COURT OF APPEAL FOR ONTARIO

CITATION: Levac v. James, 2023 ONCA 73
DATE: 20230202
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van Rensburg, Sossin and Copeland JJ.A.

BETWEEN:

Anne Levac

Plaintiff (Respondent)

and

Stephen Rose James, Sue-Ellen Solger, Izabella Gerbec, Erin Kostuch, Anita Takyi-Prah, Joana Nunes, Elizabeth Hicken, Marissa Allin, Rachel Schrijver, Annie Michaud, Anna Nudel, Elena Polyakova, Raymund Tanalgo, Jefferd Felix, Jason Foster, Paolo Galvez, Glenn Francisco, Peter Rothbart and Rothbart Centre for Pain Care Ltd.

Defendants (Appellant/Respondents)

Darryl Cruz, Erica Baron, Eric Pellegrino, Jacob Klugsberg, and Alexa Jarvis, for the appellant

Paul Harte and Maria Damiano, for the respondent Anne Levac

Voula Kotoulas, for the respondents Sue-Ellen Solger, Izabella Gerbec, Erin Kostuch, Anita Takyi-Prah, Joana Nunes, Elizabeth Hicken, Marissa Allin, Rachel Schrijver, Annie Michaud, Anna Nudel, Elena Polyakova, Raymund Tanalgo, Jefferd Felix, Jason Foster, Paolo Galvez, and Glenn Francisco

Ronald Bohm, for the respondent Marissa Allin

Heard: November 23, 2022

On appeal from the order of Justice Edward M. Morgan of the Superior Court of Justice, dated April 27, 2022, with reasons reported at 2021 ONSC 5971, and the costs endorsement dated December 2, 2021, with reasons reported at 2021 ONSC 7917.

Sossin J.A.:

OVERVIEW

[1] This class action arises from an infectious disease outbreak at the Rothbart Centre for Pain Care Ltd. ("the Rothbart Centre") in Toronto. The appellant, Dr. Stephen James ("Dr. James"), is an anesthesiologist who administered epidural injections into the area around the spine as a pain relief treatment. After receiving an injection, some of his patients subsequently developed meningitis, an abscess in or around the spine, or other serious infection. The outbreak was discovered by Toronto Public Health ("TPH") officials in November 2012.

[2] An extensive investigation concluded that the outbreak was caused by inadequate Infection Prevention and Control ("IPAC") used for the injections, referring to practices and procedures that are intended to prevent or reduce the risk of transmission of microorganisms in health care settings. No specific deficiency could be scientifically demonstrated to have caused the spread of infection. However, the rate of infection associated with Dr. James' epidural injection practice was many times greater than the reported risk of infection for such procedures generally, which was inconsistent with the use of appropriate IPAC. Furthermore, Dr. James was found to be colonized with a rare strain of *Staphylococcus aureus* ("*Staph A*") bacteria, CC59, that matched the bacteria infecting six of his patients.

[3] The respondent, Anne Levac ("Ms. Levac"), is one of Dr. James' patients who suffered an infection. She launched this action in September 2014, pursuant to the *Class Proceedings Act, 1992*, S.O. 1992, c. 6, on behalf of approximately 20 former patients of the Rothbart Centre who received injections from Dr. James ("the Class" or "Class Members") between January 2010 and November 2012 ("the Class Period"). The claim alleged that Dr. James, along with the now-defunct Rothbart Centre, its medical director, and its nursing staff, caused the infectious disease outbreak by implementing substandard IPAC, failing to report or investigate the infections, and failing to remediate IPAC after learning of the initial infections.

[4] The Class is limited to those patients who developed signs or symptoms clinically compatible with bacterial meningitis, epidural abscess, or cellulitis of a bacterial origin and/or bacteremia after receiving an epidural injection administered by Dr. James (or where such person is deceased, their estate), as well as their derivative claimants pursuant to the *Family Law Act*, R.S.O. 1990, c. F.3. There are two subclasses: (1) Patient Class Members who were infected by *Staph A* bacteria genetically matched to bacteria that colonized Dr. James (the "Genetically Linked Patients"); and (2) Patient Class Members who received injections more than two years prior to the issuance of the claim (the "Presumptively Untimely Claims").

[5] Following a five-week common issues trial, the trial judge found against Dr. James on all the common issues: negligence (duty of care, standard of care and breach, and causation), fiduciary duty, limitation period, and entitlement to punitive damages. In particular, the trial judge concluded that causation was proven in respect of the Genetically Linked Patients. For the remaining patients, he drew a rebuttable inference that Dr. James' breach of the standard of care for IPAC caused the infections, based on the statistical evidence showing that Dr. James exposed his patients to a risk of infection that was either 49 or 69 times higher than for patients not exposed to his substandard IPAC.

[6] The claims against the other defendants were not made out. The trial judge awarded costs payable by Dr. James to Ms. Levac and the successful nurse defendants, who are respondents on appeal ("the nurses").[1]

[7] When the class action proceeds to the individual issues phase, most claimants must still establish that they likely contracted their infection because of Dr. James' breaches. However, they will each benefit from the common presumption that any patient who developed an infection following an epidural injection performed by Dr. James was infected because of his negligent IPAC. This finding, which arises from the circumstantial evidence including the statistical rarity

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[1] Marissa Allin, the single uninsured nurse, is represented by separate counsel. The remaining defendants did not participate in the trial or the appeal, although Peter Rothbart (the Medical Director of the Rothbart Centre) participated in examinations for discovery.

of such infections when proper IPAC is employed, establishes *prima facie* causation for each Class Member, subject to further evidence to the contrary.

[8] Dr. James appeals essentially all the liability findings made by the trial judge and seeks leave to appeal the costs award. He argues that although the common issues were certified, based on the trial evidence they could not be answered on a Class-wide basis across the entire Class Period, given the unique interactions between Dr. James and each of his patients.

[9] According to Dr. James, the trial judge also erred in articulating and applying the legal tests for negligence, breach of fiduciary duty, and punitive damages, relieving the plaintiff of her legal burdens and using the class action regime as a shortcut to proof. He exercised the spent doctrine of *res ipsa loquitor* and worked backwards from an outcome to find liability. His reasons breached procedural fairness by failing to address all of Dr. James' defences. Furthermore, costs should have been left in the cause and the trial judge should not have ordered Dr. James to pay the costs of the nurses.

