CITATION: Head v. 859530 Ontario Inc., 2025 ONSC 4817
COURT FILE NO.: CV-21-00000142-00CP
DATE: 20250821

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:	
GEORGE HEAD by his Litigation Guardian MARCELLA LAMBIE, MARCELLA LAMBIE, the Estate of JANET MARTIN, deceased, by her Estate Representative SCOTT MARTIN, and SCOTT MARTIN Plaintiffs	Gayle Brock, Nicholas Fleming, Robert Durante, Ben Irantalab, for the Plaintiffs
– and –	
859530 ONTARIO INC., BARRIE LONG TERM CARE CENTRE INC., JARLETTE HOLDINGS INC., JARLETTE LTD., and ROBERTA PLACE RETIREMENT LODGE INC. Defendants	Deborah Berlach, Gaetana Campisi, Thomas Russell, for the Defendants
	HEARD: May 12, 2025

REASONS FOR DECISION

HEALEY J.

Introduction and Overview

[1] The Plaintiffs seek to certify this action as a class proceeding pursuant to the *Class Proceedings Act, 1992*, S.O. 1992, c. 6 ("*CPA*"). The action seeks redress for residents of a long-term care home who testified positive for COVID-19 during an outbreak in early 2021, over half of whom died, and to provide compensation for their family members. The outbreak began on January 8, 2021, and lasted until February 18, 2021 (the "Outbreak").

[2] The Outbreak occurred at Barrie Long Term Care Centre Inc., operating as Roberta Place ("Roberta Place").

[3] As the virus spread during the Outbreak, 129 residents and 105 staff members tested positive for COVID-19. A total of 73 residents died, 71 of whom tested positive for COVID-19 prior to their passing. The Plaintiffs' expert, Dr. Abdu Sharkawy, asserts that this rapid and widespread transmission throughout Roberta Place during a six-week period was disproportionate to any other long-term care facility in the province at any stage of the pandemic.

[4] The Plaintiffs' claim alleges systemic gross negligence on the part of the Defendants for failing to properly plan for and respond to the COVID-19 pandemic and for failing to implement the institutional policies and procedures required to prevent the mass spread of COVID-19. The Plaintiffs allege the Defendants' breach of the standard of care caused the widespread pain, suffering, and death experienced during the Outbreak.

[5] The only issue to be decided is whether the Plaintiffs have met the requirements for certification prescribed by s. 5 of the *CPA*.

[6] This court has the benefit of three prior certification motions involving COVID-19 in the long-term care home sector: see *Robertson v. Ontario*, 2022 ONSC 5127, 165 O.R. (3d) 528, aff'd 2024 ONCA 86, 492 D.L.R. (4th) 530, leave to appeal refused, 2024 CanLII 90826 (S.C.C.); *Pugliese v. Chartwell*, 2024 ONSC 1135, leave to appeal refused, 2024 ONSC 4671 (Div. Ct.); and *Surette v. Northwoodcare Group Inc*., 2024 NSCC 388, leave to appeal refused, 2025 NSCA 52.

Proposed Class Definitions

[7] The Plaintiffs have proposed the following class definitions, which the Defendants have agreed are appropriate:

a. All individuals who tested positive for COVID-19 living in Roberta Place Long Term Care Home from January 10, 2020, to February 18, 2021 (the Residents Class);

b. The estates of all individuals who died from a COVID-19 infection acquired between January 10, 2020, to February 18, 2021, while living in Roberta Place Long Term Care Home (the Estates Class); and

c. All family members of such persons described in (a) or (b), who have standing in this action pursuant to section 61 of the *Family Law Act*, R.S.O. 1990, c F.3 (the Family Class).

The Parties and Witnesses

[8] George Head is a Plaintiff who has lived at Roberta Place since March 2018. Mr. Head has frontal lobe dementia and has been placed on antipsychotic medication to treat paranoia and anxiety. He was 70 years old at the time of the Outbreak and was living in a private room.

[9] Marcella Lambie is the Litigation Guardian and Power of Attorney for George Head and is his sister. She has been assisting him since his dementia diagnosis. She seeks to be a representative Plaintiff.

[10] Janet Martin, now deceased, moved into Roberta Place in 2015 and died on January 15, 2021, at the age of 90. She had a complex medical history including obesity, unspecified dementia, vascular disease, and diabetes. Janet Martin did not produce a positive COVID-19 test, but her Medical Certificate of Death lists COVID-19 as the cause.

[11] Scott Martin is Janet Martin's son and was his mother's Power of Attorney for both Property and Personal Care and is her estate's Executor. He seeks to be a representative Plaintiff.

[12] The Defendant, 859530 Ontario Inc., operating as Jarlette Health Services ("JHS"), is a management company responsible for managing Roberta Place.

[13] Roberta Place is located in Barrie, Ontario, and has approximately 140 beds. It is accountable to the Ministry of Long-Term Care ("MLTC"), a successor agency to the Ministry of Health and Long-Term Care ("MOH"), Ontario Health Central Region, a successor agency to the North Simcoe Muskoka Local Health Integration Network ("LHIN"). Roberta Place falls within the jurisdiction of the Simcoe Muskoka District Health Unit ("Public Health"). Public Health is responsible for outbreak management in long-term care homes within its jurisdiction.

[14] Julia King is the Chief Operating Officer of JHS, a position that she held prior to the Outbreak.

[15] Christina Bath was the Care Services Coordinator for JHS, assigned to Roberta Place from approximately October 2020 to June 2021.

[16] Jarlette Holdings Inc. and Jarlette Ltd. are Defendants described in the Amended Statement of Claim as privately held owner-operators of retirement and long-term care facilities in Ontario. Roberta Place Retirement Lodge Inc. is described as an operator, owner or administrator of Roberta Place.

[17] Dr. Abdu Sharkawy holds specialties in internal medicine and infectious diseases, and has privileges at University Health Network as an internal medicine and infectious disease specialist. He is a longstanding member of the Guidelines Committee for the Association of Medical Microbiology and Infectious Diseases of Canada. His experience with infection prevention and control and the management of infectious diseases dates to the SARS pandemic of 2003 and includes COVID-19. The record for this certification motion contains his initial report dated April 23, 2023, and a reply report dated November 12, 2023.

[18] Dr. Mark Loeb, retained by the Defendants, holds specialties in internal medicine, medical microbiology, and infectious diseases. He is the Co-Director of the WHO Collaborating Centre for Infectious Diseases, Research Methods, and Recommendations.

He has extensive advisory, review, and research experience, including for WHO, the U.S. Centers for Disease Control and Prevention, Canadian Institute for Health Research, and the Canadian Immunization Research Network, and has published 41 peer reviewed papers on COVID-19. The record contains his report dated September 27, 2023.

[19] Gary Principe is a Chartered Professional Accountant, Chartered Accountant, and Chartered Business Valuator who was retained by the Plaintiffs to provide an expert opinion regarding whether a formula can be created to help the court determine damages on an aggregate basis. Ultimately, the Plaintiffs did not rely on his evidence for this motion.

THE FACTS

Roberta Place

[20] Like most long-term care homes, Roberta Place's residents live in a congregate setting. Its 140 beds are located across three floors and five home areas. Approximately 40% of the rooms in Roberta Place are shared by two residents and 60% of the rooms are private.

[21] Most of the residents at Roberta Place are over the age of 80. Residents are typically in Roberta Place because they require 24-hour care. 75 to 85% of the residents have some form of dementia, and/or other medical conditions including restricted mobility.

The Global Pandemic

[22] Dr. Sharkawy and Dr. Loeb agree on most of the fundamentals of COVID-19. The virus was first identified in Canada on January 27, 2020. Community transmission of COVID-19 in Canada was confirmed in March 2020.

[23] COVID-19 is spread via the respiratory tract through viral particles being inhaled by a non-immune individual, when an infected person sneezes, coughs or breathes.

[24] As early as April 2020, the risk factors for more severe outcomes were identified. Severe outcomes are most common in individuals of advanced age or with underlying conditions such as cardiovascular disease, diabetes, chronic respiratory disease, hypertension, and other similar diseases.

[25] The parties agree that long-term care facilities represented a uniquely vulnerable environment for viral transmission and residents of Roberta Place were at risk of more severe outcomes, including death.

