Court File No.: »

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Toronto

ONTARIO
SUPERIOR COURT OF JUSTICE

SIMON NISBET AS LITIGATION GUARDIAN OF DOREEN NISBET

Plaintiff

- and -

HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF ONTARIO

Defendant

Proceeding under the *Class Proceedings Act, 1992*

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 an Ontario lawyer acting for you must prepare a statement of defence in Form 18A prescribed by the *Rules of Civil Procedure*, serve it on the plaintiff's lawyer or, where the plaintiff does not have a lawyer, serve it on the plaintiff, and file it, with proof of service, in this court office, WITHIN TWENTY DAYS after this statement of claim is served on you, if you are served in Ontario.

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.

Instead of serving and filing a statement of defence, you may serve and file a notice of intent to defend in Form 18B prescribed by the *Rules of Civil Procedure*. This will entitle you to ten more days within which to serve and file your statement of defence.

IF YOU FAIL TO DEFEND THIS PROCEEDING, JUDGMENT MAY BE GIVEN AGAINST YOU IN YOUR ABSENCE AND WITHOUT FURTHER NOTICE TO YOU. IF YOU WISH TO DEFEND THIS PROCEEDING BUT ARE UNABLE TO

PAY LEGAL FEES, LEGAL AID MAY BE AVAILABLE TO YOU BY CONTACTING A LOCAL LEGAL AID OFFICE.

IF YOU PAY THE PLAINTIFF'S CLAIM, and $100,000 for costs, within the time for serving and filing your statement of defence, you may move to have this proceeding dismissed by the court. If you believe the amount claimed for costs is excessive, you may pay the plaintiff's claim and $400.00 for costs and have the costs assessed by the court.

TAKE NOTICE: THIS ACTION WILL AUTOMATICALLY BE DISMISSED if it has not been set down for trial or terminated by any means within five years after the action was commenced unless otherwise ordered by the court.

Date: June 29, 2020

Issued by _____
Local registrar

Address of court office 393 University Avenue
10th Floor
Toronto, ON

TO: **HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF ONTARIO**
Crown Law Office – Civil Law
720 Bay Street
8th Floor
Toronto, ON M5G 2K1
Tel.: 416-325-8535
Fax: 416-326-4181

CLAIM

1. The Plaintiff claims:

(a) an order certifying this action as a class proceeding pursuant to the *Class Proceedings Act, 1992*, S.O. 1992, c. 6 (**"*CPA*"**), and appointing the Plaintiff as the representative plaintiff for the Class;

(b) an aggregate assessment of damages in the amount of $500,000,000.00 for:

(i) negligence;

(ii) breach of fiduciary duty; and

(iii) breaches of sections 7 and 15 of the *Canadian Charter of Rights and Freedoms*.

(c) exemplary, punitive and/or aggravated damages in an amount that this Court finds appropriate at the trial of the common issues or at a reference or references;

(d) an order directing a reference or giving such other directions as may be necessary to determine issues not determined at the trial of the common issues;

(e) prejudgment and post judgment interest pursuant to the *Courts of Justice Act*, R.S.O. 1990, c. C.43 (**"*CJA*"**);

(f) costs of this action on a substantial indemnity basis or in an amount that provides full indemnity;

(g) pursuant to section 26(9) of the *CPA*, the costs of notice and of administration;

(h) plan of distribution of the recovery in this action plus applicable taxes; and,

(i) such further and other relief as this Honourable Court may deem just.

OVERVIEW

2. The Defendant Ontario has failed to adequately regulate and oversee long-term care ("**LTC**") homes in Ontario, resulting in widespread and avoidable illness, suffering and death among residents due to COVID-19.

3. LTC home residents are among the most vulnerable persons to COVID-19. Ontario knew from before the outbreaks began that the elderly and those with underlying health conditions were most at risk of developing severe symptoms and dying from the virus if infected. Nearly all LTC home residents are elderly, have a co-morbidity, or both. The importance of taking early, decisive action to protect LTC home residents could not have been clearer.

4. Ontario's longstanding systemic failures to properly regulate and oversee LTC homes across the province meant the system was primed for rapid spread of a disease like COVID-19. The LTC home system suffers from chronic understaffing. Precarious work conditions force staff to work part-time, low paying jobs, at multiple LTC homes, creating the conditions for community spread of the virus within the system. Ontario has acknowledged this staffing "crisis" has existed for years. LTC homes also lack the space to isolate sick residents, as many residents share cramped areas for sleeping, living and dining. Ontario has systematically reduced the number and quality of inspections of LTC homes. Ontario knew or ought to know this would erode the standards of practice necessary to protect LTC home residents from the harms of infectious disease.

5. Before COVID-19 took hold, Ontario failed to ensure that LTC homes had access to sufficient supplies of personal protective equipment ("**PPE**"). Without critical PPE it was impossible for LTC home workers to care for residents, in close-contact, without risking spread of the virus. The need for front-line care workers to have adequate medical supplies and PPE was specifically highlighted by the SARS Commission following the 2003 outbreak of that deadly disease. Ontario had no excuse for being unprepared.

6. What protective measures Ontario did implement were inadequate and ultimately too little too late. Comparable jurisdictions like British Columbia took early, decisive action and suffered a fraction of Ontario's tragedy.

7. Since the emergence of COVID-19 Ontario has repeatedly assured LTC home residents and their families that every reasonable step necessary to protect residents from the virus was being taken. It wasn't true. Ontario's actions did not match its bluster – no "iron ring" was built around LTC homes – resulting in tragic consequences for residents and their families. The failures were many and they must never happen again.

THE PARTIES

8. The Plaintiff is Doreen Nisbet, by her litigation guardian Simon Nisbet. The Plaintiff is 89 years old and is a former resident at Orchard Villa LTC home in Pickering, Ontario, who tested positive for COVID-19 while living in the home.

9. The Defendant, Her Majesty the Queen in right of the Province of Ontario (**"Ontario"** or the **"Province"**) is named in these proceedings pursuant to the provisions of the *Crown Liability and Proceedings Act*, 2019, S.O. 2019, c. 7, Sched. 7 (the **"*CLPA*"**), and the amendments thereto. Notice has been given to the Crown pursuant to section 18 of that legislation.

10. At all material times, Ontario was responsible for overseeing LTC homes in Ontario, pursuant to the *Long Term Care Home* Act, 2007, S.O. 2007, c. 8 (the **"Act"**) and Ontario Regulation 79/10 (the **"Regulation"**).

11. The Plaintiff brings this action pursuant to the *Class Proceedings Act, 1992* on their own behalf and on behalf of:

> All individuals who reside or resided in LTC homes in Ontario where one or more individuals tested positive for COVID-19 (the **" Class Members"**)
>
> All parents, spouses, siblings and children of Class Members (the **"Family Class"**)

BACKGROUND

Coronaviruses and COVID-19

12. Coronaviruses are a large family of viruses that cause respiratory illnesses.

13. COVID-19 is an infectious respiratory disease caused by the most recently discovered coronavirus.

14. COVID-19 can cause mild symptoms including fever, cough and tiredness. Other mild symptoms include aches and pains, nasal congestion, headache, conjunctivitis, sore throat, diarrhea, loss of taste or smell or a rash on skin or discoloration of fingers or toes.

15. Some people who become infected only have mild symptoms, and some people become infected but do not develop any symptoms and do not feel unwell.

