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October 22, 2015

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Re: Sharon Clegg as Litigation Guardian of Marlene McIntyre
Court File No.: CV-14-50642300CP

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October 22, 2015

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Attention: Kirk Baert/Celeste Poltak/David Rosenfeld/Garth Myers

Dear Counsel:

RE: Ontario Schedule 1 Facilities – Sharon Clegg as Litigation Guardian of Marlene McIntyre

Please find enclosed our Statement of Defence served in accordance with the *Rules of Civil Procedure*.

Yours truly,

Lisa Brost
Counsel

Encl.

Court File No.: CV-14-50642300CP

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

SHARON CLEGG AS LITIGATION GUARDIAN OF MARLENE MCINTYRE

Plaintiff

- 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 the twelve facilities identified in the Amended Statement of Claim at paragraph 1(b) as amended. The Crown further admits the facts set out in paragraphs 5, 7 and 9.

2. The Crown has no knowledge of the allegations contained in paragraph 4.

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

Marlene McIntyre

4. The admission and discharge dates put forward by Ms. McIntyre in the Amended Statement of Claim do not correspond with the information contained in the Ministry of Community and Social Services' historical records.

5. Rather, and contrary to the factual assertions set out in the Amended Statement of Claim, the historical records show that Ms. McIntyre's admissions and discharges were as follows:

a) *February 1, 1955* – Admitted to O.H. Orillia (Huronia Regional Centre)

b) *March 3, 1959* – Transferred to R.R.C., Smith's Falls (Rideau Regional Centre)

c) *April 1969* – Transferred to Lorimer Lodge (not a Schedule 1 Facility)

d) *December 1969* – Returned to R.R.C., Smith's Falls

e) *March 9, 1972* – Transferred to Cobourg (D'Arcy Place)

f) *August 7, 1973 – December 16, 1974* – Adult Occupational Centre, Edgar

The Evolution of Developmental Services

6. Like many jurisdictions, Ontario's early history of developmental services was based, in part, on the understanding that individuals with developmental disabilities were often best served by providing long-term residential services, often in rural locations, and caring for them in large institutional settings. It was believed that these long-term residential facilities were beneficial in relieving the strain on families who would otherwise be caring for the individuals. Community based care options did not exist and were not considered as appropriate options until the 1960s and 1970s.

7. Dr. Dymond, the Minister of Health for Ontario between 1958 and 1969, had a major impact on policies for people with developmental disabilities. In his view, a better way to help meet the demand from families was to find ways to keep individuals with developmental disabilities in the community and close to their families.

8. In the 1960s, changing attitudes towards people with developmental disabilities continued to gain momentum. 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.

9. To that end, many changes were made to help drive this fundamental shift to the care of these individuals. Throughout much of the 1970s, the Crown retained an internationally renowned proponent of the approach, Mr. Bengt Nirje, to provide guidance on the application of 'normalization' to the services delivered. A fundamental shift in how society addressed the needs of individuals with developmental disabilities was starting. This change in approach would ultimately lead away from the institutional or congregate care model to having individuals receiving community based services and care. As the capacity of community services grew, the institutions could be and were ultimately closed.

10. Other changes were legislative. Regulations made under the *Developmental Services Act, S.O. 1974, c. 2 ("DSA")*, designated facilities operated by the Crown which provided assistance and/or services to individuals with a developmental disability. These facilities were listed in Schedule 1 of the regulations made under the *DSA*, and as a result, have become referred to as Schedule 1 facilities. As a result of this legislative change, the operations of these facilities were transferred to the Ministry of Community and Social Services from the Ministry of Health.