[26] Dr. Sharkawy's report states that from March 17 to August 31, 2020, Ontario long-term care homes accounted for 64.5% of the province's COVID-19 deaths, the highest proportion of long-term care deaths among 16 other countries forming the Organization for Economic Co-operation and Development.

[27] On December 14, 2020, Simcoe County entered the Red Control level under the province's COVID-19 Response Framework because of the swift growth of COVID-19 in the area. Public Health's advice was to do everything possible to contain viral spread.

[28] On December 26, 2020, Ontario entered a period of lockdown.

The Defendants Planning and Response

[29] The Plaintiffs allege that the Defendants "failed to protect the residents living in [Roberta Place] through their grossly inadequate general planning and preparation for a viral respiratory outbreak".

[30] JHS began to review its existing processes and prevention protocols in December 2019. This included taking steps to place orders for additional personal protective equipment ("PPE") and to secure distribution agreements with various PPE vendors. An Infection Prevention and Control ("IPAC") assessment conducted by Public Health on January 11, 2021, indicated that the Defendants maintained a sufficient inventory of PPE during the Outbreak.

[31] The Defendants' evidence is that Roberta Place implemented a comprehensive IPAC policy and followed protocols and procedures as required by MLTC, MOH, LHIN, and Public Health by February 2020. Prior to the Outbreak, they worked closely with Public Health and its hospital partner, the Royal Victoria Hospital ("RVH"), to ensure compliance with best practices.

[32] The Defendants' position, supported by Dr. Loeb, is that no amount of preparation could have prevented the Outbreak that eventually occurred at Roberta Place.

[33] The IPAC protocols at Roberta Place included procedures for the orientation and training of staff regarding use of PPE, a hand hygiene program, auditing tools, and procedures for monitoring residents with infections. Throughout the pandemic, it maintained an online learning platform to keep staff informed, providing staff with updated education modules to complete on PPE and IPAC.

[34] Roberta Place began active screening of visitors on March 12, 2020, and restricted visitor access on March 13, 2020. Masks were supplied to every visitor entering Roberta Place, and each was required to perform the required hand hygiene and replace an existing mask with a new one. In the same month, it began to address staffing demands.

[35] On March 26, 2020, JHS implemented a COVID-19 Operational Plan at the home with directives from the MOH, MLTC, and Public Health.

[36] It is Bath's evidence that the IPAC policies are reviewed annually by Roberta Place and updated. They are reviewed by Public Health every two years, the last review being conducted in the spring of 2020. During its last review prior to the Outbreak, Public Health made very few recommendations, which resulted in almost no changes to the existing IPAC policy.

[37] King's evidence is that by September 2020, JHS began to plan and prepare for a second wave of COVID-19. Between September and December 2020, Roberta Place implemented various directives and guidance from the MLTC and Public Health, in accordance with the evolving understanding of COVID-19 best practices. The various directives that were undertaken at Roberta Place, according to King, were consistently updated.

[38] King also stated that JHS prescribed additional measures. These included testing more frequently than required and the implementation of the "single site employer" policy before it was mandated by the province.

Inspections

[39] The MLTC performed an inspection of Roberta Place between August 24 and 28, 2020; August 31, 2020; and September 1 to 3, 2020. The Inspector found Roberta Place failed to comply with section 229 of the *Long-Term Care Homes Act*, O. Reg 79/10, by failing to ensure all staff participated in implementing IPAC protocols.[1] The Inspector made the following findings in their report:

a. Appropriate isolation precautions were not implemented for two residents. One resident was unwell and the other had returned from another facility. Under the regulation, staff were required to use gowns, gloves, masks, and goggles/face shields when within two metres of these residents. However, the Inspector observed staff wearing only a procedural mask and gloves when interacting with the residents.

b. Reusable isolation gowns were observed hanging on a handrail outside of a resident's room, increasing the risk for contact surfaces to become contaminated.

c. Mobility aides of residents were visibly soiled with staining and debris. This was observed on both initial and follow-up observations.

[40] The Inspector determined the scope of non-compliance with IPAC requirements was a pattern at Roberta Place and posed an actual risk to residents.

[41] The Inspector ordered Roberta Place to retrain all staff on isolation precautions related to COVID-19 and the appropriate use of PPE. The Inspector also ordered Roberta Place to develop and implement an auditing process to ensure staff were utilizing appropriate PPE when caring for residents on isolation precautions. Lastly, the Inspector ordered that Roberta Place develop and implement a process for ensuring that PSW staff are correctly handling soiled items, including soiled incontinence products.

[1] The *Long-Term Care Homes Act* was in force until April 11, 2022, as repealed by *Fixing Long-Term Care Act*, 2021, S.O. 2021, c. 39, Sched. 1, O. Reg 246/22.

[42] The Ministry of Long-Term Care completed a follow-up inspection of Roberta Place between December 7 and 11, 2020. The Inspector found Roberta Place had again failed to comply with section 229 of the *Long-Term Care Homes Act*, O. Reg 79/10, by failing to ensure staff participated in implementing IPAC protocols. The Inspector made the following findings in their report:

a. Staff failed to use proper eye protection when providing care to residents.

b. Staff failed to utilize proper PPE when providing care to residents.

c. Staff reported, and the Inspector observed, that staff did not have access to a specific supply of procedural masks. The lack of access resulted in staff being unable to change their masks as required.

d. Staff were observed to be within six feet of residents without wearing masks.

[43] The Inspector found the severity of staff not implementing appropriate IPAC protocols for residents who were on isolation precautions posed an actual risk to residents and staff through potential transmission. The scope of the non-compliance was deemed widespread.

[44] The Inspector spoke with the Co-Director of Care at Roberta Place about their observations, who verified that the Inspector's observations were a safety issue and that it was not due to a lack of education within Roberta Place.

[45] The Inspector issued several orders aimed at ensuring Roberta Place enforced staff participation in the IPAC program, specifically, the appropriate use of PPE when attending residents who are placed on isolation precautions.

The Outbreak at Roberta Place

[46] Precipitating the Outbreak, a resident tested positive for COVID-19 on January 8, 2021, after being admitted to the hospital for a fall. Thus began the Outbreak, which lasted until February 18, 2021.

[47] King's evidence is that due to its rapid onset, the Defendants were unable to implement resident cohorting, and it was difficult to track viral spread given how quickly transmission was occurring.

[48] It was determined that the Outbreak involved the B.1.1.7 (or "UK") variant of COVID-19. The parties agree that the UK variant is more transmissible and leads to more severe outcomes than the original strain of the virus.

[49] King's evidence is that the UK variant changed the landscape for institutions in attempting to prevent outbreaks, creating increased challenges to implement policies that were more effective against the original strain.

[50] A Technical Brief released by the Ontario Government on January 29, 2021, stated that managing the UK variant did not require any changes to the IPAC measures already mandated, but noted that the margin of error for failing to apply the required IPAC measures was lower.

[51] The Defendants' evidence is that they worked closely with Public Health to ensure that they were following the most recent best practices, and communicated regularly with various Public Health members, including its Medical Officer of Health, Dr. Gardner, to ensure that they were doing everything possible to facilitate the end of the Outbreak.

[52] New COVID-19 cases began decreasing at Roberta Place by the end of January 2021 and only one resident remained positive by the first week of February.

[53] In total, Roberta Place had 129 resident cases of COVID-19 during the Outbreak. Of those 129 residents, 73 died, which represents 57% of the resident population. There were 105 staff cases of COVID-19 during the Outbreak.

[54] It is the position of the Defendants that the virulence of the UK variant, the vulnerability of the resident population in conjunction with the absence of vaccinations, and the challenges of congregate living, were all significant contributing factors to the spread of COVID-19 during the Outbreak. These factors were out of the Defendants' control and could not have been mitigated by any combination of preventative measures.

Response Protocols and IPAC Procedures

[55] All 129 residents were swabbed on January 8, 2021. On the same day, all visitation except for end-of-life care was suspended.

