

CITATION: Williams v. Ontario, 2009 ONCA 378
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COURT OF APPEAL FOR ONTARIO

Sharpe, Juriansz and LaForme JJ.A.

BETWEEN:

Andrea Williams

Plaintiff (Appellant/
Respondent by way of cross-appeal)

and

The Attorney General of Canada, Her Majesty The Queen in
Right of Ontario and The City of Toronto

Defendant (Respondent/
Appellant by way of cross-appeal)

R. Douglas Elliott and J. Adam Dewar, for the appellant

Lise G. Favreau, Kim Twohig and Leslie McIntosh, for the respondent

Heard: February 25 & 26, 2009

On appeal from the order of Justice Maurice Cullity of the Superior Court of Justice dated August 22, 2005 and reported at (2005), 76 O.R. (3d) 763.

Sharpe J.A.:

[1] This appeal, heard together with four other similar appeals,¹ raises the issue of whether Ontario can be held liable for damages suffered by individuals who contracted SARS during the outbreak of that illness in 2003.

[2] Ontario moved to strike out the fresh as amended statement of claim (the “claim”) at the pleading stage on the ground that the province did not owe the plaintiff a private law duty of care. The motion judge, relying on the decision of the Divisional Court in *Eliopoulos (Litigation Trustee of) v. Ontario (Minister of Health and Long-Term Care)* (2005), 76 O.R. (3d) 36, where it held that Ontario could be liable to those who contracted West Nile virus, struck out portions of the claim but refused to strike it out entirely. The Divisional Court’s *Eliopoulos* judgment was later reversed by this court which held that while Ontario did owe a public law duty to promote health and protect against the spread of the West Nile virus, there was no relationship of proximity between the plaintiff and Ontario capable of giving rise to a private law duty of care: (2006), 82 O.R. (3d) 321 (“*Eliopoulos*”). The Supreme Court of Canada refused leave to appeal: [2006] S.C.C.A. No. 514.

[3] The plaintiff appeals the order striking out portions of the claim. Ontario cross-appeals the order refusing to strike the claim in its entirety arguing that this case cannot

¹ *Abarquez v. Ontario* (C48011); *Laroza v. Ontario* (C48010); *Henry v. Ontario* (C48012); and *Jamal v. Ontario* (C48013). As it was in the interests of justice to have all appeals heard by the same court at the same time, the appeals that fell within the jurisdiction of the Divisional Court were, on consent, ordered to be heard by this court at the same time as the present appeal as a special case, pursuant to Rule 22. The judgments all five appeals are being released at the same time.

be distinguished from *Eliopoulos* and that it is “plain and obvious” that the claim as pleaded cannot succeed.

FACTS

[4] This is a proposed class action. The claim alleges that Ontario learned of the outbreak of SARS in China in mid-February 2003 and that the first case of SARS in Toronto occurred in late February. By mid-March a cluster of SARS cases had been identified in Toronto and as a result, on March 23, 2003, Scarborough Grace Hospital closed its emergency room. On March 25, 2003, the Minister of Health declared SARS a reportable, communicable disease under the *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7 (“*HPPA*”), and on March 26, 2003, the Premier of Ontario declared SARS a provincial emergency pursuant to the *Emergency Management Act*, R.S.O. 1990, c. E.9, as am. by S.O. 2002, c. 14 (“*EMA*”). Also on March 26, 2003, the Minister of Health ordered hospitals in the Greater Toronto Area to activate “Code Orange” emergency plans, under which only essential services were to be offered. Ontario issued a series of Directives to hospitals to limit non-urgent care, to control the entrance and movement of staff and patients within health care facilities, to require protective measures and gear, to provide for reporting of suspected SARS cases, and to create isolation areas for SARS patients.

[5] In late April 2003, Ontario began to relax the infection control imposed on hospitals. The plaintiff alleges that Ontario knew or should have known that failure to

eradicate SARS completely would result in a recurrence of the disease. The plaintiff further alleges that Ontario's actions were motivated by concern over the World Health Organization's ("WHO") warning to travelers to avoid Toronto, issued on April 23, 2003. The WHO travel warning was lifted on April 30, 2003 and, on May 14, 2003, the WHO removed Toronto from its list of areas with recent SARS transmissions. That same day, the Minister of Health declared that the SARS outbreak was completely under control and contained. On May 17, 2003, the Premier lifted the declaration of emergency.

