CITATION: Robertson v. Ontario, 2022 ONSC 5127
COURT FILE NO.: CV-20-648597-CP
DATE: 20221220

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

KATHRYN ROBERTSON by her estate representative ALLISON GAANDERSE, MAURICE ALBERT ORCHARD by his estate representative CHRISTINA KINDER, BERNARD RENAUD by his estate representative LORI RENAUD, JEAN PATRICIA POLLOCK by her estate representative PAMELA CHRISTINE SMITH, INNIS INGRAM, CHRISTINA KINDER, LORI RENAUD, PAMELA CHRISTINE SMITH and ALLISON GAANDERSE

Plaintiffs

-and-

HIS MAJESTY THE KING IN RIGHT OF ONTARIO

Defendant

Proceeding under the *Class Proceedings Act, 1992*

BEFORE: Justice Edward P. Belobaba

COUNSEL: *Joel P. Rochon, Golnaz Nayerahmadi, Annelis K. Thorsen and Juela Xhaferraj* for the Plaintiffs / Moving Parties

Christopher A. Wayland, Jeffrey Claydon, Joanna Chan and Jennifer Boyczuk for the Defendant / Responding Party

HEARD: July 4, 5 and 6, August 25 and 26, and November 4, 2022 via Zoom video

Motion for Certification

[1] Thousands of elderly residents in provincially-regulated long-term care ("LTC") homes died from Covid-19 or sustained serious illness because of the gross negligence of the Government of Ontario.

[2] This is the core allegation in this proposed class action against the provincial government.

[3] The plaintiffs say that the Government of Ontario knew from the outset of the pandemic and certainly by the end of January 2020 that the frail and the elderly, and especially the residents of LTC homes, were the most vulnerable to the ravages of the coronavirus. Yet for weeks, as the deadly virus spread through the LTC communities and while other jurisdictions including other provinces took immediate action, Ontario's key ministers and health officials did nothing even though they had regulatory authority over the private-sector LTC homes. And when action was finally taken and government directives were issued, they proved to be too little, too late.

[4] As a result, say the plaintiffs, 3836 LTC residents, volunteers or visitors died unnecessarily from Covid or Covid-related complications and another 23,000 were infected and endured serious illness.[1] But for the provincial government's inaction and delay, the vast majority of the LTC deaths and illnesses could have been prevented.

[5] A parallel class action has also been filed actions against the owners or operators of the LTC homes. The certification motions relating to the consolidated actions against eight groups of owners/operators[2] are scheduled to be heard over the next several months. The certification motion before me today only considers the proposed class action against the provincial government.[3]

The core allegation

[6] Although the plaintiffs advance three causes of action — negligence/gross negligence, breach of fiduciary duty and breach of s. 7 of the *Charter of Rights and Freedoms* — the only viable cause of action (as I explain below) is the tort claim in negligence/gross negligence, summarized in the plaintiffs' factum as follows:

> This proposed class action concerns Ontario's grossly negligent response to the risks posed by COVID-19 to LTC residents – a response that began far too late in mid-March 2020, nearly *six weeks* after COVID-19 had arrived in the province. That response – in the form of various Directives and memoranda issued by the Ministry of Health and Ontario's Chief Medical Officer of Health – was not only grossly delayed, but also piecemeal, substantively deficient, vague, and confusing.

[1] I recognize that COVID-19 is typically written in upper-case letters. For easier readability, I will use lower case letters - except when quoting from studies or reports that used the upper-case version.

[2] In an Endorsement dated January 21, 2022, I approved consolidation and amendment motions that reorganized dozens of actions into eight parallel class proceedings. The defendants are grouped by the owners/operators – namely, Sienna, Revera, Schlegel, Responsive, Extendicare, Chartwell, the independently owned LTCs and those owned by municipalities. The certification motions are scheduled to be heard January to April in the coming year.

[3] In a decision released on May 6, 2021, I granted carriage of the action against Ontario to a consortium of class action law firms: see *Nisbet v. Ontario*, 2021 ONSC 3072.

> It left an entire sector with a distorted understanding of the serious risks posed by COVID-19 to elderly confined to the province's LTC homes and exposed this vulnerable population to an unreasonably high risk of infection, complications, and death.

[7] The cause of action, strictly speaking, is negligence not gross negligence. Gross negligence is not a distinct cause of action that requires a discrete pleading and a separate set of facts.[4] It differs from negligence only in degree, not in kind. The same evidence can be weighed to determine proof of negligence and gross negligence,[5] the latter simply being "very great negligence".[6] Hence, the plaintiffs' allegations that Ontario's conduct both before and during the pandemic — including its failures in pandemic preparedness and its deficient and delayed responses when the pandemic took hold in LTC homes — was "reckless," "woefully deficient," "extremely careless," "wholly inadequate" and "a marked departure from any reasonable standard of care."

[8] The plaintiffs also allege that the extent of the defendant's gross negligence was so great that one can infer an absence of good faith — that is, that the defendant's impugned acts or omissions were done in bad faith. Courts have recognized that the bad faith can be inferred from gross negligence or recklessness, extreme carelessness and conduct that is so inexplicable or "so markedly inconsistent" with the events in which they were carried out that the court cannot reasonably conclude that the defendant's impugned acts or omissions were done in good faith.[7]

[9] As counsel for the plaintiffs explained, the statement of claim was specifically amended to provide additional detail about the gross negligence and lack of good faith allegations in order to avoid the reach of Bill 218, *Supporting Ontario's Recovery Act*,[8] known to most lawyers as SORA.

[10] The SORA law, enacted in 2020, prohibits almost all Covid-related litigation. Section 2(1) makes clear that no Covid-related cause of action can arise where the defendant made a good faith effort to comply with the applicable law or regulations *and* the defendant's act or omission did not amount to gross negligence.[9] In other words, no Covid-related lawsuits may proceed against any

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[4] Consolidation and Amendment Endorsement, *supra*, note 2, at para. iii.

[5] *Gelinas et al. v. City of Hamilton, Cockman, Third Party*, [1970] 2 O.R. 157-161 (ONSC), at para. 10. See also *Johnson v. Studley*, 2014 ONSC 1732 at para. 54 and *Lawless v. Anderson*, 2011 ONCA 102 at para. 22-23.

[6] *Drennan v. Kingston (City)*, (1897) 27 S.C.R. 46 at para. 33.

[7] *Finney c. Barreau (Québec)*, 2004 SCC 36 at para. 39; *Hinse v. Canada (Attorney General)*, 2015 SCC 35 at paras. 44, 47-53, 69; *Entreprises Sibeca Inc. c. Frelighsburg (Municipalite)*, 2004 SCC 61 at para. 26; and *Bennett v. Bennett Environmental Inc*., 2009 ONCA 198 at para. 30.

[8] *Supporting Ontario's Recovery Act*, S.O. 2020, c. 26.

[9] *Ibid.*, s. 2 (1).

defendant, including the provincial government, unless there are allegations either of bad faith *or* gross negligence. Hence the amended and more detailed statement of claim.

[11] Gross negligence and a related lack of good faith, say the plaintiffs, can be found in the defendant's inordinate delay and inaction. The plaintiffs argue that it was only in mid-March, six weeks after Covid began to spread through the province, that the Chief Medical Officer of Health ("CMOH") finally began to issue mandatory directives to the owners and operators of the LTC homes under s. 77.7 of the *Health Protection and Promotion Act*[10] ("HPPA"). The directives, issued over the next several months mandated active screening tests, universal masking and the use of other personal protection equipment or PPE, a cohorting protocol (separating the well and the unwell) and a single work-site requirement. The Minister of Long-Term Care ("MLTC") added a further order under s. 174.1 of the *Long-Term Care Homes Act*[11] ("LTCHA") requiring LTC homes to co-operate with incoming health experts and army personnel.