[56] On January 11, 2021, Public Health completed an inspection of Roberta Place, which revealed critical concerns relating to adherence to IPAC and outbreak management. Dr. Gardner issued an Order based in part on his findings that Roberta Place had inadequate staffing levels to meet the needs of residents, inadequate or insufficient IPAC knowledge and processes to protect residents' needs, and the number of COVID-19 infections and related resident decline, including two deaths, was continuing to rise at Roberta Place. He also noted that an IPAC assessment undertaken that day, and reviewed with on-site leadership, outlined multiple critical concerns.

[57] The Order stipulated that a failure to comply with the instructions could result in a daily fine of $5,000 for each day of non-compliance. Roberta Place was never fined for failing to comply with the Order.

[58] During January 12 and 13, 2021, the MLTC completed an inspection of Roberta Place. The Inspector found a failure to ensure the home was a safe and secure environment for the residents. Roberta Place was found to be in violation of the direction of the Chief Medical Officer of Health's COVID-19 Directive #3 for Long-Term Care Homes. The Inspector made the following findings in the report:

a. Resident rooms were being shared by both confirmed COVID-19 positive residents and residents not confirmed to have COVID-19. A Roberta Place staff member told the Inspector residents in shared rooms often came into close contact with each other.

b. Staff were providing care to both confirmed COVID-19 positive residents and residents not confirmed to have COVID-19.

c. Residents, including COVID-19 positive residents, were seen out of isolation, touching high-touch surfaces, and coming into close contact with other residents.

[59] The Inspector found that Roberta Place did not cohort staff and residents or isolate COVID-19 positive residents, thereby placing other residents at risk of disease transmission.

[60] The Defendants sought and obtained support from RVH. On January 12, 2021, RVH conducted an IPAC audit of Roberta Place. The RVH team raised concerns and delivered recommendations about staff distancing, cohorting residents, proper PPE signage and re-use of PPE, cleaning of high-touch surfaces, best practices for waste disposal, and the discontinuance of the use of fans in patient spaces, including the rooms of COVID-19 positive residents.

[61] On January 16, 2021, Roberta Place received another Order from Dr. Gardner that required it to comply with all Outbreak-related directions provided by Public Health, Orillia Soldiers' Memorial Hospital, RVH, the County of Simcoe, the Red Cross, and Georgian College. Again, Roberta Place was never fined for failing to comply with the Order.

[62] On January 16, 2021, Orillia Soldiers' Memorial Hospital began to assist after Roberta Place entered into a voluntary leadership contract. Additionally, on that same day, a team from the Red Cross arrived to support residents' essential care needs and make IPAC recommendations. The Red Cross remained on site until January 29, 2021.

[63] On January 22, 2021, Public Health delivered an action plan to Roberta Place for containing the Outbreak. The action plan directed Roberta Place to implement increased isolation periods, single site employment, and more stringent masking requirements.

[64] By January 17, 2021, Roberta Place had 62 resident cases and 43 staff cases. Nine residents had died due to COVID-19.

[65] On January 17, 2021, a Professional Standards Supervisor from the County of Simcoe's Health and Emergency Services branch attended Roberta Place. The Supervisor made the following observations:

a. Residents who were COVID-19 positive were sharing rooms with residents who were COVID-19 negative. The curtain in between beds was only partially drawn to separate residents.

b. Isolation carts outside of resident rooms were stocked with masks, gloves, and disposable gowns.

c. Signage was not clear as to which residents were COVID-19 positive versus negative.

d. No one was observed to be wiping down high-touch surfaces and there did not appear to be regular housekeeping.

e. When a call bell was used in a resident room, no one responded over a 15-minute period, after which the call bell was turned off.

f. No linens (towels/face cloths) were available to residents. Some rooms had disposable paper towels that were used when cleaning an incontinent resident.

g. There was no universal masking of residents.

Aerosol Generating Medical Procedures

[66] The Simcoe County Professional Standards Supervisor also raised specific concerns about aerosol generating medical procedures ("AGMP") being performed in Roberta Place.

[67] AGMPs are medical procedures that, through disruption of the respiratory tract, create small aerosol droplets which significantly increase the risk for viral transmission.

[68] AGMPs were recognized as a means of COVID-19 transmission early in the pandemic. By March of 2020, the Ontario Government had mandated airborne precautions when providing AGMPs. By no later than October 5, 2020, the Ontario Government had mandated that all health care workers in a room where AGMPs were happening must be wearing an N95 respirator.

[69] Dr. Loeb notes that there is now insufficient evidence to support the conclusion that AGMPs are risk factors for the spread of the virus. His evidence is also that many experts are currently taking the position that AGMPs are not risk factors at all.

[70] In Roberta Place, the Simcoe County Professional Standards Supervisor observed an order for a resident's oxygen flow rate to be increased to 8L/min. The Supervisor alerted Roberta Place staff that the suggested flow rate would constitute high flow oxygen, which is an AGMP. The Supervisor informed staff that N95 respirators needed to be worn in rooms where AGMPs are being performed. The Supervisor's assessment of the resulting

conversation was that Roberta Place staff did not know what AGMPs were or how to safely manage them.

Staffing and Visitors

[71] Even before the Outbreak, JHS undertook initiatives to increase its hiring rate in anticipation of staff shortages. Despite this pre-planning, King's evidence is that staffing shortages were experienced due to the many staff members who tested positive for the virus or took leaves of absence.

[72] The Defendants took steps to improve the staffing situation, including implementing a 1.5 times pay raise for all front-line staff between January 22, 2021, and February 16, 2021. They also offered hotels and a meal stipend for those staff who were fearful of bringing the virus home after a shift.

[73] Despite these measures, the staffing shortage became increasingly challenging. On January 10, 2021, the Defendants requested assistance from the Red Cross.

[74] Roberta Place made further attempts to alleviate the situation by hiring from four different staffing agencies, recruiting nursing students from Georgian College, and seeking out additional physicians to work in Roberta Place. Securing the latter was challenging because of mandates from Public Health, which limited the rotation of unvaccinated physicians within Roberta Place.

[75] By January 20, 2021, around 50% of the regular staff at Roberta Place were replaced by agency staff.

Vaccines

[76] Vaccination was first made available in Canada in December 2020. Dr. Loeb's report states that vaccination is the most effective way to limit the spread and prevent the serious complications from COVID-19, particularly in long-term care facilities. Vaccination led to a significant reduction in both spread and mortality from COVID-19 in long-term care residents.

[77] However, supply issues plagued Roberta Place. Initially only Pfizer vaccinations were approved for use in long-term care homes. Around January 1, 2021, Moderna became an approved vaccination. King's affidavit outlines the challenges created by a shortage of vaccines within Simcoe County in December 2020 and January 2021.

[78] On January 16, 2021, Roberta Place residents, staff, and essential caregivers began vaccination. Because no one with a positive test or symptoms was permitted to receive the vaccination, only 21 residents, 39 staff members, and 11 essential caregivers were able to be vaccinated that day.

[79] As of February 16, 2021, 46% of residents and 74% of staff and essential caregivers at Roberta Place had received their first dose.

George Head and the Estate of Janet Martin

[80] In early 2020, George Head was suffering from cognitive and physical decline. Later that year, Marcella Lambie indicated that his advanced directive was to be "Do Not Resuscitate", and that he was not to be transferred from Roberta Place under any circumstances, nor have his diet supplemented should he stop eating.

[81] Ms. Lambie visited with him at least once a week throughout the fall of 2020, as his one permitted essential caregiver. During those visits she found him to be robust and able to communicate in short sentences, eat whole foods, walk on his own, and able to tend to his own toileting and personal hygiene needs with limited assistance.

[82] In December 2020, a staff member noted that George was unable to consent to or comply with mask wearing. He tested positive for COVID-19 on January 18, 2021.

[83] After the Outbreak, Ms. Lambie noticed a significant decline in his condition: he lost 10 kg of weight, he is wheelchair bound and cannot get out of bed on his own, is now on a pureed diet and using diapers, and he can no longer communicate effectively.

[84] During the Outbreak, Ms. Lambie observed that her brother's condition was worsening. She had difficulty getting through to staff. When she spoke to Sara-Lynn Garrow, the family member liaison, she was told that Ms. Garrow was working remotely and unable to access records. The Defendant denies that there were any such difficulties; it is their evidence that staff constantly communicated with Ms. Lambie to update her on George's condition and request her instructions.

