File No. CI18-01-17220

THE QUEEN'S BENCH
Winnipeg Centre

BETWEEN:

DAVID WEREMY

Plaintiff

- and -

THE GOVERNMENT OF MANITOBA

Defendant

Proceeding under *The Class Proceedings Act*, C.C.S.M. c. C.130

AMENDED STATEMENT OF CLAIM

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AMENDED STATEMENT OF CLAIM

TO THE DEFENDANT:

A LEGAL PROCEEDING HAS BEEN COMMENCED AGAINST YOU by the plaintiff. The claim made against you is set out in the following pages.

IF YOU WISH TO DEFEND THIS PROCEEDING, you or a Manitoba lawyer acting for you must prepare a statement of defence in Form 18A prescribed by the *Queen's Bench Rules*, serve it on the plaintiff's lawyer or where the plaintiff does not have a lawyer, serve it on the plaintiff, and file it in this court office, WITHIN TWENTY DAYS after this statement of claim is served on you, if you are served in Manitoba.

If you are served in another province or territory of Canada or in the United States of America, the period for serving and filing your statement of defence is forty days. If you are served outside Canada and the United States of America, the period is sixty days.

IF YOU FAIL TO DEFEND THIS PROCEEDING, JUDGEMENT MAY BE GIVEN AGAINST YOU IN YOUR ABSENCE AND WITHOUT FURTHER NOTICE TO YOU.

_____
Date

Issued _____
Deputy Registrar
100C - 408 York Avenue
Winnipeg, Manitoba R3C 0P9

To: **GOVERNMENT OF MANITOBA**

c/o Cliff Cullen
Minister of Justice and Attorney General
104 Legislative Building
450 Broadway
Winnipeg, MB R3C 0V8

CLAIM

1. The Plaintiff claims:

(a) an order certifying this proceeding as a Class Proceeding pursuant to *The Class Proceedings Act,* C.C.S.M. c. C130 and appointing the Plaintiff as Representative Plaintiff for the Class;

(b) a declaration that the Defendant breached its fiduciary, statutory, and common law duties to the Plaintiff and the Class through the operation, management, administration, supervision and control of the Manitoba Developmental Centre ("**MDC**");

(c) a declaration that the Defendant was negligent in the operation, management, supervision and/or control of MDC;

(d) a declaration that the Defendant is vicariously liable for the harms perpetrated upon MDC residents by the Defendant's servants, employees, representatives and agents;

(e) a declaration that the defendant is liable to the plaintiffs and the Class for the damages caused by its breach of fiduciary, statutory and common law duties and for its negligence in relation to the operation, management, administration, supervision and control of MDC;

(f) damages for breach of fiduciary duty, negligence, and vicarious liability in an amount to be determined by the court;

(g) punitive damages in the amount of $50 million;

(h) pre-judgment and post-judgment interest pursuant to the *Court of Queen's Bench Act*, C.C.S.M. c. C280;

(i) costs of this action on a substantial indemnity basis or in an amount that provides full indemnity to the Plaintiff;

(j) costs of notice and of administering the plan of distribution of the recovery in this action, plus applicable taxes, pursuant to subsections 24(1) and 33(6) of *The Class Proceedings Act;* and

(k) such further and other relief as this Honourable Court deems just.

A. THE PARTIES

2. The Plaintiff, David Weremy ("**Weremy**"), is an individual residing in the City of Winnipeg, in the Province of Manitoba. Weremy was born on March 12, 1944. He was admitted as a resident to the Manitoba Developmental Centre ("**MDC**") in 1954 at the age of 11. Weremy continued to reside at MDC from 1953 through to 1972.

3. The Defendant, Her Majesty the Queen in the Right of the Province of Manitoba (the "**Crown**") is named in these proceedings pursuant to the provisions of *The Proceedings Against the Crown Act*, C.C.S.M. c. P140, and the amendments thereto.