16. COVID-19 can also become more severe and lead to pneumonia or breathing difficulties that may require medical attention or hospitalization. Around 1 out of every 5 people who gets COVID-19 becomes seriously ill and develops difficulty breathing.

17. In severe cases, infection can lead to death.

18. There is an increased risk of more serious illness and severe outcomes for older adults, and those with compromised immune systems or underlying medical conditions.

19. Seniors are at an increased risk of more severe respiratory illness because their immune systems are weaker due to age, and they are more likely to have underlying health conditions and chronic illnesses. This reduces their ability to cope with and recover from the illness.

20. People can contract COVID-19 from others who have the virus. The disease is most commonly spread from person to person through respiratory droplets from the nose or mouth, generated when a person with COVID-19 coughs, sneezes or speaks. Individuals can catch COVID-19 if they breathe in these droplets from an infected person.

21. These respiratory droplets can also land on objects and surfaces. People can become infected by touching these objects or surfaces, and then touching their eyes, nose or mouth. From there, the virus can enter an individual's body and infect them.

22. COVID-19 is easily spread, person to person, when two or more people spend time in enclosed spaces.

23. The time between exposure to COVID-19 and development of symptoms is typically around 5 to 6 days, but symptoms may take up to 14 days to appear.

24. The virus can be transmitted to others from someone who is infected but not showing symptoms, including those who have not yet developed symptoms and those who never develop symptoms.

25. Early and aggressive protective action is critical to prevent the spread of COVID-19 within vulnerable populations. Once COVID-19 establishes in a community it spreads exponentially without aggressive social distancing measures. The cruel math of exponential spread means that even small delays in implementing protective measures, particularly within population settings like LTC homes where the virus spreads more easily, result in many more people ultimately becoming infected.

26. Absent protections, one infected person on average spreads the virus to 2.5 people within the first five days they are infectious. The spread then radiates outward until 406 people total are infected within 30 days. In contrast, if protective measures reducing the spread by 75% are in place, the one infected person only infects on average 0.625 people during the first five days, and the further spread is limited to 2.5 people total within 30 days.

27. COVID-19 is a serious health threat and the risk to Canadians at this time is considered high.

28. As of the date this claim is issued, there is no specific treatment for the virus.

Vulnerability of LTC home residents in Ontario

29. Residents of LTC homes in Ontario are particularly vulnerable to becoming infected with COVID-19 due to systemic factors the prevail across LTC homes, including but not limited to:

(a) The LTC home system suffers from chronic understaffing. For years Ontario has known that a "staffing crisis" exists because there are too few personal support workers (PSWs) and nurses in the LTC home system to adequately care for residents. These limited resources become even more stretched during a serious outbreak of disease.

(b) Precarious work conditions force many staff to work part-time, low paying jobs, at multiple LTC homes. LTC home staff do not have paid sick days and suffer financially if they do not show up to work even when symptomatic. These conditions facilitate the rapid spread of infectious diseases within the system.

(c) The understaffed LTC home system relies on extensive support provided by third parties, namely the families and loved ones of residents. If an outbreak of disease prevents those persons from providing that support, LTC homes are not able to adequately care for residents.

(d) The LTC homes themselves are ill-designed and ill-equipped to manage outbreaks of highly infectious and deadly diseases. The buildings lack the space to isolate sick residents. Many residents live with three other residents in four-bed rooms. Meals are typically served in common areas. LTC homes lack the necessary PPE to enable staff provide care to residents in close-contact while also preventing the spread of COVID-19;

(e) Ontario has reduced the number and quality of inspections of LTC homes across the province. In particular, Ontario has failed to conduct sufficient unannounced comprehensive inspections of LTC homes.

(f) The LTC homes are inadequately overseen, leading to widespread routine failure to observe policies and best practices for prevent the spread of infectious diseases.

30. Residents of LTC homes in Ontario are particularly vulnerable to severe negative health outcomes if they become infected with COVID-19 for reasons including but not limited to:

(a) Most LTC home residents are over 85 years old (over 55%), placing them in the highest overall risk bracket for COVID-19, with a further 27% over 75 years old;

(b) Over 76% of LTC home residents have heart/circulation diseases that increase the risk of a severe outcome if they contract COVID-19;

(c) Over 64% of LTC home residents have hypertension that increases the risk of a severe outcome if they contract COVID-19;

(d) Over 28% of LTC home residents have diabetes that increases the risk of a severe outcome if they contract COVID-19; and

(e) LTC home residents who become isolated from their family and loved ones because their home has failed to prevent the spread of COVID-19 into and within the facility are at higher risk of death due to the despair and despondency of suffering alone.

Timeline of the Outbreak

31. On December 31, 2019, the World Health Organization (the "**WHO**") was alerted to an outbreak of pneumonia in Wuhan, China, with an unknown cause.

32. On January 4, 2020, the WHO reported that there was a cluster of pneumonia cases in Wuhan, Hubei.

33. On January 5, 2020, China announced that the unknown pneumonia cases were not SARS or MERS. That same day, the WHO published their first Disease Outbreak News on the new virus containing risk assessment and advice.

34. On January 7, 2020, Chinese authorities identified the cause of the outbreak as a new coronavirus that did not match any other known virus. The disease has since been named COVID-19.

35. On January 10, 2020, the WHO issued technical guidance and advice on how to detect, test and manage potential cases, in addition to infection and prevention control guidance.

36. On January 11, 2020, China reported its first known death from an illness caused by the coronavirus. The patient was 61 years old.

37. On January 13, 2020, officials confirmed the first recorded case of COVID-19 outside of China.

38. On January 14, 2020, the WHO reported there may be limited human-to-human transmission of COVID-19.

39. On January 22, 2020, the WHO issued a statement that there was evidence of human-to-human transmission in Wuhan.

40. On January 23, 2020, the WHO convened the Emergency Committee to consider the outbreak of coronavirus in China. That same day, the first presumptive case in Canada was admitted to a hospital in Ontario.

41. On January 25, 2020, Ontario (and Canada) confirmed its first case of COVID-19 related to travel within Wuhan, China.

42. On January 28, 2020, Ontario issued its first COVID-19 guidance to LTC homes. The guidance requested the LTC homes prepare for screening of residents for COVID-19, through asking questions and signage.

43. On January 30, 2020, the WHO declared the outbreak of COVID-19 a public health event of international concern.

44. By January 31, 2020, Epidemiological data from researchers based in the United Kingdom and China showed that older adults were at a greater risk of dying from the virus.

45. On January 31, 2020, Ontario issued *Novel Coronavirus (2019-nCOV) Fact Guidance for Long-Term Care*, which explicitly recognized the special vulnerability of LTC home residents given their age, frailties and chronic conditions which weaken their immune systems. The guidance to LTC home operators recommended passive measures, such as signage and review of infection prevention policies.

46. On February 2, 2020, the first coronavirus death was reported outside China.

47. On February 9, 2020, the death toll from coronavirus surpassed the toll from the SARS epidemic of 2002-2003.

48. On February 10, 2020, the WHO warned that countries should prepare for the spread of COVID-19 to accelerate outside of China.

49. On February 13, 2020, Ontario's Minister of Long-Term Care publically recognized the "severe shortage of personal support workers and other key roles" within LTC homes. She stated with respect to LTC home residents, "their well-being and their safety is paramount for me, for the ministry and for the government."

