CITATION: Simons et al v. Minister of Public Safety et al, 2020 ONSC 1431
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2020 ONSC 1431 (CanLII)

ONTARIO

SUPERIOR COURT OF JUSTICE

B E T W E E N:

STEVEN SIMONS, CANADIAN HIV/AIDS LEGAL NETWORK, PRISONERS WITH HIV/AIDS SUPPORT ACTION NETWORK, CANADIAN ABORIGINAL AIDS NETWORK and CATIE

Applicants

-and-

MINISTER OF PUBLIC SAFETY, CORRECTIONAL SERVICE OF CANADA, COMMISSIONER OF THE CORRECTIONAL SERVICE OF CANADA and ATTORNEY GENERAL OF CANADA

Respondents

- and -

PIVOT LEGAL SOCIETY, WEST COAST PRISON JUSTICE SOCIETY, VANCOUVER AREA NETWORK OF DRUG USERS; BRITISH COLUMBIA CIVIL LIBERTIES ASSOCIATION; CANADIAN PUBLIC HEALTH ASSOCIATION; NURSING COALITION (REGISTERED NURSES ASSOCIATION OF ONTARIO, CANADIAN NURSES ASSOCIATION, ASSOCIATION OF REGISTERED NURSES OF BRITISH COLUMBIA, CANADIAN ASSOCIATION OF NURSES IN HIV/AIDS CARE) and ABORIGINAL LEGAL SERVICES.

Interveners

BEFORE: Justice Edward P. Belobaba

COUNSEL: *Lori Stoltz, Adrienne Telford and Jillian Evans* for the Applicants

Kathryn Hucal, James Gorham, Andrew Law and Marianne Breese for the Respondents

Daniel Sheppard for the Interveners Pivot Legal Society, West Coast Prison Justice Society and Vancouver Area Network of Drug Users

H. Michael Rosenberg, Christine Wadsworth and Simon Cameron for the Intervener British Columbia Civil Liberties Association

Jennifer L. King for the Intervener Canadian Public Health Association

Lars Brusven for the Interveners Nursing Coalition (Registered Nursing Association of Ontario, Canadian Nurses Association, Association of Registered Nurses of British Columbia, Canadian Association of Nurses in HIV/Aids Care)

Caitlyn Kasper and Douglas Varrette for the Intervener Aboriginal Legal Services

HEARD: March 6, 2020

2020 ONSC 1431 (CanLII)

CONSTITUTIONALITY OF THE PNEP

Justice Belobaba:

Introduction

[1] The applicants, supported by the interveners, bring this application to challenge the constitutionality of the prison needle exchange program or PNEP that was recently introduced in the Canadian prison system.

[2] PNEPs are based on three realizations rooted in medical science and prison realities: one, drug addiction is a disease best addressed by sensible health policies; two, illegal drugs and injection drug use ("IDU") in prison is a constant that cannot be eradicated; and three, the availability of sterilized injection equipment ("SIE") to IDU inmates will help prevent the sharing of needles and the spread of infectious diseases such as HIV and Hepatitis C.

[3] The first PNEP was introduced in the early 1990s in Switzerland. Today about a dozen countries have PNEPs in one or more of their correctional facilities.[1]

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[1] The country count varies from year to year depending on the ebb and flow of prevailing legislative opinion. According to a recent Google search, the following countries have PNEPs in one or more of their prisons: Armenia, Belarus, Germany, Iran, Kyrgyzstan, Luxembourg, Moldova, Portugal, Romania, Spain, Switzerland and most recently, Canada.

2020 ONSC 1431 (CanLII)

The Canadian PNEP

[4] In June 2018, the Correctional Service of Canada ("CSC") announced that it would be rolling out a PNEP in all 43 federal penitentiaries. The CSC described the PNEP as "a harm reduction measure available to inmates to manage their health needs" and noted that "the program will help limit the sharing of needles and the spread of blood-borne diseases in federal penitentiaries, which contributes to safer communities."

[5] By early March 2020, the PNEP had been implemented at 11 federal institutions.[2] The roll-out was suspended in the middle of March because of the spread of the Covid-19 virus in federal prisons. It is expected that the roll-out to the remaining 32 facilities will resume as soon as it is medically appropriate.

[6] In the Q and A portion of its PNEP website, the CSC explained how inmates can participate in the PNEP:

> Prior to participation in the PNEP, inmates are required to meet with CSC Health Services, where a nurse will provide health teachings related to substance use, safe consumption practices, education on the harms of drug use, counselling on the risk of infectious diseases, and referral to other health care services. Inmates must then be approved by the Institutional Head or Deputy Warden, who confirms if there are any security concerns related to an inmate's participation in the PNEP. This is determined through *a threat risk assessment*, similar to the ones completed for Epipens and needles used for insulin use. Inmates who participate in the PNEP must also sign a contract acknowledging that they understand the rules of the PNEP and any breach may lead to their termination from the program. [Emphasis added.]

[7] It is the "threat risk assessment" ("TRA") feature of the Canadian PNEP that, in large part, provides the basis for this constitutional challenge.

The constitutional challenge

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[2] Grand Valley Institution, Atlantic Institution, Fraser Valley Institution, Edmonton Institution for Women, Nova Institution, Joliette Institution, Joyceville Institution (minimum security), Mission Institution (medium security), Dorchester Penitentiary, Bowden Institution, and Warkworth Institution.