4. At all materials times, the Crown, through and with its agents, servants and employees, owned and was responsible for the operation, funding and supervision of MDC as a residential developmental centre for the care and control of adults with a mental disability.

5. MDC is currently designated as a developmental centre pursuant to the *Vulnerable Persons Living with a Mental Disability Regulation*, C.C.S.M. c. V90 and is operated by the Ministry of Family Services and Labour.

6. MDC is located in Portage La Prairie, Manitoba, and is under the sole jurisdiction and control of, and is operated by, the Crown. The Crown retained and authorized servants, agents, representatives and/or employees to operate MDC and/or gave instructions to such servants, agents, representatives and employees as to the manner in which the facility was to function and operate.

B. THE CLASS

7. The Representative Plaintiff brings this action pursuant to the *Class Proceedings Act,* on his behalf and on behalf of the following Class:

> "All persons who resided at MDC between July 1, 1951 and the date of the certification order herein, and who were alive as of the date two years prior to the commencement of this action."

C. HISTORY OF MDC

8. MDC has operated from 1890 to the present day.

9. The MDC has housed since 1890 individuals labelled developmentally challenged and delayed. The Class, as people with disabilities, are a particularly vulnerable population within society.

10. MDC originally opened as the Home for the Incurables in Portage la Prairie and later became the Manitoba School for the Mentally Retarded.

11. From 1890 – 1938 the Minister of Public Works oversaw MDC. From 1938 – 1965, the Department of Public Welfare provided oversight at MDC. From 1965 onwards MDC has had ministerial oversight by what is now the Department of Families.

12. Individuals were either placed in MDC by reason of: (i) a court order if the individual could not be safely managed in the community or is a threat to themselves or the public; (ii) voluntary placement by family members or their principal caregivers; (ii) expulsion from the public school system; (iii) if the child is too old for school and there is no other program available; (iv) delinquency; (iv) inability to control sexual desire and promiscuity; or (v) a public school's inability to provide services to rural and isolated areas. Many individuals currently residing at MDC were committed to MDC in the 1960s and 1970s.

13. MDC was intended to provide a residential program of activity, developmental programs and adult training to individuals of all ages labelled mildly, moderately, severely and profoundly mentally challenged. In the 1960s MDC housed around 1,200 residents per year. As of 2018 MDC is reported to house approximately 160 residents. The persons who were admitted into MDC were of all ages and for many of these individuals, placement at MDC was permanent.

14. All material aspects of MDC residents' lives were dictated, controlled and provided for by the Crown. Individuals at MDC had virtually no control over any material aspect of their lives. The opportunities to make choices or provide any input into their daily lives were extremely limited if not non-existent. The vulnerability of these individuals as a result of their placement in the institution was further compounded by virtue of their being disabled.

15. In 1973, the J.C. Clarkson and M.D.T Associate report, sponsored by the Department of Health and Social Development, entitled "Mental Health and Retardation Services in Manitoba"

(the "**Clarkson Report**") was released. The Clarkson Report was a scathing indictment of large institutions for the developmentally disabled in Manitoba.

16. J.C. Clarkson made the following criticisms of MDC:

(a) older buildings are in poor condition;

(b) MDC suffers from overcrowding and a lack of adequate plumbing;

(c) due to the gross overcrowding the facility is not geared to provide for many of its residents the intensive progressive and condition programs;

(d) there is lack of qualified personnel in some positions including social services;

(e) the centre is grossly understaffed;

(f) there is a lack a privacy provisions for residents including bathing or going to the toilet;

(g) the infirmary and medical ward are grossly inadequate and;

(h) the medical ward is so overcrowded that patient's had to be wheeled out in order for oxygen to be wheeled in for other patients.

