IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: *Ng v. Ng,*
2013 BCSC 97

Date: 20130124
Docket: S125673
Registry: Vancouver

Between:

Chan Yiu Ng, Lena Ling Ng, and Susan Lai Sum Novosel

Petitioners

And

Lora Sing Ching Ng, in her capacity as the Committee of the Person of Kenny Yiu Kan Ng

Respondent

Corrected Judgment: The text of the judgment was replaced at paragraph 63 on February 6, 2013;

Before: The Honourable Madam Justice Gropper

Reasons for Judgment

Counsel for the Petitioners:	C. Cho R. T. Todd
Counsel for the Respondent:	G. R. Fraser D. P. Dahlgren
Counsel for the Public Guardian and Trustee	C. G. Herb-Kelly, Q.C.
Place and Date of Trial/Hearing:	Vancouver, B.C. December 3 and 4, 2012
Place and Date of Judgment:	Vancouver, B.C. January 24, 2013

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Introduction

[1] Kenny Ng, his wife, Lora Ng, and their three children were involved in a tragic motor vehicle collision in Washington State on September 9, 2005. The eldest son was killed in this collision. Kenny suffered a profound and irreversible brain injury. Lora and the two younger children suffered physical and emotional injuries.

[2] Kenny has lived in a minimally conscious state since the collision. At the time of the collision he was 49 years of age. He is now 56 years old.

[3] Lora was appointed as Kenny's committee in 2006, with the full consent of Kenny's siblings and parents. In essence, the committee is a trustee for a patient found to be incapable of managing his or her affairs for their custody of the person and their estate.

[4] In the summer of 2012, Lora made the decision to instruct Kenny's caregivers to remove him from life support by removing his feeding and fluid tubes.

[5] The petitioners Chan Yiu Ng, Susan Lai Sum Novosel and Lena Lai Ling Ng are Kenny's siblings. The petitioners challenge Lora's decision. They seek an order rescinding Lora's appointment as Kenny's committee, or, in the alternative, a permanent injunction to prevent Lora from making the decision. They further seek an order that they be appointed in her stead as committees of Kenny. Finally, they seek special costs to be paid out of Kenny's estate or, in the alternative, costs.

[6] For the reasons that follow, I dismiss the petition.

Issues

[7] The parties disagree over the proper issues before this Court. I have determined that the issues are whether Lora, acting as committee of Kenny's person, has breached her duties and obligations under the *Patients Property Act*, R.S.B.C. 1996, c. 349 [*PPA*] to act in Kenny's best interests, and if so, whether she should be removed as committee and be replaced by the petitioners. I will expand on my findings with respect to the proper issue before this Court in my analysis.

Background

[8] At the time of the collision, Kenny and Lora had been married for 12 years and they had known each other three years before that.

[9] Before the collision, Kenny was a successful professional engineer. He was an active and independent man.

[10] The collision caused permanent brain damage to Kenny.

[11] Kenny was hospitalized after the collision and there he has remained. In October 2005, a neurosurgeon, Dr. Barrie Woodhurst, advised Lora that Kenny was in a minimally conscious state and that the prognosis for his recovery was poor.

[12] In February 2006, Kenny was admitted to the George Pearson Centre. The centre is a long term health facility for adults with severe disabilities. Throughout his time at the centre, Kenny has been treated by a care team, which includes his treating physician Dr. Mojgan Namazi, a social worker, a physiotherapist, an occupational therapist, a dietician, nurses, a pharmacist, a recreational therapist and a speed therapist (together referred to as the care team).

[13] On May 29, 2012, after meeting with Dr. Namazi, Lora decided that Kenny's feeding and fluid tubes should be removed. Dr. Namazi had advised Lora that removal of the feeding and fluid tubes would not cause Kenny any pain or discomfort and that it would be accompanied by an increase in morphine or other pain medication. Kenny would die painlessly.

Expert Evidence

[14] Expert evidence was tendered before this Court by both parties. I will summarize this evidence here.

[15] Counsel for Lora objected to the admissibility of the report submitted by the petitioners by Dr. Adrian Owen for several reasons. I reserved my decision on the admissibility of the report. I will address the admissibility issue later in these reasons. However, for the purpose of providing a complete description of the

expert evidence, I will refer to the report in this summary of the expert evidence.

Dr. Chun W. (Joseph) Tham

[16] Dr. Tham is a neuropsychiatrist who examined Kenny and prepared a report for Kenny's primary physician on December 11, 2009.