50. On February 15, 2020, the WHO addressed the Munich Security Conference about COVID-19, warning that the pathogen has pandemic potential.

51. On February 17, 2020, the WHO issued guidance on mass gatherings and taking care of ill travellers.

52. On February 18, 2020, the WHO shipped supplies of personal protective equipment to 21 countries. That same day, Health officials in China published the results of a study of all cases diagnosed as of February 11, 2020. The study showed that 2.3% of

confirmed cases died. However, the fatality rate amongst individuals aged 80 or older was the highest, at 14.8%. By contrast, the fatality rate was 1.3% in individuals aged 50-59, 0.4% in individuals aged 40-49, and 0.2% in individuals aged 10 to 39.

53. On February 19, 2020, the first outbreak of COVID-19 at a LTC home in North America was reported at Life Care Center nursing home in Washington State.

54. On February 20, 2020, Canada confirmed its first case of COVID-19 related to travel outside mainland China.

55. On February 21, 2020, Dr. Tedros Adhanom Ghebreyesus emphasized that the window of opportunity to contain the outbreak was "narrowing" and the international community needed to act quickly.

56. On February 26, 2020, two residents at Life Care Center nursing home in Washington passed away after contracting COVID-19. By February 29, 2020, twenty-seven residents and twenty-five staff members were showing symptoms of the virus, and 4 residents had died.

57. On February 27, 2020, Canada confirmed the first human-to-human transmission. That same day, Canada's Chief Public Health Officer, Dr. Theresa Tam, said the window to contain COVID-19 was closing.

58. On February 28, 2020, the WHO published the *Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19)*. The report recommended that governments "Ensure processes are in place for infection prevention among the most vulnerable, including the elderly", and noted that China had developed guidelines for elderly care specifically targeting prevention in individuals and introduction of COVID-19 to nursing homes.

59. Also on February 28, 2020, the WHO increased the risk assessment of COVID-19 across all countries to its highest level of alert, "very high".

60. On March 5, 2020, the first outbreak in a Canadian long-term care home was reported in British Columbia.

61. On March 9, 2020, Canada's first death from COVID-19 was reported. The victim was a man in his 80s, who resided in a long-term care home in British Columbia.

62. That same day, Ontario issued for the first time guidance to LTC homes to begin conducting screening of visitors, resident admissions, re-admissions and returning residents, for symptoms and question them as to their recent travel history. Staff were not covered by this screening guidance. Nor did the guidance make any special provision for testing of LTC home residents or staff.

63. On March 11, 2020, the WHO declared the global outbreak of COVID-19 a pandemic.

64. That same day, Ontario's Minister of Health issued a statement representing that:

(a) the Ministry of Health and the Ministry of Long-Term Care (the "**Ministry**") were working together in close cooperation with LTC homes to ensure the continued safety and well-being of residents, families and staff;

(b) LTC homes enforce rigorous provincial standards for all public health concerns, including outbreak management systems for detecting, managing, and controlling infectious disease outbreaks; and

(c) The health and well-being of Ontarians, including long-term care residents, their families, and staff, is the government's number one priority.

65. On March 11, 2020, Ontario recorded its first death attributed to COVID-19. The victim was a 77-year old man. Ontario extended its screening guidance to cover LTC home volunteers and staff.

66. On March 13, 2020, Ontario recommended that LTC homes only allow essential visitors until further notice. No mandatory order was made to that effect.

67. On March 16, 2020, the WHO urged countries to increase testing for COVID-19.

68. That day, Ontario's Minister of Health and Minister of Long-Term Care issued a statement representing that "all necessary precautions" were being taken to ensure LTC homes residents were safe and secure.

69. On March 17, 2020, Ontario declared a state of emergency and ordered many businesses to close. Gatherings of more than 50 people were prohibited. That same day, Ontario confirmed its first death related to COVID-19, a 77-year old man. British Columbia announced that it was moving to restrict visitors in LTC homes to essential visitors only.

70. On March 18, 2020, British Columbia confirmed another seven deaths linked to a LTC home in Vancouver. Ontario recommended but did not order 14 days of self-isolation for health-care workers who have travelled internationally, but does not make it mandatory.

71. On March 19, 2020 Ontario confirmed another four residents tested positive for COVID-19 in a LTC home in Ottawa.

72. On March 20, 2020, an outbreak was declared at a LTC home in Bobcaygeon, Ontario. Nine residents and one volunteer had died, and 34 staff members had symptoms or tested positive.

73. As early as March 21, 2020, British Columbia Health Authorities were issuing orders prohibiting LTC staff and volunteers from working at more than one LTC home, requiring facilities to deny access to all visitors to the facility, with the exception of immediate family members and spiritual advisors of residents at the end of their lives, prohibiting resident transfers between health care facilities, requiring facilities to carry out enhanced cleaning of facilities and enhanced screening of staff, contractors and visitors, and to adhere to higher standards for notification of cold and flu-like illnesses, and cancelling or postponing all group social activities.

74. On March 22, 2020, Ontario recommended without requiring that LTC homes limit, wherever possible, the number of work locations that employees are working at.

The Province also recommended LTC homes not permit residents to leave the home for short-stay absences to visit family and friends. No orders were made to that effect.

75. On March 23, 2020, Ontario issued a temporary order under the March 17, 2020 declaration of emergency giving LTC homes the ability to identify staffing priorities and develop, modify and implement redeployment plans.

76. By March 24, 2020, there had been two deaths reported in Ontario's LTC homes related to COVID-19.

77. On March 24, 2020, the Minister of Long-Term Care represented that Ontario would put in place "any process necessary" to our fight against COVID-19 outbreaks to protect "our province's most vulnerable." The Minister of Health stated that Ontario had been working with LTC home operators for "several months" to put processes in place to contain this virus and be ready to respond to any scenario. No details about the several months' worth of work were provided.

78. On March 26, 2020, British Columbia made mandatory orders limiting movement of staff at LTC homes, to ensure that staff work in only one facility, and requiring all operators to hand over a staff roster to the Ministry of Health.

79. That same day, Ontario issued a second temporary order relieving licensed LTC homes from reporting, documentation and care requirements, and providing LTC homes with greater flexibility regarding staffing, admissions, transfers and discharges.

80. On March 27, 2020, when asked why Ontario does not order testing on all residents of LTC homes where outbreaks are declared, Ontario's associate chief medical officer of health responded that they do not want to use up their limited lab resources to test everybody when they already know what the cause of the outbreak is.

81. That same day, Ontario's Health Minister acknowledged that most deaths so far had been with more elderly individuals who had underlying health issues and further that it was important to protect those vulnerable populations, particularly those in LTC homes.

82. On March 28, 2020, the Minister of Long-Term Care represented that Ontario would not stop acting to keep LTC residents and staff are safe and secure.

83. On March 30, 2020, Ontario's Premier (the **"Premier"**) announced that there had been an increase in outbreaks and deaths at LTC homes in the past few days. The Premier acknowledged the need to put an "iron ring of protection around seniors, especially those at LTC homes" and further stated "we must do everything we can to prevent further spread in these homes."

84. Also on March 30, 2020, Ontario's associate chief medical officer of health stated "we <u>always knew</u> that the population in LTC homes is a particularly vulnerable, high risk population, for serious illness, complications and even death." The associate chief medical officer represented that Ontario was working with facilities to increase resources and practices in place.