[12] Had these and other actions been taken weeks sooner, say the plaintiffs, the vast majority of LTC resident deaths and illnesses could have been prevented.

The evidence

[13] The evidentiary hurdle on a motion for certification is much lower than the hurdle that has to be cleared when the dispute is adjudicated on the merits either at trial or on a motion for summary judgment.

[14] On a motion for certification, the plaintiffs only have to satisfy the five requirements for a workable class proceeding as set out in s. 5(1) of the *Class Proceedings Act.*[12] That is, (i) a cause of action that is not plainly and obviously doomed to fail; and some evidence (some basis in fact) for the four remaining requirements: (ii) an identifiable class of two or more persons; (iii) one or more common issues that exist and can be decided on a class-wide basis; (iv) that a class proceeding is the preferable procedure for the resolution of the common issues; and (v) a suitable representative plaintiff.

[15] I will discuss each of these requirements in more detail below. Here I briefly consider the evidence filed by the plaintiffs to establish a sufficient basis in fact for the core allegation of gross negligence. The evidence filed by the plaintiffs includes personal-experience affidavits, three recent reports of the Auditor General and the Final Report of the Ontario Long-Term Care Covid-19 Commission ("the LTC Commission") released on April 30, 2021. Each of these reports detail

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[10] *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7.

[11] *Long-Term Care Homes Act*, 2007, S.O. 2007, c. 8.

[12] *Class Proceedings Act, 1992*, S.O. 1992, c. 9 ("CPA"). Because the proposed class action was commenced in September, 2020, before the amendments took effect, the old (unamended) CPA applies.,

Ontario's long-standing neglect of the LTC sector and its delayed and deficient response to the Covid pandemic as the first wave began to hit LTC homes.

[16] The defendant's historic neglect of the LTC sector is discussed in these reports under various headings: chronic underfunding, poor and outdated infrastructure, severe staffing shortages, inadequate Infection Prevention and Control ("IPAC") practices, an inexplicable failure to maintain an emergency stockpile of PPE, poor oversight and enforcement of legislative standards and increasingly lax inspections. As the Commission concluded, the wide array of systemic issues which had plagued the LTC sector for years prior to the onset of the Covid pandemic, "create[d] fertile ground for excess mortality" of LTC residents during the pandemic.

[17] The LTC Commission found that "alarm bells should have been ringing loudly in Ontario" when LTC homes and congregate settings in other jurisdictions began experiencing outbreaks in February 2020. However, Ontario continued to down-play the threat of the virus and failed to recognize the existence of community spread and asymptomatic transmission until well into March and April 2020 despite compelling evidence to the contrary.

[18] The LTC Commission found that Ontario "demonstrated a lack of urgency" and delayed in implementing several key measures such as universal masking, cohorting and single work-site requirements for LTC staff. The LTC Commission's findings were unequivocal:

> There were ample warnings that the virus posed a risk to LTC residents. Those warnings were not acted upon with sufficient speed…
>
> The risks were known, and in the first few months of 2020, the devastating impact of Covid-19 outbreaks in the LTC facilities was evident in countries such as Italy and the United States. And yet when the virus breached the doors of a handful of LTC homes in March 2020, few were prepared for the horror that was to come.

[19] In addition to the reports of the Auditor General and the LTC Commission, the plaintiffs also filed the expert opinion of Dr. Dick Zoutman, former Chair of the Ontario SARS Scientific Advisory Committee during the SARS epidemic in 2003 and one of the most distinguished microbiologists in the country.

[20] In Dr. Zoutman's opinion, the 3,836 LTC deaths from Covid or Covid-related complications were "largely preventable". As were "the vast majority of the over 23,000 cases of Covid-19 infections that have occurred in Ontario long-term care homes." Dr. Zoutman compared Ontario's weeks of inaction to the direct actions that had been taken in other jurisdictions, including other provinces in Canada, and concluded that "as much as 90 per cent" of the Ontario LTC deaths and infections could have been prevented if Ontario had simply acted on what they knew and had moved more quickly.

[21] Dr. Zoutman analyzed how government health ministers and officials failed to implement basic IPAC measures and disregarded the "precautionary principle",[13] causing thousands of preventable LTC deaths or serious illnesses. He examined the directives that were eventually issued, almost all by the CMOH, and said this:

> Between March 12, 2020 and June 9, 2021 Ontario issued approximately 35 different directives relevant to LTC facilities and their response to the COVID-19 pandemic. Directives 1, 3 and 5, in their various iterations, repeatedly referred to the precautionary principle as guiding and informing the Chief Medical Officer of Health's directives and response to the pandemic, including in the long-term care sector Despite this explicit acknowledgement, the content of the directives and the timing of their issuances did not reflect either the precautionary principle or the well-established IPAC standards and best practices applicable to the health care sector, including the long-term care system. Nor did these directives reflect Ontario and the medical community's state of knowledge regarding the various frailties and deficiencies in the province's long-term care homes, which had been documented for years [references omitted].
>
> The poor quality of these documents made understanding them and complying with them difficult. By way of example, the preamble to Directive 1 (March 12, 2020) expressly notes that the CMOH must consider the precautionary principle. Yet, Directive 1 did not take into account asymptomatic transmission of COVID-19 despite the accumulated evidence for this type of spread in late January 2020. If it had it should have said so and been written sooner, around the beginning of February 2020 not the middle of March (i.e., a full month earlier). The CMOH's acknowledgement of the precautionary principle would have required active surveillance and universal masking far sooner than actually occurred.
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> Similarly, Directive 3, dated March 20, 2020, finally requires active screening of residents, staff and visitors in LTC facilities. This is much too late as outbreaks in LTC facilities were very numerous by this time. Further, the knowledge of asymptomatic spread dated back to late January 2020, some two months prior.
>
> On April 8, 2020 the CMOH finally issued a directive for staff to wear masks in long-term care, a full 20 days after receiving the recommendation from an Associate Medical Officer of Health …
>
> Once again, on April 16, 2020, an Emergency Order entitled "Limiting Order to a Single Long-Term Care Home" was passed, which was effective as of April 22,

[13] The "precautionary principle" principle provides that precautionary measures should be applied in the face of a real threat to safety and well-being even in the absence of scientific certainty. The precautionary principle was first articulated in the 1997 report of the Krever Commission's inquiry into Canada's tainted blood supply and was reaffirmed in the final report of the SARS Commission of December 2006. The precautionary principle remains a vital component of IPAC best practices.

> 2020. This was the order for staff to only work in a single LTC facility. Referencing the Precautionary Principle and the knowledge of asymptomatic spread of COVID-19 from person to person, this requirement should have been made of LTC facilities in early February 2020 when this information was readily available.
>
> There was thus a significant disconnect between the government's state of knowledge regarding COVID-19 and its risks to the elderly …and the specific IPAC measures it was adopting in practice and recommending. There has been no explanation for the government's delayed and piecemeal approach to the prevention of outbreaks in long-term care homes in Ontario or the mitigation of the risks to the resident population, which faced serious and, in many cases, more deadly outbreaks during the second and subsequent waves of the pandemic.

