient is unlikely to understand the wrongfulness of a therapy designed and prescribed by a psychiatrist entrusted with that patient’s medical care. Over the years during and following Oak Ridge, Mr. Miller was in a position to comprehend and complain about some wrongful treatment, but was not in a position to comprehend and complain about all of the wrongful treatment he encountered at Oak Ridge.

[1003] Mr. Miller’s particular vulnerabilities never appear to have been taken into account, even though they were recognized and diagnosed by Dr. Barker at the outset of his time at Oak Ridge. Dr. Barker continued for some time to be seized with his case, until it was ultimately taken over by Dr. O’Reilly. Subjecting Mr. Miller to the rigours of MAPP, in the company of aggressive ‘patient-teachers’, may have conformed with Dr. Barker’s theories of pairing submissive and anxiety-ridden schizophrenics with dominant and self-confident psychopaths, but it was harmful to Mr. Miller.

[1004] Oak Ridge generally, and specifically Moto-Pro/mini-MAPP, did not motivate Mr. Miller; it harmed him. Oak Ridge as an institution and Dr. Barker as the responsible psychiatrist inflicted short-term harm on Mr. Miller in the form of increasing the fear and anxiety felt by a vulnerable patient. They also inflicted long-term harm on Mr. Miller in the form of ongoing anxiety, nightmares, and aggression and anger management problems that developed in later years. Whether or not the overall trajectory of Mr. Miller’s life would have been different without the Oak Ridge experience, Mr. Miller would today be in less pain had he not been a patient in the STU and subjected to MAPP, or MotoPro.

x) James Motherall

[1005] James Motherall died on May 26, 2018 at the age of 68. He had been living in Winnipeg, Manitoba at the time of his death. His family friend and estate representative, Jane Marion, testified on his behalf at trial.

[1006] Mr. Motherall had a troubled childhood and was diagnosed with a pathological personality disorder at the age of 20. At the age of 23 he was admitted to Oak Ridge from Kingston Penitentiary for treatment, where he was serving a custodial sentence for an assault causing bodily harm in which he attacked a 15-year-old girl with a tire iron in an apparent fit of anger.

i) Pre-Oak Ridge and index offence

[1007] Mr. Motherall deposed in his affidavit dated November 15, 2016 that he was physically and verbally abused by his adoptive mother who he felt did not love him or accept him. He also deposed hat he managed to complete school up to grade 10, and that he was sexually assaulted by his hockey coach when he was 16 to 17-years old.

[1008] In his examination for discovery, Mr. Motherall stated that since the time he was 8 years old he was unable to trust people, and that he experienced feelings of "intense rage" as a result of the abuse he suffered by his mother and, later, his coach. In response to a discovery question about his employment history prior to Oak Ridge, he made a point of stressing that as a young person he was consumed with pent-up anger: "[Y]ou don't walk away from the kind of ... childhood that I did have thinking that the world is a beautiful place full of rainbows and butterflies. It's not, and I was angry."

[1009] In a Penetanguishene Case History dated August 22, 1972, it is indicated that Mr. Motherall described assaulting women on 3 different occasions – December 16, 1967, October 22, 1968, and February 2, 1970 – which either did not result in a charge or resulted in a trial without him being convicted. On each occasion, Mr. Motherall described giving in to what seemed to be an uncontrollable impulse to place his hands around the throats of his victims and try to choke them.

[1010] In early 1970, Mr. Motherall confessed to a teacher that he had choked a neighbour unconscious, following which he voluntarily admitted himself to the psychiatric ward of Brantford General Hospital. He was assessed there from February 20, 1970 to March 16, 1970. The psychiatrist who did the assessment wrote in the Brantford Discharge Note dated March 16, 1970 that Mr. Motherall was an extremely dangerous person who had carried out an "apparently planned and deliberate assault which could have resulted in this woman's death." He was diagnosed as having a pathological personality disorder.

[1011] Mr. Motherall was committed on an involuntary basis to the Hamilton Psychiatric Hospital for another assessment from March 16, 1970 to May 21, 1970. A psychiatric Consultation Report dated June 9, 1971 reports that Mr. Motherall "describes a very pathological family constellation… He is considered to have a personality disorder with poor impulse control and may be a candidate for a security setting such as offered by Penetang Mental Health Centre."

[1012] The Penetanguishene Case History goes on to relate that shortly after his discharge from the Hamilton Psychiatric Hospital, on December 9, 1970, Mr. Motherall assaulted a 50-year old woman on December 9, 1970 and then, on February 20, 1971, an 11-year old girl. He apparently was not criminally charged on either occasion. Four months after this latter incident, on June 17, 1971, he was charged and convicted of assault with intent to commit an indecent assault after having hid in the back seat of a woman's car and attempted to choke her from behind. The court sentenced him to 12 months at Guelph Correctional Institute, plus 2 years of probation. The Case History records that he was diagnosed at the time with a severe personality disorder.

[1013] In his examination for discovery, Mr. Motherall related that on July 7, 1972, he was convicted and sentenced to 5 years for assault causing bodily harm after striking a 15-year-old girl with a tire iron. Several weeks later, on July 28, 1972, he was committed to Oak Ridge pursuant to a Warrant of Remand for a 30-day assessment. The assessment was conducted by Dr. Maier;

the Clinical Record from this first admission indicates that Mr. Motherall did not receive any treatment during these 30 days. After conducting a mental status examination on August 22, 1972, Dr. Maier wrote that he would diagnose Mr. Motherall with antisocial personality.

[1014] The Discharge Note dated August 26, 1972 indicates that Mr. Motherall was released to the custody of the Brantford City Police. Then, on February 20, 1973, he was again tried and convicted on a charge of assault causing bodily harm. Justice Moorhouse, the trial judge, recommended that he be treated. A letter in the record dated February 28, 1973 written by the trial judge recommends that Mr. Motherall be sent to Penetanguishene as advised in the trial testimony of several psychiatrists, one of whom was Dr. Maier. The judge specifically noted that Mr. Motherall was dangerous and was likely to continue assaulting women.

[1015] On September 19, 1973, a physician at Kingston Penitentiary submitted an application under the *Mental Health Act, 1967* for Mr. Motherall's involuntary committal to Oak Ridge. The next day, Mr. Motherall was admitted to Oak Ridge for the second time, and remained there for nearly 3 years, until August 12, 1976. In his Admission Record dated September 20, 1973, Dr. Maier diagnosed him as having anti-social personality disorder, with "aggressive and assaultive features towards pubertal girls."

ii) Experience in the STU

[1016] Mr. Motherall's Penetanguishene Case History, written by a social worker on his admission to Oak Ridge, records that he had identified the source of his impulsive and violent actions: "He stated that he now understands that whenever he was assaulting a woman he was trying to hurt his mother; however, he could not lash out at her physically and therefore took out his anger on other people." Further in the Case History, the author reports the results of interviews with Mr. Motherall's close family members, who provide insight into their history of dealings with him. In a final comment, the author of the Case History observes: "Patient was also said to be a chronic liar, often without motive."

[1017] The Capsule Therapy Contracts and Bedside Nursing Notes for Mr. Motherall disclose that he was in the Capsule on the following occasions:

> November 5, 1973, signed a Capsule Therapy Contract and was in an 'ICU room' – for which the Capsule was on occasion used – on November 8, 1973, where he received an Amytal-Ritalin treatment.
>
> May 1, 1974 signed a Capsule Therapy Contract and was in the Capsule as a patient-observer on May 27, 1974.
>
> February 7-9, 1975 for an LSD treatment administered by Dr. Maier. The Bedside Nursing Notes of February 8, 1975 note that Mr. Motherall was upset and pounding the mattress with his fists, but 'settled down' after some time.
>
> July 12-16, 1975 for an LSD treatment administered by Dr. Maier. The Bedside Nursing Notes report that Mr. Motherall had no complaints about this session.

> May 11, 1976 for approximately 2 hours. A Bedside Nursing Note indicates that Mr. Motherall was kept busy in the Capsule 'organizing materials for the LSD program'.

[1018] On examination for discovery, Mr. Motherall had only dim memories of the Capsule sessions, and could only recall one such session where he was nude with seven other men. In his affidavit, he described the Capsule as making the patients defensive. He embellished on this thought in examination for discovery, where he made it clear that he was unimpressed with the intelligence of the theory behind the entire Capsule program.

> Q. And what was your understanding of the purpose of the Capsule?
>
> A. Well, my understanding of it was that it was supposed to get us to go inside of ourselves to our deepest, darkest places and act that out, which is really kind of foolish and dangerous, when you've got seven guys who all have demonstrated violence, asking them to go to their darkest place locked in a room together. Not smart.
>
> And I don't think a lot of guys did it. I think, if anything, defences got sharper, defences got harder. They – you know, we got better at being defensive, not worse.

[1019] The Clinical Records and Special Treatment Records disclose that Mr. Motherall received a long list of DDT treatments:

> March 19, 1974-April 10, 1974, Scopolamine 3 times daily, authorized by Dr. Maier. Also doses of 15 mg of Dexedrine during this time.
>
> May 29, 1974, 15 mg of Dexedrine on May 29, 1974, authorized by Dr. Maier.
>
> June 17, 1974, Sodium Amytal (500 mg) administered intravenously with Ritalin (40 mg), ordered by Dr. Maier.
>
> September 12, 1974-October 28, 1974, Dexamyl-Tofranil for 7 weeks, ordered by Drs. Barker and Maier.
>
> January 28, 1975, Amytal-Ritalin treatment, ordered by Dr. Maier.
>
> February 7, 1975, LSD (300 mg) intravenously and Dexedrine (15 mg), authorized by Dr. Maier in the Capsule.
>
> July 12 and 14, 1975, Dexedrine, authorized by Dr. Maier.
>
> July 14, 1975, LSD (300 mg) administered intravenously by Dr. Maier in the Capsule.
>
> August 1, 1975, Amytal-Ritalin, administered intravenously by Dr. Maier.

September 7, 1975, Dexedrine, authorized by Dr. Maier.

[1020] According to the relevant Clinical Records, Mr. Motherall spent 8 weeks reading literature about LSD, and had sessions with that drug in the Capsule. There are letters in the file from Mr. Motherall to Dr. Maier requesting that he participate in the LSD program, and, as indicated above, he signed Capsule contracts for his sessions in that program. In discovery, he testified that these consensual actions were in one sense informed, but in another sense were induced out of him or coerced by his situation.

> Q. But you would have read this document and signed it?
>
> A. Yeah, I would have known – before I went in there I would have known what was expected of me, but that would not matter. If they had asked me to go up on a roof and jump off down into the yard and it would get me out of there a day sooner I would have done it and I would have signed a document saying I was willing to do it.

[1021] The Oak Ridge records show that Mr. Motherall experienced significant stress-induced mood swings during and in the aftermath of the LSD treatments. This can be illustrated on a single page of Mr. Motherall's Bedside Nursing Notes that records the aftermath of an LSD/Dexadrine treatment in the Capsule from July 12-14, 1975. On July 16, 1975, the Notes report that he was "Removed from Capsule at 7:45. Assessed by group to full status… Doing well since coming out of Capsule." Six days later, on July 22, 1975, he was recorded as having had a deterioration in mood: "Appears to be resentful toward staff and form of therapy offered here… some arguing with dyad partner". Six days after that, on July 28, 1975, the Notes relate that he was "[a]sking staff if he is getting sick because he is getting a lot of mood swings, depression."

[1022] On the next page of Bedside Nursing Notes, one learns that four days after slipping into depression, Dr. Maier had Mr. Motherall back in DDT. On August 1, 1975, the Notes state: "Rec'd Amytol Ritalin drug treatment by Dr. Maier and Alexander R.N… Headache, given aspirin…placed in I.C.U. with observers". He appears to come out of the crisis the following day, although the stress did not disappear. The Notes of August 2, 1975 relate: "Assessed to full status after I.C.U. Severe headache this morning."

[1023] The other DDT treatments followed a similar course of emotionally painful ups and downs, not just in the aftermath of the treatments but during the course of some of the more extended treatments. For example, the Clinical Record of Mr. Motherall's Dexamyl-Tofranil treatment of September 1974 states:

> On September 10th he commenced a Dexamyl Tofranil drug regime for a period of seven weeks. He has been more talkative since being on this regime. On two occasions over the past month he has become emotional during diads *[sic]* when speaking of how he had attacked an eleven year old girl. On one of these occasions on September 19, 1974 he required a single supportive cuff after an assessment was called on him when he was crying and stated he was totally confused. He stated he was all tied up in knots and did not understand what he was feeling. After a few

> hours he was able to express himself in groups, was calm and more rational. Stated that if these feelings re-occurred he would be able to go to his group and speak with them. James was interviewed by Dr. Maier on September 20th and at that time was re-certified.

[1024] The Clinical Records report that on August 10, 1976, medical and professional staff discussed Mr. Motherall's case, and came to the conclusion that he could be discharged with mandatory supervision. He as then discharged the following week, on August 26, 1976, on condition that he live with a family member and report to a parole officer.

[1025] Shortly after his discharge, Mr. Motherall appears to have reverted to anti-social behaviour. Within 3 months, he was charged with possession of dangerous weapons and was readmitted to Oak Ridge on a Warrant of Remand for a 30-day assessment. On November 18, 1976, while still being assessed, he was found not guilty of those charges. Dr. Barker discharged him from Oak Ridge on December 5, 1976, recording in his Discharge Summary a diagnosis of "Pathological Personality, Antisocial Type".

iii) Post-Oak Ridge experience

[1026] In June 1977, Mr. Motherall was sentenced to 2 years less a day and 2 years' probation for the seizure and choking of his female neighbour. After serving the custodial portion of this sentence, in November 1979 he was again charged and convicted of assault causing bodily harm to a woman and sentenced to 6 years. Then, when that sentence came to an end, in November 1985 he was convicted of attempted murder of a female customer at the store where he worked, having grabbed her and choked her with intent to kill until a police officer walked in and intervened. He was sentenced to 18 years in prison, and served his sentence at Stony Mountain Institution. He was released from Stony Montain in 2003. With the exception of a breach of recognizance in 2004, Mr. Motherall did not offend again.

[1027] In his examination for discovery, Mr. Motherall testified that the treatment he finally received at Stony Mountain allowed him to rehabilitate himself and improve his life. He described his emotional well-being at that time, roughly 10 years after his release, as "the best that it had ever been", explaining that he had learned to master his own emotional cycles and to turn it around when it was headed toward feelings of depression and anger.

iv) Causation and harm

[1028] In Dr. Booth's Report of November 21, 2019, he was dismissive of any negative effect the DDT drugs might have had on Mr. Motherall. Specifically, he indicated:

> While the medications administered can cause short-term side-effects, there is limited evidence to suggest long-term changes in brain function or in worsening psychiatric conditions from limited exposure…

> When given opportunities to complain about the treatment components of the program in the current case, Mr. Motherall instead elected to advocate with a lawyer and other resources for visits from a girlfriend.
>
> On the whole, Mr. Motherall's psychiatric presentation and difficulties can be explained entirely outside of the Oak Ridge program exposure.

[1029] With respect, Dr. Booth's observation that it is significant that Mr. Motherall complained about seeing his girlfriend rather than having been given dangerous drugs reflects a misapprehension of Mr. Motherall's mindset and, frankly, of human nature. The LSD was, in Mr. Motherall's understandable view, medication prescribed by his doctor for therapeutic use, regardless of how destressing the experience may have been. The security staff not allowing his girlfriend to visit could not be taken as a therapeutic measure, but rather appears to be unfair administrative conduct.

[1030] For Mr. Motherall to complain about the obvious annoyance of the latter problem does not negate the more profound harm done by the former. Exclusion of a friendly visitor by guards in a custodial institution prompts an obvious and immediate complaint that the guards are acting beyond their authority; prescription of dangerous drugs by a doctor is a matter that takes time to comprehend and prompts the patient to assume that the doctor is acting within his authority.

[1031] As for Dr. Booth's characterization of DDT drugs as having the short-term "side effects", in fact those supposed side effects – breaking down a person's defenses and removing all mental and emotional safeguards – are the very stress-inducing goals of the program. Dr. Barker termed this approach "Defense Disrupting Therapy", in acknowledgment of the extreme insecurity that would thereby be induced.

[1032] Much as it is obvious that the DDT treatments were designed to cause a form of mental breakdown, Dr. Booth was reluctant to concede that this might have happened to Mr. Motherall. Indeed, he justified the DDT approach by comparing it to the kind of stress that hardened drug addicts put themselves through, as if the breakdown caused by these drugs is a normalized process. The following exchange illustrates this perspective on Mr. Motherall's DDT experiences:

> Q. Okay. And what we know from the record – and just ask you if you understand this – that Mr. Motherall was given a heavy amount of drugs in the DDT program – scopolamine, Dexedrine, LSD, Ritalin, Sodium Amytal, Dexamyl-Tofranil. Is that consistent with your understanding?
>
> A. Yes.
>
> Q. And did you understand that when he was given a – he was given a four-week regime of Scopolamine in March and April '74, which involved three to four injections daily?
>
> A. I'm aware of that. I thought it was three weeks, but if it's four weeks, I could accept that.

Q. And do you recall that he was also given Dexedrine for five days of each of those weeks to keep him awake 24/7?

A. I – I saw a medication administration records. Most of those, from my recollection, were from two days. But it could have been for up to five days.

Q. So, he was given medication in order to keep him awake while he was on Scopolamine treatment?

A. Yes. That would be part of the DDT approach, I believe.

Q. Right. And this sleep deprivation, he says, induced significant, serious hallucinations. You understand that that's part of the record?

A. I understand, yes.

Q. And that's consistent with your understanding of the impact of putting somebody on Scopolamine and then keeping them awake for days or up to a week?

A. Yes, that could occur.

Q. And that would have a significant – cause significant stress to an individual – to be kept awake for a week with drugs, put on Scopolamine, and having significant hallucinations. Correct?

A. It has that potential, yes.

Q. Do you recall, in his discovery transcript, he saw toilet paper as rats chasing him, and was talking to a Coca-Cola can, and it was talking to him – this type of extreme hallucination?

A. That's what he described, yes.

Q. Okay. That's a sign of significant stress, isn't it? For any human being?

A. Again, he did describe distress from it in the transcripts. Those experiences have – could have all – various – that could cause various stress or not for individuals...

Q. ...do you agree with me that keeping any human being awake for up to a week at a time, pumping them full of three or four injections of Scopolamine while they're kept awake, would cause significant stress to any human being...

A. Uh...

> Q. ...who was subjected to that type of treatment?
>
> A. No, I wouldn't agree with that.
>
> Q. Okay. So, for some people, it's just perfectly fine?
>
> A. A number of my drug addicts actually go on drug binges with cocaine and crystal meth, and they keep themselves awake for weeks at a time.
>
> Q. So, that's what their psychiatrist - psychiatrists do to them? They give them crystal meth and cocaine and keep them awake for weeks at a time?
>
> A. No, sorry, you had asked keeping – somebody staying awake for five days in a row, that would cause distress for everyone. And – and it wouldn't. It would cause – it's a potential stressor for individuals.

[1033] In addition, Dr. Booth indicated in his Report that Mr. Motherall's later in life depression was entirely new, and that it must therefore have erupted suddenly from some other, non-Oak Ridge-related cause:

> Mr. Motherall was diagnosed with depression in 2006 by Dr. Ellerby, which did not appear to be part of his pathology prior to Oak Ridge. He did have some suicidal ideation at times prior to Oak Ridge. That said, Dr. Ellerby did not make a causal link to his time at Oak Ridge and Mr. Motherall had numerous other stressors at the time, which would explain his depression including adjusting to the transition from the penitentiary, coping with the realisation of his years lost in jail, limited work potential and limited social supports. Depression in older criminals is not uncommon as their antisocial traits settle down and they are faced with the reality of their life not being 'successful.'

[1034] As has been pointed out above, Mr. Motherall did indeed suffer depression as a result specifically of the LSD sessions at Oak Ridge. These mood swings and depressive occasions were noted at the time in his Clinical Records. It is entirely improbable that a patient given mind-altering chemicals in the guise of psychiatric therapy, who suffers depression within days of these sessions and who continues to suffer mood swings and depression years later, was not caused both short and long-term harm as a result of these drugs. What Dr. Booth calls short-term side effects were, for Mr. Motherall, short and long-term direct effects of the DDT program.

[1035] Oak Ridge and Dr. Maier, who was in charge of Mr. Motherall's treatment, caused Mr. Motherall significant short-term and long-term harm. Although the very last years of his life appear to have been relatively happier ones, according to his friend and executrix Ms. Marion, he never truly recovered from the harm inflicted on him at Oak Ridge. Although he did not survive to testify and personally narrate the story of his suffering, his medical records demonstrate the way in which he was harmed.

y) Michael Pinet

[1036] Michael Pinet was first committed to Oak Ridge on March 9, 1971, when he was 17-years old, after admitting to doctors at Guelph Reformatory that he had obsessive thoughts of killing people and himself. He had begun reporting that he had homicidal urges several years before that, at the age of 12. He did two stints in Oak Ridge, from March 9, 1971- February 9, 1972, and from May 1977-1984.

i) Pre-Oak Ridge and index offence

[1037] Mr. Pinet was born in 1953. An Agreed Statement of Facts relates that he had a difficult childhood, and was placed in St. John's Training School at the age of 15 where he was sexually abused by a number of priests. He was shortly thereafter detained at Whitby Psychiatric Hospital where he was diagnosed with a personality disorder. Then, in 1971, at the age of 18, he was sent to Guelph Reformatory. He states that while there he reported to doctors that he had obsessive homicidal and suicidal thoughts.

[1038] A Psychiatric Consultation report dated March 5, 1971 written by a psychiatrist at Gueph notes that Mr. Pinet was "quite capable of committing murder" and that psychopathic elements of the personality are too predominant." In this Report he was diagnosed with borderline personality disorder with psychopathic elements. At the same time, he was involuntarily committed to Oak Ridge under the *Mental Health Act*.

ii) Experience in the STU

[1039] The Clinical Records show, and Mr. Pinet confirmed in cross-examination, that he was never in MAPP during this first admission to Oak Ridge. He was, however, in the DDT program. The Clinical Records and Treatment Records from March 9, 1971 to December 27, 1971 disclose the following drug treatments, all of which were prescribed by Dr. Barker:

> March 23, 1971, Sodium Amytal followed by Methedrine administered intravenously.
>
> July 20, 1971, Sodium Amytal followed by Methedrne administered intravenously.
>
> May 21 and 26, 1971, Dexamyl-Tofranil.
>
> June 22-28, 1971, Dexedrine spansules.
>
> April 12, 1971, Scopolamine.
>
> June 8-9, 1971, Scopolamine.
>
> June 22, 1971, Scopolamine.
>
> July 20 1971, Dexamyl spansules.
>
> July 21, 1971, Dexedrine spansules.

July 22, 1971, Sodium Amytal.

August 12, 1971, Sodium Amytal.

August 17, 1971, LSD.

August 27, 1971 - September 2, 1971, Dexamyl-Tofranil.

[1040] Although in his testimony at trial Mr. Pinet denied its accuracy, a Penetanguishene Administrator's Report to the Ontario Review Board dated October 14, 2005 states: "Mr. Pinet reportedly consumed alcohol in a binge pattern and experimented with street drugs during his teen years, including LSD and Amytal." This, of course, would fit Dr. Barker's approach of giving LSD to patients who had some experience with it on the street. In any case, the Clinical Records show that the various drug treatments had a marked effect on Mr. Pinet's personality at the time.

[1041] More sspecifically, in May 1971, Mr. Pinet was reported to be "withdrawn and mute" and in group sessions his participation at one point was said to be "nil." The Bedside Nursing Notes from July 1971 state that he was withdrawn and in a "near catatonic state", and reported feeling like he was going crazy but did not know why. That lasted the better part of the month, until the Notes of July 26, 1971 indicate that he continued to be withdrawn but was now at least talking with others and "appeared to be in better spirits".