[6] The plaintiff alleges that the easing of infection control procedures was premature and led to the second outbreak of SARS on or about April 20, 2003. She pleads that she contracted SARS while she was a surgery patient at North York General Hospital from May 21 to May 22, 2003. On May 23, 2003, Ontario announced that SARS had not been completely contained, and shortly thereafter all hospitals in the Greater Toronto Area were ordered to reinstate heightened infection control procedures. The plaintiff pleads that she was re-admitted to North York General on May 30, 2003 and diagnosed with SARS.

[7] The plaintiff's factum describes the allegations made in the claim as being "framed in negligence and systemic negligence" and summarizes the allegations in the following manner:

- Ontario's failure to control the first outbreak of SARS in Toronto in March 2003 lead to SARS II;

- Ontario failed to properly manage the prevention measures for SARS, which lead to SARS II;
- Ontario failed to have in place a proper public health system to adequately deal with outbreaks such as SARS;
- Ontario failed to issue proper Directives to hospitals to control or limit the spread of SARS; and,
- Ontario prematurely lifted the state of emergency before the first outbreak of SARS was eradicated.

[8] As the proposed class action has not been certified, we must consider the viability of the claim on the basis of the facts pleaded in relation to the named plaintiff. I note, however, that the proposed class is broadly defined to include all persons who contracted the virus causing SARS in Toronto or from a person in Toronto during the period of April 20 to July 31, 2003 (SARS II) and for all family members of those persons pursuant to the *Family Law Act*, R.S.O. 1990, c. F.3.

ISSUE

[9] The central issue on this appeal is whether, on the facts pleaded in the claim, it is arguable that Ontario owes a private law duty of care to the plaintiff sufficient to ground an action in negligence for damages.

ANALYSIS

1. The Test on a Rule 21 Motion

[10] As this appeal arises from a Rule 21 motion to strike the claim as disclosing no cause of action in law, the record before us is essentially limited to the claim and the

Directives that are referred in the pleading. It is common ground that in the circumstances of this case:

- the allegations of fact pleaded in the claim must be accepted as proven;
- to succeed Ontario must show that it is plain and obvious and beyond doubt that the plaintiff could not succeed if the matter were to proceed to trial;
- the claim should not be struck merely because it is novel; and
- the pleading must be read generously in favour of the plaintiff with allowances for drafting deficiencies.

[11] See *Hunt v. Carey Canada Inc.*, [1990] 2 S.C.R. 959.

2. The *Cooper-Anns* Test and the Duty of Care

[12] It is common ground that the test for determining whether a duty of care exists in a given situation is that enunciated by the Supreme Court of Canada in *Kamloops v. Nielsen*, [1984] 2 S.C.R. 2, and *Cooper v. Hobart*, [2001] 3 S.C.R. 537 (“*Cooper*”). This test has its origin in the House of Lords decision in *Anns v. Merton London Borough Council*, [1977] 2 All E.R. 492, and I will refer to it as the *Cooper-Anns* test.

[13] Before applying the *Cooper-Anns* test in any given action, the court must first determine whether the duty of care asserted by the plaintiff has already been recognized by the law. *Cooper* holds that if the facts of the case bring it within a category that has already been recognized as giving rise to a duty of care, a duty of care is thereby established, and it is unnecessary to engage in the two step *Cooper-Anns* test: *Childs v.*

Desormeaux, [2006] 1 S.C.R. 643, at para. 15 (“*Desormeaux*”). If the proposed duty of care has not been recognized, then the *Cooper-Anns* test is used to determine whether the novel duty should be given legal recognition.

[14] The *Cooper-Anns* test consists of two stages. The first stage, which determines whether the relationship between the parties justifies the imposition of a duty of care on the defendant, involves consideration of foreseeability, proximity and policy. For a duty of care to arise, more is required than foreseeability - the two parties must also be sufficiently proximate to one another: *Desormeaux* at para. 12. Proximity, explained the court in *Cooper* at para. 31, “is generally used in the authorities to characterize the type of relationship in which a duty of care may arise.” Two parties are in proximity with one another if their relationship is sufficiently close and direct that it is fair to require the defendant to be mindful of the legitimate interests of the plaintiff: *Cooper* at paras. 32-34. The evaluation of whether a relationship is sufficiently proximate to ground a duty of care entails a consideration of the “expectations, representations, reliance, and the property or other interests involved. Essentially...factors that allow us to evaluate the closeness of the relationship between the plaintiff and the defendant and to determine whether it is just and fair having regard to that relationship to impose a duty of care”: *Cooper* at para. 34.