17. In 1987, the 17th annual Report of the Manitoba Ombudsman (the "**Ombudsman Report**") was released, which extensively covered MDC. The Ombudsman Report made the following conclusions:

(a) the MDC is less than desirable for the residents;

(b) the standard of care at the MDC has been a long standing issue;

(c) the MDC is unable to meet its stated objectives relating to standards, physical care, and training and education;

(d) despite a decreasing resident population, unexplained injuries continue to increase on an annual basis;

(e) an injury that resulted in the death of a resident had a direct correlation to the staffing level at the MDC;

(f) there is a lack of programming and training opportunities;

(g) the living areas are very congested and lack environmental stimulation;

(h) many of the residents are unable to speak and are "forgotten souls";

(i) the residents of MDC are a particularly vulnerable group;

(j) staffing issues significantly impact the social, psychological, educational and physical well-being of the residents;

(k) there is inadequate air condition system to facilitate the comfort, health, and well-being of the residents; and

(l) the MDC is failing its stated mission "to assist client to attain the highest developmental possible.

18. The Ombudsman Report provided a series of recommendations to the Ministry and held meetings with the Minister and senior department officials to discuss the conclusions and recommendations of the Ombudsman Report.

19. However, notwithstanding various reports on the conditions and failures of residential care at MDC and various recommendations, no adequate internal safeguards were put into place to improve the quality of care or living at MDC. In the alternative, even if the Crown adopted some of the recommendations, those measures were inadequate and failed to meet the standard of care which was applicable in the circumstances.

20. Most notably, the Crown did not act to effectively and appropriately prevent or report the known abuse which was occurring and being perpetrated upon MDC residents by staff or other residents. As the Crown knew that the residents of MDC were not always in a position to complain, report or be listened to, it would have been reasonable for the Crown to establish appropriate institutional means of quality assurance to ensure individuals resided in an inherently safe environment.

21. The operation, control, and management of MDC became the subject of local and national media attention and of grievance settlements and arbitration decisions over the years. Through numerous publications and decisions, information regarding MDC's operations should have become well-known to the Crown. Amongst other things, those publications and decisions documented and publicized the following incidents for the period 1990 onward:

(a) 1990: Two male staff removed the bathing suit of a female resident as punishment for behaviour that irritated them;

(b) 1990: A psychiatric nurse was terminated for abusing a resident, including using force and threatening the resident;

(c) 1996: An employee was terminated for sexual harassment and the arbitrator noted "the sensitivity required of workers at MDC in order to care for the mentally disabled residents in accordance with the express role and mission of

MDC. was certainly non-existent insofar as the Grievor's behaviour towards his co-workers was concerned";

(d) 1998: A psychiatric nurse at MDC had been observed displaying intolerance towards residents, including negative conduct of yelling, unrealistic expectations and behaviour which was inconsistent and aggressive in the handling of patients. In total, 15 allegations had been made against her and 6 of them were plead guilty to;

(e) 2000: An individual with a Nurse II designation was seen hitting a resident on the back of the head. That same individual previously been disciplined for using inappropriate and derogatory language with a resident while they were having a seizure; on another incident choking a resident; and on another occasion teaching a resident to say "I am a mongoloid deformity, I am a genetic defect";

(f) 2001: A feasibility study conducted by the Province of Manitoba noted "[t]he Manitoba Developmental Centre, however, has yet to achieve the standards of physical living conditions found in present-day correctional institutions and other long-term care facilities";

(g) 2001: A nurse was charged with professional misconduct for inappropriate force and language and was not to have "displayed intolerance towards residents, there was negative conduct involving yelling, unrealistic expectations, and behavior which was inconsistent and aggressive in the way Ms. Bermel handled patients. A pattern of behavior with respect to Ms. Bermel's approach to the resident population was revealed";

(h) 2004: "The Freedom Tour" documentary created by People First of Canada is released and recounts tales of repeated attempts to escape institutions, followed

by epilogues of repeated "captures" and subsequent punishments, accounts of unsupervised locked wards at night and provides images of toilets without partitions and archival footage of people naked, fighting, sexualized and otherwise objectified from various institutions including the MDC.