85. By that date, nine residents in just one LTC home in Ontario had already passed away due to COVID-19, and over thirty-four workers had symptoms of the virus.

86. On March 31, 2020, the Premier again acknowledged the need to protect seniors "at all costs". Ontario's Health Minister represented that Ontario would "leave no stone unturned" to make sure seniors living in LTC homes receive the protection they deserve. By that date, Ontario still did not require testing of all residents and staff in LTC homes nor did they require workers to only work in one home.

87. Also on March 31, 2020, when asked why PSWs were not being supplied PPE in LTC homes, Ontario's chief medical officer of health responded that workers do not need to wear PPE every day when there is not an outbreak, as long as the other measures put in place were being followed. By that date, it was well-known that the virus could be spread by asymptomatic carriers, and workers were not restricted to working in only one home.

88. On that same day, the associate chief medical officer of health announced, while acknowledging that these statistics were not up to date, that there were ten LTC homes with outbreaks and one-third of the deaths in the Province were in LTC homes.

89. On April 1, 2020, Ontario's Health Minister stated that the Province was very concerned about the outbreaks in LTC homes and acknowledged that residents are a "very, very vulnerable" group of people that the Province needs to "protect, absolutely." She further acknowledged that the government had more work to do to protect seniors in LTC homes. By that date, outbreaks had been reported in 26 LTC homes in Ontario, cases had been reported among 163 residents, and 18 residents had died from the virus.

90. On April 2, 2020, COVID-19 cases surpassed 1 million worldwide, with over 50,000 confirmed deaths. That same day, Canada surpassed 10,000 confirmed cases.

91. On April 8, 2020, Ontario directed, for the first time, that all staff and essential visitors at LTC homes should wear masks at all times. The guidelines also provided for staff and resident cohorting. By that date, outbreaks had been reported in 69 LTC homes in Ontario, cases had been reported among 498 residents, and 86 residents had died from the virus.

92. Also by April 8, 2020, Ontario's daily testing levels had fallen to 3,000 or below, about 10,000 fewer than the stated capacity. The Premier acknowledged that these numbers were "absolutely unacceptable", and that other "countries that have tested and ramped up testing have shown results". Despite the capacity to ramp up testing and despite many public pleas to do so, Ontario still did not require tests for all residents or health care workers, even in LTC homes with an outbreak.

93. On April 9, 2020, Ontario released a directive requiring LTC homes to provide workers with information on the safe utilization of PPE, to assess the supply of PPE on an ongoing basis, and to develop contingency plans if there is a shortage of PPE.

94. That same day, Ontario finally released guidance on testing in LTC homes. By that date, outbreaks had been reported in 73 LTC homes in Ontario, cases had been reported among 560 residents, and 98 residents had died from the virus.

95. By April 13, 2020, Ontario still did not require testing of all residents and staff in LTC homes nor did they require workers to only work in one home. That day, Ontario's associate chief medical officer of health said that testing everyone in the system could

result in "wasting a lot of tests that should be done on other people who are in an outbreak situation." The associate chief medical officer of health stated that the fact that workers were still working in multiple homes in Ontario is "definitely" contributing to the outbreaks. She stated that stopping the practice would make a difference. Despite this, the practice would not be implemented for another nine days.

96. By that date, outbreaks had been reported in 93 LTC homes in Ontario, cases had been reported among 813 residents, and 135 residents had died from the virus.

97. On April 14, 2020, the Chief Public Health Officer of Canada announced that nearly 50% of COVID-19 deaths in Canada were LTC home residents. She warned that the deaths would continue to increase, even as the epidemic growth rate slows. By that date, there had already been twenty-eight deaths at just one LTC home in Ontario alone.

98. Also on April 14, 2020, Ontario extended the state of emergency for another four weeks through May 12, 2020. Ontario amended the existing emergency order for work deployment measures in LTC homes to prevent employees from working at more than one LTC home. This order did not come into effect until April 22, 2020, almost one month after British Columbia issued orders restricting staff to one facility, and twenty days after Quebec announced its rules restricting workers to one facility. The order also left loopholes for temporary workers.

99. By April 14, 2020, outbreaks had been reported in 98 LTC homes in Ontario, cases had been reported among 834 residents, and 144 residents had died from the virus. By that date, about 40% of all COVID-19 cases in Ontario involved individuals aged 60 or older.

100. On April 15, 2020, COVID-19 cases surpassed 2 million cases worldwide. By that date, Ontario was still only recommending that testing for COVID-19 be done on symptomatic residents and staff in the LTC home. The Province continued to recommend against testing of asymptomatic residents or staff, with the exception of those who were a close contact of a known case.

101. By April 16, 2020, outbreaks had been reported in 106 LTC homes in Ontario, 1,229 cases had been reported among residents, and 216 residents had died from the virus.

102. On April 17, 2020, Ontario rejected calls to take over operations at long term care homes where large numbers of residents have died.

103. By April 18, 2020, outbreaks had been confirmed in 112 LTC homes in Ontario, cases had been reported among 1,272 residents and 240 residents had died from the virus.

104. On April 20, 2020, Ontario released projections on the spread of COVID-19 in Ontario and acknowledged the spread of the virus was accelerating in LTC homes.

105. On April 21, 2020, Ontario announced that it would begin "proactive" testing in LTC homes. By that date, the Ontario Health Coalition reported 155 LTC home outbreaks, and Public Health Ontario had reported 1,587 cases among residents and 295 resident deaths.

106. On April 22, 2020, Ontario announced that it had to call in the Canadian Armed Forces (the **"CAF"**) to stop the spread of COVID-19 in some of Ontario's LTC homes.

107. On April 23, 2020, Ontario extended its emergency orders through May 6, 2020.

108. On April 24, 2020, Ontario issued a directive requiring all LTC homes in outbreak to cooperate with Ontario Health and to provide entry to staff and any resources being made available from the federal government or public hospitals. Ontario issued an emergency order enabling hospitals to support LTC homes.

109. By April 27, 2020, outbreaks had been confirmed in 170 LTC homes in the province, 2,346 cases had been confirmed among residents, and 498 residents had died from the virus.

110. By May 2, 2020, outbreaks had been confirmed in 209 LTC homes in Ontario, 2,488 cases had been confirmed among residents, and 590 residents had died from the virus.

111. On May 9, 2020, Ontario issued an emergency order to enable school board employees to be voluntarily redeployed to congregate care settings during the COVID-19 pandemic, including LTC homes.

112. On May 13, 2020, Ontario issued an emergency order giving the Province the power to appoint temporary managers to any LTC homes struggling with COVID-19 outbreaks. Ontario has not used this authority.

113. On May 19, 2020, Ontario extended emergency orders through May 29, 2020. That same day, Ontario announced that it will launch an independent commission in September to investigate how the province's LTC system responded to the pandemic.

114. On May 25, 2020, Ontario issued an order appointing local hospitals to temporarily manage two long-term care homes in Ontario for 90 days.

115. On May 26, 2020, the CAF released a report on disturbing conditions in five Ontario LTC homes. The report highlighted the following concerns:

(a) shortages of PPE;

(b) staffing shortages;

(c) staff being overworked, burnt out and having no time off;

(d) a culture of fear to use supplies;

(e) the need for more PSWs, RPN and RNs;

(f) COVID-19 positive residents being allowed to wander, risking exposure and spread of the virus; and

(g) COVID-19 positive residents rooming with negative residents.

