CITATION: DK v. Gilfoyle, 2021 ONSC 7248
COURT FILE NO.: CV-21-668875
DATE: 20211102

ONTARIO
SUPERIOR COURT OF JUSTICE

IN THE MATTER OF an application pursuant to subsection 37(1) of the *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Schedule A as amended.

BETWEEN:	
DK Appellant	*Mercedes Perez* for the Appellant DK
- and -	
DR. ELAINE GILFOYLE, BH, and KHK Respondents	*Sam Rogers* and *Morgan Watkins* for the Respondent Dr. Elaine Gilfoyle *Allan R. Horton* for the Respondent BH *Maureen Addie* for the Respondent KHK

AND BETWEEN:

IN THE MATTER OF an application pursuant to subsection 37(1) of the *Health Care Consent Act, 1996,* S.O. 12992, c. 2, Schedule A as amended.

BH Appellant	*Allan R. Horton* for the Appellant BH
- and -	
DR. ELAINE GILFOYLE, DK and KHK Respondents	*Sam Rogers* and *Morgan Watkins* for the Respondent Dr. Elaine Gilfoyle *Mercedes Perez* for the Respondent DK *Maureen Addie* for the Respondent KHK
	HEARD: October 27, 2021

PERELL, J.

REASONS FOR DECISION

A. Introduction and Overview

[1] This is a heart-rendering appeal from a decision of the Consent and Capacity Board ordering BH (the mother) and DK (the father), the parents and substitute decision-makers of the one-year infant KHK (born, August 28, 2020), to consent to the withdrawal of KHK's life support at the Hospital for Sick Children in Toronto.

[2] KHK suffered a catastrophic brain injury. KHK is a patient at SickKids Hospital. Dr. Elaine Gilfoyle leads the treatment team for KHK. KHK is in a coma in the hospital's intensive care unit. Dr. Gilfoyle's treatment plan for KHK is: (a) discontinuance of artificial nutrition and hydration; (b) discontinuance of the drug desmopressin (a treatment for diabetes); (c) no CPR (cardiopulmonary resuscitation); and (d) palliative care. It is Dr. Gilfoyle's opinion that KHK's best interests require allowing her to die. BH and DK disagree.

[3] After a six-day hearing, the Consent and Capacity Board found that DK and BH had not complied with the principles for substitute decision-making set out in s. 21 of the *Health Care Consent Act, 1996*.[1] The Board directed that if BH and DK do not comply and consent to Dr. Gilfoyle's treatment plan by 5:00 p.m. on September 10, 2021, they would cease to be KHK's substitute decision-makers.

[4] BH and DK, respectively, appeal the September 7, 2021 decision of the Consent and

[1] S.O. 1996, c. 2, Schedule A.

Capacity Board. The Board's order was automatically stayed by the appeals.

[5] At the hearing before the Consent and Capacity Board, Maureen Addie was appointed *amicus* for the infant KHK. Allan R. Horton represented BH. Mercedes Perez represented DK. By Endorsement dated September 20, 2021, I directed that Ms. Addie, Ms. Perez, and Mr. Horton be appointed *amicus curiae* for the appeal pursuant to Rule 13.02 of the *Rules of Civil Procedure*,[2] and the inherent jurisdiction of the Superior Court.[3]

[6] On their respective appeals, the appellants BH and DK, respectively request:

> 1. that the decision of the Board be quashed and that, in its place, this Honourable Court find that the appellant has complied with the principles for substitute decision-making set out in section 21 of the *Health Care Consent Act, 1996* and that no directions pursuant to sections 21 and 37 of the *Health Care Consent Act, 1996* are required; and
>
> 2. in the alternative, that this Honourable Court make an order remitting this matter back to the Board for a new hearing, in whole or in part, in accordance with such directions as this Honourable Court considers necessary and appropriate.

[7] The crux of BH's and DK's appeals of the Board's decision is that of determining whether the Board erred in deciding: (a) whether KHK's "condition" or "well-being" was likely to improve, remain the same, or deteriorate without the withdrawal of life support; (b) whether the benefit expected from the withdrawal of life support outweighed the risk of harm to KHK; and (c) whether a less restrictive or less intrusive treatment would be as beneficial as the withdrawal of life support, the treatment that Dr. Gilfoyle proposed.

[8] For the reasons that follow, I conclude that the Board made no reviewable error. I dismiss the appeals. I commend BH and DK for their devotion to KHK. However, KHK has an irreparable and untreatable bilateral uncal herniation of her brainstem at the mid-brain from which there is absolutely no chance of recovery, but there is the certainty of deterioration from her current tragic condition. The Board was correct in its assessment of KHK's best interests in the heart-rendering sad circumstances of this case, where the comatose KHK cannot move purposefully, hear, see, smell, or feel anything and does not experience any self-consciousness or wakefulness of any kind. She is alive only because of invasive and intense medical therapies 24 hours a day, every day.

B. The Submitted Errors of the Consent and Capacity Board

[9] BH and DK submit that the Consent and Capacity Board made three errors of law; namely:

a. BH and DK submit that the Board erred by confining its best interests analysis as to the alternative of whether it was in KHK's best interest to be kept alive or to be allowed to die. They submit that the Board erred by not considering the alternative that they proposed, which was to maintain the *status quo* of KHK's current treatment and to wait and see if KHK's condition does not sufficiently improve, remains the same, or deteriorates, in which case a decision can then be made to withdraw life support.

b. BH and DK submit that the Board erred in its best interests analysis by taking into account irrelevant considerations external to the statutory criteria in end of life cases.

c. BH and DK submit that the Board erred in its best interests analysis by considering

[2] R.R.O. 1990, Reg 194.
[3] *DK v. Gilfoyle*, 2021 ONSC 6215.

KHK's quality of life and dignity when assessing the impact of their treatment proposal that the *status quo* be maintained.

C. The Submissions of Dr. Gilfoyle

[10] Dr. Gilfoyle submits that the appeal of the Board's decision that BH and DK had not complied with the principles for substitute decision-making set out in s. 21 of the *Health Care Consent Act, 1996* should be dismissed.