11. For the purpose of the defence of this matter, the applicable class periods for each of the Schedule 1 facilities have been defined as reflected in the Consent Certification Order, based on the time periods during which the function and purpose of each facility's operations were to provide residential care to individuals with developmental disabilities. For some of the facilities, this occurred at the point of their designation as a Schedule 1 facility. Other of the facilities began to provide residential care to individuals with developmental disabilities earlier, when

these services were offered by the Ontario Department of Health or later by the Ontario Ministry of Health. The applicable class periods are as follows:

(a) St. Lawrence Regional Centre between April 1, 1975 and June 30, 1983;

(b) D'Arcy Place between September 1, 1963 and December 31, 1996;

(c) Adult Occupational Centre between January 1, 1966 and March 31, 1999;

(d) Pine Ridge between September 1, 1963 and August 31, 1984;

(e) Muskoka Centre between August 28, 1973 and June 30, 1993.

(f) In the unit known as the "Mental Retardation Unit" or "MR Unit" of the Oxford Mental Health Centre between January 1, 1969 and March 31, 1974 ("OMHC Class Members") and not in the other units of the Mental Health Centre;

(g) Oxford Regional Centre between April 1, 1974 and March 31, 1996;

(h) Midwestern Regional Centre between September 1, 1963 and March 31, 1998;

(i) L.S. Penrose Centre ("Penrose Centre") between April 1, 1974 and March 31, 1977;

(j) Bluewater Centre between April 1, 1976 and December 20, 1983;

(k) Durham Centre for the Developmentally Handicapped between April 1, 1974 and September 28, 1986;

(l) Prince Edward Heights between January 1, 1971 and December 31, 1999; and

(m) Northwestern Regional Centre between April 1, 1974 and March 31, 1994.

12. These were all separately operated facilities with their own operations and internal policies applicable to the day-to-day operations of the institution.

13. The facilities operated first under the Ministry of Health [earlier called the Department of Health] and later operated under the Ministry of Community and Social Services. The respective Ministries implemented additional overarching policies applicable to all of the facilities.

14. There were extensive Ministry-wide policies prohibiting the abuse of residents from well before the beginning of the class period in this matter, dating back to at least 1922. Through the years, the policies addressing abuse were refined and expanded the definition of abuse and requirements pertaining to abuse to include the duty to report abuse committed by others. Directives that were implemented provided that the failure to report abuse was itself a ground for discipline. For example, by memo dated February 15, 1965 from the then Minister, Dr. Dymond, the various facilities at the time were advised that "UNDER NO CIRCUMSTANCES SHALL A PATIENT BE STRUCK BY A MEMBER OF STAFF OR OTHERWISE PHYSICALLLY ABUSED" (capitals in original). This memo went on to state:

> "Rough treatment of our patients has no place in our hospitals and this should be forcibly impressed upon trainees and any staff who are involved in patient care. It is, furthermore, my direction to you that you issue a directive to those concerned that in their instruction to trainees it be made eminently clear that maltreatment of patients will not be tolerated and will result in dismissal."

15. Those of the twelve facilities at issue that were in operation prior to 1974, and prior to their designation as a Schedule 1 facility, were often operated on a medical model of care that focused primarily on the physical health of their residents (called patients). As such, prior to 1974, these facilities were operated under the Ontario Department of Health and, later, the Ontario Ministry of Health. By the early 1970s, this model was replaced with a unit system approach which was a significant departure from the medical model and which attempted to apply a developmental approach to services and the individual's needs.

16. Most of the residents of the twelve facilities had what is now known as developmental disabilities, which were in some cases quite profound. Residents also often suffered from mental illness, physical disabilities and other medical and social problems.

17. Residents of the twelve facilities were admitted with the consent of their family or legal guardian, sometimes based on the advice of doctors or other medical experts. In order to gain admission to a facility, a priority assessment would generally be carried out to determine the individual's need for services.

18. In some limited cases, individuals were wards of the Crown and were placed in the facility by the local Children's Aid Society. However, individuals did not become wards of the Crown simply by virtue of their admission to one of the twelve facilities. Most of the residents of the facilities were not Crown wards and remained under the legal authority of their parents and families.

19. The twelve facilities encouraged continuing contact and care between residents and their families. Moreover, the twelve facilities encouraged community involvement with individual residents and the facilities themselves. Throughout the history of the facilities, there was ongoing contact and access between the residents and their families, if they wished, and the community.

