Court File No. CV-09-376927 CP00

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

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

- and -

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

Proceeding under the *Class Proceedings Act, 1992*

AMENDED STATEMENT OF CLAIM

TO THE DEFENDANT

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

IF YOU WISH TO DEFEND THIS PROCEEDING, you or 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.

AMENDED THIS Dec 8/10 PURSUANT TO
MODIFIÉ CE CONFORMÉMENT À
☒ RULE/LA RÈGLE 26.02 (A)
☐ THE ORDER OF
L'ORDONNANCE DU
DATED / FAIT LE

REGISTRAR GREFFIER
SUPERIOR COURT OF JUSTICE COUR SUPÉRIEURE DE JUSTICE

Date April 21 2009

Issued by S. Chandradat.

Local registrar

Address of court office
393 University Avenue
10th Floor
Toronto, ON M5G 1E6

TO: **HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF ONTARIO**
Crown Law Office – Civil Law
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Toronto, ON M5G 2K1
Tel.: 416-325-8535
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AND TO: **HURONIA REGIONAL CENTRE**
700 Memorial Avenue
Orillia, ON L3V 6L2

CLAIM

1. The plaintiffs, on behalf of the Class as described herein, claim:

   i. an order certifying this action as a class proceeding and appointing the plaintiffs as representative plaintiffs for the Class and any appropriate sub-class thereof;

   ii. a declaration that the defendant breached its fiduciary, statutory and common law duties to the plaintiffs and the class through the establishment, funding, operation, management, administration, supervision and control of the Huronia Regional Centre ("Huronia");

   iii. a declaration that the defendant was negligent in the establishment, funding, operation, management, supervision and/or control of Huronia;

   iv. a declaration that the defendant is liable to the plaintiffs and the Class for the damages caused by its breach of fiduciary, statutory and common law duties and for its negligence in relation to the establishment, funding, operation, management, administration, supervision and control of Huronia;

   v. damages for negligence and breach of fiduciary duty, in the amount of $1 billion, or such other sum as this Honourable Court may find appropriate;

   vi. punitive damages in the amount of $1 billion, or such other sum as this Honourable Court may find appropriate;

   vii. an order appointing Marilyn Dolmage and Jim Dolmage as litigation guardians of the proposed representative plaintiffs,

   viii. pre judgment and post judgment interest pursuant to the *Courts of Justice Act*, R.S.O. 1995, c. C. 43, as amended;

   ix. costs of the action on a substantial indemnity basis or in amount that provides full indemnity;

   x. pursuant to section 26 of the *Class Proceedings Act, 1992*, S. 1992, c. 6, the costs of notice and of administering the plan of distribution of the recovery in this action, plus applicable taxes; and

   xi. such further and other relief as to this Honourable Court may seem just and appropriate in all the circumstances.

A. THE PARTIES

2. The plaintiff, Marie Slark ("Slark"), is an individual residing in the City of Toronto, in the Province of Ontario. Slark was born on January 31, 1954 and recalls that she was admitted to Huronia in 1961, at the age of seven (7) years old. Slark continued to reside at Huronia, as a ward of the institution, full-time, from 1961 through to 1970. In 1970, at sixteen (16) years of age, Slark was placed into a group home off the official property and ground of Huronia and operated by Huronia but nevertheless continued to attend school and went to ODCVI and Twin Lakes S.S.

3. The litigation guardian of Slark, Marilyn Dolmage ("Marilyn"), is an individual residing in the City of Toronto, in the Province of Ontario. Marilyn's educational credentials include a Bachelor of Arts, Bachelors of Social Work and a Masters of Social Work. Marilyn has worked alongside individuals with disabilities for over 40 years. Between 1968 and 1973 Marilyn was employed as a social worker at Huronia. In particular, she was assigned as Slark's social worker. Since that time, Marilyn and Slark have maintained their friendship.

4. The plaintiff, Patricia Seth ("Seth"), is an individual residing in the City of Toronto, in the Province of Ontario. Seth was born on May 22, 1958 and recalls that she was admitted to Huronia in 1964 at the age of six (6) years old. Seth continued to reside at Huronia, as a ward of the institution, on a full-time basis between 1964 and 1974. In 1974, at sixteen (16) years of age, Seth was placed into a group home on the official grounds and premises of Huronia. Seth moved away from Huronia in 1979 when she was twenty-one (21) years old.

