Court File No.: CV-15-53262500-CP

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

CHRISTOPHER BRAZEAU and DAVID KIFT

Plaintiffs

and

ATTORNEY GENERAL OF CANADA

Defendant

STATEMENT OF DEFENCE OF THE DEFENDANT THE ATTORNEY GENERAL OF CANADA

ATTORNEY GENERAL OF CANADA

Department of Justice Canada
Civil Litigation Section
50 O'Connor Street, Suite 500
Ottawa, ON, K1A 0H8
Fax: 613-954-1920

Per: **Gregory S. Tzemenakis** (LSUC #42764U)
Stephen Kurelek (LSBC #502005)
Philippe Lacasse
Tel: (613) 670-6338
(613) 670-6314
(613) 670-6220
Email: Gregory.Tzemenakis@justice.gc.ca
Stephen.kurelek@justice.gc.ca
Philippe.Lacasse@justice.gc.ca

Lawyers for the Defendant

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I. OVERVIEW

1. The Attorney General of Canada defends this action on behalf of Her Majesty the Queen in Right of Canada who is, pursuant to sections 3, 10 and 23 of the *Crown Liability and Proceedings Act*, responsible for actions committed by Her servants, when they act in their official capacities, in good faith and within the scope of their employment.

2. The Defendant admits the allegations contained in paragraphs 7(1st sentence), 8(1st, 2nd and (4th sentence), 9(1st, 2nd, 3rd, 6th sentence), 11 to 12, 46, 56, 60(a), (b), (c), (e), (f), (h), (i), (j), (m), and (n), and 61 of the Fresh as Amended Statement of Claim.

3. The Defendant has no knowledge of the allegations contained in paragraphs 38(last sentence), 47 and 48(2nd sentence).

4. The Defendant does not plead to the allegations contained in paragraphs 71 and 72.

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5. Except as otherwise pleaded in this Statement of Defence, the Defendant denies the allegations made in the Fresh as Amended Statement of Claim.

II. REPRESENTATIVE PLAINTIFFS

6. Mr. Christopher Brazeau was a first time federal offender serving a 12 year sentence for Robbery – All Others (x2) and Break, Enter and Commit Robbery with Violence (x2). His sentence commenced on November 17, 2004. His Day Parole Eligibility date was May 17, 2008. His Full Parole Eligibility Date was November 17, 2008. His Statutory Release Date was November 17, 2012. However, Mr. Brazeau was ordered detained by the Parole Board of Canada and was not released until his warrant expiry. His warrant expiry date was November 16, 2016. He was classified as a medium security offender prior to his release.

7. Mr. David Kift is a second time federal offender serving a 6 year sentence for Possession of Restricted Firearm (x20), Possession of Non-Restricted Firearm While Prohibited (x8), Possession of Firearm knowing Serial Number Removed (x2), Possession of a Prohibited Weapon Without Being a Holder of License (x2), Possession of Prohibited Weapon (x5) and Careless Storage of Firearm/Ammunition (x20). His sentence commenced on November 19, 2014. His warrant expiry date is November 18, 2020. His Day Parole Eligibility date was May 18, 2016, his Full Parole Eligibility Date is November 18, 2016 and his Statutory Release Date is November 19, 2018. He is currently classified as a medium security offender.

8. Mr. Kift's first federal sentence commenced on January 28, 2008. He received a five year sentence for Defacing/Removing a Serial Numbers on a Firearm, Possession of a Firearm having a Defaced Serial Number, Possession of a Firearm at an Unauthorized Place, Transferring a Firearm when Knowingly Unauthorized to do so (x2), Possession of a Prohibited Firearm with Ammunition, Knowingly possessing an Unauthorized Firearm and Possession of a Prohibited firearm. His Warrant Expiry Date was January 27, 2013.

III. BACKGROUND

A. CORRECTIONAL SERVICE OF CANADA (CSC)

9. The purpose of the federal correctional system is to contribute to the maintenance of a just, peaceful and safe society by (a) carrying out sentences imposed by courts through the safe and humane custody and supervision of offenders; and (b) assisting in the rehabilitation of offenders and their reintegration into the community as law-abiding citizens through the provision of programs in penitentiaries and in the community.

10. The protection of society is the paramount consideration for CSC in the corrections process.

11. CSC is responsible both for managing institutions of various security levels and supervising offenders in the community. More specifically, CSC is responsible for:

- The care and custody of offenders;
- The provision of correctional, educational and other programs that contribute to the rehabilitation of offenders and to their successful reintegration into the community;
- The preparation of offenders for release;
- Parole supervision, statutory release supervision and long-term supervision of offenders; and
- Maintaining a program of public education about the operations of CSC.

12. CSC's involvement in the criminal justice process begins once an offender is sentenced to a term of imprisonment of two years or more. Offenders given probation sentences or sentenced to a term of imprisonment of less than two years are the responsibility of the provinces/territories. Juvenile corrections, which are governed by the *Youth Criminal Justice Act*, are also administered by the provinces and territories.

13. CSC operates under three levels of management: national, regional, and institutional/district parole offices. CSC is headed by the Commissioner of Corrections,

who reports to the Minister of Public Safety and Emergency Preparedness Canada. The Commissioner is supported by an Executive Committee of national and regional officials.

14. CSC manages forty-three institutions (four of which include aboriginal healing lodges), fifteen Community Correctional Centres, and ninety-one parole offices.

15. CSC also operates five Regional Treatment Centres (RTCs). These are hybrid facilities that are both federal penitentiaries and provincially-recognized hospitals that are subject to relevant provincial health legislation.

16. In fiscal year 2014/15, there were 15,043 offenders in federal custody.

B. THE CSC'S PROVISION OF MENTAL HEALTH CARE

17. In answer to the Fresh as Amended Statement of Claim as a whole, and in particular to paragraphs 13 and 14, the Defendant states as follows.

(i) Legislation

18. By operation of sections 85 and 86 of the *Corrections and Conditional Release Act* (CCRA) offenders are to be provided with essential mental health care and to have reasonable access to non-essential mental health care that will contribute to their rehabilitation and successful reintegration into the community. The provision of these services must conform to professionally accepted standards.

19. Mental health care is defined in the CCRA as the care of a disorder of thought, mood, perception, orientation or memory that significantly impairs judgment, behaviour, and capacity to recognize reality or the ability to meet the ordinary demands of life.

20. Section 87 of the CCRA directs CSC to take into consideration an offender's state of health and health care needs in all decisions affecting the offender, such as placement and

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transfer, administrative segregation and in the preparation of an offender for release and the supervision of the offender.