116. On May 28, Ontario's Minister of Long-Term Care acknowledged publically that the LTC home system had been in a "staffing crisis" with too few staff "for years".

ONTARIO'S PROXIMATE RELATIONSHIP TO LTC HOME RESIDENTS

117. All LTC homes in Ontario are governed by the Act and Regulation. The Act and Regulation provide a complete and comprehensive scheme in respect the operation of LTC homes in Ontario.

118. The fundamental principle under the Act is that a LTC home is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met.

119. The Act and its Regulation were intended to strengthen residents' rights and safeguards; standards of care; and the compliance, inspection and enforcement regime.

120. Ontario, through the Ministry, created and oversees the system in place controlling the creation and operation of LTC homes in the Province.

121. Ontario is responsible for funding, regulating, licensing and inspecting of all LTC homes in the Province.

122. Under the Act, it is an offence to operate a LTC home without a license. Ontario is responsible for licensing all LTC homes in Ontario. The Province has the authority to restrict who may be issued a license, particularly when a home does not comply with the Act and Regulation or where there are reasonable grounds to believe the home will not be operated in accordance with the law and with honesty and integrity.

123. Ontario is responsible for safeguarding residents' rights, safety, security and quality of life. Specifically, Ontario must ensure that LTC homes comply with the Act and Regulation. Ontario is required to conduct annual inspections of each home, and has the authority to conduct unannounced inspections. Ontario is also responsible for inspecting complaints and critical incidents reported at LTC homes.

124. Ontario has, through statute and conduct, undertaken to be the ultimate guarantor of the health and well-being of residents in LTC homes in Ontario.

125. In the Preamble of the Act, Ontario has made the following representations to residents:

(a) that it remains committed to the health and well-being of Ontarians living in LTC homes now and in the future;

(b) that it firmly believes in clear and consistent standards of care and services, supported by a strong compliance, inspection and enforcement system;

(c) that it recognizes the responsibility to take action where standards or requirements under the Act are not being met, or where the care, safety, security and rights of residents might be compromised;

(d) affirms its commitment to preserving and promoting quality accommodation that provides a safe, comfortable, home-like environment and supports a high quality of life for all residents of LTC homes;

(e) that it recognizes the importance of fostering the delivery of care and services to residents in an environment that supports continuous quality improvement; and

(f) that it is committed to the promotion of the delivery of long-term care home services by not-for-profit organizations.

126. Under the Act, LTC home residents have the following rights, among others: to be treated with courtesy and respect and in a way that respects their dignity, not to be neglected, and to live in a safe and clean environment. It is Ontario's ultimate responsibility to ensure compliance with these rights.

RESIDENT ILLNESS AND DEATH

127. As of June 25, 2020, 356 LTC homes in Ontario have experienced an outbreak of COVID-19. 69 of those outbreaks are ongoing.

128. As of June 25, 2020, 5,445 LTC home residents in Ontario have tested positive for COVID-19. As of that same day, 2,268 health care workers in LTC homes in Ontario have tested positive for COVID-19.

129. As of June 25, 2020, there have been 1,692 resident deaths in LTC homes as a result of COVID-19. As of that same day, 5 health care workers in LTC homes in Ontario have died as a result of COVID-19.

130. As of June 25, 2020, confirmed cases of COVID-19 in LTC homes account for 22% of all confirmed cases in Ontario and deaths in Ontario's LTC homes account for 64% of all COVID-19 related deaths in Ontario.

131. In contrast, as of June 25, 2020, British Columbia has reported outbreaks in 48 care facilities (acute/long-term care/independent living). Further, British Columbia has reported 379 resident cases and 121 resident deaths in care facilities. The number of resident cases in British Columbia is less than 7% of resident cases in Ontario, and the number of resident deaths in British Columbia is just over 7% of the number of resident deaths in Ontario.

KNOWLEDGE OF THE PROVINCE

132. Prior to the COVID-19 outbreak, several reports and guidelines were developed in preparation for the next pandemic. The need to take precautionary and preventative measures to prevent the spread of infectious diseases such as COVID-19 has been well documented for several years. Ontario knew, or ought to have known, that early recognition of cases and appropriate PPE were both vital to effectively managing an outbreak, but failed to implement such measures in a timely manner.

133. Systemic vulnerabilities in LTC homes have been an identifiable and documented problem for several years. These systemic deficiencies continue to this day,

despite these issues repeatedly being brought to the attention of the Province since at least 2001. Ontario knew, or ought to have known, of the systemic vulnerabilities in respect of LTC homes, but has failed to act in any meaningful, reasonable or prudent manner to address these issues.

134. As a result of these failures, COVID-19 spread rapidly through Ontario's LTC homes, and caused residents to suffer avoidable illness and, in many cases, loss of life.

SARS Commission Final Report

135. The Independent Commission to Investigate the Introduction and Spread of Severe Acute Respiratory Syndrome (SARS) was created by the Government of Ontario to investigate, among other things, how the virus spread and how it was dealt with.

136. The SARS Commission found that one of the most important lessons to take from the SARS outbreak was the precautionary principle—to err on the side of caution. During the SARS outbreak, Ontario failed to recognize this principle in worker safety and identification and diagnosis of the respiratory illness. The SARS Commission made the follow recommendations:

(a) that the precautionary principle, which states that action to reduce risk need not await scientific certainty, be expressly adopted as a guideline throughout Ontario's health, public health and worker safety systems;

(b) that, in any future infectious disease crisis, the precautionary principle guide the development, implementation and monitoring of procedures, guidelines, processes and systems for the early detection and treatment of possible cases; and

(c) that, in any future infectious disease crisis, the precautionary principle guide the development, implementation and monitoring of worker safety procedures, guidelines, processes and systems.

137. Despite these recommendations, Ontario failed to adopt the precautionary principle in response to the COVID-19 pandemic.

138. Ontario should have taken precautions to protect residents long before COVID-19 reached LTC homes. Had Ontario adopted the precautionary principle in developing guidelines for the detection and treatment of possible cases of COVID-19 in LTC homes, widespread illness and loss of life would have been prevented.

139. Even in light of its own guidance as early as January 31, 2020 acknowledging the special vulnerability of the elderly and those with underlying health conditions—the main demographic in LTC homes—Ontario failed to adopt appropriate measures for the detection and treatment of possible cases of COVID-19. When measures for protection and mitigation of COVID-19 were finally implemented by the Province, it was too late because the virus spreads exponentially and each day of delay is critical.

140. Ontario also failed to use the precautionary principle in developing worker safety procedures for staff and volunteers at LTC homes. Early on in the outbreak, there was evidence of human-to-human transmission of the virus. Despite this, Ontario failed to ensure that workers at LTC homes had appropriate PPE to prevent the spread of the virus. Such steps should have been taken well in advance of the first confirmed case and first outbreak in a LTC home. Had Ontario adopted the precautionary principle, and ensured that all workers in LTC homes had appropriate PPE early on, widespread illness and loss of life would have been prevented. When Ontario finally directed all staff to wear masks at all times, on April 8, 2020, it was already too late.

141. The SARS Commission found that front-line doctors, nurses and other health workers had the greatest experience in diagnosing and treating SARS patients, yet there was no process in place to ensure that their voices and experiences were heard. The Commission recommended:

(a) that effective processes and systems be established to provide a path for communication and consultation with front-line staff; and

(b) that the health concerns of health workers be taken seriously, and that in the spirit of the precautionary principle health workers be made to feel

safe, even if this means continuing with levels of heightened precautions that experts believe are no longer necessary.