[1042] In Dr. Bourget's expert Report and in her cross-examination, this severe withdrawal into himself was described as an admittedly harmful side effect of the DDT drugs. She testified that, "[a]ll medications potentially can produce side effects and – and the idea there is not to cause harm, but it is to help the person, but we acknowledge that there are side effects, negative side effects by definition, it is always negative, to the medication that we give or to – to substances that we give." She did concede in cross-examination that Scopolamine, in particular, could cause anxiety or other symptoms such as those described in Mr. Pinet's medical records, but that the assessment needed to be on a case by case basis.

[1043] The Bedside Nursing Notes also show that Mr. Pinet was in the Capsule program for the better part of a week in August 1971 and that he spent one full day in the Capsule itself. Like other patients, Mr. Pinet signed a Capsule contract upon entering this program. Mr. Pinet's contract shows that he had voiced some objection to being naked in the Capsule, as reviewed with him in cross-examination:

> Q. And in this case, I don't need to go through the whole document with you, but I just want to highlight item six here. You say, you're – 'I'm willing to be – I'm willing to be' - it says, 'I'm willing to be unclothed throughout my stay in the capsule in the printed version, but 'unclothed' has been crossed out, 'pyjamas' has been over-written. Correct?
>
> A. Correct. That doesn't mean it was crossed out before I signed it or after.
>
> Q. But the point being, sometimes you were naked in the capsule, sometimes you weren't?

A. Correct.

[1044] Mr. Pinet was discharged from Oak Ridge on February 9, 1972. As he explained it in cross-examination, medical staff at Oak Ridge recommended his transfer to a less secure facility, but he insisted on being released into the community. He agreed to sign a document stating that he was being discharged against medical advice and that he accepted responsibility for his future. At trial, Mr. Pinet testified that Dr. Barker told him at the time: "I am releasing you, however I know that you will return and that you will return for killing people."

[1045] Approximately one month after his release, Mr. Pinet was in Hay River, Northwest Territories and was charged and convicted of raping a woman. At the time he confessed to having had thoughts of killing her, but he ultimately put her in a taxi and let her go. He testified in chief that after serving his time for this offense, he quit drinking and got married. However, he explained that his wife felt pressure from her family to have a baby, which he resented. On April 14, 1976, at the age of 23, he sought his revenge by shooting and killing 4 members of his wife's family.

[1046] He was eventually found Not Guilty by Reason of Insanity for the murders and was transferred to Alberta Hospital Edmonton.

[1047] After the quadruple homicide, Mr. Pinet was assessed by a psychiatrist at the Alberta Hospital in Edmonton. According to the Psychiatric Consultation dated May 5, 1976 at Alberta Hospital, Mr. Pinet stated that "he has always had the urge to kill somebody but that he'd never had the courage to carry it out before." The Agreed Statement of Facts then goes on to indicate that on May 27, 1977, he was transferred from the Alberta hospital to Pentanguishene because the Alberta facility could not safely manage him. From the date of this admission, Mr. Pinet remained at Oak Ridge until 1984.

[1048] Just under a year after this admission to Oak Ridge, on April 7, 1978, Mr. Pinet was first placed in MAPP. The Ward Transfer Slips indicate that he stayed there over 2 weeks, until April 24, 1978. Mr. Pinet testified that he was sent to MAPP because he had been sexually acting out. Dr. Maier, when he testified, confirmed that this was against the STU rules and resulted in a stint in MAPP. The records show that he did raise various complaints about MAPP, which he characterized as a form of mistreatment. In his Agreed Statement, Mr. Pinet described the MAPP as he experienced it:

> Inside the MAPP room, I was forced to sit on a bare Terrazzo floor with my feet straight out in front of me in the attention position. My hands were sometimes cuffed and when they were not cuffed, I would be forced to keep my hands in front of me. I was given a space of approximately three square feet in which I would be allowed to move only four times during each four hour session. Standing was not permitted in MAPP and failure to comply with any of the strict rules resulted in verbal confrontations.
>
> There was no therapist in the room, no visits and no communication with anyone outside. The MAPP experiment was run by other psychiatric patients called 'MAPP teachers'.

[1049] The Ward Transfer Slips show that Mr. Pinet was in MAPP from July 10 to July 29, 1980. In his Agreed Statement of Fact, he concedes that this was because he was considered to be acting in a way that would put other patients at risk. This stint in MAPP came at a time when Dr. O'Reilly was the STU Director. It was after Drs. Barker, Maier, Boyd and Tate had left Oak Ridge. Shortly after his stint in MAPP, in September 1980, Dr. O'Reilly recorded in Mr. Pinet's Clinical Record that she was reviewing his medication.

[1050] Mr. Pinet was also in the Capsule for 14 days in September 1977. In cross-examination, he agreed that he signed the Capsule contract form, which advised the patients of the duration, restrictions on communication, the possibility of using restraints, and the fact that they would be fed a liquid diet through straws.

[1051] In addition to time spent in MAPP and the Capsule, Mr. Pinet was also given a number of DDT drugs during his second admission to Oak Ridge. The Treatment Records show that he received the following DDT treatments:

> September 22, 1977, Alcohol-Ritalin.
>
> November 19, 1977, Alcohol-Ritalin on the orders of Dr. Maier.
>
> February 3, 1978, Alcohol, on the orders of Dr. Maier. This followed a report in the Clinical Record of January 12, 1978, in which he said he was 'still' thinking of murder. The Treatment Record from this date states: 'During the treatment he tried to kick patient Johnson in the groin area. He was approached by staff to stop this and he became verbally abusive towards staff, spitting in their faces and threatening to kill them with a knife. During the night Mike was boisterous and profane towards patients and staff. He later apologized for this behaviour and slept the rest of the night.'
>
> February 20, 1978, Alcohol-Ritalin. The Treatment Record states that Mr. Pinet reported he had 'been under a lot of pressure in the last month and learned to work with these pressures. I find myself getting a lot of treatment as a member of STU.' Staff, on the other hand, stated that the pressure was too much for Mr. Pinet and that he needed to be watched closely. The Treatment Record states that on February 21, 1978, Mr. Pinet was given Alcohol-Ritalin, and that subsequently he expressed homicidal thoughts toward patients and staff. He was placed on restraints, and it was suggested that he remain on restraint until March 6, 1978. Ironically, Mr. Pinet was on the staff-patient liason committee at this stage, and, as he said at trial, 'I was allowed to recommend sanctions and drugs to fellow patients.'
>
> February 24, 1978, alcohol-Ritalin.
>
> February 27, 1978, Alcohol.

iii) Post-Oak Ridge experience

[1052] Mr. Pinet was discharged from Oak Ridge in 1984. His Discharge Summary dated January 30, 1984 provides that his final diagnosis was "Personality Disorder with Antisocial Trends". He was transferred to St. Thomas Psychiatric Hospital, but returned to Oak Ridge 3 years later. A psychiatric Consultation Report dated February 1, 2002 sets out the history of this incident, and relates that Mr. Pinet had an intimate relationship with a staff member at St Thomas, and was considered homicidal and had planned a hostage taking.

[1053] In 1987, he stabbed a co-patient at Oak Ridge in the knee. At the time, he reported that he would commit homicide if he were out in the community. The following year, he punched a co-patient in the face, and threatened further assault in an emotional entanglement over a female staff member. He was again discharged to St. Thomas in 1995, but was returned to Oak Ridge in 2000 after staff at the medium security facility concluded they could not manage Mr. Pinet.

[1054] In 2005, Mr. Pinet was transferred to Brockville Mental Health Centre. He agreed to pharmacological treatment of his sex drive with Lupron, which lowered his risk of sexual offending. However, in 2013, he was turned down in a request for privileges to enter the community as he was still considered to pose a risk to public safety.

iv) Causation and harm

[1055] Dr. Bourget examined Mr. Pinet's records on behalf of the Defendants. She opined that his experience at Oak Ridge is unlikely to have caused his psychiatric problems. Dr. Bourget pointed out that he was diagnosed with a number of sexual disorders, anti-social personality disorder, borderline paranoid, and that these preexisting conditions are notoriously difficult to treat. According to Dr. Bourget, Mr. Pinet's conditions were neither caused nor exacerbated by Oak Ridge. In particular, she noted that his homicidal tendencies were already recognized prior to his admission to Oak Ridge.

[1056] Dr. Bourget did acknowledge that after receiving LSD, Mr. Pinet was in a drug-induced psychotic state lasting a few days. She also testified that she has never seen Sodium Amytal or Methedrene given I.V. to a psychiatric patient, although Mr. Pinet's Clinical Record of March 23, 1971 indicates that this is exactly what he was given and how it was administered. She also testified that she has never heard of Scopolamine being used as a psychiatric medication to treat mental illness. In Dr. Bourget's view, these experiences may have caused some short term discomfort, but they did not have long term effects.

[1057] In his Supplementary Report, Dr. Bradford stated that he "saw Mr. Pinet in consultation on a number of occasions and then took over his care and treatment at the Brockville Mental Health Centre". Dr. Bradford took note of Mr. Pinet's history at Oak Ridge, and concluded that his vulnerability made him susceptible to the very adverse impact of the DDT drugs he had been given. He opined that the Oak Ridge experience, and in particular the DDT program, is responsible for his later criminality and for his ongoing mental suffering:

> In my opinion, Mr. Pinet was vulnerable as he went to Oak Ridge as a teenager. He subsequently was readmitted when most of his exposure to the programs occurred. In 1971 he was in the Capsule and was administered Sodium Amytal. He was also

> involved in the DDT program and was given Amytal and methedrine in 1971. He was also on a 90-day Scopolamine treatment program in 1971. He also received LSD in 1971. He describes that after these treatments and his release he developed violent thoughts, including sexually violent thoughts, and subsequently committed a mass murder that included sexual violence and necrophilia. This was completely out of character for Mr. Pinet who did not have a history of sexual violence or violence. In my opinion the subsequent sexual violence, including the mass murder, was related to the treatments he received in 1971.

[1058] When Mr. Pinet was first admitted to Oak Ridge in March 1971, he was 17 years old and had been convicted of only minor, non-violent offences: uttering a cheque and stealing a car. When he was released, he emerged as a rapist and mass murderer. In Dr. Bradford's view, this progression was a result of the DDT drugs he had been given by Dr. Barker. Then, in his second admission to Oak Ridge, he began displaying signs of serious depression in the wake of a very intensive DDT program. This included an LSD treatment administered by Dr. Maier which, according to the Clinical Records, put him into a "catatonic state".

[1059] The contemporaneous records make it clear that Mr. Pinet suffered in the short term from the various DDT treatments. Further, he exhibited subsequent violent, sexualized criminality, which did not exist prior to Oak Ridge and which after Oak Ridge he was unable to control until undergoing pharmaceutical castration. That is indicative of long-term harm inflicted by the STU programs, and in particular the drugs he was given to break down his defenses.

[1060] Both Dr. Barker and Dr. Maier were directly involved in Mr. Pinet's drug treatments. Oak Ridge as a Crown institution, along with both Doctors, together caused the short-term and long-term harm that Mr. Pinet suffered.

z) Edwin Sevels

[1061] It would appear that although Edwin Sevels spent time at Oak Ridge during the period covered by the Plaintiffs' claim, he was briefly in only 1 of the 3 impugned STU programs. His first admission to Oak Ridge was in September 1978, shortly after the DDT and Capsule programs ended. For that reason, there is no mention of either program in his Oak Ridge file. A review of his Clinical Records and Bedside Nursing Notes reveals that Mr. Sevels was in MotoPro, or mini-MAPP, for one 8-day stint.

i) Pre-Oak Ridge and index offence

[1062] Mr. Sevels was born in Latvia on August 9, 1943, in the midst of the Second World War in which his country was a battleground. He fled the Baltics with his family while still a young child, going first to a displaced persons camp in Sweden before resettling in Canada. His father was an alcoholic, and Mr. Sevels himself began showing signs of schizophrenia as a young man. He never finished high school and was repeatedly institutionalized prior to his admission to Oak Ridge. Dr. Booth opined in cross-examination that Mr. Sevel's background would have put him at heightened risk for psychiatric harm.

[1063] In a Clinical Record dated December 23, 1965 from Queen Street Mental Health Centre, the assessing psychiatrist noted that Mr. Sevels suffered from depression and aggression:

> It was stated that he has become depressed *[sic]* in Sept. after failing to make the Argonaut football team; also he did not attend to his studies and refused to go to work, showing increasing irritability and mistreated the parents. Dr. Burns filled in OMPC in the admitting office, the patient being tense and threatening.
>
> On arrival on the ward, he turned physically violent and after a period of hyperactivity, it became necessary to administer i.m. CPZ and to apply CWP. When seen this morning, pt. was out of CWP; he talked under moderate pressure and showed a definite psycho-moto overacitvity; his conversation was rambling and aimless.

[1064] According to a Queen Street Conference Report dated February 8, 1966, Mr. Sevels was treated with electroshock therapy, tranquilization, milieu therapy, occupational therapy and supportive psychotherapy. His diagnosis was tentatively recorded as "Catatonic Schizophrenia", with a guarded prognosis.

[1065] In 1978, Mr. Sevels was charged with forcible seizure, common assault, willful damage, and threatening. He was committed to Oak Ridge on September 15, 1978 on a Warrant of Remand. In his admission Clinical Report, his diagnosis is documented as "Schizophrenia, Paranoid Type". The Report notes, "He is clearly unfit to stand trial at the present time and in need of treatment." Mr. Sevels was discharged and re-admitted to Oak Ridge several more times, but it is this first admission that falls within the time frame relevant to the present law suit.

ii) Experience in the STU

[1066] A review of the Clinical Records reveal that Mr. Sevels had one session in MotoPro, and that otherwise he did not participate in the STU programs at issue in this claim.

[1067] Having said that, he did not have an easy time at Oak Ridge. He started his time there on confined status, and remained that way for weeks. The Clinical Records indicate that during all that time he was depressed, uncooperative, sometimes incommunicative and sometimes verbally aggressive. He was given injections of the anti-schizophrenia drug IMAP on a number of occasions, along with Nozinan and Largactil, all of which were standard medications used in the treatment of schizophrenia in the late 1970s.

[1068] The Treatment Records indicate that on September 8, 1978, Dr. Barker prescribed for Mr. Sevils a course of medication designed to address "disturbed behaviour". Those instructions were repeated by Dr. Barker on October 6, 1978 and again through November and early December 1978.

[1069] A Certificate of Incompetence was issued for Mr. Sevels on October 3, 1978, stating that Mr. Sevels continued to "exhibit very disordered thought processes." On October 6, 1978, Mr. Sevels was transferred to a different ward on Dr. Barker's orders, where he remained until his transfer back to F Ward, where the STU was housed, on December 14, 1978.

[1070] In the meantime, the Clinical Record discloses many occasions through the fall of 1978 when Mr. Sevels refused to take his prescribed medication. He is also recorded on a number of occasions "displaying poor attitude", being non-participatory in groups, and being angry and depressed and kept on confined status.

[1071] On November 30, 1978, Mr. Sevels met with a representative of the Ombudsman to voice his objection to treatment. The Ombudsman's representative, in turn, met with Dr. Fleming and pressed this case on Mr. Sevel's behalf. In a Clinical Record dated December 1, 1978, Dr. Fleming recorded the gist of that conversation:

> Following a conversation today with Donna Hall of the Ombudsman's Office, I have discontinued all active psychiatric treatment of this patient and he will remain confined on H Ward at least until his situation can be reviewed next week. Briefly, he came to this hospital early in September as a Warrant of Remand with serious charges. He was obviously psychotic at that time and was certified under the previous Mental Health Act as of October 13, 1978. Therefore, at the time of the implementation of the new Mental Health Act on November 1st he had already been re-certified. His progress in treatment, although in a positive direction has been very slow and he continues to have very limited insight into his illness or his need for treatment. After November 1st he became periodically belligerent with respect to his need for treatment and at that time we discontinued a part of his medication in response to his complaint of not wishing to receive treatment. Nevertheless, in order that he not regress so that the ground already gained would be lost, he was kept on some medication in the form of IMAP which was given every five days…
>
> From my discussion with the Ombudsman's representative, it would appear to be their opinion that we do not even have the right to provide the level of protection that we have currently been providing for Mr. Sevels. We will now provide only his p.r.n. medication for the prevention of very immediate physical harm to himself or to other persons until such time as the situation can be clarified…

[1072] The Agreed Statement of Facts for Mr. Sevels indicates that the necessary clarification was sought by Dr. Barker on behalf of Oak Ridge in an application to the Ontario Review Board seeking permission to treat. Before the application could be heard, Mr. Sevels apparently changed his mind and delivered a handwritten note addressing Dr. Barker's application. That note, dated December 5, 1978, reads:

> I, Edwin Sevels, agree to attend program and take whatever drugs are prescribed by the doctors at the Oak Ridge Division of the Mental Health Centre, Penetanguishene, Ont.
>
> I have read and understood the above.

[1073] Mr. Sevels' change of heart with respect to his medication did not, however, satisfy Dr. Barker that the treatments he was receiving at Oak Ridge could continue without further

interruption. In a letter dated December 20, 1978 to Mr. Sevels' lawyer, it was explained that Dr. Barker was disinclined to withdraw his application for authorization to engage in a course of treatment. The letter is signed on behalf of the STU at Oak Ridge, and makes clear that Dr. Barker was writing in his capacity as the doctor responsible for Mr. Sevels' treatment in the Social Therapy Unit:

> Dr. E.T. Barker's decision to apply for a Review Board hearing and hopefully secure an Order authorizing treatment is an effort on the part of this treatment unit to obtain a sanction of treatment in view of patient Sevels past history of constantly changing his mind, and making last minute decisions.

[1074] A panel of the Review Board convened the following day, December 21, 1978, and rejected Mr. Sevels' request for a discharge and authorized continued custody and involuntary care.

[1075] The Clinical Records reveal that on December 16, 1978, Mr. Sevels was transferred back to F Ward, and on December 20, 1978 he appears to have been placed in the "motivation program", or mini-MAPP. The Clinical Record of that first day in the program states:

> Ward staff reports that Ewin constantly complains about physical discomfort. Patient does not like being told when he is wrong and blames everyone else for his mistakes.

[1076] The following week, on December 27, 1978, the Clinical Record indicates that he was still unhappy in the mini-MAPP: "Patient Sevels continues to function in a petulant, tearful, and disruptive manner…" He then continued to make trouble the following day, where the Clinical Record reports: "…It appears this patient is determined to get his own way. He is very unpredictable at this time."

[1077] Finally, on December 29, 1978, Mr. Sevels was removed from mini-MAPP. His stint in that program was therefore less than the minimum cycle of 10 days that was standard in order to earn permission to exit. The Clinical Record provides:

> The daily ward report states that Edwin cannot function in the F Ward motivation programme, he is disoriented. Patient was placed in the F Ward Pilot Programme.

[1078] Being removed from mini-MAPP did not exactly make things pleasant for Mr. Sevels. The following week, on December 31, 1978, his Clinical Record states: "Ward staff report that Edwin is still having an authority problem; disregarding direction from teachers." The following month, on January 27, 1979, he was placed on double restraints after being recorded as "laughing inappropriately and very emotional."

[1079] On February 20, 1979, Mr. Sevels was again removed from the STU. He was transferred to the E ward and was given a work assignment. This was obviously more suitable to him. The Clinical Record of that date states: "Patient appears to be very pleased with this transfer. There are no complaints at this time."

[1080] Mr. Sevels was discharged from Oak Ridge on March 15, 1979. The Discharge Summary states that, “It is recommended that Mr. Sevels continue with regular psychiatric follow-up which very likely should include a maintenance level of tranquilizing medication.” The Summary noted a diagnosis of “Schizophrenia”.

[1081] On July 19, 1983, Mr. Sevells was again admitted to Oak Ridge on a Warrant of Remand for psychiatric evaluation relating to a charge of assault against a neighbour. The evaluation was done by Dr. O’Reilly, who recorded that he was uncooperative when she met with him and that he refused to undergo psychological testing. He was discharged on September 15, 1983 with a diagnosis of Paranoid Schizophrenia.

iii) Post-Oak Ridge experience

[1082] Mr. Sevels had numerous more admissions to Oak Ridge subsequent to his September 1983 discharge. These were frequently associated with misconduct he perpetrated when not taking his medication. In a Clinical Summary for Review Board dated July 2, 2010, these various periods at Oak Ridge are summarized:

> Jan. 17, 1984 to Aug. 30, 1984 – Warrant of Remand for psychiatric evaluation in regards to charges of Willful Damage and Breach of Recognisance. Mr. Sevels was detained in hospital under provisions of the Mental Health Act subsequent to January 30, 1984. Mr. Sevels again denied that he suffered from psychiatric illness and declined to participate in psychological testing or agree to follow-up psychiatric treatment. Discharge diagnosis: Paranoid Schizophrenia.
>
> Oct. 26, 1987 to Dec. 21, 1987 – Warrant of Remand for psychiatric evaluation in regards to charges of Threatening and Possession of a Dangerous Weapon. Discharge diagnosis: Bipolar Disorder.
>
> Apr. 27, 1988 to Aug. 20, 1988 – Transferred to Oak Ridge from Millbrook Correctional Centre on a Mental Health Act Form 1 due to bizarre and threatening behaviour. Treated on substitute consent of his mother. Discharged on Fluphenazine Decanoate, Lithium Carbonate and Benztropine for treatment of Bipolar Disorder. Mr. Sevels evidently attended an outpatient clinic at Peterborough Civic Hospital to receive these medications as a condition of probation but discontinued treatment immediately upon its expiry.
>
> Dec. 3, 1990 to Jan. 21, 1991 – Warrant of Remand for psychiatric evaluation in regards to charges of Theft and Breach of Probation. Inappropriate, euphoric and disorganized on admission, Mr. Sevels stabilized on Fluphenazine, Lithium and Benztropine.
>
> October 11, 1991 to December 30, 2003 – Mr. Sevels was admitted to Oak Ridge in 1991 for psychiatric treatment following a Judicial determination that he was unfit on account of mental disorder to stand trial on minor criminal charges. Mr. Sevels remained at Oak Ridge until quite recently as an involuntary patient since

his charges were dropped around 1993. Mr. Sevels was transferred from Oak Ridge to the Regional Forensic Services Program on May 30, 2002 and from there to the Psychosocial Rehabilitation Program on Feb. 20, 2003. Between December 2003 and November 2004, Mr. Sevels was in the community on a Community Treatment Order.

November 2004 to March 8, 2005 – Mr. Sevels returned to hospital because he did not have suitable accommodation for cold weather. This provided the opportunity to undertake some changes to his medication, in particular a transition over several weeks from Zuclopenthixol to Risperidone, in the depot injectable version. This was gradually increased up to 50 mg IM for 14 days. Although Mr. Sevels continued to insist throughout that he does not need any medication, he did acknowledge that the new medication was more comfortable in regard to side effects. Upon discharge he was placed on a new Community Treatment Order.

June 7, 2005 to June 13, 2005 – Mr. Sevels returned to hospital voluntarily for a review following a contravention of his Community Treatment Order. He persuaded a friend to take him to his son's place at Norwood where an angry confrontation ensued. Because of Mr. Sevels previous estrangement from family, particularly his son, this was specifically included in his Community Treatment Order. He once again agreed not to return to that area without appropriate prior arrangements.

November 1, 2005 to June 7, 2006 – Once again as winter weather approached, Mr. Sevels returned to hospital and was admitted voluntarily. After considerable discussion over the next several weeks, Mr. Sevels' Risperidone injection was discontinued because of his insistence that he needed an opportunity to demonstrate that he does not require the medication and does not in fact have a mental disorder. His final injection was on December 15, 2005…

In spite of this reinstatement of treatment, Mr. Sevels continued to present concern because of unpredictability and aggression and on March 10, 2006 was transferred to the Oak Ridge setting for safer management where he remained until April 24, 2006 when he returned to PSRP. Following the drafting of a new Community Treatment Plan, he was discharged again to the community on June 7, 2006.

March 9, 2007 to March 29, 2007 – Due in substantial part to living in less than satisfactory accommodations for winter weather, Mr. Sevels was admitted for a short stay in March 2007.