[85] Janet Martin never tested positive for COVID-19 but was treated as if positive. She was ultimately considered a "probable case".

[86] During December 2020, Scott Martin visited his mother several times and observed that her mind was sharp, and she looked well. On January 13, 2021, he received a call from a nurse suggesting that he should visit his mother, as she was not doing well. On his arrival the next day, he was screened and provided with PPE but not told how to use it. He was surprised at the "relaxed protocol" for entering the building and observed limited staff throughout the day and evening before his mother passed away around midnight. He saw only one nurse, who looked "exhausted and distraught".

ANALYSIS

Certification General Principles

[87] Section 5(1) of the *CPA* requires that the court certify a class proceeding if all the requirements of that section are met. The Plaintiffs must satisfy all following five criteria:

(a) the pleadings disclose a cause of action;

(b) there is an identifiable class of two or more persons;

(c) the claims of the class members raise common issues;

(d) a class proceeding would be the preferable procedure for the resolution of the common issues; and

(e) there is a representative plaintiff who would fairly and adequately represent the interests of the class, has produced a workable litigation plan for advancing the proceeding on behalf of the class and does not, on the common issues, have a conflict of interest with other class members.

[88] The test for certification is to be applied in a purposive and generous manner, to give effect to the goals of class actions; namely: (1) to provide access to justice for litigants; (2) to encourage behaviour modification; and (3) to promote the efficient use of judicial resources: *Hollick v. Toronto (City)*, 2001 SCC 68, [2001] 3 S.C.R. 158, at paras. 15-16; *Western Canadian Shopping Centres Inc. v. Dutton*, 2001 SCC 46, [2001] 2 S.C.R. 534, at paras. 27-29.

[89] The law is clear that the certification stage is not meant to be a test of the merits of the action. The focus is on whether the claim can appropriately proceed as a class action: *Hollick*, at para. 16.

[90] For the first requirement, the claim will disclose a cause of action unless it is plain and obvious that it cannot succeed: *Cloud v. Canada (Attorney General)* (2004), 73 O.R. (3d) 401 (C.A), at para. 41, leave to appeal refused, [2005] S.C.C.A. No. 50, rev'g (2003), 65 O.R. (3d) 492 (Div. Ct.).

[91] For the last four requirements, the Plaintiffs must show "some basis in fact" for each of the certification requirements. This is a lower evidentiary standard than a balance of probabilities. Nonetheless, certification is meant to be a meaningful screening device. Although the merits are not to be determined, certification does not involve "such a superficial level of analysis into the sufficiency of the evidence that it would amount to nothing more than symbolic scrutiny": *Pro-Sys Consultants Ltd. v. Microsoft Corporation*, 2013 SCC 57, [2013] 3 S.C.R. 477, at paras. 99-103.

[92] In *Pro-Sys*, at para. 104, the Supreme Court of Canada explained that "some basis in fact" means that "there must be sufficient facts to satisfy the applications judge that the conditions for certification have been met to a degree that should allow the matter to proceed on a class basis without foundering at the merits stage".

Cause of Action Criterion - s. 5(1)(a)

[93] Although pled in their Amended Statement of Claim, the Plaintiffs are not pursuing claims for breach of fiduciary duty or breach of contract.

[94] The only cause of action they intend to pursue is gross negligence. The Defendants agree that gross negligence is a viable common issue, not barred by the operation of the *Supporting Ontario's Recovery Act, 2020*, S.O. 2020, c. 26, Sched. 1 ("*SORA*"). It is accepted that due to s. 2(1) of *SORA*, no COVID-related lawsuits may proceed against a defendant unless there are allegations of bad faith or gross negligence: *Robertson*, at para. 10, cited with approval in *Pugliese*, at para. 29.

[95] A negligence action requires the plaintiff to demonstrate: (1) that the defendant owed him a duty of care; (2) that the defendant's behaviour breached the standard of care; (3) that the plaintiff sustained damages; and (4) that the damage was caused, in fact and in law, by the defendant's breach: *Mustapha v. Culligan of Canada Ltd*., 2008 SCC 27, [2008] 2 S.C.R. 114, at para. 3.

[96] Gross negligence is not a distinct tort from the tort of negligence. It is simply a matter of a more aggravated departure from the standard of care. The Plaintiff's Amended Statement of Claim pleads that the Defendants breached their duty of care through various listed acts and omissions, alone or in combination, "in a manner that reflects a marked departure from the standards of care applicable in the circumstances". In *Pugliese*, at para. 33, Morgan J. explained that the elevated degree of fault necessary to prove gross negligence involves "a very marked departure from the standards by which responsible and competent people… habitually govern themselves", citing *McCulloch v. Murray*, [1942] S.C.R. 141 at 145.

[97] There is no dispute that gross negligence is a viable cause of action and has been properly pled by the Plaintiffs.

Certifying Against Some Defendants Only

[98] The Defendants argue that if the action is certified as a class proceeding, it should only be certified in respect of two of the five defendants, the numbered company operating as JHS, and the entity operating as Roberta Place. The basis for excluding the remaining three is that there is no evidence on this motion that establishes any potential liability against these entities, and the Defendants submit that the efficient progress of this action requires that they be weeded out at this early stage.

[99] I cannot agree. In the assessment of gross negligence as a viable cause of action, the parties implicitly agree, and the court must assume, that the supporting facts as pled in the Amended Statement of Claim are true and accept them as proven, unless patently ridiculous or incapable of proof: *Cloud*, at para. 41 (C.A.); *Hollick*, at para. 25.

[100] The pleading alleges that these three additional defendants act as operator, owner or administrator of Roberta Place, and the allegations of negligence are stated as applying to all named Defendants, without differentiation. Accordingly, the required *lis* between the Plaintiffs and the three defendants in question has been pled and must be assumed to be proven. There is no basis for this court to find that the allegations against the three defendants in question are incapable of proof at this point in the proceeding.

[101] The Defendants' argument is premature; if the action is certified, it will be certified against all the Defendants.

Identifiable Class Criterion – s. 5(1)(b)

[102] This criterion requires the court to determine whether there is some basis in fact for concluding that the class definition is satisfactory. As earlier stated, the parties have reached consensus on the class definition. The Defendants argue that the 13-month time period of January 10, 2020, to February 18, 2021, raises problems for commonality and the preferrable procedure criteria, but do agree that the Plaintiffs have satisfied this criteria.

[103] The definition of an identifiable class serves three purposes: (1) it identifies the persons who have a potential claim against the defendant; (2) it defines the parameters of the lawsuit so as to identify those persons bound by the result of the action; and (3) it describes who is entitled to notice: *Banman v. Ontario*, 2023 ONSC 6187, at para. 263.

[104] An identifiable class is one that is defined by objective criteria, and which has a rational relationship between it and the common issues: *Pearson v. Inco Ltd*. (2006), 78 O.R. (3d) 641, (C.A.) at para. 57, leave to appeal refused, [2006] S.C.C.A. No. 1, rev'd (2004), 183 O.A.C. 168 (Div. Ct.). Whether a given person is a member of the class must be able to be determined without reference to the merits of the action: *Hollick*, at para. 16.

[105] Accordingly, the Plaintiffs bear the burden of showing that there is some basis in fact that: (1) the class is defined by objective criteria; (2) the class can be defined without reference to the merits of the action; and (3) that there is a rational connection between the common issues and the proposed class definition.

[106] In this case, the class is open only to a discrete number of individuals who were residents of Roberta Place and who contracted COVID-19 and became ill and/or died, and their family members. The class period includes time prior to the Outbreak because of the allegations of a failure to properly prepare for and mitigate the chance of viral outbreak. The class includes only those individuals to whom a duty of care is alleged to be owed, and those harmed by the Defendants' alleged breaches. I conclude that there is a rational connection between the class and each of the proposed common issues. The class definition will be certified.

Common Issues Criterion – s. 5(1)(c)

Proposed Common Issues

[107] The parties agree that if the action is certified as a class proceeding, the following four common issues should be certified:

1. Did the Defendants owe a duty of care to the members of the Classes related to COVID-19 outbreaks at Roberta Place Long Term Care Home?

