**Court File No.: CV-09-376927CP00**

*ONTARIO*
**SUPERIOR COURT OF JUSTICE**

B E T W E E N:

**MARILYN DOLMAGE AS LITIGATION GUARDIAN OF MARIE SLARK and JIM DOLMAGE AS LITIGATION GUARDIAN OF PATRICIA SETH**

**Plaintiffs**

**- and -**

**HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF ONTARIO**

**Defendant**

**Proceeding under the *Class Proceedings Act, 1992***

# STATEMENT OF DEFENCE

1. The Crown admits that it owned, operated and managed a facility in Orillia, Ontario for individuals with developmental disabilities which came to be known as Huronia Regional Centre. The Crown further admits that both of the Representative Plaintiffs in this proceeding, Marie Slark and Patricia Seth, were at one time residents at Huronia Regional Centre.

2. The Crown has no knowledge of the allegations contained in paragraphs 2-6, 9, 31-33, and 35 to 37 of the Amended Statement of Claim.

3. The Crown denies all other allegations contained in the Amended Statement of Claim.

**Huronia Regional Centre and the Evolution in Care for Individuals with Developmental Disabilities**

4. Like many jurisdictions, Ontario's early history of developmental services was based, in part, on the notion that individuals with developmental disabilities were often best served by segregating them from the rest of the community and caring for them in large institutional settings. It was believed by some that it was beneficial for the individual with the developmental disability to be institutionalized. It was also believed that institutionalization was somewhat beneficial in relieving the strain on families who would otherwise be caring for the individuals and, in some cases, serving to protect society from the individual.

5. Pursuant to "An Act to Authorise the Erection of an Asylum within this Province for the Reception of Insane and Lunatic Persons", the first institution in Ontario for individuals with a developmental disability was formally opened in Orillia in 1876. Although it was known by a number of names during its operation, this facility ultimately became known as Huronia Regional Centre ("HRC").

6. At the outset of its operation, HRC was operated on a medical model of care that focused primarily on the physical health of its residents. For the first several decades, HRC was operated under the auspices of the Ontario Department of Health.

7. Many of the residents of HRC had what would now be known as developmental disabilities, in some case quite severe. Residents also suffered from mental illness, physical disabilities and other medical and social problems.

8. Some of the residents, however, had no developmental disability at all. Some were sent to HRC by families who could not or would not care for them.

9. Residents of HRC were admitted with the consent of their family or legal guardian, sometimes based on the advice of doctors or other medical experts.

10. In some cases, the individuals admitted were wards of the Crown. However, individuals did not become wards of the Crown simply by virtue of their admission to HRC and many of HRC's residents were not Crown wards. They remained under the legal authority of their families.

11. Many of the residents of HRC were long-term care residents in that, once admitted, they spent the remainder of their lives at HRC.

12. At the height of its operation in 1965, HRC housed approximately 2,916 residents.

13. For a variety of reasons, most of the residents of HRC had little if any contact with their families during their time at HRC.

14. Many of the residents of HRC were entirely supported financially by the government throughout their residency at HRC.

15. By the 1940s at HRC, a multi-disciplinary team would assess each individual who entered HRC and assign a developmental level to each so that appropriate decisions could be made regarding the appropriate residence at HRC, educational and training programs and other social activities for the individual.

16. Where appropriate, residents of HRC were involved in a variety of educational and training activities including classroom instruction, participation in ward schools and occupational therapy.

17. It was often considered beneficial for residents to work, at HRC and elsewhere, when appropriate. Work was seen as a valuable way to provide training to people and to improve confidence.

18. At HRC, some residents were involved in skills development activities in the facility's beauty parlour, laundry, dining room and on the farm.

19. Some residents were temporarily discharged from the institution to the community, where they worked as domestics, farm hands, or helped in restaurants.

20. Residents of HRC were also involved in a variety of other activities for recreation and relaxation including sports and outings in the community. Recreation, leisure, clubs and special events were included to foster a sense of wellbeing and community.

21. The program at HRC was structured and controlled, in an appropriate manner by, HRC staff. Although some residents were given choices and opportunities, some were considered too disabled to exercise any significant degree of control over their day-to-day lives.

22. HRC residents received different types of care depending on and appropriate to their condition and needs. This care included medical, dental, psychiatric and psychological care, as appropriate.

23. Throughout the years of HRC's operation, the Crown ensured that only qualified candidates were selected for employment at the facility.