[11] Dr. Gilfoyle submits that the submitted errors of the Board are not errors of law. Moreover, she submits that the three submitted errors were not made.

[12] Dr. Gilfoyle submits that the Board made no error in its considerations of the best interests analysis. She submits that the Board made reasonable findings of fact based on the medical records and testimony and it did not make any palpable and overriding error. She submits that there is no basis for appellate intervention.

D. The Position of the *Amicus* for KHK

[13] As noted above, Ms. Addie was appointed *amicus* to advocate for KHK at the hearing before the Board. In this capacity, having heard all of the evidence at the hearing, she took the position that the substitute decision-makers in this case were not making decisions in KHK's best interests.

[14] For this appeal, Ms. Addie reviewed the hearing documents and the facta submitted by all parties to this appeal, and she reconsidered all of the issues with a fresh mind. Having done so, she adopted the submissions made by Dr. Gilfoyle.

[15] In her factum, Ms. Addie submitted:

> KHK has not regained consciousness since she drowned in bathtub on July 8, 2021; she has no awareness of herself, her family, or her surroundings. Since the moment of her drowning, she has not existed as the subject of her own life; she continues to exist only as object of her parents' desire to not let her go. The SDMs are not making decisions based on KHK's best interest and, as such, the appeal should be dismissed.

E. The Principles of Substitute Decision Making

[16] In the immediate case, KHK is an infant without the capacity to consent to medical treatment. BH and DK are her substitute decision-makers.

[17] Where a patient does not have the capacity to consent to treatment, pursuant to s. 10 of the *Health Care Consent Act, 1996* (the "*HCCA*"), a physician who proposes a treatment shall not administer the treatment unless the person's substitute decision-maker has given consent on the person's behalf in accordance with the Act.

[18] The withdrawal or removal of life support falls within treatment as defined by the *HCCA* and health practitioners are required to obtain consent from a patient or their substitute decision-maker before withdrawing or ending life support.[4]

[4] *Ackie v. Manocha*, 2014 ONSC 669 at para. 26; *Cuthbertson v. Rasouli*, 2013 SCC 53.

[19] Section 21 of the *Health Care Consent Act, 1996* stipulates for substitute decision-makers, the principles for giving or refusing consent. Section 21 states:

> *Principles for giving or refusing consent*
>
> 21(1) 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.
>
> *Best interests*
>
> (2) 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.

[20] The substitute decision-maker's consideration of a patient's best interests must be an objective assessment. The obligation of the substitute decision-maker is to weigh all of the factors and make a decision that is objectively in the best interests of the incapable person, not a decision based on what the substitute decision-maker wants or wishes for the incapable person.[5]

[21] In the immediate case, due to KHK's age, she has no wishes or beliefs to take into consideration, and, therefore, the focus of the immediate case is on subsection 21(2)(c), which sets

[5] *Murray v. Dev*, 2017 ONSC 2966 at para. 81; *Cuthbertson v. Rasouli*, 2013 SCC 53 at para. 88.

out a four criteria test for determining KHK's "best interests."

[22] The excruciating sad circumstance of the immediate case is that the ultimate question is whether a treatment that prescribes the withdrawal of life support can be in a patient's best interests. At first blush, one might think and argue that the withdrawal of life support cannot ever be in a patient's best interests. However, the case law establishes, and BH and DK concede, that there are circumstances where the withdrawal of life support could be in a patient's best interests and satisfy the test or standard set out in subsection 21(2)(c).[6] The particular facts of each case determine whether withdrawal of life support is in the best interests of the patient.[7]

[23] Pursuant to s. 37(1) of the *Health Care Consent Act, 1996,* if a physician who proposes a treatment is of the opinion that the substitute decision-maker for the patient did not comply with the principles for giving or refusing consent under s. 21 of the Act, the physician may apply to the Board for a determination as to whether the substitute decision-maker complied with s. 21. This application pursuant to s. 37 of the Act is referred to as a Form G application.

[24] The Board is not required to show deference to the findings of the substitute decision-maker and is entitled to draw its own conclusions.[8] Section 37 of the *Health Care Consent Act, 1996*, among other things, empowers the Board to give directions to the substitute decision-maker and substitute its opinion for that of the substitute decision-maker. Section 37 of the Act states:

> *Application to determine compliance with s. 21*
>
> 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.
>
> *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.
>
> *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.
>
> *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.

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[6] *Murray v. Dev*, 2017 ONSC 2966; *Ackie v. Manocha*, 2014 ONSC 66; *Scardoni v. Hawryluck* (2004), 69 O.R. (3d) 700 (S.C.J.); *Barbulov v. Cirone* [2009] O.J. No. 1439; *Janzen v. Janzen*, [2002] O.J. No. 450 (S.C.J.).
[7] *Cuthbertson v. Rasouli*, 2013 SCC 53 at para. 102.
[8] *Ackie v. Manocha*, 2014 ONSC 66 at para. 36.

Time for compliance

(5) The Board shall specify the time within which its directions must be complied with.

Deemed not authorized

(6) If the substitute decision-maker does not comply with the Board's directions within the time specified by the Board, he or she shall be deemed not to meet the requirements of subsection 20 (2).

[…]

F. Procedural and Evidentiary Background

[25] On August 12, 2021, Dr. Gilfoyle submitted a Form G Application to the Consent and Capacity Board challenging BH and DK's status as substitute decision-makers. The plan of treatment that Dr. Gilfoyle proposed, based on the consensus of the medical team, was: (a) extubation; (b) discontinuance of artificial nutrition, hydration, and desmopressin; (c) no administration of CPR; and (d) the provision of palliative care.

[26] As required by statute, the Board moved quickly to convene an initial case conference on August 16, 2021.

[27] There were three subsequent case conferences on August 19, 2021, August 20, 2021, and August 24, 2021.