2. If the answer to (1) is "yes", what was the standard of care applicable to the Defendants relating to their duty?

3. Did the Defendants breach the applicable standard of care?

4. If the answer to (3) is "yes", did any of the breaches amount to gross negligence or a failure to make good faith efforts to act in accordance with laws and public health guidance relating to COVID-19?

[108] Additionally, the Plaintiffs seek certification of five other common issues:

5. If the answer to (3) is "yes", did the Defendants' breaches of the standard of care cause or contribute to the harms suffered and/or losses incurred by the Classes?

6. If liability is established, can the amount of damages, or some portion thereof, be determined on an aggregate basis either before or after the resolution of any individual issues?

7. If the answer to (6) is "yes", in what amount, and who should pay it to the Classes?

8. Does the conduct of the Defendants warrant an award of punitive, exemplary or aggravated damages if the prerequisites of such awards are satisfied?

9. If the answer to (8) is "yes", in what amount, and who should pay it to the Classes?

General Principles for Certification of Common Issues

[109] A condition for certification is that the claims of the class members must raise common issues. This is the criterion that is the most critically disputed on this motion.

[110] This requirement has been described as a low bar: *Cloud* (C.A.), at para. 52. However, there must be an evidentiary basis – again, some basis in fact – for establishing the existence of a common issue that exists beyond a bare assertion in the pleadings: *Fulawka v. Bank of Nova Scotia*, 2012 ONCA 443, 111 O.R. (3d) 346, at para. 79, leave to appeal refused, [2012] S.C.C.A. No. 326.

[111] An issue will be common when its resolution is necessary to resolve each of the class members' claims: *Hollick*, at para. 18. The point behind a common issue is that its resolution will avoid duplication of fact-finding or legal analysis of an issue that is a substantial ingredient of each class member's claim: *Western Canadian Shopping Centres Inc.*, at para. 39. Its resolution will advance the litigation for or against the class: *Fulawka*, at para. 81; *Harrington v. Dow Corning Corp* (1996), 22 B.C.L.R. (3d) 97 (B.C.S.C.), aff'd 2000 BCCA 605, leave to appeal refused, [2001] S.C.C.A. No. 21.

[112] A common issue cannot be dependent upon individual findings of fact that have to be made with respect to each individual claimant: *Williams v. Mutual Life Assurance Co. of Canada* (2000), 51 O.R. (3d) 54 (S.C.), at para. 39, aff'd *Kumar v. Mutual Life Assurance Company of Canada* (2003), 226 D.L.R. (4th) 112 (C.A.) and *Zicherman v. Equitable Life Insurance Company Of Canada* (2003), 226 D.L.R. (4th) 131 (C.A.); *Fulawka*, at para. 81.

[113] If questions relating to causation or damages are proposed as common issues, the plaintiff must demonstrate that there is a workable methodology for determining such issues on a class-wide basis: *Chadha v. Bayer Inc*. (2003), 63 O.R. (3d) 22 (C.A.), at para. 52, leave to appeal refused, [2003] S.C.C.A. No. 106; *Fulawka*, at para. 81; *Andriuk v. Merrill Lynch Canada Inc.*, 2014 ABCA 177, 575 A.R. 208, at para. 10.

Duty of Care

[114] The Defendants do not dispute that they owe a duty of care to the members of the classes to mitigate infectious outbreaks by ensuring that IPAC measures are in place in the long-term care home. The Defendants do not argue that the duty of care owed to any member of the proposed Class differs from any other member. Accordingly, the first proposed common issue is acceptable, as a uniform duty of care will apply across the Residents Class and Estates Class.

Standard of Care

[115] With respect to the proposed common issue relating to the applicable standard of care arising from that duty, the Defendants submit that there is no single standard of care throughout the class period, because COVID-19 and the strategies to protect it changed during the class period. The guidance provided by the province and public health authorities likewise changed during that time.

[116] *Pugliese*, which alleged a systematic failure to create and implement IPAC systems from the very beginning of the pandemic, involved a class period of 3.5 years. It began on January 25, 2020, the date that COVID-19 was first reported in Ontario, and ended on May 5, 2023, the date that the World Health Organization declared an end to the global state of emergency. Yet Morgan J. found that the class period was acceptable, as the record contained some basis in fact for the plaintiffs' allegation that the breaches of the standard of care continued throughout the class period, and not just prior to and during the first "wave" of COVID-19. He certified the standard of care as a common issue.

[117] Just as in *Pugliese*, the record in this action contains some basis in fact for determining the applicable standard of care in common for the entire Residents and Estates Class. It is not concerning that the standard of care may have changed during the class period, as long as that changing standard was applicable to all members of the classes. Such was the case at Roberta Place, where all residents were vulnerable by reason of age or infirmity and reliant on their caregivers for protection from the pandemic. Despite individual differences in age and health across the Residents and Estates Class, the classes are not so

divergent as to render a common issue based on an across-class standard and systematic breach to be unworkable, particularly since IPAC policies and procedures apply to all long-term care homes in the province.

[118] Dr. Sharkawy's expert evidence contains more than sufficient basis for the commonality of the standard of care across the class. His executive summary regarding the standard of care makes two main points:

1. Roberta Place should have acknowledged and adopted the Precautionary Principle and its essential role by incorporating it within the infrastructure and best infection prevention and control (IPAC) practices to minimize risk to its residents; and

2. Roberta Place should have demonstrated a more heightened level of awareness and understanding regarding the transmission of a pathogen such as SARS-COV2 by meeting standards that err on the side of caution, to best prepare for the potentially severe impact on a highly susceptible resident population.

[119] His report covers the period preceding January 2020 and discusses the information that was available to the Defendants about infectious disease and pandemic outbreaks in long-term care homes, and the standards that applied heading into January 2020 and thereafter. At para. 57 of his report, he opines:

> Due to its failure to implement adequate IPAC practices as would have been mandated by both pre-pandemic and Ontario Ministry guidelines and directives, Roberta Place became a spawning ground for unimpeded viral transmission of COVID-19 between January and March of 2021, when outbreaks and incident deaths ensued with alarming frequency and disproportionately to any other institutional or community population setting in Canada.

[120] The core of the gross negligence claim is an alleged systematic failure to implement policies and procedures limiting the spread of COVID-19. The fact that the residents may be of different ages or have different underlying conditions does not prevent liability issues from being common, when the claim addresses a system that was inadequate to protect the class from harm: *Levac v. James*, 2023 ONCA 73, at para. 47.

[121] In *Levac*, at para. 50, the court summarized this point:

> Similarly, Dr. James' failure to adhere to the required IPAC standards in all cases exposed his patients to a common risk of harm. Whether this breach led to the infections is a question for the causation analysis. Direct evidence from every Class Member was not required where the plaintiff's theory, and the trial judge's findings, were based on other evidence of systemic practices: see

e.g., *Cavanaugh v. Grenville Christian College*, 2021 ONCA 755, 72 E.T.R. (4th) 28, at para. 78 (*Cavanaugh (ONCA)*).

[122] In another case alleging systemic negligence, *Rumley v. British Columbia*, 2001 SCC 69, [2001] 3 S.C.R. 184, the Court recognized that the nature of the duty owed to the class members and whether that duty was breached are issues that are amenable to resolution in a class proceeding: at para. 36.

[123] Resolution of the standard of care will significantly advance the litigation for all members of the Classes. And as the Plaintiffs' counsel concede, if they are not successful on the standard of care issue, the action is over. There is significant judicial economy in requiring the plaintiffs to prove the standard of care, and its breach, at a common issues trial.

Breach of Standard of Care

[124] The next proposed common issues are whether there was a breach of the standard of care, and whether it amounted to gross negligence or a failure to make good faith efforts to act in accordance with laws and public health guidance relating to COVID-19. The Plaintiffs have met the onus of showing some basis in fact for these issues, again contained in Dr. Sharkawy's evidence and in the various inspection reports which comment on breaches of IPAC protocols, creating risk of infection for residents and staff.

Causation

[125] Causation is the most fiercely contested of the proposed common issues.