24. Furthermore, once hired, the Crown ensured that all staff were adequately and appropriately trained and supervised. In the early years, the training program focussed on care issues and the medical problems which arose in HRC's resident population. In later years, staff training was expanded to include other areas including individual planning and programming, behavioural programming,

appropriate discipline for residents, recognizing signs of abuse and the proper steps to take if abuse is suspected.

25. If, at any time, an allegation of mistreatment or abuse of an HRC resident by an HRC staff member was substantiated, the Crown took any and all appropriate steps including dismissing the involved staff member and reporting the alleged mistreatement or abuse to appropriate authorities.

26. HRC was a large facility which included a variety of buildings. In the early decades of HRC's operation, residents of HRC lived and slept in large wards. Washrooms were also communal.

27. By the 1960s, attitudes towards people with developmental disabilities began to change. Academics, families and experts in the area of developmental disabilities came to believe in the principle of normalization – that individuals with developmental disabilities should have available to them patterns and conditions of everyday life which are as close as possible to the norms and patterns of the rest of society. Just as attitudes were changing throughout the world, those working in Ontario with individuals with developmental disabilities – including the Crown - determined that it would be better for the individuals in question to live and work in the community rather than being cared for in large-scale facilities.

28. In the early 1970s, the Crown in Ontario embarked on a process that saw the care provided to persons with developmental disabilities shift from segregated, large-scale institutions operated by the Crown to community based services delivered by local agencies but still funded by the Crown.

29. Because the new approach focused on community and social supports and services as opposed to the original medical model of care, as part of the transition, the Crown transferred responsibility for services for people with a developmental disability from the Ministry of Health to the Ministry of Community and Social Services.

30. Also as part of this evolution, in 1974, the Ontario legislature passed the predecessor to the *Developmental Services Act*. R.S.O. 1990, CHAPTER D.11 which would govern the operation of HRC until its closure on March 31, 2009.

31. At HRC, the Crown prepared for the eventual closure of the facility by changing some aspects of its operation. For instance, in the 1970s and 1980s, to help residents prepare for their eventual move to new homes in the community, large living units at HRC were divided into apartments or smaller dormitory-style units to accommodate smaller groups of people. These units had their own common areas, washrooms and eating areas. Sometimes, stand-alone buildings on site

were renovated into "transition" group homes where a small group of residents would live.

32. Over the many years that it took to transition to a community-based model of care, the Crown carried out a planning process for each resident of HRC to ensure that a placement was developed for them in the community which would adequately meet their needs.

33. Ultimately, HRC, the last remaining Schedule 1 facility operated in Ontario, was closed on March 31, 2009.

34. During the years of HRC's operation, various reports and articles were written about the facility.

35. With respect to the report referred to in paragraph 18 of the Amended Statement of Claim, this report was prepared by Dr. F.W. Sneddon, not Dr. F.C. Hamilton. The report was provided by Dr. Sneddon to Dr. Hamilton who was then the Superintendent at HRC. The report describes an inspection which occurred on November 29 and 30 and December 3 and 4, 1956. In the report, Dr. Sneddon notes that:

- the general state of maintenance at HRC was quite good;
- the general quality of medical and nursing care was quite good;
- there were generally good relations between staff and patients;

- the "turn-out" of the patients who were capable of being up and about HRC was very good;
- housekeeping at HRC was of very good quality; and
- he did not feel that excessive restraint and seclusion was being practised at HRC.

36. Specifically with respect to the two boys referred to at paragraph 18 of the Amended Statement of Claim, Dr. Sneddon concluded that he did not question the necessity for the restraint described but he believed that it would have been appropriate to issue an order with definite time limits with respect to the restraint.

37. With respect to the article by Pierre Berton referred to at paragraph 19 of the Amended Statement of Claim, nowhere in the article did Mr. Berton refer to "atrocities going on" at HRC. This phrase was not used in the article, nor was the suggestion implied by the article. Although Mr. Berton did allege that there was overcrowding and there was a danger of fire at HRC, a subsequent report by the Orillia fire inspector, carried out shortly after Mr. Berton's visit, concluded that there was no fire hazard at HRC.

38. The Williston Report referred to at paragraph 21 and 22 of the Amended Statement of Claim was produced in 1971 and its criticisms of HRC reflect the change in thinking then taking place concerning the appropriate way to care for individuals with developmental disabilities. The Williston Report advocated a move away from the institutional model towards community living. The Crown responded appropriately to this Report at least in part by moving forward with the

expansion of the community-based model for caring for individuals with developmental disabilities.