[28] At the request of BH's and DK's counsel there was an adjournment of the originally scheduled hearing dates, and the hearing began on August 26, 2021.

[29] At the start of the hearing BH and DK sought a two-week adjournment to retain an expert. Their adjournment request was denied, and the hearing got underway.

[30] The hearing took place by video conference on August 26, 27, 28, September 1, 5 and 6, 2021.[9]

[31] The Board had a comprehensive record including more than 340 pages of notes of health care practitioners, including physicians, nurses, respiratory therapists, social workers, and a bioethicist. There was also a clinical summary prepared by Dr. Gilfoyle.

[32] BH and DK testified at the hearing.

[33] Four doctors testified at the hearing. Dr. Gilfoyle testified. Dr. Andrew Helmers, another of the Hospital's pediatric intensive care physicians testified. The other two physicians that testified were Drs. Muratta and Catherine Proulx.

[34] Drs. Muratta and Proulx testified about the mutually mistrustful relationship between BH and DK and the doctors at SickKids Hospital. Drs. Muratta and Proulx did not testify about the proposed treatment plan proposed by Dr. Gilfoyle. The Board, correctly in my view, held that the bad relationship between BH and DK and the staff at the hospital was not relevant to an objective assessment of what was in KHK's best interests.

[35] During the hearing, the Board members visited KHK virtually through a Zoom call.

[9] The Board panel was Mark Handelman (lawyer, presiding member), Julie Handsor and Gary Strang (public members)

[36] The hearing concluded on September 6, 2021.

[37] As required by the Act, a decision was released on September 7, 2021, and a 30-page Reasons for Decision was released four days later, on September 11, 2021.

[38] On the appeal, none of the parties made an application for leave to file fresh evidence.

G. Facts

1. Preamble to the Facts

[39] The following findings of fact are taken from the evidentiary record of the six-day hearing before the Board and from the Board's findings.

[40] On this appeal, there is no dispute about the Board's findings of fact. The dispute between the parties is about whether the Board correctly applied the principles of substitute decision-making stipulated by the *Health Care Consent Act, 1996* in the circumstances of an end of life case where the proposed treatment is the withdrawal of life support. The underlying facts are not disputed.

[41] To understand and appreciate the significance of the facts of this case, it is necessary to keep in mind that the crux of BH's and DK's appeals of the Board's decision is that of determining whether the Board erred in deciding: (a) whether KHK's "condition" or "well-being" was likely to improve, remain the same, or deteriorate without the withdrawal of life support; (b) whether the benefit expected from the withdrawal of life support outweighed the risk of harm to KHK; and (c) whether a less restrictive or intrusive treatment than the withdrawal of life support would be as beneficial as the withdrawal of life support proposed by Dr. Gilfoyle.

[42] In the immediate case, the less restrictive treatment proposed by BH and DK for KHK is to maintain the *status quo* of her current treatment and to wait and see if KHK's condition does not improve enough, remains the same, or deteriorates, in which case the change, if any, can be evaluated and a decision could then be made to withdraw life support.

[43] It appears that BH and, more so, DK, would direct life support be withdrawn should KHK's conditions deteriorate; however, they do not have a measure of what degree of improvement would be not enough to continue life support, and they do not have a measure of how long the wait and see period should be.

2. The Tragedy and the Care and Treatment of KHK

[44] On July 8, 2021, KHK, an 11-month-old female infant, was found by her parents BH and DK underwater in a bathtub. KHK had drowned. She had suffered a heart attack. She was not breathing. She had no heart rate. Her body organs were not being oxygenized.

[45] BH and DK administered CPR. Paramedics were called at approximately 7:50 pm, and they arrived 10 minutes later. The paramedics continued to administer CPR, while rushing KHK to Humber River Regional Hospital. At the hospital a heartbeat was re-established. KHK had not had a heartbeat for between 30 to 45 minutes.

[46] At Humber River Regional Hospital, KHK was started on mechanical ventilation, and then she was transported to the Hospital for Sick Children in Toronto ("SickKids Hospital"). She was

admitted to the Pediatric Intensive Care Unit ("PICU").

[47] Upon arrival at SickKids Hospital, KHK's condition was critical and unstable. She displayed no neurological activity other than "agonal" breathing, which is very deep abnormal breaths. Agonal breathing is a symptom that there had been damage to the brainstem. KHK had bowel ischemia, and hemodynamic instability. Her heart was not beating properly. She was administered high doses of medication to maintain heart function and her blood pressure. Her bowel was injured because of oxygen deprivation, and there was a high risk of perforation. She was suffering from coagulopathy (blood clotting), and her liver had been damaged due to oxygen deprivation. She was not moving. Her pupils were unreactive to light, and she was suffering from seizures and brain swelling.

[48] As a consequence of the drowning, KHK had suffered cardiac arrest, which, in turn, caused a hypoxic brain injury. She had suffered a devastating brain injury and was in multiorgan failure. The cardiac arrest caused KHK to suffer two types of brain injury: (a) hypoxic ischemic encephalopathy (HIE), a diffuse bilateral white matter brain injury with significant swelling and damage to brain cells; and (b) bilateral uncal herniation of her brainstem at the mid-brain.

[49] Uncal herniation is a condition where parts of the brain at the base of the skull permanently herniate (push out) causing irreversible injury to the brainstem that contains the structures essential to life, including breathing, control over circulation of blood and heart function, and wakefulness. The effect of the bilateral uncal herniation on KHK is that electrical signals cannot flow through her brainstem to her upper brain. KHK's upper brain will never receive information from her body or be able to send instructions to her body's organs.

[50] In the days, following her admission, KHK's bowel ischemia and hemodynamic improved without surgery. Cardiac dysfunction and coagulopathy resolved. Epinephrine, a medication to control blood pressure, was discontinued on July 25, 2021. Seizures were controlled with antiseizure medications, which were no longer needed as of August 5, 2021. Her bowel and liver both healed. One incident of deep vein thrombosis (DVT) resolved on its own. Her agonal breathing stopped; however, she does not display any respiratory effort, and she is entirely dependent on a ventilator.

