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26-3032-01
26-3032-02

REASONS FOR DECISION

FORM G – COMPLIANCE WITH S.21 HCCA
FORM A - FINDING OF INCAPACITY

The patient	MF
The health practitioner	Dr. Simon Oczkowski
The substitute decision maker	MZ
Date and form of hearing	August 24, 2026 via videoconference
Date of Decision(s)	August 24, 2026
Date of Reasons for Decision	September 8, 2026
Panel	Shashi Raina, senior lawyer & presiding member
Counsel to the patient	Veena Pohani
Counsel to the health care practitioner	Carolyn Brandow
Counsel to the substitute decision maker	Self-represented

REASONS FOR DECISION

OVERVIEW

1. MF was an 89-year-old man admitted to the Intensive Care Unit (ICU) of Juravinski Hospital, Hamilton. He had been admitted on April 10, 2026, following a cardiac arrest suffered at home.

2. MF had several medical conditions including Parkinson's disease (possibly Lewy Body Dementia), hypertension, dyslipidemia, gout, type 2 diabetes and hypothyroidism.

3. Following the cardiac arrest, Emergency Medical Services (EMS) had attended at MF's home and provided CPR. He was intubated and transferred to the hospital.

4. An electroencephalogram (EEG) completed on April 14, 2026, demonstrated lack of discernable brain activity and a magnetic resonance imaging (MRI) scan of his brain from April 17, 2026, reported findings consistent with severe anoxic brain injury.

5. MF had very minimal brain stem function like gag and cough. He did not have corneal reflex (blinking of the eye) and other brainstem reflexes. He did not perceive or interact with his environment. He was dependent on a ventilator and was fed through a feeding tube.

6. According to the medical opinions of several ICU physicians and a neurologist, MF was in a persistent vegetative state. His brain damage was deemed permanent and irreversible. MF's care team was unanimous in their opinion that he would not experience any meaningful recovery of consciousness or function.

7. MF's medical team was of the opinion that ongoing use of life support did not confer any medical benefit, as there was no hope of a meaningful recovery, and was therefore not indicated. The team believed that keeping MF on life support was only prolonging his suffering and eventual death, with no possibility of benefit.

8. The medical team had therefore recommended withdrawal of life sustaining treatments and implementation of comfort care measures and palliative care.

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9. MZ, MF's spouse and substitute decision maker ("SDM") did not consent to the proposed treatment plan. Instead, she wanted to continue with intensive care. She wanted to leave it in God's hand as she believed MF could recover through God's miracle.

10. The Board convened at the request of Dr. Oczkowski, the health practitioner who had proposed the treatment for MF, to determine whether MZ had complied with the principles for giving or refusing consent set out in section 21 of the *Health Care Consent Act 1996 (HCCA).*

11. For the reasons set out below, I found MZ had not complied with the principles for giving or refusing consent set out in the *HCCA*.

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PROCEDURAL MATTERS

Interpretation

12. An Arabic interpreter, arranged by the Board, was present throughout the hearing to provide translation for MZ.

Deemed Form A Application

13. Before deciding whether MZ, the SDM had complied with the principles for giving or refusing consent set out in s. 21 the *HCCA*, the Board had to be satisfied that MF was incapable with respect to the proposed treatment (the deemed Form A Application pursuant to section 37.1 of HCCA [1]).

14. Therefore, the deemed Form A application was heard before the Form G application.

ISSUES

1. The issues before the panel were as follows:

   i) Capacity to Consent to treatment under 4(1) of the *Health Care Consent Act, 1996 (HCCA):*

[1] Section 37.1 An application to the Board under section 33, 34, 35, 36 or 37 shall be deemed to include an application to the Board under section 32 with respect to the person's capacity to consent to treatment proposed by a health practitioner unless the person's capacity to consent to such treatment has been determined by the Board within the previous six months

a. Did the evidence establish that it was more likely than not that MF was unable:
    i. to understand the information that was relevant to making a decision about the treatment; or
    ii. to appreciate the reasonably foreseeable consequences of a decision or lack of decision about the treatment

Under section 4(1) of the *HCCA?*

ii) Compliance with section 21of the *Health Care Consent Act, 1996 (HCCA):*

a. Did the evidence establish that it was more likely than not that MZ, the substitute decision-maker did not comply with section 21 of *HCCA* in making treatment decisions for MF.

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DECISION

15. For reasons set out below, I found that the evidence established on a balance of probabilities that:

a. MF was incapable with respect to the proposed treatment; and
b. MZ did not comply with section 21 of the *HCCA*.