[22] This excerpt from Dr. Zoutman's report captures the gist of his expert opinion:

> By the end of January 2020, it was abundantly clear that the risk of death and serious complications was extremely high in the elderly following infection with COVID-19. Human to human spread of COVID-19 had been demonstrated and the possibility of asymptomatic spread of COVID-19 was published from China's observations. As a result, Ontario should have acted by this time to implement the IPAC programs that had been developed, studied and known to be effective in preventing outbreaks and minimizing rates of infection in LTC homes. By the end of January 2020 these measures should have been in place consistent with a preventive, rather than reactionary model (precautionary principle). It would have been apparent that, given the conditions in LTC homes, including the congregate living environment, crowding, staff shortages, the age of the population and its vulnerabilities, it would be significantly more challenging to control infections and spread of the virus once residents began to be infected than it would have been to prevent outbreaks and fatalities.
>
> The outbreaks of COVID-19 in LTC homes were preventable. Had Ontario adopted, mandated, and enforced timely, measured, and consistent steps to implement the available and accepted IPAC practices, the vast majority of the outbreaks and the deaths that occurred in LTC homes would have been prevented.

[23] None of Dr. Zoutman's findings or conclusions were seriously contested by the defendant's expert. In any event, the court's concern on a certification motion is not to weigh and resolve conflicting expert reports but to be satisfied that the plaintiffs have cleared the relatively low "some basis in fact" hurdle. And here, the reports of the Auditor General, the LTC Commission and Dr. Zoutman's expert opinion have done so with room to spare. Put simply, this motion for certification does not turn on the "some evidence" requirement, at least not for the allegation of negligence/gross negligence.

The proposed class and the representative plaintiffs

[24] The proposed class consists of the resident class, a visitor class and a family class. The resident class includes all persons who were resident in, or received care at, the LTC homes during

the Covid-19 pandemic and, where the person is deceased, the estate of that person. The visitor class includes all those who were visitors or volunteers at the LTC homes during the pandemic and, where the person is deceased, the estate of that person. The family class includes all persons who may have a derivative claim based on their personal relationship to a resident or visitor class member.

[25] There are four proposed representative plaintiffs. Each of them lost their mothers or fathers to Covid or Covid-related complications and are suing in their capacity as estate representatives and as representatives of the proposed visitor and family classes:

- Allison Gaanderse lost her mother, *Kathryn Robertson* who was a resident at the Camilla Care Community in Mississauga, owned by Sienna Senior Living Inc. She contracted Covid and died on October 14, 2020. Ms. Gaanderse and her brother, Innis Ingram, are also proposed as representatives for the visitor and family classes;

- Christina Kinder lost her father *Maurice Orchard* who was a resident at the Eatonville Care Centre in Etobicoke, owned by the Responsive Group Inc. He died on April 2, 2020. Ms. Kinder is also a proposed representative for the visitor and family classes;

- Lori Renauld lost her father *Bernard Renauld* who was a resident of Carlingview Manor in Ottawa, owned by Revera Inc. He died on May 16, 2020. Ms. Renauld is also a proposed representative for the visitor and family classes; and

- Pamela Smith lost her mother *Jean Pollock* who worked as a volunteer at the Pinecrest Nursing Home in Bobcaygeon, owned by the Medlaw Corporation. She died from Covid-related complications on March 28, 2020. Ms. Smith is also a proposed representative for the visitor and family classes

The defendant

[26] The defendant named in the style of cause is His Majesty the King in Right of Ontario as per convention in proceedings against the federal or provincial government. However, the parties understand that under the provisions of the *Crown Liability and Proceedings Act*[14] ("CLPA") the provincial Crown (that is, the provincial government) cannot be sued directly in tort. It can only be sued in tort on the basis of vicarious liability — that is, the provincial government may be found vicariously liable, on sufficient evidence, for the negligence/gross negligence of its officers, agents and employees.

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[14]*Crown Liability and Proceedings Act,* 2019, S.O. 2019, c. 7, Sch. 17, replacing the *Proceedings Against the Crown Act,* R.S.O. 1990, c. P.27.

[27] The proposed common issues ("PCIs") are attached in the Appendix and identify three such individuals: the Minister of Long-Term Care ("MLTC"), the Minister of Health ("MOH"), and the Chief Medical Officer of Health ("CMOH"). The PCIs define "defendant" as follows:

> The Defendant" means: (a) Ontario, acting through the Minister of Long-Term Care, the Minister of Health and the Chief Medical Officer of Health, with respect to the common issues related to claims for negligence and gross negligence for which Ontario is vicariously liable; and (b) His Majesty the King in Right of Ontario with respect to the common issues related to claims for breach(es) of fiduciary duty and the *Charter* for which the Crown may be directly or vicariously liable.

[28] Whether the Crown's liability on the facts herein is direct or vicarious was debated at length in counsels' written and oral submissions. I am satisfied that the tort claim being advanced by the plaintiffs for negligence/gross negligence is intended solely as a vicarious liability claim for the allegedly tortious acts or omissions of three targeted officer or agents of the Crown: the MLTC, the MOH and the CMOH.

[29] As I will explain shortly, only the MLTC emerges as an arguably viable Crown officer or agent for whose acts or omissions the provincial Crown may be vicariously liable. The other two, the MOH and the CMOH, may well deserve criticism for the alleged delay and inaction but there is no basis for a cause of action against either of them. The latter determination requires a rigorous "duty of care" analysis that is discussed in detail below.

[30] One further point. Because the core allegation is gross negligence (and a related lack of good faith) the plaintiffs are able to avoid not only the reach of SORA but also the complexities of the "operational versus policy" distinctions that often plague Crown liability analyses. The law is clear that the Crown's immunity for both operational and policy decisions only applies if these decisions were made in good faith.[15] Here, the allegations go beyond the protected zone of good faith.

[31] In sum, this motion for certification (as it pertains to the tort claim) does not turn on the "some basis in fact" or "some evidence" requirement. It turns on a legal analysis relating to Ministerial liability for tortious misconduct and the possible existence of a private law duty of care. More specifically, the key legal issue, as discussed below, is whether the tort claim against the MLTC, acting under the LTCHA, has some chance of success or is plainly and obviously doomed to fail.

[32] I now turn to the certification analysis.

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[15] CLPA, ss. 11(2) and (4). Also see *R v. Imperial Tobacco Canada Ltd*., 2011 SCC 42, at para. 90; and *Nelson (City) v. Marchi*, 2021 SCC 41 at para. 22 and 39-41.

Certification analysis

Section 5(1)(a): Cause of action

[33] As already noted, the plaintiff advances three causes of action: negligence/gross negligence, breach of fiduciary duty and breach of s. 7 of the *Charter of Rights.*

[34] The law as it applies to the "cause of action" requirement is not in dispute. Assuming the facts as pleaded are true, is it plain and obvious that the claim cannot possibly succeed and is doomed to fail? If there is even a chance of success, the s. 5(1)(a) hurdle is cleared.[16] Courts have generally adopted a "generous approach"[17] in the analysis of a claim's chance of success because as the Supreme Court noted in *Imperial Tobacco,* "the law is fluid, evolving over time so that actions that yesterday were deemed hopeless may tomorrow succeed." [18]

[35] In my view, there is enough in the pleadings and the applicable legal analysis to support at least an arguable chance of success for the tort claim as against the MLTC. However, the same cannot be said about the breach of fiduciary duty claim or the *Charter of Rights* claim. I will discuss each of these causes of action in turn.