21. Section 88 mandates CSC to obtain consent from an offender for medical treatment. Consent must be given for all treatments and the offender has the right to refuse consent or to withdraw from treatment at any time. In addition, provincial legislation allows for treatment for individuals either by court order or if they are certified and do not have the capacity to provide consent.

(ii) Commissioner's Directives

22. CSC policies are contained in Commissioner's Directives, which set out services, standards, corporate responsibilities and accountabilities within CSC relating to the fundamental roles, responsibilities and procedures for the provision of mental health services. The main policies are outlined in *Commissioner's Directives (CD) 800: Health Services* and *843: Management of Inmate Self-Injurious and Suicidal Behaviour*. These services must be provided in accordance with professional standards of practice and ethics, as well as standards established by CSC.

23. Commissioner's Directives have evolved over time to keep pace with, amongst other things, best practices; changes in mental health care; research and technological advances; and, provincial, professional and community standards. Additional changes are expected.

24. Direction for CSC health professionals with respect to roles and responsibilities in regard to psychological and other services related to the management of risk and to assist case management decision-making can also be found in *CD 705-5: Supplementary Assessments; CD 712-1: Pre-release decision-making; CD 712-2: Detention; CD 708: Special Handling Unit; CD 709: Administrative Segregation;* and *CD 710-2: Transfer of Inmates*.

(iii) Provincial Regulations

25. The provision of mental health services in CSC is also governed by the provincial regulatory and licensing bodies of the licensed mental health professionals employed by CSC. Each province and territory regulates the practice of its health care professionals. Regulatory bodies set entrance level standards and outline expectations to be met for competence in chosen areas of practice. CSC mental health professionals must be licensed for autonomous practice and adhere to the standards of their governing bodies, and must operate within their scope of practice and competence. Unlicensed mental health staff may only provide mental health services under the supervision of a licensed mental health professional who takes professional responsibility for the services provided in accordance with their provincial regulatory body.

(iv) CSC's Mental Health Strategy

26. CSC delivers mental health services to meet the needs of offenders from the time of intake to warrant expiry, as outlined in CSC's *Mental Health Strategy*. The *Strategy* recognizes that:

- Offenders are the central partner in their interdisciplinary team and are encouraged to collaborate with staff to develop and monitor their individual treatment plans;
- Mental health services are delivered within a holistic framework, which merges all intervention models, including: medical, psychological, social, spiritual, correctional and recovery;
- Mental health services respond to the diverse backgrounds and needs of offenders, including women and Aboriginal offenders;
- Information sharing respecting policy and legislative requirements is required to support an integrated continuum of mental health services; and,

- There is a shared responsibility among all invested partners (e.g. CSC, community agencies, etc.) to support an integrated continuum of care for offenders with mental health concerns throughout their sentence.

(v) CSC Mental Health Guidelines

27. CSC's mental health guidelines outline the provision of mental health services available to offenders in institutions, RTCs and in the community. The guidelines outline the standards of practice that are applicable at all levels of mental health care provided by CSC across the continuum of care, and provide detailed direction regarding requirements specific to each level of care. The guidelines are informed by both standards of professional practice and relevant policy and legislation.

(vi) CSC's Mental Health Services

28. CSC provides essential mental health care for offenders who have significant mental health needs in the areas of emotion, cognition and/or behaviour indicative of a mental health disorder. These needs create, or are likely to create:

- Significant impairment in the individual's functioning within his/her institution; and /or
- Significant impacts on the individual's successful reintegration into the community.

29. There are three overarching levels of mental health care within CSC: Primary Mental Health Care, Intermediate Mental Health Care, and Psychiatric Hospital Care.

30. Primary Mental Health Care is care provided to offenders with mental health needs that can be accommodated by mental health teams in mainstream CSC institutions. Primary Care services include mental health screening and triage; group and individual interventions; assessment and individualized treatment planning; monitoring and assessment of offenders in administrative segregation; and, coordination of referrals to psychiatric hospitals and Intermediate Mental Health Care. Pursuant to CSC's mental

health guidelines, these services are required to be evidence-based and are provided in a manner that is respectful of diversity.

31. Intermediate Mental Health Care is provided to offenders who do not need to be in a hospital, or do not consent to hospital admission, but still need more mental health care than is available in Primary Mental Health Care. In addition to the services provided in Primary Care, Intermediate Mental Health Care services include clinical case coordination; psychiatric symptom management; therapeutic recreation and leisure activities; increased access to clinical staff; and, provision of care associated with activities of daily living. Offenders can be admitted to an Intermediate Mental Health Care unit, but offender consent is required for such treatment.

32. Psychiatric Hospital Care is provided to offenders with acute mental health concerns that cannot be addressed by Primary or Intermediate Care. In addition to the services offered in Primary Care and Intermediate Mental Health Care, Psychiatric Hospital Care services provide intensive psychiatric and nursing services for stabilization. Psychiatric Hospital Care is provided within RTCs or may be provided by an external hospital, with which CSC has an exchange of service agreement. Where an offender does not have the capacity to give an informed consent (in accordance with the requirements of s. 88(2) of the CCRA), the provision of treatment to an offender is governed by the applicable provincial law.

33. CSC has five RTCs across Canada, one in each region. They are accredited facilities that provide intensive interdisciplinary treatment to offenders with mental and physical health care needs in safe and supportive environments. RTCs are "hybrid" facilities, in that they are considered to be a "penitentiary" subject to the provisions of the CCRA, and a "hospital" subject to the provisions of relevant provincial legislation, where applicable. RTCs offer both acute Psychiatric Hospital level Care and Intermediate Mental Health Care.

(vii) **Regional and National Complex Mental Health Committees**

34. There are five Regional Complex Mental Health Committees across Canada: one per region. These committees are responsible for overseeing and monitoring complex mental health cases in their region. These committees are a mechanism to assist and support institutions in providing an effective continuum of care to offenders experiencing significant mental health concerns during their period of incarceration that pose challenges for sites in regards to effective management and treatment.

35. The National Complex Mental Health Committee reviews the most challenging cases from the regions and reviews complex mental health cases where specialized funding has been allocated to support the mental health care needs of a particular offender.

(viii) **CSC's Essential Mental Health Care**

36. An offender may enter the federal correctional system with a formal mental disorder diagnosis from a healthcare professional in the community, may be diagnosed while in CSC custody, or may have no formal diagnosis.