[8] ***The application*** was filed in 2012, six years before the PNEP was announced. The initial application targeted the absence of a PNEP and argued in essence that effective access to SIE under a properly designed PNEP was "essential health care" under s. 86(1)(a) of the *Corrections and Conditional Release Act*[3] ("CCRA"). Relying on national and international studies, including UN reports and related protocols, the applicants presented compelling constitutional arguments in their initial application based on ss. 7 and 15(1) of the *Canadian Charter of Rights and Freedoms*.

[9] The s. 7 argument was that the denial of SIE (as "essential health care") to inmates was a breach of their right to life, liberty and security of the person. The s. 15(1) argument was that the failure to provide SIE to these inmates constituted discrimination on the basis of disability (drug addiction) and also on the basis of sex and race (given the disproportionate number of IDU inmates that are either female or Indigenous).

[10] In 2018, shortly before the application was to be heard, the CSC announced the roll-out of the PNEP to all federal penitentiaries. This court adjourned the application for one year. It was my hope, as I noted in my Endorsement, that over the course of the year:

> [T]he PNEP may be operational in a significant number of penitentiaries and as a result there may be a measurable/sufficient evidence basis about the workings (and alleged deficiencies) of the PNEP model that is currently being implemented.[4]

[11] The applicants amended the application and added allegations that the PNEP/TRA model that was being implemented was ineffective and unconstitutional, again under ss. 7 and 15(1) of the Charter. The gist of the PNEP challenge is that decisions about the availability and distribution of SIE should be decided by CSC Health Services alone without a "threat risk assessment" conducted by the Deputy Warden.

[12] The revised constitutional challenge, as made clear on the amended application, (an extract of which is attached in the Appendix) makes two basic points:

(i) SIE is not contraband but essential health care under s. 86(1) of the CCRA and must be provided "in accordance with professionally accepted standards"; and

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[3] S.C. 1992, c. 20, s. 86(1)(a).

[4] *Steven Simons et al v. Minister of Public Safety et al,* (September 13, 2018).

2020 ONSC 1431 (CanLII)

(ii) "Professionally accepted standards" require "that access be provided by means designed and implemented as a health service under the direction of CSC Health Services".

[13] The applicants submit that: (i) the PNEP model that has already been rolled out to 11 institutions is in violation of ss. 7 and 15(1) of the Charter; and (ii) in the remaining 32 institutions, the continuing prohibition of SIE and the absence of a properly designed (health services-centered) PNEP is likewise in violation of the Charter.

[14] ***The parties.*** The lead applicant is Steven Simons. Mr. Simons was released from prison in 2010, some eight years before the PNEP was announced. He is supported by four respected non-profit organizations, each of which has a genuine interest in the issues that are before the court. Adding their insights to the constitutional claims are five interveners, also respected advocates in their specialized areas of interest.

[15] Each of the four government respondents have some responsibility for the Canadian correctional service or at least for litigation relating to the correctional service. The primary respondent is the CSC. For ease of reference I will refer to the respondents collectively as the CSC.

[16] ***The suggested adjournment.*** I advised the parties that I was not inclined to decide the second prong, the SIE/essential health care issue, in the remaining 32 prisons while the CSC in good faith was rolling out a PNEP to all 43 federal prisons. This would not be a sensible use of judicial resources. It was better to wait until the roll-out was completed or otherwise terminated.

[17] I further advised the parties that, on balance, it also seemed sensible to adjourn the hearing on the first prong, the design of the current PNEP, until the roll-out was complete or at least until the expected year-end study by Dr. Lynne Leonard, an independent expert, would be available for review. I suggested that it was only at that point, after most of the roll-out had been completed, that an informed constitutional assessment could be made.

[18] Both sides, however, resisted the adjournment suggestion and for different reasons insisted that the amended two-pronged application proceed as scheduled. It could still be dismissed as premature if the court so decided, and if not, it would be decided on the merits based on the record as filed, even though the roll-out was only one-quarter complete. I agreed to proceed, albeit reluctantly, as per counsels' request.

[19] Here is my decision.

Decision

2020 ONSC 1431 (CanLII)

[20] The application is dismissed for three reasons:

(i) Both prongs of the application as drafted are premature;

(ii) The applicants have not established that professionally accepted standards require a health services-centered model; and,

(iii) The applicants have not established any violations of ss. 7 or 15(1) of the Charter.

[21] I will explain each of these points in turn.

Analysis

(1) The application is premature

[22] In my view, both prongs of the application – the challenge to the PNEP that has already been rolled out to 11 institutions and the challenge to the absence of a PNEP in the remaining 32 institutions awaiting the roll-out – should be dismissed for prematurity.