[15] While a number of different factors may be helpful in determining whether proximity exists between two parties, the Supreme Court has stated that proximity is not defined by any “single unifying characteristic”, nor is there a clear test to be applied to

determine whether proximity exists in a given case: *Cooper* at para. 35. In *Cooper*, the court held that the statutory duty imposed on the Registrar of Mortgage Brokers to oversee the conduct of mortgage brokers was owed to the public as a whole, rather than to individual mortgage investors. While losses to investors were reasonably foreseeable from carelessness in carrying out the Registrar's duties, there was nothing in the statute or in the relationship between individual investors and the regulator to create the required element of proximity. In a companion case, *Edwards v. Law Society of Upper Canada*, [2001] 3 S.C.R. 562 ("*Edwards*"), the court rejected on similar grounds the proposition that the body given power to regulate the legal profession in Ontario owed a duty of care to individuals who had entrusted funds to an errant solicitor.

[16] At both stages, the *Cooper-Anns* test involves looking at policy reasons for refusing to impose a duty of care on the defendant. At the first stage, when determining whether to recognize a prima facie duty of care, the policy reasons must arise from the nature of the relationship between the parties, rather than any external concerns, which are not considered until the second stage of the test: *Cooper* at para. 30.

[17] If the first stage of the *Cooper-Anns test* is met, the plaintiff has established a prima facie duty of care owed by the defendant and the analysis proceeds to the second stage. It is here that the court considers whether there are "residual policy considerations" that militate against recognizing a novel duty of care: *Cooper* at para. 30. These are policy considerations that "are not concerned with the relationship between the parties, but with the effect of recognizing a duty of care on other legal obligations, the

legal system and society more generally”: *Cooper* at para. 37. One such residual policy concern is the need to immunize the policy decisions of the government from tort liability: *Cooper* at para. 38. Policy decisions, as contrasted with operational decisions, are based on social, political or economic factors: *Swinamer v. Nova Scotia (Attorney General)*, [1994] 1 S.C.R. 445, at p. 455 (“*Swinamer*”). Determining whether a governmental decision is a policy decision requires evaluating the nature of the decision itself, rather than the identity of the actors: *Swinamer* at p. 457.

(a) Does the case fall within a recognized category?

[18] The plaintiff submits that the case as pleaded falls into the existing category of “negligence causing physical harm to person or property” and that accordingly, it is unnecessary to engage in a full *Cooper-Anns* analysis.

[19] In my view, the category advanced by the plaintiff is cast at such a level of generality that it fails to provide sufficient analytic content capable of obviating the need for a full *Cooper-Anns* analysis. As *Eliopoulos and Attis v. Canada (Minister of Health)* (2008), 93 O.R. (3d) 35 (C.A.), leave to appeal to S.C.C. refused [2008] S.C.C.A. No. 491 (“*Attis*”), demonstrate, the proximity analysis cannot be short-circuited by focusing simply on the fact that the plaintiff has alleged that the defendant’s negligence has resulted in physical harm to plaintiff’s person or property. This is especially so in cases where the defendant did not create the risk that actually caused the harm, and the alleged negligence consists of a failure to take adequate steps to prevent physical harm arising from the external or existing risk: see *Desormeaux*.

[20] Accordingly, I find it necessary to assess the claim using the two-step *Cooper-Anns* test.

(b) Proximity

[21] Ontario accepts that the harm alleged by the plaintiff was foreseeable. The issue is whether Ontario was in a relationship of proximity with the plaintiff.

[22] The plaintiff places considerable weight upon the detailed nature of the Directives issued by Ontario. She alleges that it is at least arguable that by promulgating these Directives, Ontario became engaged in the management of the SARS crisis in a manner that established a relationship with her sufficient to give rise to a duty of care.

[23] I agree that the Directives were more detailed in nature than the West Nile prevention plan at issue in *Eliopoulos*, and that unlike the plan in *Eliopoulos*, the Directives here were cast in mandatory terms. However, I am not persuaded that this case can be distinguished from *Eliopoulos* simply due to the detailed and mandatory nature of the Directives, or that these differences have any bearing on the issue of proximity.