5. The litigation guardian of Seth, Jim Dolmage ("Jim"), is an individual residing in the City of Toronto, in the Province of Ontario. Jim's educational credentials include a Bachelor of Arts, Bachelors of Physical Education and a Masters of Physical Education. Jim is a retired Guidance Department Head and former Integration Action Group Board Member. Jim has known Seth for over twenty years and continues to maintain a friendship with her.

6. The defendant, Her Majesty the Queen in right of the Province of Ontario (the "Crown") is named in these proceedings pursuant to the provisions of the *Proceedings Against the Crown Act*, R.S.O. 1990, c. P. 27, and the amendments thereto.

7. At all materials times, the Crown, through and with its agents, servants and employees, owned and was responsible for the operation, funding and supervision of Huronia as a residential facility for the care and control of mentally challenged and mentally disabled individuals and other persons in need of psychiatric care. Huronia is a Schedule I facility pursuant to the *Developmental Services Act*, R.S.O. 1990, c. D. 11.

8. Huronia is located in Orillia, Ontario and is under the sole jurisdiction and control of, and is operated by, the Crown. The Crown retained and authorized servants, agents, representatives and/or employees to operate Huronia and/or gave instructions to such servants, agents, representatives and employees as to the manner in which the facility was to function and operate.

9. The plaintiffs bring this action pursuant to the *Class Proceedings Act, 1992* on their own behalf and on behalf of all other persons who resided at Huronia.

10. The proposed members of the Class are:

i. all persons who resided at Huronia between ~~1876 and 2008~~ January 1, 1945 and March 31, 2009 who were alive as of April 21, 2007 (the "Resident Class"); and

ii. all parents, spouses, children and siblings of persons who resided at Huronia between ~~1876 and 2008~~ March 31, 1978 and March 31, 2009 who were alive as of April 2007 (the "Family Class").

B. HISTORY OF HURONIA REGIONAL CENTRE

11. Huronia ~~has~~ operated from 1876 to ~~the present day~~ March 31, 2009. Huronia houses, and has housed since 1876, over 3,000 individuals labelled severely developmentally challenged and delayed. The Resident Class, as people with disabilities, might be seen as a particularly vulnerable population within society..

12. Individuals were either placed in Huronia by (i) family members or their principal caregivers who voluntarily placed them to receive medical or personal care or by (ii) becoming wards of the Crown, having been legally remanded into the care of the province as wards of the state. Individuals were placed in Huronia as a result of their mental disabilities.

13. Huronia was intended to provide a residential program of hospital care, activity, educational programs and adult training to individuals of all ages labelled mildly, moderately, severely and profoundly disabled.

14. Originally, Huronia was founded in 1876 as the Orillia Asylum for Idiots and was operated under the Inspector of Asylums, Prisons and Public Charities until 1930. In 1890, the centre was renamed the Ontario Hospital for Idiots and then the Hospital for the Feeble-Minded in 1911. In 1936, the institution was again renamed as the Ontario Hospital School to reflect its educational component which operated under the direction of the provincial Department of Health until 1972 when the Department became the provincial Ministry of Health. Over time, Huronia's catchment admission area covered the regions of Halton, Peel, York, Simcoe, Muskoka and Parry Sound.

15. The Depression in the 1930's and the aftermath of the Second World War in the 1940's and 1950's, created problems for Huronia. Shortages of staff and funding, coupled with an expanding operation, led to a rapid growth in the institution's population which added to the overcrowding of Huronia. Huronia quickly became a large, overcrowded, isolated and undermaintained institution. During this time, the number of residents doubled.

16. Huronia continued to operate under the auspices of the Ministry of Health until 1974 when the institution was transferred to the Ministry of Community and Social Services. In 1974, the *Development Services Act*, 1974, S.C. 1974, c. 2, was enacted, which gave the Ministry of Community and Social Services legislative responsibility for all government and board-operated institutions for people with developmental disabilities. Huronia ~~is scheduled for closure by~~ closed on March 31, 2009 and ~~presently houses~~ housed approximately 311 residents at that time.