ANALYSIS

16. At a hearing for a Form G application, the onus is on the health practitioner to satisfy the Board that the SDM in question has not complied with the principles of substitute decision-making under the *HCCA*. For a deemed Form A (treatment) application the onus is on the health practitioner to prove that, on the day of the hearing, the person is incapable of making treatment decisions according to the test set out in the *HCCA*. The standard of proof in all cases is proof on a balance of probabilities (that is more likely than not). The Board must be satisfied on the basis of clear, cogent and compelling evidence that the health practitioner's onus has been discharged. There is no onus whatsoever on the existing SDM for the Form G Application or the person who is the subject of the deemed Form A Application. The Board must consider all evidence before it properly. Hearsay evidence may be accepted and considered, but it must be carefully weighed.

i) The finding of MF's incapacity to consent to the proposed treatment was upheld

17. Under the HCCA, a person is presumed to be capable to consent to the proposed treatment (*HCCA* s. 4(2)). The health practitioner must prove otherwise.

18. Dr. Oczkowski had outlined the proposed treatment in his CCB Summary (Exhibit 1, page 2) which included withdrawal of life sustaining measures and provision of comfort care and treatment of pain and suffering.

MF was unable to understand the information relevant to making a decision about the treatment and unable to appreciate the reasonably foreseeable consequences of a decision or lack of decision about treatment

19. Dr. Oczkowski testified that since his arrival at the hospital after his initial cardiac arrest on April 10, 2026, MF had demonstrated no ability to understand or appreciate any information.

20. Dr. Oczkowski testified that MF had suffered anoxic brain damage due to the cardiac arrest and that he was in a persistent vegetative state. He said MF was unable to communicate or respond and was unable to understand any information.

21. After being admitted to the ICU, MF underwent several diagnostic tests and was assessed and examined by the ICU physicians and a neurologist. The diagnostic testing included the following:

- CT Scan and EEG performed on April 14, 2026
- MRI performed on April 17, 2026

(Exhibit 1 pages 15, 18, 24)

22. The results of all the above tests were consistent in the conclusion that MF had suffered an anoxic brain damage (complete stoppage of supply of oxygen to the brain).

23. The physicians who examined MF were of the unanimous opinion that MF had suffered catastrophic brain injury, which was deemed permanent and irreversible.

24. Dr. Wyman, neurologist, who had examined MF on April 17, 2026, had opined that MF had suffered catastrophic brain injury with a poor prognosis for meaningful neurological recovery, and that MF would not regain meaningful alertness or survive hospitalization. (Exhibit 1, page 30)

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25. All further assessments were consistent with the above.

26. Dr. Oczkowski said he had last examined MF on August 9, 2026, and there had been no change in his condition. He said MF was unable to take in, understand, or appreciate any information.

27. The evidence was clear, cogent and compelling that MF was unable to communicate with his external environment and would never be able to do so.

28. I therefore found that MF was unable to cognitively process any information about the proposed treatment. As such, he lacked the ability to understand that information for the purposes of making a decision about the treatment and lacked the ability to appreciate the reasonably foreseeable consequences of a decision. MF was therefore incapable of consenting to the proposed treatment.

ii) The substitute decision-maker did not comply with section 21 of HCCA

29. A Form G application under the *HCCA* enables the Board to determine whether a SDM is acting in accordance with the principles of giving or refusing consent enshrined in s. 21 *HCCA*. If the Board determines that the SDM has not followed such principles, it may substitute its own opinion for that of the SDM and direct the SDM to comply with the Board directions.

30. A capable person has an inviolable right to make treatment decisions for themselves the way they deem fit. A capable person has the right to make foolish or selfish decisions, and nobody has the right to interfere with a treatment decision which may be deemed to be unwise. In other words, a capable person is the final arbiter of his or her own best interests.

31. On the other hand, an SDM does not have the right to make unwise decisions on behalf of an incapable person; an SDM must make decisions in accordance with the principles of giving or refusing consent set out in section 21 of the *HCCA*.

32. The law requires an SDM to follow the following principles in making treatment decisions on behalf of an incapable person:

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- If the SDM is aware of a prior capable wish of the incapable person, the SDM is required to give or refuse consent in accordance with the wish.
- If the SDM does not know of a prior capable wish, the SDM must act in the incapable person's best interests. In deciding what would be in the incapable person's best interests, the SDM is required to consider the incapables persons values and beliefs that the incapable person would still act on if capable, any non-binding wishes, and the medical implications of the proposed treatment.

[2]See section 21, *HCCA*

Prior capable wishes applicable to the circumstances

33. Dr. Oczkowski was not aware of any prior capable wishes expressed by MF that were applicable to his current circumstances and the proposed treatment.