The negligence/gross negligence claim

[36] The plaintiffs say that almost all of the Covid-related deaths and illnesses in LTC homes could have been prevented if the CMOH or the MLTC had simply used their ample regulatory powers under HPPA and the LTCHA and issued LTC directives in a more timely and effective manner.

[37] It appears that the tort claim herein is primarily focused on the acts and omissions of the CMOH and the MLTC – very little is said about the MOH. This may be best explained by the following.

[38] Section 77.7 of the HPPA provides a broad directive-making power to the CMOH. Section 174.1 of the LTCHA provides a more focused directive-making power to the "Minister" that is limited to LTC homes. In 2007, when the LTCHA was enacted, there was one combined Ministry of Health and Long-Term Care. Section 2 of the LTCHA defined the "Minister" therein is the Minister appointed by Order-in-Council. In June 2019, the combined Ministry was formally divided into two ministries headed by two separate ministers, the MOH and the new MLTC. Orders-in-

[16] *Cloud v. Canada (Attorney General),* (2004) 73 O.R. (3d) 401 (C.A.) at para. 41.

[17] *J.B. v. Ontario (Child and Youth Services),* 2020 ONCA 198 at para. 25.

[18] *Imperial Tobacco, supra,* note 15, at para. 21.

Council, dated August 8, 2019, provided that the MLTC would exercise the powers, duties, functions and responsibilities under the LTCHA.[19]

[39] Whatever role the MOH may have had under the LTCHA to issue directives aimed at LTC homes during the era of combined ministries changed in 2019. Although both Ministers no doubt consulted with each during the transition process and well into 2020, the directive-making powers set out in s. 174.1 of the LTCHA could only be exercised by the MLTC. This may explain the absence of any real focus on the MOH.

[40] In any event, as the plaintiffs well understand, suing a public authority such as the CMOH or the MLTC in tort for negligence/gross negligence is challenging at best. As in any tort case, the plaintiff must show that the defendant breached a duty care that was owed to the plaintiff, causing the alleged loss or damage. The plaintiffs accept that most public authorities are authorized by statute to regulate or issue directives "in the public interest". Generally speaking, the government's discharge of public law duties "in the public interest" does not give rise to a private law duty of care to a particular group of affected individuals.[20]

[41] The plaintiffs also accept that the negligence/gross negligence claim against the CMOH and the MLTC does not fall within a pre-existing category of cases in which a duty of care has been recognized. Therefore, the existence of a duty of care owed by these Crown agents must be determined from scratch using the two-part test that was set out by the House of Lords in *Anns v. Merton London Borough Council*[21] and refined by the Supreme Court in *Cooper v. Hobart*.[22] The two-part *Anns-Cooper* test requires the plaintiff to establish (i) foreseeability and proximity, and (ii) the absence of any policy considerations that would negate the imposition of a duty of care.[23]

[42] Here the issue is not foreseeability — there is sufficient evidence that the losses alleged herein were reasonably foreseeable to the defendant. The issue is proximity. The proximity analysis asks whether there a relationship of "sufficient closeness" between the government actor and the impacted individual or group of individuals that it would be "just and reasonable"[24] to impose an

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[19] Orders-in-Council 1110/2019 and 1111/2019.

[20] As explained by the Court of Appeal in *Eliopoulos (Litigation Trustees of) v. Ontario (Minister of Health and Long-term Care)*, (2006) 82 O.R. (3d) 321 at paras. 14 and 32; *Williams v. Canada (Attorney General)*, 2009 ONCA 378 at para. 25; and *Abarquez v. Ontario*, (2009) 95 O.R. (3d) 414 at para. 25 et seq.

[21] *Anns v. Merton London Borough Council*, [1977] 2 All E. R. 492 (H.L.).

[22] *Cooper v. Hobart*, [2001] 3 S.C.R. 537.

[23] *Imperial Tobacco, supra*, note 15, at para. 30. The two-stage test was succinctly summarized in *Aylmer Meat Packers Inc v. Ontario*, 2022 ONCA 579 at para. 24 et seq.

[24] *Imperial Tobacco, supra*, note 15, at para. 41; *Nelson, supra*, note 15, at para. 17.

obligation on the government actor to take reasonable care not to injure the individual or group of individuals.

[43] As the Supreme Court explained in *Imperial Tobacco*,

> It may be difficult to find that a statute creates sufficient proximity to give rise to a duty of care. Some statutes may impose duties on state actors with respect to particular claimants. However, more often, statutes are aimed at public goods, like regulating an industry (*Cooper*), or removing children from harmful environments (*Syl Apps*). In such cases, it may be difficult to infer that the legislature intended to create private law tort duties to claimants. This may be even more difficult if the recognition of a private law duty would conflict with the public authority's duty to the public: see, e.g., *Cooper* and *Syl Apps*. As stated in *Syl Apps*, "[w]here an alleged duty of care is found to conflict with an overarching statutory or public duty, this may constitute a compelling policy reason for refusing to find proximity" (at para. 28) …[25]

[44] A private law duty of care, as allegedly owed in this case by the CMOH or the MLTC, can arise in only two ways: by statute or by evidence of specific interactions between the public authority and the plaintiff.[26] Here there is no evidence of any specific interactions between the CMOH or the MLTC and any of the putative class members. There is some evidence of correspondence from the health officials to the owners or operators of the LTC homes but nothing between the health officials and LTC residents. There is also evidence that the CMOH and the MLTC (eventually) issued directives to LTC homes that affected the LTC residents. But, issuing directives to the LTC owners and operators is not enough to establish "specific interactions" with LTC residents. In any event, exercising statutory authority does not qualify as "specific interaction."[27]

[45] If a private law duty of care (and thus sufficient proximity) is to be established, it can only be established by considering the language used in the applicable statute.

[46] There can be no private law duty of care claim as against the CMOH based on statutory language because it is plain and obvious that the directive-makings powers under the HPPA are to be exercised in the public interest.[28] There is no mention or identification of any discrete group that may require or command special attention. I therefore conclude that the allegation that a private law

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[25] *Imperial Tobacco, supra,* note 15, at para. 41.

[26] *Imperial Tobacco*, *supra* note 15, at paras 43-46; *Aylmer Meat Packers, supra,* note 23, at para. 24 et seq.

[27] *Eisenberg v Toronto*, 2021 ONSC 2776 (Div. Ct.) at para. 47; *Edwards v. Law Society of Upper Canada*, 2001 SCC 80 at para. 9.

[28] *Abarquez, supra,* note 20.

duty of care is owed to LTC residents based on the HPPA is doomed to fail. I note there is no suggestion to the contrary.

[47] However, the 'private law duty of care' analysis as it relates to the MLTC is different in one important respect. As already noted, the basis for the tort claim against the MLTC cannot be found in any evidence of "specific interactions" with LTC residents. Indeed, no such interactions are pleaded. However, the basis for a possible tort claim against the MLTC can arguably be found in the language of the applicable statute, the LTCHA.