[23] ***The challenge to the PNEP in 11 institutions.*** This is the main focus of the constitutional challenge. The problem with this part of the application is that it is directed at a PNEP roll out that is only partially complete and that continues to evolve in both design and operation. Several material changes have already been made, including certain changes that were the target of the applicants' constitutional challenge. For example:

- ***Needs flag.*** In the original design of the PNEP, when an inmate was approved for participation, a "needs" flag was activated in the Offender Management System ("OMS") identifying that inmate as a participant in the PNEP. The inclusion of this information is necessary to allow CSC staff to know the location of known sharps within the institution. The applicants' affiants criticized this aspect of the PNEP as failing to provide adequate confidentiality to participants. In September 2019, CSC revised the PNEP Guideline so that participants are no longer specifically identified in OMS. Now the OMS only records that the inmate possesses a needle for health use. As a result of this change, any person accessing OMS will be unable to distinguish between PNEP participants and other inmates who have been authorized to possess a needle for health reasons, such as inmates who have needles for diabetes or anaphylaxis;

- ***Parole.*** CSC's initial position was that information about PNEP participation should be shared with Parole Board of Canada for use in release decision-making. The CSC has since decided that an inmate's participation in the PNEP will not be shared unless directly linked to risk-related behaviour. In other words, PNEP usage is not considered risk-related behaviour on its own. This change was made in response to inmate concerns that their PNEP participation would be used in release decision-making. It also disposes

2020 ONSC 1431 (CanLII)

of the concerns expressed by Dr. Stover and others that PNEP use will mean negative consequences for an inmate's current sentence;

- ***Timelines.*** PNEP guidelines did not initially contain timelines for the processing of applications. The guidelines were amended in September 2019 and now contain clear and reasonable timelines for the processing of PNEP applications.

[24] Changes in design and operation are being made as the roll-out continues. A formal evaluation by independent expert Dr. Leonard, as already noted, is expected by year end. Dr. Leonard's evaluation may well lead to further design changes. Passing judgment on the constitutionality of a PNEP that is only one-quarter complete and whose final design remains uncertain would be neither prudent nor just. This portion of the application is dismissed in my discretion as premature.

[25] ***The challenge to the absence of a PNEP in the 32 remaining institutions.*** In my view, the prematurity argument is even stronger with regard to this prong of the application. It would not be an appropriate or sensible use of judicial resources to rule on the absence of a PNEP in the 32 remaining institutions while a good faith PNEP is being rolled out to address this very point.

[26] It would also not be fair. In the blur of the adjournments and amendments, the merits or demerits of the health measures that are currently available in all 43 prison facilities,[5] and arguably satisfy the "essential health care" requirement, was not the subject of any real analysis or argumentation. This second prong of the constitutional challenge is dismissed in my discretion as premature.

(2) The applicants have not established that a health services-centered model is required by professionally accepted standards

[5] This "suite" of harm reduction measures include: screening and testing at reception and throughout incarceration; education on admission and throughout incarceration regarding infectious diseases and how to prevent their acquisition and/or transmission; access to trained peers for advice, information and support; access to harm reduction material and information (e.g. condoms); access to substance abuse programs; opiate agonist treatment (methadone/suboxone); mental health referral and counselling; and pre and post-exposure prophylaxis. The respondents say these harm reductions measures have resulted in "a significant decline in prevalence rates of BBVI [blood borne viral infections] even without a PNEP." These issues were not fully briefed or argued.

2020 ONSC 1431 (CanLII)

[27] As already noted, s. 86(1) of the CCRA obliges the CSC to provide every inmate with "essential health care". Section 86(2) adds that this health care "shall conform to professionally accepted standards." These standards are not legislatively defined.

[28] The applicants ask for a declaration that "professionally accepted standards" require that "access be provided by means designed and implemented as a health service under the direction of CSC Health Services." In other words, the Canadian PNEP/TRA model is unconstitutional because of the TRA feature and the related protocols that involve prison security staff.

[29] The applicants support their submission with affidavits from prison health experts who have studied some of the PNEP systems in the European and Eurasian countries. The gist of their evidence is that an effective PNEP, one that is trusted and used by IDU inmates, must have a strict separation between health services and security staff – otherwise it won't be used. The experts also opine that the TRA model adopted in Canada imposes "the very highest barrier to access." For example, Dr. Stover, one such expert, explained his "belief" as follows:

> I believe it to be a universally accepted feature of PNEP design that there must be a strict separation between health services and the security staff … Any inter-linkage between the two is likely to severely limit access to this effective preventive measure. Most prisoners in need are otherwise unlikely to accept to participate …The role of security staff [should be] limited to … locating and confiscating contraband. This must nonetheless be done in a way that is not informed by knowledge of prisoners' PNEP participation (which is confidential medical information) and which does not otherwise discriminate or stigmatize participants … CSC's PNEP design – the TRA model – is contrary to these important precepts. Indeed, it is my view that to construct the [PNEP] in this way is to impose the very highest barrier to access.

[30] The "beliefs" of the prison health experts would be more credible if they were based on actual research findings. Unfortunately, nothing in the record provides any empirical support for their bare assertions about what is "likely" or "unlikely" if security staff are told or discover that a particular inmate engages in IDU.

[31] The record before the court contains nine empirical studies relating to four different models of PNEPs used in four of the European countries (Switzerland, Spain, Germany and Moldova). The four models involve distribution of SIE via (i) prison health services, (ii) trusted prisoners, (iii) automatic dispensing machines located in the common area, and (iv) less often, outside agencies that come into the prison to provide this service.

2020 ONSC 1431 (CanLII)

[32] The key point is that none of the empirical studies or literature reviews before the court – including those authored by Dr. Stover – identify a need for a strict separation between health and security staff or state that such a requirement is a professionally accepted standard. This alone is enough to reject the applicants' submission that the health services-centered model alone is a professionally accepted standard.

[33] But one can go further.