37. The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), published in May 2013, is the handbook used by health care professionals within CSC as the primary guide for the diagnosis of mental disorders. The DSM contains descriptions, symptoms, and other criteria for diagnosing mental disorders. It provides a common language for clinicians to communicate about their patients and establishes clear and consistent diagnostic criteria.

38. The provision of mental health services must be consistent with the individual's level of need. Need is defined as an ability to benefit from an intervention and is distinguished from both "use" and "demand". The level of need is assessed by taking into account available mental health assessment information and clinical judgement and is based on signs and symptoms indicative of a mental health disorder and level of functioning. A

high demand for mental health services and rates of service utilization do not equate with need.

(ix) CSC's Training in Mental Health

39. CSC provides mandatory training designed to support health care professionals, such as nurses, in the performance of certain aspects of their roles and responsibilities. These national training standards comply with law and policy and are in line with provincial professional practices. Moreover, licensed health professionals such as nurses and physicians are required by their respective governing bodies to maintain continued competence in their practice settings.

(a) CSC's Suicide and Self-Injury Training

40. Since the 1980s, CSC has had a national policy that specifically addresses prevention and management of suicide and self-injury (*CD 843*). This policy requires all employees who have regular interactions with offenders to receive orientation training on intervention in relation to suicide and self-injury.

41. In 2006, CSC's training approach was changed to add a refresher component which must be taken every two years. CSC provides a national training program that provides employees with the necessary knowledge and skills to safely intervene with offenders who are suicidal or self-injurious. This national program is offered as part of the Correctional Training Program and the New Employee Orientation Program and makes use of various instructional methods, such as traditional in-class training, computer-based training and self-directed learning. As part of CSC's National Training Standards, all staff (including casuals) having regular interaction with offenders are required to complete both initial and refresher suicide and self-injury intervention training.

42. In 2011, the Learning and Development Governance Board approved a blended model of the Suicide and Self-Injury Intervention Refresher Training. The new blended model consists of a one-hour online course that must be completed each year, as well as in-class training, entitled *Suicide and Self-Injury Intervention Refresher Training for Employees*

Working in the Institution or in the Community. In-class training must be taken every two years.

(b) **CSC's Mental Health Training**

43. CSC's *Fundamentals of Mental Health Training* (FMHT) was developed in 2006 with the goal of enhancing staff and community partners' knowledge of mental health and their ability to respond to the needs of offenders with mental disorders. It was revised in 2012.

44. The FMHT is currently a two-day training package, is co-facilitated by a mental health professional and an operational staff member, and is mandatory for all correctional officers, correctional managers and parole officers. The training is available to other institutional and community staff and community partners.

45. Within its seven learning modules, the FMHT addresses the following learning objectives:

- Increase understanding of mental disorders and symptoms;
- Increase knowledge and understanding of offenders who have a mental disorder;
- Promote a collaborative, interdisciplinary approach within the correctional environment; and,
- Enhance skills and strategies for effectively interacting with and supporting offenders with mental disorders.

(x) **Correctional Interventions**

46. CSC completes a Correctional Plan for every offender. The plan details the level of intervention in respect of the offender's needs, objectives for the offender's behaviour, program, and interventions required to manage risk and any court-ordered obligations.

47. CSC has an Integrated Correctional Program Model (ICPM) for male offenders comprised of three distinct streams: the multi-target stream, the Aboriginal offender

stream, and the sex offender stream. Each of these streams in turn includes three phases: readiness, main program, and maintenance (or follow-up). There is also a Community Program which combines and compresses the readiness and main program phases for offenders who are released into the community without having completed the required programs. The Community Program includes multi-target and sex offender specific components.

48. Programs for women offenders follow a similar model: Women's Engagement Program (readiness); Women Offenders Moderate and High Intensity Programs and Women's Sex Offender Program (main program); and Women Offender Self-Management Program (maintenance of follow-up program). There is also a second stream of Women Offender Programs for Aboriginal Women Offenders with the same three components: readiness, main program and follow-up.

49. While the three distinct program streams of the ICPM allow CSC to continue to target the needs and risks presented by specific offender populations, the multi-target nature of the program streams also allows CSC to more holistically address the individual needs and risks of offenders. As most offenders enter CSC custody with needs in more than one area, an integrated, multi-target program enhances offenders' understanding of the interplay among their multiple personal risk factors, and helps offenders learn how to use the same skill set to effectively manage those risk factors in order to reduce their chance of reoffending.

50. The multi-target and sex offender streams of the ICPM have been adapted for offenders who have deficits in functioning (e.g., cognitive impairments, and/or learning disabilities) that interfere with their ability to fully participate in, and learn from, correctional programming. These adapted programs present the same set of skills for helping offenders manage and reduce their risky or harmful behaviours, but present them in a modified fashion: complex concepts and exercises are broken down and simplified, and the content is delivered at a slower pace with more repetition and additional

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opportunities to practice the skills. The adapted programs are delivered to smaller groups than the non-adapted programs.

IV. ACCESS TO PRESCRIBED MEDICATION UPON ADMITTANCE OR TRANSFER TO AN INSTITUTION

51. In answer to paragraphs 15 to 19 of the Statement of Claim, the Defendant states as follows.

52. Upon admission to federal custody, offenders are offered an assessment of their health care needs, in accordance with applicable policies.

53. Within 24 hours of arrival at any CSC institution (including inter/intra-regional transfers, suspension of statutory release, conditional release or long term supervision, and following a return to court) a nurse will assess the offender and complete an Intake Health Status Assessment. This assessment includes physical health, mental health (including risk of suicide or self-injury), allergies (medication, food, environmental) and medication reconciliation.

54. During this Intake Heath Status Assessment, medication reconciliation is performed to ensure accurate and comprehensive medication information is communicated consistently across transitions of care. This process normally includes consultations with the offender, other provincial or federal correctional institutions, community health care providers and community pharmacies. Following verification of the offender's current medication history and after careful evaluation, an institutional physician will make the most appropriate prescribing decisions for the patient. This could include adding, changing or discontinuing medications.

55. Medications prescribed by the institutional physician will normally be provided to institutional health centres from regional pharmacies. If the institution does not have the medication on hand, it may be ordered from a community pharmacy. The urgency for

provision of the medication is assessed on an individual basis and the decision is made in collaboration with the institutional physician and pharmacist.

56. In the case of a transfer between federal institutions, the sending institution is responsible for all health-related care, including medications, until the offender reaches the receiving institution. Prior to transfer, a nurse will review the offender's health care file to identify any current health concerns or medical complications that are likely to arise during the transfer. This process allows for the receiving institution to request the prescribed medication from the regional pharmacy in anticipation of the transferred offender. Transfers from a provincial institution to a federal institution generally follow the same process.