[48] The LTCHA provides that the provincial government *"recognizes the responsibility to take action where standards or requirements under this Act are not being met or where the care, safety, security and rights of residents might be compromised.*"

[49] Note the explicit language in the Preamble and also the "fundamental principle" that "should be applied in the interpretation of this Act" as set out in s. 1:

> **Preamble**
>
> *The people of Ontario and their Government:*
>
> Believe in resident-centred care;
>
> Remain committed to the health and well-being of Ontarians living in long-term care homes now and in the future;
>
> Strongly support collaboration and mutual respect amongst residents, their families and friends, long-term care home providers, service providers, caregivers, volunteers, the community and governments to ensure that the care and services provided meet the needs of the resident and the safety needs of all residents;
>
> Recognize the principle of access to long-term care homes that is based on assessed need;
>
> Firmly believe in public accountability and transparency to demonstrate that long-term care homes are governed and operated in a way that reflects the interest of the public, and promotes effective and efficient delivery of high-quality services to all residents;
>
> Firmly believe in clear and consistent standards of care and services, supported by a strong compliance, inspection and enforcement system;
>
> *Recognize the responsibility to take action where standards or requirements under this Act are not being met, or where the care, safety, security and rights of residents might be compromised;*
>
> **…**

> Therefore, Her Majesty, by and with the advice and consent of the Legislative Assembly of the Province of Ontario, enacts as follows:
>
> **Fundamental Principle and Interpretation**
>
> **Home: the fundamental principle**
>
> 1. The fundamental principle to be applied in the interpretation of this Act and anything required or permitted under this Act is that a long-term care home is primarily the home of its residents and 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.
>
> …

[50] On a plain reading, the Preamble provides that "the government" (which arguably means the "minister" who can exercise the powers of the LTCHA, clarified in the Orders-in-Council of August 8, 2019 to mean the MLTC) has a responsibility (or duty[29]) to take action on the pleaded facts herein. Section 1 sets out the "fundamental principle" that guides the interpretation of this statute — that the LTC home is primarily the home of its residents and is to be operated so that, among other things, it remains "a place where they may live with dignity and in security, safety and comfort …".

[51] The LTCHA itself is long and detailed. The Act lists the many obligations imposed on the licensee home owners and operators to "ensure" the residents' health and safety and overall quality of life and also includes an LTC residents Bill of Rights (enforceable as against the licensees). The defendant is correct to point out that s. 5 of the LTCHA imposes the obligation to "ensure that the home is a safe and secure environment for its residents" on the licensees and not on the government. Nonetheless, the Preamble does say that the government (arguably the MLTC) has a duty to "take action" in circumstances "where the care, safety, security and rights of residents might be compromised."

[52] This articulation of a statutory duty, in my view, is sufficiently explicit that it cannot be ignored in the s. 5(1)(a) "cause of action" analysis. There is a specific and identifiable group that is targeted for protection, namely the LTC residents. And it is at least arguable on the facts as pleaded, that it would be "just and reasonable" to find "sufficient closeness" or proximity to impose a duty on the MLTC to take action without delay when the lives of LTC residents are clearly at risk and their "care, safety, security … might be compromised."

[53] The plaintiffs' interpretation of the unique language in the LTCHA and their submission about a private law duty of care may or may not prevail when the issue is argued on the merits on

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[29] See any on-line definition of "responsibility".

full evidence. But at this stage of the proceedings, I am unable to conclude in any principled fashion that that it is plain and obvious that such a submission has zero chance of success and is doomed to fail.

[54] The Court of Appeal noted in *Taylor* that if a private law duty of care can arguably be established by examining the applicable statute, the *Anns-Cooper* inquiry need go no further:

> The legislative scheme must be examined at the outset of the duty of care inquiry. If that scheme expressly or by implication forecloses or imposes a private law duty of care, the duty of care inquiry need go no further. It is not for the court to contradict the terms of the legislative scheme.[30]

[55] Counsel for the plaintiffs, out of an abundance of caution, add three additional points bolstering the "stage two" policy considerations They submit, in my view correctly, that the alleged private law duty of care is clearly limited to LTC home residents. The duty is owed to a finite number of vulnerable individuals over whose care Ontario exercises significant regulatory control and oversight. There is no risk of indeterminate liability. Nor is there any meaningful conflict with any suggested "public interest" considerations. The recognition of a duty of care, argue the plaintiffs, would be consistent with the public interest to protect the health and safety of the vulnerable population residing at LTC homes. These are compelling submissions.

[56] I therefore conclude that an alleged breach of a private law duty of care on the part of the MLTC is genuinely arguable. The negligence/gross negligence cause of action has at least a chance of success and is not plainly and obviously doomed to fail. In my view, the possibility of a tort claim against the MLTC deserves to be adjudicated on the merits on the basis of a full record.

[57] To repeat — this conclusion is based primarily on the language in the Preamble:

- The language in the LTCHA Preamble explicitly imposes a clear obligation on "the government" in certain circumstances to "take action" to protect a specifically identified group of individuals, namely LTC residents. By early 2020, this obligation to "take action" was primarily the responsibility of the MLTC. It is, therefore, at least arguable that this statutory language imposes a duty of care upon the MLTC.

- Further, as the Court of Appeal noted in *Taylor*, proximity is not "an all-or-nothing proposition", but can "evolve" as circumstances change.[31] Here, it is at least arguable that the MLTC's responsibility to "take action" evolved into a private law duty of care at least at the point where Covid materialized and began to spread to the highly vulnerable LTC community.

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[30] *Taylor v. Canada (Attorney General)*, 2012 ONCA 479 at para. 77.

[31] *Ibid*., at para. 119.

[58] The defendant, as expected, advanced several counter-arguments. However, for each of the defendant's counter-arguments, the plaintiffs responded or the court suggested arguably compelling rebuttals. For example:

- The defendant pointed to s. 174.1 of the LTCHA that requires the Minister to consider "the public interest" when issuing directives respecting LTC homes. However, "public interest" is further explained in s. 174.1(c) as including, among other things, "the quality of care and treatment of residents within long-term care homes generally." Also, the LTCHA Preamble connects the public interest, at least to some extent, with the goals of the Act when it states that LTC homes should be governed and operated "in a way that reflects the interest of the public."

  The defendant submits that simply the mention of a "public interest" criterion is enough to defeat the private law duty of care suggestion. However, the case law notes that the public interest criterion is not determinative unless it is "over-arching"[32] or "over-riding".[33] As the Supreme Court observed in *Fullowka*:

  > The fact that an alleged duty of care is found to conflict with an *over-arching* statutory or public law duty *may* provide a policy reason for refusing to find proximity (emphasis added).[34]

  On-line dictionaries define "over-arching" as "the most important" and "over-riding as "more important than anything else." Here, it is at least arguable that the public interest criterion referenced in s. 174.1 is not "over-arching" or "over-riding" but is, to some extent, diluted, modified and arguably aligned with concerns about the health and safety of LTC residents. It is also genuinely arguable that LTC health and safety concerns do not conflict with public interest concerns, at least not in any meaningful way.

- The defendant points to ss. 11(2) and (4) of the CLPA and in particular s. 181 of the LTCHA that provide statutory immunity for governmental decisions made in good faith. The defendant says these immunity provisions show that the legislature did not intend to impose a private law duty of care in the LTCHA. The plaintiffs respond that that no such legislative intention can be discerned because the statutory immunity does not extend to decisions that are not made in good faith — that is, decisions that are pleaded to be so negligent that bad faith can be inferred.[35]

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[32] *Fullowka v. Pinkerton's of Canada*, 2010 SCC 14, at para. 39.

[33] *Abarquez, supra*, note 20, at para. 28.

[34] *Fullowka, supra,* note 32, at para. 39, citing *Syl Apps Secure Treatment Centre v. B.D.*, 2007 SCC 38 at para. 26.

[35] *Rausch v. Pickering (City),* 2013 ONCA 740 at paras. 48, 50.