[51] From a neurological perspective, KHK has been in a deep unresponsive coma since July 8, 2021. The active clinical issue is KHK's neurologic state. KHK did not and does not display signs of neurological activity.

[52] The PICU team decided to perform a number of tests of KHK's brainstem functioning, including having her disconnected from a ventilator for 10 minutes to determine whether she is making any respiratory effort. These tests would determine whether KHK met the criteria for a neurological determination of death. During the first test on July 14, 2021, KHK became unstable when the ventilator was disconnected, and the test was aborted. During the second test on July 16, 2021, KHK demonstrated some faint respiratory efforts, and, therefore, she did not meet the criteria for brain death.

[53] On August 17, 2021, KHK was tested for upper brain activity. She underwent a 12-hour continuous electroencephalogram (an "EEG"). The EEG revealed no discernible cortical activity; *i.e.*, no higher brain function whatsoever. Other tests disclosed the bilateral uncal herniation in her brainstem prevented signals going from KHK's body to her brain. There is no treatment for bilateral uncal herniation.

[54] The only brainstem functions that KHK demonstrates are a shallow and inconsistent respiratory drive, and abnormal movements of her extremities described as "extensor posturing," animated by her brainstem. Because of the bilateral uncal herniation, none of KHK's movements was generated from her upper brain.

[55] KHK is in a coma. She does not respond to any stimuli. She cannot move purposefully, hear, see, smell, or feel anything. She cannot experience anything in the environment around her. She does not experience any self-consciousness or wakefulness of any kind. KHK is not able to clear secretions in her airways due to the lack of a cough or gag reflex, and her airways must be cleared through suctioning by staff throughout the day every day. She does not open her eyes or demonstrate any wakefulness. Her pupils are abnormally large and do not respond to light. She is unable to regulate her core body temperature, which requires warming with a warming blanket. She will never develop as a normal child. She will never walk, talk, or move. Because she is unconscious in bed, her muscles and bones will not grow properly as she ages. KHK's upper brain does not and cannot communicate with her body. Brain cells do not regenerate, so although some of her other organs healed after the drowning, her brain cannot. She is alive only because of invasive and intense medical therapies 24 hours a day every day.

[56] KHK is connected to a ventilator by way of a tube going into her mouth and down her throat. She has two tubes in her nose, one to deliver nutrition to her stomach or possibly her small intestine, and another to drain air from her stomach, because sometimes air from the ventilator went there instead of into her lungs. Nurses have to drain that air because KHK cannot burp. She needs equipment to suction her airways because she cannot cough or otherwise clear them of the mucous her lungs produce. She has an intravenous line surgically installed into the large vein at the top of her right leg used to deliver fluids, medications, and blood products. Desmopressin, a medication is administered every 36 hours to treat ongoing diabetes insipidus, possibly caused by injury to KHK's pituitary gland. She is covered with a "Bair Hugger," a blanket into which warm air is pumped to maintain her body temperature, which she is unable to control. KHK rests on a foam sheet to reduce skin injury of the type commonly referred to as bedsores.

[57] The medical opinion of all eleven PICU physicians at SickKids Hospital as well as the consulting neurologists is that there will never be any improvement in KHK's neurological condition. Every member of KHK's treatment team, including eleven pediatric intensive care specialists and a neurologist, concluded KHK has no prospect of recovering use of her brain. This means that KHK will never have an awareness of her environment or the use of any of her senses.

[58] Largely because of the circumstance that some of KHK's organs have healed, both BH and DK, contrary to the consensus of KHK's physicians, hope and believe that there is a possibility that KHK's neurological condition will improve.

[59] On July 19, 2021, the PICU team recommended to BH and DK the discontinuation of KHK's life support. This recommendation was repeated on a number of occasions, culminating in an August 10, 2021 letter from Dr. Gilfoyle, Dr. Gail Annich, another PICU physician who provided care to KHK, and the Chief Medical Officer of SickKids, Dr. Lennox Huang. The August 10 letter reviews KHK's medical status, and stated:

> We are writing to provide you with a summary of KHK's present condition and advise you on the next steps.
>
> Currently, KHK is in a deep unresponsive coma following her drowning: she does not have any awareness of herself or her environment, has no clinical signs of any wakefulness, has no purposeful