(i) 2005: A resident was found dead in a van after an outing during which the two staff members did personal errands, used resident money, failed to follow protocols in a number of ways, including doing a check and count of residents;

(j) 2006: As part of a human rights complaint about the future of the MDC, the Royal Canadian Mounted Police was reported to have had difficulty investigating files from MDC; and

(k) 2007: An investigation into the death of a resident in 2004 by Justice Corrin found:

(i) hiring practices to be inadequate as the MDC would hire staff with no previous experience or training;

(ii) MDC training is ineffectual as there is no formalized training or testing to ensure enforcement, relying on the honour system; and

(iii) the existence of an open door whistle blower policy to report deliberate and unintentional breaches of safety policies was ineffective as employee culture enhanced suppression of non-compliance and it was commonplace for staff not to follow policies and fail to report.

(l) 2010: In 2010 the Winnipeg Free Press published an article wherein a former resident of MDC, identified as Aime, reported his rape from more than 40 years ago and stated that sexual assault was a common occurrence when the lights were

turned off for the night. He also stated that when he told staff about it he was told "suffer". Aime also reported that staff kicked and slapped him and that a male nurse broke his hand, with the nurse being fired and charged only after his doctor complained.

D. THE PLAINTIFF'S EXPERIENCES AT MDC

22. David Weremy was born on March 12, 1944 and resides in the city of Winnipeg Manitoba.

23. Weremy was born with an intellectual disability, but as child in the 1950s, he was told he suffered from mental retardation.

24. At about age 14, Weremy was sent to MDC by his parents. Weremy lived at MDC for approximately 15 years, and then on an off again until his last discharge in 1977.

25. During his time at MDC, Weremy was repeatedly sexually assaulted by other residents.

26. Weremy also witnessed the sexual and physical assaults of other residents by residents on a nightly basis. The staff at MDC were aware of these assaults but took no action to stop them from happening.

27. During some of these assaults the staff would watch and claim that Weremy or other residents enjoyed the non-consensual sexual acts that were forced upon them.

28. Weremy was also assaulted by staff. Weremy was repeatedly whipped by staff with a strap as punishment. Weremy was hit by staff on the behind with a '2x4' for trying to escape from MDC. Weremy was injured in the shower when assaulted by a staff member.

29. Weremy also witnessed assaults of other residents by staff members.

30. Further, Weremy was constantly underfed at MDC and he often witnessed other residents not only eating out of garbage cans as a source of food, but also witnessed residents eating feces out of toilet bowls.

31. As a result of these horrible conditions, Weremy tried to escape nine separate times. After being recaptured and returned to the MDC, Weremy was placed in MDC's version of solitary confinement and was forced to sleep naked on the floor without a mattress. Weremy also observed residents who were chained to the floor as a form of a punishment.

E. KNOWLEDGE OF THE CROWN

32. The Crown failed to reasonably consider or act upon the knowledge or recommendations it had been provided with by its own commissioned reports, residents, family members of residents, and its own professional staff. Further, in addition to failing to provide proper resident care, in all respects, the Crown was also aware of the abuse occurring at MDC yet failed to take any reasonable action to prevent it from continuing or occurring

33. The operational policies and practices of the Crown were inadequate to meet the standard of operating and maintaining a residential facility and, in particular, to meet the needs of the individuals who resided there. As a result, the care provided to the class members and the conditions at the facility were poor, the staff hired were unskilled or unsuitable for dealing developmental disabled persons and the conditions at the facility were not suitable or appropriate for a residential facility for people with developmental disabilities.