142. The Commission also recommended listening to the reasonable concerns of health worker unions, as they voice the legitimate concerns of those at risk on the front lines.

143. Early on in the pandemic, health workers and unions urged Ontario to address front-line health care workers' concerns regarding both systemic and COVID-19 related issues in LTC homes. The government was called upon, again and again, to implement the following measures, among others:

(a) require LTC homes to upstaff to help provide safe care;

(b) to provide workers with access to benefits and paid sick time to enable them to stay home if they are experiencing symptoms of the virus;

(c) prevent part-time and casual staff form working in more than one facility by increased their hours to full-time, or paying for lost wages;

(d) provide immediate access to appropriate PPE for all staff;

(e) implement premium pay immediately;

(f) develop a strategy to separate COVID-19 residents from non-COVID-19 residents, and to separate staff caring for each group;

(g) to follow the precautionary principle; and

(h) to ensure directives regarding proper PPE are clear, proactive and updated.

144. Despite this, and despite the specific recommendation by the SARS Commission to take the health concerns of workers and their unions seriously, Ontario delayed the implementation of to provide appropriate PPE for all staff. Ontario's failure to listen to

health care workers in LTC homes resulted in widespread and avoidable illness, suffering and loss of life during the COVID-19 pandemic.

Control of Respiratory Infection Outbreaks in Long-Term Care Homes (2018)

145. In this Reference Document, the Ministry acknowledged that "early recognition of cases signaling suspected outbreaks and swift action are essential for effective management" and further that "timely specimen collection, communication and implementation of appropriate control measures have the potential to make a significant impact in the course of the outbreak that will benefit both residents and staff".

146. Despite this, and despite knowing that the virus can be transmitted to others from those who have not yet developed symptoms and those who never develop symptoms, Ontario continuously recommended against testing all residents in LTC homes.

147. The Ministry also acknowledged that respiratory viruses are primarily transmitted by large respiratory droplets, and wearing appropriate PPE can interrupt the spread. Despite this, and despite that fact that it was well-known that residents share rooms, bathrooms and other living spaces, Ontario failed to ensure LTC homes had appropriate PPE to prevent the spread of the virus.

Price Waterhouse Coopers: Report (2001)

148. The *Report of a Study to Review Levels of Service and Responses to Need in a Sample of Ontario Long Term Care Facilities and Selected Comparators* compared the staffing levels in Ontario LTC facilities with that of other Canadian, American and international facilities.

149. The Report, which was published in 2011, found that the LTC system in Ontario suffers from chronic understaffing. Specifically, the Report made the following findings with respect to staffing in Ontario's LTC homes:

(a) the overall hours of nursing care in Ontario LTC homes are less than that provided in other jurisdictions; and

(b) the proportion of care provided by RN is less than in other jurisdictions.

Commitment to Care: A Plan for Long-Term Care in Ontario (2004)

150. Staffing issues in LTC homes were identified again in *Commitment to Care: A Plan for Long-Term Care in Ontario*, a report prepared by the Parliamentary Assistant of the Ministry.

151. The Report, which presented the findings of a review of LTC homes in the Province that took place between January 15 and March 23, 2004, made the following findings with respect to staffing issues:

(a) funding and staff shortages impact standards of care in LTC homes;

(b) LTC homes in Ontario were staffed by part-time nurses, health care aids and PSWs, and more full time staff were required to provide consistent, resident-knowledgeable care;

(c) strategic efforts need to be developed to promote the LTC sector as a desirable career option as staff shortages and pay inequities are constant challenges; and

(d) more nurse practitioners are needed in the LTC sector.

Coroner's Inquest Recommendations Casa Verde Nursing Home (2005)

152. A Coroner's Inquest was held from January 31, 2005 to April 18, 2005 to review the circumstances surrounding two residents who had been killed by another resident at Casa Verde Nursing Home in Toronto, Ontario.

153. The Coroner's Jury made a number of recommendations related to the need for increased staffing, funding and training, including: completing a study to determine appropriate staffing levels for Ontario LTC homes, setting standards based on this information for all LTC homes in Ontario, enhancing working conditions to attract and

retain sustainable RNs and ensuring the funding provided to LTC homes is sufficient to provide the requisite level of care required by residents.

People Caring for People (2008)

154. *People Caring for People: Impacting the Quality of Life and Care of Residents in Long-Term Care Homes* presents the findings and recommendations of the Independent Review of Staffing and Care Standards for Long-Term Care Homes in Ontario.

155. This report made the following recommendations to address systemic staffing issues in Ontario's LTC homes:

(a) enhance staff capacity to provide to residents a broad range of nursing, personal care, care, programs and support services;

(b) establish provincial guidelines to support annual funding for enhanced capacity for resident care to achieve a provincial average of up to 4 hours of care per resident per day over the next four years; and

(c) develop strategies to increase recruitment and retention of health providers, including physicians, nurse practitioners, nurses, PSWs and allied health professionals to the LTC homes sector.

Long-Term Care Task Force on Resident Care and Safety (2012)

156. The Ontario Long Term Care Association, the Ontario Association of Non-Profit Homes and Services for Seniors and the Ontario Association of Residents' Councils and Concerned Friends of Ontario Citizens in Care Facilities created the Long-Term Care Task Force on Resident Care and Safety in response to reports of abuse and neglect in LTC homes.

157. The Task Force identified the following challenges with respect to staffing in LTC homes, among others:

(a) pay rates are inconsistent within the sector and are lower compared to other sectors;

(b) there is a lack of confidence in the sector, shift work, lack of exposure to LTC provides very little appeal for workers; and

(c) there is a lack of full-time employment contributes to difficulty retaining staff.

158. Recognising that there are not enough direct-care staff to meet the needs of LTC home residents safely, the Task Force echoed the recommendations in the *People Caring for People* Report regarding appropriate staffing.

Geriatric and Long Term Care Review Committee Recommendations, 2016

159. The Geriatric and Long Term Care Review Committee recommended, in response to the homicide of a resident by another resident that occurred in 2016, that the Ministry increase staffing level requirements in LTC homes.

The Gillese Report (2019)

160. The *Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System* examined the circumstances surrounding the murders of eight nursing home residents by former RN Elizabeth Wettlaufer. The Report makes a number of recommendations addressing systemic issues in Ontario's LTC system.

161. With respect to staffing, the Honourable Eileen E. Gillese, Commissioner of the Long-Term Care Homes Public Inquiry, found that nursing staff in LTC homes are "stretched thin". The Report again reiterated the necessity of increasing the number of registered staff in LTC homes and recommended the Ministry conduct a study to determine adequate levels of registered staff.

162. With respect to inspections, the following recommendations were made to the Ministry:

(a) ensure that Critical Incident reports and complaints are given the highest priority and inspected as quickly as possible;

(b) identify LTC homes struggling to provide a safe and secure environment for residents, and take action to assist these homes; and

(c) when a finding of non-compliance is issued for a home, ensure the next resident quality inspection conducted at that home is an intensive one.

163. Ontario has not complied with this recommendation on inspections.

The Plaintiff's Experience

164. The Plaintiff is an 89 year old woman and former resident of Orchard Villa LTC home.

165. The Plaintiff moved into Orchard Villa in 2018. Due to mobility issues, the Plaintiff requires a motorized wheelchair to move around.