[17] Dr. Tham provides a brief summary of Kenny's clinical history and makes the following statement regarding his prognosis:

> Overall, I believe that his mental state is best described as a "minimally conscious state". He does not seem to be completely unaware of self or environment as in the persistent vegetative state given the eye movement responses above. Nonetheless, from a prognostic perspective, there is no reasonable prospect here of improvement given the severity of brain injury demonstrated already back in 2008, and the chronicity of his illness. ...
>
> [Y]ou also asked about specific tests that might be done. I believe that his level of awareness is consistent with a severe cognitive deficit. From a clinical perspective, I do not see any benefit and any further tests. For example, an [electroencephalography] could be done to demonstrate alpha suspension with eye opening or to document the background of brain wave activity, but this would not have any bearing on clinical outcome. I believe there has also been some research into functional neuroimaging such as the [functional magnetic resonance imaging (fMRI)] in persistent vegetative states but, again, that would not be of any clinical benefit (nor do we have generally have access to fMRI scans for clinical work).
>
> [Emphasis added.]

Dr. Nazmazi

[18] Dr. Nazmazi is Kenny's primary physician. She is a medical advisor for Work Safe British Columbia and a family physician to patients at the George Pearson Centre.

[19] Dr. Namazi prepared a medical legal report on September 4, 2012 (Namazi report). She describes Kenny's injuries as follows:

(i) subarachnoid hemorrhage;

(ii) subdural hematoma;

(iii) occipital condylar fracture;

(iv) left fibular fracture;

(v) nasal fracture; and

(vi) pneumothorax.

[20] Dr. Namazi explains that these injuries have "resulted in severe and global traumatic brain injury" to Kenny.

[21] The Namazi report summarizes the acute medical conditions from which Kenny has suffered over the years after the accident:

(i) an episode of pallor and apnea in January 2008, when Kenny lost his pulse and a code blue was called, requiring that he be resuscitated and transferred to the Vancouver General Hospital (VGH);

(ii) another immediate episode of hypotension and bradycardia requiring resuscitation and transfer back to VGH;

(iii) these two episodes caused further injury to Kenny's already compromised central nervous system by causing hypoxia (low oxygen) to the brain;

(iv) progressively increase in spasticity in his limbs, making routine care difficult and at times painful for him. This condition has been treated with medication, which provides him with short term relief;

(v) recurring bouts of urinary retention and urinary tract infections (the most recent of which was in August 2012), requiring numerous episodes of re-cathertization and dilation of his urethral strictures;

(vi) aspiration of feeds arising from episodes over the years of blockage or dislodging of feeding tubes, requiring emergency transfers to VGH;

(vii) episodes of autonomic dysreflexia requiring antihypertensive medication;

(viii) episodes of autonomic seizures, now controlled with seizure medication without which the seizures would undoubtedly recur; and

(ix) complete dependence of care including suctioning of his mouth and throat to re-establish his airway and to make breathing comfortable.

[22] Recently, Kenny has suffered from problems with hyperventilation (which caused heavy sweating) and a blocked feeding tube that necessitated his transfer to VGH. To treat the hyperventilation, Kenny was put on morphine.

[23] The Namazi Report also documents the following:

(i) on May 28, 2012, Dr. Namazi met with Lora to discuss the possibility of withdrawing

Kenny's feeding and fluids tubes altogether;

(ii) given Kenny's stable condition at the time, the decision to withdraw feeds was deferred to a future date if feeding caused Kenny discomfort again;

(iii) Lora subsequently informed Dr. Namazi that she had decided that Kenny's feed and fluids tubes should be withdrawn;

(iv) Kenny's care team met on several occasions to discuss Lora's request to remove his feeds and fluids tubes;

(v) Given the enormity of the issue, the matter was referred to an ethics review consultant with the task of providing recommendations on how to deal with Lora's instructions;

(vi) The ethicist recommended that Kenny's care team meet to discuss whether it supported Lora's wishes. If the team agreed to withdraw his feed and fluids tubes, the ethicist proposed that Kenny's parents be informed so that they could decide whether they would challenge this decision;

(vii) In July 2012, Kenny's care team met and determined that the appropriate course of action was to support Lora in her decision to withdraw Kenny's feed and fluids tubes.

[24] Dr. Namazi makes the same diagnosis as Dr. Tham.

[25] After outlining Kenny's medical history and the complications he has suffered because of his injuries resulting from the collision, she and her care team determined that the appropriate course of action was to support Lora in her decision to withdraw feed and fluids tubes. She maintains that the withdrawal of Kenny's feed and fluids tubes in his condition is an appropriate medical decision.

Dr. Adrian Owen

[26] At the hearing, counsel for the petitioners provided an affidavit, appended to which is Dr. Owen's "Report on Research in Neuroimaging Prepared for Onyx Law Group", dated November 28, 2012.