F. MISTREATMENT OF RESIDENTS & CONDITIONS OF THE INSTITUTION

34. The persons who were admitted into MDC were typically of varying ages from children to adults. In many cases, they were forced to reside at MDC by the Crown

35. In addition to the incidents of abuse and negligent management or operation of MDC described *supra*, other examples of improper conduct on behalf of the Crown include, but are not limited to, the following:

(a) residents were often not bathed or cleaned;

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

(c) residents were required to perform the routine and ordinary tasks of running the institution;

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

(e) serious shortage of professional staff, falling far behind, appropriate industry and professional standards or ratios;

(f) the institution was overcrowded;

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

(h) residents were forced to continue co-habituating with their assailants, even after reporting abuse;

(i) residents with known dangerous personality traits and tendencies, or traits and tendencies which ought to have been known, were placed in shared rooms with other vulnerable residents;

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

(k) staff assaulted residents;

(l) staff condoned, facilitated and/or encouraged the assaults by residents on other residents;

(m) lavatories lacked doors and often toilet seats; and

(n) for their physical labour in and around the institution, residents were either paid nothing at all or were paid minimal and completely unrealistic wages.

G. DUTIES OWED BY THE CROWN TO THE CLASS

36. In breach of its duty of care and fiduciary obligations, the Crown operated or caused to be operated a residential facility whose residents, including the plaintiff and proposed members of the Class, were systemically subject to abuse, mistreatment and poor living conditions, amongst other things, caused or permitted by the Crown.

37. The Crown had direct contact and daily interaction with the plaintiff and the residents of MDC.

38. As a result of its sole jurisdiction over the operation of MDC, at all material times, the Crown owed a duty of care to the plaintiff and to members of the proposed Class which include, but are not limited to:

(a) adequately, properly and effectively supervising the MDC environment and the conduct of its employees to ensure the residents would not suffer harm;

(b) ensuring that physical, emotional and sexual abuse of residents by staff or other residents would not occur;

(c) protecting MDC residents from any person or thing which would endanger or be injurious to the health and well-being of any resident;

(d) using reasonable care to ensure the safety, well-being and protection of MDC residents;

(e) providing a safe environment and in particular, one free from physical sexual and/or psychological assault or harm;

(f) setting or implementing standards of conduct for its employees and MDC residents to ensure that no employee or resident would endanger the health or well-being of any resident or person;

(g) providing residents a program and system through which abuse would be recognized and/or reported;

(h) educating residents and employees in the use of a system through which abuse would be recognized and reported;

(i) pursuing and investigating complaints of physical, sexual, or psychological abuse with due diligence;

(j) taking any and all reasonable steps to prevent and end physical, sexual, or psychological abuse upon learning of a complaint;

(k) taking any and all reasonable steps to ensure that individuals coming into direct contact with residents of MDC were not in danger of abuse from other residents or employees;

(l) reporting conduct which is allegedly contrary to the *Criminal Code of Canada* to the appropriate law enforcement agency upon learning the particulars of such a complaint; and

(m) providing proper and reasonable treatment for residents upon learning that a resident was abused.

39. At all material times, the Crown was in breach of the aforementioned duties.

40. The Crown knew or ought to have known that, as a consequence of the above-documented failures, that the plaintiff and the residents of MDC would suffer immediate and long-term damages.

41. In addition, the Crown's breach of the duties outlined above condoned, facilitated and/or encouraged the physical, sexual and psychological assaults perpetrated by residents to other residents. Given the duty of care owed and the dependence of the Class on the Crown, the Crown's condoning, facilitating and/or encouraging the physical, sexual and psychological assaults perpetrated by residents to other residents, and the Crown's failure to act to stop such assaults from occurring, the Crown is liable for such assaults as if perpetrated by the Crown itself.

42. These damages were not too remote as they were a direct consequence of the Crown's failures.

H. FIDUCIARY RELATIONSHIP BETWEEN THE CROWN & THE CLASS

43. Furthermore, the Crown owed residents of MDC, as individuals in its sole care and control, a fiduciary duty which included a duty to care for and protect the residents and act in their best interests' at all material times.

44. The Crown had a fiduciary relationship with the residents of MDC. The Crown created, planned, established, set up, initiated, operated, financed, supervised, controlled and regulated MDC during the Class Period.