[34] The concern about the need for a strict separation between health services and the security staff is rooted in a genuine concern about PNEP confidentiality. Dr. Stover, and the other prison health experts, believe that IDU inmates will not use the PNEP if security staff are in any way involved because they fear that security staff will use this information against them in the parole process. The short answer is that in Canada the PNEP has been redesigned to address this very concern: as already noted, PNEP participation alone is no longer "risk-related" information to be considered in the parole process.

[35] The longer answer is that complete confidentiality or anonymity in a prison setting is "almost impossible" and that security staff quickly discover who is participating in the PNEP. In a study evaluating the PNEP in Ourense, Spain, researchers explicitly acknowledged that "… in an enclosed environment such as the penitentiary, it is almost impossible to keep the identity of [PNEP] users a secret…". The record supports this almost self-evident proposition. For example:

- In certain jails in Moldova and Germany where automatic dispensing machines are used, the prison guard must still open the cell to allow the inmate to access the dispensing machine – guards can easily share this information with their colleagues.

- In a Swiss prison, according to a filed affidavit, "The syringe and needles must be kept in the transparent box and are therefore capable of being readily identified by prison guards and other officials entering the cell." In some German PNEPs, the PNEP Kit must be kept in a plastic container on the wash basin. In the Canadian PNEP the Kit must be displayed on the inmate's desk – not much difference. (In the Canadian PNEP, similar protocols are used for other sharp objects, such as hobby craft tools).

- Dr. Stover pointed out in a 2016 publication that the practical reality of any PNEP ("even models emphasizing the necessity of confidentiality") is that participants are easily identified by security staff. Dr. Stover went even further and noted with approval the direct involvement of security staff in one German PNEP where "prison staff took over key functions as organizers and helped to implement the [PNEP] by promoting cooperation between different institutional levels and groups within the prison."

2020 ONSC 1431 (CanLII)

[36] The need for the involvement of security staff, at least to some degree, is also acknowledged by the applicants' when they say in their factum that "security staff do have a role to play in locating and confiscating contraband (including injecting equipment not compliant with the PNEP's rules)." The CSC adds, without contradiction, that no study has ever endorsed a health services-centered model without any involvement of security staff.

[37] The thrust of the applicants' position appears to be that the involvement of security staff at the admissibility stage of the PNEP process is a major deterrent to IDU inmate participation. However, there is no research-based evidence in the record that supports this proposition. If mere knowledge of PNEP participation by security staff has a deterrent effect, then the participation or take-up rates in the Canadian PNEP should be lower than those in the European and Eurasian PNEPs. But the contrary appears to be the case.

[38] The participation rates at the Canadian GVI and Atlantic prisons (where there is now data based on one year of use) appear to be higher than the participation rates at the long established PNEP at the Champ-Dollon correctional facility in Switzerland. The participation rates at Atlantic and GVI during their first year of operation were 57% and 41% respectively, compared to 29% at Champ-Dollon during its 11th year of operation.

[39] The evidence that is before the court also suggests that there is no "best model" for a PNEP. No one size fits all. Every country is different. One of the applicants' experts, Dr. Stover, agrees that "successful models of a particular prison in a particular country cannot necessarily be transferred to another prison in another country". This sentiment is again acknowledged in a literature review which recommends more research on this very point: "Research on [PNEPs] also needs to address questions relating to which service-delivery models are most suitable for different types of prison settings and populations".

[40] The Canadian Agency for Drugs and Technologies in Health concluded in a 2015 literature review that there are *no* studies that compare the clinical effectiveness and harms of different models of needle exchange for adults in correctional settings. More specifically, "it is unknown whether there is a preferred model for such a program in this setting" and "there is no official set of modalities regulating needle exchange programs: usually the projects launched are institution specific". The authoritative United Nations Office on Drugs and Crime (UNODC) encourages every prison to "find its own most appropriate method for provision."

[41] In sum, there is no best or even preferred model. There are no data-based studies that have concluded that there must be "a strict separation between health services and security staff." There are no data-based studies that have concluded that IDU inmate participation in a PNEP is deterred by a TRA or by the involvement of security staff.

2020 ONSC 1431 (CanLII)

There are no studies that have concluded that professionally accepted standards require a health services model without a TRA feature.

[42] In sum, I am unable to find on the evidence before me that a CSC Health Service-centered model for the Canadian PNEP is required by professionally accepted standards. Given that the declaratory remedies sought by the applicants (as set out in the Appendix) are all premised on a finding to this effect, this alone is sufficient for a dismissal of the application in its entirety.

2020 ONSC 1431 (CanLII)

(3) There is no breach of ss. 7 or 15(1) of the Charter

[43] The third reason for dismissal, certainly of the PNEP challenge, is the applicants' failure to establish any breaches of ss. 7 or 15(1) of the Charter.

[44] I begin by noting the appropriate role of the court on constitutional challenges involving issues of drug addiction. The Supreme Court of Canada explained the role in this way:

> The issue of illegal drug use and addiction is a complex one which attracts a variety of social, political, scientific and moral reactions. There is room for disagreement between reasonable people concerning how addiction should be treated. It is for the relevant governments, not the Court, to make criminal and health policy. However, when a policy is translated into law or state action, those laws and actions are subject to scrutiny under the *Charter* …[6]

[45] The PNEP can obviously be reviewed for Charter compliance. But the specific issue before this court is not whether the CSC's adoption of the TRA model or other security rules relating to the PNEP were good or bad policy decisions: the issue is "whether [the CSC] has limited the rights of the claimants in a manner that does not comply with the Charter."[7]

Section 7

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[6] *Canada (Attorney General) v PHS Community Servicers Society*, 2011 SCC 44 at para. 105.