20. Some of the residents of the twelve facilities were long-term care residents in that once admitted, they spent years at a facility or across several facilities.

21. For a variety of reasons, some residents of the twelve facilities had little regular, continuing contact with their families.

22. Many of the residents of the twelve facilities were entirely supported financially by the government throughout their residency.

23. Residents at the twelve facilities were involved in a variety of programming, including education courses, training, recreational activities and vocational training. The use of Individual Program Plans became widely used. Their intended objective was to provide each resident with appropriate treatment or training programs designed to assist in developing and maintaining personal maintenance, intellectual growth and social development. The programs were developed and tailored to the resident's needs, based on an assessment of the resident, and included operational descriptions of the methods to be used and a detailed procedure for implementation. The assessment was to reveal behavioural excesses and deficits, as well as strengths. In determining the resident's strengths and weaknesses, short and long terms goals to

be achieved were established. At the essence of this approach, programs were designed and selected to support and encourage individual ability and experience. Attention was given to whether other opportunities could be made available even if an individual's capacity was limited, such that little change or variation was possible.

24. It was often considered developmentally beneficial and therapeutic for residents to work, where appropriate. The opportunity to work was made available to certain residents at some of the facilities. Work was seen as a valuable way to provide training to people, improve confidence and provide socialization skills which were beneficial for community engagement.

25. Recreational opportunities were readily available to residents and many were involved in these activities, which included sports and outings in the community. Recreation, leisure, clubs and special events were included to foster a sense of well-being and community.

26. Residents were often given choices and opportunities, as appropriate. Some residents had disabilities determined to be too severe to exercise any significant degree of personal control over their day-to-day lives. The various facilities were organized as congregate care operations even if individuals were housed in apartment style units. As part of this, certain organizational routines, structures and controls were appropriate and necessary to maintain the appropriate support for individual residents and the ongoing operation of the day-to-day services of each facility as a whole.

27. Residents received all manner of health care depending on, and appropriate to, their condition and needs. This care included medical, dental, optometric, ergonomic, social, psychiatric and psychological care, as appropriate.

28. Throughout the years of the operations of the twelve facilities, the Crown ensured that only qualified candidates were selected for employment at the facility.

29. Furthermore, once hired, the Crown ensured that all staff were adequately and appropriately trained and supervised. Staff training included physical care, individual planning

and programming, behaviour programming, recognizing the signs of abuse and the proper steps to be taken if abuse was suspected.

30. Measures were taken at the operational level and at the executive or political level to address allegations of abuse. In 1978, the Minister of Community and Social Services, Keith Norton, and the government passed a special legislative bill to limit the ability of the Grievance Settlement Board to order staff who were found to have abused residents, to return to work with the residents. Through this extraordinary legislative remedy, the Province was able to better protect residents from direct contact with such persons.

Williston Report

31. The 1971 Report, "Present Arrangements of the Care and Supervision of Mentally Retarded Persons in Ontario", examined the services provided by the Crown at the time to individuals with developmental disabilities. As part of this Report, Mr. Williston surveyed the various residential operations of the facilities. His report, criticisms and suggestions focused on the Ontario Hospital Schools system, namely the Ontario Hospital School, Orillia (Huronia Regional Centre), Rideau Regional Hospital School, Smith Falls (Rideau Regional Centre), and Ontario Hospital School, Cedar Springs (Southwestern Regional Centre). These three facilities were the subject of three class actions which have now concluded.

32. Not all of the twelve facilities named in this claim are referenced by Mr. Williston. Many of these facilities were neither in existence nor operation as of the time of the report.

33. For the facilities at issue which were part of Mr. Williston's survey, the report concludes, *inter alia,* the following:

a) **Adult Occupation Centre, Edgar: "...**Most of the trainees live in individual housing units which accommodate four or five trainees and are furnished as closely as possible to any normal home in the community. ...Recreational facilities provide the trainees with such activities as swimming, basketball, volleyball, badminton, floor and ice hockey, baseball, billiards, exercise and weight-training equipment, bowling, archery, broomball, track and field, miniature golf, ping pong, darts, football, soccer,

gymnastics, and wrestling. Within the recreation department there is a large selection of clubs (twenty-two in all) ranging from photography to art, woodworking and stamp collecting..."