39. Similarly, the Welch Report focussed on the need to move away from the institutional model of care, a process which had already been commenced by the Ontario Crown. Although the Welch Report clearly advocated for the community based model of care, the Report also notes that institutions (like HRC) "provide[d] [the disabled individual] with a perfectly safe environment and afford[ed] him access to a wide range of treatment and developmental services".

40. The Willard Report referred to at paragraphs 25 of the Amended Statement of Claim was carried out at the behest of the Minister of Community and Social Services as part of the Crown's effort to ensure that appropriate care was being provided at HRC. As Dr. Willard noted, his inquiry was "problem oriented" in that his mandate was to focus on areas of concern at HRC. His Report, therefore, did not address the many services operating well at HRC. Although the Report noted areas for change and improvement at HRC, it was not "scathing" in its assessment of the facility.

**Marie Slark**

41. Marie Slark was born on January 31, 1954.

42. Slark had a deprived early childhood and she became a ward of the Children's Aid Society at 6 years of age.

43. Slark was admitted to HRC on September 11, 1961 based on the recommendation of the Hospital for Sick Children in Toronto.

44. The Children's Aid Society terminated its wardship in 1962.

45. Contrary to the allegation in paragraph 2 of the Amended Statement of Claim, Slark was never "a ward of the institution".

46. During her residence at HRC, Slark had little contact with her family.

47. In December of 1970, Slark went to live in an Approved Home. An Approved Home is a private family home in which HRC residents lived before being placed in the community.

48. While Slark was a resident at HRC and at the Approved Home, Marilyn Dolmage acted as her social worker. Dolmage conducted regular visits and prepared reports. While Slark resided at the Approved Home, Dolmage was the only employee of HRC in regular contact with Slark.

49. Slark was discharged from HRC on February 1, 1974.

50. The Crown specifically denies that:

- Slark was denied an education at HRC because of her size (para. 32, Amended Statement of Claim);
- HRC staff punished residents for no reason and that staff members instructed residents to physically punish one another (para. 34, Amended Statement of Claim);
- the Crown has or should have any knowledge or information about Slark's alleged mistreatment at the Approved Home (para. 34, Amended Statement of Claim)

**Patricia Seth**

51. Patricia Seth was born on May 22, 1958.

52. She was born prematurely and suffered developmental delays.

53. Contrary to the allegation in paragraph 4 of the Amended Statement of Claim, Seth was admitted to HRC on March 29, 1965.

54. Contrary to the allegation in paragraph 4 of the Amended Statement of Claim, Seth was not a "ward of the institution".

55. Seth was discharged from HRC on April 20, 1978.

56. The Crown specifically denies that:

- Seth was placed in an isolation ward at HRC (para. 37, Amended Statement of Claim);

- during her residence at HRC, Seth was repeatedly and continuously physically abused and punished (para. 38, Amended Statement of Claim);

- Seth was hit with a fly swatter, a rad brush and was punished for not eating by being held upside down in ice cold water (para. 39, Amended Statement of Claim);

- Seth was repeatedly and continually physically punished and beaten for speaking out (para. 40, Amended Statement of Claim);

- Seth was administered drugs inappropriately, or unnecessarily (para. 40, Amended Statement of Claim);

- the Crown has or should have any knowledge or information about Seth's alleged mistreatment at a group home (para. 41, Amended Statement of Claim).

**Defence to Allegations of Negligence and Breach of Fiduciary Duty**

57. The Crown's establishment, funding, operation, management, administration, supervision and control of HRC was to the benefit of the residents of HRC, particularly having regard to the fact that, in each and every case, the residents' families could not or would not care for them.

58. The Crown, her employees, agents and servant, acted at all times in the best interests of the residents of HRC.

59. Over the decades of HRC's operation, the best practices in the care of individuals with developmental disabilities, both in Ontario and elsewhere, have changed. Thinking has evolved and more has been learned about individuals with

disabilities. As a result, the standard of care for the operation and management of facilities for individuals with developmental disabilities has changed over time. The Crown, her employees, agents and servants, operated and managed HRC in accordance with the standard of care for such facilities at all relevant times.

60. The Crown, her employees, agents and servants provided the highest possible standard of care for the residents of HRC, having regard to all applicable constraints including budgetary constraints.

61. To the extent there may have been inadequacies in the operation and management of HRC, which is expressly denied, these inadequacies were the result of funding decisions. The decisions regarding the funding of HRC, and all institutions like it, were policy decisions. These decisions were made, at the highest levels of government, based on an assessment by the Crown of the competing demands for public resources and the government's responsibility to taxpayers to work within approved budgets.

