Consent and Capacity Board
Commission du consentement et de la capacité
Ontario

17-2884-01
17-2884-02

IN THE MATTER OF
the ***Health Care Consent Act, 1996***
R.S.O. 1990, chapter M.7
as amended

AND IN THE MATTER OF
TP
A patient at
UNIVERSITY HEALTH NETWORK – TORONTO WESTERN HOSPITAL
TORONTO, ONTARIO

REASONS FOR RULING

PURPOSE OF THE HEARING

On or about September 2, 2017, TP suffered a cardiac arrest and anoxic brain injury. He was transported to Toronto Western Hospital (the "Hospital") where a number of treatments were initiated, including mechanical ventilation. TP's condition deteriorated and on September 14, 2017 Drs. Hawryluck and Randall independently made findings of brain death or neurological determinations of death ("NDD"). On the same date the Coroner completed the Medical Certificate of Death.

By letter dated September 18, 2017, Dr. Goffi advised SP, the substitute decision-maker, that it was his intention to discontinue mechanical ventilation on September 20, 2017. SP filed an application with the Board on September 19, 2017. Essentially, SP was challenging the finding of death and was asking that the Board prevent the discontinuance of mechanical ventilation.

Dr. Goffi's position was that TP was no longer alive and mechanical ventilation was not treatment; therefore, the Board had no jurisdiction to consider the application. I agreed, for the

reasons set out below.

DATES OF THE HEARING, RULING, AND REASONS FOR RULING

The prehearing commenced on September 21, 2017 and concluded on September 22, 2107. The Ruling was released by Order/ Endorsement on September 22, 2017. Reasons for Ruling, contained in this document, were released on September 27, 2017.

LEGISLATION CONSIDERED

The *HCCA*, including sections 1, 35, 37
Trillium Gift of Life Network Act, R.S.O. 1990, c. H.20, including s. 7

PARTIES & APPEARANCES

TP, the incapable person, was represented by counsel, Ms M. Addie.
SP, the applicant and substitute decision-maker, was represented by counsel, Mr. P. Mota.
Dr. Goffi, the Health Practitioner, was represented by counsel, Mr. S. Rogers.

Ms Garmaise, counsel to the University Health Network, attended the prehearing to assist the parties and the Board but did not otherwise participate in the application.

PANEL MEMBERS

Lora Patton, senior lawyer and presiding member

THE EVIDENCE

The evidence at the hearing consisted of the oral testimony of Dr. Goffi and SP, and the following Exhibits:

1) Affidavit of Dr. Alberto Goffi, dated September 21, 2017 (with 3 exhibits); and
2) A Letter from Dr. Goffi regarding TP, dated September 18, 2017.

NOTE: The Medical Certificate of Death, signed by Dr. A. Shievitz, Coroner, dated September 14, 2017, was not made an Exhibit as it could not be legally copied. The content of that document was set out on the record and all parties had the opportunity to view the original.

PRELIMINARY ISSUES

September 21, 2017 Adjournment Request:

On September 21st, this matter commenced by teleconference. At that point, less than two days had passed since SP's application had been received by the Board; all counsel had been retained more recently. Ms Addie sought an adjournment so that she may examine the Medical Certificate of Death and review the clinical file; Mr. Mota sought an adjournment on the same grounds.

All parties agreed to a very short adjournment and stated that they would be prepared to proceed the following day. To assist counsel, Mr. Rogers agreed to provide an electronic copy of the medical chart to counsel. He also agreed to provide the motion materials electronically. Ms Garmaise agreed to facilitate access to the Medical Certificate of Death if counsel required assistance.

Ms Addie requested that the prehearing continue in-person. Although not strictly necessary, the prehearing continued the following day, in-person, at Toronto Western Hospital.

September 22, 2017 Adjournment Request:

On September 22, 2017, the Board received a Notice of Motion from LD, a friend of the family (the Motion had been emailed to counsel and myself the night before but deemed received by the Board on September 22nd). That motion stated that SP sought an adjournment of the application to allow her to apply to the Court for various remedies under *Charter of Rights and Freedoms*.

Mr. Mota spoke to the motion when the prehearing resumed. He submitted that the adjournment was necessary to resolve *Charter* questions over which the Board had no jurisdiction. Mr. Rogers

was opposed to the request, noting that the jurisdictional issue had to be resolved first, that no *Charter* application had yet been filed with the Court, and that there were no genuine *Charter* issues to be heard. Ms Addie took no position on the motion.

I denied the request for an adjournment. I agreed that the issue of jurisdiction could be addressed without direction from the Court with regard to the *Charter*. Proceeding to determine the question of jurisdiction would allow the Court (if engaged) to consider the entire record including the Board's determination of jurisdiction.