He concludes that the staffing at the Adult Occupation Centre met the standards he references in the report.

b) **Prince Edward Heights, Picton:** This facility was in the beginning stages of its operations at the time of the report. Mr. Williston makes no critical observation of this facility.

c) **Oxford Mental Health Centre, Woodstock:** Mr. Williston states that "The buildings are situated in pleasant park-like surroundings. The wards do not appear to be overcrowded."

d) **Midwestern Regional Children's Centre, Palmerston:** Mr. Williston concludes that the staffing levels of ward staff met the standards that he references in the report.

34. The Crown responded appropriately to the Williston Report, in part by moving forward with the expansion of the community-based model for caring for individuals with developmental disabilities.

The Welch Report

35. The 1973 paper by Mr. Robert Welch, "Community Living for the Mentally Retarded in Ontario – a New Policy Focus", was a public consultation paper that introduced the government's new policy focus for the delivery of services based on the concept of community living and sought public input on this endeavour. The paper focused on community service development and addressed the policy shift from a facility-based service model to one based in the community. As a policy paper, it was a government document detailing the specifics of an issue and possible courses of action. As a "green" paper, it was the usual first step taken when government undertakes a change in policy and/or enacts a major overhaul of some aspect of the government. This was not a report on "conditions that led to the abuse of residents". Indeed, although the Welch Report clearly advocated for the community based model of care, the report also notes that institutions "provide[d] [the disabled individual] with a perfectly safe environment and afford[ed] him access to a wide range of treatment and developmental

services."

36. The Crown was a pioneer in its early adoption of the normalization approach, by which it organized its services and supported community based services and undertook the closure of the large facilities. Many of the facilities were designed so as to promote the reintegration of individuals into the community. As such, the larger wards were no longer used and smaller apartment or dormitory-style units were used to accommodate smaller units and groups of residents. These units had their own common areas, washrooms and eating areas.

37. Over the many years that it took to transition residents of all twelve facilities to a community-based model of care, the Crown carried out a planning process and ensured that each resident of the facilities was transitioned to appropriate, community based care services to meet his or her needs.

38. In this regard, given that the last of the facilities at issue closed in 1999, the shift to community based care for individuals with developmental disabilities took place much earlier in Ontario than in other jurisdictions. Indeed, the Crown had to respond to applications brought by the families of the last remaining residents of the remaining Schedule 1 facilities in 2007 who were seeking to stop the closure of the large institutions on the basis that they provided the best care available to their family members and that they was the only homes their loved ones had known.

Defence to Allegations of Negligence and Breach of Fiduciary Duty

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

40. The Crown and her employees, agents and servants acted at all times in the best interests of the residents of the twelve facilities.

41. Over the decades of the twelve facilities' operations, the best practices in the care of individuals with developmental disabilities, both in Ontario and elsewhere, changed. Thinking evolved and more was learned about individuals with disabilities. As a result, the standard of care for the operation and management of facilities for individuals with developmental disabilities changed over time. The Crown and her employees, agents and servants operated and managed the twelve facilities in accordance with the applicable standard of care for such facilities at all relevant times.

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

43. With the downsizing of the facilities in the 1980's, challenges around staffing levels disappeared. By 1990, the Provincial Auditor criticized the Crown, noting that as of 1989 staffing reductions had not been made at certain facilities in response to the declining resident populations.

44. To the extent there may have been staffing shortages in the operation and management of the twelve facilities, which is expressly denied, these shortages were the result of core policy decisions, based on public policy considerations involving economic, social and political factors.

45. These policy 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. For example, in 1976, a Cabinet Submission was put forward to increase staffing levels by the Ministry of Community and Social Services. After specifically considering the cost implications and fiscal pressures of the time, Cabinet did not increase staffing levels. Instead, the facilities were allowed to keep their current staffing levels, even though staffing reductions were required throughout other parts of government because of fiscal constraint.