[24] It is clear from *Cooper*, at para. 43, that as the claim is against a public authority exercising statutory powers, the starting point for analysis is the statutory scheme.

[25] The Directives were issued by the Chief Medical Officer of Health under powers conferred by the *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7, (“HPPA”) ss. 24 and 86 (see now s. 77.7(1)). The nature of the statutory powers conferred by the

HPPA in relation to the promotion of public health and the control of infectious diseases was considered at length in *Eliopoulos*. After considering the *Cooper-Anns* test, this court held, at paras. 17-19, that the exercise of the extensive discretionary powers to take measures to protect the public from the spread of infectious disease did not create a private law duty in that case. The powers “are to be exercised...in the general public interest” and they “are not aimed at or geared to the protection of the private interests of specific individuals”. While the Minister of Health is under a general public law duty “to promote, safeguard and protect the health of Ontario residents and prevent the spread of infectious diseases...a general public law duty of that nature does not give rise to a private law duty sufficient to ground an action in negligence.” Rather, the Minister is required to act in the general public interest, and in so doing must balance “a myriad of competing interests”, the nature of which are inconsistent with the imposition of a private law duty of care.

[26] In so concluding, the court referred to the decisions of the Supreme Court of Canada in *Cooper* and *Edwards*, at paras. 18-20:

The decisions of the Supreme Court of Canada in *Cooper* and *Edwards* are particularly instructive. Both cases centred on claims by a specific class of individuals who alleged that they had suffered loss as a result of the failure of a public authority to exercise its supervisory and investigatory powers. *Cooper* involved a claim by investors who suffered losses at the hands of a mortgage broker. The plaintiffs alleged that the British Columbia Registrar of Mortgage Brokers owed them a private law duty to suspend a mortgage broker's licence or to notify investors if a mortgage broker was under investigation. In *Edwards*, the plaintiffs suffered losses at the hands of a

lawyer who allegedly used his trust account improperly. The plaintiffs alleged that the Law Society of Upper Canada, which had knowledge of the manner in which the lawyer operated his trust account, owed them a private law duty to ensure that the lawyer's trust account was operated according to the regulations or to warn the plaintiffs that it had abandoned its investigation.

In both *Cooper* and *Edwards*, the statements of claim were struck because the public authority owed no private law duty of care to the plaintiffs. In both cases, after reviewing the statutory powers and duties of the defendant, the Supreme Court concluded that any duty was owed to the public as a whole rather than to individual investors or clients who interacted with the brokers or lawyers regulated by the legislation. In *Cooper*, the Supreme Court concluded, at para. 49:

Even though to some degree the provisions of the Act serve to protect the interests of investors, the overall scheme of the Act mandates that the Registrar's duty of care is not owed to investors exclusively but to the public as a whole.

Similarly in *Edwards*, the Supreme Court found, at para. 14:

The *Law Society Act* is geared for the protection of clients and thereby the public as a whole, it does not mean that the Law Society owes a private law duty of care to a member of the public who deposits money into a solicitor's trust account. Decisions made by the Law Society require the exercise of legislatively delegated discretion and involve pursuing a myriad of objectives consistent with public rather than private law duties.

As I see it, the proximity argument in this case is significantly weaker than in either *Cooper* or *Edwards*. Those cases pertained to narrow classes of individuals whose specific interests were vulnerable to the very agents the public

authorities were mandated to supervise, yet no duty of care was found. This case is concerned with a general risk faced by all members of the public and a public authority mandated to promote and protect the health of everyone located in its jurisdiction. The risk of contracting a disease that might have been prevented by public health authorities is a risk that is faced by the public at large. It is a much more generalized risk than the type faced by mortgage investors or clients of lawyers. Moreover, the nexus or relationship between a member of the public who contracts [West Nile Virus] and the Minister is more attenuated than the nexus or relationship between a mortgage investor and the regulator of mortgage brokers or a client and the regulator of the legal profession. It was held to be plain and obvious in *Cooper* and *Edwards* that there could be no private law duty of care and I find it impossible to conclude otherwise in this case.