34. MF's family had advised that they were not aware of any advance directive or any expressed wishes applicable to his current circumstances.

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[2] 21. (1) Principles for giving or refusing consent. – A person who gives or refuses consent to a treatment on an incapable person's behalf shall do so in accordance with the following principles:
1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.
2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests.
(2) Best interests. – In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,
(a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;
(b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and
(c) the following factors:
1. Whether the treatment is likely to,
i. improve the incapable person's condition or well-being,
ii. prevent the incapable person's condition or well-being from deteriorating, or
iii. reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.
2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.
3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.
4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.

35. MZ in her testimony at the hearing confirmed that there had been no discussion about what MF would have wanted in his current condition. She was not aware of any prior capable wish that would be applicable to MF's current circumstances.

36. Father M, who testified at the hearing on behalf of the SDM with respect to MF's religious values and beliefs also said he had not had any discussion with MF about what he may have wanted in his current circumstances.

37. I therefore found that there was no prior capable wish applicable to MF's current circumstances.

38. MZ was therefore required to make treatment decisions in MF's best interests.

Best Interests

39. In the absence of a clearly expressed prior capable wish applicable to the circumstances, the analysis turned to the incapable person's best interests.

40. The factors set out in *HCCA* s. 21(2) must be weighed according to the strength of the evidence; the legislation does not establish a hierarchy among the various factors. The role of the SDM is to weigh all the factors and make a decision that is objectively in the best interests of the incapable person, not a decision based on what they want for the incapable person.[3]

41. In determining whether MZ's decision to refuse consent to the proposed treatment of withdrawal of life sustaining treatments and implementation of palliative and comfort care measure as proposed by MF's attending physicians was in MF's best interests, I considered the following factors.

Values and beliefs that MF held while he was capable and would still act on if capable

42. MF's family believed that MF would have wanted to be kept alive based on his religious faith. The family had indicated that they were Coptic Orthodox Christians and their faith dictated that only God could decide when death can occur, and stopping any life saving treatment would

[3] See *Cuthbertson v. Rasouli 2013 SCC 53* (CanLii) (Rasouli)

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amount to interfering with God's will. They believed that MF would hold the same religious belief. (see Family Meeting note dated May 12, 2026, Exhibit 1, page 38)

43. The family members had further reported that their religious beliefs included praying for healing, easing pain of the sick, and submitting to God's will in terms of recovery or not from sickness.

44. Dr. Oczkowski had noted in his CCB summary that the proposed treatment was consistent with the family's belief in easing pain of the sick and allowing God's will with respect to recovery or not, with comfort and palliative care focused on easing pain.

45. Apart from his family's view that MF would have wanted to be kept alive based on his religious faith, a major reason for MZ's refusal to the proposed treatment was **her** religious belief that God could make miracles happen and she was hoping God would do a miracle for her.

46. In her testimony MZ said:

- there had never been any discussion with MF about the beliefs of Coptic Church applicable to MF's current circumstances
- they believed in respect and dignity for mankind and maintaining dignity until end of life
- only God knew the end day of MF's life and that she was praying to God to give her the gift of miracle, if she deserved it, and improve MF's condition
- only God knew if she deserved the miracle.

47. Father M testified at the hearing on behalf of MZ. He said he had known MF since 2014. He said MF was a member of his church and attended the church regularly. In his testimony he spoke about the beliefs of Coptic Church, which included:

- not to end life directly or indirectly, if the brain is not dead;
- not to take an individual off life support systems that can help keep the person stay alive;
- leaving everything in God's hand who can do miracles.

48. During cross examination by Ms. Brandow, Father M said:

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- the belief of Coptic Church he mentioned was his interpretation of the beliefs of the Coptic Church generally, but based on his experience he believed those would be the beliefs of the Coptic Church;
- the Coptic Church did not have any guidance or directives through written documents on the subject of end of life matters like the one before the panel;
- he had not spoken with MF before April 10, 2026, about end-of-life situation like the one he was currently facing;
- he had never spoken with MF as to what he believed he would want in his current circumstances;
- that the Church accepted scientific/medical evidence about brain death and it was permissible to remove life support if an individual was declared brain dead;
- removal of life supports was permissible only in the case of complete brain death and there were no exceptions.

49. In answering my questions Father M acknowledged that as per the medical opinion:

- MF was in a vegetative state;
- MF was suffering from bed sores, infections and all the intrusive measures in place to keep him alive
- MF had no chance of any meaningful recovery, except God's miracle;
- MF could be in this state for an indefinite period of time if the life supports were kept in place.