62. To the extent the Crown owed common law duties of care, which is not admitted, such duties would have obliged the Crown to act as a reasonable person would in the operation and management of HRC. The plaintiffs have improperly pleaded the nature of common law duties of care by alleging, in paragraph 49 of the Amended Statement of Claim, that the Crown owed a duty:

- to ensure that residents would not suffer harm;

- to ensure that physical, emotional and sexual abuse would not occur;
- to protect HRC residents from any person or thing which would endanger or be injurious to the health and well-being of the resident;
- to provide an environment free from physical, sexual and/or psychological assault or harm;
- to set or implement standards of conduct for its employees and HRC residents to ensure that no employee or resident would endanger the health or well-being of any resident or person.

63. Contrary to the assertion in paragraph 52 of the Amended Statement of Claim, most of the residents of HRC were not wards of the Crown. The Crown denies that the residents of HRC were entirely within the power and control of the Crown. The Crown denies that it owed a fiduciary duty to the residents at HRC.

64. The Crown breached no common law, fiduciary or statutory duty in the establishment, funding, operation, management, administration, supervision and/or control of HRC.

65. Throughout their time at HRC, the residents of HRC received supervision, care, education, training and guidance in accordance with the highest standard of care at the time and appropriate to their needs and abilities.

66. The Crown denies the examples of improper conduct set out in paragraph 47 of the Amended Statement of Claim. Specifically, the Crown denies that:

(i) residents were left to aimlessly walk or crawl around Huronia at times, often without clothing;

(ii) residents were often not bathed or cleaned;

(iii) there was intermittent or inadequate or no attempt to supervise or program residents' activities;

(iv) residents were organized into work gangs to perform the routine and ordinary tasks of running such an institution;

(v) admissions procedures contained no opportunity for pre-admission visits and communications between residents and family members were made difficult if not impossible;

(vi) serious shortage of professional staff, falling far behind, sometimes in the nature of 30%, appropriate industry and professional standards or ratios;

(vii) total lack of personal attention or privacy given the institutional structure, facilities and overcrowding;

(viii) wards and rooms were unnecessarily locked, creating a prison-like environment;

(ix) lavatories inappropriately lacked doors and often toilet seats; and

(x) for their physical labour in and around the institution, residents were either paid nothing at all or were paid minimal and completely unrealistic wages in the range of 4 cents to 8 cents per hour.

67. The Crown denies each of the alleged breaches of fiduciary duty set out in paragraph 59 of the Amended Statement of Claim. Specifically, the Crown denies that:

(i) the Crown failed to report injuries sustained by residents of Huronia;

(ii) the Crown failed to provide adequate medical care for residents;

(iii) the Crown forced residents to work on the premises without proper, adequate or appropriate compensation to those residents for their labour;

(iv) the Crown failed to report allegations of sexual abuse and, moreover, often punished those residents who came forward with such claims;

(v) the Crown failed to properly screen applicants for positions which they were hired for at Huronia;

(vi) the Crown hired caregivers and others to work at Huronia who were not qualified to reach or to meet the needs of individuals under their care and supervision;

(vii) the Crown failed to properly supervise the administration and activities of Huronia;

(viii) the Crown failed to provide adequate financial resources or support to properly maintain the Huronia facilities or to care and provide for its residents;

(ix) the Crown failed to respond adequately, or at all, to complaints or recommendations which were made concerning Huronia, both with respect to its condition and the treatment of residents;

(x) the Crown created, permitted and fostered an atmosphere of fear and intimidation;

(xi) the Crown failed to safeguard the physical and emotional needs of the Resident Class;

(xii) the Crown permitted unhealthy and inappropriate punishments to be perpetrated against the Resident Class; and

(xiii) the Crown permitted an atmosphere that threatened the Resident Class with severe physical punishments, including violence.

68. The Crown denies that any resident at HRC was abused, mistreated or neglected by the Crown's employees, representatives or agents during the time of their placement at HRC and the Crown holds the plaintiffs to the strict proof of this allegation.

69. If abuse, mistreatment or neglect did occur, which the Crown expressly denies, the Crown specifically denies that it had or should have had any knowledge or information concerning the allegations of abuse, mistreatment and neglect in the

Amended Statement of Claim. If the abuse, mistreatment and assault occurred, which is expressly denied, the Crown was not made aware of these allegations at the relevant time. The Crown denies that any of the abuse alleged by the plaintiff was known or foreseeable by this defendant. The Crown puts the plaintiffs to the strict proof of these allegations.