The correct substitute decision-maker:

I inquired about SP's status as substitute decision-maker. TP's parents had declined to act in that capacity and SP stated that her siblings were in agreement with her position and she was speaking on their behalf.

The Board's jurisdiction to proceed with the Application following a determination of death:

Dr. Goffi brought a motion asking that the application be dismissed as the Board lacked jurisdiction. It was his position that "no interventions or cessation of those interventions are treatments" following the death of a patient, in this case a neurological determination of death. The balance of the prehearing was focused on this question.

ANALYSIS

It was Dr. Goffi's evidence that TP had been declared dead on September 14, 2017. On that date, Drs. Hawryluck and Randall examined TP and pronounced him dead in accordance with neurological determination of death criteria. Neurological death or brain death was accepted as death in Ontario. The fact of brain death and the criteria for determining same had been accepted Canadian medical practice for more than a decade. NDD and criteria for determining neurological death are described in the Canadian Medical Association Journal (Exhibit 1, Tab B) which sets out the medical consensus on this issue in Canada. Further, the criteria are detailed in the Trillium Gift of Life Network's "Donation Resource Manual: A tool to assist hospitals with the process of organ and tissue donation" (Excerpt at Exhibit 1, Tab A) as they have particular

relevance to organ transplantation following death. There was no evidence suggesting that a finding of brain death through NDD was not long-standing accepted medical practice in Ontario although questions of this nature were put to Dr. Goffi in cross-examination.

Dr. Goffi's Affidavit stated that the neurological determination of death for TP fully satisfied the criteria required for declaration of his death: very generally the testing revealed that TP had no cerebral or brain stem functions and the apnea testing (to test the breathing reflex) was negative. Although unnecessary to meet the criteria for NDD, ancillary testing was completed and confirmed the above findings as there was no blood flow to the brain when radionuclide angiography was conducted. There were no confounding factors that may have masked brain responses to the test (Exhibit 1; see the Checklist for the Neurological Determination of Death for TP at Exhibit 1, Tab c). All of these results were thoroughly canvassed in Dr. Goffi's testimony and cross-examination. Further detail was not required for my Ruling on jurisdiction.

Although a neurological determination of death for the purposes of organ transplant requires that two physicians conduct the testing independently (but perhaps at the same time), when transplant is not a factor, one physician can pronounce death. Transplant was not consented to in this case and was not an issue but, nonetheless, both Drs. Hawryluck and Randall conducted the testing.

It was Dr. Goffi's evidence that the Coroner was contacted in this situation because of the lack of clarity around the originating injury and circumstances. TP had been found without vital signs and emergency workers who began providing care noted a food obstruction in the airway. The Coroner concluded that TP had experienced asphyxiation (he had choked on food) which caused a lack of oxygen in the body, followed by cardiac arrest and the anoxic brain injury. This information was found on the Medical Certificate of Death which was viewed by all parties but not filed.

It was Dr. Goffi's evidence that the Intensive Care Unit provided care to TP for several days, observing him for signs of improvement. Over this course of time, potentially confounding factors were eliminated (the use of medications, temperature control, shock) that could mask responses to testing for NDD. Only when the team was certain that these factors had been

eliminated did the physicians begin testing according to the criteria.

It was Dr. Goffi's evidence that SP (and TP's parents) had been advised of the determination of death by multiple physicians and the Coroner. SP would not assent to the removal of mechanical ventilation. On September 18, 2017, Dr. Goffi wrote to SP indicating that mechanical ventilation would be removed on September 20, 2017 at 9am (Exhibit 2).

SP gave evidence contesting the finding of death. She stated that she had been in hospital almost consistently since her brother had been admitted. She stated that she had observed what appeared to be responsive movements (when she spoke about childhood memories or listened to his favorite band, Rush), heart rate responses and pupil dilation. SP also stated that she believed in God and that people could go into comas and wake up without explanation.

Although SP's testimony was heart-felt and genuine, and although I was moved by her family's difficult situation these last weeks, her evidence was not relevant to my considerations. Dr. Goffi's evidence was clear that TP had been declared dead. The declaration was completed in accordance with criteria for neurological determination of death that were "without dispute in Canada" (Exhibit 1, page 4). In addition to the texts cited above, the *Trillium Gift of Life Network Act*, R.S.O. 1990, c. H.20, states at section 7:

> **7.** (1) For the purposes of a post mortem transplant, the fact of death shall be determined by at least two physicians in accordance with accepted medical practice.

This confirms that NDD is accepted at law as death.

Although only one physician was required to conduct the NDD testing for TP (as organ transplant was not an issue), two physicians did so. Ancillary testing, although not required, was conducted and it confirmed the finding of brain death. The Coroner examined the body and the circumstances of injury and completed the Medical Certificate of Death, further confirming death.