[126] The Plaintiffs propose a "risk ratio approach" to prove that the Defendants' IPAC operation was the cause of the Outbreak and the ensuing harm to residents. They submit that statistical data is available to show that the rates of infection and death at Roberta Place were much higher than those experienced in all other long-term care homes in Ontario during the same six-week period of the Outbreak, and correlated with the evidence of failure to employ reasonable and necessary IPAC precautions. The Plaintiffs argue that this data will permit an inference to be drawn that the breach of the standard of care, on a balance of probabilities, caused the illness and deaths in question.

[127] This approach was adopted by Lax J. in *Andersen v. St. Jude Medical Inc.*, 2012 ONSC 3660, a case in which some patients who had received prosthetic heart valves coated with Silzone® had suffered a medical complication rate of over 50% when compared to those who had received conventional implants. Lax J. accepted that causation could be presumptively established for the class where a breach of the standard of care more than doubles the risk of harm, subject to evidence to the contrary that would be presented during individual hearings.

[128] The Plaintiffs rely on *Levac*, where the risk ratio approach was endorsed by Morgan J. on a certification motion. He also adopted the same approach to causation at the common

issues trial, which was upheld on appeal: see *Levac v. James*, 2021 ONSC 5971, aff'd *Levac* (C.A.). Referencing this same approach in *Pugliese*, at para. 223, Morgan J. stated:

> The causal question here is whether a Defendant's IPAC policies and procedures, assuming they have been determined to be substandard, "materially contributed to the risk of harm, making it a "necessary causal antecedent that contributed beyond *de minimis*.": *B.M. v. British Columbia (Attorney General)*, 2004 BCCA 402, at para. 187. The Court of Appeal has confirmed that this can be done, among other ways, through use of statistics and a rational inference therefrom if the record contains extensive evidence of the correlation between IPAC usage and harm: *Levac v. James*, *supra*, at para. 54. Accordingly, infection rate can conceivably be a proxy for IPAC implementation if the data is realistic and reliable: *Levac v. James*, 2021 ONSC 5971, at para. 130 (trial judgment).

[129] *Pugliese* involved complex litigation in which eight different class actions were consolidated. All actions were brought by the estates of persons (residents and visitors) who died of COVID-19 or who were infected in long-term care homes during the pandemic. The defendants formed various groups, including corporate and municipal owners/operators.

[130] Morgan J. determined that there was a variance in implementation of IPAC home-to-home, which impacted the variance in home-to-home infection and death rates. As such, causation could only be analyzed at the individual home level, and so could not be certified: at paras. 242-243 and 253.

[131] While Morgan J. did not certify causation as a common issue in *Pugliese*, he did recognize the possibility of the risk ratio approach being used for an outbreak in a long-term care home. At para. 255, he endorsed the approach sought to be used by the Plaintiffs in this case:

> Causation must be assessed home by home, not at the corporate head office level. The causation question necessarily addresses the implementation of COVID-related protocols and policies in each home and the experience of the residents with that implementation. The proposed question with respect to causation cannot be certified. If at a common issues trial the standard of care is found to have been breached in any of the corporate actions, the causation question will then require separate mini-trials for each LTC home in issue in those actions. At that point, statistical evidence such as that approved in *Levac*, *supra*, at para. 54 (ON CA) and para. 130 (SCJ), or any other causation evidence of systemic harms, may be brought to bear for each home as a self-contained system or enterprise.

[132] The Plaintiffs argue that in this case, with a single long-term care home involved and no divergence in the standard of care owed to each resident, the risk ratio approach is workable.

[133] The Defendants provide several arguments why the Plaintiffs have not met the causation criterion: the Plaintiffs must demonstrate that there is a workable methodology for determining such issues on a class-wide basis, and have not done so; their reliance on *Levac* is misplaced, as the facts are distinguishable; and Dr. Loeb has opined that there is no epidemiological evidence that the IPAC measures identified by Dr. Sharkawy would have reduced or made a difference to the incidence of COVID-19 at Roberta Place.

[134] I will deal with their first two points together, as I see no basis to distinguish the facts before me from *Levac* and believe that the Plaintiffs have advanced the same methodology, with some basis in fact, as presented in *Levac*.

[135] *Levac* was a class action stemming from an infectious disease outbreak at the Rothbart Centre for Pain Care Ltd., where Dr. James administered epidural injections into the area around the spine. Over a two-year period, twenty-one of his patients developed meningitis or other serious infection in or around their spine. Six of those patients were infected with Methicillin-sensitive staphylococcus aureus ("MSSA"), which had colonized on Dr. James' hands. There was no clear evidence of the source of the staphylococcal infection for the remaining fifteen patients. All twenty-one patients attended the same location and were treated by Dr. James.

[136] The evidence before Morgan J. on the certification motion was: (1) conflicting evidence as to whether Dr. James' IPAC practices were uniformly implemented with respect to all of his patients, and some additional contentious evidence about the likely sources of the infections; (2) direct observations by nurses and patients of his actual practices, and observations of the state of the clinic made by Toronto Public Health officials; (3) a higher than average infection rate for patients undergoing the same procedure (7.5:1000 as opposed to the norm of 1:1000) and (4) expert evidence from an epidemiologist who opined that the number of infections was sufficient to draw the inference that Dr. James' substandard IPAC was the cause of the infections in the fifteen patients (in addition to the six who were infected with MSSA).

[137] In *Levac*, the "workable methodology" and supporting evidence put forward on the motion was nothing more than as described in the preceding paragraph. Accordingly, the proposed methodology was simply to introduce evidence of substandard IPAC practices and evidence of the heightened incident rate comparative to the norm, to allow the trier of fact to draw the inference that the failure to adhere to IPAC practices, and the failure to correct his practices once the incidence of infections became apparent, was the cause of the infections. This rather simple approach for proving causation for the twenty-one patients was described by Sossin, J.A. on appeal as follows: "[t]he plaintiff's methodology asked whether Dr. James' patients were under higher risk than the general

population undergoing epidural spinal injections with different physicians in different clinics": at para. 23.

[138] The Defendants argue that such an inference cannot be drawn in this case because there are multiple ways by which an individual may become infected with COVID-19, and the highly transmissible UK variant affected transmission rates. Roberta Place was not a "hermetically sealed" environment; the reality is that staff, health care providers, suppliers, and supplies had to enter the building even while visitors were prohibited from entering.

[139] But the same was true at the Rothbart Center. There was no way to determine how the bacteria that infected the twenty-one patients entered what should have been a sterile field. The barrier standing between the bacteria and contracting meningitis and other infections was, or should have been, the IPAC practices. Similarly, as opined by Dr. Sharkawy, IPAC strategies such as PPE, isolation, screening, testing protocols, IPAC education and oversight, and optimal ventilation, in addition to vaccination, are what stands between long-term care home residents and staff and the COVID-19 virus. It is his opinion that all of these strategies are well recognized and accepted for the prevention of transmission of a communicable respiratory pathogen such as SARS-COV2. While acknowledging under cross-examination that these strategies cannot prevent all risk, Dr. Sharkawy's opinion is unwavering that although some IPAC strategies are less effective at reducing COVID-19 incidence in long-term care homes, the importance of multiple IPAC strategies should not be discounted.

[140] In his first report, Dr. Sharkawy presented epidemiological evidence of the same nature that was present in *Levac*, although with less precision. He set the stage by noting that the outbreaks and deaths occurring during the Outbreak was disproportionate to any other institutional setting in Canada. At para. 62 of his report, he notes that Roberta Place experienced 70 officially reported resident deaths out of the total 5,044 total COVID-19 related deaths in all long-term care homes in the period of January to August 2022. He stated that there are over 1,200 long-term care homes in Ontario. The death count at Roberta Place represented 1.4% of the total deaths during that period. He opined that "it is not defensible by either clinical or epidemiological argument that the morbidity and mortality witnessed at Roberta Place could by accounted for by chance, nor explained by risk or advanced age or comorbidity health status alone".

[141] This is certainly some evidence to show that the risk posed to residents at Roberta Place was statistically higher than at other long-term care homes. One does not have to be a statistician or epidemiologist to conclude that a single long-term care home such as Roberta Place experiencing 1.4% of the total deaths out of over 1,200 long-term care homes means that its residents had a disproportionate amount of risk compared to similarly situated residents in other long-term care homes throughout the entire province.