50. When asked if it would be the belief of the Coptic Church to let the person suffer indefinitely when the end was clear that the person was not going to wake up again and die at some point of time, Father M said "yes". This was in contradiction to what the family had reported as their religious belief, that is, relieving pain and suffering and maintaining human dignity. Letting an individual suffer indefinitely only in the hope of a miracle, would not be in line with maintaining human dignity.

51. In her closing submissions on the issue of values and beliefs, Ms. Brandow submitted that:

- There was no evidence of MF's values and beliefs applicable to his current circumstances

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- MF had not discussed with anyone his views about end-of-life situations, like the one he was facing currently
- MZ was placing too much weight on religious beliefs that MF had never discussed with anyone
- MZ was focused on her own beliefs as to whether she deserved a miracle from God.

52. In her written submissions MZ had said the following:

- MF was a devout Coptic Christian who's deeply held religious beliefs and personal values centered on the sanctity of human life, prayer for healing, and submission to divine will
- maintaining life-sustaining treatment aligned with MF's view that life remained sacred
- mechanical ventilation did not impede the natural process of life or death; rather, it sustained bodily life, offering the opportunity for God's grace or potential clinical improvement
- withdrawing life-sustaining measures would be against MF's faith and violate his personal autonomy
- preserving life until natural death occurred without human intervention was essential component of his dignity and best interests

53. Based on the evidence presented, I was unable to draw any conclusions about MF's values and beliefs. There was no direct evidence about MF's religious beliefs. The argument appeared to be that because of his association with the Coptic Church, the beliefs of the church would be MF's beliefs as well. This in my view was speculative for two reasons.

54. Firstly, the evidence was not clear as to whether the beliefs of the Coptic Church that Father M presented were really the beliefs of the Coptic Church or those of Father M. Father M acknowledged that it was his interpretation of the subject and that there were no written directives from the Church in this regard. Assuming those were the beliefs of the Coptic Church, the evidence again was not clear if the Church would strictly adhere to those beliefs in each and every case. Father M said the church accepted the medical opinion on brain death and therefore removal of life supports was permissible. However, for anything less than brain death removal of life support would not be permissible. There was nothing to back this assertion.

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55. It was remarkable that the church would accept medical opinion in the case of brain death, but not accept the medical opinion in the case of someone marginally shy of brain death (as in the case of MF with minimum brain stem reflex, and no chance of any meaningful recovery). In the absence of any written directives from the Church, I found it was uncertain that the Church beliefs would let a person suffer unnecessarily and indefinitely in the face of strong medical evidence that removal of life support was in the persons best interests.

56. The second problem I found with argument about MF's values and beliefs was that even if we accepted that the beliefs of the Coptic church about end-of-life situations were as presented by Father M, the evidence did not establish that because of his association with the church, MF would endorse and follow those beliefs. Even if he held such beliefs while capable, there was no evidence he would still act on those beliefs as there had been no discussions on this topic with anyone.

57. What the church believed in was not relevant here. What was relevant was if MF firstly held those beliefs, and if so, whether he would still act on those beliefs in his current circumstances.

58. The evidence was clear that MF had:

- no discussion with anyone before April 10, 2026, about his religious beliefs on the subject of end-of-life situation like the one currently faced by him; and
- no discussion with anyone what he would have wanted for himself in his current situation.

59. I therefore found that there was no clear evidence about MF's values and beliefs that were directly relevant to his current circumstances, and that he would have strictly adhered to no matter what the circumstance. Therefore, this factor did not have any bearing on determining MF's best interests.

60. Finally, even if there was evidence that based on his values and beliefs MF would have wanted continuation of the life supports, this factor was just one factor to be considered in determining his best interests. It had to be weighed against the medical considerations, which in the instant case warranted significant weight given the seriousness of his brain injury.[4]

[4] Rasouli (*paragraph 96)*

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61. MZ did seem to recognize the serious nature of MF's brain injury, however, I found she had an unrealistic hope of God giving her a miracle. I found she was focussing on her own religious beliefs rather than what MF believed in. She was not properly considering the medical factors which she was required to do for making a treatment decision objectively in MF's best interests.

62. While I completely understood MZ's desire to continue life sustaining treatment for MF believing that MF would recover, such belief was completely unrealistic given the overwhelming medical evidence to the contrary, all of which had been explained to MZ multiple times by multiple different physicians attending to the care of MF.