166. While the Plaintiff was a resident at Orchard Villa, the home experienced a devastating outbreak of COVID-19.

167. On April 22, 2020, Simon Nisbet, the Plaintiff's son, received a phone call from Orchard Villa and was advised that the Plaintiff had tested positive for COVID-19.

168. In the days following the Plaintiff's diagnosis of COVID-19, Simon watched from the window as his mother's health deteriorated rapidly.

169. On May 3, 2020, Simon contacted Orchard Villa and requested that they call an ambulance for the Plaintiff. The Plaintiff was subsequently transferred by ambulance from Orchard Villa to Ajax Pickering Hospital.

170. By the time she arrived in hospital, the Plaintiff had sustained kidney damage due to dehydration.

171. The Plaintiff has since recovered from COVID-19, but remains in hospital.

CAUSES OF ACTION

The Crown's Duty of Care

172. The Defendant regulated, oversaw and, if necessary, directly controlled the LTC home system in Ontario during the class period.

173. The Act defines a relationship of proximity between Ontario and the LTC home residents. The preamble contains Ontario's affirmative commitments to ensure residents' health, wellbeing and safety, and also their dignity. Ontario is effectively the guarantor of the Act's fundamental principle that residents may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met. Ontario has power under the Act to take control of LTC homes if necessary, and has in fact done so.

174. Ontario's statements and representations acknowledged the vulnerability of LTC home residents to COVID-19 and assured that all necessary steps to protect them would be taken. Ontario's statements and representations created legitimate expectations in LTC home residents and their families. These included, but were not limited to, the following:

(a) January 31, 2020, Ministry of Health *Novel Coronavirus (2019-nCOV) Fact Guidance for Long-Term Care* recognized the special vulnerability of LTC home residents given their age, frailties and chronic conditions which weaken their immune systems;

(b) February 13, 2020, Minister of Long-Term Care recognized the "severe shortage" of staff in LTC homes and stated the well-being and safety of LTC home residents was paramount for her ministry and the Government of Ontario;

(c) March 11, 2020, Minister of Health stated that Ontario was working in close cooperation with LTC homes to ensure residents' continued safety;

(d) March 16, 2020, Minister of Health and Minister of Long-Term Care stated that all necessary precautions were being taken to ensure safety of LTC home residents;

(e) March 24, 2020, Minister of Long-Term Care stated Ontario would put in place any process necessary to protect LTC home residents;

(f) March 30, 2020, the Premier stated that an "iron ring" of protection would be built around those in LTC homes;

(g) March 31, 2020, Minister of Health stated that no stone would be left unturned in protecting LTC home residents;

175. The Defendant owed a common law duty of care to the LTC home residents as a result of its relationship of proximity, defined by the Act and its statements and representations. The harm and damages suffered by the Class Members were reasonably foreseeable as a result of the Defendant's acts and omissions, constituting a breach of the common law duty.

The Crown's Negligence

176. The Defendant breached its duty of care to LTC home residents in its regulation, oversight and control of LTC homes.

177. The Defendant breached its common law duties to the residents through its negligent failure to properly regulate, oversee and, where necessary, take control of LTC homes in Ontario.

178. In particular, the Defendant acted negligently by:

(a) failing to take a proper and good faith interest in the operation and supervision of the LTC homes;

(b) failing to address the longstanding crisis of understaffing in LTC homes, leaving the system vulnerable to COVID-19;

(c) failing to curtail the practice of staff working for multiple LTC homes;

(d) ignoring or abandoning the precautionary principle in preparing the LTC home system for the onset of COVID-19;

(e) failing to administer sufficient COVID-19 testing in LTC homes;

(f) failing to provide LTC homes with sufficient PPE supplies for staff;

(g) failing to carry out sufficient inspections of LTC homes;

(h) failing to ensure directives regarding proper PPE were clear, proactive and updated;

(i) failing to ensure LTC homes separated COVID-19 residents from non-COVID-19 residents;

(j) failing to provide adequate health care to Class Members;

(k) failing to respond adequately, or at all, to complaints or recommendations which were made in numerous reports concerning LTC homes;

(l) failing to ensure that physical, emotional and psychological harm would not befall the Class Members;

(m) failing to ensure that residents who tested positive for the virus were transferred to hospital;

(n) failing to provide adequate financial resources or support to properly care and provide for Class Members; and

(o) failing to adequately investigate ongoing harm suffered by Class Members.

179. The LTC home residents suffered damages as a result of the Defendant's negligence, the particulars of which are set out in paragraphs 203 to 207 below.

180. Ontario's duty of care to the Plaintiff and the Class is not negated by any immunity under the *CLPA*.

181. The Plaintiff and Class Members do not seek to hold Ontario liable for torts committed by LTC homes within the meaning of the Act.

182. Ontario's negligence does not arise from regulatory decisions, legislative acts or decisions respecting policy matters.

183. Ontario's negligence arises from operational decisions for which they are liable.

The Crown's Fiduciary Duty

184. All LTC home residents enjoyed legislated rights that granted specific protections to them as an identified class of persons. The Defendant granted, underwrote and effectively guaranteed these rights for the specific benefit of LTC home residents, to whom the Defendant owed fiduciary duties. These duties included, but were not limited to, the duty to ensure the safety and reasonable care of residents and the duty to protect residents from harm due to COVID-19.

185. LTC home residents had a reasonable expectation that the Defendant would act in their best interests with respect to COVID-19 and its potential impact on LTC homes in Ontario by virtue of the following:

186. *Ontario's undertaking of responsibility to act in best interests of LTC home residents*

(a) Ontario's undertaking of responsibility to act in the best interests of a LTC home residents in the Act, which undertaking of loyalty is not mediated against any other interest;

(b) the representations by Ministers of the Crown that all steps would be taken to protect LTC home residents from COVID-19;

187. *Vulnerability of LTC home residents to Ontario's control*

(a) the vulnerability of LTC home residents and their longstanding dependence on the Defendant;

(b) the fact that most LTC home residents are elderly and/or infirm;

188. *Ontario's power to affect legal and substantial practical interests of LTC home residents*

(a) the Defendant's power over the regulation, funding, licensing, oversight and, if necessary, direct control of LTC homes in Ontario, which power affects the legal or substantial practical interests of LTC home residents;

189. By virtue of the relationship between LTC home residents and the Defendant being one of trust, reliance and dependence by the residents, the Defendant owed a fiduciary duty to ensure the residents were treated respectfully, fairly and safely. Ontario's statutory duties to regulate, oversee and, if necessary, directly control the LTC home system in Ontario are specific and owed only to LTC residents.

The Crown Breached its Fiduciary Duty to the Class

190. The Defendant's lax and insufficient regulation and oversight Ontario's LTC home system ensured it would be overrun by COVID-19, leading to widespread preventable illness, suffering and death among residents. Ontario knew of, or was wilfully blind to, the risks infectious diseases, including a highly infectious and deadly disease like COVID-19, posed to LTC home residents.