[27] Dr. Owen begins his report with a description of his qualifications. He has a Ph.D. in neuroscience and he is a professor at the University of Western Ontario. He has studied and published extensively in the use of functional magnetic resonance imaging (fMRI) to assess disorders of consciousness, such as vegetative and minimally conscious states, and he considers himself to be widely regarded as a world authority in this regard. For many years, he has studied the methods by which neuroscience (through fMRI and other means) can detect a level of consciousness in a patient diagnosed as vegetative or minimally conscious.

[28] Dr. Owen defines the term "disorders of consciousness" as referring to three conditions: coma, vegetative

and minimally conscious. He distinguishes between a vegetative and a minimally conscious status as follows. A "vegetative state describes a condition in which patients opens [sic] their eyes and demonstrate sleep-wake cycles ... [but] do not exhibit purposeful behavior; retaining reflex responses only." A patient in a minimally conscious state presents "inconsistent, but reproducible evidence of awareness [and] inconsistent, but purposeful responses to command and/or sensory stimulation."

[29] Dr. Owen describes the current approach to diagnosis:

> A diagnosis of vegetative or minimally conscious state is currently made on the basis of the patient's detailed clinical history supported by behavioural observations. The clinical criteria required for a diagnosis of *vegetative state* are that there must be no evidence of awareness of self or environment, no response to external stimuli of a kind suggesting volition or conscious purpose and no evidence of language comprehension or meaningful expression. These clinical criteria are typically addressed using one of several behavioural assessment scales specifically developed for this patient group. Using these techniques, the patient's spontaneous and elicited behavioural responses to sensory and cognitive stimuli are recorded over multiple sessions. The assessor must carefully determine on the basis of the patients behaviour whether they are aware and in so doing exclude the possibility that the patient may be in a minimally conscious state or a locked-in syndrome.
>
> [Emphasis in original.]

[30] Dr. Owen notes that minimally conscious patients may demonstrate inconsistent, but purposeful responses to command and/or sensory stimulation in the form of "command following", which is a clinical term describing an action by a patient that follows a specific instruction to perform that action. If the command produces reliable responses, the patient is known to have some level of awareness. However, more often than not, this assessment is based upon exhibited behaviours, which is an unreliable basis for assessment and prognosis. For instance, the patient may not have the ability to move or speak. Some movements may give rise to different inferences about their level of awareness.

[31] Dr. Owen summarizes the limitations in this approach to diagnosis as follows:

> These difficulties, coupled with inadequate experience and knowledge engendered through the relative rarity of these complex conditions, contribute to a high rate of misdiagnosis (up to 43%) ... which typically takes one of two forms; either i) patients who are diagnosed as vegetative are reclassified as 'minimally conscious state' when assessed by an experienced Neurologist who is able to detect subtle behavioural signs that were missed by the original diagnosing clinician (or were simply absent on the day of the original assessment) or ii) patients are diagnosed as 'minimally conscious' when according to accepted clinical criteria they should be diagnosed as 'vegetative state' for various reasons (including a reluctance to use the more pejorative, and sometimes distressing, term 'vegetative').

[32] Dr. Owen then goes on to explain how his research addresses this problem:

> [W]e introduced a technique into the scientific literature to detect 'command-following' in brain-injured patients using functional magnetic resonance imaging (fMRI). fMRI measures *function* in

> different areas of the brain and therefore can provide information about residual brain function that is not detectable by other techniques that measure brain *structure*, such as CT, X-ray, and (non-functional) MRI. The importance of our technique is that it required no physical response from the patient and therefore, could be used to detect command-following (and therefore covert awareness) in patients who were entirely behaviourally non-responsive.
>
> [Emphasis in original.]

[33] In 2006, the technique of command following, detected by fMRI, was first published in scientific literature. Dr. Owen and several co-authors published a paper titled "Detecting Awareness in the Vegetative State" (2006) 313 Science 1402. This article described how this technique was used on a young female patient diagnosed as vegetative. The technique demonstrated that she was consciously aware and able to follow command, based on her measured brain activity.

[34] Dr. Owen and several co-authors published their follow-up study, titled "Willful Modulation of Brain Activity in Disorders of Consciousness" (2010) 362:7 New England Journal of Medicine 579. This article maintained that of 23 vegetative state patients studied, four (or 17%) were able to generate reliable fMRI responses similar to those responses described in the study published in 2006. The authors concluded that these findings demonstrated the four patients were not vegetative, as diagnosed.

[35] Dr. Owen has since updated the technology he relies upon in conducting neuroimaging. He now uses the more reliable technology electroencephalography (EEG). In his report, he notes the benefits of this improved technology for his research:

> [p]erforming fMRI in severely brain-injured patients is enormously challenging; in addition to considerations of cost and scanner availability, the physical stress incurred by patients as they are transferred to a suitably equipped fMRI facility is significant.
>
> With this in mind, our scientific efforts of late have focused on trying to reproduce the results that we have obtained with fMRI, using EEG.