Wishes expressed by MF with respect to the proposed treatment plan that were not prior capable wishes applicable to the circumstances

63. There was no evidence about MF's wishes expressed relevant to this criterion of best interests.

The proposed treatment was likely to improve MF's condition or well-being; prevent MF's condition or well-being from deteriorating and likely to reduce the extent to which, or rate at which, MF's condition or well-being would deteriorate; and without the proposed treatment MF's condition or well-being was likely to deteriorate

64. Having found that there was no clear evidence about MF's values and beliefs or other wishes not amounting to prior capable wishes, the case primarily hinged on the medical implications of the proposed treatment, that is, an analysis of the pros and cons of implementing the proposed treatment versus the pros and cons of maintaining status quo.

65. While I have outlined MF's medical condition earlier in these reasons, it would be useful to discuss in greater detail MF's medical condition, prognosis and the recommendations of the treatment team.

66. Dr. Oczkowski said he was a critical care physician and part of a rotating team of physicians attending to the care of MF in the ICU. He said MF was in a persistent vegetative state due to extensive and irreversible brain damage. He said keeping him on life sustaining measures was not in his best interest as it would not change the outcome and it was causing him pain and suffering.

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67. Dr. Oczkowski testified that after someone was revived following a cardiac arrest, it was a standard practice to determine if there was any brain damage because of the heart having stopped (MF's likely downtime was estimated to be about 10-15 minutes). He said a multimodal approach of diagnostic testing and physical examination is undertaken, typically within 48 – 72 hours of the cardiac arrest. He said a similar approach was taken in the case of MF. He said after detailed testing and clinical examination the treatment team concluded that MF had suffered a catastrophic brain injury. He explained the findings as follows:

- The CT scan dated April 14, 2026 (Exhibit 1, page 15) showed loss of grey/white differentiation of the brain. The scan showed multiple areas of damage indicative of hypoxic brain injury.
- The EEG report dated April 14, 2026 (Exhibit 1, page 18) showed "no discernible brain activity".
- The MRI dated Apil 17, 2026 (Exhibit 1, page 24) showed damage all over the brain consistent with severe anoxic brain injury.
- Physical examination showed minimal brain stem activity. Dr. Wyman, neurologist, who had assessed MF on April 17, 2026, had found that basic brain stem reflexes like mild grimacing, cough and gag were present but other reflexes like pupillary reflex (reaction to bright light), corneal reflex (blinking to threat) and VOR (eyes staying fixed when head moved) were absent, which Dr. Oczkowski said was a sign of deep damage to the brain stem and poor outcome for MF.

68. Dr. Wyman had shared his findings with MF's family. In his consultation report he had noted as follows:

> "…… the combination of his examination findings, lack of brain activity on EEG, and severe damage on MRI result in a high degree of confidence in labelling this as a catastrophic brain injury with a poor prognosis for meaningful neurological recovery. I shared with them my honest opinion that [MF] will not regain meaningful alertness or survive hospitalization……. While patient does not meet criteria for brain death, we do not believe that he will be able to make enough recovery to leave the ICU."
> (Emphasis added)
>
> (Exhibit 1, page 30)

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69. Other ICU physicians who had assessed MF had similar opinion as Dr. Wyman. They had also communicated their opinions/findings to MF's family. Following are some of the opinions/findings of other physicians:

Dr. Oczkowski - April 20, 2026

> "Reiterated that poor neurologic prognosis is a spectrum. [MF] is able to open eyes and appears to look around the room, not obeying commands. He has some brain stem reflexes. But despite this, he is unlikely to be awake or interactive in a significant way as before. He may be on the higher end of poor prognosis, such as a minimally conscious state, but there is no expectation by ICU or neurology that he will ever recover to be discharged from hospital, even if there are some incremental improvements in his movements and awareness over the coming weeks"
> (Exhibit 1, page 35)

Dr. Hobb – April 28, 2026

> "I explained as well as I could the concept of diffuse anoxic injury, and how it affected the entire brain including the elegant/important/functional parts of the brain whereas some brain injuries affect discrete areas only. I also explained poor predictors of neuro prognosis after cardiac arrest including imaging findings and poor motor response. I explained that based on the best science/evidence we have we do not expect him to recover."
> (Exhibit 1, page 36)

Dr. Pirani – May 12, 2026

> "We explained that the one percent that was previously brought up still would represent, at best, a life with significant disability, suffering, institutionalization, and dependence on others for care. We reiterated the current suffering he is experiencing which could include pain, anxiety, confusion, breathlessness, invasive lines/tubes, an inability to talk or eat, etc. We explained that there is no plan for any further investigation for prognostication as the prognosis is quite clear."
> (Exhibit 1, page 38)

70. Dr. Oczkowski testified that there was no chance of any further improvement in MF's condition. He said after a brain injury whatever recovery had to happen, happens within the first few weeks. He explained that after a brain injury, once the brain swelling subsides, some parts of the brain can regain some function. Dr. Oczkowski said that in a partial brain injury, like a stroke or trauma, other parts of the brain could take over but in total brain damage, as was the case with MF, there was no part of the brain that could take over.