[7] *Ibid.*

[46] Section 7 of the Charter provides that "everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."

[47] Here, as already noted, the applicants say the CSC breached the IDU inmate's rights under s. 7 because it failed to provide reasonable and effective access to SIE "in accordance with professionally accepted standards". The latter are defined to mean that access to SIE must be provided under the direction of CSC Health Services (with no TRA and no knowledge on the part of the security staff).

[48] As I have already found, the applicants have not established that professionally accepted standards require a health services-centered model. In my view, this alone is sufficient to dispose of the s. 7 claim. For the sake of completeness, however, I will go on to consider the merits of the s. 7 challenge.

[49] To engage s.7 the applicants must first demonstrate a sufficient causal connection between the impugned measure and the s. 7 interest, here security of the person.[8] The connection must be "a real as opposed to a speculative link".[9] This non-speculative connection can be established by "a reasonable inference, drawn on a balance of probabilities".[10]

[50] The CSC submits that the applicants' evidence of causal connection is not real but speculative and provides no basis for reasonable inference on a balance of probabilities. I agree with this submission. The applicants have tendered evidence from three prisoners - two of them, Messrs. Simons and Bushell, were released years before the introduction of the PNEP. The remaining affiant, Ms. Aubée, although currently incarcerated, is not an injection drug user and is unable to provide any direct evidence about the PNEP. Surprisingly, there is no direct evidence from any IDU inmate that they have been deterred from applying to the PNEP because of the alleged lack of confidentiality in the TRA model. And, on the record before me, no such evidence can be reasonably inferred.

[51] The CSC is also right to say that the evidence provided by the applicants' prison health experts on this point is speculative. For instance, Dr. Stover's "belief" is that any

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[8] It is not disputed that the denial of SIE, if it is "essential health care", is arguably a denial of the affected inmate's right to security of the person (that is, their personal health and well-being).

[9] *Canada (Attorney General) v. Bedford*, 2013 SCC 72 at para.76.

[10] *Ibid.*

2020 ONSC 1431 (CanLII)

inter-linkage between health services and security staff is "likely" to limit access to the PNEP. Dr. Doltu's opinion is that the TRA model is "unlikely" to function effectively. But, as already noted, these beliefs and opinions are offered as bald assertions without research support. I therefore agree with the CSC that s. 7's causal requirements have not been established with real and non-speculative evidence. Section 7 is not engaged. This alone is enough to dismiss the s. 7 claim.

[52] However, for the sake of completeness, I will continue with the s. 7 analysis.

[53] Assuming that s. 7 is engaged, the core question is whether the TRA model has deprived any IDU inmate of their right to security of the person in accordance with the principles of fundamental justice. The Supreme Court of Canada has made clear that the principles of fundamental justice mean that laws that impinge on life, liberty or security of the person "must not be arbitrary, overbroad, or have consequences that are grossly disproportionate to their object".[11] An arbitrary, overbroad or grossly disproportionate impact on just *one* person is enough to establish a breach of s.7.[12]

[54] In order to determine whether an impugned law is arbitrary, overbroad or grossly disproportionate, the court must first identify the law's object.[13] Both sides agree that the objects of the impugned CCRA provisions are three-fold: (i) prisoner health; (iii) institutional security and security staff safety; and (iii) public health and safety. The legislative object that is of most relevance here is that of institutional security and security staff safety. The question, given this legislative objective, is whether the PNEP/TRA is arbitrary, overbroad or grossly disproportionate.

(a) Arbitrariness

[55] A deprivation of a protected interest will be arbitrary if it bears no "rational connection" to the object of the law.[14] The rational connection standard is met where it is reasonable to suppose that the deprivation created by the impugned law may further its objective based on logic or reason.[15] Importantly, the fact that a government practice is in

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[11] *Carter v. Canada (Attorney General)*, 2015 SCC 5, at para 72.

[12] *Bedford*, supra, note 9, at paras. 123 and 127.

[13] *Carter*, *supra*, note 11, at para 73; *Bedford*, *supra*, note 9, at para 123.

[14] *Carter*, *supra*, note 11, at para.83.

[15] *Carter*, *supra*, note 11, at para.99.

2020 ONSC 1431 (CanLII)

some way unsound or fails to further the government objective as effectively as a different course of action is not sufficient to establish that the effect of the impugned law is not rationally connected to its objective.[16]

[56] At first glance, most people would agree that the threat risk assessment or TRA is rationally connected to the stated legislative objective of institutional and security staff safety. Common sense tells us that sterilized needles should not be provided to IDU inmates who may pose a security and safety risk by using the "sharpies" as weapons. The applicants, however, point (correctly) to the international evidence that thus far not a single incident involving harmful use of a needle or syringe has been documented in any prison where there is access to SIE through a PNEP.