> or voluntary movements in response to any stimulation (visual, sound, touch, or pain), no ability to communicate (comprehension or expression), and a persistent absence of most brain-stem (cranial nerve) reflexes (in particular, an absence of pupillary, corneal, vestibulo-ocular, gag, and cough reflexes, with an inconsistent respiratory drive). She is reliant upon desmopressin administration for diabetes insipidus as she lacks an ability for her brain to release this and will have dangerously high sodium levels in her blood unless this is given. She is reliant upon a warming device to maintain her temperature as her brain cannot regulate this effectively. In other words, KHK cannot experience anything in the environment around her, nor does she experience any self-consciousness or even wakefulness of any kind.
>
> KHK has been in this state for more than one month, and our prognosis (prediction of her outcome) has been communicated to you on multiple occasions. Namely, based upon the severity of KHK's brain injury and her persistence in the above-described state, she will remain in this state for as long as she lives, and will only live if invasive and intense medical therapies remain in place 24 hours a day, seven days a week. We are deeply sorry that this is the case.
>
> Ontario's *Health Care Consent Act* requires that you make medical decisions on KHK's behalf that are in her best interests taking into consideration the factors outlined in section 21(2) of the *Health Care Consent Act*. The continuation of invasive medical therapies (in particular, mechanical ventilation, but also including intravenous access and temperature regulation treatments) is not in KHK's best interests for three reasons: (1) they will not improve KHK's condition or well-being; (2) they will not prevent KHK's condition from getting worse as her injury is of the maximal severity; and (3) the harms of these therapies (e.g. pneumonia, blood clots, or other bodily injury) are not offset by any benefit derived by KHK from these therapies.
>
> Unfortunately, KHK's best interests have compelled us to recommend to you on multiple occasions that we proceed with withdrawal of life-sustaining therapy, as continued invasive medical support is a continued source of harm to KHK that does not represent any benefit to her condition or any benefit experienced by her. She is not experiencing any physical healing or conscious benefit from the continued application of therapies which are at best a source of harm and at worse an indignity to a child who is in a sustained, deep, unresponsive coma.
>
> It is our continuing assessment that KHK is only experiencing harm, and no benefit, from continued mechanical ventilation. We continue to propose the following treatment plan as being the tragic but only path consistent with KHK's best interests, namely: removal of her breathing tube (extubation) and the provision of palliative care in the firm expectation that she will pass away within minutes or hours after this. In addition to extubation, this will include the discontinuation of artificial nutrition and hydration and the discontinuation of desmopressin. Cardiopulmonary resuscitation will not be provided, nor will vasoactive therapy.
>
> You have refused to consent to this treatment plan on behalf of KHK. It is the position of the care team that, by refusing to consent to our recommended treatment plan on behalf of KHK, you are not acting in KHK's best interests, as defined in section 21 of Ontario's *Health Care Consent Act*. […]
>
> Again, we are truly sorry that KHK has suffered such a severe brain injury with no prospect of recovery; it is humbling to have no medical solution to her condition, but the time has come to withdraw those therapies which are a source of continued harm, are of no benefit to KHK, and are only prolonging her state of unresponsive coma. If you do not agree to follow our recommended treatment plan by Thursday, August 12, 2021, as outlined above, we will commence an application to the Consent and Capacity Board pursuant to section 37 of the *Health Care Consent Act* for permission to implement the treatment plan. If you are willing to follow the recommended treatment plan, we will discuss the process and timelines for implementing it with you.

[60] If the recommended treatment plan is not implemented, then the prognosis is that KHK will remain on life support until she dies, which may be months or years from now. If the recommended treatment plan is implemented, KHK would not be aware she was dying, and her

passing would be painless.

[61] As Dr. Gilfoyle and Dr. Helmers testified at the hearing, KHK is at risk of: (a) ventilator acquired pneumonia (leading to scarring, potential death and antibiotic resistant bacteria), of which there has already been two incidents; (b) deep vein thrombosis, of which there has been one incident; (c) potential pulmonary embolism and anemia due to the need for periodic blood transfusions; (d) bedsores; (e) contractures in her joints (stiffness), which has already occurred; (f) muscle wasting; and (g) slowed or absence of bodily growth.

[62] Neither DK nor BH wished KHK to be on life support indefinitely. They said that they were willing to consider consenting to the withdrawal of life support interventions. Although it appears that BH and, more so, DK, would direct that life support be withdrawn should KHK's conditions change for the worse or not change for the better, they do not have a measure of what degree of improvement would be not enough to continue life support and they do not have a measure of how long the wait and see period should be.

[63] Notwithstanding the information they had received from the PICU physicians that there would be no recovery and only a precarious albeit painless deterioration and an eventually death, BH and DK hope and believe it is in KHK's best interests to give her some additional time on life support, while they investigate additional therapies not available at SickKids Hospital, including therapies such as hyperbaric oxygen treatment, which is not used in Ontario. They persist in this view, notwithstanding the evidence that their investigations would yield only futility.

H. The Reasons of the Consent and Capacity Board

[64] In its Reasons for Decision, the Board accepted the medical evidence of the physicians of the PICU.

[65] In its Reasons for Decision, the major findings of fact of the Board are that KHK suffered two catastrophic brain injuries: (a) hypoxic ischemic encephalopathy (HIE); and (b) bilateral uncal herniations of her brainstem at the mid-brain. There is no treatment for bilateral uncal herniation. KHK is in a deep unresponsive coma from which she will never emerge. She does not display signs of neurological activity. She does not experience any self-consciousness or wakefulness of any kind. She cannot move purposefully, hear, see, smell, or feel anything. She will never walk, talk, or move. Brain cells do not regenerate, so although some of her other organs did heal, her brain cannot. There will never be any improvement in KHK's neurological condition. KHK has no prospect of recovering use of her brain. KHK is alive only because of invasive and intense medical therapies 24 hours a day, every day.

[66] In its Reasons for Decision, the Board accepted the medical evidence that, while acute medical conditions such as pneumonia could be treated, KHK's overall condition would continue to deteriorate and that her muscles would continue to atrophy and contract from lack of use and lack of signals from her brain. The Board concluded that it was likely that KHK would have further bouts of pneumonia and while the lung damage could be treated, each bout would leave more scar tissue. The Board concluded that bedsores remained a possibility, if not a probability.

[67] The Board accepted the evidence that if the recommended treatment plan is not implemented, then the prognosis is that KHK will remain on life support until she dies, which may be months or years from now. If the recommended treatment plan of withdrawal of life support is implemented, KHK would not be aware she was dying, and her passing would be painless.

[68] In its Reasons for Decision, the Board reviewed the law with respect to the principles of substitute decision-making and the law with respect to the best interests criteria stipulated by the *Health Care Consent Act, 1996*. The Board considered the criteria but stated:

> While the "best interests" considerations set out in the legislation had to be considered, we did not consider the list exhaustive. In using the phrase, "shall take into consideration," the legislation recognized that other factors could be relevant.