[10] For the reasons that follow, I do not accept the arguments raised by Dr. James. I would dismiss the appeal and deny leave to appeal the costs award.

PROCEDURAL BACKGROUND

[11] In December 2016, Ms. Levac's motions for certification and partial summary judgment were granted: 2016 ONSC 7727. In November 2017, this court

overturned that decision based on a breach of procedural fairness, and sent the motions back for reconsideration by a different judge: 2017 ONCA 842. In February 2018, certification of the class action was approved by the trial judge on consent.

[12] Following examinations for discovery, in September 2019, the trial judge granted Ms. Levac's motions to amend the pleadings and common issues to add the causation-related issues and subclasses, and dismissed Dr. James' motion to decertify the class action based on insufficient commonality of claims: 2019 ONSC 5092, leave to appeal to Div. Ct. refused, 512/19 (January 31, 2020).

[13] Twelve common issues were certified and proceeded to trial in February 2021:

Negligence

1. Whether the Defendants owed a duty of care to the Class to take reasonable precautions to prevent the transmission of health care associated infections.

2. What was the standard of care applicable to each Defendant relating to their duty?

3. Whether the Defendants breached the applicable standards.

Causation

4. Was any breach sufficient to have caused or contributed to clinical infection in the infected patients?

5. Should an inference be drawn that any breach, in the absence of evidence to the contrary, caused or contributed to clinical infection in the infected patients?

6. Did any breach cause or contribute to clinical infection in the Genetically Linked Patients?

Fiduciary Duty

7. Whether the putative fiduciary Defendants owed a fiduciary duty to the Class.

8. For those putative fiduciary Defendants found to owe a fiduciary duty, what was the nature of the fiduciary duty owed to the infected patients?

9. For those Defendants found to owe a fiduciary duty, whether these Defendants, or any of them, breached their fiduciary duty.

10. Whether the fiduciary breaches, or any of them, caused or contributed to clinical infection in the infected patients.

Limitation Period

11. Could the claims of the Presumptively Untimely Claims subclass have been discovered within the meaning of section 5 of the *Limitations Act* more than 2 years prior to September 9, 2014?

Punitive Damages

12. For the putative fiduciary Defendants, whether there is conduct sufficient to attract punitive damages, and if so, whether punitive damages should be awarded and in what amount.

DECISIONS BELOW

(1) The Trial Decision

[14] The central question at the common issues trial was whether any of the infections were caused by Dr. James' negligence or breach of fiduciary duty, and whether any of the nurses were contributing causal agents.

[15] Dr. James conceded that he owed a duty of care to his patients. The trial judge found that all defendants owed a duty of care to the Class to take reasonable precautions to prevent the transmission of health care associated infections.

[16] The trial judge found that the standard of care required Dr. James and the nurses to use an "aseptic technique" – an approach aimed at the complete exclusion of harmful micro-organisms – for all epidural injections.

[17] In his testimony, Dr. James himself confirmed several practices that both TPH officials and expert witnesses identified as falling below the acceptable standard for IPAC. This included using medical glove packaging as a sterile field for resting surgical implements during certain procedures (as opposed to a multi-layered, waterproof sterile drape) and performing injections in the caudal (tailbone) area of the spine without using an aseptic technique, such as by not wearing a mask or sterile gloves. Nurse witnesses testified that Dr. James would always draw his own medication (rather than having a nurse hold the medication while being drawn) and that he only sporadically wore a mask during procedures.

[18] Based on this evidence, the trial judge concluded that Dr. James breached the standard of care by not consistently using an aseptic technique for all epidural injections during the Class Period.

[19] In contrast, the trial judge found that there were no sustainable legal claims against any of the nurses. There were no records of which nurses assisted Dr.

James on which day. No Rothbart Centre patients other than those treated by Dr. James had reported similar infections, and there was no evidence that the nurses did anything different for other doctors than for Dr. James. Moreover, none of the nurses were colonized by the same CC59 bacteria as Dr. James.

[20] The trial judge further found that Dr. James breached the standard of care for reporting any suspected infections linked to his practice. He had an ongoing duty to report all infections of which he became aware to the medical director of the Rothbart Centre, and to take reasonable steps to investigate and remediate their cause. However, Dr. James did not report any of the infections, even after one of his patients died in hospital two weeks after her treatment. He knew or should have known that the rate of infection he was observing in his patients was above the standard probability for such complications.

[21] While the plaintiff bore the burden of proving, on a balance of probabilities, that Class Members would not have suffered infections “but for” Dr. James’ substandard IPAC and/or his failure to report, this did not require absolute scientific certainty. Dr. James’ conduct had to be a contributing cause of the injury, but not necessarily the sole cause. The trial judge held he could draw factual conclusions of negligence based on circumstantial evidence, so long as he did not infer negligence by assuming circumstantial evidence, and unless the defendant negated the inference with an explanation that was at least as consistent with no

negligence as with negligence. This could include an inference of causation based on statistical evidence.

[22] The trial judge accepted that he could infer causation in this case. He had no hesitation in concluding that the Genetically Linked Patients suffered injuries caused by Dr. James. There was no other viable explanation (or any explanation at all in the record) for the genetic match between the CC59 strain of *Staph A* that infected these patients and the one that colonized Dr. James.

[23] For those Class Members for whom there was no evidence of infection with the CC59 strain, the plaintiff sought to establish causation based on epidemiological evidence. The 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.

[24] The expert evidence accepted by the trial judge was that faulty IPAC and high infection rates are correlated. The plaintiff submitted there was a common factual basis for inferring causation: by performing an epidural injection with substandard IPAC, Dr. James exposed each of his patients to a statistically higher level of risk than for other patients undergoing the same procedure.

[25] The trial judge adopted the "risk ratio" approach discussed by Lax J. in *Andersen v. St. Jude Medical, Inc.*, 2012 ONSC 3660, who found that where a breach of the standard of care more than doubles the risk of harm, causation is

presumptively established for the class (subject to proof to the contrary in individual cases).

[26] The trial judge accepted expert evidence that the rate of "severe" infections such as meningitis for those undergoing epidural injections was 1 in 10,000. Using the 24 known infected patients and the approximately 3,500 epidural injections performed by Dr. James over the Class Period, Dr. James' patients were at a nearly 69 times greater risk of developing a serious infection than patients not exposed to his substandard IPAC. Alternatively, even using the lower number of 17 infected patients suggested by the defence experts, his patients were at a nearly 49 times greater risk of serious infection. According to the trial judge, this evidence was so overwhelming that it could not be ignored.