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

18. In and around 1956, Dr. Hamilton, a government agent inspector of Huronia, drew attention to the institution's use of restraints and seclusion techniques. For example, Dr. Hamilton found two young boys in seclusion and isolation in Cottage A-2, both suffering from severe degrees of prolapsed rectum and in restraining jackets. In Cottage L, Dr. Hamilton found three women, all in seclusion, two of them for more than one (1) years, written up in their records "with no indication of a time limit".

19. In 1960, Pierre Berton authored an article entitled, "What's Wrong at Orillia – Out of Sight, Out of Mind", in which he described the overcrowding, beds jammed together from head to head, only one lavatory to service sixty-four (64) residents and one washtub for one hundred forty-four residents. Berton alluded to "atrocities going on" at Huronia in his article.

20. Ultimately, Berton's article led to a Parliamentary debate with Donald MacDonald, Minister of Parliament for York region, calling Huronia a "hell-hole" and asserted that the cottages were "buildings for human storage" and constituted "fire hazards".

21. In 1971, the Walter B. Williston report, sponsored by the Ministry of Health, entitled "Present Arrangements of the Care and Supervision of Mentally Retarded Persons in Ontario" (the "Williston Report") was released to the then Minister of Health. The Williston Report was a scathing indictment of large institutions for the mentally handicapped in Ontario. Williston's findings regarding the operation of Huronia included, but were not limited to:

(i) shortages of staff and money,

(ii) seriously overcrowded, isolated and undermaintained;

(iii) overcrowding was most apparent in wards where profoundly and seriously disabled adults were left rocking or aimlessly walking;

(iv) residents were organized into work gangs to perform a number of routine tasks necessary for the operation of the institution;

(v) deficient staff to patient ratios, sometimes approaching thirty-percent (30%) deficiencies below minimum industry or regulatory standards of the day;

(vi) the antiquated buildings housing residents constituted fire hazards; and

(vii) residents were paid nothing, or minimally unrealistic and unfair wages, for their work and labour at Huronia.

22. On a more general level with respect to the three (3) large institutions in Ontario housing individuals labelled mentally disabled, including Huronia, the Williston Report concluded that:

(i) in many cases, residents used lavatories without doors or toilet seats;

(ii) the remote location caused a dearth of highly trained individuals prepared to relocate, causing a constant and insufficient number of physicians, psychiatrists, psychologists, nurses and social workers to staff Huronia;

(iii) these institutions forced mentally disabled residents to function far below developmental possibilities;

(iv) the Ontario Hospital School system was divorced from mainstream health, education and social/family services and could not therefore adequately establish and administer services which are responsive to community need; and

(v) a "century of failure and inhumanity in the large multi-purpose residential hospitals for the retarded should, in itself, be enough to warn of the inherent weakness in the system and inspire us to look for a better solution".

23. At the time the Williston Report was authored, the daily average resident population of Huronia was 1,857 and the number of staff dealing directly with the residents was 653.

24. In 1973, a second government-sponsored report prepared by Robert Welch, Provincial Secretary for Social Development, entitled "Community Living for the Mentally Retarded in Ontario" (the "Welch Report"), was released. The Welch Report focussed on the needs of mentally disabled persons in Ontario at large, not just on Huronia residents, warning that such persons require *additional special* treatment. The Welch Report determined that, not only did mentally disabled individuals Ontario not receive the level of appropriate care required, but that since the 1960's, there had been little overall improvement in the actual pattern of care received by the mentally disabled in Ontario.