[27] Two subsequent decisions of this court came to the same conclusion in relation to statements of claim alleging a private law duty of care on the part of a public authority charged with the statutory responsibility of monitoring the quality of certain medical devices. In *Attis*, the court considered a claim against Health Canada for its alleged failure to test, ban or recall certain breast implants that allegedly caused harm to the plaintiffs. *Drady v. Canada (Minister of Health)* (2008), 300 D.L.R. (4th) 443 (Ont. C.A.), leave to appeal to S.C.C. refused [2008] S.C.C.A. No. 492, dealt with a similar claim against the same defendant for failing to enforce labeling and regulatory standards in relation to temporomandibular joint implants. In *Attis*, Lang J.A. held, at para. 59, that “the government’s duty is owed to the public as a whole, not to the individual consumer.” Likewise, in *Drady*, she concluded at para 38: “While undoubtedly Health Canada owed

a public law duty of care to the residents of Canada generally, the law is clear that a breach of such a public law duty does not give rise to a private law cause of action.”

[28] The allegations made regarding decisions and actions taken by Ontario in relation to the SARS outbreak fall into the same category as those made and dismissed as disclosing no cause of action in *Cooper, Edwards, Eliopoulos, Attis and Drady*. The Directives mandated standards to be followed and implemented by health care facilities and health care professionals. It is simply not arguable in law that by promulgating these quasi-legislative standards to hospitals and health care workers, Ontario created a relationship of proximity with the plaintiff sufficient to give rise to a private law duty of care. In addition the cases already referred to, see *Wellbridge Holdings Ltd. v. Winnipeg (Greater)*, [1971] S.C.R. 957; *Holtslag v. Alberta* (2006), 380 A.R. 133 (C.A.); *Klimpton v. Canada (Attorney General)* (2002), 9 B.C.L.R. (4th) 139 (S.C.).

[29] The plaintiff argues that *Cooper, Edwards* and *Eliopoulos* are distinguishable from the case at hand because:

1. the SARS virus can only be spread by close person to person contact, and so the risk of transmission was essentially limited to certain hospitals, unlike the West Nile virus, which was spread by mosquitoes and which therefore posed a broader risk to the public at large; and
2. the plaintiff therefore was not exposed to a general risk to the public at large but to “a very specific risk particular to her and a limited class of persons – namely

hospital patients, employees, visitors and persons in close contact with the first three groups.”

[30] I disagree that the nature of SARS and how it is spread is capable of distinguishing this case from *Eliopoulos*, and even less from *Cooper* and *Edwards*. The risk of contracting an infectious disease from attending a hospital for treatment or to visit a loved one was a random risk facing the public at large. While it may be that in Ontario mosquitoes are more frequently encountered than trips to the hospital, when it comes to assessing the proximity between the province and an individual infected by reason of one or the other, I see no meaningful distinction between the two. The fact that the plaintiff contracted SARS while she was in the hospital does not put her in a narrow class of individuals in a direct relationship with Ontario. Moreover, as in *Eliopoulos*, the proximity between the province and one who happens to visit a hospital is considerably more remote than the proximity between individuals dealing with lawyers and mortgage brokers and the public authorities charged with the duty to regulate and monitor those very dealings, as in *Cooper* and *Edwards*.

[31] When assessing how best to deal with the SARS outbreak, Ontario was required to address the interests of the public at large rather than focus on the particular interests of the plaintiff or other individuals in her situation. Decisions relating to the imposition, lifting or re-introduction of measures to combat SARS are clear examples of decisions that must be made on the basis of the general public interest rather than on the basis of the interests of a narrow class of individuals. Restrictions limiting access to hospitals or

parts of hospitals may help combat the spread of disease, but such restrictions will also have an impact upon the interests of those who require access to the hospital for other health care needs or those of relatives and friends. Similarly, a decision to lift restrictions may increase the risk of the disease spreading but may offer other advantages to the public at large including enhanced access to health care facilities. The public officials charged with the responsibility for imposing and lifting such measures must weigh and balance the advantages and disadvantages and strive to act in a manner that best meets the overall interests of the public at large.

[32] The plaintiff submits that the decisions in *Eliopoulos, Cooper* and *Edwards* must now be read in the light of *Sauer v. Canada (Attorney General)* (2007), 225 O.A.C. 143 (C.A.) (“*Sauer*”), and *Finney v. Barreau du Québec*, [2004] 2 S.C.R. 17 (“*Finney*”). I see nothing in either of those decisions capable of detracting from the applicability of *Eliopoulos, Cooper* and *Edwards* to the facts of this case, as both of those cases involved specific allegations that Crown authorities had direct dealings with the plaintiff sufficient to give rise to a private law duty of care.