[27] While each Class Member will have to demonstrate their right to a claim by showing that they partook of this common risk and suffered consequences, the inference that their injury was specifically caused by Dr. James' actions was found to be statistically proven, subject to any evidence which might emerge in an individual case rebutting this presumption.

[28] In addition, the trial judge found that Dr. James should have immediately assumed that his injection treatment was the cause of the very first infection of which he became aware. Had he addressed that case in accordance with his

professional reporting obligations, investigated its likely cause, and changed his IPAC practices, he could have prevented the subsequent infections that occurred.

[29] The trial judge also confirmed that Dr. James owed a fiduciary duty to his patients. According to the trial judge, he breached this duty initially by not reporting or investigating the first infection, and subsequently by continuing to perform injections without changing his substandard IPAC or informing patients of the increased risk of infection in his practice. That he did not take steps to inform himself of the Ontario standards for infection prevention when he began practicing and did not report the first infection supported a conclusion that he put his personal and professional interests above those of his patients.

[30] Turning to limitation period, the trial judge found that the Presumptively Untimely Claims were not barred by the *Limitations Act, 2002*, S.O. 2002, c. 24, Sched. B. While the claim was not issued until September 2014, this was within two years of the commencement of the TPH investigation. A Class Member could not have discovered the underlying facts giving rise to the causes of action through the exercise of reasonable diligence. The substandard IPAC and problem with infections came to light not because of any individual patient's diagnosis, but due to the exceptionally high rate of infection produced by Dr. James' practice. Since he did not report any of the infections, the infection rate remained undiscovered and undiscoverable until TPH conducted its investigation. Furthermore, Dr. James

could not rely on his own failure to report to provide himself with a limitation defence.

[31] The trial judge held that this was an appropriate case for punitive damages to remedy the breach of fiduciary duty, with quantum for each Class Member to be left to the individual issues phase. He noted that for punitive damages to apply, Dr. James' conduct must be seen as akin to a systemic wrong rather than an individualized one directed at a particular patient or victim. While Dr. James himself had since modified his IPAC practices, there was a rational connection between a punitive damages award and deterring similar failures to report, investigate and remediate infections by other healthcare professionals.

(2) The Costs Decision

[32] The parties agreed on the quantum of costs to be paid by Dr. James to Ms. Levac but disagreed on the timing of that payment. Ms. Levac submitted that costs were payable upon being ordered. Dr. James submitted that payment should be deferred until after the individual issues trials, given that this was the first medical malpractice common issues trial where elements of liability to the Class would not be determined until that stage.

[33] The trial judge agreed that the subject matter of the claim was unique but observed it is normal that specific liability to each Class Member is not determined

following the common issues trial. He ordered costs to Ms. Levac payable within 30 days.

[34] Dr. James submitted that the costs of the nurses should be payable by Ms. Levac because she did not establish their liability. The trial judge found this was a case to deviate from the rule that in a multi-defendant class action, the plaintiff will pay the costs of the successful defendant(s). It was reasonable for Ms. Levac to amend her pleading to name the nurses once Dr. James had brought them into the action by way of third party claim (later converted into a crossclaim). It was Dr. James' position that the nurses, and not himself as the responsible doctor, had caused some or all of the infections. He ought to have been aware that the case against the nurses was weak. He also rejected offers to settle by having his third party claim/crossclaim dismissed without costs.

[35] Even if r. 49 of the *Rules of Civil Procedure*, R.R.O. 1990, Reg. 194, did not apply, the trial judge was prepared to exercise his discretion to order partial indemnity costs up until the date of the offers to settle and substantial indemnity costs thereafter. He found that Dr. James put the nurses through a costly ordeal when he would have been better off letting them out of the action at an early stage and calling them selectively as witnesses if needed. In any event, the costs claimed were modest.

[36] Dr. James was ordered to pay costs to the insured nurses of $348,067.58, all-inclusive, and to Marissa Allin of $487,513, all-inclusive.

ISSUES

[37] Dr. James raises the following grounds of appeal:

(1) the trial judge erred by making findings applicable to the entire Class over the entire Class Period which were not open to him on the evidence;

(2) the trial judge erred by finding the appellant breached the standard of care;

(3) the trial judge erred by finding the appellant's breaches of the standard of care caused the injuries suffered by the Class;

(4) the trial judge erred by providing insufficient reasons which failed to address factual and legal arguments raised by the appellant and breached procedural fairness;

(5) the trial judge erred by finding the appellant breached his fiduciary duties to the Class and that these breaches caused the injuries suffered by the Class;

(6) the trial judge erred by finding punitive damages were available as a remedy for the appellant's breaches;

(7) the trial judge erred by finding that the claims by the Class were not statute barred by virtue of the applicable limitation period; and

(8) the trial judge erred in the award of costs against the appellant.

[38] The nurses make submissions in support of those elements of the trial judgment and costs award in their favour.

[39] I address these grounds of appeal below.

ANALYSIS

[40] Dr. James alleges the trial judge committed errors of law, errors of fact, and errors of mixed fact and law. On a pure question of law, the standard of review is correctness; similarly, a failure to apply the relevant legal principles in determining an issue is an error in principle warranting this court's intervention: *Housen v. Nikolaisen*, 2002 SCC 33, [2002] 2 S.C.R. 235, at paras. 8, 27. The standard of review for findings of fact, or mixed fact and law, is "palpable and overriding error": *Housen*, at paras. 10, 36. Findings of negligence are questions of mixed fact and law.

(1) The trial judge did not err by making Class-wide findings of negligence

[41] Dr. James argues that the trial judge made impermissible Class-wide findings on the evidence. He submits that the decision below failed to account for each patient's unique and variable experience, which made common findings

unworkable. The answers to the common issues therefore are not capable of application to every Class Member.

[42] The suggestion that it was not open to the trial judge to make determinations on Class-wide issues is misplaced. In order to assess this ground of appeal, it is necessary to take the common issues, which are set out above, as the point of departure. The very purpose of certifying common issues is to enable a trial judge to make common findings applicable to every Class Member if there is evidence presented to warrant them. While it was open to Dr. James to contest the viability of those common issues (and he did so both on the initial certification motion and his later decertification motion, from which leave to appeal was dismissed), that is no longer the question before the court.