The Board is a statutory tribunal and only has authority that is granted by legislation. There is nothing in the law that would indicate that the Board can proceed with an application about treatment when the patient has been declared dead. The application before me was a "Form G" application, filed by SP; this is an application to determine whether a substitute decision-maker has complied with the law when making a decision about treatment (s.37, *HCCA*). That application may only be brought by a health practitioner who is proposing treatment and SP had no standing to initiate the application. The application could be amended to one that SP could initiate although I found it unnecessary in the circumstances as no application would result in the Board having jurisdiction to proceed.

Upon hearing a "Form G" application, the Board must determine whether or not the substitute decision-maker has complied with the law when consenting or refusing consent to treatment. The Board may substitute its own opinion as to consent for the proposed treatment or give directions about the proposed treatment:

> **37** (1) If consent to a treatment is given or refused on an incapable person's behalf by his or her substitute decision-maker, and if the health practitioner who proposed the treatment is of the opinion that the substitute decision-maker did not comply with section 21, the health practitioner may apply to the Board for a determination as to whether the substitute decision-maker complied with section 21. 1996, c. 2, Sched. A, s. 37 (1).
> Parties
> (2) The parties to the application are:
> 1. The health practitioner who proposed the treatment.
> 2. The incapable person.
> 3. The substitute decision-maker.
> 4. Any other person whom the Board specifies. 1996, c. 2, Sched. A, s. 37 (2).
> Power of Board
> (3) In determining whether the substitute decision-maker complied with section 21, the Board may substitute its opinion for that of the substitute decision-maker. 1996, c. 2, Sched. A, s. 37 (3).
> Directions
> (4) If the Board determines that the substitute decision-maker did not comply with section 21, it may give him or her directions and, in doing so, shall apply section 21. 1996, c. 2, Sched. A, s. 37 (4).

Similarly, any other application in the *Health Care Consent Act* that may be relevant to these issues depends on treatment being proposed for a patient – and the Board is asked to either

identify the correct substitute decision-maker to consent to the treatment or determine (in various ways) whether or not treatment should proceed. The most relevant type of application to these circumstances may be a Form D application, or an application which may be brought by a substitute decision-maker to determine the impact of any prior capable wishes of the person to the treatment decision. However, it is clear that the application would result in the Board determining appropriate treatment for a person:

> **35** (1) A substitute decision-maker or a health practitioner who proposed a treatment may apply to the Board for directions if the incapable person expressed a wish with respect to the treatment, but,
> (a) the wish is not clear;
> (b) it is not clear whether the wish is applicable to the circumstances;
> (c) it is not clear whether the wish was expressed while the incapable person was capable; or
> (d) it is not clear whether the wish was expressed after the incapable person attained 16 years of age. 1996, c. 2, Sched. A, s. 35 (1); 2000, c. 9, s. 33 (1).
> Notice to substitute decision-maker
> (1.1) A health practitioner who intends to apply for directions shall inform the substitute decision-maker of his or her intention before doing so. 2000, c. 9, s. 33 (2).
> Parties
> (2) The parties to the application are:
> 1. The substitute decision-maker.
> 2. The incapable person.
> 3. The health practitioner who proposed the treatment.
> 4. Any other person whom the Board specifies. 1996, c. 2, Sched. A, s. 35 (2).
> Directions
> (3) The Board may give directions and, in doing so, shall apply section 21. 2000, c. 9, s. 33 (3).

Following a declaration of death, a body can no longer be said to be subject to "treatment" (as defined in s.1, *HCCA* "anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan"). There would be no longer any treatment at issue. Removal of mechanical ventilation in the case of a deceased person could not be considered treatment. I found that the determination of death in this case was made in accordance with law and the Board had no jurisdiction to review that determination or to further consider this or any other application with respect to TP. Both the Form G and Form A (a deemed application about TP's capacity to make the treatment decision) were dismissed.

A great deal of discussion occurred with regard the Board's process for applications of this nature. I was asked to consider whether the Board should confirm that a finding of death was made appropriately in such matters and allow a process for cross-examination and submissions on the sufficiency or appropriateness of the finding of death; such a process would differ from the process that I had set out in *EI* (16-1922-01; September 30, 2016). I was not persuaded that the process set out in *EI* was incorrect. It was argued that the Board could prevent removal of mechanical ventilation in the case of physician error, negligence or malfeasance in the finding of death (nothing of the sort was alleged in this case); however, in my view the Board has no ability to displace the finding of death. A challenge to the sufficiency or appropriateness of such an allegation would have to occur elsewhere.

RESULT

For the foregoing reasons, the panel determined that it lacked the ability to proceed as the Board had no jurisdiction to consider an application about treatment following a determination of death by neurological criteria and a Medical Certificate of Death (whether or not issued by the Coroner). Both applications were dismissed.

Dated: September 27, 2017

Lora Patton
Presiding Member