46. To the extent that the Crown owed a common law duty of care, which is not admitted, the duty of the Crown was to manage and operate each of the twelve facilities to the standard of a

reasonable well run facility in the circumstances. The Plaintiff has improperly pleaded the nature of the common law duty of care by alleging that the Crown owed a duty as defined by the assertions at paragraph 30 of the Amended Statement of Claim.

47. Contrary to the allegations at paragraph 33 of the Amended Statement of Claim, most of the residents of the twelve facilities were not wards of the Crown. The Crown denies that the residents of the twelve facilities were entirely within the power and control of the Crown. The Crown denies that it owed a fiduciary duty to the residents of the twelve facilities.

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

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

50. The Crown specifically denies the examples of improper conduct set out in paragraph 28 of the Amended Statement of Claim.

51. The Crown denies each of the alleged breaches of fiduciary duty set out in paragraph 38 of the Amended Statement of Claim.

52. The Crown denies that any resident of the twelve facilities was abused, mistreated or neglected by the Crown's employees, representatives or agents during their placement at one of the twelve facilities and the Crown holds the Plaintiff to the strict proof of this allegation.

53. 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 the Crown. The Crown puts the Plaintiff to the strict proof of these allegations.

54. If any resident of the twelve facilities 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 a resident, 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.

55. The Crown monitored and supervised the care for the residents of the twelve facilities at any and all relevant times. If the residents of the twelve facilities suffered any form of abuse, mistreatment, assault or neglect, which is not admitted but expressly 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 the twelve facilities had in place all appropriate safeguards to ensure that abuse was prevented and that, if it did occur, it was expected to be reported and appropriately addressed.

56. The Crown responded appropriately and in accordance with the standard of care at the time to any and all information it received regarding allegations of abuse or mistreatment. Measures were taken at an operational level and at an executive level to address allegations of abuse.

57. Throughout the class period, there were thousands of staff at the twelve facilities, including doctors, nurses, and other professional staff who, in addition to the policies of the facility, upheld their own professional ethical requirements.

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

59. The Crown denies that it ever forced any individual to reside at any of the twelve facilities.

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

61. The Plaintiff cannot assert a claim against the Crown for inadequate funding of the twelve facilities. Such a claim is not recognized at law.

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

63. Any and all claims brought by the Plaintiff are statute-barred by virtue of the *Limitations Act, 2002*, S.O. 2002, c. 24, Sch. B and any and all predecessor legislation.

64. 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 or knowledge either to confirm or deny the Plaintiff's allegations. The Crown relies upon the doctrine of *laches* and states that the Plaintiff is estopped from bringing this action as against the Crown.

65. The Crown denies that the residents of the twelve facilities suffered any loss or damages as alleged.

66. In the alternative, if the residents of the twelve facilities have suffered any loss or damages, such loss or damages were as a result of acts or omissions not within the power or control of the Crown. Any such loss or damages resulted from pre-existing physical, emotional

or psychological problems which were not caused or contributed to by the Crown.

67. In the further alternative, any such loss or damages were caused by matters arising subsequent to the residents' stay at the twelve facilities and were unrelated to any conduct of the Crown.

68. If the residents of the twelve facilities have suffered any loss or damages as alleged or otherwise, which is not admitted but denied, such alleged loss and damages are excessive and remote and the Plaintiff is put the strict proof thereof.

69. The Plaintiff has failed to mitigate her alleged loss or damages.

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

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

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

DATE: October 22, 2015

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Court File No. CV-14-50642100CP

SHARON CLEGG AS LITIGATION GUARDIAN OF MARLENE MCINTYRE	**- and- HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF ONTARIO**
Plaintiff	**Defendant**

ONTARIO
SUPERIOR COURT OF JUSTICE
Proceeding commenced at **TORONTO**

STATEMENT OF DEFENCE

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