25. By 1976, in response to continuing complaints about the administration of Huronia and the treatment of residents, yet another report was authored for the then Minister of Community and Social Services. This report was entitled "Inquiry into the Management and Operation of the Huronia Regional Centre, Orillia" and authored by Joseph Willard (the "Willard Report"). The findings of the Willard Report regarding the administration of Huronia were so serious and scathing that it ultimately precipitated and led to the replacement

of the administrator of Huronia at the time. Some of the specific recommendations regarding Huronia contained in the Willard Report included:

(i) review of the medication being prescribed and provided to determine the extent of the problems associated with excessive usage of psychoarmacological agents and patient toxicity;

(ii) staff ratios be raised to present day appropriate levels;

(iii) training programs for staff be implements given the fact that 20% of direct care staff were not qualified as counsellors and a lack of training existed for counsellors being promoted to supervisory positions;

(iv) increased supervision of residents, the Report finding that the inadequacy of supervision was questionable and contributing to a general relaxation of responsibility; and

(v) that the procedure for dealing with resident abuse provide for an ombudsman function so that an independent review of abuse allegations could be assured.

26. Accordingly, by 1976, numerous specific recommendations had been made directly to the Crown to identify, halt, report and eliminate abuse and to provide an appropriate level of care to Huronia residents.

27. However, notwithstanding these recommendations, over a period of some years, no adequate internal safeguards were put into place to prevent or report abuse of Huronia residents and no adequate steps were taken to improve the quality of care or living at Huronia. In the alternative, even if the Crown adopted some of the recommendations, those measures were inadequate and failed to meet the standard of care which was applicable in the circumstances.

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

29. During this same time, between approximately 1954 and 1989, the operation, control and management of Hurnoia became the subject of local and national media attention.

Through numerous publications, information regarding Huronia's operations became well-known. Amongst other things, those publications documented and publicized the following incidents:

i. March 1957: a resident strangles in strait jacket, making it the third investigation into the death of a patient at Huronia in one month;

ii. January 1960: severe overcrowding and significant fire hazards cited, including an incident where a resident suffocated during a fire in one of the buildings;

iii. May 1960: a five year old resident died following a scuffle with another resident; coroner's report criticized the lack of organized supervision as a contributing cause of death;

iv. February 1974: four staff members were investigated for perpetrating various forms of abuse on residents, resulting in two staff being discharged for physical abuse of residents;

v. May 1974: two staff members previously discharged for abusive treatment of residents were reinstated to employment at Huronia;

vi. May 1976: two residents were stabbed and another beaten to death resulting in murder charges;

vii. May 1978: an individual convicted of kicking a resident in the face was reinstated to employment at Huronia;

viii. January 1979: Ministry plans probe into abuse at Huronia which followed an earlier investigation by the Ontario Provincial Police;

ix. July 1980: calls for inquiry into use of prescription drugs at Huronia followed incident in which residents were admitted to hospital in toxic condition as a result of overmedication; and

x. February 1989: three Ministry staff faced seventeen charges in connection with alleged assaults on residents of Huronia over the prior year.

C. THE PLAINTIFFS' EXPERIENCES AT HURONIA

(i) Marie Slark

30. During the time when the various public recommendations and reports were published regarding the treatment of Huronia residents and the very operation of the institution, referred

to above, the plaintiffs were placed into Huronia as full-time residents when they were both minor children.

31. Slark was removed from her family at the age of seven (7) by the province of Ontario's Children's Aid Service. She was first placed into foster care and then admitted to Huronia as a ward of the institution ultimately, of the province of Ontario.

32. Upon admission to Huronia, Slark recalls that she was first placed into Hospital "G" and then into K3. During her early school aged years, she recalls that she was denied an education by Huronia and the Crown due to her size.

33. Slark repeatedly witnessed other children residing at Huronia being physically punished for no reason and experienced staff members instructing minor residents to physically abuse one another at the staff's direction.

34. At the age of sixteen (16), in 1970, Slark was placed, at the direction of the Crown and Huronia, into an "approved home" off the official Huronia grounds. This "approved home" was ostensibly reviewed, investigated and pre-approved by the Crown and Huronia. It was at this pre-approved home, where Slark was sent by the Crown and Huronia, having been under their exclusive care and control at the time, that she was sexually abused. Slark never told Huronia agents about this incident for fear of being returned to Huronia.