[36] Dr. Owen refers to a follow-up study he conducted in 2012 with EEG to illustrate advances in his research using this technology:

> [T]wenty-three minimally conscious state patients (15 traumatic brain injury and 8 non-traumatic brain injury) completed the same motor-imagery EEG task. Consistent and robust responses to command were observed in the EEG of 22% of the minimally conscious state patients (5/23). However, aetiology (cause of injury) had a significant impact on the ability to successfully complete this task, with 33% of traumatic patients (5/15) returning positive EEG outcomes, compared with none of the non-traumatic patients (0/8). The results suggest that one third of a group of traumatically injured patients in the minimally conscious state possess a range of high-level cognitive faculties that are not evident from their overt behaviour.

[37] Dr. Owen comments on the implications for diagnosis in his report:

> **Clearly the clinical diagnosis of vegetative state based on behavioural assessment was**

> **inaccurate in the sense that it did not accurately reflect her internal state of awareness. On the other hand, she was not *misdiagnosed* (in the sense that anyone made an error), because the accepted diagnostic standard is based on *behaviour* and no behavioural marker of awareness was missed.**
>
> [Emphasis in original.]

[38] In respect of the implications for prognosis, Dr. Owen suggests that the **"**early evidence of awareness acquired with functional neuroimaging may have important prognostic value" and "that functional neuroimaging data can provide important prognostic information beyond that available from bedside examination alone."

[39] Dr. Owen aims to use these techniques to improve the quality of life in some of these patients (those who are shown to be responsive in the fMRI scanner or using EEG)." He maintains that "[a]t the present time, the potential benefit for any patient who is enrolled in one of our research studies is an improved diagnosis." In the case of a minimally conscious diagnosis, the neuroimaging data may demonstrate that the person is able to communicate reliably in the fMRI scanner. However, he adds this caveat:

> First, although our techniques are able to detect consciousness in some patients (and even allow some patients to communicate), this will not be the case for all patients (nor even the majority of patients). Most patients will not respond in the scanner in the same way that they do not respond behaviourally.
>
> Second, although our techniques are able to detect consciousness in some patients (and even allow some patients to communicate), they are not able to detect 'lack of consciousness' or 'lack of ability to communicate'. If a negative result is returned (no apparent responses), this is statistically equivalent to a 'null result' (as if we had never even scanned the patient), for the reasons specified above in the section about 'false negatives'.
>
> Finally, our technique does not detect 'clinical errors' or 'mistakes made my qualified clinical personnel' or 'misdiagnoses' (at least in the commonly used sense that someone has made an error of clinical judgement). Indeed, for the most part, our results fully concur with the clinical diagnosis – that is to say, based on a clinical examination we would concur with the clinical diagnosis that according to internationally accepted guidelines the patient appears to be 'vegetative' or 'minimally conscious'. What our technique provides is a new method for detecting in some patients (through the use of clinically non-standard neuroscientific tools), when such patients are not what they clinically appear to be.

[40] The above portions of Dr. Owen's report do not address Kenny's circumstances directly. In respect of Kenny, he makes this statement:

> I am committed to recruiting patients from across Canada who are diagnosed as vegetative state or minimally conscious state into our research studies. In order to be considered, patients must first be examined by one of my team members for fMRI compatibility and deemed suitable for inclusion according to our standard acceptance criteria as laid out in our research ethics agreement at the University of Western Ontario. The immediate research costs (my staff's salaries, my time, scans etc) are covered by one of my grants, but we are unable to cover patient transport costs (particularly over long distances). I have not examined Mr Ng, so I can not judge whether he

would be suitable for inclusion or not, but considering his clinical diagnosis (minimally conscious state), his age, and the nature of his injury I see no reason why he would not be an ideal candidate, subject to an assurance from his referring clinician that he would be safe to travel the distance.

Statutory Framework

[41] The relevant statutory provisions governing the issues before the Court are found in the *PPA* and the *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181 [*HCCFA*], which are excerpted here:

> ***Patients Property Act***
>
> **Appointment of committee**
>
> **6** (1) Subject to section 13, on application by the Attorney General or any other person, the court may appoint any person to be the committee of the patient.
>
> (2) On application by the Attorney General, the Public Guardian and Trustee or any other person, the court may, subject to section 13, rescind the appointment of a person appointed as committee.
>
> (3) Subject to section 16, except during the time that a person appointed under subsection (1), other than the Public Guardian and Trustee, is the committee of a patient, the Public Guardian and Trustee is the committee of the patient.
>
> (4) An application under subsection (1) and an application under section 2 may be made as one application.
>
> ...
>
> **Passing of accounts**
>
> **13** (1) If
>
> ...
>
> (b) an application is made for the rescission of the appointment of a committee other than the Public Guardian and Trustee,
>
> the court may, and must if requested by the Public Guardian and Trustee, order that the committee pass the accounts and may, in the order, specify the time and the manner of passing the accounts, and must adjourn the application until the carrying out of the order.
>
> ...
>
> (3) After the order made under subsection (1) has been carried out, and the court is satisfied that no further passing of accounts is necessary, the court may order that the committee is discharged.
>
> ...