> In my view, the implications of these statutory immunity provisions in discerning legislative intent are not plain and obvious. Their scope and content are at least arguable and should be adjudicated on the merits on the basis of a more complete record.

[59] As I have already noted, the defendant may well prevail when the viability of the tort claim against the MLTC and the existence of a private law duty of care to LTC residents is fully argued and adjudicated on the merits at trial. However, at this stage of the proceeding, on what is essentially a pleadings motion, I cannot conclude that the plaintiffs' submissions in this regard are not genuinely arguable and have no chance of success.

[60] I can do no better than track Doherty J.A.'s conclusion in *Taylor*:

> Ultimately, I come to this point. It is not clear to me that [the proposed representative plaintiffs] will at the end of the day succeed in making out a private law duty of care owed to [them] by [the MLTC]. However, bearing in mind that at this stage the allegations must be assumed to be true and must be read generously, and also having regard to the dynamic nature of the jurisprudence, it is not plain and obvious that the claim as pleaded is bound to fail for want of a private law duty of care. The courtroom door cannot be closed [to the] … members of the class at this stage. [36]

[61] However, the certified cause of action must be limited to LTC residents because they are the only statutorily-identified group to whom a private law duty of care may arguably be owed. The reach of the private law duty of care analysis cannot be extended to include visitors or volunteers.

[62] I acknowledge that the LTCHA Preamble mentions "visitors" and also that the LTC resident's Bill of Rights (enforceable against the licensees) includes "the right to receive visitors of his or her choice." I also recognize that it was at least foreseeable, as the evidence shows, that visitors could well be infected with the Covid-19 virus as they interacted with the residents and others in the LTC homes. However, foreseeability alone is not sufficient in the private law duty of care analysis. The real hurdle is proximity as based on statutory language. And here, the strongest, indeed only, statutory hook is the Preamble's assertion that the government will take action when the care and safety of "residents" might be compromised.

[63] The possible imposition of a private law duty of care on the MLTC in these circumstances is already tenuous given the issues and arguments discussed above. I am not persuaded on the statutory language before me that the reach of the private law duty of care analysis can or should go beyond the LTC residents to include visitors.

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[36] *Taylor*, *supra*, note 30, at para 120.

[64] The visitors class can take comfort in knowing that their claims can still be advanced in the parallel litigation that is proceeding against the LTC licensees — the owners and operators of the LTC homes.

Breach of fiduciary duty

[65] I agree with the defendant that the Supreme Court's decision in *Elder Advocates*,[37] a decision that also involved elderly residents of LTC facilities, is determinative and compels the conclusion that the plaintiffs' breach of fiduciary duty claim has no reasonable prospect of success.

[66] As the Court made clear, to establish that the provincial government (or as here, one of its Ministers) owes a fiduciary duty to, say, LTC residents, the plaintiffs must show, among other things, (i) not just vulnerability but a vulnerability arising from the relationship; and (ii) an undertaking by the alleged fiduciary to act solely and in the best interests of the alleged beneficiaries.

[67] The plaintiffs plead that the LTC residents were vulnerable, fragile and "completely dependent" on the defendant and the MLTC for their safety and care. And further that the defendant and the MLTC had a fiduciary duty to act in the best interests of the LTC residents and should therefore have issued timely directives to protect the LTC residents from the ravages of the Covid-19 pandemic. The plaintiffs plead and rely on the provisions of the LTCHA, in particular the language in the Preamble that the government (here, the MLTC as already discussed) would "take action" in circumstances "where the care, safety, security and rights of residents might be compromised."

[68] The problem with this submission is three-fold.

[69] First, there is nothing in the facts as pleaded or the LTCHA that even arguably shows that the LTC residents' vulnerability or fragility arose from their relationship with the government or the MLTC, as opposed simply to the realities of aging, related medical issues and the higher and more deadly health risks if exposed to Covid-19.

[70] Second, there is nothing in the facts as pleaded or in the LTCHA that even arguably supports the otherwise bald assertion that the LTC residents were "completely dependent" on the provincial government or the MLTC. The provincial government does not own or operate the LTC homes. The LTCHA, as discussed above, provides a long and detailed regulatory framework that imposes a wide range of obligations on the LTC home owners and operators, including the protection of the residents' health and safety. The suggestion that the LTC residents were "completely dependent" on either the provincial government or the MLTC finds no support in the statute and cannot possibly succeed. The LTC residents may depend to some extent on the

[37] *Alberta v. Elder Advocates of Alberta Society*, 2011 SCC 24.

provincial government and its ministers — for proper funding, the licensing of the LTC homes, regular inspections, overall oversight and enforcement, and yes, issuing health and safety directives in appropriate situations. But none of these, even in combination, amount to "complete dependency" at a level that would trigger a fiduciary duty standard.

[71] Third, I am not persuaded that the duty of care language in the Preamble (as discussed above) can support an arguable fiduciary duty to act solely in the best interests of the LTC residents, to the exclusion of all others. As already noted, s. 174.1 of the LTCHA provides that the Minister must consider "the public interest" when issuing directives respecting LTC homes. The Minister's consideration is obviously not limited solely and exclusively to the best interests of the residents. My discussion of s. 174.1 (above at paragraph 58) acknowledged the public interest criterion set out in s. 174.1 but noted, given the sub-sections, that "*the public interest criterion is not over-arching or over-riding but is — at least to some extent — diluted, modified or aligned with the concerns about the health and safety of LTC residents*". This discussion was intended to reinforce the possibility that the private law duty of care issue was arguable and not plainly and obviously doomed to fail. There was no suggestion in this discussion that the Minister's consideration of the public interest in s. 174.1 had been entirely eliminated and replaced with a fiduciary duty to issue directives solely in the best interests of the LTC residents.

[72] The plaintiffs referred to *Barker v Barker,*[38] a recent decision of the Court of Appeal. The Court affirmed the trial judge's imposition of a fiduciary duty on government psychiatrists engaging in non-therapeutic medical experimentation on inmates at a provincial psychiatric facility. In *Barker*, however, the Court noted that the claimants' vulnerability arose from their relationship with the provincial government and that the provincial government had "complete control" over "every aspect over the [inmates] care and treatment as persons".[39] This is certainly not the case here and is not supported by the plaintiffs' pleading.

[73] I therefore have no difficulty concluding that the breach of fiduciary duty claim, on the facts as pleaded, has no chance of success and is plainly and obviously doomed to fail.

Section 7 of the Charter of Rights

[74] Section 7 of the *Charter of Rights* provides that: "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice." The applicable law is not in dispute. In order to establish a violation of a s. 7 right, the must plaintiff must show that the state has deprived her of her right to

[38] *Barker v. Barker*, 2022 ONCA 567.

[39] *Ibid.*, at para. 88.

life, liberty or security of the person *and* that the deprivation is contrary to a principle of fundamental justice.[40]

[75] In most cases alleging a breach of s. 7, the court's focus in the "cause of action" analysis is two-fold: finding some evidence of state action, such as a prohibitory law or regulation[41] that arguably amounts to a deprivation of a s. 7 right, and some evidence that this state-related deprivation arguably contravenes a recognized principle of fundamental justice (here the plaintiffs argue arbitrariness).

[76] As I have already noted, the core allegation is that the defendant, specifically the MLTC, deprived LTC residents of their section 7 rights to life and security of the person by inexplicably (and thus arbitrarily) failing to take potentially life-saving action in a timely manner. The question here is whether the long government delay in issuing potentially life-saving directives can arguably constitute a state-related deprivation. Put simply, can government delay alone arguably amount to a deprivation?