[142] To help demonstrate the risk to which residents of Roberta Place were exposed, Dr. Sharkawy references a publicly available database. This database was maintained by the province from data collected by Public Health Ontario, which tracked COVID-19 cases

and deaths daily in every long-term care home from April 24, 2020, to March 30, 2023. It is his evidence that the disproportionality of death and infection rates can be determined through a statistical analysis of that data, which tracked by date and location, for each long-term care home, the number of beds, total cases of COVID-19, total deaths, and total staff cases. His evidence is that "based on a statistical analysis, the court will be able to determine if the Roberta Place outbreak was disproportionately larger than other Ontario long-term care homes".

[143] The Defendants argue that this is not enough, as Dr. Sharkawy does not provide any evidence of how that statistical analysis would be undertaken.

[144] On cross-examination, the Defendants' expert, Dr. Loeb, gave the following evidence about this database:

> Q: Thank you. Doctor, if every COVID-19 infection in a long-term care home was recorded and the number of beds in the long-term care home is also recorded, are we able to calculate the average rate of, of residents infected at a long-term care home during an outbreak in Ontario at a specific time?
>
> (discussion of whether the data is provided on a daily basis, answered affirmatively by counsel)
> ….
>
> Q: Right, can we calculate the average rate of residents infected during an outbreak at specific times?
>
> A: Yes, we could, but we'd, we would, we would need to be cautious in interpreting that data because we would want that, we'd want the surveillance to have been done in a systematic manner in the same, in the same way across all those facilities. In order to, to compare, you know, apples to apples of course.

[145] Further, the Defendants point out that during Dr. Sharkawy's cross-examination, he admitted that vaccines had the single most dramatic effect in terms of mortality and morbidity and reducing transmission. When referencing the time span of January to August 2022, in his report, he agreed that it was not an "apples to apples" comparison because vaccines were not available to Roberta Place during part of the period of the Outbreak. As his cross-examination progressed, he clarified his point:

> A: But the long-term care community as a whole has access to vaccines and the long-term care community will differ in terms of their individual practices and their compliance with directives and their ability to manage infection prevention and control… and that's… that's where the disparity lies.

> Q: But Roberta Place did not have access to vaccine before the outbreak in January of 2021?
> A: And, and, and neither did the other facilities which did not fare anywhere near as poorly from a… functional… standpoint.

and

> Q: That's what I was referring to. So, when you look at the whole paragraph the homes were not all in the same situation for a number of reasons, including the availability of vaccines?
>
> A: I think you're misrepresenting, the, the homes were on an equal footing when it comes to availability of vaccines.

[146] This point is made in Dr. Loeb's report, where he states: "it has been estimated that between January 15, 2021, and March 31, 2021, 95% of residents of long-term care facilities in most jurisdictions had received a first dose of the COVID-19 vaccination." The Outbreak falls within this timeline, and it is an accepted fact that vaccines were initiated at Roberta Place for residents and staff on January 16, 2021. Dr. Sharkawy's supplementary report notes that it can take longer than three weeks for a protective level of antibodies to be present following vaccination in the elderly population and for those with chronic underlying illnesses, it may be "significantly longer".

[147] Dr. Sharkawy may not be the expert who can ultimately provide the statistical analysis, but in my view, his evidence has adequately laid the groundwork. He has pointed to the link between the failure to observe both the precautionary principle and adequate IPAC measures and the Outbreak. And he has provided evidence that the experience at Roberta Place was significantly disproportionate to any other long-term care home. The task is ultimately a numbers game, focused on the period of the Outbreak. Dr. Loeb admits that the database contains the necessary information to compare cases between homes, subject to controls, to ensure an "apples to apples" approach. Whether the Plaintiffs can adequately do this while factoring in the more contagious variant at issue, or whether that even must be done to arrive at a final number for the risk ratio approach, is yet to be seen, but in my view is a matter that goes directly to the merits and should not attempt to be determined on this motion.

[148] While the expert methodology must not be purely theoretical or hypothetical (*Pro-Sys*, at para. 118), it must also be kept in mind that it is a relatively low standard – "some basis in fact" – for the existence of a common issue. The Plaintiffs have offered some evidence of the availability of data collected by an objective agency, and a basis to draw the rebuttable inference of causation from those numbers taken together with the documented deficits in the Defendants' infection control practices.

[149] In reaching this conclusion, I have considered *Surette*, in which causation was not certified as a common issue. In *Surette*, the plaintiff sought to apply the same risk ratio approach endorsed in *Levac* to determine causation on a class-wide basis. However, the plaintiff in *Surette* identified no evidence to explain or identify the methodology and

provided no evidence to establish some basis in fact that a statistical epidemiological approach could be taken to determine causation: at para. 65. I consider this case to be distinguishable from the one before me, as statistics are available, the same standard of care applies across the class, and the methodology proposed is the same as adopted in *Levac*.

[150] As earlier indicated, another of the Defendant's objections is that Dr. Loeb has opined that there is no epidemiological evidence that the IPAC measures identified by Dr. Sharkawy would have reduced or made a difference to the incidence of COVID-19 at Roberta Place. These experts both offered competing opinions about this topic in *Pugliese*, being the same opinions asserted here. Essentially, Dr. Loeb's view is that other than vaccines, there is no data to support the efficacy of the measures that Dr. Sharkawy says should have been heeded to reduce the incidence of COVID-19 – such as PPE, case detection, isolation, quarantine, contact tracing, IPAC training and education, and so forth.

[151] In response, Dr. Sharkawy notes that controlled trials in infectious disease research would be unethical, which is largely why the data does not exist. However, he states that it has long been recognized that additional precautions beyond vaccination are necessary components of risk management for infection outbreaks in long-term care homes.

[152] The inspection reports present evidence contradicting Dr. Loeb's view that it was nothing that Roberta Place did nor did not do which caused the spread of COVID-19– the health agencies involved held a differing view on the importance and efficacy of IPAC measures. But in any event, the law is clear that resolving conflicts between experts is not something to be engaged in at the certification stage: *Pro-Sys*, at para. 126.

[153] For the preceding reasons, I am prepared to certify causation as a common issue. I note also that causation was certified as a common issue in *Robertson*.

Aggregate Damages

[154] The next two proposed common issues relate to the determination of damages on an aggregate basis, whether before or after the resolution of any individual issues.

[155] In *Lilleyman v. Bumblebee Foods LLC,* 2023 ONSC 4408, aff'd 2024 ONCA 606, 173 O.R. (3d) 682, leave to appeal refused, [2024] S.C.C.A. No. 406, at para. 362, Perell J. explained the basis on which an award of aggregate damages may be made:

> For there to be an award of aggregate damages, the plaintiff must advance a methodology or show that there is a reasonable likelihood of assessing the defendant's aggregate liability to the class without proof by individual class members. Aggregate damages cannot be ordered where "individual questions of fact relating to the determination of each class member's damages remain to be determined", or where there is no available data to determine what individual class members were owed. Aggregate

> damages are not appropriate where the use of non-individualized evidence is not sufficiently reliable, or where the use of that evidence will result in unfairness or injustice to the defendant, such as overstatement of its liability for damages. In other words, the Plaintiff must present a methodology that offers a realistic prospect of establishing aggregate damages on a class-wide basis. [citations omitted]

[156] There is no evidence in the record to support the methodology for an aggregate damages assessment once the Plaintiffs decided not to rely on the expert report of Gary Principe. There is also nothing in the proposed litigation plan with respect to the procedure for such an assessment. In *Canada v. Greenwood*, 2021 FCA 186, [2021] 4 F.C.R. 635, leave to appeal refused, [2021] S.C.C.A. No. 377, the court was faced with similar lack of evidence. At para. 188, the court stated:

> Which leaves the fourth question regarding an aggregate assessment of damages. As noted, the representative plaintiffs tendered no evidence to suggest a method for the conduct of such assessment and their litigation plan is similarly silent on the point. There was accordingly no basis in fact for the certification of a common question related to an aggregate damages assessment given the factual vacuum on the point before the Federal Court.

[157] Accordingly, the determination of damages on an aggregate basis cannot be certified as a common issue.