Mr. Sevels, due in large part to repeated Community Treatment Orders, has remained in the community since March of 2007. In April of 2008, I reduced his dose of Risperidone "Consta" from 50 mg q 2 weeks to 37.5 mg to allow him an opportunity once again to prove that he can be well and function appropriately. Past experience dictates caution, but after much discussion, it was decided that this would be one way to help Mr. Sevels learn about and understand better his

> psychiatric disorder. Again, in April of 2009, his medication dose has been reduced to 25 mg IM q 2 weeks. By December 2009, there was a consensus that an increase in paranoid thinking had been observed, and Mr. Sevels himself admitted an increase in energy and less sleep although of course he does not see that as a negative result. In January 2010 Mr. Sevels became increasingly resistant to having medication, refused to have any routine bloodwork and as a result had no Risperidone after January 27th, 2010. As happened before in 2006 his mental deterioration continued and in fact accelerated.
>
> February 23rd, 2010 to present – By late February he was profoundly thought disordered and was readmitted to hospital to the PSRP on the 23rd. Over the next month or so repeated attempts to persuade him to restart treatment failed. In order to undertake forced treatment safely he was transferred to the AAP Constant Care Unit where he remained until transferred back to PSRP having been re-established on medication and as a result sufficiently improved to be managed in that more open ward. He now has some privileges on the grounds and early discussions are underway regarding his eventual discharge.

[1083] In general, Mr. Sevel's pattern of admissions over a 35-year period shows that he has had life-long difficulty with his mental illness. He frequently failed to perceive his ongoing need for medication. As a result of going off his medication, his mental condition did not improve, and in fact deteriorated, over the years.

iv) Causation and harm

[1084] Both Dr. Bradford, who examined Mr. Sevels' records for the Plaintiffs, and Dr. Booth, who examined Mr. Sevels' records for the Defendants, agree that failure to take needed medication is a relatively common phenomenon for patients with schizophrenia, and that this leads to deterioration of their condition. It is this feature of Mr. Sevels' mental illness that is the most prominent cause of his post-Oak Ridge troubles.

[1085] In Dr. Bradford's Report of January 8, 2019, he states that Mr. Sevels was in the DDT program and was "given a regimen of Nozinan, Largactil, and IMAP injections, and later Largactil and Cogentin." However, as counsel for the Defendants point out, none of those drugs were associated with the DDT program. In fact, Dr. Bradford agreed in cross-examination that those were all standard medications for treatment of a patient with Mr. Sevels' illness. The DDT program had already ceased operation, and Dr. Maier had already departed the institution, when Mr. Sevels was admitted to Oak Ridge in September 1978.

[1086] Accordingly, Dr. Bradford's conclusion that the STU experience caused Mr. Sevels harm, and that his psychiatric condition was worsened by his stay at Oak Ridge, is based on erroneous facts and cannot be accepted.

[1087] For his part, Dr. Booth acknowledged in his Report of April 2, 2019 that Mr. Sevels had a "clear dislike of psychiatric medications", but he goes on to point out that this dislike was already

present and documented prior to Mr. Sevels' arrival at Oak Ridge. It is Dr. Booth's view that Mr. Sevels' course of illness can be entirely explained by his condition.

[1088] As for the many records indicating that Mr. Sevels was deeply unhappy during his time at Oak Ridge, Dr. Booth explained that simply having a stressful experience does not mean that psychological damage arises from that event. In the course of cross-examination, counsel for the Defendant put to Dr. Booth a passage from Mr. Sevels' examination for discovery to illustrate the pressure Mr. Sevels was under in mini-MAPP.

> Q. Mr. Sevels was being questioned by Mr. Rogers, and he said, when he was talking about, – he was talking about this MAP Program, or the MAP-like program, they have different names: You remind me of being in a room, being in a room, being – being educated by a guy named Jeffrey Dahmer while on the cuffs. They put me in with a teacher like that. I am angry about it still today.

[1089] Dr. Booth was careful to say that in psychiatry one has to examine the specific impact of a given experience on the individual patient, and not rest one's opinion on the impact of similar experiences on others:

> A. ...I was answering your question about the potential impact, the psychological impact of that, and, again, it seems that you're saying because he experienced it, he must have had psychological suffering from it. But, that's not in psychiatry how we see it, because we see people with severe sexual assaults who don't develop PTSD.

[1090] Looking at Mr. Sevels' lengthy history of dealing with schizophrenia, often without his prescribed medication, it is hard not to agree with Dr. Booth that the long-term trajectory of Mr. Sevels' illness and his life was not impacted one way or the other by his STU experience. The roughly one week he spent in mini-MAPP was stressful and unpleasant, but appears to have been a drop in the bucket, as it were, in the context of a very troubled history. Mr. Sevels was a schizophrenic who for years resisted taking his medication, and for that reason could not live a functional life without being constantly re-admitted to a maximum-security mental hospital. An 8-day punishment session was not going to change that, almost regardless of how harsh the regimen may have been.

[1091] Although Mr. Sevels was not caused long-term harm by his experiences with the one STU program to which he was subjected, he did suffer at least a modicum of short-term pain. The Clinical Records specifically note that he complained of physical discomfort while in mini-MAPP. They also indicate that he was mentally unable to handle the experience and had to be removed earlier than usual. This sense of mental and physical discomfort, and the accompanying assault to his dignity, is a manifestation of short-term harm caused by Oak Ridge.

[1092] Although Mr. Sevels' daily care was often in the hands of Dr. Fleming, the Clinical Records and Treatment Records disclose that for the periods in which he was in the STU he was under the treatment of Dr. Barker. This includes the specific period from September to December 1978, culminating in his week-long stint in mini-MAPP. It was during this period of Dr. Barker's direct

involvement in his treatment that Oak Ridge as an institution, and Dr. Barker himself, caused Mr. Sevels unnecessary short-term pain.

aa) Samuel Shepherd

[1093] Samuel Shepherd spent just over 6 months in Oak Ridge, for an assessment from October 5 to November 3, 1972, and for treatment from December 29, 1972 to June 15 1973. This was pursuant to a Certificate under the *Mental Health Act*, *1967*, signed by a physician at the Guelph Correctional Centre after Mr. Shepherd was found to have set several small fires.

i) Pre-Oak Ridge and index offence

[1094] In his Agreed Statement of Facts and his affidavit, Mr. Shepherd explains that he was born on April 12, 1951, and that his father was an alcoholic who physically and sexually abused him from the age of 6 to 14. He testified that the abuse from his father finally came to an end when he brandished a knife and threatened to kill his father. In his affidavit, he deposed that his mother had severe emotional problems.

[1095] A Clinical Record Mental Status prepared by Dr. Maier on Oct 27, 1972 indicates that Mr. Shepherd used street drugs as a teenager. Dr. Maier specified in this Record that Mr. Shepherd "has been involved with LSD about 20 times. He has smoked grass 30 or 40 times, and at other times has taken anti-depressant pills purchased on the black market."

[1096] Mr. Shepherd was sent to the Yorkdale Vocational School at the age of 14 and left school permanently at the age of 16 with a grade 9 education. At Yorkdale, he was involved in numerous episodes of theft and was accused of sexually assaulting younger boys, although he denied this when cross-examined about it at trial. A Treatment Summary dated March 27, 1967 states that he was a "solemn, hostile, dependent and aggressive young male" that engaged in therapy on a superficial basis.

[1097] After leaving the Yorkdale school, Mr. Shepherd appears to have gone on something of a crime spree. His Agreed Statement of Facts sets out that he was convicted of 3 charges of theft in 1967, impersonating a peace officer in 1968, attempted arson in 1969, theft over $50 in 1970, and a parole violation in 1970. It also relates that he spent time in numerous institutions in his teenage years. He was at different times remanded to the Whitby Psychiatric Hospital, the Clarke Institute of Psychiatry and the Lakeshore Psychiatric Hospital. He was also incarcerated in the Mimico Correctional Centre, the Guelph Correctional Centre, the Burwash Industrial Farm and the Millbrook Correctional Centre.

[1098] A Conference Report prepared at the Whitby Psychiatric Hospital dated May 30, 1969 describes the youthful Mr. Shepherd's overall presentation. Although he disagreed with the contents of this Report when it was put to him in cross-examination, it is revealing in what it relates:

> The patient has not shown any motivation to learn socially acceptable behaviour patterns. He breaks hospital regulations whenever he is able to. He has stolen valuable objects belonging to other patients. He has stolen a master key and made

> duplicates of it. He left the hospital grounds without authorization several times. Twice he stole cars belonging to hospital staff and smashed them up. According to reports received he could easily have killed people on the street. Once he stole a knife and gave it to another patient to try to attack a nurse's aid. A metal chain with a ring was found in his possession, this chain could easily be used for strangling a person. The attending staff consider him to be dangerous to staff and other patients…
>
> In his anti-social activities, he showed considerable mental agility. When questioned about his misdeeds, he tells lies and he tries to do it in a most convincing manner, he is a good actor, he starts weeping when he thinks that his tears may influence the interviewer. He was reported, and observed, laughing and ridiculing the interviewer afterwards.

[1099] The Agreed Statement of Facts states that in 1972, Mr. Shepherd was charged with Theft, Possession of Burglar Tools, Driving under Suspension, Failing to Attend Court and Possession of Stolen Property. He was admitted to Oak Ridge from October 5 to November 3, 1972 pursuant to a Warrant of Remand, and was diagnosed by Dr. Maier with Personality Disorder, Antisocial type. In his assessment, Dr. Maier opined that it was unlikely that Mr. Shepherd would respond to treatment unless he were sentenced to at least 5 years and spent them in a psychiatric institution.

[1100] From Oak Ridge, Mr. Shepherd was sent to Guelph Correctional Centre. A memo dated December 27, 1972 from the Superintendent at Mimico to a psychiatrist at Guelph identified Mr. Shepherd as a safety concern and described him as "a very complex and seriously disturbed fellow." That same week, on December 29, 1972, he was admitted to Oak Ridge pursuant to a Certificate under the *Mental Health Act, 1967*.

[1101] The Certificate was signed by a physician at the Guelph Correctional Centre after a number of small fires were set at the institution and the staff suspected that Mr. Shepherd, who had previously been convicted of attempted arson, had set them as a form of acting out. In a letter dated December 28, 1972 from the Director of the Guelph Correctional Centre to Oak Ridge, it is observed that Mr. Shepherd "realizes that this will be [his] last chance to stabilize and he is therefore able to consider the Penetang treatment program in his best interest."

ii) Experience in the STU

[1102] Mr. Shepherd was never in MAPP. In cross-examination, Mr. Shepherd described his understanding of that punitive program and explained why he was never sent there:

> Q. Okay. And I understand you were never in the MAPP program while you were in Penetanguishene?
>
> A. No, sir… And the reason I wasn't in the MAPP program was my behaviour wasn't as such that it warranted going into that particular program.
>
> Q. And the MAPP program was viewed as a sanction, correct?

> A. Yes, for people that were extremely and routinely disruptive, or violent or aggressive, you know, towards staff or – or other – other patients and resist – anyone that would resist going into the various programs.

[1103] On March 29, 1973, Mr. Shepherd signed a Capsule Therapy Contract. He deposed in his affidavit that he entered the Capsule with 10 other patients. During cross-examination, Mr. Shepherd revised this figure and said there were 7 patients with him, but when shown documentation agreed there were 5 patients. As usual, the Capsule contract included details of the restrictions on communication, restraints, feeding, and clothing that Mr. Shepherd experienced in the capsule.

[1104] There is no notation in the Clinical Records that indicates whether Mr. Shepherd exhibited any distress while in the Capsule, although on the days leading up to the signing of the Capsule contract Mr. Shepherd is described in the Clinical Records as being "non-cooperative" and "argumentative". Dr. Maier signed his Involuntary Certificate renewal on March 29, 1973, the same date as the Capsule Therapy Contract.

[1105] Mr. Shepherd testified that he was in the DDT program and that he was given Scopolamine and Dexamyl-Tofranil on the basis of another patient's recommendation. However, neither the Clinical Records nor the Treatment Summaries indicate that DDT drugs were ever administered to Mr. Shepherd. In cross-examination, Mr. Shepherd agreed that there is no documentation of his DDT treatments, and stated that he was relying on his memory of these 46-year old events.

[1106] On June 15, 1973, Mr. Shepherd was discharged from Oak Ridge. In a letter of that same date to Guelph Correctional Centre, Dr. Maier indicated that Mr. Shepherd's diagnosis "has varied over the years but has finally come to rest at Antisocial Personality with Immature Features." He concluded his letter by stating, "We are not optimistic about his future."

iii) Post-Oak Ridge experience

[1107] Roughly 18 months after his discharge from Oak Ridge, Mr. Shepherd faced new criminal charges, and in the wake of those pending charges his lawyers arranged for him to be assessed and his treatment records reviewed at the Clarke Institute. In a letter to his lawyer dated September 25, 1974, the psychiatrist at the Clarke who did the assessment commented: "On examination, it was my opinion that this man functioned with very immature judgment, and in many areas seemed to function at a level of low normal or borderline intelligence." The reporting letter went on to observe that although Mr. Shepherd did not suffer from a mental illness that warranted involuntary certification under the *Mental Health Act*, "he does have a considerable personality disorder and sexual problem."

[1108] In his Agreed Statement of Facts, Mr. Shepherd indicated that he was convicted of assault in 1976, indecent assault in 1977, assault in 1980, and sexual assault in 1990, 1991, 1993, and 2005. He also has a number of convictions for public mischief, theft, and failure to comply with recognizances or attend court. In cross-examination, he stated that the impulse to commit sexual assault began to occur with more frequency in the late 1980's and early 1990's. In submissions to an Ontario court sentencing hearing of February 8, 1993 with respect to 3 counts of sexual assault,

defense counsel identified for the court what he submitted was a source of Mr. Shepherd's ongoing sexual aggression:

> Sam's history of sexual abuse by his father ran from the ages of 10 to 14.
>
> I suggest a breakthrough of sorts exists before the Court today, as this is the first time that Mr. Shepherd has ever related this to anyone and was able to relate it to Ms. Beale the probation officer in this matter.
>
> He still doesn't understand why his mother didn't intercede on his behalf to save him from his father.
>
> He now for the first time is willing to have psychiatric help to resolve these problems. He has had help in the past but he hasn't let this part of his personality go, hasn't got into the abuse before.

[1109] On September 4, 2002, Mr. Shepherd was assessed at Penetanguishene in respect of yet another sexual assault charge. In 2005, after conviction for that offense, Mr. Shepherd was the subject of a dangerous offender hearing and was ultimately designated a long-term offender. In his Agreed Statement of Facts, he indicated that he was released from custody in June 2005 but was jailed again the following year for violating the terms of his release.

[1110] Mr. Shepherd has received anti-androgen treatment and psychotherapy from the Royal Ottawa Hospital beginning in 2008. This treatment assisted him in having his long-term offender status terminated in 2015. In his Agreed Statement of Facts, he states that he now lives in the community without conditions or supervision. He deposed in his affidavit that he works part-time as cleaning staff at a commercial building and as a dishwasher at a restaurant. He further deposed that he is now diagnosed with antisocial personality disorder and psychopathy.

iv) Causation and harm

[1111] In his Report dated January 8, 2019, Dr. Bradford stated that Mr. Shepherd "most likely has long-standing problems related to the trauma he was exposed to at Oak Ridge. He likely was not evaluated extensively in relation to his sexual problems and, therefore, did not receive the appropriate treatment." As discussed above, it is not surprising that Mr. Shepherd was not evaluated properly in relation to sexual problems at Oak Ridge. While he had a background that included a number of sexual assaults (or suspected sexual assaults), the origin of his issues and the extent to which they were deeply embedded in his childhood was never revealed to anyone at Oak Ridge.

[1112] It was not until a criminal proceeding in 1993 that Mr. Shepherd experienced what his own lawyer termed a "breakthrough" and revealed to a parole officer that he was sexually abused as a child by his father. One cannot blame Oak Ridge or any of its medical staff for failing to address what the patient did not reveal. In addition, this claim is not a medical malpractice claim; it is a claim about 3 specific programs in the STU created and run by the Doctors at Oak Ridge. Whether Mr. Shepherd was diagnosed or medically treated to the appropriate standard separate and apart from those programs is not an issue to be determined here.

[1113] Dr. Bradford also opines in his Report that, “Mr. Shepherd suffered harm from exposure to the Capsule program and appears to have had long-standing problems with anxiety and depression, which were likely the direct result of his exposure to the trauma from the program.” This portion of Dr. Bradford’s Report is more to the point of the action, as it addresses the effect of the one impugned program to which Mr. Shepherd was exposed.

[1114] Having said that, Dr. Bradford’s opinion is also confusing in part. No psychiatrist assessing him over the years has ever diagnosed Mr. Shepherd with anxiety and anxiety and depression. His psychiatric diagnosis has always revolved around his having an antisocial personality disorder of one form or another. This includes the diagnosis submitted by Dr. Bradford himself when he assessed Mr. Shepherd in 2004 for his dangerous offender application. That very thorough assessment did not contain any diagnosis of anxiety and/or depression.

[1115] As the Doctors’ counsel point out in their submissions, in view of the absence of any diagnosis of anxiety and depression, it is hard to know how Dr. Bradford concluded that the anxiety and depression from which Mr. Shepherd now claims to suffer was caused by a single experience in the Capsule during a 6-month stay in Oak Ridge over 45 years ago. There is nothing in Dr. Bradford’s report that indicates how he could connect the events at Oak Ridge, and in particular Mr. Shepherd’s one stint in the Capsule, with his current allegations of anxiety and depression.

[1116] By way of contrast, Dr. Booth’s Report of April 2, 2019 reaches the conclusion that although the Capsule could potentially be stressful, there is “more significant evidence suggesting… Mr. Shepherd was not significantly harmed by the treatment programs”. In reaching this conclusion, Dr. Booth noted that “[a]lthough Mr. Shepherd voices problems with anxiety and depression in the current complaint, there does not appear to be significant evidence of this in the record.” He also observed that, “Mr. Shepherd was only in the program for a short time, reducing the likelihood of longstanding and significant harm.”

[1117] Finally, Dr. Booth addresses Mr. Shepherd’s contention that his post-Oak Ridge recidivist behaviour was an after-effect of Oak Ridge that lingered with him. In Dr. Booth’s view, the post-Oak Ridge criminality engaged in by Mr. Shepherd is far more likely to be a result of his underlying antisocial personality disorder and psychopathy than it is any particular treatment he underwent at Oak Ridge in 1972-73. As stated in Dr. Booth’s Report:

> Although Mr. Shepherd suggests that the program caused him to continue to offend, it was likely his underlying sexual disorder and psychopathic personality traits/antisocial personality that were the main cause of his offending. He showed a longstanding difficulty with antisocial and inappropriate sexual behaviours prior to being in the program. He would have been rated at a high risk of reoffending at that time and was noted by other observers to be at high risk of offending. His offending and further difficulties were likely a ‘natural course’ of his previous diagnoses and difficulties.

[1118] Dr. Booth is therefore of the overall view that although Mr. Shepherd “may have had some stressful experiences at the time”, his current mental state and behavioural difficulties “can be explained entirely outside of the Oak Ridge Program exposure.” It is more likely than not that it is

not Oak Ridge or the Capsule program that caused Mr. Shepherd the long-term problems that he continues to encounter, but rather it is his underlying disorder that is the cause.

[1119] That said, Dr. Booth also testified that Mr. Shepherd's contention that the Capsule made him feel very stressed is likely to be accurate. Dr. Booth pointed out that this is consistent with other patients' evidence about being enclosed in the Capsule. In this regard, I note that Dr. Barker's theory described in his article "The Total Encounter Capsule", p. 355, is that "groups of naked mental patients have been locked in a small room… [in] intensive methods of group therapy which made maximum use of the resources of patients alone; programs which rested in part on the assumption that a genuine encounter between persons…was the aim and achievement of therapy." It was specifically designed to be intense, disorienting, and stressful.

[1120] Dr. Bradford, in his affidavit of February 17, 2017, commented on the lack of therapeutic value of the Capsule:

> The Total Encounter Capsule was a small windowless room with a toilet and sink where up to seven patients would remain for three days to two weeks. In the Capsule patients would be naked and would be fed a liquid diet through straws. There was one toilet and a basin with no privacy… It is not clear to me how long the Capsule operated and although it clearly operated under Dr. Barker, and also Dr. Maier. The administration of these programs were inappropriately supervised by co-patients and the programs themselves were dangerous from both a psychological and medical standpoint.

[1121] Importantly, not only did Dr. Bradford opine that the Capsule program was not within the reasonable standard of care for psychiatric treatment at the time, but that Oak Ridge as an institution was responsible for this failing. As he put it in his affidavit, "The administration of a prudent and reasonable mental health centre would have had mechanisms in place to ensure that the standard of care provided would be of an acceptable standard of care according to the standards of peer hospitals and the accepted standard of care in Ontario and in Canada."

[1122] I find that Oak Ridge and, in particular, Dr. Maier, who was directly involved with his treatment, caused Mr. Shepherd short-term harm by placing him in the Capsule. The intense environment heightened by the isolation from the outside world caused the Capsule to be an attack on Mr. Shepherd personal dignity and an emotionally painful experience, even if only for a few days.

[1123] Mr. Shepherd did not suffer long-term harm from this experience, as his harmful experience in the Capsule lasted for only a few days. However, a few days of mental distress is more than he deserved. The Capsule served no positive therapeutic goal for Mr. Shepherd and only hurt him, at least in the very short term.

bb) Shauna Taylor

[1124] On January 26, 1976, Shauna Taylor was committed to Oak Ridge after perpetrating a violent rape when she was a 20-year old male. She was discharged on February 23, 1979, and then

returned from January 1981 until July 1984. Ms. Taylor has been diagnosed with psychopathy in combination with gender identity issues and paraphilias.

[1125] In a Psychiatric Report dated January 23, 2002 written by Dr. Brian Hoffman at North York General Hospital, it is indicated that in early 2002 Ms. Taylor had changed her name from Vance Egglestone, the name given to her at birth, and had begun the process of transitioning from male to female. When Ms. Taylor testified at trial she identified as female, although her identification as transgender had actually started many years before that. In her examination-in-chief she testified that at the age of 15, in the early 1970s, she had already "found a way of being accepted by people through the use of drugs and becoming a prostitute as a female."

[1126] In these reasons, I refer to her with female pronouns for all periods of her life, since that is the way she refers to herself.

i) Pre-Oak Ridge and index offence

[1127] In her affidavit, Ms. Taylor deposed that as a child she exhibited many behavioural problems, and was hyperactive, impulsive, and generally unable to handle school. At the age of 12 she began experimenting with street drugs, and as a teenager regularly drank heavily and used marijuana, cocaine, mescaline, and LSD. In a Psychiatric Report from York-Finch Hospital dated January 16, 1976, it is reported that Ms. Taylor was sent to Hillcrest Training School when she was 15 years old for repeatedly stealing her father's car.

[1128] At the age of 17, Ms. Taylor, then a male, had a child with his girlfriend at the time.

[1129] In her affidavit, she describes this period of her life as one of turmoil: "Unfortunately, my mental health issues and addiction to drugs and alcohol ruined my family life and eventually my girlfriend left me with our one year old daughter. I was mentally broken and succumbed further to my mental health and addiction issues…" Her criminal record, which forms an exhibit adduced at trial, shows that prior to her admission to Oak Ridge she was convicted of several offences, including assault, malicious damage, trespassing, theft, possession of narcotics and marijuana, breaking and entering, and assault causing bodily harm.

[1130] On August 31, 1975, at the age of 19, Ms. Taylor was charged with rape. In her affidavit, she relates that at the time she was having serious mental health issues, which included suicidal thoughts and drug addiction. In the York-Finch report, it was recorded that she said she had no memory of the attack and that the morning following the alleged sexual assault she woke up to find blood on her pants. Other contemporaneous records, including a police report of the incident, indicate that the female victim of this assault was badly injured. The doctor writing the assessment at York-Finch commented on Ms. Taylor's propensity to tell the story in a way that she thought would please the listener: "It was very difficult assessing how much of what he had said is reliable… One can regard him as a pathological liar in that he lies so much that even he is not sure when he lies."