[57] The CSC acknowledged this point in its website and openly referred to the finding of the United Nations Office on Drugs and Crime ("UNODC") that PNEPs are not associated with increased assaults on prison staff or inmates:

> The safety and security of staff, the public, and inmates is a priority for CSC. Appropriate safeguards have been established in every institution to ensure that PNEP kits are safely stored and accounted for at all times. The need for inmates to produce a PNEP kit to correctional officers falls under the same principles as any other authorized sharp objects (hobby craft tools, insulin needles, Epipen). According to information provided by [UNODC] prison needle exchange programs are not associated with increased assaults on prison staff or inmates [and in fact] contribute to workplace safety …

[58] Does the fact that *to date* no international PNEP participant has used SIE to cause harm mean that the TRA feature of the Canadian PNEP is arbitrary and irrational? In my view, it does not. The international evidence, based primarily on research data collected in low-security or open/semi-enclosed institutions does not undermine a reasonable perception of risk that needles in other settings with more violent prisoners can easily be used to inflict injury on staff and other inmates. This risk is neither speculative nor irrational.

[59] There is evidence before me that inmates can and do make weapons out of almost anything, especially sharp objects. There is evidence that inmates have converted syringes into weapons to be used as a means of protection or for trade as a commodity. In Canadian prisons, there has been at least one major incident involving an assault on a

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[16] *Ewert v. Canada*, 2018 SCC 30, at para.73; *Bedford, supra*, note 9, at para.123.

2020 ONSC 1431 (CanLII)

correctional officer using a syringe. In that case, an inmate dragged the staff member into a living unit to inject him with a homemade syringe filled with bleach. In a study of the Champ-Dollon prison in Switzerland, over 90% of prison officers reported feeling that a syringe could be used as a weapon against them.

[60] There are also the workplace safety obligations under the *Canada Labour Code*[17] that would expose CSC to liability if they failed to provide a safe workplace for its security staff. Inmate possession of needles poses risks of workplace injury to CSC staff who may be poked or pricked by intentionally-placed needles while conducting routine searches. These concerns are made even more acute by the high number of unreturned needles (approaching on average 30 per cent) in nearly every international PNEP.

[61] The TRA model attempts to limit this potential for harm by requiring the Deputy Warden to conduct an individualized assessment to determine whether an inmate's participation in the PNEP presents a manageable risk. This assessment is guided by considerations such as whether the inmate has been recently involved in any incident using a weapon and/or any incident involving the use of bodily fluids in an attempt to harm staff. These are reasonable considerations.

[62] The suggested health services-centered model would not be able to make these risk assessments. The uncontroverted evidence is that that prison health care staff are not able to make determinations regarding manageable security and safety risks because they are not trained in correctional operations and do not have full access to information regarding institutional security. Further, the imposition of security-related demands on prison nurses and doctors run counter to the principles of clinical independence and patient-centered care.[18] In any event, this type of argument – that the government's legitimate objective can also be achieved in a different way – is not a proper consideration under the arbitrariness analysis.[19]

[63] The international PNEPs and even the applicants themselves, as I have already noted, acknowledge that there are circumstances in which exclusion based on security and safety considerations may be appropriate. The *UNODC Guidelines* state: "There

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[17] "Occupational Health and Safety and Return to Work Programs" *Canada Labour Code*, R.S.C. 1985, c. L-2, Part II, paras. 124 and 125.

[18] Section 86.1 of the *CCRA* requires CSC to support the "professional autonomy" and "clinical independence" of registered health care professionals to exercise their professional judgment in the care and treatment of inmates.

[19] *Ewert*, *supra*, note 16, at para.73; *Bedford*, *supra*, note 9, at para.123.

2020 ONSC 1431 (CanLII)

should be no exclusion criteria except medical ones or a severe breach of the rules that endangers the safety of other prisoners or staff." The applicants implicitly acknowledge the security risks posed by SIE assaults when they state that inmates who commit a "severe breach of the rules that endangers the safety of other prisoners or staff" should be excluded from the PNEP.

[64] The arbitrariness argument as it relates to the PNEP/TRA does not succeed.

[65] In addition to the involvement of security staff in the administration of the PNEP, the applicants also argue that there is no rational connection between institutional security and (i) the long delays in processing PNEP applications; (ii) the inspections of PNEP kits during stand-to counts; and (iii) the rule about one-to-one Kit exchange.

[66] There is no merit to these submissions. The PNEP guidelines were recently amended to provide reasonable deadlines for the timely processing of PNEP applications. Accordingly, the applicants' submissions regarding past processing times are no longer relevant. With respect to the PNEP kit inspections and one-to-one needle exchanges, there is, in my view, a clear and rational connection between these requirements and institutional safety. Inspections aid in the enforcement of PNEP rules concerning storage of injection equipment, which in turn, helps to protect staff from the risk of injury posed by such equipment being present in the workplace. One-to-one kit exchanges help to avoid the proliferation of lost needles in the institutional environment. Notably, both of these requirements are present in nearly all international PNEPs.

[67] In sum, I have no difficulty concluding that there is a rational connection between the security and safety objectives of the impugned legislation and the alleged deprivation created by the TRA feature of the PNEP and related protocols.

(b) Overbreadth

[68] The overbreadth inquiry asks whether a law that deprives a protected interest in a way that generally supports the object of the law goes too far by denying the rights of *some* individuals in a way that bears no relation to the object. Overbreadth is not concerned with whether the impugned law is the least restrictive means available to achieve the object. Rather, the issue is whether the means chosen by policy-makers infringe upon a protected interest in a way that has no connection with the mischief contemplated by the legislature.[20]

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[20] *Carter*, *supra*, note 11, at para.85; *Bedford*, *supra*, note 9, para. 112.