Powers of a committee

15(1) Subject to section 16,

(a) the committee of a patient as defined by paragraph (a) of the definition of patient in section 1 has all the rights, privileges and powers with regard to the estate of the patient as the patient would have if of full age and of sound and disposing mind, and

(b) the committee of a patient

(i) declared to be incapable of managing his or her affairs has all the rights, privileges and powers with regard to the estate of the patient as the patient would have if of full age and of sound and disposing mind,

(ii) declared to be incapable of managing himself or herself has the custody of the person of the patient, and

(iii) declared to be incapable of managing himself or herself or his or her affairs has all the rights, privileges and powers with regard to the estate of the patient as the patient would have if of full age and of sound and disposing mind, and as well the custody of the person of the patient.

…

Special direction limiting powers of committee

16 (1) On the appointment of a committee, the court may, by the same order, attach conditions or restrictions on the committee's exercise of certain rights, privileges or powers specified in the order, including requiring the written consent of the Public Guardian and Trustee prior to the committee's exercise of any right, privilege or power.

...

Rights, powers and privileges included

17 The rights, powers and privileges vested in the committee include all the rights, powers and privileges that would be exercisable by the patient as a trustee, as the guardian of a person, as the holder of a power of appointment and as the personal representative of a person, if the person were of full age and of sound and disposing mind.

Exercise of powers

18 A committee must exercise the committee's powers for the benefit of the patient and the patient's family, having regard to the nature and value of the property of the patient and the circumstances and needs of the patient and the patient's family.

Health Care (Consent) and Care Facility (Admission) Act

Definitions

1 In this Act:

"adult" means anyone who has reached 19 years of age;

...

"health care" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other purpose related to health, and includes

(a) a series or sequence of similar treatments or care administered to an adult over a period of time for a particular health problem,

(b) a plan for minor health care that

(i) is developed by one or more health care providers,

(ii) deals with one or more of the health problems that an adult has and may, in addition, deal with one or more of the health problems that an adult is likely to have in the future given the adult's current health condition, and

(iii) expires no later than 12 months from the date consent for the plan was given, and

(c) participation in a medical research program approved by an ethics committee designated by regulation;

"health care provider" means a person who, under a prescribed Act, is licensed, certified or registered to provide health care;

...

"personal guardian" means a committee of a person who is declared under the *Patients Property Act* to be

(a) incapable of managing himself or herself, or

(b) incapable of managing himself or herself and his or her affairs;

...

"spouse" means a person who

(a) is married to another person, and is not living separate and apart, within the meaning of the *Divorce Act* (Canada), from the other person, or

(b) is living and cohabiting with another person in a marriage-like relationship, including a marriage-like relationship between persons of the same gender;

...

Consent rights

4 Every adult who is capable of giving or refusing consent to health care has

(a) the right to give consent or to refuse consent on any grounds, including moral or religious grounds, even if the refusal will result in death,

(b) the right to select a particular form of available health care on any grounds, including moral or religious grounds,

(c) the right to revoke consent,

(d) the right to expect that a decision to give, refuse or revoke consent will be respected, and

(e) the right to be involved to the greatest degree possible in all case planning and decision making.

...

Exception — urgent or emergency health care

12 ...

(3) If a personal guardian or representative becomes available or a person is chosen under section 16 after a health care provider provides health care to an adult under this section, the personal guardian, representative or person chosen under section 16 may refuse consent for continued health care, and, if consent is refused, the health care must be withdrawn.

...

Temporary substitute decision makers

16 (1) To obtain substitute consent to provide major or minor health care to an adult, a health care provider must choose the first, in listed order, of the following who is available and qualifies under subsection (2):

(a) the adult's spouse;

(b) the adult's child;

(c) the adult's parent;

(d) the adult's brother or sister;

(d.1) the adult's grandparent;

(d.2) the adult's grandchild;

(e) anyone else related by birth or adoption to the adult;

(f) a close friend of the adult;

(g) a person immediately related to the adult by marriage.

(2) To qualify to give, refuse or revoke substitute consent to health care for an adult, a person must

(a) be at least 19 years of age,

(b) have been in contact with the adult during the preceding 12 months,

(c) have no dispute with the adult,

(d) be capable of giving, refusing or revoking substitute consent, and

(e) be willing to comply with the duties in section 19.