[1131] The Agreed Statement of Facts sets out that Ms. Taylor was subsequently admitted to Oak Ridge from January 26, 1976 to February 23, 1979, pursuant to a Warrant of the Lieutenant

Governor, having been found not guilty by reason of insanity for the index rape offence. The Ward Transfer Slips show that she was at first admitted to H Ward for assessment and then subsequently went to the STU on G Ward on March 2, 1976. Ms. Taylor stated that she felt that her participation in the STU programs was mandatory in order to eventually be released from Oak Ridge.

ii) Experience in the STU

[1132] Ms. Taylor testified in her examination-in-chief that the STU was a coercive environment and that her ostensibly willing participation was in reality mandatory in order to ever be released from Oak Ridge. On the other hand, on cross-examination, she stated that she believed at the time that Dr. Maier was sincere in his faith in the STU programs – in particular the DDT program. She then qualified this with the *caveat* that the STU programs did not work and did her no good.

[1133] The Clinical Records, along with the Agreed Statement of Fact, show that Ms. Taylor was in MAPP on the following occasions:

> May 15 to June 28, 1976, after Dr. Maier wrote that she: …'has a great deal of difficulty with ward rules and has tried breaking most of them. When Vance was confined for manipulative behaviour designed to feed his vanity and had to wear an untearable gown to groups, it was discovered that his self-image was so fragile he simply could not function at all without the protection that his clothing supplied...'
>
> January 19 to February 24, 1978, after acting out sexually with another patient. Following this 5-week stretch in MAPP a seemingly penitent Ms. Taylor wrote a lengthy letter stating that she was not mistreated and that she benefitted from being in MAPP.
>
> May 15 to June 5, 1978, after staff recorded her in the Clinical Records as being argumentative, displaying a bad attitude, and deliberately ignoring instructions in the ward kitchen. While in MAPP she was assessed as a suicidal risk so she was put on confined status.

[1134] The fact that 'patient-teachers' were in charge of supervising MAPP was a matter of specific concern to Ms. Taylor, who expressed intense dislike of this delegation of authority to other patients who misused their power. In cross-examination, however, she was willing to describe herself as being diplomatic and humane when she herself was a member of the security committee and was forced to sanction patients for their rule-breaking. She also explained in cross-examination that she was on the security team at various times when violence broke out, and stated that some of the patients had weapons in the STU. The STU committee system made patients responsible for quelling this kind of dangerous situation instigated by other patients.

[1135] Ms. Taylor also testified that what caused her "extreme anxiety" was the fact that one could be sent to MAPP at any time, often for a "sustained period of time". Although this view by its very nature is subjective, Dr. Chaimowitz in cross-examination conceded that this reaction was, objectively speaking, certainly a possibility for patients:

> Q. Well, she said MAPP was extremely anxiety provoking because there was always the threat of going back to MAPP?
>
> A. I understand that, yes.
>
> Q. And in a coercive environment, that can result in extreme anxiety for a sustained period of time, every day?
>
> A. It could do.

[1136] It was Ms. Taylor's testimony that MAPP was "torture, it was aggressive, it was confrontive *[sic]*, it was painful" because of the ways the patients' movements were limited. Furthermore, a significant part of Ms. Taylor's discomfort with MAPP was with the confinement period preceding each stint in MAPP, which she described in her testimony as amounting to solitary confinement. As she put it, the several days alone in a cell preceding each MAPP cycle was "no different from solitary confinement" because she lost "creature comforts" like a toothbrush and all such other amenities except for Styrofoam cups, bedding, and a mattress at night.

[1137] In cross-examination Dr. Chaimowitz, a recognized expert in solitary confinement, disagreed with Ms. Taylor and denied that the confinement in Oak Ridge was the same as that in a prison setting. But he did so in a way that all but confirmed her perception that the two were the same. His distinction was, in effect, that confinement in prison was meant to punish, while confinement in Oak Ridge was meant to teach a misbehaving patient a lesson:

> Q. I'm not asking about the design of the program, or why you think confinement was taking place in Oak Ridge, in the broader sense. I'm asking you, in this particular instance, Ms. Taylor was placed in confinement as punishment. There's no sign that she was dangerous to herself or others, correct?...
>
> A. … She wasn't following rules, and as a consequence, in a hospital situation, that would be considered negative reinforcement. So, she's doing something that was, I guess, unintended and was not considered therapeutic, and as a consequence, some of her liberties were taken away and she was placed in confinement. In a hospital system, that is different from a correctional facility where, I don't know if it's punishment, but people are placed in segregation for different reasons.
>
> Q. Well, Ms. Taylor had spent time in prison and she spent time in Oak Ridge, and she testified that the conditions of confinement in Oak Ridge were exactly the same as those in prison?
>
> A. That may have been her perspective, but one was a hospital, one was a prison.

[1138] The Treatment Records and Bedside Nursing Notes record that Ms. Taylor received the following treatments as part of the DDT program:

November 1, 1976, Dexamyl-Tofranil for 7 weeks.

May 3, 1977, Dexamyl-Trofranil for 7 weeks.

December 9, 1976, Alcohol-Ritalin.

November 22, 1977, Alcohol-Ritalin on the orders of Dr. Maier, administered to her while in the Capsule.

[1139] The Clinical Records also show that Ms. Taylor was in the Capsule on two occasions:

November 29, 1976, for two weeks, in combination with an Alcohol-Ritalin treatment. The record contains a signed Capsule Therapy Contract dated November 15, 1976, that stated the length of treatment would be at the discretion of staff, the Capsule group could not communicate with anyone outside the Capsule, physical restraint may be used by security staff, they would be give a liquid diet, there would be no music or showers, and that they would be naked.

June 17, 1977, for two weeks. Ms. Taylor signed a Capsule Contract dated June 17, 1977 whose terms were the same as above except that it specified that she would be in the Capsule for 14 days and would have pajamas.

[1140] Ms. Taylor claimed that she only agreed to sign the contracts and enter the Capsule because she feared further punishment if she did not do so. That said, on January 14, 1977, Ms. Taylor wrote: "The last six months have been most beneficial to me. I have broken through a lot of defences become much more open & honest… I have had a Dexamyl and Capsule group that's proven to be very beneficial to me."

[1141] Similar information was contained in a letter from the Clarke Institute to the Ontario Review Board dated May 3, 1978. That letter reported that at Oak Ridge, Ms. Taylor had been in the Capsule, received Dexamyl-Tofranil, and that from these treatments she indicated that she "got a lot of insight…and on his second trip to the capsule, he was more aggressive, and less restricted, not so insecure, nor would he let other people dominate the conversation. He stated he also shared some remorse when he was in the capsule over the girl he had raped."

[1142] Ms. Taylor was discharged from Oak Ridge and transferred to St. Thomas Psychiatric Hospital on February 23, 1979. The Discharge Summary of that date provides that she left Oak Ridge with a diagnosis of Personality Disorder with Antisocial Features.

iii) Post-Oak Ridge experience

[1143] On August 5, 1980, Ms. Taylor was discharged from St. Thomas to Queen Street Mental Health Centre. In a letter dated January 20, 1981 from Queen Street to Oak Ridge, it is related that shortly after her arrival at Queen Street Ms. Taylor went AWOL for two months and married a nurse from Queen Street. She was thereafter returned to Oak Ridge the next day, on January 21, 1981. She remained at Oak Ridge until July 24, 1984, when she was transferred to Brockville

Mental Health Centre. It does not appear from the evidence that Ms. Taylor was in any of the 3 impugned STU programs during this admission.

[1144] Ms. Taylor remained at Brockville from July 25, 1984 to December 10, 1984. On December 10, 1984, she was admitted to the Kingston Psychiatric Hospital where she remained until April 7, 1989. Then, on October 16, 1986, she was charged with sexual assault, forcible confinement, and choking. Her affidavit relates that she pleaded guilty to a charge of sexual assault and received a sentence of 6 months and 3 years' probation. In December 1987, Ms. Taylor ran away from the Kingston; upon her return, she was given an additional 3 months for escaping lawful confinement.

[1145] Her records show that after Kingston, Ms. Taylor was transferred among several institutions before being re-admitted to Oak Ridge on August 10, 1995. She remained at Oak Ridge until January 26, 2012. Finally, on June 20, 2017, she received an absolute discharge from the Royal Ottawa Health Centre.

iv) Causation and harm

[1146] In his trial testimony, Dr. Bradford, who opined on Ms. Taylor for the Plaintiffs and who had also assessed her in the past for a Review Board hearing, explained that prior to her gender transition Ms. Taylor was considered a pathological liar. It is unclear as to whether this aspect of her personality disorder has changed.

[1147] By way of illustration, testifying in 1984 before the Ontario Review Board, Ms. Taylor was positive about the STU programs. She stated that she made great strides in the programs, that she even did well enough to have been made a teacher in the STU, and that she was successful in that role as well.

> Mr. Lunnie: Again, how did it come about that you were chosen amongst others to be a teacher?
>
> The Patient: I guess the system felt that I had made substantial progress for the time I spent on G Ward, and, as a result of that, that warranted me being asked and set up to teach.
>
> Mr. Lunnie: And how did you do generally as a teacher?
>
> The Patient: I did good.
>
> Mr. Lunnie: You're sure of that? The reports would be good?
>
> The Patient: Yes.

[1148] By contrast, in her affidavit filed sworn in 2017, Ms. Taylor deposed that she received no treatment of any value at all in the STU, and that she made no progress while there.

> While I was at Oakridge, I did not receive any real psychiatric treatment, I was very committed to addressing the mental health issues I was battling at the time, including severe depression, drug and alcohol addiction, psychosis, gender and sexual identity issues, and other stressors at home. 1 wanted to become a productive member of society. I believe that if I had received the kind of rehabilitation that I was supposed to get at Oakridge, I could have gotten better much sooner, and my life would not have been spent almost entirely in confinement.

[1149] Similarly, the Clinical Records show that on February 24, 1978, Ms. Taylor wrote a report on her experience in MAPP. In this report she described the physical and emotional side of the MAPP experience as painless and positive.

> There was no mistreatment physically, mentally I found through what I've learnt there, some of the psychological concepts in the MAP program hard to adjust to. I've learnt my lesson… I'm not homosexual or bisexual. I'm heterosexual. But what I've learnt I will not lose sight of. I think the MAP program should continue and never be shut down…

[1150] In her affidavit submitted at trial, Ms. Taylor described her experience in MAPP in some detail. She wrote that the physical and emotional side of the MAPP experience was painful and negative.

> The Motivation, Attitude, and Participation (MAP) program was designed as a form of punishment. In the MAP program, I was in restraints, and my hands and feet were cuffed. At times, I was hand-cuffed to another patient. I was required to sit on the bare Terrazzo floor and the 'teacher' could take away my freedom to move if he saw fit. If I wanted to move, I had to raise a finger and wait for the 'teacher' to notice. The 'teacher', who was also a fellow patient, would then enquire why 1 needed to move and it was only if the 'teacher' found my answer 'satisfactory' that I was allowed to move. I was allowed to move only three times per hour and sometimes the 'teacher' would refuse to permit any movement. The pain I experienced on my feet and spine was excruciating. I was often verbally abused by fellow patients including the MAPP 'teacher' because I was not able to stay in the same position for a prolonged period.

[1151] Was Oak Ridge enjoyable or horrible for Ms. Taylor, and did she find it beneficial or detrimental? She obviously says different things at different times, and it is not possible to discern which is true and which is false. In my view, however, it does not particularly matter. The debate over her credibility is a debate about what she thought then and thinks now. But what is relevant at the moment is whether or not, objectively, the STU programs did her harm. Ms. Taylor's subjective perspective is, in a sense, neither here nor there in terms of the causation of harm.

[1152] As an example, in a Clinical Record dated January 13, 1978, a nurse recorded that Ms. Taylor found alcohol treatments in the Capsule to be positive and motivating experiences:

> Vance has had an alcohol treatment, a Dexamyl-Tofranil treatment, and two capsule groups, which he found beneficial…He would like to work as a teacher.

[1153] In his trial testimony, Ms. Taylor testified that he found alcohol treatments, whether in the Capsule or otherwise, to be negative experiences that fed his pre-existing addiction:

> …So I mean, you know, I was an alcoholic, cheap drunk... Alcohol, well, why would you give people that are, admittedly, prior to even coming there, alcoholics or drug addicts – I was a youth, troubled, no doubt about it, had problems, there's no question about it.

[1154] Whether the early answer, reflecting Ms. Taylor's unrecovered alcoholic phase, or the later answer, reflecting Ms. Taylor's sober, post-alcoholic phase, is reflective of her real feelings about drinking is not a relevant point. The relevant question is whether giving large quantities of alcohol to an alcoholic and putting her in an enclosed Capsule to deal in close quarters with other psychopathic and/or schizophrenic personalities was harmful. It is an objective, not a subjective question.

[1155] Dr. Bradford answers this question in the affirmative. He states in his Supplementary Report that Ms. Taylor recidivated into sexual violence, resulting in her prolonged incarceration and delayed rehabilitation, and that this was a consequence of the harm caused by the Oak Ridge programs. Dr. Chaimowitz, on the other hand, answers this question in the negative. He states in his trial testimony that Ms. Taylor's file does not reveal any indications of ongoing trauma or harm that she has incurred, and that the coupling of sexual disorders and psychopathy is a potent one that explains the trajectory of her life.

[1156] Dr. Chaimowitz elaborated on his view when cross-examined on it at trial. He explained that psychopaths are safe when contained and are dangerous when given liberties. Thus, what Ms. Taylor was put through at Oak Ridge was difficult, but was for her own good – the more severe the restrictions on liberty the better and safer for the person. This treatment was designed to improve her mental state by increasing rather than decreasing her anxiety. Dr. Chaimowitz stated that Dr. Barker recognized that this would also potentially increase the risk of violence by the distressed patient, but that is always the risk in taking away liberties. There is a risk-reward calculus to be done in trying to improve this kind of patient, and what appears to us to be harsh treatment was calibrated to produce a positive result.

[1157] Dr. Bradford's view is that inducing psychotic-type experiences through hallucinogenic and other drugs is designed to break down a person's personality, and that as a result Ms. Taylor described the experiences as humiliating and stressful. Added to this is that the drug treatments were combined with sleep deprivation and close proximity with other patients, creating a constellation of anxiety-producing factors. This, he opines, induced severe depression and exacerbated her existing drug and alcohol addiction and psychosis, as well as her gender identity disorders.

[1158] Oak Ridge and its MAPP, DDT, and Capsule programs did not create Ms. Taylor's drug and alcohol addiction, psychosis, and gender and sexual identity issues. But there is little doubt

from the evidentiary record that Ms. Taylor took decades to recover from these detrimental programs. Her criminal record after Oak Ridge was worse and more violence-prone than before Oak Ridge, and the intense emotional maelstrom of weeks in MAPP and the Capsule, with cocktails of psychosis-inducing drugs, was the cause of that deterioration in her ability to control her own behaviour.

[1159] As Dr. Bradford states, Oak Ridge and the STU programs caused her to take more time than would otherwise have been necessary to deal effectively with her psychiatric disorders under control and to earn some degree of liberty. The long-term trajectory of her life would have been different, and better, but for her comparatively lengthy exposure to the 3 impugned, harmful programs.

[1160] The STU programs at issue also caused Ms. Taylor significant short-term harm. Like most other patients who experienced MAPP, she reported serious discomfort. Likewise, the close and intense encounters in the Capsule were emotionally painful and were an affront to her dignity, which is noted repeatedly in the Clinical Records. And finally, the DDT exposure to drugs and alcohol which she had been consuming on the street caused her short-term negative experiences of which she was barely aware at the time. Just because an alcoholic does not particularly complain about alcohol, and a street user of psychoactive drugs does not actually complain about LSD, does not make them good experiences even in the short term. The STU programs were non-therapeutic, harm-causing experiences that she was put through at a time when she should have been exposed to more standard forms of therapy.

[1161] Dr. Maier was directly involved in Ms. Taylor's treatments in the impugned STU programs.

VII. Causes of action

[1162] The Plaintiffs' case against the Doctors centres around the cause of action in breach of fiduciary duties. In short, they submit that the doctor-patient relationship is inherently fiduciary and that in implementing the STU programs in issue the Doctors breached those duties. They contend that the breach of duty applies to the Doctors in their capacity as treating physicians as well as in their capacity as researchers and experimenters. In addition, the Plaintiffs submit that the Doctors are liable for two intentional torts: battery and assault as well as intentional infliction of emotional distress.

[1163] It is noteworthy that the Amended Second Fresh as Amended Statement of Claim, at para 176, pleads negligence in the failure to disclose the experimental nature of the impugned programs and, at para 180, pleads negligence in the failure to adhere to the requisite standard of care in conducting medical research. However, no claim in negligence is pursued by Plaintiffs' counsel in their final submissions. They have taken this approach despite the fact that, as the Doctors' counsel point out in their written submissions, claims of negligence "have been front and centre in this action for its entire 20 years." The Plaintiffs submit that the professional and ethical standards of the day are relevant, but that they go to establishing the fiduciary duties owed to the Plaintiffs rather than to establishing a measure of the Doctors' professional negligence.

[1164] The Plaintiffs' case against the Crown also centres around the claim of breach of fiduciary duties. In short, they submit that the Plaintiffs were exploited as subjects of human experimentation in a psychiatric facility directly operated and controlled by the Crown. They contend that the Plaintiffs having been admitted to Oak Ridge, the Crown was under a statutory obligation to provide them with observation, care and treatment by a qualified psychiatrist, but that instead the Plaintiffs were coerced into unethical forms of treatment and experimentation.

[1165] The Plaintiffs also claim that the Crown directly and knowingly assisted in the Doctors' breaches of fiduciary duties, and that as a result of this knowing assistance the Crown itself committed an equitable wrong and is liable on the basis of accessory liability. In addition, the Plaintiffs bring a claim based on the Crown's liability for the acts of the Doctors, who were their employees and agents. They contend that the Crown is vicariously liable for the Doctors' breach of fiduciary duties and for their intentional torts.

a) The Doctors' breach of fiduciary duties

[1166] The physician-patient relationship has long been considered to be a fiduciary one: *Kenny v Lockwood*, [1932] OR 141 (CA). More than 60 years ago, the predecessor to this Court had occasion to observe that, "The legal relationship between a patient and his physician or surgeon has been touched upon in only a few cases, but it is clearly established in them that it is fiduciary and confidential": *Henderson v Johnston*, [1956] OR 78 (HCJ). As the Supreme Court of Canada put it in *Norberg v Wynrib*, [1992] 2 SCR 226, at para 64, "All the authorities agree that the relationship of physician to patient also falls into that special category of relationships which the law calls fiduciary." In articulating what lies at the heart of this special relationship, the Supreme Court has emphasized that, "Vulnerability is common to many relationships in which the law will intervene to protect one of the parties": *Hodgkinson v Simms*, [1994] 3 SCR 377.

[1167] The relationship between researcher/experimenter and subject can also be a fiduciary one, although the courts have not opined on whether it is *per se* fiduciary: *Stirrett v Cheema*, 2020 ONCA 288, at para 51 (CA). As the Court of Appeal put it, at para 62, "The presence or absence of a fiduciary relationship will depend on the evidence in each particular situation." In this *ad hoc* analysis, the factors to be examined are set out by the Supreme Court of Canada in *Elder Advocates of Alberta Society v Alberta*, [2011] 2 SCR 261, paras 30, 33, 34 [citations omitted]:

> First, the evidence must show that the alleged fiduciary gave an undertaking of responsibility to act in the best interests of a beneficiary…
>
> Second, the duty must be owed to a defined person or class of persons who must be vulnerable to the fiduciary in the sense that the fiduciary has a discretionary power over them…
>
> Finally, to establish a fiduciary duty, the claimant must show that the alleged fiduciary's power may affect the legal or substantial practical interests of the beneficiary.

[1168] Building on the traditional analysis of fiduciary relationships articulated by Wilson J. (dissenting) in *Frame v. Smith*, [1987] 2 SCR 99, and adopted and applied by the Supreme Court in *Lac Minerals Ltd. v. International Corona Resources Ltd.*, [1989] 2 SCR 574, the *Elder Advocates* analysis of *ad hoc* fiduciary relationships can be summarized as an inquiry into the presence or absence of 3 ingredients: i) an undertaking on behalf of the alleged fiduciary, ii) vulnerability of the alleged beneficiary of the fiduciary duty, and iii) an interest that can be adversely impacted by the exercise of discretion or control.

[1169] In the case at bar, the Doctors, as medical staff in a Crown institution, were under a statutory duty to undertake care and treatment of the Plaintiffs. Correspondingly, the Plaintiffs as involuntary patients in a statutorily-created custodial mental hospital, were entirely vulnerable to the Doctors and the institution's administration. As a consequence of this relationship of power, duty, and discretion on the part of the Doctors and hospital administration, and vulnerability and reliance of the Plaintiffs as mentally ill patients, the Plaintiffs were in a position to be adversely impacted by the Doctors' exercise of their discretion and control.

[1170] The Court of first instance in *Stirrett v Cheema*, 2018 ONSC 2595 (SCJ), observed that the physician-patient and researcher-subject relationships were in that case, as here, combined. The motions judge pointed out, at para 47, that it is only logical that "[t]he obligation of a researcher to the subject when it involves humans is stricter than a doctor to patient relationship." In arriving at this conclusion, the Court cited contemporary medical ethics literature in order to establish that the scope of the fiduciary duty is coterminous with the scope of the ethical duties of the experimenter/physician.

[1171] While the Court of Appeal found that the motions judge fell into error by eliminating the factual causation requirement from the analysis of breach of fiduciary duties, it confirmed that the contours of a medical researcher's duties mirror the obligations set out in the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*, a policy adopted by the Canadian Institutes of Health Research, the Natural Sciences and Engineering Research Council of Canada, and the Social Sciences and Humanities Research Council of Canada: *Stirrett* (CA), at para 10. The Court specifically indicated, at para 36, that these obligations entailed the setting up of a methodological protocol and safeguards for the research. It further stated, at para 10, that the applicable ethical obligations stipulate that "[r]esearchers shall provide, to prospective subjects … full and frank disclosure of all information relevant to free and informed consent" and that participants shall be given "continuing and meaningful opportunities for deciding whether or not to continue to participate".

[1172] In a similar elaboration on the content of the duties, the Saskatchewan Court of Appeal in *Halushka*, *supra*, reasoned that the experimenting physicians were obligated to provide their subjects with full and frank disclosure of all information relating to their experiment. The Court went on to declare, at para 29, that the duty to the subjects was "at least as great as, if not greater than, the duty owed by the ordinary physician or surgeon to his patients."

[1173] As indicated earlier in these reasons, the impugned STU programs collided with medical ethics obligations that prevailed at the time. Professor Bernard Dickens, the only expert witness qualified as a medical ethicist, as opposed to physician or psychologist, to testify at trial, opined

that the MAPP, DDT and Capsule programs "were not carried out in accordance with the ethical and professional standards of the time". In his Reply Affidavit, he pointed out that, "even if at the time, other psychiatrists did engage in similar methods of patient management and care, this would not satisfy the ethical criterion of scientific proven effectiveness" to justify the subjection of the Plaintiffs to the programs at issue here.