[43] In order to prove negligence, the plaintiff must demonstrate (1) that the defendant owed the plaintiff a duty of care; (2) that the defendant's behaviour breached the standard of care; (3) that the plaintiff sustained damage; 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. Common issues were certified in relation to duty of care, standard of care, and both general and specific causation.

[44] That Dr. James owed a duty of care to his patients was not contested.[2] The contested Class-wide findings with respect to the standard of care and causation are discussed below.

(a) The Class-wide findings on the standard of care

[45] The trial judge found that Dr. James breached the standard of care owed to his patients by not using an aseptic technique for all epidural injections. Dr. James argues such a finding cannot ground liability in negligence for the whole Class as it does not identify a specific breach of the standard of care, in the sense of a particularized act or omission, that applies to each Class Member. According to Dr. James, only if such an individual breach is shown may a Court proceed to the next step of the analysis, namely, whether each infection would not have occurred "but for" that act or omission. In his view, the trial judge could not undertake this analysis without evidence from each Class Member.

[46] Ms. Levac contends that, in the context of a common issues trial, it is sufficient for the plaintiff to establish: (1) the standard of care required an aseptic technique for every epidural injection; (2) Dr. James did not consistently use an aseptic technique; and (3) his failure to consistently use an aseptic technique caused infection.

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[2] While the answer to Common Issue #1 refers to a duty of care owed to the Class, which would include the derivative *Family Law Act* claimants, it is clear that no such broader duty was conceded by Dr. James or found by the trial judge. When read in context, this finding addresses Class-Member patients only.

[47] Ms. Levac also emphasizes that this class action alleges systemic negligence, which is not specific to any one victim, but rather to a class of victims as a group, relying on *Rumley v. British Columbia*, 2001 SCC 69, [2001] 3 S.C.R. 184, at paras. 30-34. The theory of negligence in such cases is that the impugned acts or omissions of the defendant are negligent because they resulted in a system that was inadequate to protect the class from harm: *White v. Canada (Attorney General)*, 2002 BCSC 1164, 4 B.C.L.R. (4th) 161, at para. 48.

[48] In a medical malpractice case, the court must determine what a reasonable physician would have done (or not done) in order to meet the standard of care: *Armstrong v. Royal Victoria Hospital*, 2019 ONCA 963 at para. 87, *per* van Rensburg J.A. (dissenting), rev'd 2021 SCC 1 for the reasons of van Rensburg J.A. In my view, it was open to the trial judge, relying on the expert evidence, the evidence of nurses who worked with Dr. James, and Dr. James' own evidence, to conclude that he breached the applicable standard of care by not consistently using an aseptic technique.

[49] IPAC is akin to a systemic policy or practice that is intended to be applied consistently. The fact that there may have been some variation in individual experience does not preclude answering the question in common given the finding that an aseptic technique was always required. In *Fresco v. Canadian Imperial Bank of Commerce*, 2022 ONCA 115, 160 O.R. (3d) 173, the failure to pay employees for working overtime in accordance with the *Canada Labour Code*,

R.S.C. 1985, c. L- 2, was recognized as a breach even though the evidence disclosed that some employees were in fact paid overtime. The court characterized the breach as exposing all class members to the bank's unlawful overtime pay practices: at paras. 39, 47, 56.

[50] 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)*).

[51] Dr. James also argues that the trial judge erred in finding that Dr. James breached the standard of care by failing to report, investigate, and remediate the source of potential infections in his practice as they became known to him, beginning in August 2010.

[52] Again, in this context, he submits that a Class-wide finding over the entire Class Period was unavailable. He suggests that the findings about Dr. James' failure to report relied "heavily" on the Out of Hospital Premises Standards published by the College of Physicians and Surgeons of Ontario ("the

OHP Standards”), which were not in place at the start of the Class Period, and did not apply to the Rothbart Centre until 2011.

[53] Ms. Levac submits it was sufficient to establish: (1) there was a duty to report, investigate, and remediate; (2) Dr. James failed to report, investigate, and remediate; and (3) had he not breached his duty, the deficiencies in his IPAC technique, whatever they may have been, would have been remedied, resulting in no infections. I agree.

[54] First, the trial judge himself stated that the OHP Standards simply “codified” the existing reporting obligation, which he accepted formed part of the standard of care based on the expert evidence, and which was also articulated as part of the Rothbart Centre’s own policies.

[55] Second, it was open to the trial judge to find that Dr. James knew or ought to have known of the infections occurring in his practice beginning in August 2010, and that as part of his professional obligations, he was required to report them regardless of any uncertainty as to their exact cause.

[56] For these reasons, I would dismiss this ground of appeal.

(b) The Class-wide findings on causation

[57] Dr. James argues that the trial judge erred in finding that Dr. James’ breaches of the standard of care caused the infections in his patients. While Dr. James accepts that it was open to the trial judge to make general findings with

respect to causation – for example, that a breach of IPAC can cause infection – he submits that only patient-specific evidence was capable of leading to any conclusion on specific causation, i.e., that his breach of IPAC caused the infections in any given patient's case.

[58] Furthermore, according to Dr. James, the trial judge erred in articulating the test for causation and applied the spent doctrine of *res ipsa loquitor* by accepting and relying on statistical evidence of causation in order to make Class-wide negligence findings, thereby reversing the burden of proof.

[59] After recounting the traditional "but for" test for causation, the trial judge referred to the "material contribution to risk" test as clarified in *Clements v. Clements*, 2012 SCC 32, [2012] 2 S.C.R. 181. However, reading that paragraph of his reasons in context, I understand the trial judge to be saying that Dr. James' breach of IPAC need not be the sole cause of the infections, but merely a "contributing" one under the but for analysis, rather than applying the material contribution test that is theoretically available in situations where proof of causation is otherwise impossible. This did not affect the outcome here, much like in *Moran v. Fabrizi*, 2023 ONCA 21, at para. 17, where the trial judge superfluously referred to the material contribution test, but this did not amount to a reversible error as causation was otherwise proven. See also *Donleavy v. Ultramar Ltd.*, 2019 ONCA 687.