191. The LTC home residents were entitled to rely and did rely upon the Defendant, to their detriment, to fulfill its fiduciary duty to protect them. The particulars of the Defendant's breach of fiduciary duty include, but are not limited to:

(a) failing to take a proper and good faith interest in the operation and supervision of LTC homes;

(b) failing to address the longstanding crisis of understaffing in LTC homes, leaving the system vulnerable to COVID-19;

(c) failing to curtail the practice of staff working for multiple LTC homes;

(d) ignoring or abandoning the precautionary principle in preparing the LTC home system for the onset of COVID-19;

(e) failing to administer sufficient COVID-19 testing in LTC homes;

(f) failing to provide LTC homes with sufficient PPE supplies for staff;

(g) failing to carry out sufficient inspections of LTC homes;

(h) failing to ensure directives regarding proper PPE were clear, proactive and updated;

(i) failing to ensure LTC homes separated COVID-19 residents from non-COVID-19 residents;

(j) failing to provide adequate health care to Class Members during the pandemic;

(k) failing to respond adequately, or at all, to complaints or recommendations which were made in numerous reports concerning LTC homes;

(l) failing to ensure that physical, emotional and psychological harm would not befall the Class Members;

(m) failing to ensure that residents who tested positive for the virus were transferred to hospital;

(n) failing to provide adequate financial resources or support to properly care and provide for Class Members; and

(o) failing to adequately investigate ongoing harm suffered by Class Members.

Breaches of the Canadian Charter of Rights and Freedoms

192. The conditions particularized above violate the rights of LTC residents to life, liberty and security of the person under Section 7, and equal treatment under Section 15 of the *Charter of Rights and Freedoms* ("*Charter*").

193. As a government actor, Ontario owed, and continues to owe, duties under the *Charter* to the Class Members herein.

194. Section 7 of the *Charter* guarantees that every individual has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

195. The Defendant put Class Members' life and security of the person in jeopardy by failing to take adequate steps to protect this vulnerable group during the pandemic. Ontario's failures, as particularized above, have resulted in widespread illness, suffering and loss of life. Ontario's conduct has violated the right of the Class to life and security of the person, contrary to section 7.

196. There is no justification in a free and democratic society for Ontario's failures under section 1 of the *Charter.*

197. Section 15(1) of the *Charter* guarantees that every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability, or other related or recognizable grounds.

198. The Plaintiff and Class Members have been discriminated against based on their age. The Defendants' conduct is discriminatory on its face, in its effect, and in its application. In particular, such actions include but are not limited to:

(a) Ontario allowed the Plaintiff and Class Members to receive sub-standard care during the pandemic;

(b) Ontario failed to administer sufficient COVID-19 testing in LTC homes despite having the testing capacity to do so;

(c) Ontario failed to ensure LTC homes were adequately staffed to protect vulnerable residents from the virus;

(d) Ontario failed to provide LTC homes with sufficient PPE supplies for staff; and

(e) Ontario failed to transfer residents who tested positive for COVID-19 to hospitals.

199. In contrast to Ontario's treatment of LTC home residents and their families during the pandemic, Ontario took active steps to prepare hospitals for the outbreak and to protect patients, including ensuring hospitals had adequate staff, proper PPE, and access to testing and other medical supplies including ventilators.

200. There is no justification in a free and democratic society for said discrimination under section 1 of the *Charter*.

201. The impact of the differential treatment was to devalue the integrity, dignity and lives of the Class Members.

202. In the circumstances, the Plaintiff and Class are entitled to monetary damages pursuant to section 24(1) of the *Charter* for violation of the Class Members' constitutional rights and freedoms in order to:

(a) compensate them for their suffering and loss of dignity;

(b) vindicate their fundamental rights; and

(c) deter systemic violations of a similar nature.

The Plaintiff and Class have suffered damages

203. At all material times, Ontario knew, or ought to have known, that as a consequence of its failures, residents would suffer immediate and long term physical, mental, emotional, psychological and spiritual harm.

204. Both residents and their families were traumatized by residents' experiences arising from Ontario's failures in overseeing LTC homes during the pandemic.

205. As a result of Ontario's negligence, breach of its fiduciary duty and breach of the *Charter*, Class Members suffered and continue to suffer damages which include, but are not limited to the following:

(a) physical harm, including widespread illness and loss of life;

(b) exacerbation of physical and mental disability;

(c) loss of care and companionship;

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

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

(f) development of new mental, psychological and/or psychiatric disorders;

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

(h) pain and suffering;

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

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

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

(l) suicidal ideation;

(m) the loss of general enjoyment of life; and

(n) such other and further damages as the Plaintiff may advise and this Honourable Court may consider.

206. As a result of the conduct alleged herein, the Family Class members suffered and will continue to suffer damages, including, but not limited to, the following, which were reasonably foreseeable to the Defendant:

(a) actual expenses reasonably incurred for the benefit of the Resident Class;

(b) loss of care and companionship;

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

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

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

(f) development of new mental, psychological and/or psychiatric disorders;

(g) suicidal ideation;

(h) the loss of general enjoyment of life; and

(i) such other and further damages as the Plaintiff may advise and this Honourable Court may consider.

207. As a result of these injuries, Class Members have required and will continue to require further medical treatment, rehabilitation, counselling and other care. 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 Ontario's conduct for which they claim complete indemnity, compensation and payment from the Defendants.

The Plaintiff and Class request aggravated or punitive damages

208. Ontario conducted its affairs with wanton and callous disregard for the Class Members' interests, safety and well-being. Class Members were treated in a manner that

could only result in significant physical, mental and emotional impacts, particularly for vulnerable elders.

209. The cruel, inhuman and degrading treatment to which the Class Members were exposed have violated their rights. In these circumstances, the Plaintiff and other Class Members request aggravated or punitive damages.

The Plaintiff's claim, and the claim of each Class Member, is limited to the amount of the Plaintiff's or other Class Member's damages that would be apportioned to the Defendant in accordance with the relative degree of fault that is attributable to the Defendant. The Plaintiff's claim is against the Defendant for those damages that are attributable to its proportionate degree of fault, and she does not seek, on her own behalf or on behalf of the Class, any damages that are found to be attributable to the fault or negligence of any other person, or for which the Defendant could claim contribution or indemnity.

June 29, 2020

Koskie Minsky LLP
900-20 Queen Street West
Toronto ON M5H 3R3

Kirk M. Baert LSUC#: 30942O
Tel: 416-595-2092
Fax: 416-204-2889
James Sayce LSUC#: 58730M
Tel: 416-542-6298
Fax: 416-204-2809
Charles Hatt LS#: 64418I
Tel: 416-595-2124
Fax: 416-204-2890
Demi Cartwright LS# 77257C
Tel: 416-595-2266
Fax: 416-204-2871

Lawyers for the Plaintiff

SIMON NISBET AS LITIGATION GUARDIAN OF DOREEN NISBET
Plaintiff

and

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

Court File No.: »

ONTARIO
SUPERIOR COURT OF JUSTICE

Proceeding commenced at TORONTO

Proceeding under the *Class Proceedings Act, 1992*

STATEMENT OF CLAIM

Koskie Minsky LLP
900-20 Queen Street West
Toronto ON M5H 3R3

Kirk M. Baert LSUC#: 30942O
Tel: 416-595-2092
Fax: 416-204-2889
James Sayce LSUC#: 58730M
Tel: 416-542-6298
Fax: 416-204-2809
Charles Hatt LS#: 64418I
Tel: 416-595-2124
Fax: 416-204-2890
Demi Cartwright LS# 77257C
Tel: 416-595-2266
Fax: 416-204-2871

Lawyers for the Plaintiff

KM-4384637v3