[69] Focusing on the criterion of KHK's "condition" the Board disagreed with DK's submission that because under the current life support treatment regime (the *status quo* alternative to a withdrawal of life support), some of KHK's organs had healed, the withdrawal of life support did not satisfy the best interests criteria. The Board stated:

> The problem with Ms Perez' submission was that it spoke to discrete medical conditions and not to KHK's overall medical condition. The legislation directed us to consider KHK's "condition," not "conditions." We rejected the submission that we could conclude KHK's condition would not deteriorate, or deteriorate more slowly, if we ignored the fact that her brain could not function.
>
> Continuing KHK's life would continue deterioration of her overall condition. Allowing her to die would stop it. Treating individual acute medical conditions would prevent, reduce or delay deterioration from them but would not improve her overall condition because she would never regain useful brain function.
>
> Was there a less restrictive or less intrusive treatment that would be as beneficial to KHK as the proposed treatment?
>
> Was Dr. Gilfoyle's proposed treatment likely to improve KHK's condition or well-being? Did the benefit that KHK was expected to obtain from the proposed treatment outweigh the risk of harm to her?
>
> The damage to KHK's brain was irreversible. She would never see, hear, smell or feel. Her other internal organs might heal by themselves to some extent but there was nothing that could be done for her underlying brain damage. In that sense, there was no way to improve her condition.
>
> In the context of KHK's condition these three questions are more philosophical than practical. Is death always a harm? Is life always a benefit? What does it mean to be alive? The answers to those questions ran the gamut. We were aware that many people have "no heroic measures" provisions in their Powers of Attorney for Personal Care and in our view KHK was being kept alive by heroic measures. Medical Assistance in Dying is available in Canada and has become somewhat commonplace for persons whose death is foreseeable and whose condition is intolerable to them. At the other end of the spectrum are people to whom every moment of life is sacred, no matter the pain, no matter the suffering or futility, to the point that being kept on a ventilator, even after brain death, is valuable to them: See for example *McKitty v. Hayani*, 2019 ONCA 805.
>
> KHK had no wishes, values or beliefs to guide us. Her absence of brain function meant she was not enduring pain or suffering, other than possibly suffering in an existential context. The overarching question was whether KHK should be kept alive or allowed to die. Which, as objectively as possible to determine, was in her best interests?
>
> Quantitively, KHK was so close to the line between life and death that her treatment team twice conducted the NDD (neural determination of death) test. Qualitatively, what were her life's prospects? Examining the statutory considerations alone led us to find as fact that KHK's best interests required allowing her to die. Considering KHK's well-being led us to the same conclusion.

[70] Focusing on the criterion of "well-being" the Board referred to: (a) its own decisions in *Re*

EJG[10] and *Scardoni v. Hawryluck*, [11] which was affirmed on appeal; (b) Justice Aitken's decision in *Janzen v. Janzen*;[12] (c) the English decisions of *Inland Revenue Commissioners v. Baddeley*[13] and *Airedale NHS Trust v. Bland*[14]; and, (d) the American decision, *Re Conroy*.[15]

[71] The Board stated that well-being is a phrase with a broader meaning than condition and includes considerations such as the person's dignity and level of pain and that well-being was a very broad concept which encompasses many considerations, including quality of life. The Board stated that KHK's well-being also included consideration of the dignity to which she, like every human being, was entitled. The Board agreed with the comments in *Airedale NHS Trust v. Bland* and *Re EJG* that a mentally incompetent patient has a right to avoid unnecessary humiliation and degrading invasion of his or her body for no good purpose and that medical treatment is not requisite simply to prolong a patient's life when such treatment has no therapeutic purpose of any kind, as when it is futile because the patient is unconscious and there is no prospect of any improvement in his or her condition. The Board stated that mere prolongation of the life with no hope of any recovery, is not in a patient's best interest.

[72] In its Reasons for Decision, the Board agreed with the following observation from its own case *Re EJG*:

> Since the withdrawal of treatment Dr. Choong proposed was likely to result in EJG's death, it might be argued that continuing his mechanical respiratory assistance could not logically be a risk because the greatest risk is death. We disagreed. Every living thing eventually dies, and the risk is not whether, but when and how, as well as what happens to a person until he or she dies. Those factors had to form part of the discussion of EJG's "well-being," which is a much broader term than "condition."

[73] In its Reasons for Decision, the Board agreed with the following observation from the American decision:

> The medical and nursing treatment of individuals in extremis and suffering from these conditions (persistent vegetative state) entails the constant and extensive handling and manipulation of the body. At some point, such a course of treatment upon the insensate patient is bound to touch the sensibilities of even the most detached observer. Eventually, pervasive bodily intrusions, even for the best motives, will arouse feelings akin to humiliation and mortification for the helpless patient. When cherished values of human dignity and personal privacy, which belong to every person living or dying, are sufficiently transgressed by what is being done to the individual, we should be ready to say: enough.

I. <u>The Standard of Appellate Review</u>

[74] Under s. 80(1) of the *Health Care Consent Act, 1996,* a party to a proceeding before the Board may appeal the Board's decision to the Superior Court of Justice on a question of law or fact or both. The court on appeal has a broad remedial jurisdiction. The court may: (a) exercise all the powers of the Board; (b) substitute its opinion for that of a health practitioner, substitute decision-maker, or the Board; or (c) refer the matter back to the Board with directions for rehearing in whole

[10] 2007 CanLII 44704 (Ont. CCB).
[11] (2004), 69 O.R. (3d) 700 (S.C.J.)
[12] [2002] O.J. No. 450 (S.C.J.).
[13] [1955] A.C. 572 (H.L.).
[14] [1993] 1 All E.R. 821 (H.L.).
[15] (1985), N.J. 321.

or in part.

[75] Section 80 of the Act permits a party to a proceeding before the Board to appeal to the Superior Court on a question of law, fact or both. The standard of review on questions of law is correctness. The standard of review on questions of fact or mixed fact and law is palpable and overriding error.[16]

[76] The word "palpable" means "clear to the mind or plain to see",[17] and "overriding" means "determinative"[18] in the sense that the error "affected the result".[19] The Supreme Court has held that other formulations capture the same meaning as "palpable error": "clearly wrong", "unreasonable" or "unsupported by the evidence".[20]

J. Discussion and Analysis

[77] Although it is arguable that the three errors that BH and DK submit were made by the Board are errors of mixed fact and law, for which considerable deference should be given to the Board's expertise, I shall review the submitted errors on the more stringent standard for the review of questions of law.

[78] Based on the correctness standard, I conclude that the Board made no error and I conclude that the Board's application of the law was correct. I add that if the submitted three errors were errors of fact or of mixed fact and law, then the Board's decision was reasonable, and the Board made no palpable and overriding error.