35. Thereafter, Slark attended public high school and Georgian College, after moving off Huronia's grounds.

36. Slark has no recollection or confirmation of ever being formally or officially discharged from Huronia.

(ii) Patricia Seth

37. Seth recalls that she was removed from her family at the age of six (6) and placed into the admissions unit at Huronia at which time she was immediately placed into an isolation ward. Ultimately, Seth was placed into the Children's Dorm and then K3 at Huronia.

38. During her residence at Huronia, Seth was repeatedly and continuously physically abused and punished. The physical abuse commenced upon Seth's admission to Huronia in 1964 and continued during her whole duration of residence there.

39. Amongst other things, Seth was hit with a fly swatter, a rad brush and was punished for not eating by being held upside down in ice cold water. Seth found her life at Huronia terrifying and for many years, watched her fellow residents being physically beaten by staff or by one another.

40. Seth was repeatedly and continually physically punished and beaten for "speaking out". Additionally, as a result of her "speaking out", Huronia administered large doses of inappropriate, unnecessary and dangerous drugs such as paraldehyde, largactil and placidl, amongst other things. The administering of various drugs, such as largactil, was also done as punishment to Seth. The ingestion of largactil has the effect of inducing nausea and vomiting of children.

41. At sixteen (16) years of age, Seth was placed into a group home, "operated" by Huronia, on the grounds of the institution. Seth experienced further abuse, physical and emotional, during her residence at the group home which was wholly operated and under the supervision of Huronia and the Crown.

42. Neither of Seth nor Slark were able to report the abuse they experienced due to their fear of repercussions and the threat of increased abuse upon reporting.

D. KNOWLEDGE OF THE CROWN

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

44. The funding provided by the Crown was inadequate to meet the costs of operating and maintaining Huronia and in particular, to meet the needs of the individuals who resided there.

As a result, the care provided to the resident class members and the conditions at the facility were poor, the staff hired was unskilled or unsuitable for dealing with mentally challenged persons and the conditions at the facility were not suitable or appropriate for a residential facility for people with mental disabilities.

45. The members of the class are all of the present and past residents of Huronia. ~~Presently~~ At the time of its closure in 2009, there ~~are~~ were approximately 311 residents of Huronia.

E. MISTREATMENT OF RESIDENTS & CONDITIONS OF THE INSTITUTION

46. The persons who were admitted into Huronia were typically between the ages of six (6) and twenty-one (21) years of age. In many cases, they were forced to reside at Huronia by representatives of the Crown.

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

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

(ii) residents were often not bathed or cleaned;

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

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

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

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

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

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

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

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

F. DUTIES OWED BY THE CROWN TO THE CLASS

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

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

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

(ii) ensuring that physical, emotional and sexual abuse would not occur;

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

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

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

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

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

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

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

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

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

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

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

G. FIDUCIARY RELATIONSHIP BETWEEN THE CROWN & THE CLASS

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

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

52. All individuals who resided at Huronia did so as wards of the Crown, with the Crown as their guardian, and were persons to whom the Crown owed the highest non-delegable, fiduciary, moral, statutory and common law duties, which included, but was not limited to, the duty to ensure that reasonable care was taken of the residents of Huronia, the duty to protect residents while at Huronia, the duty to protect the resident Class from intentional torts perpetrated on them while at Huronia, liability if these non-delegable and fiduciary duties were performed negligently or tortiously and the special responsibility to ensure the safety of the resident Class while at Huronia.

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

(i) for the administration of the Ministry of Health, the Ministry of Community and Social Services and the *Development Services Act,* R.S.O. 1990, c. D. 11,

as amended, and its predecessor statutes as well as any other statutes relating to disabled persons and all Regulations promulgated under these Acts and their predecessors during the Class Period;

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

(iii) for the management, operation and administration of the Ministry of Health and Ministry of Community and Social Services and their predecessor Ministries and Departments during the Class Period;

(iv) for decisions, procedures, regulations promulgated, operations and actions taken by the Ministry of Health and Ministry of Community and Social Services, their employees, servants, officers and agents and their predecessors during the Class Period;

(v) for the construction, operation, maintenance, ownership, financing, administration, supervision, inspection and auditing of Huronia during the Class Period;

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

(vii) for inspection and supervision of Huronia and all activities that took place therein during the Class Period and for full and frank reporting to the Family Class Members with respect to conditions at Huronia and all activities that took place therein during the Class Period; and

(viii) for communication with and reporting to the Family Class with respect to the activities and experiences of Class Members while residing at Huronia during the Class Period.