57. The Defendant specifically denies that its health professionals do not have the requisite training or time to meet and assess offenders who present with mental health needs.

V. ACCESS TO PRESCRIBED MEDICATIONS

58. In answer to paragraphs 20 to 23 of the Statement of Claim, the Defendant states as follows.

59. CSC has a National Drug Formulary, similar to all publicly-funded federal, provincial and territorial drug plans in Canada. The Formulary is a list of medications which CSC will fund when providing essential medical care to federal offenders. Consistent with community practices, the purpose of the Formulary is to provide a tool for physicians and pharmacists to select the most appropriate and cost effective medication.

60. The Formulary describes, amongst other things, the steps in the drug review process, the process for including or removing medications, drug benefit categories, restrictions on the quantity of medication distributed and/or duration of therapy, non-formulary processes, and continuity of care guidelines.

61. The Formulary sets out three categories of medications that CSC will provide:

- An **open benefit** listing refers to a drug that can be prescribed by the attending physician without prior approval;
- A **benefit with criteria** listing refers to a drug that has value in specific circumstances, but is inappropriate for general listing. It can be prescribed by a treating physician without prior approval where it meets the criteria listed in the Formulary;
- An **exception benefit** refers to a drug that is not listed or does not meet the criteria listed in the Formulary, but that can be approved on a case-by-case basis.

62. Requests for medications not listed on the Formulary (considered Non-Formulary requests) will be considered against the following criteria:

- The prescription is for a recognized clinical indication and dose which are supported by published evidence or authoritative opinion;
- There is supporting evidence that available Formulary alternatives are ineffective, toxic, or contraindicated (personal preference alone does not justify an exception); and,
- There is significant evidence that the requested drug is superior to drugs already listed as program benefits.

63. The Formulary identifies restrictions on a number of drugs known or suspected of having high abuse potential, meaning that they may be used or diverted by offenders for purposes, such as trafficking, other than their intended use.

64. In response to paragraphs 20 to 23, the Defendant specifically denies that the clinical judgment of its health professionals, who must operate in accordance with professional standards and provincial regulatory requirements, is impaired such that mental health services are not available to offenders.

VI. CSC EMPLOYS APPROXIMATELY 1200 HEALTH PROFESSIONALS

65. In answer to paragraphs 24 and 25 of the Statement of Claim, the Defendant states as follows.

66. CSC currently employs approximately 1200 health professionals and staff. Mental health services are provided by licensed mental health professionals. Unlicensed mental health staff may only provide mental health services under the supervision of a licensed mental health professional, who takes professional responsibility for the services provided in accordance with their provincial regulatory body.

67. At all levels of care, mental health services in CSC are provided by Interdisciplinary Mental Health Teams. Current standards of practice recognize that resources from a variety of disciplines working as a team are necessary in order to deliver high-quality mental health care that is recovery-oriented, patient-centred, holistic, and responsive to individual need.

68. Interdisciplinary Mental Health Teams coordinate the provision of mental health services to offenders. They are responsible for identifying needs and service requirements, prioritizing services, and monitoring and documenting clinical progress. The size and interdisciplinary mix of Mental Health Teams vary between sites but can include psychologists, nurses, clinical social workers, occupational therapists, behavioural science technicians, behavioural counsellors, mental health clinicians, mental health officers, and psychiatrists. Team members may also include other health care staff, parole officers, correctional officers, primary workers, correctional managers, elders, and other ad hoc members as appropriate. The ratio of offenders to mental health professionals varies with the level of care, with a higher staff ratio for a higher level of care (i.e., more staff for fewer offenders).

69. The offender participates as a partner in their own interdisciplinary team and is encouraged to collaborate with staff to develop and monitor their individual treatment

plans. Just as when they reside in the community, offenders are expected to be proactive in safeguarding their own health.

70. Further, and as described above, CSC has a comprehensive continuum of care model such that mental health care is available to offenders based on their needs. CSC denies that offenders do not have access to therapies or that they are unable to change prescribed medications.

VII. ADMINISTRATIVE SEGREGATION

71. In answer to paragraphs 26 to 33 of the Fresh as Amended Statement of Claim, the Defendant states as follows.

72. The purpose of administrative segregation is to maintain the security of the institution or the safety of any person by not allowing an offender to associate with other offender for a period of time.

73. Administrative segregation is governed legislatively by sections 31 to 37 of the CCRA and sections 19 to 23 of the Regulations. Some of these provisions are the subject of expected legislative change.

74. The Defendant states that CSC's policies and practices with regard to administrative segregation must be assessed based on the facts established in this proceeding and not on the basis of terminological categories seeking to equate CSC's conduct with "solitary confinement" as practiced in other jurisdictions. The Defendant denies that the Plaintiffs' use of the term "solitary confinement" has any legal or evidentiary consequences in the determination of liability.

75. Pursuant to subsection 31 of the CCRA, the Institutional Head, meaning the Warden or his or her delegate, may order that an inmate be confined in administrative segregation if he/she is satisfied that there is no reasonable alternative and he/she believes on reasonable grounds that:

- The inmate has acted, has attempted to act or intends to act in a manner that jeopardizes the security of the penitentiary or the safety of any person and allowing the inmate to associate with other inmates would jeopardize the security of the penitentiary or the safety of any person;
- Allowing the inmate to associate with other inmates would interfere with an investigation that could lead to a criminal charge or a charge under subsection 41(2) of the CCRA regarding a serious disciplinary offence; or
- Allowing the inmate to associate with other inmates would jeopardize the inmate's own safety.

76. Administrative segregation is used by CSC as a last resort to manage the risk to the security of the penitentiary or the safety of any person posed by the offender's association with other offenders.

77. Subsection 31(2) of the CCRA requires that an inmate is to be released from administrative segregation at the earliest appropriate time.

78. Pursuant to section 37 of the CCRA, an inmate in administrative segregation has the same rights and conditions of confinement as other inmates, except for those that can only be enjoyed in association with other inmates, those that cannot be enjoyed due to the limitations specific to the administrative segregation area, or because of security requirements.