(3) If no one listed in subsection (1) is available or qualifies under subsection (2) or if there is a dispute about who is to be chosen, the health care provider must choose a person, including a person employed in the office of the Public Guardian and Trustee, authorized by the Public Guardian and Trustee.

(4) A health care provider is not required to do more than make the effort that is reasonable in the circumstances to comply with this section.

...

Duties of a temporary substitute decision maker

19 (1) A person chosen under section 16 to give or refuse substitute consent to health care for an adult must

(a) before giving or refusing substitute consent, consult, to the greatest extent possible,

(i) with the adult, and

(ii) if the person chosen under section 16 is a person authorized by the Public Guardian and Trustee, with any near relative or close friend of the adult who asks to assist, and

(b) comply with any instructions or wishes the adult expressed while he or she was capable.

(2) If the adult's instructions or wishes are not known, the person chosen under section 16 must decide to give or refuse consent in the adult's best interests.

(3) When deciding whether it is in the adult's best interests to give, refuse or revoke substitute consent, the person chosen under section 16 must consider

(a) the adult's current wishes, and known beliefs and values,

(b) whether the adult's condition or well-being is likely to be improved by the proposed health care,

(c) whether the adult's condition or well-being is likely to improve without the proposed health care,

> (d) whether the benefit the adult is expected to obtain from the proposed health care is greater than the risk of harm, and
>
> (e) whether a less restrictive or less intrusive form of health care would be as beneficial as the proposed health care.

Analysis

Definition of the Issues

[42] The petitioners suggest that I am required to determine whether Kenny should live or die. Counsel for Lora and the Public Guardian and Trustee assert that the issue is whether Lora, acting as the committee of Kenny's person has breached her duties and obligations under the *PPA* to act in Kenny's best interest.

[43] According to the *PPA*, Lora as the court-appointed committee has the powers defined under s. 15 of the *PPA*. I note that there are no relevant restrictions on Lora's powers as committee.

[44] The *HCCFA* entitles her as a personal guardian (and committee) to make decisions concerning the provision of health care to Kenny, enumerated in s. 4. Also, she can refuse the provision of health care in accordance with s. 12(3).

[45] The statutory provisions clearly empower Lora to direct Kenny's care team to withdraw his feeding and fluid tubes provided, of course, she is acting in Kenny's best interests.

[46] In framing the issues, the petitioners suggest that the decision about Kenny's health care, or the withdrawal of it is this Court's decision. With respect, it is not. My decision addresses whether there is a basis to conclude that Lora is not acting in accordance with her obligations as a committee, specifically whether she is acting in the best interests of Kenny.

The Admission of Dr. Owen's Report

[47] As noted, counsel for Lora argued that Dr. Owen's report should not be found admissible. The basis of her position is the e-mail from petitioners' counsel to Lora's counsel on August 11, 2012, which states:

> I am in receipt of your letter dated August 8, 2002. I write to advise that I have decided not to order the clinical records of the patient, nor retain a doctor for an expert report regarding the patient's condition. My client's basis of removing your client as committee is grounded in a breach of fiduciary duty which does not involve the medical evidence.

[48] At the time this e-mail was sent, Lora's counsel points out that the only medical evidence of Kenny at the time was from Dr. Tham, which established that as of 2009:

> (a) Kenny Ng had suffered a severe traumatic brain injury;
>
> (b) He was in a minimally conscious state;

(c) There was no reasonable prospect of recovery; and

(d) Additional testing, including a small fMRI, would not be of clinical benefit.

[49] After petitioners' counsel received Dr. Namazi's report, she sought to cross-examine Dr. Namazi. Lora's counsel agreed to the cross-examination on certain conditions, reflected in a consent order of October 17, 2012. One of the conditions was that the petitioners would not seek to obtain or rely upon any independent medical expert evidence in the petition hearing. On November 23, 2012, petitioners' counsel advised Lora's counsel that she intended to tender Dr. Owen's report.

[50] In spite of the objections presented, I exercise my discretion to admit Dr. Owen's report. The petitioners' position at the hearing was that Dr. Owen's report is the "only reliable and relevant evidence before the court about Kenny's prognosis … [and] provides hope that Kenny's condition could quite possibly improve in the immediate future, once he is entered into Dr. Owen's research study and he is re-diagnosed using brain-imaging technology."

[51] The petitioners describe Dr. Owen's research as follows:

> ... recent, groundbreaking medical research that is revolutionizing the diagnosis of patients like Kenny, and providing hope that these patients can communicate with the outside world, and improve their quality of life. The technology shows so much promise that its limits cannot be known. Kenny is a man of science who would love to be part of this new scientific movement, and the lead researcher, Dr. Owen has confirmed that Kenny is an ideal candidate to be entered into this program.