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71. Dr. Oczkowski said MF had no brain control and contrary to his family's report of spontaneous movement of limbs, on clinical examination and nursing observation the team had never seen any purposeful moves.

72. Dr. Oczkowski said that he had last assessed MF on August 9, 2026, and there had been no further improvement in MF's condition. MF had been most recently seen by Dr. T. Karachi on August 23, 2026, and there was no change in his condition reported.

73. Dr. Oczkowski said there was no further improvement expected in the case of MF and that he would remain in his current state for the rest of his life and would not be able to leave the ICU. He said it was the unanimous opinion of the treatment team that MF was in a vegetative state. The brain injury was so severe that MF was not expected to live long, with or without life supports.

74. The recommended treatment for MF was withdrawal of life sustaining treatment and implementation of palliative and comfort care measures.

75. MF's condition, prognosis and the proposed treatment had been discussed with and explained to his family in multiple family meetings and ethics consultation. The family had been informed that:

- MF had a poor neurologic prognosis
- MF was unlikely to wake up or interact in a meaningful way
- there was no expectation that MF would ever recover to be discharged from ICU
- MF was experiencing pain and suffering due to the invasive ICU measures put in place to keep him alive
- if MF was continued on life supports, he would remain in his current state and likely develop recurrent infections, skin breakdown, and other complications of critical illness until he ultimately died in the ICU
- continuation of life sustaining measures when there was no medical benefit to the treatment was not the standard of care
- removal of life sustaining treatments and implementation of comfort focused care in order to offer MF a peaceful and dignified dying process was in his best interests

(Exhibit 1, pages 29, 35 ,36, 38 and 40) 1

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76. MF's family had questioned the medical opinion that MF would not improve. They had reported that they had seen movements at the bedside and had enquired why other parts of the brain could not take over as was the case in stroke or other type of brain injuries. As noted above, Dr. Hobbs had explained to the family how anoxic injury affected the entire brain including the important functional parts whereas stroke and trauma related brain injuries affected discrete areas of the brain. Therefore, there was no healthy brain left to take over the function of damaged parts of the brain.

77. The family had reported MF opening his eyes and making spontaneous movements. Dr. Oczkowski said while MF did open his eyes sometimes, but he never followed or tracked objects. The opening of eyes was documented in Dr. Oczkowski's note of April 20, 2026. There had been no further improvement in any brain stem reflexes since that time, and as Dr. Oczkowski said none was expected. Dr. Oczkowski said there was no purposeful movement documented in any clinical notes. He said whatever improvement had to happen, would have happened in the first few weeks post the cardiac arrest.

78. MZ in her testimony reiterated the family's position that she had seen some improvements in MF. She said:

- she had noticed MF react to her by opening his eyes when she read prayers and made mention of her children and grandchildren
- when nurses changed his position, MF moved his head and legs as if trying to help them move him
- she felt MF was feeling everything but was unable to say anything
- MF was not brain dead and therefore he should be kept alive until his life ended as per Gods will
- she believed in respect and dignity for mankind until the end of life
- she was hoping that God would give her a chance of a miracle, if she deserved it
- MF always looked comfortable and she had never noticed that he was suffering or in pain

79. On cross examination by Ms. Brandow, MZ said:

- she did not accept the clinical opinion that MF was in a persistent vegetative state. In her view MF was able to feel everything

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- she acknowledged MF had a minimal chance of improvement, she said there was "a little above zero" hope of improvement.
- she initially denied MF was experiencing pain and suffering, saying he looked comfortable. However, later she acknowledged, that MF was suffering "for sure".

80. In summary, MZ appeared to recognize the seriousness of MF's brain injury and the near zero chance of his recovery, however she was hopeful that God would give her the miracle, if she deserved it, and improve his condition.