[1174] In fact, Professor Dickens did not have to make such a far-reaching point. It turns out that the Defendants' experts could not identify another institution in the world where programs similar to the Capsule, MAPP and DDT were used as purported treatment for personality disorders or schizophrenia. Defendants' expert, Dr. Jonathan Freedman, who, as indicated earlier, conceded in his testimony that the 3 programs were experimental, described the programs as unreasonable and "very painful". In cross-examination, Plaintiffs' counsel put to him a description of the Capsule which came from the combined testimony of a number of the Plaintiffs, but which is almost as described by Dr. Barker himself in his published writings and verified in the Clinical Reports prepared by medical staff for each patient:

> Q. The patients testified, and I'm asking you to assume, that the Capsule was a constantly lit, windowless ten-by-ten room, with an exposed toilet in the corner, lights constantly lit, no clock, patients lost track of time, didn't know whether it was day or night, liquid food only dispensed through straws in the wall, anywhere between eight to twelve patients in the capsule group at any time. Patients were in the capsule naked… No access to a shower. No basic hygiene. They had to use the facilities in front of everyone else, often cuffed to another patient. No mattress, no blankets, no pillows… One patient, Danny Joanisse, was terrified that he was going to be abused by a pedophile or a child murderer, I can't remember which. He slammed and banged at the door, begging to be let out, wouldn't be let out…

[1175] After a number of clarifications and reiterations of the question, Dr. Freedman acknowledged that the program could not have met the ethical standards and obligations of medical practitioners or medical institutions applicable either then or now:

> Q. Would you agree with me, sir, based on your learnings and teachings, that if the evidence I have described to you were true, about the way in which these young men were treated, coercively, and the sanctions imposed upon them, would you agree with me that, that was pretty horrific treatment, based on what you know?
>
> A. I've already said that if what the plaintiffs testified to was all accepted and was true, that they went through a terrible experience.
>
> Q. And they shouldn't have gone through that experience, based on the standards at the time?
>
> A. They shouldn't have gone through it in any case.

[1176] As the Supreme Court of Canada pointed out in *Hodgkinson*, at para 35, "The precise legal or equitable duties the law will enforce in any given relationship are tailored to the legal and practical

incidents of a particular relationship." Thus, expert evidence of this nature is of "considerable importance in establishing standard practice in the industry from which one can determine the nature of the obligations which will be imposed by law": *Lac Minerals Ltd. v International Corona Resources Ltd.*, [1989] 2 SCR 574, at para 46. As the Alberta Court of Appeal explained in *Huet v Lynch* (2000), 184 DLR (4th) 658, at para 39, a psychiatric patient, "[a]s the beneficiary in a fiduciary relationship…[is] entitled to rely on the defendants, at a bare minimum, to comply with the [relevant professional obligations]."

[1177] Professor Dickens testified that the applicable ethical standards during the period in issue in this trial are found in a combination of the ancient Hippocratic Oath, the *Declaration of Geneva, 1948*, and the *1970 Canadian Medical Association Code of Ethics*. Collectively, these instruments require medical practitioners to: a) practice medicine without causing patients unnecessary harm, b) to practice medicine with the best interest of the patient in mind; and c) to maintain the well-being of the patient as their primary consideration.

[1178] McLachlin J. (as she then was) stated in *Norberg*, *supra*, at para 78, that these duties are even more stringently applied to psychiatrists than to other practitioners: "The Task Force of the Ontario College of Physicians and Surgeons has in its report also recognized the greater danger of breach of trust inherent in psychotherapeutic relationships, and has as a consequence recommended even more stringent guidelines for appropriate psychotherapist behaviour than it has for physicians practicing in other areas." Accordingly, "[t]he physician is pledged by the nature of his calling to use the power the patient cedes to him exclusively for her benefit. If he breaks that pledge, he is liable": *Ibid.*, at para 98. In other words, a breach of professional ethics can in and of itself qualify as a legally cognizable breach of fiduciary duty.

[1179] It is obvious from Dr. Barker's writings and Dr. Maier's evidence that the STU programs were experimental – Dr. Maier himself acknowledged in cross-examination that he had boasted, "The STU was one of the great experiments in psychiatry." The nature of the experiment was that the programs were designed to break down and change the Plaintiffs' personalities. This, according to Dr. Maier, had not been tried before.

[1180] As Professor Dickens explained in his expert Report dated February 28, 2017, while attempts to bring about change in a patient's personality can be carried out ethically, they call for heightened caution. The STU programs, however, contained no safeguards. In fact, the Clinical Records establish that the Doctors were often all but absent from the STU, and that many Plaintiffs asked for interviews or meetings with Dr. Barker or Dr. Maier but were ignored. This designing of and assigning patients to programs that were intentionally hurtful – with an experimental hope, but no realistic prospect, that they would ultimately be for a greater good – constituted a breach of the ethical duties under which the Doctors were obliged to operate.

[1181] The same can be said for the excessive use of confinement as a means to turn the patients around. At least for Joseph Bonner, for whom this is specifically pleaded as an element of the Doctors' wrongful conduct, confinement of longer than 15 days' duration is a breach of ethics and professional obligations.

[1182] Moreover, the Doctors delegated fundamental medical duties to patients, contrary to their professional responsibilities. It was Professor Dickens' view that the use of 'patient-teachers' and 'patient-observers' in the Capsule, MAPP and DDT programs amounted to a delegation of the Doctors' ethical duties as recognized in the *Nuremberg Code*, the *Declaration of Helsinki, 1964*, and the *1970 CMA Code of Ethics*.

[1183] Numerous Plaintiffs testified that the patient-teachers frequently abused their positions of power over other patients; and while the Plaintiffs were not always entirely credible witnesses, this evidence has the virtue of being logical and predictable. The so-called patient-teachers were themselves individuals suffering from psychopathy and other serious psychiatric disorders, the majority of whom had demonstrated violent aggression during the course of their lives. It would be surprising if, having been placed in a position of actual authority for the first time in their lives, they had the knowledge and self-control to use their power non-abusively.

[1184] In addition to all of this, Professor Dickens opined it was a fundamental ethical obligation to ensure that patients participating in the experimental STU programs give their voluntary and informed consent. As already discussed at some length in these reasons, that obligation was not fulfilled by the Doctors or by the Oak Ridge administration. The Plaintiffs' purported consent was not fully informed and it was coerced in the sense that it was tied to the Doctors' eventual recommendation as to whether or not the Ontario Review Board should release the patients from a custodial institution.

[1185] Further, it was an explicit policy of the Doctors that once a patient was already a participant in one of the impugned programs, he could no longer opt out. The record shows that this was a policy regularly applied in Oak Ridge. Indeed, in an article published in the patient newsletter *The Seventh Circle* dated February 15, 1973, Dr. Maier himself set this out explicitly. In doing so, he simultaneously illustrated the delegated authority that patients had in determining what drug treatments each other would undergo:

> Eldon Hardy recently requested that his Scopolamine treatment be discontinued as he feels the measure of discomfort he is experiencing is too much to pay for the amount of treatment he is receiving… The drug treatment policy was reiterated and this was feedback to the ward. Although the ward had previously expressed agreement with Eldon's request he is remaining on the treatment in light of the policy and that it is felt the treatment will be beneficial for him.
>
> Editor's Note: In discussion with Dr. Maier it became evident that it would be appropriate to re-express the drug treatment policy for the benefit of all to prevent similar misunderstandings from arising.
>
> When you volunteer for a drug treatment you make a commitment for an entire regime and you will be held to it unless physical reasons necessitate termination… A person refusing to stick with his commitment will be sent to MAP.

[1186] Liability for breach of fiduciary duty is analyzed on what could be called a strict liability basis – that is, liability established upon a finding that a fiduciary duty has in fact been breached.

Again, as McLachlin J. stated in *Norberg*, "[e]quity has always held trustees strictly accountable in a way the tort of negligence and contract have not". Of course, factual causation of harm is also a necessary element, as the Court of Appeal held in *Stirrett*, *supra*. The harms redressed by a remedy for breach of fiduciary duty include physical and psychiatric harms, as well as less tangible harms such as injury to a patient's right of inviolability and human dignity: Paul Miller, Sujit Choudhry, Angela Campbell, *Legal Regulation of the Physician-Patient Relationship*, Royal College of Physicians and Surgeons of Canada: <http://www.royalcollege.ca/rcsite/bioethics/primers/legal-regulation-physician-patient-relationship-e>.

[1187] In addition to providing a remedy for harm caused by the breach, the courts have also infused breach of fiduciary duty with deterrent remedies that address the "public concern about the maintenance of the integrity of fiduciary relationships": *McBride Metal Fabricating Corp. v H & W Sales Co.* (2002), 59 OR (3d) 97, at para 30 (CA). For this reason, a breach of fiduciary duty can potentially constitute a basis for punitive damages, as pleaded by the Plaintiffs. Having said that, I make no findings here with respect to punitive damages, as that is not an issue to be addressed in this portion of the trial. In the quantification of damages stage of the trial, counsel for all parties may wish to adduce expert evidence or make submissions with respect to the appropriateness and/or quantity of punitive damages in the circumstances of this case.

[1188] Furthermore, breach of fiduciary duty is governed by flexible principles that give the claimant the "full benefit of hindsight": *Canson Enterprises Ltd. v Boughton & Co.*, [1991] 3 SCR 534 (McLachlin J., concurring). Liability is therefore not limited by principles of the foreseeability or remoteness of the harm caused by the breach. While quantification of the loss may be a difficult exercise, it is to be kept separate in the analysis and does not cloud the determination of liability. The Supreme Court confirmed and reiterated this approach in *Williams Lake Indian Band v. Canada (Aboriginal Affairs and Northern Development*), [2018] 1 SCR 83: "Equity addresses such questions under the heading of remedy or damages once the existence and breach of a fiduciary obligation have been established."

[1189] Given the scheduling of this trial, it suffices at this juncture to find that there is a valid claim against the Doctors for breach of fiduciary duties, and that the evidence establishes that those fiduciary duties have in fact been breached. On the record before me, both Doctors disregarded the ethical obligations that were on them to treat the patients in a way that did not cause them further harm, to ensure that they obtained truly voluntary and informed consent for treatment and/or experimentation, and to refrain from delegating their oversight and professional judgment to untrained persons (and especially to other patients likely to perpetrate abuse).

[1190] In view of all of this, breaches of fiduciary duties by both Doctors have been established.

b) The Doctors' intentional torts

[1191] The Supreme Court of Canada in *Non-Marine Underwriters, Lloyd's of London v Scalera*, [2000] 1 SCR 551, at para 2, indicated that, "The law of battery protects this [bodily] inviolability, and it is for those who violate the physical integrity of others to justify their actions." The Court went on to explain, at para 16, that "the tort requires contact 'plus' something else. One view…is that the 'plus' refers merely to non-trivial contact. The caselaw to date tends to support this view,

and generally does not require actual physical or psychological injury." The *Scalera* judgment also instructed, at para 15, that, "If [defendant] can show that he acted with consent, the *prima facie* violation is negated and the plaintiff's claim will fail. But it is not up to the plaintiff to prove that, in addition to directly interfering with her body, the defendant was also at fault."

[1192] As illustrated by the individual Plaintiffs' testimony and Clinical Records, some of the Plaintiffs signed forms of consent or gave what appeared to be verbal consent to the STU treatments, while others did not. None of the Plaintiffs, however, gave legally recognizable consent to participation in the Capsule, MAPP, or DDT. I have already found that even where there was a semblance of consent, truly voluntary and informed consent was not possible in the coercive environment of Oak Ridge. As such, the Defendants have failed to establish a defense of consent to battery.

[1193] All 3 of the impugned STU programs amounted to a non-consensual, non-trivial invasion of the Plaintiffs' bodily integrity. The physical regiment of MAPP, whether or not accompanied by restraints, was self-evidently an infringement of bodily inviolability, as was the stripping and placing of patients in the Capsule with unhygienic conditions and sleep deprivation, again with or without restraints. Finally, the administering of DDT drugs without properly informed consent, whether by injection or orally, constituted a physical invasion that is legally a battery. For Joseph Bonner, being placed in confinement for extended periods of time – 6 of the 9 months that he was at Oak Ridge – likewise amounted to a physically invasive battery.

[1194] Turning to the tort of assault, the courts across Canada have embraced a common definition, as expounded upon by the Saskatchewan Court of Appeal in *McLean v McLean*, 2019 SKCA 15, at paras 59-60:

> Allen Linden and Bruce Feldthusen, in *Canadian Tort Law*, 10th ed (Toronto: LexisNexis, 2015) at 49, provide a definition of civil assault:
>
> §2.42 Assault is the intentional creation of the apprehension of imminent harmful or offensive contact. The tort of assault furnishes protection for the interest in freedom from fear of being physically interfered with. Damages are recoverable by someone who is made apprehensive of immediate physical contact, even though that contact never actually occurs.

[1195] To establish a claim for assault, the evidence must demonstrate that a Plaintiff had reasonable grounds to believe that they were in danger of violence from the tortfeasor: *Bruce v Dyer*, [1966] 2 OR 705, at paras 10-12 (SC), aff'd [1970] 1 OR 482 (CA). As with battery, assault is a trespass to the person and is actionable without proof of quantifiable damages: see *McLean*, at para 63. In fact, even without a completed battery, if assault is established on the evidence it can potentially ground punitive damages as a means of signaling the need for public "condemnation and outrage": *Herman v Graves*, 1998 ABQB 471, at para 52.

[1196] Plaintiffs' counsel submits that while older decisions required an assault to be based on an imminent apprehension of harm, recent jurisprudence has determined that an actionable assault can be made out on the basis of fear of future harm. Thus, for example, in *Warman v Grosvenor*,

[2008] OJ No 4462, at para 1 (SCJ), the Court concluded that a "two year 'campaign of terror' against" the plaintiff constituted an actionable assault. Counsel for the Plaintiffs contends that patients who were in Oak Ridge endured 4 varieties of assault: a) the threat of Nazanin and other pharmacological restraints, b) the threat of cuffs and other physical restraints, c) the threat of being coerced into DDT drugs, d) and the threat of being placed in MAPP and/or solitary confinement.

[1197] Two of the threats that Plaintiffs' counsel identify were possibly real, but are not actionable here. As indicated a number of times throughout these reasons, this lawsuit is about the 3 specifically impugned STU programs. It does not seek to hold the Defendants liable for the fact that any given Plaintiff had to endure spending time in a maximum-security mental hospital, no matter how frightening or unpleasant that experience may have been. To do so would be beyond what is pleaded in the Amended Second Fresh as Amended Statement of Claim.

[1198] The prospect of either pharmacological sedation or physical restraint was an aspect of the maximum-security environment that may have been justified or unjustified depending on the particular circumstance in which these interventions were deployed. However, they were not a special part of, or particularly related to, the programs impugned in this action. Like bars on the windows and "rooms" that looked more like prison cells, these features were part of the Oak Ridge terrain. They were not part of the novel/experimental "therapeutic environment" designed and implemented by the Doctors at Oak Ridge.

[1199] Furthermore, I find little evidence to support the contention that the Plaintiffs lived at Oak Ridge under the threat of coerced participation in the DDT program. While I have found that the consents given by various Plaintiffs for participation in DDT were not properly informed or voluntary, that does not mean that they were induced by fear in an assaultive sense. Consent to the DDT program was sometimes improperly enticed – e.g. Plaintiffs such as Donald Everingham and John Finlayson, who were alcoholics who "consented" to alcohol treatments. At other times, consent to DDT treatments was a result of an incentivized prodding or inducement – e.g. Plaintiffs such as Reginald Barker and James Motherall, who indicated that they would have agreed to any program that held out the prospect of contributing to their eventual release from custody.

[1200] None of the Plaintiffs testified that DDT participation was a product of fear in the way of a looming or threatened assault; rather, participation was for the most part a product of what Dr. Barker in his writings termed a "goad to freedom". This approach was wrongful and vitiated the purported consent of each DDT participant, but it was not exactly a threatened assault. The only "threat" perceived by the Plaintiffs was that the legal status-quo would remain in place.

[1201] That said, the threat of being placed in MAPP or, at least for Joseph Bonner, being placed in confinement, was more in line with the case law on assault. As discussed elsewhere in these reasons, MAPP was a physically harsh, punitive regime which patients strived, out of fear, to avoid if they could. It was also one of the impugned STU programs about which this trial is concerned. Plaintiffs such as Allen McMann, who were sent to MAPP repeatedly, testified that they consented to other programs and treatments at Oak Ridge out of fear of being sent to MAPP yet again. Other Plaintiffs, such as Samuel Shepherd, testified that they were intimidated into passivity and the appearance of cooperation, for fear of being sent to MAPP. Stanley Kierstead appears to have had

such a fear of MAPP that he transposed in his mind his real experience of solitary confinement at Oak Ridge with others' narratives of MAPP.

[1202] Either way, the well-documented Clinical Records, along with the Plaintiffs' testimony, establish that the patients at Oak Ridge lived under the shadow of the MAPP threat. In this respect, the Defendants' design, administration, and implementation of the MAPP amounted to an assault on the Plaintiffs. This assault was perpetrated not only against those Plaintiffs who were in MAPP, but against those who were not. Its constant presence as Oak Ridge's favoured punitive program had an impact on each of the Plaintiffs, who under the circumstances were on reasonable grounds in believing that they were in danger. As this court long ago determined, and the Court of Appeal long ago upheld, "if a person shakes his fist at another", even without striking a blow, an actionable assault has taken place: *Bruce v Dyer* (SC), *supra*, at para 11.

[1203] As mentioned at the outset of this section, Plaintiffs' counsel has also put forward the theory that the implementation of the impugned STU programs constitutes the tort of intentional infliction of emotional distress. Broadly speaking, a claim under this tort requires that the Plaintiffs show that the Defendants engaged in a) flagrant or outrageous conduct; b) calculated to produce harm, and c) resulting in mental or psychological injury: *Prinzo v Baycrest Centre for Geriatric Care* (2002), 60 OR (3d) 474, at para. 48 (CA).

[1204] The first of these ingredients encompasses a relatively wide range of conduct, including humiliating or demeaning verbal abuse. The second ingredient requires that "…the actor desires to produce the consequences that follow from the act, or if the consequences are known to be substantially certain to follow", such as where a supervisor derides an employee with the aim to getting her to quit: *Boucher v Wal-Mart Canada Corp.*, 2014 ONCA 419, paras 35, 46. The third ingredient requires a psychiatric injury that "is 'serious and prolonged and rise[s] above the ordinary annoyances, anxieties and fears' that come with living in civil society", *Saadati v Moorhead*, [2017] 1 SCR 543, at para 37. Examples of such injuries would include serious levels of stress, disturbed sleep, and mood-related issues: *Boucher*, at paras 37-38.

[1205] I have little hesitation agreeing with Plaintiffs' counsel that the conduct in issue – the Capsule, DDT, and MAPP – is "flagrant and outrageous". Dr. Barker in his own writings conceded this, indicating in "Buber Behind Bars", p. 71, that, as pointed out earlier in these reasons, the programs on first blush "may suggest the weekend pastimes of Storm Troopers". Several of the Defendants' own expert witnesses – specifically, Dr. Freedman and Dr. Gutheil – as well as the Plaintiffs' expert witness, Dr. Bradford, indicated that they were unaware of anything similar to the STU's combination of programs at the time or since. In a similar vein, the editor of a professional psychiatric journal, in a February 1979 letter to Dr. Tate reviewing an article written by Drs. Tate and Maier accurately describing the DDT program, indicated that if published it would "incit[e] ethical controversy".

[1206] Likewise, I have little hesitation in agreeing with Plaintiff's counsel that the third ingredient of this tort – that the acts complained of produced "serious and prolonged" mental harm – is satisfied here. I have already concluded that a number of the Plaintiffs suffered both short-term and long-term harm in the form of unstable work and personal lives, severe anxiety, depression, recidivist criminality, and substance abuse. Michael Pinet, to take just one example,

was given LSD as part of the DDT program, and the emotional overload on him as a vulnerable teenager induced him to enter into a catatonic state. Years later, he emerged from Oak Ridge into a life of sexually violent crimes, which had not characterized him prior to his STU experiences.

[1207] Of greater concern in making out the tort of intentional infliction of emotional distress is the second ingredient – whether the Defendants, or, more specifically, the Doctors, desired to produce the harmful consequences that flowed from the impugned programs. Plaintiffs' counsel relies on the fact that the impugned programs, and especially the DDT program, were designed with the goal of breaking down the patients' mental defenses in order to get them to reveal and confront their true selves. As referenced earlier in these reasons, Dr. Barker in his writings described the pain induced by DDT sessions, explaining that the "hyperventilating and vomiting that occur are mostly due to the extreme anxiety evoked."

[1208] The imposition of pain and suffering, although doubtless very real, was intentional in an immediate, assaultive sense, but was not the goal of the DDT or other programs. Rather, the goal was, as Dr. Bradford characterized it, a "demystifying" process. As referenced earlier, Dr. Barker wrote that his programs were aimed at "loosening the rigidly implanted patterns of behavior behind which many patients hide the turmoil of their disorders." In other words, the pain that was inflicted on the Plaintiffs was akin to the athletic coach or personal trainer's mantra, 'No pain, no gain.'

[1209] Dr. Barker's foundational idea, misguided as it turned out to be, was to break down the patients' psyche in order to build them a better, more stable mind. This infliction of harm for a greater end is not analogous to the example proffered by Plaintiffs' counsel – i.e. the deriding of an employee with the specific intent of driving her out of her employment: *Boucher*, at para 36. That, of course, is an illustration of the infliction of harm not for a greater end, but for no good end beyond the immediate and hurtful result. The Court of Appeal has been clear that to qualify for the intentional infliction tort, the Defendants' conduct must be shown to have been "plainly calculated to produce some effect *of the kind* which was produced": *Piresferreira v Ayotte*, 2010 ONCA 384, at para 78, quoting *Wilkinson v Downton*, [1897] 2 QB 57, 59 [emphasis in the original].

[1210] The STU programs were not plainly calculated to produce the lasting, harmful effects that that those programs had on many of the Plaintiffs. They were calculated – a miscalculation, as it turns out – to produce immediate harm but beneficial long-term psychiatric effects. Dr. Bradford, despite being highly critical of the STU programs, conceded that the intentions behind them were for an eventual good:

> Q. …[G]enerally speaking, and I think we've agreed on this, that was the intention, was to help people and get them into the community?
>
> A. That – I think that – I think that that's fair. I think that there were other issues as well, but I think if, at least at face value and I think Doctor Boyd probably voiced that more clearly in my opinion, but I think Doctor Barker gave some mixed messages in that regards, but generally, I will accept your thesis.

[1211] Dr. Bradford went on in his testimony to say that, from the point of view of a physician, "[g]ood intentions are not good enough." I accept that – care, competence, prioritizing the patient's

welfare, and doing no harm, are all of paramount concern in medicine and medical ethics. They are also central to the fiduciary duties of physicians. But from the point of view of the law of the tort of intentional infliction of emotional distress, good intentions are indeed good enough. They are precisely what a defendant needs to establish in order to avoid liability.

[1212] The Doctors created and ran a bad set of programs, but with intentions that were not quite as bad as the programs. The Plaintiffs have a valid claim against them on several legal bases, but not on the basis of intentional infliction of emotional distress. The crucial second ingredient of that tort – the intention to cause harm – is not established on the evidence adduced at trial.

c) The Crown's breach of fiduciary duties

[1213] As can be seen by the review of the individual Plaintiffs' case histories, each Plaintiff in this action was ultimately held at Oak Ridge either via a physician's certificate under the *Mental Health Act* or a Warrant of the Lieutenant Governor under the *Criminal Code*. Either way, the Crown in Right of Ontario, having responsibility for the institution, owed duties to the Plaintiffs that were of a fiduciary nature. These duties arise by virtue of the statutory scheme under which Oak Ridge operates and by virtue of the discretionary powers exercised by the Crown's employees and agents in administering Oak Ridge and carrying out their responsibilities toward the patients admitted there.

[1214] In short, the governing statute and regulations "place[d] a duty on psychiatric facilities to provide services to persons suffering from mental disorders… For patients in those facilities, those services include observation, care and treatment": *Perez v Governing Council of the Salvation Army in Canada* (1998), 42 OR (3d) 229 (CA). In describing the purpose of the Act and the nature of the duty imposed on "psychiatric facilities" such as Oak Ridge, the Court of Appeal has underscored that "[t]he Act recognizes and gives statutory force to the duty to treat those who are patients in the facility." This statutory duty, in turn, gives rise to a fiduciary duty in the authority with the power and duty to administering the institution toward those under its care: *Elder Advocates*, at para 52.