[52] I consider that it would be unresponsive if I were simply to find that the report inadmissible and not comment on it, the consent order aside. This evidence arose after the consent order was obtained and it should be heard by the Court as it meets the admissibility criteria. In particular, it is relevant to the issue of whether Lora is acting in Kenny's best interests as his committee.

***Parens Patriae* Jurisdiction**

[53] The petitioners also argue that s. 6(2) of the *PPA* allows for the court to rescind a committee. However, this provision does not set out the criteria by which the court must determine whether to rescind the committee. The petitioners argue the *parens patriae* jurisdiction of the court applies in order to address what they describe as a legislative gap.

[54] The petitioners refer to *E. (Mrs.) v. Eve,* [1986] 2 S.C.R. 388 at 427, which described the *parens patriae* jurisdiction as follows:

> Simply put, the discretion is to do what is necessary for the protection of the person whose benefit it is exercised … [t]he discretion is to be exercised for the benefit of that person, not for that of others. It is a discretion, too, that must at all times be exercised with great caution, a caution that must be redoubled as the seriousness of the matter increases. This is particularly so in cases where a court might be tempted to act because failure to do so would risk imposing an obviously heavy

burden on some other individual.

[55] Based on their interpretation of this decision, the petitioners argue it is this Court's function to determine who will best serve Kenny's best interests. The petitioners suggest that Kenny's best interests can only be served by the petitioners who wish to preserve his life, and on this basis rescind Lora as committee.

[56] The petitioners further rely on a statement in *Bowman (Re)*, 2009 BCSC 523 (*Bowman*) where the court held:

> **32** On an application for either the appointment or removal of a committee, the test for determining who is appropriate to act as a committee invokes the *parens patriae* jurisdiction of this court and is governed by an assessment of who will serve the patient's best interests ... .

[57] Lora and the Public Guardian and Trustee assert that there is no gap in the legislation. The *PPA* and the *HCCFA* expressly, or by implication, provide the committee with the authority to make medical decisions on behalf of an incapacitated adult, including a decision to withdraw medical care. Lora points out that s. 18 of *PPA* sets out a standard of review for a committee: a committee must exercise their power for the benefit of the patient and the patient's family. Accordingly, Lora argues, a committee may be removed or sanctioned if he or she fails to act in the best interests of the patient. The *parens patriae* jurisdiction of the Court is therefore not engaged.

[58] My decision must be made in accordance with legislative provisions to which I have referred. Taken together, there is no legislative gap as suggested by the petitioners. While s. 6(2) of the *PPA* does not define the criteria for removal of a committee, s. 18 sets out a standard of review for the committee's decisions. Nor does *Bowman* support the petitioners' position. In *Bowman*, the court was considering the appointment of a committee, not its removal.

[59] As I have stated in regard to framing the issues, I must consider whether Lora is in breach of her rights and obligations as the committee of Kenny. If she fails to act in accordance with s. 18, she risks being removed or sanctioned.

Onus

[60] The petitioners argue that the onus is on Lora to demonstrate that she is not in breach of her duty to act in Kenny's best interests. The basis for this assertion is that s. 18 of the *PPA* requires that committees be held to the standard of care expected of a fiduciary, that is, she must not use her power to further her own interests. Honesty of purpose is not a defence.

[61] The petitioners say that Lora is serving her interests as well as the interest of her children. She will benefit financially from Kenny's estate; she and her children will also experience emotional relief with his death.

[62] The petitioners argue that because the committee owes a fiduciary duty, it is therefore "trite law that there is a reverse onus for proving and defending against breaches of fiduciary duty" relying upon *Regal (Hastings)*

Ltd. v. Gulliver, [1942] 1 All E. R. 378 (H.L.). This decision dealt with the fiduciary duty owed by the directors of a company to their company. The petitioners argue that this onus of proof can be imported into these circumstances:

> In asserting a breach of fiduciary duty claim, the plaintiff need only establish a *prima facie* inference of the fiduciary obligations and the breach. The fiduciary concept then imposes a reverse onus that shifts the burden of proof onto the fiduciaries to disprove the beneficiaries' allegations: [citation omitted.]

[63] Lora says there is no authority for the petitioners' assertion that there is a reverse onus if there is a conflict alleged against a committee. She argues that reliance on the duties of a director to the company is not analogous to these circumstances: it does not have a useful framework for consideration of a committee's position under the *PPA* or the *HCCFA*. Indeed, as Lora points out, if a mere "*prima facie* inference" of a breach of fiduciary obligations applies in these circumstances, any disagreement which anyone has with a court-ordered committee would create an unwieldy problem in the administration of the *PPA*. It would affect the security of a committee and require him or her to use funds from the estate to demonstrate that he or she is not in breach of the fiduciary duty.