70. If any resident at HRC was abused, mistreated or neglected, which is not admitted but expressly denied, such conduct was not carried out as part of the authorized duties of its employees, representatives or agents. If such conduct was carried out upon the Representative Plaintiffs or any other resident of HRC, then such conduct was in no way authorized, condoned or permitted by the Crown nor was it carried out with the knowledge of the Crown. With respect to the allegations of abuse, mistreatment and neglect, which are expressly denied, the Crown denies that it is in any way vicariously liable for any such alleged acts.

71. The Crown monitored and supervised the care for the residents of HRC at any and all relevant times. If the residents of HRC suffered any form of abuse, mistreatment, assault or neglect, which is not admitted but denied, there was an ongoing opportunity to report such alleged abuse so that it could be investigated in a timely fashion. The Crown ensured that HRC had in place all appropriate safeguards to ensure that abuse was prevented and that, if it did occur, it could be reported and appropriately addressed.

72. The Crown responded appropriately and in accordance with the standard of care to any and all information it received regarding allegations of abuse or mistreatment.

73. The Crown responded appropriately and in accordance with the standard of care to any and all reports, article and studies and any other information received by it concerning the management and operation of HRC.

74. The Crown denies that it failed to adequately monitor, train or supervise its staff.

75. The Crown denies that it ever forced any individual to reside at HRC.

76. The Crown, her employees, agents and servants, managed the lives of HRC residents only as appropriate to ensure that the residents were safe and well cared for.

77. The plaintiffs cannot assert a claim against the Crown for inadequate funding of HRC. Such a claim is not recognized at law.

78. The plaintiffs cannot assert a claim for breach of statutory duty. Such a claim is not recognized at law.

79. The Crown is immune to any claims in tort prior to September 1, 1963 when the *Proceedings Against the Crown Act* R.S.O. 1990, CHAPTER P.27 was first enacted. No claim in tort can be asserted for any actions or events which predate the passage of this act.

80. Any and all claims brought by the plaintiffs are statute-barred by virtue of the *Limitations Act, 2002* S.O. 2002, CHAPTER 24 Schedule B and any and all predecessor legislation.

81. The Crown states that, due to the many years that have elapsed since the alleged events occurred, the documentary and evidentiary record is incomplete and cannot be reconstructed. The lengthy passage of time has also resulted in the death or unavailability of many potential witnesses and recollection difficulties for any witnesses that can still be found. Accordingly, the Crown has suffered severe prejudice in its ability to fully defend this action in that it has insufficient information and/or knowledge either to confirm or deny the plaintiff's allegations. The Crown relies upon the doctrine of *laches* and states that the plaintiffs are estoppped from bringing this action as against the Crown.

82. The Crown states that Marilyn Dolmage was, at times material to this proceeding, an employee of HRC with responsibility for the care of Slark, Seth and other members of the class. Her conduct is and will be at issue in this proceeding. She has a conflict of interest in acting as the Litigation Guardian for Slark and should

not continue to act as such. Similarly, Jim Dolmage has a conflict of interest by virtue of his marriage to Marilyn Dolmage and should not continue to act as a Litigation Guardian.

83. The Crown denies that the residents of HRC suffered any loss or damages as alleged.

84. In the alternative, if the residents of HRC have suffered any loss or damages, such loss or damages were as a result of acts and/or omissions not within the power or control of the Crown. Any such loss or damages resulted from pre-existing physical, emotional and/or psychological problems which were not caused or contributed to by the Crown.

85. In the further alternative, any such loss or damages were caused by matters arising subsequent to the plaintiff's stay at HRC and were unrelated to any conduct of the Crown.

86. If the residents of HRC have suffered any loss or damages as alleged or otherwise, which is not admitted but denied, such alleged loss and damages are excessive and too remote and the plaintiffs are put to the strict proof thereof.

87. The plaintiffs have failed to mitigate their alleged loss or damages.

88. The Crown states that nothing in its conduct warrants the awarding of punitive or exemplary damages.

89. The Crown pleads and relies upon the *Negligence Act*, R.S.O. 1990, c. N. and the *Developmental Services Act* R.S.O. 1990, CHAPTER D.11.

90. The Crown asks that this action be dismissed with costs.

**January 31, 2011**

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**STATEMENT OF DEFENCE**


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