[77] In *Leroux v. Ontario*,[42] I reviewed appellate authorities and concluded that "there is some support in the case law for the proposition that governmental delay can sometimes constitute a deprivation as intended and understood under s. 7 of the *Charter*."[43] In coming to this conclusion, I was mindful of the Supreme Court's admonition in *Blencoe*[44] that judges should maintain a degree of flexibility in the interpretation and evolution of s. 7 of the *Charter*:

> We must remember though that s. 7 expresses some of the basic values of the *Charter* … it would be dangerous to freeze the development of this part of the law. The full impact of s. 7 will remain difficult to foresee and assess for a long while yet. Our Court should be alive to the need to safeguard a degree of flexibility in the interpretation and evolution of s. 7 of the *Charter*.[45]

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[40] *Leroux v. Ontario*, 2018 ONSC 6452, at para. 43.

[41] See the discussion and case law examples in *Barbara Schlifer Commemorative Clinic v. Canada (Attorney General)* 2014 ONCS 5140 and *Leroux v Ontario*, 2021 ONSC 2269 (Div. Ct.).

[42] *Leroux, supra*, note 40.

[43] *Ibid.*, at para. 49.

[44] *Blencoe v B.C. (Human Rights Commission)* 2000 SCC 44.

[45] *Ibid.*, at para. 188.

[78] My decision to certify the s. 7 cause of action in *Leroux* was reversed on appeal by the Divisional Court.[46] The three-judge panel was clear that "mere inaction" or delay does not engage s. 7 of the *Charter* and it is an error to suggest otherwise.[47]

[79] I am, of course, bound by the decision of the Divisional Court.

[80] I am advised by counsel that this decision has been appealed and was recently argued, and that the decision of the Court of Appeal is forthcoming. As I mentioned to counsel at the hearing, if the appellate court's decision merits a reconsideration of the s. 7 claim herein, they should advise accordingly.

[81] At this point, however, I remain bound by the decision of the Divisional Court. I am obliged to conclude that government delay in issuing allegedly life-saving directives is not a "deprivation" under s. 7 of the *Charter*. The section 7 claim is struck.

Section 5(1)(b): Class definition

[82] Here again the applicable law is not in dispute.

[83] The resolution of mass claims involving a large number of individuals requires a flexible approach to defining the class.[48] It is not necessary that everyone in the class share the same interest in the resolution of the asserted common issues.[49] Individual class members may ultimately have to prove limited individual issues at individual issue hearings. This does not mean that the class definition lacks a common interest, is individualistic, or overly broad.[50] In any event, s. 25 of the CPA provides the judicial machinery to deal with individual issues that do arise.

[84] There is obviously an identifiable class of two or more persons with sufficient standing as LTC residents to bring this proposed class action. The class definition, as I have already noted, cannot not include visitors.

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[46] *Leroux, supra,* note 41.

[47] *Ibid.,* at paras. 116 and 119.

[48] As Winkler J. noted in *Frohlinger v. Nortel Networks Corp.,* [2007] O.J. No. 148 (S.C.J.) at para. 28: "[i]t must be remembered that the *CPA* is a procedural statute meant to provide a mechanism for the resolution of mass claims …The statute must be interpreted liberally and a rigid approach to class definition based on concerns about over inclusiveness may well defeat its purposes."

[49] *Hollick v. Toronto (City)* 2001 SCC 68 at para. 21.

[50] *Ontario v. Mayotte*, 2010 ONSC 3765 at para. 66; *Kalra v Mercedes Benz*, 2017 ONSC 3795 at para. 36; *Crisante v. DePuy Orthopaedics Inc*., 2013 ONSC 5186, at para. 37. See also *Markson v. MBNA Canada Bank*, 2007 ONCA 334 at paras. 19 and 35.

[85] However, the class may include the surviving family members who are advancing *Family Law Act* claims mainly for "loss of care, guidance and companionship".[51] Even though these are derivative claims that will be addressed at the individual assessment stage of the proceeding, if this point is reached, the individual claimants must be class members to have standing at these assessments. That is probably the reason why class action judges have routinely certified class definitions and PCIs claims including FLA claimants without much if any discussion. I do so here as well.

Section 5(1)c): Common issues

[86] The PCIs are set out in the Appendix. For the reasons set out above, I am prepared to certify PCIs 1 to 4 that ask about a private law duty of care and gross negligence. As already discussed, there is some evidence that these issues exist and that they can be answered on a class-wide basis — the analysis of a duty of care on the part of the MLTC and the impact of a breach of this duty would apply to all class members in the same way. Further, the resolution of PCIs 1 to 4 would significantly advance the litigation.

[87] I am also prepared to certify PCI 9 that asks about general causation. I note that Dr. Zoutman provided some evidence about both the existence of this issue at the individual level and its obvious class-wide commonality. Here is one excerpt from his report:

> Ontario's lack of preparation and its significant delay in taking precautions or actions to prevent and control outbreaks in the LTC homes were directly responsible for the startling rate of outbreaks in Ontario LTC homes and the disproportionately high rate of fatalities in Ontario's LTC homes during the first wave of the pandemic".

[88] The defendant makes much of the fact that after the tort liability issues in PCIs 1 to 4 and 9 are decided, individual damage inquiries will still be needed and that these individual assessments will be so extensive that they will overwhelm the commonalities. I do not agree. First, the determination of the tort liability issues alone will advance the litigation to a significant extent. Second, the defendant's understanding of the case law about individual assessments, at least under the unamended CPA, may be misguided.

[89] For an issue to be a common issue, it need only be a necessary and substantial ingredient in the resolution of each class member's claim. There can be many individual issues which remain

[51] *Family Law Act*, R.S.O. 1990, c. F.3, s. 61.

after the determination of the common issues.[52] As the Court of Appeal reaffirmed in *Hodge v. Neinstein*[53]:

> [E]ven a significant level of difference among the class members does not preclude a finding of commonality. If material differences do emerge, the court can deal with them at that time.[54]

[90] It is also important to remember that s. 6 of the CPA provides that the court "shall not refuse to certify a proceeding as a class proceeding" by reason of "a claim for damages that would require individual assessments." This statutory reminder reinforces the oft-repeated proposition in the case law that any individual issues which may remain after the common issues trial need not detract from the core commonality of the action. Here the core allegation provides a core commonality.

[91] The PCIs that ask about fiduciary duty and s. 7 of the *Charter* — that is PCIs 5 to 8 and 11 — are not certified because both of these causes of action have been struck.

[92] The PCIs that ask about damages, and in particular aggregate damages — that is PCIs 10 and 12 —will be deferred to the trial judge who, in my view, will be in a better position, if liability is established, to determine the scope and content of the subsequent damages inquiry. As the Supreme Court noted in *Pro-Sys Consultants Ltd. v. Microsoft*:[55]

> The question of whether damages assessed in the aggregate are an appropriate remedy can be certified as a common issue. However, this common issue is only determined at the common issues trial after a finding of liability has been made. The ultimate decision as to whether the aggregate damages provisions of the CPA should be available is one that should be left to the common issues trial judge.[56]

[93] I will, however, certify PCI 13 that asks about punitive damages (availability not quantum) because the availability of punitive damages is a determination about the defendant's conduct that can be made without evidence from individual class members.[57] Also, there is some basis in fact for this question and the extent of the defendant's alleged gross negligence will no doubt be explored in some detail when the tort liability PCIs are adjudicated.