[60] I also see no error in the trial judge's conclusion that causation was proven in respect of the Genetically Linked Patients, based on the genetic match between the CC59 strain colonizing Dr. James (and only Dr. James) and infecting some of his patients (and only his patients), the expert evidence pointing to his substandard IPAC as the source of transmission, and the lack of a viable alternative explanation for the genetic match, relying on case law including *Snell v. Farrell*, [1990] 2 S.C.R. 311, and *Hassen v. Anvari*, 2003 CanLII 1005 (Ont. C.A.), leave to appeal refused, [2003] S.C.C.A. No. 490.

[61] For the remaining patients, the trial judge treated the statistical evidence as a basis to infer causation in negligence. He explained as follows:

> The Supreme Court has also instructed that causation may be inferred from evidence, including from circumstantial evidence. This is so even where the record contains inconclusive or contrary expert evidence, provided that the inference takes into account all of the available evidence and is reasonable in the circumstances. Thus, for example, in analyzing a claim that exposure to carcinogens at a plaintiff's employment caused a plaintiff's cancer, the Court has indicated that evidence of "historical exposures followed by a statistically significant cluster of cases" can suffice to satisfy the causation requirement: *British Columbia (Workers' Compensation Appeal Tribunal) v. Fraser Health Authority*, 2016 SCC 25 (CanLII), [2016] 1 SCR 587, at para 38. Causation can therefore be discerned by inference from the statistical evidence. [Emphasis added.]

[62] Dr. James relies on statements from other cases advising caution in using statistical evidence to establish causation: see e.g., *Andersen*, at paras. 393-95;

Benhaim v. St-Germain, 2016 SCC 48, [2016] S.C.R. 352, at paras. 74-76. Here, the statistical evidence was not relied upon to establish causation in respect of a single individual, but rather to establish an inference across the entire Class, adding to these dangers.

[63] Ms. Levac asserts that there is no bar to a court relying on statistical evidence of causation, and that such reliance has been accepted at least since *Rothwell v. Raes* (1988), 66 O.R. (2d) 449 (H.C.).

[64] While correlation is not scientific causation, scientific certainty is not required for legal proof: *Snell*, at pp. 330-31; *Benhaim*, at para. 47. The trial judge had the benefit of extensive expert evidence on the relationship between proper IPAC and infection rates. He found that the risk of serious infection among Dr. James' patients was staggering – at least 49 times higher than expected – and concluded that the statistical evidence was "so overwhelming that it cannot be ignored."

[65] As Wagner J. (as he then was) stated in *Benhaim*, at para. 78, deference is owed to trial judges when drawing inferences of causation based on statistics:

> Drawing an inference from a general statistic in a particular case is an inherent, and often implicit, part of the fact-finding process. A statistic alone reveals nothing about a particular case. It must be interpreted in light of the whole of the evidence. This interpretation is the role of the trial judge, and it is entitled to considerable deference on appeal. Respectfully, the Court of Appeal in this case failed to show such deference.

[66] In this case, there was powerful circumstantial evidence on which to conclude that a statistical association represented a causal link on a balance of probabilities. The trial judge further found that Dr. James had not put forward a viable, non-negligent explanation for the outbreak as a whole.

[67] The trial judge's common finding on specific causation includes the important caveat, "absent sufficient evidence to the contrary." In this way, he recognized that the ultimate determination of whether a Class Member was infected because of Dr. James' breaches remains an individual issue. This does not shift the onus or burden of proof. Rather, at individual trials, each Class Member still must prove their case on a balance of probabilities. However, they will be able to rely on the trial judge's common findings, including that the infections among the non-Genetically Linked Patients are presumptively attributable to Dr. James' substandard IPAC. As the trial judge explained:

> While each Class member will have to demonstrate their right to a claim by showing that they partook of this common risk and suffered consequences, the inference that their injury was specifically caused by Dr. James' actions is statistically proven. As in *Andersen*, *supra* and [*Buchan v. Ortho Pharmaceutical (Canada) Ltd.* (1984), 46 O.R. (2d) 113, aff'd (1986) 54 O.R. (2d) 92 (C.A.)], *supra*, the evidence before me demonstrates that the risk ratio of Dr. James' epidural injections is well above 2.0, thus presumptively proving causation for class members (subject, of course, to any evidence which might emerge in an individual case rebutting this presumption).

[68] This approach is consistent with well-established causation principles in negligence generally, and medical negligence specifically, where the defendant is often in a better position than the plaintiff to determine the cause of an injury: see e.g., *Snell*, at paras. 328-29; *Benhaim*, at paras. 48-49. As the trial judge noted, the procedures here occurred literally behind each patient's back.

[69] Furthermore, although the *prima facie* finding was made on a Class-wide basis, it remains open to Dr. James to rebut this inference in respect of individual non-Genetically Linked Patients, where such evidence exists. While the reality is that a complete finding of causation may be an evidentiary inevitability in most cases, that is not the same as a shift in onus.

[70] I see no error in the trial judge's reliance on statistical evidence in drawing a Class-wide, rebuttable inference that Dr. James' substandard IPAC caused the infections.

[71] Dr. James also argues that even if he breached the standard of care based on his failure to report, investigate, and remediate the first infection, the trial judge erred in drawing the rebuttable inference that these breaches caused the infections of the non-Genetically Linked Patients after August 7, 2010. In Dr. James' view, there was no evidence that a material change in outcome would have occurred had he reported the first infection of which he became aware (which was itself seven months into the Class Period).

[72] I disagree that there was no evidence on which to find a different outcome would have resulted had Dr. James acted differently. Specifically, the trial judge reasoned that if Dr. James had reported the first infection, it was likely that the medical director would have addressed it in accordance with his professional obligations, as he did when the TPH investigation was launched. Either Dr. James would have improved his IPAC or the medical director would have caused him to do so. On this basis, it is unlikely the subsequent infections would have occurred. This conclusion was open to the trial judge on the record.

[73] For these reasons, I would dismiss this ground of appeal.

(2) The trial judge did not err by providing insufficient reasons or breaching procedural fairness

[74] According to Dr. James, the trial judge's reasons fail to consider key factual and legal arguments raised in his defence. He argues that the parties and this court are left to speculate on how the trial judge reached his conclusions on critical issues, particularly as he did not refer to certain evidence that is contrary to those conclusions.

[75] Dr. James contends that the reasons were "far from the comprehensive assessment the Trial Judge himself stated was demanded from such a complicated case", referring to comments made by the trial judge in his certification amendment decision. Dr. James points out that while his closing submissions at

trial were over 200 pages, the trial judge's legal analysis consisted of approximately 28 pages.