45. All individuals who resided at MDC were under the complete care and control of the Crown to whom the Crown owed the highest non-delegable, fiduciary, moral, statutory and common law duties, which included, but was not limited to, the duty to ensure that reasonable care was taken of the residents of MDC, the duty to protect residents while at MDC, the duty to protect the resident Class from intentional torts perpetrated on them while at MDC, liability if these non-delegable and fiduciary duties were performed negligently or tortiously and the special responsibility to ensure the safety of the Class while at MDC.

46. Amongst other things, the Crown was solely responsible:

(a) for the administration of the various government departments responsible of the operation of MDC over time, the *Vulnerable Persons Living with a Mental Disability Regulation Act,* C.C.S.M c. V90, as amended its predecessor statutes as well as any other statutes relating to disabled persons and all Regulations

promulgated under these Acts and their predecessors during the Class Period, and the *Mental Health Act,* C.C.S.M c. M110, as amended its predecessor statutes as well as any other statutes relating to disabled persons and all Regulations promulgated under these Acts and their predecessors during the Class Period;

(b) for the promotion of the health, safety and well-being of Class Members during the Class Period;

(c) for the management, operation and administration of the Ministry of Family Services and Labour and their predecessor Ministries and Departments during the Class Period;

(d) for decisions, procedures, regulations promulgated, operations and actions taken by the Ministry of Family Services and Labour and their predecessor Ministries and Departments during the Class Period, their employees, servants, officers and agents and their predecessors during the Class Period;

(e) for the construction, operation, maintenance, ownership, administration, supervision, inspection and auditing of MDC during the Class Period;

(f) for the care and supervision of all members of the resident Class while they resided at MDC during the Class Period and for the supply of all the necessities of life to resident Class Members, *in loco parentis*, during the Class Period.

47. At all material times, the resident class members who resided at MDC were entirely and exclusively within the power and control of the Crown and were subject to the unilateral exercise of the Crown's power or discretion. By virtue of the relationship between the developmentally disabled residents and the Crown, being one of trust, reliance and dependence, by the residents, the Crown owed a fiduciary obligation to ensure that the residents of the facility were treated

respectfully, fairly, safely and in all ways consistent with the obligations of a party standing *in loco parentis* to an individual under his or her care or control.

48. At all material times, the Crown owed a fiduciary duty to the residents at MDC to act in the best interests of those individuals and to protect them from any abuse, including but not limited to, mental, emotional, physical, sexual or otherwise.

49. The individuals who resided at MDC were entitled to rely and did rely upon the Crown to their detriment to fulfill their fiduciary obligations, the particulars of which include, but are not limited to:

(a) the Crown failed to report injuries and the causes thereof sustained by residents of MDC;

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

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

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

(e) the Crown failed to properly supervise the administration and activities of MDC;

(f) the Crown failed to provide adequate support to properly maintain the MDC facilities or to care and provide for its residents;

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

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

(i) the Crown failed to safeguard the physical and emotional needs of the Class Members;

(j) the Crown permitted unhealthy and inappropriate punishments to be perpetrated against the Class Members; and

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

50. The residents of MDC, had a reasonable expectation that the Crown would act in their best interests with respect to their care and the existence and operation of MDC by virtue of the following:

(a) the historic duties of the Crown to individuals deemed mentally incompetent or developmentally challenged;

(b) the unilateral assumption of responsibility for the care of the Class Members and similarly situated persons by the Crown at MDC;

(c) the involvement of the Crown in the initial establishment of MDC;

(d) the long standing dependence of MDC residents on the Crown;

(e) the nature and severity of the mental and physical disabilities experienced by MDC residents;

(f) the fact that the MDC environment was itself further disabling to these individuals, physically, emotionally and psychologically;

(g) the vulnerability of MDC residents as a result of their range of disabilities;

(h) the involuntary nature of the relationship between MDC residents and the Crown.

51. The Crown knew, or ought to have known, that as a consequence of its operation, care and control of MDC, that residents of MDC would suffer both immediate and long-term mental, emotional, psychological and physical harm.