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[52] *Hollick, supra* note 49, at para. 18.

[53] *Hodge v. Neinstein*, 2017 ONCA 494.

[54] *Ibid.* at para. 114.

[55] *Pro-Sys Consultants v. Microsoft*, 2013 SCC 57.

[56] *Ibid.* at para. 134.

[57] *Rumley v. British Columbia*, 2001 SCC 69 at para. 34.

[94] I should also add that I have deleted "the defendant" and the related footnote from the list of certified PCIs because the fiduciary duty and *Charter* claims have been struck and thus there is no further possibility for a direct liability claim.

Section (5)(1)(d): Preferability

[95] Here again, the case law is not in dispute. The focus of the preferability analysis is not whether a class action is the preferable procedure for resolving each individual class member's claim, but rather whether it is a preferable procedure for the resolution of the common issues.[58] The preferability analysis is conducted through the lens of the three principal goals of class actions: access to justice (the primary goal), judicial economy and behaviour modification. The focus is not on the convenience or burden of a class action *per se,* but on the relative advantages of a class action over other forms of litigation.[59]

[96] In my view, the proposed class action satisfies the preferable procedure requirement. The key issue — whether the LTCHA imposed a private law duty of care on the MLTC to "take action" when the care and safety of the LTC residents might be compromised — is best answered in one proposed class action rather than a myriad of costly individual claims. The resolution of the certified common issues, even if a substantial number of individual assessments remain, would advance the litigation significantly for all class members.

[97] The defendant submits that the repeal of the LTCHA and the recent enactment of the *Fixing Long-Term Care Act*[60] shows that a significant measure of behaviour modification has already been achieved. However, as the plaintiffs note, forward-looking legislation that may improve the condition of LTC homes for future residents but does not compensate for past harms does nothing to advance the access to justice concerns of the putative class members.[61]

[98] I agree with the plaintiffs that the preferability requirement is satisfied.

Section 5(1)(e): Suitable representatives

[99] There is no suggestion that the proposed representative plaintiffs would not fairly and adequately represent the interests of the class. Nor is there any suggestion of any conflicts of interest with other class members. The proposed litigation appears practical and workable.

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[58] *Kirsh v. Bristol-Myers Squibb*, 2020 ONSC 1499 at para. 90.

[59] *AIC Limited v. Fischer*, 2013 SCC 69 at para. 23.

[60] *Fixing Long-Term Care Act 2021*, S.O. 2021, c 39, Sch 1.

[61] *Fischer*, *supra* note 59, at paras. 20-23.

[100] The final requirement satisfied.

Conclusion

[101] The proposed class action is certified but only as against the MLTC and only on the tort claim, negligence/gross negligence. The other two causes of action, fiduciary duty and breach of s. 7 of the *Charter of Rights* have no chance of success and are struck. The class definition is limited to the LTC residents and surviving family members and does not include the visitor class. The PCIs are revised as set out in the attached Appendix.

[102] As counsel on both sides well understand, this is only the certification decision. The merits of this claim — whether or not the MLTC's alleged inaction and inordinate delay amounted to gross negligence that needlessly caused the deaths and illnesses of thousands of LTC residents and if so, whether this delay attracts legal liability — are not before me. The merits of this dispute will be decided at trial or by way of a motion for summary judgment, either of which is still many months away.

Disposition

[103] The proposed class action is certified as a class proceeding as per the parameters described above.

[104] As for costs, I have concluded that no costs should be awarded because the parties' success on this motion was almost evenly divided. Both sides devoted much time and energy sparring about the direct or vicarious liability issue, a protracted discussion that was largely resolved in favour of the defendant. The plaintiffs prevailed on the tort/private law duty of care claim but only as against the MLTC and only after significant amendments to the pleadings. The defendant prevailed on the fiduciary duty and *Charter* claims. The defendant successfully excluded visitors from the class definition. The disputes about the oft-revised PCIs were on balance resolved in favour of the defendant or at best resulted in a draw. The plaintiffs prevailed on the relatively straight-forward preferability analysis. The plaintiffs also prevailed on the suitability of the proposed representative plaintiffs but this last requirement was not contested by the defendant.

[105] Because success on this certification motion was almost evenly divided, it is fair and reasonable that no costs be awarded.

[106] I thank counsel for their assistance.

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Belobaba J.

Date: December 20, 2022

Appendix attached.

Appendix

Plaintiffs' Amended Proposed Common Issues

[Note: PCIs 1-4, 9 and 13, as revised, are certified; PCIs 5-8 and 11 are not certified; PCIs 10 and 12 are deferred to the trial or summary judgment judge].

Negligence and Gross Negligence

1) Did the MLTC ~~Defendant~~[62] owe a duty of care to the members of the Class~~es~~ to prevent and mitigate COVID-19 outbreaks in long-term care homes in Ontario?

2) If the answer to 1) is "yes", what is the nature of that duty of care?

3) If the answer to 1) is "yes", did the MLTC ~~Defendant~~ breach the duty of care she ~~it~~ owed to all or any of the members of the Class~~es~~? If so, when and how did the breach(es) occur?

4) If the answer to 3) is "yes", did any or all of the MLTC's ~~Defendant's~~ breach(es) amount to gross negligence?

~~***Breach of Fiduciary Duty***~~

~~5) Did the Defendant owe a fiduciary duty to the members of the Resident Class?~~

~~6) If the answer to 5) is "yes", what was the nature of this duty?~~

~~7) If the answer to 5) is "yes", did the Defendant breach its fiduciary duty to the members of the Resident Class?~~

~~***Breach of Section 7 of the Charter of Rights and Freedoms***~~

~~8) Did the Defendant's conduct related to COVID-19 outbreaks in long-term care homes in Ontario deprive the Resident and Visitor Class Members of their rights to life and/or security of the person, in a manner contrary to the principles of fundamental justice?~~

~~[62] "The Defendant" means: (a) Ontario, acting through the Minister of Long-Term Care, the Minister of Health and the Chief Medical Officer of Health, with respect to the common issues related to claims for negligence and gross negligence for which Ontario is vicariously liable; and (b) His Majesty the King in Right of Ontario with respect to the common issues related to claims for breach(es) of fiduciary duty and the *Charter* for which the Crown may be directly or vicariously liable.~~

Causation

9) If the answer to 4) ~~and/or 7)~~ is "yes", did the MLTC's ~~Defendant's~~ breach(es) of her ~~its~~ duty of care ~~and/or her breach(es) of fiduciary duty~~ cause or contribute to the harm(s) suffered and/or losses incurred by Class Members?

Damages

~~10)~~ Deferred. If the answer to 4) ~~and/or 7)~~ is "yes", are the members of the Class~~es~~ entitled to pecuniary and non-pecuniary damages arising from the MLTC's ~~Defendant's~~ negligence/gross negligence? ~~and/or its breach(es) of fiduciary duties?~~

~~11) If the answer to 8) is "yes", are damages available to the Resident Class Members and the Visitor Class Members under section 24 of the *Charter*?~~

12) Deferred. ~~If the answer to 8) and/or 11) is "yes",~~ Can the Court make an aggregate assessment of the damages suffered by the Class Members pursuant to sections 24 and 25 of the CPA, as a part of the common issues trial?

13) Does the conduct of the MLTC ~~Defendant~~ warrant an award of aggravated, exemplary and/or punitive damages?

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