81. Dr. Oczkowski said keeping MF on mechanical ventilation was causing him discomfort and was likely to lead to further deterioration due to several factors. He said it was the unanimous opinion of the treatment team that withdrawal of life sustaining treatment and implementation of palliative and comfort care measures was the best treatment option for MF. He said keeping MF on intrusive life support measures was resulting in pain and suffering to MF. Dr. Oczkowski said:

- MF was prone to recurrent infections from the ventilator, catheters and intravenous (IV) tubes, which were common sources of infection
- MF had multiple episodes of ventilator associated pneumonia, blood stream infections and urinary tract infections. These infections would be a recurrent feature and were common for someone in MF's condition.
- MF was also at high risk of developing pressure sores due to lack of limb movement. While MF had existing bed sores upon admission due to lack of mobility due to his Parkison's disease, the bed sores were only going to get worse
- if MF remained in his current condition, there was a high likelihood of MF deteriorating further. He would have more severe infections, and he would die of those infections as he would become resistant to antibiotics

82. Dr. Oczkowski said MF was likely experiencing pain and suffering due to the invasive ICU measures in place to keep him alive, which included:

- breathing tube inserted through mouth for supply of oxygen through the ventilator
- feeding tube for nutrition
- catheter for draining urine
- IV lines for giving medication and checking blood work
- suctioning required to clear his lungs

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- need to be turned over in bed every two hours by nurses
- wound dressings for his pressure sores

83. Dr. Oczkowski said while MF appeared to be comfortable, the ICU intrusions and procedures were generally quite uncomfortable and likely causing pain and suffering. He said MF was cared for by trained ICU nurses who review symptoms and manage patient pain and suffering and try to manage the distress.

84. He said it was difficult to assess how much pain and suffering MF was experiencing, but given the procedures in place, MF was likely experiencing some pain. He said ICU patients who had recovered had reported that ICU experience was distressful and uncomfortable. He said the suctioning procedure was particularly uncomfortable. He said MF was also likely suffering from hunger and thirst, notwithstanding being provided nutrition.

85. The concerns of the treatment team had been raised and documented in all family meetings, including the Ethics Consultation meeting held on June 16, 2026 (Exhibit 1, page 42).

86. Dr. Oczkowski said that without the proposed treatment MF was likely to continue to suffer, with no medical benefit by keeping him on life supports. He said the proposed treatment of withdrawal of mechanical ventilation and implementation of palliative care had been discussed with the entire care team and all agreed that this would be in MF's best interest.

87. He said there was no chance of neurological improvement and no other option except comfort care measures. He said it was the unanimous opinion of the care team that MF was suffering and that the proposed treatment would end his suffering and prevent his condition from further deteriorating. He would no longer experience discomfort and pass away naturally.

88. In summary, Dr. Oczkowski's evidence was that:

- MF had serious and permanent brain damage that was irreversible
- MF would not recover or improve and be able to leave the hospital. He would die in the ICU with or without life supports
- Based on science, the chances of a miracle happening, where MF would wake up and interact with his family, as hoped by MZ, was near zero

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- There was no medical benefit of continuing MF on life sustaining treatments and was therefore not indicated
- MF was experiencing pain and suffering from the invasive ICU measures in place to keep him alive
- Keeping him on life support would prolong his suffering and the inevitable death. He would likely deteriorate and have multiple complications, such as infection, skin breakdown, contractures, ongoing pain and suffering with no corresponding benefit
- The proposed treatment would end MF's suffering, and let him die peacefully
- The benefits of the treatment outweighed the risks of keeping him on artificial life supports
- Death without further pain and suffering was the best possible outcome for MF
- There was no less intrusive treatment available to meet the best outcome for MF

89. Dr. Oczkowski's evidence was corroborated by extensive clinical notes, diagnostic imaging reports and opinions of other physicians discussed earlier in these reasons.

90. Ms. Brandow in her closing submissions said that MZ was required to weigh all the factors of section 21(2) of the HCCA equally and make a decision that would be objectively in MF's best interest. She said MZ was not giving appropriate weight to MF's medical condition. She said MZ's hope that God could give her a miracle, was unrealistic and not supported by any medical evidence.

91. MZ in her written submissions had reiterated her position discussed above.

92. The medical opinion was unanimous that continuing life sustaining measures was not a standard of care indicated in MF's case. The proposed treatment of withdrawal of life sustaining measures and provision of comfort care treatment would ensure that MF's suffering was effectively treated and reduce the duration of his suffering and dying process as he was unlikely to improve or recover, and life sustaining measures would only cause him to experience more complications for a longer period of time followed by death in the ICU.

93. After due consideration of all the evidence, I found that MZ had an unrealistic belief that MF would one day miraculously wake up and interact with his family. Dr. Oczkowski said that based on science and medical evidence available, for such a miracle to happen, MF's dead brain cells had to revive and the chances of such a thing happening were "near zero"

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94. While I understood MZ had this belief, like any close family member in her situation would have for a loved one, that MF was improving, however her observations were not supported by any medical evidence. Her claim that MF was opening his eyes, was acknowledged by the medical team. However, there had been no other improvement in any other brain stem reflexes since April. I accepted Dr. Oczkowski's clinical opinion about the initial improvement and that there was no prospect of any further improvement.