[79] More precisely, the Board did not err in its interpretation and application of s. 21(2)(c). paras. 1, 2, 3, and 4 of the *Health Care Consent Act, 1996*.

[80] The Board did not err by characterizing the issue in the immediate case as whether the treatment for KHK should be to keep her alive or to allow her to die. In the immediate case, the circumstances were that the withdrawal of the *status quo* would lead inevitably to KHK's death, but the Board's analysis was in accordance with the criteria of the *Health Care Consent Act, 1996* to ask and to answer the questions of: (a) whether KHK's "condition" or "well-being" was likely to improve, remain the same, or deteriorate without the withdrawal of life support; (b) whether the benefit expected from the withdrawal of life support outweighed the risk of harm to KHK; and (c) whether a less restrictive or less intrusive treatment would be as beneficial as the withdrawal of life support, the treatment that Dr. Gilfoyle proposed.

[81] The evidence overwhelmingly supported the conclusion that the withdrawal of life support was in KHK's best interests notwithstanding it would inevitably lead to her death.

[82] Further, the Board did not ignore BH's and DK's proposal that the *status quo* be maintained to wait and see if there were positive or negative changes in KHK's condition. Based on the medical evidence, the Board concluded that positive change was impossible and negative change was inevitable and had already occurred.

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[16] *KM v. Agrawal*, 2021 ONSC 5748 at paras. 80-81.
[17] *Housen v. Nikolaisen*, [2002] 2 S.C.R. 235 at para. 5.
[18] *Schwartz v. Canada*, [1996] 1 S.C.R. 254 at para. 35.
[19] *KM v. Agrawal*, 2021 ONSC 5748 at para. 82; *(H.) v. Canada (Attorney General)*, [2005] 1 S.C.R. 401 at para. 55.
[20] *L. (H.) v. Canada (Attorney General)*, [2005] 1 S.C.R. 401 at paras. 55, 56.

[83] Contrary to BH's and DK's submissions, the Board did not err in its best interests analysis by taking into account irrelevant considerations external to the statutory criteria. The Board identified the criteria required by the statute and analyzed the medical evidence in accordance with those criteria.

[84] The Board did say in its Reasons for Decision that the best interests considerations of the Act are not an exhaustive list. That is a correct statement of the law because "condition", and "well-being" are nuanced and complex notions. In any event, in the immediate case, the Board's Reasons for Decision demonstrate that it correctly applied the criteria from the legislation and did not stray to irrelevant, subjective considerations. Indeed, the Board stated: "Examining the statutory considerations alone led us to find as fact that KHK's best interests required allowing her to die."

[85] Contrary to BH's and DK's submissions, the Board did not err in its best interests analysis by considering KHK's quality of life and her dignity when assessing the impact of BH's and DK's treatment proposal that the *status quo* be maintained. While the Board did mention quality of life, its consideration did not improperly skewer or affect their analysis of the statutory criteria in any material way. More to the point, and in any event, it was not an error to consider KHK's quality of life and her dignity in the context of the well-being criterion of the *Health Care Consent Act, 1996,* as I shall next explain.

[86] Quality of life is not a factor foreign to the *Health Care Consent Act, 1996*. In the Act, quality of life is expressly referred to as an aspect of the best interests criterion for: (a) consent to admission to a care facility; and (b) consent to a personal assistance service. These express references make sense because quality of life is a patently obvious relevant consideration when one is making a decision about living in a care facility or living at home with the assistance of a personal care worker.

[87] In contrast, quality of life is not specifically referred to in s. 21 of the *Health Care Consent Act, 1996* about consent to treatment. However, it does not follow that quality of life is excluded from a best interests analysis for the purpose of consent to treatment. The legislator would appreciate that quality of life is a case specific and not a general consideration where the issue is medical treatment.

[88] Many medical treatments are neutral to a patient's quality of life. In particular cases, however, a medical treatment may positively or negatively affect a patient's well-being precisely because the treatment enhances the quality of life (corrective eye surgery would be an example or a hip replacement would be another example) or the treatment diminishes the patient's quality of life (an amputation or a lobotomy would be examples). In cases in which a medical treatment did have quality of life consequences, a substitute decision-maker and the Board would not err in considering quality of life in its consideration of the best interests criteria.

[89] I agree with Justice Cullity's comments in *Scardoni v. Hawryluck*[21] a case where the court set aside the decision of the Board that the substitute decision-maker was not properly considering the best interests of the patient. In this case, Justice Cullity addressed the consideration of quality of life and stated:

> 46. […] Ms. Chan who submitted that matters that are to be considered relevant to the well-being of a patient were intended to be confined to those relating to her health. In her submission, the Board

[21] (2004), 69 O.R. (3d) 700 (S.C.J.).

> erred in law in taking into consideration evidence with respect to Mrs. Holland's quality of life and, particularly, that of the discomfort and indignity she had experienced in undergoing treatment in the intensive care unit and would experience again if she was returned there.
>
> 47. The phrase "quality of life" is used in other sections of the Act in connection with decisions with respect to an incapable person's best interests. It does not appear in the sections relating to consent to treatment. Whether or not the considerations on which the Board relied are aptly encapsulated by the phrase, I am satisfied that the Board's interpretation of the reference to the "well-being" of a patient is to be preferred to the more narrow definition that Ms. Chan urged me to accept.
>
> 48. The interpretation accepted by the Board is supported by dictionary definitions of wellbeing that refer to a person's state of happiness, contentment, and prosperity as well as good health: see for example, the *New Oxford Shorter Dictionary*; *Random House Unabridged Dictionary*; and *Nelson's Canadian Dictionary of the English Language*. Generally, the dictionaries treat the term as synonymous with "welfare". Similarly, in *Inland Revenue Commissioners v. Baddeley*, [1955] A.C. 572, [1955] 1 All E.R. 525 (H.L.), at p. 616 A.C., Lord Somervell of Harrow referred to a person's "wellbeing" as meaning "a happy or contented state".
>
> 49. Finally, in *Janzen v. Janzen* (2002), 44 E T.R. 217 (Ont. S.C.J.) in which the interpretation of s. 21(2) of the Act was considered in the context of competing applications for appointment as an incapable person's guardian of the person, Aitken J. stated:
>
> > Treatment in the form of a ventilator, medications and periodic heroic interventions as required might improve other medical conditions suffered by Mr. Janzen, such as pneumonia or kidney or heart failure; but according to the medical evidence it would not improve Mr. Jansen's quality of life. I consider the concept of "well-being" a very broad concept which encompasses many considerations, including quality of life. Many of the interventions contemplated as being necessary to prolong Mr. Janzen's life involve procedures that could be painful or uncomfortable for Mr. Janzen. Maria Janzen's Guardianship Plan focuses on keeping Mr. Janzen comfortable and pain free. I find that this focus will improve his overall well-being.
>
> 50. I accept that interpretation and find no error of law in the Board's conclusion on the meaning of "well-being" in the Act.