Punitive, Exemplary, or Aggravated Damages

[158] The final proposed common issue relates to an award of punitive, exemplary or aggravated damages.

[159] The Plaintiffs have pled that, through their collective mismanagement of the COVID-19 pandemic, the Defendants have displayed a wanton disregard for some of the most vulnerable of society's members. This failure to protect the lives and well-being of the residents and their family members is alleged to demonstrate callous and reprehensible behavior deserving of an award of punitive damages.

[160] This claim alleges systemic negligence, and so an inquiry into the conduct of the Defendants toward individual members of the Classes is not the focus. The focus is on the residents as a group, and their families. The Court in *Rumley*, at para. 34, confirmed that this is the kind of fact-finding that will be necessary to determine whether punitive damages are justified, and therefore will be appropriate to certify as a common issue.

[161] The Defendants submit that the Plaintiffs have led no evidence to support claims for aggravated, exemplary or punitive damages. They rely on, in addition to the evidence of King and Bath, Dr. Loeb's opinion that the Outbreak was an unpreventable and inevitable

consequence of a highly transmissible variant, compounded with factors common to long-term care living.

[162] There is some evidence to support a claim for punitive, aggravated or exemplary damages. OMH inspection reports dating as far back as August and September of 2020 demonstrate non-compliance with IPAC policies and standards. And in the opinion of Dr. Sharkawy, the Defendants "failed at almost every meaningful level of execution", including at all levels of the hierarchy of controls. Dr. Sharkawy's evidence, if accepted by the court, is highly critical of what he identifies as the Defendant's failures. This is sufficient evidence of the existence of reprehensible or high-handed behavior, or intentional conduct that disregards the Plaintiffs' rights in a malicious or outrageous manner, which could support an award of punitive, aggravated or exemplary damages.

[163] This will be certified as a common issue.

Preferable Procedure Criterion

[164] This criterion is prescribed by sections 5(1)(d) and 5(1.1) of the *CPA*. Section 6 of the *CPA* guides the court on the grounds which the court should not rely on to refuse to certify a proceeding. The addition of s. 5(1.1) through the 2020 amendments to the *CPA* imposes a stricter test for preferability than the former one: *Banman*, at paras. 317-18.

[165] Subsection 5(1.1) requires determining whether:

a. The design of the class action is manageable as a class action;

b. There are reasonable alternatives;

c. The common issues predominate over the individual issues; and

d. The proposed class action is superior to the alternatives.

[166] For a plaintiff to establish that the class action would be the preferred procedure, the Plaintiffs must establish some basis in fact that the proposed class action would be a fair, efficient, and manageable method of advancing the claim, and that it is better than any other reasonably available means of resolving the claims of the proposed class members: *Hollick*, at paras. 28, 31; *AIC Limited v. Fischer*, 2013 SCC 69, [2013] 3 S.C.R. 949, at para. 48. These two tests are to be measured through the lens of the purposes of the *CPA*, namely, access to justice, behaviour modification, and judicial economy: *Banman*, at para. 315.

[167] The common issues are to be looked at together to determine whether they predominate over the individual issues, to ensure that the objectives of judicial economy and access to justice are achieved by having the claims of the class members sufficiently advanced through the mechanism of a class action: *Banman*, at para. 321.

[168] There is nothing inherently unmanageable about this claim proceeding as a class action. Systemic negligence cases have been routinely certified, and this court's determination of the first three certification criteria indicate that the claims of all classes will be largely advanced by the common issues trial, followed by individual assessments of damages if necessary.

[169] In terms of reasonable alternatives, the Defendants submit that individual actions for potentially meritorious claims would be more practical and efficient and would allow for an earlier resolution of the claims "that would take into account the important factual nuances of each of the Plaintiff's circumstances".

[170] There will be little need for such an in-depth probing of individual circumstances. The classes in this case are neatly circumscribed and readily subject to proof – those residents who tested positive, those who died from a COVID-19 infection, and those who are eligible to claim under the *FLA*. The factual and legal issues that need to be determined are common to all members of the classes.

[171] Nonetheless, the reasonable alternatives to address the Plaintiffs' claims are: (1) 129 individual trials, with up to 896 plaintiffs; (2) a single joinder action addressing the claims of up to 896 plaintiffs; and (3) two joinder actions where claims are grouped based on whether the resident lived or died.

[172] There is no evidence to demonstrate the efficacy of a joinder action over a class action. Additionally, the court's powers set out in s. 25 of the *CPA*, which allow for ongoing refinement of the class proceeding as necessary, are not available if individual claims were to be combined through joinder.

[173] One of the significant factors that makes a class action the superior procedure in this case is the quantum of damages that any plaintiff could expect to recover in an individual action. Negligence claims involving elderly and infirm plaintiffs and derivative *FLA* claims do not typically result in high damage awards. Requiring individual plaintiffs and family members to proceed with individual actions would be impractical and needlessly expensive when considering the costs and risks of an individual trial involving the use of expert witnesses. Many, if not most, would undoubtedly choose not to proceed.

[174] Certification of this case will advance the goals of the *CPA* by providing access to justice to the class members who would not otherwise have the financial resources for individual claims. Class actions address the economic barrier posed by expensive litigation, such as this, by distributing costs among the class members: *Hollick*, at para. 15.

[175] The other barrier to individual claims is the characteristics of the class members. It is uncontested that the residents in this case are elderly, and many have dementia or other cognitive or physical challenges. Further, over 50% are deceased. There are significant evidentiary hurdles in proceeding with individual actions or joinder. The class action allows the willing representative plaintiffs to participate in the litigation in a way that

would not be available to many of the deceased's estates and those residents who remain alive, some of whom still live in Roberta Place.

[176] The common issues trial is now expected to dispose of all issues except damages, which will require individual assessments. Duty and standard of care, breach, causation, and liability for punitive or exemplary damages will not require proof in separate individual cases. The common issues predominate over the individual ones, which supports a class proceeding being the preferrable procedure. As stated by Morgan J. in *Pugliese*, at para. 269, it is not preferable to analyze systemic negligence on an individual basis.

[177] Certifying the action as a class proceeding therefore promotes judicial economy.

[178] In terms of behavior modification, undoubtedly there remains significant social value in exploring how and whether the Defendants appropriately met the challenges of COVID-19 and did all that was required of them to protect the residents. As stated by Morgan J. in *Pugliese*, at para. 271, "inhibiting the LTC home industry from repeating any mistakes is a significant goal of this class action that would be diluted if individual claims were pursued in its place".

[179] I conclude that proceeding as a class action is the superior means to all reasonable options of determining the entitlement of the classes to relief.

Representative Plaintiff Criterion – s. 5(1)(e)

[180] The parties agree that Marcella Lambie and Scott Martin are viable representative plaintiffs on behalf of the members of the classes.

[181] There is no evidence that Ms. Lambie or Mr. Martin have interests that conflict with any other proposed class member. Their affidavits indicate that they are aware of the progress of this litigation and the procedural steps involved, their duties as class representatives, and that they are committed to fulfilling their duties. Both pass the s. 5(1)(e) test.

[182] The parties agree that Brock Medical Malpractice Law PC and Oatley Vigmond LLP be appointed as class counsel if the action is certified.

[183] The parties have agreed to work collaboratively on a workable Litigation Plan following the outcome of the motion, failing which they will arrange a hearing before me to address the issue.

Conclusion

[184] For the above reasons, this court orders that the Plaintiffs' motion to certify their action pursuant to the *CPA* is granted.

[185] The draft Certification Order provided in the amended motion record will require revision. If the parties have any difficulty reaching consensus on the formal order, an appointment may be made through my judicial assistant for a case conference.

Costs

[186] If the parties are unable to reach a decision on costs within 30 days of the release of these Reasons, they may provide written cost submissions on a timetable to be determined between them, provided that all submissions are received by October 31, 2025. Written submissions are limited to 5 double-spaced pages not including authorities, plus a Costs Outline and any settlement offers.

[187] The submissions are to be filed with the court, with a copy emailed to my judicial assistant at BarrieSCJJudAssistants@ontario.ca, in addition to being uploaded to Case Center with hyperlinks as required.

HEALEY J.

Released: August 21, 2025