[76] The adequacy of reasons must be determined functionally based on whether they permit meaningful appellate review. If they do, then an argument that the reasons are inadequate fails, despite any shortcomings: *Farej v. Fellows*, 2022 ONCA 254, leave to appeal to S.C.C. requested, 40198, at para. 45. Adequacy is contextual, and includes the issues raised at trial, the evidence adduced, and the arguments made before the trial judge. In general, reasons are to be read as a whole with the presumption that the trial judge knows the record and the law and has considered the parties' arguments.

[77] In *R. v. G.F.*, 2021 SCC 20, 459 D.L.R. (4th) 375, at paras. 74-76, the Supreme Court of Canada cautioned against appellate courts reviewing trial judge's reasons with an overly critical eye, especially in cases turning on credibility assessments. The majority stated, at para. 79:

> To succeed on appeal, the appellant's burden is to demonstrate either error or the frustration of appellate review. Neither are demonstrated by merely pointing to ambiguous aspects of the trial decision. Where all that can be said is a trial judge may or might have erred, the appellant has not discharged their burden to show actual error or the frustration of appellate review. <u>Where ambiguities in a trial judge's reasons are open to multiple interpretations, those that are consistent with the presumption of correct application must be preferred over those that suggest error. It is only where ambiguities, in the context of the record as a whole, render the path</u>

> taken by the trial judge unintelligible that appellate review is frustrated. An appeal court must be rigorous in its assessment, looking to the problematic reasons in the context of the record as a whole and determining whether or not the trial judge erred or appellate review was frustrated. It is not enough to say that a trial judge's reasons are ambiguous – the appeal court must determine the extent and significance of the ambiguity. [Emphasis added.] [Citations omitted.]

[78] Dr. James mistakes length for thoroughness. The trial judge's reasons addressed precisely the certified common issues and disclosed the path he took to address those issues. In my view, the trial judge's reasons are sufficient to meet the threshold established in *G.F.* and the related case law.

[79] More specifically, Dr. James argues that the trial judge failed to engage with the expert evidence favourable to him and explain why he preferred one expert over another. Dr. James highlights that the opinion of Dr. Mark Loeb, challenging Ms. Levac's causation methodology, was not specifically mentioned.

[80] I do not accept this argument.

[81] The trial judge referred to the expert evidence on Dr. James' IPAC in part as follows:

> That said, Dr. James himself confirmed a number of things in his own testimony that the TPH officials, along with expert witnesses at trial, identify as falling below the acceptable standard of IPAC. These include using the sterile glove packaging or wrapper as a sterile field for resting surgical implements during a procedure, and performing an injection in the caudal area of the spine without using an aseptic technique.

> <u>None of the experts at trial</u> testified that a non-aseptic technique met the standard of care for a caudal injection, and Dr. James could not identify a single text book or other piece of medical literature that suggested that was the case. Dr. Richard Doran, a pain management expert called by Dr. James, testified that all epidural injections, including caudal injections, require an aseptic technique. Dr. Catherine Smyth, a pain management expert called by the Plaintiff, stated in her testimony that the non-use of an aseptic technique when performing caudal epidural injections was "shocking". [Emphasis added.]

[82] The trial judge was under no obligation to refer to every piece of evidence, or every expert by name, and had the discretion to accept some, none, or all of the evidence presented.

[83] Dr. James further argues that the trial judge failed to consider alternative theories of causation. On this point, the trial judge concluded that, "Dr. James produced no evidence that contradicted or cast serious doubt" on the conclusion that the genetic match between the CC59 strains was the result of his substandard IPAC. Dr. James contends that this statement was incorrect, pointing to evidence from Dr. Neil Rau that infections in one room at the Rothbart Centre occurred at a higher rate than another, suggesting that other factors such as cleaning practices may have played a role in the outbreak.

[84] As Ms. Levac emphasizes, while Dr. Rau testified about possible causes of infection in the abstract, Dr. James offered no convincing alternative explanation for how bacteria genetically matched to a strain present in his nose came to cause infections in his patients. A trial judge is not obliged to consider potential non-

negligent causes where there is no evidentiary foundation to do so: *Hassen*, at para. 9; *Armstrong*, at para. 134.

[85] The trial judge did not err in concluding that Dr. James presented no evidence to cast doubt on the conclusion that he caused the infections for purposes of the common issues trial.

[86] Finally, Dr. James challenges an adverse inference drawn by the trial judge based on Dr. James' failure to call witnesses to corroborate his evidence that he spoke with other Rothbart Centre physicians about the infections. Dr. James argues that his evidence on this point was uncontradicted and so these witnesses were unnecessary.

[87] Whether or not the inference was warranted, the trial judge clarified that it was not relevant to his finding on this point. He explained, "As already indicated, it would <u>in any case</u> have been the medical director, and not two friends and colleagues, that would have been the required avenue of reportage in accordance with the OHP Standards and the applicable professional standard of care" (emphasis added).

[88] For these reasons, I am not persuaded the trial judge's reasons are insufficient or breached procedural fairness. I would dismiss this ground of appeal.

(3) The trial judge did not err in finding a breach of fiduciary duty

[89] Dr. James does not contend that the trial judge erred in setting out the law with respect to doctor-patient fiduciary relationships. Rather, he argues the trial judge erred in finding Dr. James breached his fiduciary duty to Class Members.[3]

[90] Dr. James relies on his concerns regarding the trial judge's treatment of IPAC and failure to report in the negligence analysis. These grounds of appeal have already been disposed of above. He further argues that the trial judge erred in finding that Dr. James misled his patients as to the risk of infection and contends there was no evidence that patients would not have gone through with their injections had they been accurately advised of the risks.

[91] These arguments do not reveal any reversible error on the part of the trial judge.

[92] It was open to the trial judge to find, on the evidence, that Dr. James had obscured the level of risk to his patients in the procedures he performed after becoming aware of the first infection. The trial judge's factual findings are entitled to deference.