[64] The Public Guardian and Trustee takes the same position.

[65] I reject the petitioners' position that there is an onus on Lora to demonstrate that she is not in breach of her fiduciary duty.

[66] Lora and the Public Guardian and Trustee assert, correctly in my view, that the petitioners' argument that Lora bears the onus of demonstrating that she has not breached her responsibilities as trustee is not sound. There is simply no authority for this proposition. The reliance on authority describing the duties of directors of a company to their company is unhelpful. I agree with Lora that to find a reverse onus for establishing whether a court-appointed committee is carrying out his or her duties would be unwieldy and cause the position of the trustee to be constantly insecure. The appointment of a committee is not honourific; it is an appointment with serious responsibilities and duties, and at times it bears grave consequences. These responsibilities are governed by a complete legislative scheme, underscoring the importance of these duties in our society.

Should Lora be removed as Committee?

[67] I find that Lora's decision to remove Kenny's feeding and fluid tubes is based on the medical evidence of Dr. Tham and Dr. Namazi. It has already been found to be a medically appropriate decision. There is no medical opinion in the evidence that points to a contrary conclusion.

[68] I have already determined that Lora has the authority to make the decision that she has made in accordance with her appointment as committee.

[69] In addressing Kenny's best interests, many affidavits have been filed by the petitioners and Lora referring

to Kenny's character. The petitioners say that Kenny's particular characteristics support their view that he would disagree with Lora's decision. They refer specifically to his former person as a man of science, one who valued life and good health. They say he was a man who was independent and conducted himself with great personal dignity. The petitioners say these characteristics prove Kenny would want to live and participate in Dr. Owen's study.

[70] Lora refers to the same characteristics but she reaches the opposite conclusion. She refers to Kenny's passion for life. She also highlights Kenny's love for his family. He would always put them first. On that basis, she asserts that Kenny would not "want to continue living at any cost, even while minimally conscious ... [to be] kept alive in a state where there is no indication (or medical evidence), of any kind, that he even understands he is alive, let alone enjoys his life."

[71] She further argues that as a man of science, Kenny would not believe in miracles. He would be realistic and rational about scientific developments. He would not wish to live a life of complete dependency, being kept alive through feeding tubes and other highly invasive medical interventions.

[72] It is clear that the differing views of what Kenny would want are a matter of perspective. I cannot find that either opinion of what Kenny would have wished is wrong or mistaken. These arguments simply reflect a difference in opinion.

[73] The petitioners put great emphasis on Dr. Owen's research and report. They maintain his studies are a ray of hope for Kenny.

[74] With respect, Dr. Owen's findings do not contradict the opinions of Dr. Tham and Dr. Namazi. Dr. Owen is a neuroscientist. His studies have been remarkable. He has been able to show that some patients diagnosed as vegetative are really minimally conscious. The fMRI preformed at bedside along with a command following has demonstrated brain activity. Kenny is already diagnosed as being minimally conscious and, according to his physicians, he is not completely unaware of himself or his environment. But, as Lora points out, his current medical condition cannot be improved with what modern medicine has to offer and the only medical treatment plan available is to keep him alive.

[75] The petitioners suggest that Dr. Owen's study might provide a cure. While this scientific development might hold some promising benefits in the future, at present, it is a speculative conclusion at best.

[76] As Dr. Owen points out in his report, he has not reviewed Kenny's medical records. He conceded that performing fMRI upon severely brain injured patients is enormously challenging. There are limitations to Dr. Owen's technique. In order to be included in this study, patients must seek to be examined by one of Dr. Owen's team members for compatibility. This requires the patient being transported to the university where Dr. Owen conducts his research.

[77] The petitioners fail to address these limitations in Dr. Owen's research.

[78] In my view, Lora's decision, supported by Dr. Namazi, is medically appropriate. Kenny has been in a minimally conscious state since September 2005. It cannot be said that Lora is acting irrationally or without proper consideration.

[79] In respect of the criticism of her motives, that Lora is driven by self-interest, I also disagree. Lora and the children's claim on his estate is no different than it was before Kenny was injured. It cannot be argued that Lora and the children will have emotional relief. They will be relieved from observing Kenny struggle, but they must still face the consequences of his death.

[80] The petitioners simply disagree with Lora's decision. They have not provided any cogent reason to rescind Lora's appointment as committee. Lora is the proper person to make the decision and she has the authority to do so.

[81] As Lora points out:

(i) she has been married to Kenny since 1993 and she has known him since 1990;

(ii) she and Kenny have a close family relationship; and

(iii) for over seven years she has been the person who has dealt with Kenny's care team on every important medical decision.

[82] Accordingly, the petition is dismissed.

[83] The parties have leave to speak to costs.

"Gropper J."