~~54. The Crown also owed the residents' legal guardians a fiduciary duty which included a duty to care for and protect Huronia's residents, a duty to act in the residents' best interests and a duty to fully inform the legal guardians of any and all factors which could endanger the residents' safety or well being.~~

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

~~56. The Crown also owed contractual obligations to the residents' legal guardians which included, but were not limited to, acting in the residents' best interests at all material times and to inform the residents' guardians of any and all factors which might affect or threaten the residents' safety or well-being.~~

57. At all material times, the resident class members who resided at Huronia were entirely and exclusively within the power and control of the Crown and were subject to the unilateral exercise of the Crown's power or discretion. By virtue of the relationship between the mentally challenged residents and the Crown, being one of trust, reliance and dependence, by the residents, the Crown owed a fiduciary obligation to ensure that the residents of the facility were treated respectfully, fairly, safely and in all ways consistent with the obligations of a party standing *in loco parentis* to an individual under his or her care or control.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

60. The residents of Huronia, ~~their legal guardians and family members~~, had a reasonable expectation that the Crown would act in their best interests with respect to their care and the existence and operation of Huronia by virtue of the following:

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

(ii) the unilateral assumption of responsibility for the care of the class members and similarly situated persons by the Crown;

(iii) the involvement of the Crown in the initial establishment of Huronia;

(iv) the long standing dependence of Huronia residents on the Crown;

(v) the nature and severity of the mental and physical disabilities experienced by Huronia residents;

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

(vii) the vulnerability of Huronia residents as a result of their range of disabilities;

(viii) the involuntary nature of the relationship between Huronia residents and the Crown.

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

H. DAMAGES SUFFERED BY THE CLASS

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

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

(i) emotional, physical and psychological abuse;

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

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

(iv) an impaired ability to trust other persons;

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

(vi) alienation from family members;

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

(viii) pain and suffering;

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

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

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

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

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

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

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

(xvi) loss of friendship and companionship;

(xvii) sexual disorientation; and

(xviii) the loss of general enjoyment of life.

64. At all materials times, the Crown has known, or ought to have known, particularly since 1970, and continues to know, that ongoing delay in failing to rectify the institutional failures would continue to aggravate and contribute to the Resident Class members' injuries and damages.

65. As a result of the injuries referred to *supra*, the Resident Class members have required and will continue to require further medical treatment, rehabilitation, counselling and other care. The plaintiffs and other Resident Class members, or many of them, will require future medical care and/or rehabilitative treatment, or have already required such services, as a result of the Crown's conduct for which they claim complete indemnity, compensation and payment from the Crown for such services.

66. Members of the Family Class have suffered, and continue to suffer, loss of care, guidance and companionship which arises directly, or indirectly, from the physical, mental and emotional trauma sustained directly, or indirectly, by the Resident Class who resided at Huronia. The harm suffered by the Family Class was reasonably foreseeable and was caused by the conduct of the Crown and its agents for whom they are in law responsible.

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

I. PUNITIVE DAMAGES

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

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

70. In these circumstances, the plaintiffs and the Class Members request aggravated and punitive damages to demonstrate to other institutions that such wilfully irresponsible and tortious behaviour will not be tolerated and will act as a deterrence to other institutions in Canada who are in the position of acting as care-givers to likewise vulnerable populations of individuals with disabilities. These individuals, by virtue of both disability and of social and institutional structures, are among the most vulnerable in Canadian Society.

71. Notice of this action was provided to Her Majesty, the Crown, on October 14, 2008.

72. This action is commenced pursuant to the *Class Proceedings Act, 1992*.

73. The trial of the action should take place in the city of Toronto, in the Province of Ontario.

April 21, 2009

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and

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Court File No: CV-09-376927 CP00

ONTARIO
SUPERIOR COURT OF JUSTICE

Proceeding commenced at TORONTO

AMENDED STATEMENT OF CLAIM

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