[93] Furthermore, the thrust of the trial judge's informed consent finding was that Dr. James continued his injection practice without any modification in the face of

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[3] Again, it is clear the trial judge found a fiduciary duty was owed to the patient Class Members only.

one or more serious infections, without advising his patients (or anyone else) of this apparent increase in risk, and that had he complied with his professional obligations, all infections after August 2010 could have been avoided. There was ample basis for the trial judge to find that Dr. James' failure to report, investigate, and remediate rose to the level of a breach of fiduciary duty (in addition to that same conduct grounding the trial judge's finding of negligence). It was likewise open to the trial judge to conclude that these breaches of fiduciary duty caused the Class Members' injuries, including Dr. James' failures to inform himself of his professional obligations in relation to IPAC (as codified in the OHP Standards), to report any infections, and to advise patients of the risks.

[94] For these reasons, I would dismiss this ground of appeal.

(4) The trial judge did not err in finding punitive damages were appropriate

[95] The trial judge found that punitive damages were appropriate to denounce and deter the conduct of Dr. James.

[96] Dr. James argues that the findings in this case do not meet the test established by the Supreme Court in *Whiten v. Pilot Insurance*, 2002 SCC 18, [2002] 1 S.C.R. 595, at para. 36, which states that punitive damages are appropriate only in "exceptional cases" involving "malicious, oppressive and high-handed" misconduct that "offends the court's sense of decency".

[97] The trial judge properly instructed himself on the test governing punitive damages in *Whiten*. His conclusion that Dr. James' conduct constituted "a marked departure from ordinary standards of decent behaviour" is a finding of mixed fact and law entitled to deference.

[98] I see no error with the trial judge's answer to the common issue regarding punitive damages.

[99] Rather, he properly characterized this class proceeding as rooted in a "systemic wrong" rather than an individualized one directed at a particular patient or victim. The trial judge found that general deterrence was particularly important with respect to a physician's duty to report:

> Of particular concern with respect to punitive damages and deterrence is Dr. James' failure to report, investigate, and remediate the infections as he learned of them arising in his practice. His testimony demonstrated that he now understands the importance of using aseptic technique for caudal injections, properly donning a mask, using an appropriate sterile field for his medical implements, thorough hand hygiene, not wearing his scrubs in his commute to work, etc. These are matters personal to his own practices and there is no real need to make a further point to other physicians engaged in the same kind of medical practice. <u>But having failed to take any action as the reports of infections came to him is precisely the type of conduct for which a deterrent message should be broadcast to the medical profession</u>.
>
> …
>
> Doctors must know that reporting infections is the first step in preventing further infections, and that a breach of

> the duty to report, investigate, and remediate issues like infection is as integral to the public's confidence in medical care as is the treatment of the patient's underlying condition. A compensatory remedy may well suffice in driving this message home to Dr. James, but it requires a punitive one to broadcast it to the medical profession and public at large. [Emphasis added.]

[100] However, even where punitive damages are found justified "writ large" to address a systemic wrong, they still must be considered together with any other damages to which a Class Member is entitled. While the trial judge acknowledged that the quantum of punitive damages will be determined in individual trials, whether such damages are appropriate in any individual case where liability is established must also be considered at that stage.

[101] Indeed, the trial judge referred to authority which emphasizes that if compensatory damages achieve the objectives of retribution, deterrence, and denunciation, punitive damages may not be warranted at all: see *Performance Industries v. Sylvan Lake Golf and Tennis Club*, 2002 SCC 19, [2002] 1 S.C.R. 678, at para. 87; *Cavanaugh et al. v. Grenville Christian College et al.*, 2020 ONSC 1133, 58 E.T.R. (4th) 51, at para. 361, appeal dismissed, *Cavanaugh (ONCA)*. In other words, there remains the theoretical possibility that the appropriate quantum of punitive damages in an individual case could be zero.

[102] For these reasons, I would dismiss this ground of appeal.

(5) The trial judge did not err in finding the Presumptively Untimely Claims were not statute barred

[103] Dr. James submits that the trial judge erred by finding the Presumptively Untimely Claims could not have been discovered more than two years prior to issuance of the claim. He asserts that this finding was not available to the trial judge because it cannot be concluded on a Class-wide basis what all Class Members knew or did not know based solely on what Dr. James did or did not tell them, as there were other potential sources of information and most Class Members did not testify.

[104] Ms. Levac counters that both causes of action, in negligence and breach of fiduciary duty, were predicated on Dr. James' infection rate and his response to it. This information was only revealed through the TPH investigation.

[105] Under s. 5 of the *Limitations Act, 2002*, a claim is discovered on the earlier of the date when the plaintiff knew or ought to have known that an incident occurred that resulted in a loss (s. 5(1)(a)(i)), that the defendant did or failed to do something to cause that loss (s. 5(1)(a)(ii) and (iii)), and that, having regard to the nature of the injury, loss, or damage, a court proceeding is an appropriate means to seek a remedy (s. 5(1)(a)(iv)): *Gordon Dunk Farms Limited v. HFH Inc.*, 2021 ONCA 681, 16 C.C.L.I. (6th) 289, at para. 34. A plaintiff need not know the exact act or omission by the defendant that caused the loss, but rather must have knowledge

of the material facts upon which a "plausible inference of liability" can be drawn: *Gordon Dunk Farms*, at paras. 30-36, citing *Grant Thornton LLP v. New Brunswick*, 2021 SCC 31, 461 D.L.R. (4th) 613, at para. 42.

[106] Because discoverability involves an inquiry into the individual claimant's state of knowledge, courts have generally been hesitant to certify common limitations issues in class proceedings. Where such an issue is certified, as in this case, the plaintiff must prove that no class member knew or ought to have known the material facts in issue prior to the presumptive discovery date. As this court stated in *Smith v. Inco Limited,* 2011 ONCA 628, 107 O.R. (3d) 321, at para. 164:

> If, as the trial judge found in this case, the evidence does not establish that all class members were not aware of and ought not to have been aware of the material facts, then the application of the [*Limitations Act*, R.S.O. 1990, c. L.15] to the claims is an individual and not a common issue. <u>It is an error to treat the limitation period as running from the date when a majority, even an overwhelming majority, of the class members knew or ought to have known the material facts in issue</u>. [Emphasis added.]

[107] In this case, I accept that it was open to the trial judge to find that material facts grounding both the claims in negligence and breach of fiduciary duty were not discoverable by any Class Member prior to the TPH investigation. In the unique circumstances of a disease outbreak where liability is based not on a single infection but on a group of infections far exceeding the expected rate, which was itself evidence of a systemic failure to follow appropriate IPAC and to investigate,

report, and remediate infections, this information was necessary to discover the claims.