79. Administrative segregation is not a punitive measure.

80. There is an internal CSC review process currently in place whereby confinement in administrative segregation is reviewed on the following schedule, with a view to releasing the offender from segregation:

- On the first working day by the Institutional Head if the decision to confine the inmate in administrative segregation was made by a delegate;

- On the fifth working day by the Institutional Segregation Review Board, chaired by the Deputy Warden;
- On day 30 by the Institutional Segregation Review Board, chaired by the Warden, and every 30 subsequent days thereafter;
- Prior to day 45 by the Regional Project Officer responsible for segregation;
- After day 60 by the Regional Segregation Review Board, chaired by the Assistant Deputy Commissioner (Correctional Operations or Integrated Services) of the Region, and every 30 days thereafter;
- The National Long Term Segregation Review Committee, chaired by the Director General Security at National Headquarters, reviews any placements longer than 60 days when the Regional Segregation Review Board has not identified or determined a resolution.

81. Section 87 of the CCRA and CSC policy require that an offender's state of health and health care needs be taken into account when rendering decisions regarding administrative segregation. Health care professionals are normally consulted before an inmate is placed in administrative segregation; a suicide risk screening is conducted upon placement; and a registered health care professional must visit each inmate in segregation daily. Regular mental health checks and/or assessments of the inmate are also conducted, and mental health services are provided as required.

82. Administrative segregation procedural safeguards are reinforced in *CD 709* and *Guidelines 709-1.* These policies provide that an offender in administrative segregation has access to: (a) correctional programs and interventions; (b) case management services; (c) spiritual support; (d) psychological counselling as required; (e) the opportunity to exercise at least one hour every day; (f) a shower no less than every second day; (g) access to personal effects if the offender is maintained in segregation following the fifth working day review; (h) access to legal counsel without delay; and, (i) structured visits from inmate committee members or peer support. In addition, offenders have access visits and the ability to make phone calls.

83. The Defendant specifically denies that confinement in administrative segregation may be for an indefinite period of time. Further, the Defendant denies that confinement in administrative segregation frustrates the overall rehabilitative aspect of its mandate.

VIII. CSC's MANAGEMENT OF SECURITY INCIDENTS

84. In answer to paragraphs 34 to 37 of the Statement of Claim, the Defendant states as follows.

85. The management of security incidents within a CSC institution, outlined in *CD 567-Management of Security Incidents*, is critical to the safety of all inmates, staff and the institutions themselves. The purposes underlying the management of security incidents are to maintain safe institutional environments; to maintain respectful environments that promote dynamic security and positive interactions between staff and inmates and encourages inmates to actively participate in their Correctional Plan; and to return the institution to normal operations in a safe and timely manner after an incident.

86. Situations are managed and controlled using a framework which includes, but is not limited to, the following CDs:

- *CD 567-1 – Use of Force* identifies the processes and requirements for the use of force, ensuring that the response and the manner in which force is used are appropriate and in accordance with CSC policy and applicable legislation;
- *CD 567-2 – Use of and Responding to Alarms* identifies the processes and requirements for the use of and responding to alarms;
- *CD 567-3 – Use of Restraint Equipment for Security Purposes* identifies the processes and requirements for the appropriate use of restraint equipment;
- *CD 567-4 – Use of Chemical and Inflammatory Agents* identifies the processes and requirements for the appropriate use of chemical and inflammatory agents;
- *CD 567-5 – Use of Firearms* identifies the processes and requirements for the appropriate use of firearms; and,

- *CD 600 – Management of Emergencies* identifies the processes and requirements to ensure that all critical locations are prepared to deal effectively with emergencies.

87. CSC promotes the peaceful resolution of an incident using the safest and most reasonable measures to prevent, respond to, and resolve the situation. Any use of force must be limited to only what is necessary and proportionate to attain the purposes pf the CCRA and must respond to changes in the situation through continuous assessment.

88. In identifying procedures for use of force incidents, CSC policy requires that, if time and circumstance permit, a health care professional will i) advise the Crisis Manager of any mental and/or physical health issues concerning the inmate(s) involved that may assist in the development of an Intervention Plan, ii) offer a physical assessment to every inmate involved in the use of force incident, and iii) conduct a physical examination of inmates who have consented. In the absence of a health care professional, the Offender Management System is accessed to determine health needs. In addition, the institution's Chief, Health Services participates in the review process of all use of force incidents and evaluates any physical assessment of inmates involved following the incident.

89. CSC staff receive training on the application of the applicable law, policies and procedures and as well as training allowing for the consideration of cultural, physical health, mental health and gender issues in their interventions. Training is ongoing with mandatory refresher courses and new training being provided to adapt to changing situations, lessons learned and best practices.

90. The training program required for all correctional officers is called the Correctional Training Program (CTP). The CTP is a blended learning approach conducted in a variety of settings, including on-line learning at home and in classrooms, gymnasiums, exercise fields, and the firing range. Correctional Officers are trained to handle firearms and chemical agents. They also participate in self-defence and other physical training.

91. Currently, the CTP is divided into three stages, which include online learning (80 hours), pre-session online assignments and material (40 hours) and in-class training at the CSC Training Academy in Regina, Saskatchewan (465 hours).

92. Training is provided to correctional officers in the areas of law and policy, safety, security, administrative segregation, management of security incidents, use of force and mental health. For example, training in use of force has been provided since 1996, training on administrative segregation policy and procedures since 2000, and training in the fundamentals of mental health since 2006.

IX. CSC's RESPONSE TO THE ALLEGED EXPERIENCES OF CHRISTOPHER BRAZEAU

93. In answer to paragraphs 38 to 45 of the Statement of Claim, the Defendant states as follows.

94. Mr. Brazeau was incarcerated at Stony Mountain Institution from November 24, 2004 to April 21, 2005. He did not report taking any psychiatric medications prior to his arrival at Stony Mountain. He self-reported a mental health history of Attention Deficit Hyperactivity Disorder (ADHD), and was being treated with Ritalin for only a short period when he was a child.

95. Upon his arrival at Stony Mountain Institution, Mr. Brazeau was voluntarily confined in administrative segregation until CSC facilitated his transfer to a maximum security institution.

96. Mr. Brazeau was voluntarily transferred to Saskatchewan Penitentiary where he was incarcerated from April 21 to July 20, 2005. There is no documentation in his CSC health care records indicating that Mr. Brazeau requested mental health treatment or reported any concerns to CSC's Health Services during that time.

97. Mr. Brazeau was incarcerated at Kent Institution from July 20, 2005 to July 10, 2006. He requested a transfer to Kent Institution from Saskatchewan Penitentiary due to community and family supports. While he was at Kent Institution, he was confined in administrative segregation on several occasions.