95. I found MZ herself was not convinced that MF would improve. She acknowledged, MF had a "little above zero" chance of recovery. It was MZ's wishful thinking, rather than anything based on rationality, evidence and reality, that God would give her a miracle. Even the miracle she was hoping for, in her own words, was subject to her being deserving of it.

96. Despite best efforts of the care team to improve MF's health, his condition had not improved in four months. The prognosis for MF was very poor. I accepted Dr. Oczkowski's evidence, which was corroborated by other clinical documentation that MF was suffering and in discomfort from multiple sources discussed above. Keeping him on mechanical ventilation was prolonging his suffering with no possibility of benefit.

97. This matter had to be decided based on objective medical evidence. Doing otherwise would be simply speculative. Continuing MF on life support with the hope that one day some miracle might happen, and he would recover from his catastrophic brain injury was wishful thinking to say the least.

98. The medical evidence overwhelmingly suggested that MF had no chance of recovery and that he was in discomfort and the intrusive measures and total care were indignity to his body.

99. I accepted Dr. Oczkowski evidence, which was the opinion of the entire treatment team, that:

- continuing life-sustaining treatment would not improve his condition or well-being
- continuing with life-sustaining treatment was not likely to improve MF's condition or prevent it from deteriorating or reduce the rate of deterioration
- continuing life-sustaining therapy did not meet the standard of care and was not in MF's best interest

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- continuing life-sustaining treatment was causing more harm than benefit to MF.
- there were no benefits to MF in continuing life sustaining interventions

This evidence was uncontradicted. Even MZ acknowledged that MF was suffering and had a minimal chance of recovery.

100. I found that the medical evidence weighed in favour of the proposed treatment.

The benefit MF was expected to obtain from the proposed treatment outweighed the risk of harm to her?

101. I found the expected benefits of the proposed treatment significantly outweighed the risks.

102. As discussed earlier in these reasons, Dr. Oczkowski said the proposed treatment was likely to alleviate MF's suffering from his current condition that he would never recover from, and implementing the proposed treatment would result in MF passing away without suffering.

103. MF would not improve or recover, would not be able to interact with his family, and was likely suffering based on knowledge about consequences of long-term ventilation and being bedridden in an ICU.

104. The benefit of withdrawing life sustaining measures and providing comfort care was to eliminate the prolonged increased suffering and protracted dying process that would otherwise take place.

105. I found the evidence established that the benefits of the proposed treatment outweighed the risks of harm.

There was no less restrictive or less intrusive treatment that would be as beneficial to MF as the proposed treatment?

106. MZ in her written submissions had submitted that instead of withdrawing life support, MF should be transferred to a long-term or complex continuing care facility, which would be a less intrusive alternative to the proposed treatment or continuation in the ICU.

107. The family had enquired about the possibility of tracheostomy and transfer to long term care. It had been explained to the family that tracheostomy would not change MF's situation as he

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would remain dependent on the ventilator, would not be able to communicate, and would not be able to leave critical care. As such, tracheostomy was not indicated in MF's case.

(Exhibit 1, page 36)

108. Dr. Oczkowski testified that tracheostomy was a surgical procedure and was done for people who needed ventilation tube for a prolonged period but was not indicated for people in a vegetative state or coma. He further said that MF was not a candidate for long term care facility.

109. Dr. Oczkowski said the proposed treatment of withdrawal of life sustaining measures and provision of comfort care treatment was the least intrusive way to manage his prolonged suffering and protracted dying process. There was no other less restrictive or intrusive treatment that would be as beneficial as the proposed treatment.

110. I accepted Dr. Oczkowski's professional opinion that the proposed treatment was the least restrictive or least intrusive treatment that would be beneficial to MF.

Conclusion Regarding Best Interests

111. In summary, after carefully weighing the above factors, I concluded that MZ had made treatment decisions not in accordance with MF's best interests

RESULT

112. For the foregoing reasons, I found that:

a. MF was incapable of consenting to the proposed treatment of removal of life sustaining measures and implementation of palliative and comfort care measures.
b. MZ had not complied with the principles for giving or refusing consent set out in the *HCCA* and ordered MZ to consent to the proposed treatment plan by September 1, 2026.

Dated: September 8, 2026

Shashi Raina, Presiding Member

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