[108] As the trial judge found that Dr. James did not report any of the infections, his concealment of material facts resulted in a lack of actual or objective knowledge by Class Members of the elements set out in s. 5(1)(a), preventing discovery until the date the concealed facts were revealed: *Zeppa v. Woodbridge Heating & Air-Conditioning Ltd.*, 2019 ONCA 47, 144 O.R. (3d) 385, at para. 72.

[109] For these reasons, I would dismiss this ground of appeal.

(6) Leave to appeal costs is not warranted

[110] Dr. James seeks leave to appeal the order that he pay the costs of Ms. Levac and the nurses.

[111] There is no dispute that a trial judge's discretion to award costs is broad, and that leave will only be granted where there are strong grounds upon which the court could find that the motion judge made an error in principle or the costs award is plainly wrong: *Hamilton v. Open Window Bakery Ltd.*, 2004 SCC 9, [2004] 1 S.C.R. 303, at para. 27.

[112] On the costs to Ms. Levac, Dr. James argues that as the Class has not established complete liability against him and may in theory never establish that liability, a costs order at this stage of the litigation is premature. It remains open to Dr. James to defend the claims against him by rebutting the trial judge's

presumptive findings at individual trials. He contends that costs should have been left in the cause instead.

[113] I would reject this submission. The general rule that costs follow the event applies in Ontario class proceedings, just as it does in other forms of litigation: *Ruffolo v. Sun Life Assurance Company of Canada*, 2009 ONCA 274, 95 O.R. (3d) 709, at para. 34. While liability may ultimately be rebutted in respect of individual Class Members, the common findings finally resolved the certified common issues in favour of the Class. The costs of individual trials, should they occur, can be dealt with in those proceedings.

[114] Dr. James also argues that this case fits within s. 31 of the *Class Proceedings Act, 1992*, which allows for unique costs arrangements where the action is a test case, raises a novel point of law, or involves a matter of public interest.

[115] I would reject this submission. The trial judge addressed this very question, concluding that, "The present case is unique in terms of its subject matter but it is not unique in terms of its process or any features that would go to the payment of costs." I see no basis to interfere with this finding, and in any event the determination that a special arrangement is justified under s. 31 is entirely discretionary.

[116] There is no basis on which to conclude that costs in favour of the Class were not appropriate following the common issues trial.

[117] Dr. James further argues that the trial judge erred in principle by ordering him to pay the costs of the co-defendant nurses.

[118] The trial judge relied on *Moore v. Wienecke*, 2008 ONCA 162, 90 O.R. (3d) 463, at para. 37, which confirmed that in a multiple-defendant case where the plaintiff succeeds against some defendants but not others, the "normal course" is for the unsuccessful defendant to pay the plaintiff's costs and the plaintiff to pay the successful defendant's costs. Deviations from this norm may be justified where it was reasonable for the plaintiff to sue multiple defendants in the same action and it is fair in the circumstances to shift costs from the plaintiff to the unsuccessful defendant: *Moore*, at para. 41.

[119] The trial judge explained why he ordered Dr. James to pay the costs of the nurses in this case as follows:

> In my view, it is fair to shift to Dr. James any costs owed by the Plaintiff to the Nurse Defendants. It was evident to me early in the trial that the physician is responsible for the treatment and preparatory procedures performed by the nurses under his supervision and authority. He conceded as much himself in his testimony. For Dr. James to have sued the nurses in the first place instead of simply summonsing them as witnesses is perplexing to me. The responsible physician was not going to enjoy any positive findings or helpful answers to the common issues questions by trying to pin some of his responsibility on the nurses who assisted him.

[120] Dr. James argues such a deviation was not warranted for four reasons. First, he never attempted to shift the blame for the Class Members' injuries onto the nurses. Second, the trial judge mistakenly accepted that Dr. James had brought the nurses into the action through a third party claim, when in fact Ms. Levac had claimed against the generic "Nurse Doe" beforehand. Third, the nature of the allegations against Dr. James and the nurses differed significantly. Fourth and finally, there is no evidence in the record that the Class would be unable to pay the costs of the nurses.

[121] I would reject this submission. The trial judge considered and applied the relevant factors in deciding whether to exercise his discretion, which need not be applied mechanically in every case: *Moore*, at para. 45. Trial judges are best positioned to assess the conduct of the parties in a lengthy class proceeding and to determine what costs arrangement is fair and reasonable in this regard: see e.g., *Taylor v. Canada (Attorney General)*, 2022 ONCA 892, at para. 36. It was open to him to conclude that Dr. James was driving the case against the nurses and was primarily responsible for their remaining in the action. Indeed, Dr. James has maintained, in oral argument on appeal, that his crossclaims against the nursing defendants remain active and could be pursued if evidence of the nurses' negligence is adduced at the individual trials, notwithstanding the trial judge's conclusions that the case against them following a five-week trial was "remarkably thin" and disclosed "no sustainable legal claim."

[122] Finally, Dr. James contends that the quantum of the costs awards in favour of the nurses was unreasonable and unsupported. He argues that, because the nurses' counsel did not provide detailed time dockets, their overall costs should be reduced as it is impossible to determine whether the hours were reasonably necessary. He also asserts that there was no basis for awarding costs on a substantial indemnity basis.

[123] The trial judge found the amounts claimed for the entire action culminating in a five-week trial to be "extremely reasonable" and "relatively modest." He stated that he was not inclined to look behind the costs claimed to evaluate their hourly content. As for the award of costs on a substantial indemnity basis, the trial judge accepted that all of the nurses had offered to settle the third party claims and crossclaims on a dismissal without costs basis at a very early stage in the litigation and that, even if r. 49 did not strictly apply, there was no basis for Dr. James to have kept them in the action. The trial judge was satisfied that the nurses' claim for costs was reasonable, and he clearly explained the basis for awarding costs on a substantial indemnity basis.

[124] In light of the deference afforded to trial judges in their assessment of costs, I see no potential error that would justify granting leave to appeal the costs award.

DISPOSITION

[125] For the reasons set out above, I would dismiss the appeal and decline to grant leave to appeal the costs award.

[126] The parties have an agreement relating to the costs of the appeal and so further submissions and a further determination on that issue is unnecessary.

Released: February 2, 2023 KMvR

L. Sossin J.A.

I agree. K. van Rensburg J.A.

I agree. Copeland J.A.