2020 ONSC 1431 (CanLII)

[69] Here the TRA model requires an individualized assessment of each potential participant's security risk based on their recent conduct. This type of individualized evaluation ensures that access to the PNEP is restricted no more than is necessary to maintain institutional security and precludes any overbreadth argument.[21]

[70] The applicants submit that the involvement of security staff in the admissibility and administration phases of the program operates as a threshold barrier that deters inmates from participating in the PNEP even if they do not pose a security risk.

[71] There are two problems with this argument. First, there is no such evidence of deterrence. As already noted, there is no direct evidence before the court from any witness who wishes to participate in the PNEP but has not, either because they were deterred by the involvement of security staff in the program or because they were denied access under the TRA.

[72] Second, even on its face, the applicants' argument does not establish any overbreadth in the PNEP design. One of the objectives of the TRA model is the maintenance of institutional security and protection of CSC staff. The policy achieves this object through a process of individualized assessment of *all* PNEP applicants to determine if their possession of a needle is a manageable risk in the institutional setting. For most inmates, access to needles will not pose a security risk. But this is not true for all inmates. As the applicants acknowledge, some exclusions from the program will be necessary. The policy therefore confers discretion to permit access to SIE only where doing so will further its legitimate security objective.

[73] There is no overbreadth.

(c) Gross disproportionality

[74] As the Supreme Court of Canada noted in *Bedford,*[22] the rule against gross disproportionality only applies in extreme cases where, despite being rationally connected to its objective, the seriousness of the deprivation is completely out of sync with the objective of the challenged law.[23]

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[21] *Winko v. British Columbia (Forensic Psychiatric Institute)*, [1999] 2 SCR 625, at para.70.

[22] *Bedford*, *supra*, note 9.

[23] *Ibid.*, at para.120.

2020 ONSC 1431 (CanLII)

[75] The provision of harm reduction services to inmates in a manner that is consistent with institutional safety is a fundamental objective in Canada's correctional system.[24] The TRA model achieves an appropriate balance between harm reduction, on the one hand, and institutional safety, on the other, by placing reasonable limitations on inmates' access to SIE based on an individualized assessment of that inmate's personal needs and personal history. This is not grossly disproportionate.

[76] In any event, because security risk cannot be known in advance and without assessment, I agree with the CSC that it is not possible to narrow the policy's application while still achieving valid security objectives. The gross disproportionality argument does not succeed.

[77] In sum, the alleged breach of s. 7 is not established.

Section 15(1)

[78] Section 15(1) of the Charter provides that:

> Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

[79] To establish a violation of s. 15(1), the applicants must demonstrate that: (i) the PNEP in its purpose or effect denies access to SIE on a distinction that is based on an enumerated or analogous ground; and (2) the distinction discriminates.[25] The question at the second step is whether the distinction violates the norms of substantive equality[26] – that is, "whether [the impugned law] imposes burdens or denies benefits in a way that reinforces, perpetuates, or exacerbates disadvantage".[27]

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[24] *CCRA*, ss. 3 and 4.

[25] *Québec (Procureure générale) c. Alliance du personnel professionnel et technique de la santé et des services sociaux*, 2018 SCC 17, at para 25; *Kahkewistahaw First Nation v. Taypotat*, 2015 SCC 30, at para. 21; *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, [2004] 3 S.C.R. 657, at para. 63.

[26] *Quebec v. A*, 2013 SCC 5 at paras. 324-331; *Taypotat, supra*, note 25, at paras. 16-21.

[27] *Centrale des syndicats du Quebéc v. Quebec*, 2018 SCC 18, at para. 30; *Alliance, supra*, note 25, at para. 25.

2020 ONSC 1431 (CanLII)

[80] The applicants and the interveners note correctly that addiction is a disability; that a disproportionate number of IDU inmates in federal penitentiaries are female or Indigenous. Thus, if this were still 2012 with no PNEP and the constitutional challenge was focused only on the impugned provisions of the CCRA that prohibit SIE, the arguments about discrimination on the basis of disability, sex and race would have been compelling. As of 2018, however, as already noted, a PNEP is being rolled out to all 43 federal prisons. The PNEP is the main focus of the s. 15(1) challenge.

[81] The way the applicants frame the s. 15(1) challenge is important. The applicants submit that:

> The impugned Program does not merely distinguish between prisoners who are granted access to SIE and prisoners who are denied, or between prisoners who require SIE for injection drug use and prisoners who require it for diabetes or anaphylaxis. Rather, the Applicants' s. 15 claim is that, contrary to s. 86 of the *CCRA*, the impugned Program draws a distinction by denying *all* prisoners who inject drugs effective access to essential health care – SIE – in accordance with professionally accepted standards. The impugned Program treats the claimant group differently than other prisoners by imposing significant barriers on access to SIE which do not accord with professionally accepted standards. These barriers deter, deny, delay and severely restrict access to SIE for a significant number of prisoners who need this essential health care.

[82] In other words, the constitutional challenge to the PNEP under s. 15(1) of the Charter is that the PNEP denies effective access to SIE/essential health care to all IDU inmates *in accordance with professionally accepted standards.* The latter is defined to mean that access to SIE must be provided by CSC Health Services alone, without any TRA or other involvement or knowledge of the prison security staff. The applicants' s. 15(1) argument, in essence, is that because the federal PNEP/TRA model does not accord with professionally accepted standards, all IDU inmates are in fact being denied access to SIE on enumerated grounds such as disability, sex or race.