98. On May 26, 2006, Mr. Brazeau was referred to the Institutional Mental Health Team following self-reported symptoms of mood swings associated with paranoia. On June 8, 2006, he was assessed by the registered psychiatric nurse who recommended to his treating physician a low dose of Risperidal (antipsychotic) as initial treatment to alleviate his symptoms. He refused to be seen by his treating psychiatrist on June 12, 2006. When he was reassessed by the registered psychiatric nurse on July 6, 2006, he self-reported symptoms of perceptual disturbance, paranoid ideation and hallucinatory behaviour. Arrangements were initiated to have him transferred to the RTC in order to obtain a formal psychiatric assessment. He was transferred four days later on July 10, 2006.

99. Mr. Brazeau was incarcerated at the RTC from July 10, 2006 to April 11, 2008.

100. Mr. Brazeau was incarcerated at Kent Institution from April 11, 2008 to October 27, 2011. Upon his return to Kent Institution from the RTC, an Ambulatory Mental Health Team – which included a Registered Social Worker, a Registered Psychiatric Nurse, a Psychologist, and a Psychiatrist – was assigned to support him. He received extensive support, counselling and psychological assessments while at Kent. He was confined in administrative segregation on several occasions.

101. Mr. Brazeau was incarcerated at Saskatchewan Penitentiary from October 27, 2011 to October 29, 2013. On October 28, 2011, he was assessed by the nurse in Health Services and he denied mental health concerns. On November 7, 2011, he was assessed by the psychiatrist. He was confined in administrative segregation on several occasion while at Saskatchewan Penitentiary.

102. On April 18, 2012, Mr. Brazeau was referred to the Mental Health Team after he expressed interest in developing coping techniques. He was assessed on April 25, 2012, and it was determined that he would benefit from one on one therapy. In addition to receiving cognitive behavioural therapy, Mr. Brazeau also received five individual therapy sessions with a psychologist.

103. Towards the end of May 2013, Mr. Brazeau was transferred to the Regional Psychiatric Centre (RPC) in Saskatoon for assessment of his mental health in light of his stated concerns. Following a one month stay, the psychiatrist's assessment at RPC was that Mr. Brazeau could return to Saskatchewan Penitentiary as he did not require further mental health interventions. There was no evidence that further treatment was required for a mental health diagnosis while at RPC, except for ADHD which was being treated with Vyvanese since August 2011.

104. Mr. Brazeau returned to Saskatchewan Penitentiary on June 26, 2013 and remained there until October 28, 2013. Upon his arrival, he was referred to the Mental Health Nurse for an assessment and he requested to be confined to administrative segregation. On July 16, 2013, he reported to the Manager, Assessment and Intervention, that he would not return to the general population.

105. Mr. Brazeau was transferred to Edmonton Institution on October 29, 2013 and was referred to the Mental Health Team on arrival. He was assessed on November 1, 2013. Shortly after, on November 6, 2013, he started Occupational Therapy individual sessions in order to improve his anxiety-coping strategies. He received a total of ten sessions between November 2013 and March 2014. He was assessed by a psychiatrist on April 30, 2014.

106. Mr. Brazeau was transferred to Grande Cache Institution on September 25, 2014 following a decrease in his security classification. He was confined in administrative segregation on two occasions.

107. Mr. Brazeau was transferred to Edmonton Institution on April 27, 2015 following an increase in his security classification.

108. Mr. Brazeau was voluntarily transferred to Matsqui Institution on September 20, 2016 following a decrease in his sec classification and in preparation for his release from custody. He was confined in administrative segregation on one occasion for his own safety. On October 31, 2016, Mr. Brazeau was transferred to Mission Institution and reached his warrant expiry date on November 16, 2016.

109. The Defendant specifically denies the allegation that Mr. Brazeau was subjected to extreme physical force and that improper medications were prescribed to him.

X. RESPONSE TO THE ALLEGED EXPERIENCES OF DAVID KIFT

110. In answer to paragraphs 46 to 52 of the Statement of Claim, the Defendant states as follows.

111. Mr. Kift was incarcerated at the Millhaven Assessment Unit from March 20, 2008 to June 13, 2008. He reported suffering from PTSD and major depression upon admission and he was referred to a psychiatrist. While in provincial custody, Mr. Kift had been prescribed Celexa, Wellbutrin and Sinequan, for his depression. These medications were continued once he was incarcerated at Millhaven.

112. While at Millhaven, Mr. Kift did not report significant impairment as a result of mental health concerns. From the date of his admission to May 1, 2008, his main complaint was anxiety/stress/tension as a result of his incarceration. On May 1, 2008, he was assessed by the institutional physician following the death of his father. On May 6, 2008, he was assessed by the mental health nurse and he declined Chaplaincy/Psychology services. On May 30, 2008, he was assessed by the psychiatrist. He was scheduled for a follow-up appointment with the psychiatrist during the week of July 21, 2008, but was transferred to Pittsburgh Institution before the appointment took place.

113. Mr. Kift was transferred to Pittsburgh Institution on June 13, 2008. He was released on Appeal Bail on June 18, 2008, five days after his arrival. There were no changes to his prescribed medications during this period and he was seen by a behavioural science technician on June 16, 2008.

114. Mr. Kift was re-incarcerated on April 22, 2009 at Pittsburgh Institution. His warrant expiry date was amended to November 28, 2013. He was released on September 28, 2009 on Accelerated Day Parole to the Cornerstone Community Residential Facility.

115. On April 23, 2009, and following confirmation from his family physician, Mr. Kift was prescribed the same medications (Celexa and Wellbutrin) at the same doses previously prescribed by his family doctor.

116. Between April 26, 2009 and August 11, 2009, he was assessed/offered support on eight different occasions by health care professionals/security personnel following self-reported symptoms of depression and anxiety. On April 26, 2009, he was assessed by nursing staff. On April 28, 2009, April 30, 2009 and May 12, 2009, he was assessed by a psychologist. On May 13, 2009, he was assessed by the psychiatrist. On July 2, 2009, he was assessed by the institutional physician. On July 15, 2009, he was re-assessed by the psychiatrist. On August 11, 2009, he was again re-assessed by the psychiatrist. Mr. Kift's treatment plan during this period included counselling services with the psychologist and an antidepressant used to treat major depressive disorder.

117. While on parole from September 28, 2009 to March 7, 2013 – the date on which an apprehension and suspension warrant was issued due to Mr. Kift's breach of his parole conditions resulting from new weapons' related charges) – Mr. Kift refused several counselling sessions/psychologist's supports when they were offered by CSC.