52. In addition, the Crown's failure to fulfill its fiduciary duties outlined above condoned, facilitated and/or encouraged the physical, sexual and psychological assaults perpetrated by residents to other residents. Given the fiduciary duty owed and the dependence of the Class on the Crown, the Crown's condoning, facilitating and/or encouraging the physical, sexual and psychological assaults perpetrated by residents to other residents, and the Crown's failure to act to stop such assaults from occurring , the Crown is liable for such assaults as if perpetrated by the Crown itself.

I. VICARIOUS LIABILITY

53. The Crown is vicariously liable for the physical, sexual and psychological abuse committed by its servants, employees, agents and representatives to residents of MDC.

54. By virtue of its quasi-parental, or in *loco parentis*, responsibility for the safety, care and control of residents, the Crown is vicariously liable for the harms perpetrated upon residents by the Crown's servants, employees, representatives and agents.

55. The relationship between the Crown and its servants, employees, agents and representatives was close and direct. The Crown exercised or ought to have exercised control over its employees, agents and representatives including the power of assignment and supervision, the power to remove and the power to discipline them.

56. The Crown's servants, employees, agents and representatives were afforded the opportunity to abuse their power over and to physically, sexually, and psychologically abuse residents of MDC by virtue of their relationship with the Crown:

(a) they were constantly placed in direct contact with residents of MDC;

(b) they were provided with opportunities to physically, sexually, and psychologically abuse residents of MDC by virtue of their employment or representation of the Crown;

(c) the physical, sexual, and psychological abuse committed by the Crown's employees, agents and representatives took place while the residents of MDC were participating in programs or activities required by the Crown;

(d) they were permitted to be alone with the residents of MDC and supervise them in intimate activities, such as bathing and toileting;

(e) by virtue of their roles with the Crown, its servants, employees, agents and representatives were conferred with power over residents of MDC, including power to organize, discipline, and train them; and

(f) by virtue of their power and authority as servants, employees, agents and representatives of the Crown, they were allowed and encouraged to exercise a degree of control over the residents of MDC that was parental in nature.

57. The Crown's servants, employees, agents and representatives' physical, sexual, and psychological abuse was directly related to the friction, confrontation and psychological intimacy inherent in their roles:

(a) the Crown was responsible for disciplining the residents of MDC;

(b) the Crown encouraged physical and psychological intimacy between its servants, employees, agents and representatives and the residents of MDC;

(c) the Crown's servants, employees, agents and representatives and the residents of MDC were in a parent-like and role-model relationship;

(d) the Crown's servants, employees, agents and representatives taught the plaintiff and the residents of MDC the differences between right and wrong and they represented authority figures to them; and

(e) this psychological intimacy encouraged the plaintiff and the residents of MDC'S submission to the Crown's servants, employees, agents and representatives abuse increased their opportunity to physically, sexually, and psychologically abuse the plaintiff and the residents of MDC.

58. The Crown conferred significant power on its servants, employees, agents and representatives relative to the residents of MDC who were vulnerable to the wrongful exercise of their power, in part because:

(a) the residents of MDC were disabled;

(b) the length of the residents of MDC's residence was indeterminate;

(c) the Crown required the exercise of power and authority for its own successful operation, and it required and encourages its servants, employees, agents and representatives to stand in a position of respect, which was required for the successful operation of MDC; and

(d) MDC was located in a geographically isolated area, which enhanced the opportunity for, extent, and frequency of physical, sexual, and psychological abuse remaining unchecked for years.

59. The relationship between the Crown's servants, employees, agents and representatives and the Crown was close and direct. The connection between the Crown's servants, employees, agents and representatives and the Crown created and enhanced the risk of physical, sexual and psychological abuse.

60. In addition to the direct physical, sexual and psychological assaults committed by its servants, employees, agents and representatives to residents of MDC, those Crown servants, employees, agents and representatives condoned, facilitated and/or encouraged the physical, sexual and psychological assaults perpetrated by residents to other residents. Given the relationship between the Crown and its servants, employees, agents and representatives and the class, and given the Crown's knowledge of the physical, sexual and psychological assaults perpetrated by residents to other residents and the Crown's and the Crown's servants, employees, agents and representatives' failure to act to stop such assaults from occurring, the Crown is vicariously liable for the physical, sexual and psychological assaults perpetrated by residents to

other residents that were condoned, facilitated and/or encouraged by its servants, employees, agents and representatives.