[1215] Like the currently in-force *Mental Health Act, 1990*, the *Mental Health Act, 1970* and the *Mental Health Act, 1980* both stressed the requirement that a mental health facility such as Oak Ridge is infused with a duty of observation, care and treatment of its patients. The various iterations of the statute defined a "patient" as "a person who is under observation, care and treatment in a psychiatric facility". Both defined a "psychiatric facility" as a "a facility for the observation, care and treatment of persons suffering from mental disorder, and designated as such by the regulations". As the Crown directly controlled and operated Oak Ridge through its servants, Dr. Boyd and his successors as Superintendents/administrators, the duties and undertakings of "psychiatric facilities" as described under the *Mental Health Act* are directly imputed to the Crown.

[1216] Section 5(1) of the Regulations under the *Mental Health Act* provides that "the observation, care and treatment of patients of a psychiatric facility shall be under the direction and supervision of a psychiatrist." This requirement is in keeping with the policy of the statute and regulations thereunder to provide patients in the facility with professional observation, care and treatment; a

strictly custodial detention or punitive regime or non-therapeutic medical experimentation were incompatible with the Crown's obligations at Oak Ridge.

[1217] This duty is reinforced by sections 7 and 26(1) of the *Mental Health Act* , which provide, respectively, that "any person who is believed to be in need of the observation, care and treatment provided in a psychiatric facility may be admitted thereto" and "[a] patient shall be discharged from a psychiatric facility when he is no longer in need of the observation, care and treatment provided therein". "Observation, care and treatment" are therefore the touchstones of the institution's duties at all phases of its dealings with the patients – i.e. in determining when they are to be admitted, how they are to be related to for the duration of their admission, and when they are to be discharged.

[1218] The *Mental Hospitals Act*, RSO 1990¸ c. M.8 and its predecessors applied to designated "hospitals", which has at all relevant times included the maximum-security Oak Ridge division of the Mental Health Centre in Penetanguishene. The *Mental Hospitals Act* designated authority over Oak Ridge to the Deputy Minister of Health, who was in turn answerable to the Minister of Health. This authority was then delegated to the superintendent of each hospital who, like Dr. Boyd, were granted "charge of… and control over the institution", and who would exercise their authority through employees and agents.

[1219] These provisions afforded Dr. Boyd and his successor superintendents control over all aspects of the hospital's operations, physicians, who were directly employed by the Department of Health. Likewise, the delivery of treatment was overseen and implemented by the superintendent, making Dr. Boyd and his successors (and, consequently, the Crown) responsible to ensure the observation, care and treatment of Oak Ridge's patients. In other words, the overall effect of the scheme was to make Oak Ridge an institution directly administered by the province's Department of Health. Neither Oak Ridge nor the Penetanguishene Mental Health Centre had an independent board of directors, nor did they have any corporate legal personality or charter distinct from the scheme under the relevant statutes. As entities, they were legally indistinguishable from the provincial Crown.

[1220] The Court of Appeal has held that the Crown is directly liable for injuries sustained by psychiatric patients of such non-incorporated mental health facilities, and any claim against hospital must be brought against Crown: *McNamara v North Bay Psychiatric Hospital* (1994), 16 OR (3d) 633 (CA). Since the Crown can only act through its agents, *Swinamer v Nova Scotia (Attorney General)*, [1994] 1 SCR 445, a Crown body "created by statute" is responsible for the actions of the individuals serving as the body's "principal organs": *KLB v British Columbia*, [2003] 2 SCR 403.

[1221] In a claim asserting the direct liability of the Crown, the focal point of liability is therefore the "conduct of the principal public servants involved in the plaintiff's case within the framework of the statute": see *JCR (Litigation Guardian) v British Columbia*, 2007 BCCA 496, at para. 27. As the Nova Scotia Court of Appeal has put it, "This practical reality that the government may act only through its employees means that the actions of the governmental fiduciary's employees may implicate the government's direct liability": *Nova Scotia (Attorney General) v Carvery*, 2016 NSCA 21, at para 88.

[1222] In his affidavit of April 24, 2019, Professor Dickens opined that the Doctors in running the STU programs did not safeguard the health and welfare of their patients: "The risks of Dr. Barker and Dr. Maier's treatment, including of psychotic outbursts, homicide and suicide, are recognized, but there is no evidence to justify those risks beyond Dr. Barker's assertion that the benefits of the experimental treatment showed sufficient promise. That is, it is not shown that the ethical test of a favourable benefit-to-risk ratio was met." He went on to state in his Reply affidavit of April 25, 2019 that the Crown was equally remiss in its failure to safeguard those in its care and custody: "the Province of Ontario did not provide adequate oversight of the patients' welfare and rights, leaving vulnerable, mentally-ill patients to the custody and care of psychiatrists who; in the absence of adequate oversight and necessary funding, embarked on experimental programs in conditions that fell short of the ethical standards of the day."

[1223] I have not lost sight of the fact that a number of the Plaintiffs were minors when they were admitted to Oak Ridge. The Supreme Court of Canada has held that persons and institutions exercising "overriding power and influence" over minors in a "power dependent relationship" are fiduciaries of those minors: *EDG v Hammer*, [2003] 2 SCR 459. Just as the government and children placed in foster homes are in a fiduciary relationship, *M (K) v M (H)*, [1992] 3 SCR 6, so one can conclude that "standing in the parents' stead, the Superintendent has considerable power over vulnerable children and…may affect their lives and well-being in fundamental ways": *KLB v British Columbia*, [2003] 2 SCR 403, at para 38. Recognizing this, it is apparent that a psychiatric institution's responsibility to care for, and to avoid harm to, its underage patients is its "paramount duty": *D (B) v Children's Aid Society of Halton (Region)*, [2007] 3 SCR 83, at para 53.

[1224] It is this responsibility for vulnerable patients that creates a fiduciary duty in the Crown that is analogous to a private law fiduciary duty. This duty is mirrored for all patients, both minors and adults alike, in the statutory duties imposed on the institution and its Superintendent. In this respect, the Crown stood toward the Oak Ridge patient much like a traditional trustee stands toward a beneficiary, or a guardian to a ward. The Supreme Court of Canada acknowledged in *Authorson v Canada (Attorney General)*, [2003] 2 SCR 40, at para 8, that where the Crown has undertaken a relationship resembling a traditional trusteeship, it undertakes fiduciary obligations.

[1225] All of the Plaintiffs were involuntary patients at Oak Ridge, and all were under the complete authority and control of its doctors and administration. As indicated, some of the Plaintiffs were certified and held involuntarily because they were suffering from a "mental disorder of a nature or degree so as to require hospitalization in the interests of his own safety or the safety of others": *Mental Health Act, 1970*, s. 8. Others were sent there for their "safe custody" after a verdict of Not Guilty by Reason of Insanity, and held "for the purpose of [their] rehabilitation... with the consent of the person in charge of such place": *Criminal Code*, 1970, s. 545(1) and (2).

[1226] Either way, the vulnerable Plaintiffs were entirely under the control of the Crown, whose powers in the administration of every aspect of their "care and treatment" went beyond "the ordinary exercise of statutory power": *Elder Advocates*, at para 53. Unlike where the Crown is prosecutor or otherwise in an adversarial role, under these circumstances the Crown is custodian and guardian of the patients: see *Cirillo v Ontario*, 2019 ONSC 3066, at paras 13-16 (SCJ). Furthermore, the Crown's position in administering the STU programs does not impose "a burden

on the Crown [that] is inherently at odds with its duty to act in the best interests of society as a whole": *Elder Advocates*, at para 444.

[1227] The Crown is under an obligation, *inter alia*, to keep the Plaintiffs in safe custody, and to keep the public safe from them given the violent background from which they for the most part come. In *Ontario v Phaneuf*, 2010 ONCA 901, at para 22, the Court of Appeal understandably said that this duty cannot take a back seat to the interests of the individual in custody:

> The Crown's duties to the appellant and to the public are circumscribed by the terms of the orders made in respect of the appellant's custody and the relevant provisions of the *Criminal Code*. The Crown was obliged to implement the court orders in accordance with their terms and in a manner consistent with the relevant provisions of the *Criminal Code*. In doing so, its obligation was to act in the public interest. That obligation could not possibly co-exist with a fiduciary obligation to the appellant to act in her best interests to the point of disregarding or compromising the Crown's obligation to act within the terms of the court orders and the provisions of the *Criminal Code*.

[1228] The challenge in *Phaneuf* was to the custodial arrangement itself, which the Crown could rightly say was part and parcel of its duty. Not holding the claimant in custody would certainly have been a conflict with this public duty, making it a logical impossibility for the Court to find that there was a fiduciary obligation to do so.

[1229] The case at bar poses a similar question in a substantially different context. It is not part of the Crown's custodial duty to administer mind altering hallucinogens or pain and anguish-inducing Scopolamine to the Plaintiffs. The Crown has no public safety obligation to place the Plaintiff stark naked in isolated and close quarters with each other in the Capsule, or to require them to sit rigidly immobile for hours on end in MAPP at the mercy of another patient, or 'patient-teacher', with a mental health background similar to their own. There is no conflict between the "observation, care, and treatment" duty of the Crown toward the Plaintiffs and the protection and safety obligation of the Crown toward the public. The only conflict that arises between them is a result of the breach of the fiduciary duty; it is not a result of the existence of a fiduciary duty such as to make that existence a logical impossibility.

[1230] The three characteristics that the Supreme Court has said are the hallmark of fiduciary relationships are all present with respect to the Plaintiffs at Oak Ridge:

> (1) The fiduciary has scope for the exercise of some discretion or power.
> (2) The fiduciary can unilaterally exercise that power or discretion so as to affect the beneficiary's legal or practical interests.
> (3) The beneficiary is peculiarly vulnerable to or at the mercy of the fiduciary holding the discretion or power.
>
> *Frame v Smith*, [1987] 2 SCR 99, at para 60 (Wilson J., dissenting), cited approvingly in *Elder Advocate*s, at para. 36.

[1231] A medical institution, and each individual physician working within it, has a duty not to engage in abuse of power, which abuse would be a breach of fiduciary duty: *Arndt v Smith*, [1997] 2 SCR 539, at para 38. Furthermore, as the administrator of a "psychiatric facility" under the *Mental Health Act*, the Crown had a fiduciary duty to exercise its discretionary powers over the Plaintiffs in good faith and in a manner consistent with the duty to provide them with observation, care and treatment. Especially for the more vulnerable among them, that duty included refraining from tortuous punishment such as the MAPP.

[1232] In addition, it is obvious from the testimony of the Defendants' experts, as well as from the writings of Dr. Barker, that the STU milieu run by 'patient-teachers' and patient committees was founded on the need to operate the STU cheaply rather than on the imperatives of medical science. As Plaintiffs' counsel put it in their written submissions, the Doctors, and by extension the Crown, "indulged in 'bad science'" – a characterization agreed to by Defendants' expert, Dr. Hucker, during cross examination. What's more, this was done "at the Plaintiffs' expense and aggrandized themselves and their institution through publications in medical literature." The Crown breached its fiduciary duty to the Plaintiffs by permitting patients to recommend treatment, enforce the institution's rules, and recommend and implement punishment of each other.

[1233] Similarly, although in a somewhat more formal sense, the Crown breached its fiduciary duty to the Plaintiffs by allowing them to receive psychiatric treatment under the direct supervision and control of Dr. Maier. The evidence in the record establishes that during the time he was in charge of the STU, Dr. Maier was a physician but was not a qualified psychiatrist as required by the *Mental Health Act*. In cross-examination, Dr. Maier conceded that he only passed his exams and became a member of the College of Psychiatrists qualified to practice psychiatry after he left Oak Ridge in 1978.

[1234] Furthermore, as the entity responsible for an institution administering DDT drugs and placing patients in the Capsule without voluntary, informed consent, the Crown breached a fiduciary duty to the Plaintiffs. The Court of Appeal has observed that so-called 'mind altering' treatments demand fully informed and freely given patient consent. In the Court's words, "Few medical procedures can be more intrusive than the forcible injection of powerful mind-altering drugs which are often accompanied by severe and sometimes irreversible adverse side effects": *Fleming v Reid* (1991), 4 OR (3d) 74, at para 42 (CA). In permitting the administering of hallucinogenic drugs in unusual combinations in an effort to break down the patients' personalities without adequately explaining this procedure and in a context in which the patients were coerced or enticed to agree, the Crown's fiduciary duty was certainly breached.

[1235] As indicated, these programs were experimental in nature, and in that respect can be characterized as research, albeit without the proper structures and controls in place to constitute competent research. Professor Dickens observed in his Reply affidavit that, "Research [is] not conducted in an ethical vacuum, without external accountability." He specifically noted that at no time during the relevant period were the STU programs reviewed by a suitably independent research review committee, constituting yet another ethical violation and breach of fiduciary duty.

[1236] In implementing the impugned STU programs, the Crown had an ethical obligation to assess their relative risks. As these experimental programs employed methods and administered

drugs known to be harmful, including brainwashing techniques touted by Dr. Boyd, the Crown had a fiduciary duty not to permit the implementation of the programs. The Crown also had an ethical duty not to permit experimental programs to be carried out in the absence of adequate staffing. Professor Dickens testified at trial that "lack of that independent assessment… was the ethical flaw in these procedures" and "if the – the equipment and the personnel to conduct the scientific study ethically are not present, then the study should not be undertaken." All of these ethical breaches also constitute actionable breaches of the fiduciary duties under which the Crown operated Oak Ridge.

d) The Crown's knowing assistance and vicarious liability

[1237] Counsel for the Plaintiffs also submit that, separate and apart from the Crown breaching its own fiduciary duties to the Plaintiffs, it knowingly assisted the Doctors in perpetrating their wrongdoing. If established on the evidence, knowing assistance in a breach of fiduciary duty is itself an equitable wrong: *Christine DeJong Medicine Professional Corp. v DBDC Spadina Ltd.*, 2019 SCC 30, approving 2018 ONCA 60, at para. 245 (van Rensburg J., dissenting). The party rendering the assistance is jointly and severally liable with the principal wrongdoer: A.H. Oosterhoff, Robert Chambers & Mitchell McInnes, *Oosterhoff on Trusts: Text Commentary and Materials*, 8th ed (Toronto: Carswell, 2014), at p. 1131.

[1238] In establishing joint and several liability with those directly responsible for breach of fiduciary duty, the tort of knowing assistance is a version of accessory liability: *Citadel General Assurance Co. v Lloyds Bank Canada*, [1997] 3 SCR 805, at paras 46-47. Counsel for the Doctors contends that this cause of action is not specifically pleaded by the Plaintiffs and so ought not be considered here. However, as a version of accessory liability leading to joint and several liability with the Doctors for their equitable wrongs, I am not convinced that it need be separately pleaded. It is part and parcel of the principle wrongdoing, which is pleaded, and establishes accessory actors.

[1239] The elements of this accessory liability were set out in *Harris v Leikin Group Inc.*, 2011 ONCA 790, at para 8, and reconfirmed more recently in *Enbridge Gas Distribution Inc. v Marinaccio*, 2012 ONCA 650, at para 23:

> There is no dispute concerning the constituent elements of the tort of knowing assistance in breach of fiduciary duty: (1) there must be a fiduciary duty; (2) the fiduciary must have breached that duty fraudulently and dishonestly; (3) the stranger to the fiduciary relationship must have had actual knowledge of both the fiduciary relationship and the fiduciary's fraudulent and dishonest conduct; and (4) the stranger must have participated in or assisted the fiduciary's fraudulent and dishonest conduct.

[1240] While the Doctors certainly owed a fiduciary duty to their patients, the Plaintiffs, and that duty was breached, there is an interesting question as to whether the Doctors acted "fraudulently and dishonestly". They acted in disregard of the Plaintiffs' interest and contrary to the prevailing medical ethics of their day by engaging in experimental, harmful, and, arguably, recklessly designed and implemented programs; and they also failed to obtain the kind of fully informed,

freely given consent that they were obliged to obtain, primarily due to the near impossibility of obtaining that kind of consent in a coercive environment such as Oak Ridge.

[1241] On the other hand, they were in many ways transparent about what they were doing, allowed the media and the Ombudsman's office to investigate the programs, and wrote freely about them in medical journals. They were not "dishonest" or "fraudulent" in the common law sense of actively engaged in deceit: *Derry v Peek*, [1875] 14 App Cas 337 (HL).

[1242] That said, the Supreme Court of Canada has instructed that it is not the common law sense of deceitfulness in which those terms are used here. In *Gold v Rosenberg*, [1997] 3 SCR 767, at para 31, it was observed that for the purposes of the tort of knowing assistance, "A 'dishonest and fraudulent design' includes the taking of a knowingly wrongful risk resulting in prejudice to the beneficiary." Focusing on the way in which the Defendants measured risk moves the analysis some distance from the intentionality more commonly imputed to the term "fraud". It entails not the intentional conveying of an untruth or intentional appropriation of that which belongs to another, but the "the taking of a risk to the prejudice of another's rights, which risk is known to be one which there is no right to take": *Air Canada v M & L Travel Ltd.*, [1993] 3 SCR 787, at para 45.

[1243] The case law has established that "recklessness or willful blindness will also suffice" to establish the "knowledge" requirement: *Air Canada*, at para 39. Thus, for example, this court has held that, "Willful blindness arises where a party is aware of the need for inquiry but declines to undertake it because he does not wish to know the truth": *1169822 Ontario Limited v The Toronto-Dominion Bank*, 2018 ONSC 1631, at para 136. Recklessness, on the other hand, entails "acting in such a way to create obvious or serious risk and…doing so either without thought to the risk or recognizing the risk but deciding to take it": *Ibid*., at para 138.

[1244] There is little doubt in the record that the Doctors took great risks to the detriment of their patients. Indeed, in cross-examination, Dr. Maier conceded that he had no difficulty describing his LSD program as experimental in his memoranda to Dr. Boyd. He likewise testified that, at the time that LSD was used in the STU, the "popular view in the medical community was that it was destructive" as it induced psychosis and caused adverse effects such as "severe" hallucinations.

[1245] Dr. Boyd's supervision of the STU programs constitutes actual knowledge and participation of the institution's management in the risky behaviour. Dr. Boyd publicized the STU programs through the media. In the 1975 BBC documentary "Oak Ridge Mental Hospital Ontario, he stated that the impugned programs were modelled on "brainwashing" techniques used in China in the 1960s, particularly identifying the use of "defense-disrupting drugs". Dr. Boyd also testified before a Parliamentary committee in March 1977, describing the milieu of the Capsule and explaining to the parliamentarians that DDT drugs were being used to induce patients into states of delirium lasting for weeks.

[1246] It is also noteworthy in this regard that the record contains a memo written by Dr. Maier dated July 22, 1975 entitled "Medical Experimentation and the Law – F Ward LSD Program", which describes the first years of the LSD treatments: "In earlier days Dr. Boyd and Dr. Barker were the entire hospital committee system. Consequently, agreement between the two of them was sufficient to see their decisions implemented." In his examination for discovery, the Crown's

deponent, Mr. Kytayko, confirmed that this arrangement continued into Dr. Maier's years carrying out the program. He deposed that while Dr. Barker and Dr. Maier had "overall responsibility" for implementing all 3 of the impugned programs, Dr. Boyd was "intrinsically involved" in their operation at Oak Ridge. He explained that the programs were only made operational with Dr. Boyd's participation.

[1247] Dr. Boyd, as superintendent, was the Crown's direct agent at Oak Ridge, and reported to the Department of Health. He circulated Oak Ridge's Annual Reports to the Director of the Psychiatric Services Branch. These Reports contained thorough descriptions of the STU programs – e.g. the 1970 Report, dated March 19, 1971, which described the "Therapeutic Community" approach as providing "intensive and prolonged Encounter groups" run mainly by "patients and Attendants", and informed the reader that ongoing "research" at Oak Ridge was being conducted into "the effect of the Compressed Encounter Program in the Capsule".

[1248] The Crown, through its agents, therefore had actual knowledge of both the fiduciary relationship and the fiduciary's risky and wrongful conduct. With his overall approval and supervisory function, the superintendent of Oak Ridge, and therefore the Crown itself, participated in or assisted the fiduciary's breach of duty. The Crown in its capacity as the body responsible for the administration of Oak Ridge, was fully apprised of, and was a participant in, the Doctors' imposition of a "wrongful risk that prejudiced [the Plaintiffs]": *Enbridge*, at para 28. It therefore is liable for knowingly assisting the wrongful conduct of the Doctors in implementing the impugned STU programs.

[1249] Turning to the issue of vicarious liability, counsel for the Crown concedes that the Crown can be held vicariously liable in respect of torts claims against its agents, but not for equitable claims against its agents. The Crown's position, simply stated, is that it is immune from claims in equity such as breach of fiduciary duty, and it has not waived that immunity either for direct claims or vicarious claims. The issue of Crown immunity will be discussed below in the next section of these reasons.

[1250] There is no doubt that the Doctors were agents and employees of the Crown, as were Drs. Tate and O'Reilly as directors of the STU and staff psychologist and psychiatrist, respectively, and Dr. Boyd as superintendent of Oak Ridge. The Crown is vicariously liable for intentional torts committed by its employees and agents in the carrying out functions imposed by law upon the Crown: *A (C) v Critchley* (1998), 166 DLR (4th) 475 (BC CA).

[1251] The wrongful conduct of the Doctors took place in the course of their employment and was inextricably linked to their duties to provide the Plaintiffs with professional care and treatment. This is all that needs be proved to attract liability to the Crown on a vicarious basis. As the Supreme Court explained in *671122 Ontario Ltd. v Sagaz Industries Canada Inc*., [2001] 2 SCR 98, at para 26, "Vicarious liability…is considered to be a species of strict liability because it requires no proof of personal wrongdoing on the part of the person who is subject to it."

[1252] In *Bazley v Curry*, [1999] 2 SCR 534, the Supreme Court of Canada set out the guiding principles for determining a question of vicarious liability. At para 41, McLachlin J. (as she then was) opined, for a unanimous court, that "the fundamental question is whether the wrongful act is

sufficiently related to conduct authorized by the employer to justify the imposition of vicarious liability." In its more recent decision in *Ivic v Lakovic*, 2017 ONCA 446, the Court of Appeal reviewed the *Bazley* list of factors relevant to analyzing the connection between an employer's creation or enhancement of a risk of an intentional tort or other wrongful act done by an employee. As summarized by Hoy, ACJO, at para 24, these include:

> (a) the opportunity that the enterprise afforded the employee to abuse his or her power…
>
> (d) the extent of power conferred on the employee in relation to the victim;
>
> (e) the vulnerability of potential victims to wrongful exercise of the employee's power.

[1253] McLachlin J. indicated in *Bazley*, at para 46, that these factors must be assessed "with a sensitive view to the policy considerations that justify the imposition of liability". She explained, at para 42, that vicarious liability is not meant to address "an incidental or random attack by an employee that merely happens to take place on the employer's premises"; rather, for the employer to be liable for the acts of the employee, "[i]t must be possible to say that the employer significantly increased the risk of the harm by putting the employee in his or her position and requiring him to perform the assigned tasks."

[1254] The relative positions of Drs. Barker, Maier, Boyd, Tate, and O'Reilly vis-à-vis the Plaintiffs as patients in a maximum-security mental hospital, presents a paradigm case of opportunity and power on one hand, and vulnerability on the other. These individuals were tasked by the Crown to administer Oak Ridge and the STU and to carry out its mandate of observation, care, and treatment, and carried those tasks out in breach of fiduciary duties and in a tortious manner.

[1255] The Doctors, along with their colleagues Drs. Boyd, Tate, and O'Reilly, were, as important employees of the Crown, in a position to misuse their power and authority over the Plaintiffs. They did so not as a matter of one-time bad behaviour but in a systemic way as part of the Crown's operations in running the Oak Ridge institution. This is a context in which the doctrine of vicarious liability is meant to, and does, operate. The Crown is vicariously liable for the harms done to the Plaintiffs through the acts of these 5 servants and agents of the Crown.