[33] *Sauer* involved a proposed class action by cattle farmers against the federal Crown alleging negligence in the regulation of bovine spongiform encephalopathy. The plaintiff alleged that the federal authorities had represented to members of the proposed class that they would protect the private interests of cattle farmers, and that it was therefore arguable that federal authorities had entered into a relationship of proximity and were acting with the interests of the plaintiff class in mind rather than in the broad public

interest: see *Attis* at para. 49. In *Finney*, the plaintiff, who sued the Barreau du Québec for its failure to deal with an errant member, had directly engaged with the Barreau by complaining about the actions of the member. The Barreau failed to deal with those specific complaints in a proper and timely manner. The actions of the Barreau were described as “made in a relationship of proximity with a clearly identified complainant”: *Finney* at para. 46. Here, no facts are pleaded to suggest that the plaintiff had any direct contact or dealings with Ontario, and the allegations of negligence relate to the manner in which Ontario dealt with the risk SARS posed to the public at large: see *Attis*, at para. 45.

[34] I conclude that, as pleaded, this case is not distinguishable from *Eliopoulos*, and that the plaintiff has failed to satisfy the first stage of the *Cooper-Anns* test.

(c) Residual policy concerns

[35] As I have concluded that on the facts pleaded by the plaintiff, there is no relationship of proximity and no prima facie duty of care, it is unnecessary for me to consider the second stage of the *Cooper-Anns* test. I would observe, however, that when it comes to residual policy concerns, it is difficult to see any meaningful distinction between this case and *Eliopoulos*, where the court concluded, at paras. 32-33:

In deciding how to protect its citizens from risks of this kind that do not arise from Ontario's actions and that pose an undifferentiated threat to the entire public, Ontario must weigh and balance the many competing claims for the scarce resources available to promote and protect the health of its citizens.

I agree with Ontario's submission that to impose a private law duty of care on the facts that have been pleaded here would

create an unreasonable and undesirable burden on Ontario that would interfere with sound decision-making in the realm of public health. Public health priorities should be based on the general public interest. Public health authorities should be left to decide where to focus their attention and resources without the fear or threat of lawsuits.

[36] I would add that this result does not leave the plaintiff without a remedy if she can show that she suffered harm as a result of negligence at the operational level on the part of those responsible for the application and enforcement of the Directives; namely, health care facilities and health care professionals.

(d) Bad faith

[37] The plaintiff argues that her case is different from *Eliopoulos* because she has alleged bad faith. That allegation is found in para. 83 of the claim:

To the extent that any of the actions taken by the defendants in responding to SARS are characterized by the Court as policy and not operational, the plaintiff states that the said policy choices were made irrationally or in bad faith.

[38] The motions judge found, at para. 94, that to the extent the plaintiff relied on alleged negligence “involving, or calling for, policy decisions”, those allegations could not be saved by “the unparticularized assertion that...[the policy decisions] were made irrationally or in bad faith”. I agree with and adopt that analysis.

CONCLUSION

[39] Several recent decisions of the Supreme Court of Canada and of this court recognize that it is appropriate to analyze claims alleging negligence against public

authorities based on the exercise of discretionary statutory duties at the pleading stage to determine whether there is any possibility that a duty of care could be found to exist: *Cooper; Edwards; Syl Apps Secure Treatment Centre v. B.D.*, [2007] 3 S.C.R. 83; *Eliopoulos; Attis; Drady*.

[40] For the foregoing reasons, I conclude that it is plain and obvious on the facts pleaded in the claim that Ontario did not owe a private law duty of care to the plaintiff and that, in law, this claim has no prospect of success.

[41] Accordingly, I would dismiss the plaintiff's appeal, allow Ontario's cross-appeal, strike the claim in its entirety and dismiss the action. If the parties are unable to agree as to costs, we will receive brief written submissions, from Ontario within fifteen days and from the plaintiff within ten days thereafter.

“Robert J. Sharpe J.A.”

“I agree R.G. Juriansz J.A.”

“I agree H.S. LaForme J.A.”

RELEASED: May 7, 2009