J. DAMAGES SUFFERED BY THE CLASS

61. The Crown knew, or ought to have known, that as a consequence of its negligent operation of MDC and mistreatment of the Class, that those individuals would suffer significant mental, emotional, psychological and spiritual harm which would adversely affect their relationships with their families and the community at large.

62. Members of the Class were physically, mentally, emotionally and spiritually traumatized by their experiences arising from their residence at MDC. As a result of the negligence and breach of fiduciary duty of the Crown and its failure to provide proper and adequate care or supervision, the Class members suffered and continue to suffer damages which include, but are not limited to the following:

(a) emotional, physical, sexual and psychological abuse;

(b) exacerbation of mental disability and deprivation of healing opportunities;

(c) impairment of mental and emotional health and well-being;

(d) an impaired ability to trust other persons;

(e) a further impaired ability to participate in normal family affairs and relationships;

(f) depression, anxiety, emotional distress and mental anguish;

(g) pain and suffering;

(h) a loss of self-esteem and feelings of humiliation and degradation;

(i) an impaired ability to obtain and sustain employment, resulting either in lost or reduced income and ongoing loss of income;

(j) an impaired ability to deal with persons in positions of authority;

(k) an impaired ability to trust other individuals or to sustain relationships;

(l) a sense of isolation and separateness from their community;

(m) a requirement for medical or psychological treatment and counselling;

(n) an impaired ability to enjoy and participate in recreational, social and employment activities;

(o) loss of friendship and companionship;

(p) sexual disorientation; and

(q) the loss of general enjoyment of life.

63. At all materials times, the Crown has known, or ought to have known that failing to rectify the institutional failures would continue to aggravate and contribute to the Class members' injuries and damages.

64. As a result of the aforementioned injuries, Class members have required and will continue to require further medical treatment, rehabilitation, counselling and other care. The Plaintiff and other Class Members, or many of them, will require future medical care and/or rehabilitative treatment, or have already required such services, as a result of the Crown's

conduct for which they claim complete indemnity, compensation and payment from the Crown for such services.

65. The Crown is strictly liable in tort for the damages set out above as the Crown was aware that residents of MDC were being physically, emotionally and psychologically abused but permitted the abuse to occur. Further, the Crown is strictly liable in tort for the damages enumerated herein as the Crown was aware that its operation, management and control of MDC was in breach of all mental health industry standards and in breach of the duties it owed to the Class Members.

K. PUNITIVE DAMAGES

66. The high handed and callous conduct of the Crown warrants the condemnation of this Honourable Court. The Crown conducted its affairs with wanton and callous disregard for the class members' interests, safety and well-being. In all the circumstances, the Crown breached, and continues to breach, its fiduciary duty and duty of good faith owed to MDC residents.

67. Over a long period of time, the plaintiff and the Class Members were treated in a manner that could only result in aggravated and increased mental stress and anxiety for vulnerable persons already suffering from some degree of mental disability. The anxiety, depression and sub-standard conditions to which the Plaintiff and Class Members were exposed to has grossly violated their rights and severely altered the paths of their lives.

68. In these circumstances, the Plaintiff and the Class Members request aggravated and punitive damages to demonstrate to other institutions that such wilfully irresponsible and tortious behaviour will not be tolerated and will act as a deterrent to other institutions in Canada who are in the position of acting as caregivers to likewise vulnerable populations of individuals with

disabilities. These individuals, by virtue of both disability and of social and institutional structures, are among the most vulnerable in Canadian Society.

69. This action is commenced pursuant to the *Class Proceedings Act.*

70. The trial of the action should take place in the city of Winnipeg, in the Province of Manitoba.

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