VIII. Liabilities and immunities of the Crown

[1256] Counsel for the Crown submits that except for vicarious liability for torts committed by its servants and agents, for which it has waived immunity, the Ontario Crown is immune from liability in respect of the Plaintiffs' claims. The Crown relies on the recently revised version of Crown immunity now contained in sections 11(4) of the *Crown Liability and Proceedings Act, 2019*, SO 2019, c 7, sch. 17 ("*CPLA*"):

> (4) No cause of action arises against the Crown or an officer, employee or agent of the Crown in respect of any negligence or failure to take reasonable care in the

> making of a decision in good faith respecting a policy matter, or any negligence in a purported failure to make a decision respecting a policy matter.

[1257] Crown immunity from suit has its origins in the common law. Thus, in *R v Imperial Tobacco Canada Ltd,* [2011] 3 SCR 45, at para 72, the Supreme Court of Canada observed that, "There is general agreement in the common law world that government policy decisions are not justiciable and cannot give rise to tort liability. There is also general agreement that governments may attract liability in tort where government agents are negligent." The distinction between these two categories, however, has been described as "a vexed one": *Ibid*.

[1258] Some of the confusion has arisen from the tendency to focus on the position of the governmental actor rather than the nature of the impugned act. This was addressed by the Supreme Court of Canada in *Brown v British Columbia (Minister of Health)*, [1994] 1 SCR 420, where it was observed that, "Policy decisions can be made by persons at all levels of authority. In determining whether an impugned decision is one of policy, it is the nature of the decision itself that must be scrutinized."

[1259] The key is that policy decisions are "decisions that are based on public policy considerations, like economic, social and political considerations": *Imperial Tobacco*, at para 88. On the other hand, the antithesis of a policy decision is one which deals directly with an individual member of the public without addressing public concerns a large. As the Court of Appeal has stated on a number of occasions, "[o]nce the government has direct communication or interaction with the individual in the operation or implementation of a policy, a duty of care may arise, particularly where the safety of the individual is at risk": *Heaslip Estate v Ontario* (2009), 96 OR (3d) 401, at para 21, quoting *Attis v Canada (Minister of Health)* (2008), 93 OR (3d) 35, at para 66.

[1260] Counsel for the Crown explains that this traditional distinction has been reiterated and more sharply defined in the new *CPLA* provisions. Subsection 11(4) of the *CPLA* provides Crown immunity for all claims "in respect of negligence or failure to take reasonable care in the making of a decision in good faith respecting a policy matter." The phrase "policy matter" is defined in subsection 11(5)(a) to include the "creation, design, establishment, redesign or modification of a program, project or other initiative", and encompasses in subsection 11(5)(b) its funding and in subsection 11(5)(c) the manner in which it was carried out and supervised.

[1261] It is of note that in s. 11(5)(c), the carrying out and supervising of a policy matter is illustrated in a way which gives that phrase a definition that is in line with the way that policy matters are described in ss. 11(5)(a) and (b) and in prior case law. These illustrations include:

> (i) the carrying out, on behalf of the Crown, of some or all of a program, project or other initiative by another person or entity, including a Crown agency, Crown corporation, transfer payment recipient or independent contractor,
>
> (ii) the terms and conditions under which the person or entity will carry out such activities,

> (iii) the Crown's degree of supervision or control over the person or entity in relation to such activities, or
>
> (iv) the existence or content of any policies, management procedures or oversight mechanisms concerning the program, project or other initiative.

[1262] The immunity in s. 11(5) does not extend to any and all operational or implementational acts done in furtherance of a public policy. Rather, as the Supreme Court had already made clear in *Imperial Tobacco* and *Brown*, the *CLPA* provisions refer to those discretionary decisions, at either higher or lower levels of the governmental hierarchy or by independent contractors with government, that are made with a view to public policy considerations. As an example, the immunity circumscribed by s. 11(5) would, as in *Brown*, encompass not only the high level decision to have a snow clearing policy for public roads, but the lower level design and oversight decision as to how frequently to dispatch snow clearing services since this could be made on budgetary or other policy considerations. It would not, however, protect government from the wrongful implementation or operation of the policy, if that took the form of negligent snow clearing by government employees, agents or contractors on a particular road causing injury to a particular motorist.

[1263] The *CLPA* is still relatively new, and so has only been subject to limited judicial interpretation. Plaintiffs' counsel relies on two recent cases, *Leroux v Ontario*, 2020 ONSC 1994 and *Francis v Ontario*, 2020 ONSC 1644. In *Francis*, Justice Perell held that s. 11(4) immunizes the Crown against negligence in policymaking, but otherwise codifies and preserves the policy-operational distinction developed in common law. Counsel for the Crown submits that, in fact, the enactment of section 11 of the *CLPA* was never intended to altogether eliminate Crown liability in negligence and that the Crown remains liable for the negligence of its front-line employees where they have a duty of care toward individuals. It is the Crown's view that the *CLPA* "merely clarified the extent of that liability by defining where the line is drawn to enable identification of non-justiciable 'policy matters'".

[1264] In other words, both sides are of the view that the new statute sharpens the definition, but essentially preserves the traditional line between matters for which the Crown can be held liable and policy matters for which the Crown is immune from liability. Under s. 11 of the *CLPA* the Crown cannot be sued for negligent design flaws in the creation of the STU programs or for negligence in its general supervision of the programs. This reiterates the common law rule as it had developed before the *CLPA*, where the Crown could not be sued for systemic negligence in designing the programs: *Hinse v Canada (Attorney General)*, [2015] 2 SCR 621, at paras 91-92.

[1265] At the same time, the statutory rule preserves the ability to hold the Crown liable in tort for decisions and breaches causing specific harm to specific individuals in the Crown's care. As the Court of Appeal put it in *Heaslip*, at para 21, citing *Just v British Columbia*, [1989] 2 SCR 1228, immunity does not extend to "a public authority's negligent failure to act in accordance with an established policy where it is reasonably foreseeable that failure to do so will cause physical harm to the plaintiff." In other words, not properly implementing a policy is not a policy decision.

[1266] It is self-evident that, as an institution or embodiment of government, the Crown must act through persons. This idea is reinforced in section 5(2) of the *Proceedings Against the Crown Act ("PACA")*, RSO 1970, c 365, now replaced and continued by the section 31 of the *CLPA*, which provides:

> (2) No proceeding shall be brought…in respect of such an act or omission of a servant or agent of the Crown unless a proceeding in tort in respect of such act or omission may be brought against that servant or agent or the personal representative of the servant or agent.

[1267] In view of this provision, the Supreme Court of Canada has instructed that the "Crown cannot be held liable for its own actions, but is only liable in respect of the fault of its servants": *Hinse*, at para 92. By way of illustration, a lawsuit cannot hold liable those "unnamed Crown officials whose funding decisions have left the persons responsible for the implementation of [the given policy] incapable of fulfilling their obligations": *Ontario v Phaneu*, 2010 ONCA 901, at para 12. Likewise, allegations of "'institutional' inertia' or 'institutional indifference'" toward the way a policy is implemented does not amount to a cause of action directly against the Crown as the body responsible for the given institution: *Hinse*, at para 91.

[1268] In 2006, the Plaintiffs amended their pleading to specifically name 5 doctors at Oak Ridge during the relevant time whose acts can be attributed to the Crown for the purposes of Crown liability. Crown counsel argues that to the extent that immunity does not attach to the Crown in this claim, it is only with respect to the tortious actions of the specified 5 doctors. The Amended Fresh As Amended Statement of Claim, para 36, now specifies the 5 responsible Crown actors as Doctors Barker and Maier, along with the 3 consecutive directors of the STU during the relevant time period:

> Other agents of the Crown employed at Oak Ridge participated in running the STU programs as defined herein. Dr. Barry Boyd was medical superintendent throughout the 1970's and assisted Barker and Maier in running the STU programs. Dr. Doug Tate took over Maier's position as Director of the STU during his leave of absence in 1977-1978. Following the departure of both Barker and Maier, there was a period of uncertainty and disorganization at Oak Ridge. A psychiatrist by the name of Dr. Julia O'Reilly…took over the STU and continued Barker and Maier's programs beginning in 1978 until 1983 when Oak Ridge underwent major reorganization.

[1269] The Plaintiffs each suffered individual harm as a result of their experiences at Oak Ridge, as reviewed earlier in these reasons. Any one or more of Dr. Barker, Dr. Maier, Dr. Boyd, Dr. Tate, or Dr. O'Reilly was directly involved in their treatment in the STU. That involvement was tortious and actionable, and caused or contributed to the harm that the individual Plaintiffs suffered. As indicated earlier in these reasons, the liability of the Doctors and the Crown is not in respect of the design of the impugned STU programs or the policy reasons for their creation, although the creation and design of the programs is important by way of background and for understanding how they worked. Rather, the Plaintiffs' liability claims address the specific and harmful ways in which the programs were used to treat them on an individual basis. The Crown enjoys no immunity for such acts is both directly liable and vicariously liable for wrongful acts

perpetrated by its employees and agents in directly treating patients: *Heasli*p, at para 21; *Attis*, at para 66.

[1270] Ontario counsel submits that, unlike for claims in tort based on the acts of any of the Doctors and Drs. Boyd, Tate, and O'Reilly, the Crown is immune from direct and vicarious liability for breach of fiduciary duties. They rely on *Canada (Attorney General) v Thouin*, [2017] 2 SCR 184, at para 1, for the proposition that, "to override this [Crown] immunity, which originated in the common law, requires clear and unequivocal legislative language." According to Crown counsel, there is no language in any statute that amounts to such a statement of waiver.

[1271] The wording of the statute indicates, however, that Crown immunity applies only to claims in tort, not in equity. Section 11(4) of *CLPA*, which establishes (or reiterates) the immunity, refers only to negligence and the duty to take reasonable care – i.e. the duty of care in negligence. This limited scope is in keeping with the historical development of Crown immunity.

[1272] In *Dolmage v Ontario*, 2010 ONSC 1726, Cullity J. traced the history of immunity in some detail. He explained, at paras 76-125, that Crown immunity from claims in tort was historically a construct of the common law courts. Crown immunity legislation in its various historic incarnations, in effect, abolished the judicially created immunity insofar as it was applied to non-policy decisions. However, there was never Crown immunity for claims of breach of fiduciary duty or other claims in equity.

[1273] Indeed, in *M(K) v M(H)*, [1992] 3 SCR 6, at para 73, La Forest J. observed that the Canadian development of the "fiduciary principle" as a ground for claiming compensation from the Crown only commenced with *Guerin v Canada*, [1984] 2 SCR 335. Justice Cullity reasoned in *Dolmage*, at para 87, that Crown immunity for a claim of breach of fiduciary duty could therefore not arise from a statutory intervention such as *PACA* that pre-dated it. Other forms of equitable relief against the Crown were always available, without any issue of immunity arising or any waiver of immunity required. "Any doubt whether declaratory relief could be granted in respect of equitable rights against the Crown was removed by the landmark decision in *Dyson v Attorney-General*, [1911] 1 KB 410 (CA)…[which] held that declaratory relief…could be granted in an exercise of the inherent equitable jurisdiction of the court without recourse to the petition of right procedure and the necessity of a fiat": *Dolmage*, at para 111.

[1274] The breach of fiduciary duty by Oak Ridge as a Crown institution was, like all institutional conduct, perpetrated through its staff. As already noted, any one or more of Dr. Barker, Dr. Maier, Dr. Boyd, Dr. Tate, or Dr. O'Reilly was directly involved in the individual treatment of the Plaintiffs in the STU and in causing them individual harm. That involvement constituted a breach of fiduciary duty to the Plaintiffs and is actionable as such.

[1275] Crown immunity does not bar such equitable claims; but even if claims in equity operated on the same basis as claims in tort such that Crown immunity could potentially or in theory apply, it would not operate here. Sections 11(4) and (5) of the *CLPA* would in any case not apply. The Crown, through the identified Crown actors, caused or contributed to the harm that each of the individual Plaintiffs suffered by the unethical, and thereby inequitable, imposition of STU treatments directly on them. These were not discretionary decisions made out of public policy

considerations; they were direct treatment decisions and actions. The Crown is not immune from a claim based on these breaches of fiduciary duty, either directly or on a vicarious liability basis.

[1276] As a further argument, Defendants' counsel submit that the Defendants are protected by virtue of section 142 of the *Courts of Justice Act* and section 12 of the *Public Authorities Protection Act, 1970*. They argue that the Plaintiffs were held at Oak Ridge either under assessment orders, warrants of remand, warrants of the Lieutenant Governor under the *Criminal Code*, or physicians' certificates and certificates of renewal under the *Mental Health Act*, and that they are immune from liability in respect of those orders. Respectively, the *Courts of Justice Act* and the *Public Authorities Protection Act* provide:

> **Protection for acting under court order**
> 142. A person is not liable for any act done in good faith in accordance with an order or process of a court in Ontario.
>
> **Persons obeying mandamus protected**
> 12. No action or other proceeding shall be commenced or prosecuted against any person for or by reason of anything done in obedience to a mandamus or mandatory order.

[1277] Both these defences are designed to address the issue of potential liability for enforcement of court orders. As the Divisional Court put it in *Canada (Attorney General) v Tremblay*, 2011 ONSC 3763, at para 16, "In order to ensure that court orders are complied with, the law provides an assurance to persons called upon to enforce court orders that no action will lie against them provided they acted in good faith." In my view, neither of the statutory provisions are applicable here.

[1278] Warrants of the Lieutenant Governor are, as their name suggests, issued by the executive branch, not a court; and physicians' certificates and certificates of renewal, as their name also suggests, are issued by physicians and reviewed by the Ontario Review Board, not a court. They simply are not the type of instruments at which either statutory provision is aimed. Neither section 142 of the *Courts of Justice Act* nor section 12 of the *Public Authorities Protection Act* applies to these types of non-judicial instruments: see *Kub International Ltd. v Ontario*, [1995] OJ No 2384.

[1279] Not only must the Defendants identify a court order if they are to succeed on the basis of these two provisions, but the conduct in question must be identified as being within the bounds of the court order. It is this requirement that excludes the applicability of warrants of assessment and warrants of remand. Although those two instruments are, indeed, orders issued by courts, the conduct of the STU programs does not fall within their purview as they do not call for any kind of treatment – certainly not the kind of programs at issue in this litigation. In order to avail themselves of the two statutory immunities based on enforcing court orders, the Defendants must demonstrate that the text of the order on which they rely mandates the complained of activity: *Re Nortel Networks Corp.*, 2016 ONSC 2732, at paras 22-25.

[1280] A reading of the text of an assessment order reveals they are not orders for treatment (and certainly not for experimentation), but rather are orders for assessment and diagnosis.

Administering DDT drugs, or placing a patient in the Capsule or MAPP, is not an assessment methodology under any understanding of that term. Drs. Barker and Maier, in their professional writings, characterized these as either treatment or research programs, but they never characterized them as forms of assessment. The programs depended on the patients placed in them already being assessed as suffering from psychiatric disorders that could not be otherwise treated.

[1281] Similarly, a warrant of remand only countenances detaining an individual and does not immunize persons detaining an individual from liability for any and all conduct that takes place following the detention. Just as a remand order is not a sentence and so a person under such an order should not ordinarily be sent to a federal penitentiary for punishment instead of a provincial remand institution for holding, *R. v Melvin*, 2016 NSSC 130, at paras 37-38, a warrant of remand is not a committal and so a person under such an order should not be sent to a mental hospital for treatment instead of for assessment.

[1282] This limitation on the scope of a warrant of remand based on a careful reading of what it actually orders is in keeping with the Divisional Court's application of the statutory immunities in section 142 of the *Courts of Justice Act* and section 12 of the *Public Authorities Protection* Act. In *1731393 Ontario Ltd. (c.o.b. Thomkess Crane Rental) v Strmota*, 2014 ONSC 6729, at paras 5 and 8, the Divisional Court made it clear that the requirement for immunity for enforcing a court order is that the conduct in question must have been done "in good faith in accordance with a court-issued order". In approaching this question it read the court order closely, and commented that "[t]he words 'in accordance with an order' have to be given a common sense interpretation."

[1283] Neither section 142 of the *Courts of Justice Act* nor section 12 of the *Public Authorities Protection Act* apply in the present circumstances to protect the Defendants from the Plaintiffs' claim.

IX. Limitations and laches

[1284] The present claim began on October 25, 2000, when the Plaintiffs, Danny Joanisse and Shauna Taylor (then Vance Egglestone), issued a Statement of Claim alleging, *inter alia*, breach of fiduciary duty against the Defendants on behalf of a purported class composed of the other Plaintiffs. At that time, there was no limitation period applicable to equitable claims. Prior to January 1, 2004, the *Limitations Act, 2002*, SO 2002, c. 24, Sched B, had not come into effect, and the *Limitations Act,* RSO 1980, c. 240 was in force. In *M (K) v M (H)*, *supra*, at para. 14, the Supreme Court of Canada expressly held that, under the then current version of the *Limitations Act*, "the time for bringing a claim for breach of a fiduciary duty is not limited by statute in Ontario".

[1285] The 2000 version of this action was a proceeding in respect of the same acts and omissions of the Defendants that are the subject of the current claim, namely, the use and operation of the 3 impugned STU programs – i.e. the Capsule, DDT and MAPP. The pleading issued by Mr. Joanisse and Ms. Taylor, on behalf of the putative class, included the same equitable and common law causes of action as the present Amended Second Fresh As Amended Statement of Claim. In 2006, the action was permitted to continue in its present form, with the same court file number as the 2000 proposed class action, as a claim on behalf of individual Plaintiffs, all of whom had been

members of the putative class represented by the 2000 version of the claim: *Joanisse v. Barker*, 2006 CarswellOnt 10233. In 2013, the court approved adding several other putative class members as individual Plaintiffs: *Barker v. Ontario*, 2013 ONSC 7381.

[1286] The commencement of the action as a proposed class action in 2000 had the effect of tolling the proceeding for individual class members, pursuant to section 28(1) of the *Class Proceedings Act, 1992*, SO 1992, c. 6. That provision states that,

> 28(1) …any limitation period applicable to a cause of action asserted in a class proceeding is suspended in favour of a class member on the commencement of the class proceeding and resumes running against the class member when,
>
> (a) the member opts out of the class proceeding;
>
> (b) an amendment that has the effect of excluding the member from the class is made to the certification order;
>
> (c) a decertification order is made under section 10;
>
> (d) the class proceeding is dismissed without an adjudication on the merits;
>
> (e) the class proceeding is abandoned or discontinued with the approval of the court; or
>
> (f) the class proceeding is settled with the approval of the court, unless the settlement provides otherwise.

[1287] None of the events described in subsections 28(1)(a) through (f) have taken place. In *Canadian Imperial Bank of Commerce v. Green*, [2015] 3 SCR 801, at para 199, the Supreme Court advised that "on a plain reading of s. 28, the limitation periods applicable to all causes of action asserted in the proceeding are suspended upon the commencement of the class proceeding, regardless of whether some…would require leave to proceed individually." As Plaintiffs' counsel state, the policy objectives of judicial economy and access to justice – especially for absent class members – require section 28(1) to operate so that it suspends all applicable limitation provisions for all causes of action or the "factual matrix" pleaded in a proposed class action upon the issuance of the pleading: *Logan v Canada (Minister of Health)* (2004), 71 O.R. (3d) 451, at paras 13, 23 (CA).

[1288] Similarly, in *CIBC v Green*, at para 60, the Supreme Court reasoned that all class members can shelter under the limitation freeze implemented with the issuance of the class proceeding pleading:

> The purpose of s. 28 CPA is to protect potential class members from the winding down of a limitation period until the feasibility of the class action is determined, thereby negating the need for each class member to commence an individual action in order to preserve his or her rights … Once the umbrella of the right exists and is established by a potential class representative in asserting a cause of action, class

> members are entitled to take shelter under it as long as the right remains actively engaged.

[1289] In keeping with these remedial purposes, the opening words in section 28(1) – "any limitation period applicable to a cause of action asserted in a class proceeding" – must be interpreted liberally to capture not only specified statutory limitation periods, but also the broader limitation regime which governed their claims at the time of the commencement of action. This court reasoned in *Green v The Hospital for Sick Children*, 2019 ONSC 5659 that any unfreezing of the limitation period would require the specific approval of the court even where, as here, the proposed class action had not been certified:

> In my opinion, in circumstances where a motion to certify an action as a class proceeding is dismissed and none of the other enumerated circumstances under s. 28 applies, a motion by the defendant is required in order to deactivate the suspension of the running of limitation periods. Until such a motion is brought, not having been formally dismissed, the proposed class action is still active albeit it has not been certified.

[1290] Accordingly, where there was no former limitation period for the Plaintiffs' equitable claims, the limitation regime as at the commencement date of the action is preserved and tolled until one of the events set out in subsections 28(1)(a)-(f) occur and/or a court rules otherwise. The equitable claims brought by the Plaintiffs are therefore not limitation barred, as no limitation period applied to those claims under the version of the *Limitations Act* in force in 2000.

[1291] In addition to all of that, section 24 of the *Limitations Act, 20*02, found under the statutory heading "No former limitation period", provides:

> 24 (6) If there was no former limitation period and if a limitation period under this Act would apply were the claim based on an act or omission that took place on or after January 1, 2004, the following rules apply:
>
> 1. If the claim was not discovered before January 1, 2004, this Act applies as if the act or omission had taken place on that date.
>
> 2. If the claim was discovered before January 1, 2004, there is no limitation period.

[1292] It is self-evident that the claim was "discovered" in the limitations sense of the term by January 1, 2004, since the Statement of Claim covering the identical claim was issued nearly 4 years earlier, in October 2000. As to when the claim was discovered by each of the Plaintiffs, they for the most part testified that it was discovered, and was only discoverable by them, shortly before 2000, when the experimental and medically meritless nature of the STU programs became known to Shauna Taylor through her own persistent and thorough investigations. Ms. Taylor was in contact with a number of them, who were then in contact with others, explaining the knowledge she had acquired regarding the nature of the 3 impugned programs, the injuries they caused, and the appropriateness of commencing a civil claim against the Defendants.

[1293] Although several of the Plaintiffs had been litigious in previous cases alleging mistreatment at Oak Ridge, it took Ms. Taylor's information for them to discover that what they had thought was a medically sanctioned course of treatment was actually wrongful and actionable. In any case, the point under section 26(6)2 of the *Limitations Act, 2002*, is not, as in the usual 'discoverability' analysis, how late the Plaintiffs were in bring the claim, but rather in how early they were in discovering its existence. It is only logical that the claim was known prior to its having been commenced in October 2000 – i.e. well before January 1, 2004.

[1294] Turning to the Plaintiffs' claim for assault, section 16 (1)(h.2) of the *Limitations Act, 2002* provides that there is no limitation period if, at the time of the assault, the person with the claim was a minor or was "financially, emotionally, physically or otherwise dependent" on the person against whom the claim is made. Under section 16 (1.1), this applies notwithstanding the expiry of any previously applicable limitation period, and under section 19 it supplants historic limitations statutes: see *BH v Dittani*, 2010 SKCA 1. As Plaintiffs' counsel point out, this necessarily includes the limitation periods applicable to claims for assault, battery, and other torts under section 45(1) of the *Limitations Act, 1960*, *Limitations Act, 1970*, and *Limitations Act, 1980.*

[1295] It should also be noted that in section 1 of the *Limitations Act, 2002*, an "assault" is defined to include a battery. Thus, whatever limitation period, or lack thereof, applies to one of those torts applies equally to the other.

[1296] Section 16 (1)(h.2), which the Plaintiffs have specifically pleaded pursuant to a ruling granting them a mid-trial amendment to the Amended Fresh As Amended Statement of Claim, applies to the relationships characterized by physical and psychological dependence: *Barker v Barker*, 2019 ONSC 3015. Neither section 16 (1)(h.2) nor any other provision of the *Limitations Act, 2002* places restrictions on the type of relationships which may give rise to this dependence. The relationship between mental health patients and their doctors and hospital is one such relationship that falls within the section's parameters.