118. Following the execution of that apprehension and suspension warrant, Mr. Kift was incarcerated at the Joyceville Temporary Detention Unit from March 15, 2013 to March 22, 2013. On arrival, he self-requested protective custody and was voluntarily placed in administrative segregation. He remained in administrative segregation for seven days

until he was returned to the Quinte Detention Centre for a court appearance. While in segregation he was assessed every day by a registered nurse. He was also assessed by a psychiatrist on March 21, 2013. The only prescribed medication noted on his transfer from the Quinte Detention Centre was Cymbalta, not Wellbutrin. Cymbalta had first been prescribed three days prior to his arrival. Mr. Kift reported that the Cymbalta was not working for either his pain or depression symptoms, so the medication was discontinued by the psychiatrist on March 21, 2013.

119. Mr. Kift was transferred from the Quinte Detention Centre to the Joyceville Assessment Unit on May 10, 2013. His transfer summary noted that he was not on any psychiatric medication. A pending appointment with a psychiatrist was noted and included on his subsequent transfer summary to Fenbrook Institution.

120. Mr. Kift was at Fenbrook Institution from June 6, 2013 to August 30, 2013, at which time he was statutorily released into the community. On June 6, 2013, an intake assessment was completed, which prompted a meeting with his Mental Health Team. On June 13, 2013, Mr. Kift was assessed by the institutional physician who prescribed two antidepressants (Effexor and Remeron). Between June 7 and July 25, 2013, Mr. Kift attended six psychotherapy sessions to address anxiety and coping issues. On August 8, 2013, he advised the nurse that the medications were not effective. He was statutorily released before he saw the psychiatrist. At the time of his departure from the institution, he was still receiving Effexor and Remeron. Mr. Kift reached his warrant expiry on November 28, 2013.

121. Mr. Kift commenced his second sentence on November 19, 2014. He was transferred from provincial custody to the Joyceville Assessment Unit on November 27, 2014 and remained incarcerated there until March 6, 2015.

122. The Transfer Summary from the Provincial Jail indicated Mr. Kift was taking Cymbalta, Remeron and Imovane (a hypnotic). The day after his arrival, Mr. Kift was scheduled to see the psychiatrist, who met with him on December 12, 2014. At that time, he informed

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the psychiatrist that the Remeron was not working, therefore it was discontinued and Nozinan (a sedative) was prescribed.

123. As part of the intake assessment process, on December 4, 2014, Mr. Kift was assessed by the Mental Health Nurse and he completed the Computerized Mental Health Intake Screening System. He declined a referral to the Mental Health Team stating that he was not interested in pursuing Mental Health Services at this time.

124. On December 17, 2014, Mr. Kift sent an Inmate's Request stating that the Nozinan was not working and he wanted to be prescribed the Remeron again. He was re-assessed by a psychiatrist on January 23, 2015, and Remeron was restarted.

125. Mr. Kift was transferred to Joyceville Institution Minimum Security on March 6, 2015.

126. He was assessed on March 23, 2015 by a psychiatrist. On July 13, 2015, Mr. Kift was re-assessed by a psychiatrist. In October 2015, he was again re-assessed by a psychiatrist who documented several symptoms of depression. Mr. Kift was asked to complete the Quick Inventory of Depressive Symptomatology-Self-Report. He scored 21 (which indicates very severe depression), therefore his dose of Sinequan, which was initially prescribed for sleep, was increased to the full antidepressant dosage. Again during this appointment, he noted that he did not want to speak with the psychologist.

127. Mr. Kift was reassessed by the psychiatrist on November 30, 2015. He reported that he was still very depressed and felt the Sinequan was not helping. He noted that Wellbutrin was the most helpful medication that was prescribed to him in the most recent years. The psychiatrist advised him that a Non-Formulary Medication Request had to be submitted for approval from the pharmacist. The request was sent on the same day. The Non-Formulary Medication Request for Wellbutrin was approved by the pharmacist. On December 1, 2015, the prescription for Sinequan was discontinued and Wellbutrin was prescribed by the psychiatrist.

128. The Defendant specifically denies the allegation that improper medications were prescribed for Mr. Kift, that his medications were arbitrarily discontinued, and that he was provided with inadequate medical assistance.

XI. CANADA'S POLICIES REGARDING OFFENDERS

129. In answer to paragraphs 53 to 55 of the Statement of Claim, the Defendant states as follows.

130. With respect to paragraph 53, the Defendant denies that its policies and practices, amended over time, and made, applied and carried out in good faith, resulted in the alleged failures as suggested. CSC policies have evolved over time to keep pace with, amongst other things, best practices; changes in mental health care; research and technological advances; and, provincial, professional and community standards.

131. With respect to paragraphs 54 and 55, the Defendant admits that these statements appear in the Reports from the Office of the Correctional Investigator of Canada but denies that they are applicable or determinative of any of the alleged failures complained of.

XII. NO BREACHES OF THE *CHARTER*

132. In answer to paragraphs 56 to 65 of the Statement of Claim, the Defendant states as follows.

133. The Defendant denies that Class members were, or are, systemically subjected to punishments or administrative segregation contrary to the requirements of the law, denied access to essential health care and reasonable access to non-essential mental health care that would have contributed to their rehabilitation and successful reintegration into the community or were subjected to wrongful acts.

134. The Defendant denies that Messrs. Brazeau and Kift experienced "extended periods in administrative segregation", as alleged in the Fresh as Amended Statement of Claim. If

they did, which is not admitted, they did so at institutions for which CSC is not responsible for at law, such as when in provincial custody, or they did so within the strict parameters of section 31 of the CCRA. Further, any periods of administrative segregation were governed by section 31 of the CCRA.

135. The Defendant denies that Mr. Brazeau and Mr. Kift were deprived of health care, as alleged. The Defendant states that they both received health care, including mental health care, in accordance with professionally accepted standards, and further to section 85 to 87 of the CCRA. The Defendant denies that Mr. Brazeau and Mr. Kift suffered physical abuse as alleged and puts them to the strict proof thereof.

136. The Defendant denies that there has been any breach of sections 7, 9 or 12 of the *Charter*. The Defendant specifically denies the allegations found in paragraph 62; puts the Class members to the strict proof thereof; and, states that all of these allegations are addressed in this Defence, and in context.

137. The Defendant denies that each or all of the allegations in paragraph 62 may be considered a breach of sections 7, 9 or 12 of the Charter, and states that, to the extent a particular allegation could engage *Charter* guarantees, it is unfounded. Aggregate generic statements of alleged misconduct are insufficient to ground a breach of a *Charter* right. Each offender is a unique individual with unique needs that require an individualized correctional plan and health care needs assessment.