[83] However, as I have already found, the applicants have not established that professionally accepted standards require a health services-centered model. Given that this critical component of the s. 15(1) submission was not established on the record before me, the "distinction" that is relevant in the first step of the analysis is no longer

2020 ONSC 1431 (CanLII)

about any of the enumerated grounds. The IDU inmates that apply to the PNEP gain access or are denied access based solely on their individual security risk assessment.[28]

[84] The TRA decision by the Deputy Warden, on the evidence before me, has nothing to do with any distinction that is based on disability, sex or race.[29] Any exclusion from PNEP is not based on a personal characteristic, but on the security risk posed by the inmate's possession of SIE in the institutional setting.

[85] The s. 15(1) challenge therefore fails at the first step of the required analysis.

Conclusion

[86] In sum, I am dismissing this application for three separate reasons: (i) both prongs of the application are premature and should at least await the evaluation report of the independent expert,[30] if not the complete roll-out of the PNEP; (ii) the applicants have not established that "professionally accepted standards" require a health services-centered model and not a TRA model; and (iii) the applicants have not established any breaches under ss. 7 or 15(1) of the Charter in the design or operation of the PNEP.

Disposition

[87] The application is dismissed.

[88] I am not inclined to award any costs. The initial application, filed in 2012, raised important prison and public health issues and may well have prompted the CSC to implement the PNEP. The revised application continued the public interest nature of the constitutional challenge and, as the respondents candidly acknowledge, resulted in certain

2020 ONSC 1431 (CanLII)

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[28] As the Supreme Court of Canada noted in *Winko v. British Columbia (Forensic Psychiatric Institute)*, [1999] 2 SCR 625 at paras. 87 and 88, individualized assessment in the administration of a legislative scheme "is the antithesis of the logic of the stereotype, the evil which lies in prejudging the individual's actual situation and needs on the basis of the group to which he or she is assigned."

[29] It would arguably be different if there was empirical evidence that the IDU inmates who were denied access to the PNEP on the basis of security risks were disproportionately female or Indigenous. No such evidence has been presented and no such suggestion has been made. If such evidence did exist, the issue would probably be resolved under s. 1 of the Charter.

[30] At the time of the hearing, it was expected that Dr. Leonard's independent evaluation would be conducted sometime this fall. Given that the PNEP has been suspended because of the spread of Covid-19 in federal prisons, it is possible that Dr. Leonard may defer her evaluation until after the suspension is lifted and more of the roll-out has been completed. However, I have no information in this regard.

positive changes in the design or operation of the PNEP. In my view, this is not a case for costs.[31] If the respondents disagree, I will be open to a brief written submission within 21 days and a brief response from the applicants within 21 days thereafter.

[89] I am obliged to all counsel for their assistance.

Signed: *Justice Edward P. Belobaba*

Notwithstanding Rule 59.05, this Judgment is effective from the date it is made and is enforceable without any need for entry and filing. In accordance with Rules 77.07(6) and 1.04, no formal Judgment need be entered and filed unless an appeal or a motion for leave to appeal is brought to an appellate court. Any party to this Judgment may nonetheless submit a formal Judgment for original signing, entry and filing when the Court returns to regular operations.

Date: April 30, 2020

Appendix

Extract from Amended Amended Notice of Application

1. The applicant makes application for:

    a. a declaration ~~finding~~ that the failure of the Correctional Service of Canada, and the refusal of its Commissioner and of the Minister of Public Safety, to make sterile injection equipment available for those incarcerated in federal penitentiaries established and operated under the *Corrections and Conditional Release Act*, C.S. 1992, c.20, as amended (CCRA), and said respondents' apparent treatment of sterile injection equipment as prohibited contraband and/or unauthorized item(s), and their preclusion of or failure to make available inmates' reasonable and effective access to sterile injection equipment in accordance with professionally accepted standards, constitute violations of sections 7 and 15 of the *Canadian Charter of Rights and Freedoms*;

[31] I note that, as per norm, the interveners do not seek costs.

2020 ONSC 1431 (CanLII)

b. a declaration pursuant to section 52(1) of the *Constitution Act, 1982* ~~*Canadian Charter of Rights and Freedoms*~~ that, *inter alia*, sections 2(1), 40(i) and 40(j) and 45 and all related CCRA statutory provisions and regulations and policies (the latter including but not limited to rules of general application, memoranda, guidelines and standing orders) that prevent inmates of federal penitentiaries from receiving and/or possessing sterile injection equipment are constitutionally invalid and of no force and effect insofar as they preclude or fail to make available inmates' reasonable and effective access to sterile injection equipment in accordance with professionally accepted standards;

c. a declaration pursuant to section 52(1) and/or the court's inherent jurisdiction that reasonable and effective access to sterile injection equipment is essential health care within the meaning of section 86(1) of the CCRA, to be provided in accordance with professionally accepted standards;

d. a declaration pursuant to section 52(1) and/or the court's inherent jurisdiction that professionally accepted standards as referred to above require:

    i. that access be provided by means designed and implemented as a health service under the direction of CSC Health Services;

    …

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2020 ONSC 1431 (CanLII)