[1297] In fact, in interpreting the place of consent in the assault provisions under the *Criminal Code*, La Forest J. observed in *Norberg*, *supra*, that "dependency relationships" encompass those of "parent-child, psychotherapist-patient, physician-patient, clergy-penitent, professor-student, attorney-client, and employer-employee". Perhaps even more to the point, in *Rauback v Canada (Attorney General*), 2004 MBQB 154, at para 6, the Manitoba Court of Queen's Bench held that a provision almost identical to section 16 (h.2)(ii) "exempts sexual assaults and assaults committed by a person in a fiduciary or intimate relationship with a plaintiff".

[1298] In Oak Ridge, the Plaintiffs were physically and psychologically dependent on the Defendants by virtue of the physician-patient relationship, a relationship of trust and an inherently fiduciary one even where the patient is a voluntary one. Where the patients are involuntarily admitted to a maximum-security psychiatric hospital, their dependence on the physicians and administration of the institution is complete.

[1299] Furthermore, section 16 (1.3) of the *Limitations Act, 2002* makes it clear that section 16 (1)(h.2) protects all of the Plaintiffs' equitable and common law claims against the Defendants,

whether on a direct or a vicarious liability basis. This is confirmed by both the plain words of s. 16(1.3) and this court's decision in *Weinstein*. Section 16(1.3).

[1300] In *Jane Doe v Weinstein,* 2018 ONSC 1126, at para 23-27, the court held that these subsections of section 16 of *the Limitations Act, 2002* are remedial, addressing a broad range of problems relating to both sexual assault and assault, and that they are intended to protect claims against perpetrators of assault, third parties, and institutional defendants. Accordingly, no limitation period applies to any claims against either the Doctors or the Crown, whether the claim of liability is direct or vicarious.

[1301] In the context of this claim, no limitation periods, including the specially short ones invoked by Defendants' counsel for involuntarily admitted patients, are applicable. In the first place, where there is any ambiguity or question, limitation provisions are to be construed in favour of the person whose right of action is being truncated: *Berardinelli* v. *Ontario Housing Corp.*, [1979] 1 SCR 275, 280. Moreover, it has long been the position of this court that conduct that is an abuse of power, rather than an exercise of power, would "not be deserving of the special protection afforded by the short limitation period": *Cascone v Rodney*; *Prochnicki, Third Party* (1981) 34 OR (3d) 618 (HCJ). That characterization readily applies to the acts of the Defendants in breaching fiduciary duties and perpetrating intentional torts on the Plaintiffs.

[1302] In addition to their reliance on limitation periods, both sets of Defendants rely on the doctrine of laches in their defences to the claim of breach of fiduciary duties. The laches principle is, of course, similar to limitations in that it provides a temporal defence to a claim that is found to have been brought too late. However, it does not present a bright line cutoff for a claim in the same way as a limitations statute. As the Supreme Court of Canada put it in *M (K) v M (H), supra*:

> The rule developed in [*Lindsay Petroleum Co. v Hurd* (1874), LR 5 PC 221] is certainly amorphous, perhaps admirably so. However, some structure can be derived from the cases. A good discussion of the rule and of laches in general is found in [Meagher, Gummow and Lehane, *Equity Doctrines and Remedies* (2nd ed. 1984)], at pp. 755-65, where the authors distil the doctrine in this manner, at p. 755:
>
> It is a defence which requires that a defendant can successfully resist an equitable (although not a legal) claim made against him if he can demonstrate that the plaintiff, by delaying the institution or prosecution of his case, has either (*a*) acquiesced in the defendant's conduct or (*b*) caused the defendant to alter his position in reasonable reliance on the plaintiff's acceptance of the status quo, or otherwise permitted a situation to arise which it would be unjust to disturb…

[1303] As it is applied with respect to laches, acquiescence refers to an unreasonable delay in commencing an action well after the deprivation of the claimant's rights and with full knowledge of their existence. La Forest J. explained in *M (K) v M (H)*, that "an important aspect of the concept is the plaintiff's *knowledge* of her rights. It is not enough that the plaintiff knows of the facts that support a claim in equity; she must also know that the facts give rise to that claim" [emphasis in the original].

[1304] Under the circumstances, the level of knowledge required by the Supreme Court is an important feature of the analysis. The Court of Appeal has emphasized in the context of limitation periods and discoverability, which demands an analysis similar to the doctrine of laches, that a "motion judge [is] required to determine (i) the day on which [the plaintiff] 'first knew…that, having regard to the nature of the injury, loss or damage, a proceeding would be an appropriate means to seek to remedy it' (s. 5(1)(a)(iv)); and (ii) the day on which a reasonable person with the abilities and in the circumstances of [the plaintiff] first ought to have known of that matter (s. 5(1)(b))": *Clarke v Sun Life Assurance Company of Canada*, 2020 ONCA 11, at para 21.

[1305] The Plaintiffs had factual knowledge contemporaneous with the Defendants' wrongful acts in the sense that they were aware that they were being placed in MAPP, or given DDT drugs, or sent naked into the Capsule, etc. The question is whether they knew that acts presented as therapeutic treatment in a hospital setting were wrongful and actionable.

[1306] The evidence presented by the Plaintiffs casts considerable doubt on whether they had such knowledge. They consistently testified that they understood participation in the impugned STU programs to be a necessary part of their therapy and a requirement for their eventual release from Oak Ridge. To take only two illustrations, Roy Dale testified that the programs were part of the legitimate authority he was told that the Doctors had over him at Oak Ridge:

> Q. And did Doctor Maier have any power over when you would be released?
>
> A. Oh, all the power in the world, yeah.
>
> Q. Why is that?
>
> A. Well, as he used to say, I hold the key to your release, I'm the one that makes the decisions here.

[1307] Reginald Barker testified that he had written a letter to the Barrie Examiner, signed by a group of Oak Ridge patients, praising the LSD program. His explanation was that Dr. Maier had lauded the therapeutic benefits of the mind-altering drug:

> Q. And next, I'd like to ask you about your participation in the LSD Program, and I'd like you to turn to Tab 'L' of your brief in front of you. So, that's Tab 'L' of your – or Exhibit 'L' to your affidavit. And this letter is dated January 30th, 1976, and it's a letter to the Barrie Examiner. We've seen it a few times. I understand, from our discussion yesterday, that you would like to say something about this letter.
>
> A. Ah, at the time of the LSD program, the Church of Scientology believed that the LSD was poison, that it would hurt us. The Church of Scientology wasn't aware of what went on prior to that, before any of this happened. Umm, Dr. Maiers *[sic]* stood in the centre of the sunroom and said to them – and said, In my – in the palm of my hand, I hold the cure to Psychopathy, and if you were a psychopath back

then, you would sign up for LSD, and we would do anything, even writing letters. Sorry.

Q. So, could you just repeat what you said to make sure that everyone hears it.

A. What, that I wrote the letter?

Q. No, what Dr. Maier said?

A. Doctor Maiers stated, in the centre of the sunroom, I hold in my hand, I hold the power -- the cure to psychopathy. And I was a psychopath, and I still am today, ...

Q. So, you ...

A. ... but not like I was back then.

Q. Did you understand at the time, then, that LSD was a cure to psychopathy?

A. It was a cure to get me out of the hospital.

[1308] Perhaps even more powerfully, the Doctors themselves embraced these viewpoints in their own writings. Dr. Maier testified to the effect that the STU programs were the way out of the mental hospital:

Q. Do you agree with me that these patients were interested in their freedom? They wanted to get out of Oak Ridge.

A. Yes, most did.

Q. And they understood that the path to freedom led through the Capsule and the DDT.

A. Some believed that, yes.

Q. If they were interested in their freedom, they had to participate in the system to gain their freedom. They understood that.

A. Yes, but that doesn't mean they had to participate in the Capsule group or in a DDT group but they had to participate when they were on the ward as a sort of responsible citizen on the ward…

Q. And the STU. Your answer [reading examination for discovery transcript]: 'Answer: If you're interested in your freedom, you're not giving yourself an opportunity to do the things available in the system to earn your freedom to gain your freedom, yes. Question: The path to freedom is to go through Capsule and

> DDT and they understood, well, excuse me let me finish. They understood that. I think by the time I was there that was – they understood that.' Now, you gave those answers under oath?
>
> A. I did.
>
> Q. And you stand by it?
>
> A. Yes.

[1309] Dr. Maier's testimony repeats what Dr. Barker had been saying ever since his seminal "Buber Behind Bars" article – i.e. that the Capsule, DDT, and MAPP programs were the "goad to freedom". The Doctors, like the Plaintiffs themselves, considered the psychiatric disorders suffered by the Plaintiffs to be incurable through traditional therapeutic technics, and the novel techniques of the STU to be their only hope for recovery. As Dr. Maier confirmed in cross-examination, the DDT, Capsule, and MAPP were the Plaintiffs' only hope for a cure:

> Q. And what Doctor Barker said to you is society considers these throw away people, anything we can do will be positive.
>
> A. Yes.

[1310] Indeed, Dr. Barker wrote in one of his publications that he was of the view that even handcuffs and other physical restraint were therapeutic approaches, and not really security or disciplinary measures. In Dr. Barker's words:

> In an age when progress in the care and treatment of the mentally ill has been measurable in terms of increased freedom from physical restraints, it is paradoxical to say the least, that we find ourselves in one section of the Ontario Hospital Penetanguishene using handcuffs as a valuable aid in an intensive treatment program.
>
> E.T. Barker, M.H. Mason, J. Walls, "Protective Pairings in Treatment Milieux: Handcuffs for Mental Patients" (1968), p. 1.

[1311] Accordingly, it is understandable that, regardless of how painful and harsh the impugned programs may have appeared to the Plaintiffs, they were understood as part of the medical treatment they were in Oak Ridge to receive – that is, as medically indicated and rightful, not medically pointless and wrongful. In this regard, it is important to keep in mind the objective standard that the Supreme Court in *M (K)* confirmed is the proper way to analyze the Plaintiffs' understanding of their rights when analyzing the laches question: "[t]his Court has held that knowledge of one's claim is to be measured by an objective standard; see *Taylor v. Wallbridge* (1879), 2 S.C.R. 616, at p. 670. In other words, the question is whether it is reasonable for a Plaintiff to be ignorant of her legal rights given her knowledge of the underlying facts relevant to a possible legal claim."

[1312] Defendants' counsel have spent considerable effort highlighting whether each Plaintiff may have subjectively known they were being done wrong in having to submit to the programs in issue. However, as the Supreme Court has made clear, the analysis is an objective one applicable to all of the Plaintiffs: what could they have reasonably known, given their circumstances as involuntary patients in custody in a maximum-security mental hospital? First and foremost, their knowledge would be based on what they were advised by the psychiatrists under whose care they were entrusted. If the Doctors were telling them that the STU programs were medically indicated and therapeutic to the point of leading to their eventual release from Oak Ridge, how were the Plaintiffs as patients to understand otherwise?

[1313] There is, of course, no answer to that rhetorical question, except to say that the Plaintiffs were in an impossibly confusing situation. Even those such as Eldon Hardy, who were litigious in other contexts, were slow coming to an understanding of the actionable quality of the STU programs. Mr. Hardy testified, for example, that he had been compensated as part of a class action against St. John's Training School for having been sexually abused by school staff when he attended there prior to his admission to Oak Ridge. There is a substantial difference, however, between understanding the wrongfulness of being sexually assaulted by a teacher at school and understanding the wrongfulness of a course of treatment prescribed by a doctor in a hospital. They both may take years to come to grips with, but the former is patently wrong without further knowledge once one becomes an adult, while the latter takes some research and depth of understanding before the wrongfulness becomes apparent regardless of one's age and life experience.

[1314] Despite the Plaintiffs having been provided a substantial amount of pop culture literature on mind-altering drugs and psychedelic experiences, the readings available to patients at Oak Ridge did not include Dr. Barker's publications about the very programs in which the Plaintiffs were enmeshed. The evidence from Plaintiff after Plaintiff is that they never heard of these explanatory writings, and had never understood the unaccepted, non-therapeutic nature of the programs, until the writings were located by Shauna Taylor and introduced to them in the mid-to-late 1990's. Ms. Taylor testified that she did extensive research and acquired knowledge of the nature of the programs, the risks embodied in them and the harms caused by them, and the appropriateness of seeking a legal remedy. Plaintiffs' counsel submit that it was at that time that she uncovered documents and information relating to the nature of the programs, and started contacting her co-Plaintiffs one at a time and eventually retained counsel.

[1315] In assessing the question of acquiescence that is fundamental to a laches analysis, Justice La Forest in *M (K) v M (H)* asked himself what is reasonable to expect of a traumatized victim:

> In the present case, was it reasonable for the appellant to know the facts of her abuse and yet be unable to determine that her father was in the wrong and that a suit in equity could be launched? I believe that in the circumstances of the typical incest survivor the failure to know that one has been wronged is entirely reasonable.

[1316] In my view, the same applies to patients at a maximum-security mental hospital diagnosed with personality disorders, psychopathy, schizophrenia, and other serious forms of mental illness. Interestingly, the Defendants spent considerable effort in this trial attempting to establish that for

virtually all of the Plaintiffs the trajectory of their lives was not significantly changed by their STU experiences. In reviewing the individual evidence, I have found that that was sometimes the case and sometimes not, in differing degrees. But the very fact that vulnerable, traumatized, and mentally ill individuals are still vulnerable, traumatized, and mentally ill following the therapeutically useless treatments they received speaks volumes about how much one can expect them to understand about their situation.

[1317] The Plaintiffs were not cognizant of the programs' wrongfulness when they entered Oak Ridge and the STU, and likewise were not cognizant of it for decades after the programs ended. Nothing in that scenario speaks to acquiescence in any reasonable meaning of that word.

[1318] Furthermore, although delay is never a good thing for the trial process, the passage of years did not prejudice the Defendants beyond their ability to mount a fulsome defence of the claims. The Clinical Records and other records from Oak Ridge are exceptionally well preserved, and, as can be seen in the review in these reasons of each individual Plaintiff, they serve to either specifically corroborate or specifically counter much of the testimony at trial.

[1319] Dr. Maier and Dr. Tate testified about the operation of the STU programs, and each has a sound memory. Dr. Quincey, the 1970s-era Director of Research for Oak Ridge, also testified and provided useful evidence. Dr. Boyd has passed away, but as the Superintendent of Oak Ridge, his most important functions were memorialized in the administrative records of the institution. Moreover, Dr. Boyd's death came some 27 years before the trial began and before the Plaintiffs had any chance to come to grips with the facts needed for a law suit; speeding up their process would not have had an impact on the ability of Dr. Boyd to participate.

[1320] Fortunately, the Crown was able to have George Kytayko, the Chief Administrator of the Penetanguishene Mental Hospital from 1986 to 2000, be examined for discovery and testify at trial. He testified that he has become familiar with the STU during the relevant years by reading all of Dr. Boyd's notes and documents. In his testimony, he confirmed that Dr. Boyd's notes reveal that Dr. Barker was hired in 1965 to develop the programs within the Oak Ridge division that would give patients who previously had no hope of ever being released from custodial care a chance to improve and eventually be released. He also confirmed what the documentary record reveals – that Dr. Boyd worked in collaboration with Dr. Barker in implementing the impugned programs.

[1321] As for Dr. Barker, he was unable to testify, which is certainly unfortunate. But it is fair to say that, as the trial record demonstrates, his publications, his various unpublished writings, his psychiatric reports, and his notes in the Plaintiffs' Clinical Records, all live on. Although he is in one sense a missing witness, he is in a very realistic sense the most well-documented witness. I concede that it would have been interesting to hear him testify, but considering the wealth of written evidence his absence at trial was not prejudicial to the Defendants. In some ways, any witness is at his best in his writings in a professional context; putting Dr. Barker on the witness stand and subjecting his well-articulated writings to real time cross-examination may have less helpful to the Defendants. As it turns out, the court has now 'heard from' Dr. Barker, as it were, at his most articulate and in a way that did not allow him to be directly countered or visibly undermined.

[1322] In one unusual turn of events, the Crown argues that it was unduly delayed not by anything done or not done by the Plaintiffs, but by operation of privacy laws. Crown counsel submits that since the Crown was legally barred from accessing the Plaintiffs' private medical records in a timely fashion, it was prejudiced in preparing its case.

[1323] Plaintiff's counsel responds by pointing out that this appears to be a misapprehension of the state of privacy law. Section 21(a) of the *Freedom of Information and Protection of Privacy Act*, RSO 1990, c. F.31 expressly permits personal information to be disclosed with the individual's consent. Assorted provisions in the *Mental Health Act*, as amended from time to time, have over the years reflected the same policy. The Crown could have inspected the Plaintiffs' health records at any time; it had only to ask, which apparently it did not do, nor did it ever move for an Order to inspect those records. Moreover, pre-trial motions revealed that the disclosure of medical records by the Plaintiffs during the years in which the discovery process took place was voluminous. It is not for counsel for a Defendant to come to trial to say that it did not have early access to documents to which it ultimately had access and could have had at an earlier time with a modicum of effort.

[1324] Moreover, the laches doctrine is directed toward the Plaintiffs' conduct, and asks whether they acquiesced in the sense that they sat on their case instead of bringing it when they first were able. The record here does not establish that kind of acquiescence by the Plaintiffs. It admittedly took them many years to come to a level of understanding that allowed them to finally bring their claim, but that was due to their medical circumstances and to the way in which the conduct in issue was imposed on them by the Defendants. If the Crown, through no fault or doing of the Plaintiffs, was unable until a couple of years before trial to obtain the documents that it needed, that does not provide a basis for a laches defence.

[1325] The Plaintiffs have brought a claim at least partly grounded in equity, and are entitled to do so. There is no ground for equity to intervene on behalf of the Defendants as there was no undue and prejudicial delay on the part of the Plaintiffs bringing their case. The case was launched a relatively short time after the Plaintiffs, objectively speaking and taking their circumstances into account, came to an understanding that they had been wronged and could bring a claim. To ask mental health patients who had been subjected to the Capsule, DDT, and MAPP as young men to come to this understanding and bring their claim more promptly, would be asking too much of them. The doctrine of laches does not apply or work in the Defendants' favour here.

X. Summary of findings and disposition

[1326] The Doctors and/or the Crown, in various combinations, are liable to each of the Plaintiffs for having caused them varying degrees of harm by breaching their fiduciary duties and by perpetrating assault and battery. In the case of the Crown, it is liable to each of the Plaintiffs for these claims on a direct and vicarious liability basis. Where either or both of the Doctors are liable, the Crown is also liable for knowingly assisting them in perpetrating assault and battery.

[1327] The findings of harm are described below with the adjectives "substantial, moderate, mild". I hasten to add that those descriptions do not reflect any externally established standards or my own subjective response to any individual Plaintiff. Rather, the adjectives are meant to qualify the

level of harm for the individual Plaintiffs as a reflection of what the evidence establishes about each, *relative only to each other*. These qualifications are included here as a guide to the quantification of damages to be pursued at the next part of the trial.

[1328] The specific findings with respect to each of the Plaintiffs and Defendants are:

- Reginald Barker – Dr. Barker, Dr. Maier, and the Crown are liable for having caused substantial long-term harm and moderate short term-harm.

- Jean-Paul Belec – Dr. Barker, Dr. Maier, and the Crown are liable for having caused moderate long-term harm and substantial short-term harm.

- Eric Bethune – Dr. Barker and the Crown are liable for having caused moderate long-term harm and substantial short-term harm.

- Joseph Bonner – Dr. Barker and the Crown are liable for having caused moderate long-term harm and substantial short-term harm.

- William Brennan – Dr. Maier and the Crown are liable for having caused mild long-term harm and substantial short-term harm.

- Stephen Carson – Dr. Barker and the Crown are liable for having caused moderate short-term harm only.

- Roy Dale – Dr. Maier and the Crown are liable for having caused mild long-term harm and substantial short-term harm.

- Maurice Desrochers – the Crown is liable for having caused mild long-term harm and substantial short-term harm.

- Donald Everingham – Dr. Maier and the Crown are liable for having caused mild short-term harm.

- John Finlayson – Dr. Maier and the Crown are liable for having caused mild short-term harm only.

- Terry Ghetti – Dr. Barker, Dr. Maier and the Crown are liable for having caused mild short-term harm only.

- Bruce Hamill – Dr. Maier and the Crown are liable for having caused substantial short-term harm only.

- Eldon Hardy – Dr. Barker, Dr. Maier, and the Crown are liable for having caused moderate long-term harm and substantial short-term harm.

- William Hawboldt – Dr. Maier and the Crown are liable for having caused substantial short-term harm only.

- Danny Joanisse – Dr. Barker, Dr. Maier, and the Crown are liable for having caused substantial long-term harm and substantial sort-term harm.

- Russ Johnson – Dr. Barker, Dr. Maier, and the Crown are liable for having caused mild short-term harm only.

- Stanley Kierstead – Dr. Barker and the Crown are liable for having caused moderate short-term harm only.

- Denis LePage – Dr. Barker and the Crown are liable for having caused moderate long-term harm and substantial short-term harm.

- Christian Magee – Dr. Barker and the Crown are liable for having caused moderate long-term harm and substantial short-term harm.

- Douglas McCaul – Dr. Barker, Dr. Maier, and the Crown are liable for having caused moderate long-term harm and moderate short-term harm.

- Brian McInnes – Dr. Maier and the Crown are liable for having caused moderate long-term harm and moderate short-term harm.

- Allen McMann – Dr. Barker, Dr. Maier, and the Crown are liable for having caused moderate long-term harm and moderate short-term harm.

- Leeford Miller – Dr. Barker and the Crown are liable for having caused mild long-term harm and mild short-term harm.

- James Motherall – Dr. Maier and the Crown are liable for having caused moderate long-term harm and substantial short-term harm.

- Michael Pinet – Dr. Barker, Dr. Maier, and the Crown are liable for having caused substantial long-term harm and moderate short-term harm.

- Edwin Sevels – Dr. Barker and the Crown are liable for having caused mild short-term harm only.

- Samuel Shepherd – Dr. Maier and the Crown are liable for having caused mild short-term harm only.

- Shauna Taylor – Dr. Maier and the Crown are liable for having caused moderate long-term harm and moderate short-term harm.

[1329] I am inclined to reserve any decision on costs until the second part of the trial has been completed. However, I am open to receiving written submissions from counsel as to whether costs should be addressed at this stage. I would ask that any such request and response be no longer than one page in length and be sent to me via my assistant.

Morgan J.

Released: June 25, 2020

CITATION: Barker v. Barker, 2020 ONSC 3746
COURT FILE NO.: 00-CV-199551
DATE: 20200625

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

REGINALD BARKER, JEAN-PAUL BELEC, ERIC BETHUNE (formerly Jean-Jacque Berthiaume), JOSEPH BONNER, WILLIAM BRENNAN by the Estate Trustee MAXWELL BRENNAN, STEPHEN CARSON, ROY DALE, MAURICE DESROCHERS by the Estate Trustee LORRAINE DESROCHERS, DONALD EVERINGHAM, JOHN FINLAYSON, TERRY GHETTI, BRUCE HAMILL, ELDON HARDY, WILLIAM HAWBOLDT by the Estate Trustee BARBARA BROCKLEY, DANNY A. JOANISSE, RUSS JOHNSON, STANLEY KIERSTEAD, DENIS LEPAGE, CHRISTIAN MAGEE, DOUGLAS McCAUL, BRIAN FLOYD McINNES, ALLEN McMANN, LEEFORD MILLER, JAMES MOTHERALL by the Estate Trustees DEBORAH KAREN MOROZ and JANE ALEXIS MARION, MICHAEL ROGER PINET, EDWIN SEVELS, SAMUEL FREDERICK CHARLES SHEPHERD and SHAUNA TAYLOR (formerly Vance H. Egglestone)

Plaintiffs

– and –

ELLIOTT THOMPSON BARKER, GARY J. MAIER and HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO

Defendants

REASONS FOR JUDGMENT

Released: June 25, 2020 E.M. Morgan J.