A. No Breach of Section 7

138. Section 7 of the *Charter* requires that laws or state actions that deprive anyone of life, liberty or security of the person conform to the principles of fundamental justice.

139. In answer to paragraphs 62 to 65 of the Fresh as Amended Statement of Claim, the Defendant denies that any of its actions or omissions engaged or limited any Class members' right not to be deprived of life, liberty or security of the person except in accordance with the principles of fundamental justice, under section 7 of the Charter.

140. Alternatively, if any of the Class members' section 7 *Charter* rights were engaged and limited as pled, which the Defendant denies, the Defendant says that any infringement was demonstrably justified in a free and democratic society and hence saved by section 1 of the *Charter*.

B. No Breach of Section 9

141. Section 9 safeguards the liberty of the individual. It is directed towards any form of deprivation of liberty by the state. It defines the circumstances in which a detention is permitted or prohibited.

142. In answer to paragraphs 62 to 65 of the Statement of Claim, the Defendant states that a lawful detention is not arbitrary within the meaning of section 9 of the *Charter* unless the law authorizing the detention is itself arbitrary. The Defendant denies that sections 31 to 37 of the *CCRA*, which authorize and constrains CSC'S use of administrative segregation, is arbitrary.

143. Further, detention is not arbitrary where there are standards that are rationally related to the purpose of the power of detention and it is readily apparent that not only is the incarceration statutorily authorized, but that the legislation narrowly defines a class of offenders with respect to whom it may properly be invoked, and prescribes quite specifically the conditions under which incarceration may take place.

144. In further answer to paragraph 65 of the Statement of Claim, the Defendant denies that any of its actions constituted over-reliance on administrative segregation, and denies that its practices with regard to administrative segregation violated section 9.

145. Alternatively, if any of the Class members' section 9 *Charter* rights were engaged and limited as pled, which the Defendant denies, the Defendant says that any infringement was demonstrably justified in a free and democratic society and hence saved by section 1 of the *Charter*.

C. No Breach of Section 12

146. Section 12 prevents the state from imposing punishment or treatment that is so excessive as to outrage our standards of decency.

147. In answer to paragraphs 62 to 65 of the Statement of Claim, CSC denies that Class members were subjected to cruel and unusual treatment or punishment contrary to section 12 of the *Charter* or that any of Canada's actions or omissions subjected Class members to cruel and unusual treatment or punishment contrary to section 12 of the *Charter*.

148. Alternatively, if any of the Class members' section 12 *Charter* rights were engaged and limited as pled, which CSC denies, CSC says that any infringement was demonstrably justified in a free and democratic society and hence saved by section 1 of the *Charter*.

XIII. LIMITATIONS

149. In further answer to the Fresh as Amended Statement of Claim as a whole, the Defendant pleads that no action lies against Her Majesty in respect of any alleged breach of sections 7, 9, and/or 12 of the Charter for Class members barred by virtue of section 32 the *Crown Liability and Proceedings Act*.

XIV. NO DAMAGES

150. In answer to paragraphs 66 to 70 of the Claim, the Defendant states as follows.

151. If a breach of the Class members' *Charter* rights, or any one of them, is found, then a remedy pursuant to section 24(1) of the *Charter* is not appropriate and just, including an award of monetary damages, which would not serve the objectives of compensation, vindication and deterrence, and would be inappropriate based on countervailing factors.

152. Further, the claim for section 24(1) damages is premised on particular *Charter* violations in individual circumstances, which cannot reasonably be assessed in the aggregate or in a factual vacuum based on a series of generalized allegations of misconduct.

153. Further, declaratory relief pursuant to section 24(1) is not an appropriate remedy.

154. As to the Claim as a whole, the Defendant denies that the Class members suffered any damage as a result of any act or omission by the Defendant. The Defendant states that, if the Class members suffered any damages or losses as alleged, which is denied, such damages or losses were not caused by the Defendant.

155. Contrary to paragraph 70 of the Fresh as Amended Statement of Claim, the Defendant denies the suggestion that Class members' need for medical treatment, rehabilitation, counselling or other care, in addition to the statutory requirements set out in sections 85 to 87 of the CCRA, gives rise to aggregate claims for indemnity, compensation and payment.

156. The Defendant pleads and relies upon the *Corrections and Conditional Release Act;* the *Corrections and Conditional Release Regulations;* all *Commissioner's Directives* mentioned in the Statement of Defence, the defence of statutory authority; and, the *Crown Liability and Proceedings Act*, RSC 1985 c. C-50.

Date: February 10, 2017

ATTORNEY GENERAL OF CANADA

Department of Justice Canada
Civil Litigation Section
50 O'Connor Street, Suite 500
Ottawa, ON, K1A 0H8

Per: **Gregory S. Tzemenakis** (LSUC #42764U)
Stephen Kurelek (LSBC #502005)
Philippe Lacasse

Tel: (613) 670-6336
(613) 670-6314
(613) 670-6220
Email: Gregory.Tzemenakis@justice.gc.ca
Stephen.kurelek@justice.gc.ca
Philippe.Lacasse@justice.gc.ca

Lawyers for the Defendant

TO: KOSKIE MINSKY LLP
20 Queen Street West
Suite 900, Box 52
Toronto, ON M5H 3R3

Per: **Kirk M. Baert, LSUC # 30942O**
Tel: 416-595-2117
Fax: 416-204-2889

James Sayce, LSUC# 58730M
Tel: 416-542-6298
Fax: 416-204-2809

Lawyers for the Plaintiffs

Court File No. CV-15-53262500-CP

BETWEEN:

CHRISTOPHER BRAZEAU and DAVID KIFT

Plaintiffs

-and-

ATTORNEY GENERAL OF CANADA

Defendant

ONTARIO
SUPERIOR COURT OF JUSTICE

Proceeding commenced at Toronto

STATEMENT OF DEFENCE OF THE DEFENDANT THE ATTORNEY GENERAL OF CANADA

ATTORNEY GENERAL OF CANADA
Department of Justice Canada
Civil Litigation Section
50 O'Connor Street, Suite 500
Ottawa, Ontario
K1A 0H8
Fax: (613) 954-1920

Per: **Greg Tzemenakis (LSUC #42764U)**
Stephen Kurelek (LSBC #502005)
Philippe Lacasse
Tel: (613) 670-6338
(613) 670-6314
(613) 670-6220
Email: Gregory.Tzemenakis@justice.gc.ca
Stephen.Kurelek@justice.gc.ca
Philippe.Lacasse@justice.gc.ca

Lawyers for the Defendant