[90] In arguing that the Board erred, BH and DK rely on a paragraph in a judgment of Justice D.M. Brown in *Barbulov v. Cirone*,[22] where Justice Brown disagreed with the view of Justice Aitken in *Janzen v. Janzen*;[23] that quality of life was an aspect of the well-being analysis for the purposes of s. 21 (2) of the *Health Care Consent Act, 1996.*

[91] Relying on Justice Brown's comment in *Barbulov v. Cirone*, BH and DK submitted that the Board had erred in relying on *Janzen v. Janzen* to support a consideration of quality of life in the immediate case. Justice Brown's comment, however, requires a careful reading, and, in my opinion, his comment does not categorically exclude consideration of quality of life in an end of life case. Rather, *Barbulov v. Cirone* sensibly directs that care and caution must be taken in considering quality of life in end of life cases, a proposition with which I agree. In this regard, in *Barbulov v. Cirone*, Justice Brown stated:

> 87. In the course of its reasons the court in *Janzen* commented that the concept of "well-being" in section 21(2) of the *HCCA* was "a very broad concept which encompasses many considerations, including quality of life". With respect, I question whether that is so. The phrase "quality of life" does not occur in section 21 of the *HCCA*, whereas it is found in the Act's provisions dealing with

[22] [2009] O.J. No. 1439 at para. 87 (S.C.J.).
[23] [2002] O.J. No. 450 (S.C.J.).

> best interests criteria for the purposes of making decisions for incapable persons about the admission to care facilities (s. 42(2)) and personal assistance services (s. 59(2)). That the Legislature omitted the concept of "quality of life" from Part II of the *HCCA* dealing with "treatment" may very well signal that it was alive to the possible dangers associated with the use of that term, especially in the context of end-of-life treatment. Dignity attaches to a person from the beginning through to the end of his or her physical existence, irrespective of a person's ability to act on the various capacities he or she possesses as a human being. Dignity surrounds the unresponsive, dying person, just as it does the active one. To the extent that one equates the notion of "quality of life" with one's ability to pursue an "active life", one risks diminishing the innate dignity of those whose ability to act on their human capacities may be impaired through temporary illness, handicap, or the approach of death. A person at death's door possesses a dignity as robust and worthy of protection as the active one. The difference between a healthy, self-conscious human being and an incapacitated, or impaired, human being is not one of kind, but only one of degree. To fold the concept of "quality of life" into the statutory concept of "well-being" in section 21(2) of the *HCCA* risks losing sight of this innate dignity when considering the appropriateness of treatment plans at the end of life.

[92] To give *Barbulov v. Cirone* a careful reading, the first point to note is that in the result, Justice Brown dismissed an appeal of a Board decision in which the Board decided that the substitute decision-maker had not complied with the principles of a substitute decision-maker in a case where the treatment proposed was the withdrawal of life support for a patient who had no neurological functioning because of an irreparable brain injury.

[93] Giving *Barbulov v. Cirone* a careful reading, the second point to note is that Justice Brown's comment is an eloquent statement of the importance of considerations of human dignity in end of life cases, of which consideration I will have still more to say later in this judgment.

[94] The third point to note is that neither "quality of life," nor "dignity" are expressly mentioned aspects of a well-being analysis. The significance of this third point is that Justice Brown's reading-in dignity as an aspect of well-being analysis undermines BH's and DK's argument that a substitute decision-maker cannot consider factors other than the expressly mentioned factors when undertaking a best interests analysis.

[95] The fourth point to note is that by reading-in "dignity" Justice Brown was not treating "well-being" as an exclusionary, narrow concept.

[96] In the context of the immediate case, the fifth and last point to note about Justice Brown's comment in *Barbulov v. Cirone* is that quality of life was in any event a barren consideration in the immediate end of life case.

[97] Pathetically, in the immediate case, the evidence was that KHK is barely alive, is without neurological function, and is without any awareness of her own existence. She is without any prospect of awareness. She is constrained to a bed with invasive life-supporting measures, and with a high likelihood of more physiological decline. With respect to both the withdrawal of life support proposed by the Hospital for Sick Children and also the continuation of the *status quo* treatment proposed by BH and DK, the Board did not err in comments about the already non-existent quality of life brought about by KHK's tragic drowning.

[98] The Board also did not err in its consideration of dignity as an aspect of the well-being and best interests analysis. In this regard, Justice Brown's comments in *Barbulov v. Cirone* about dignity support the reasoning and the conclusion of the Board.

[99] Thus, I disagree with BH's and DK's categorical argument that considerations of "quality of life" and "dignity" can play no part in a substitute decision-maker's consideration of best

interests because the *Health Care Consent Act, 1996* requires an objective assessment of best interests.

[100] I disagree because while quality of life and dignity may sometimes have elements of relativity and subjectiveness, in appropriate cases, these factors can be assessed objectively under the *Health Care Consent Act, 1996* just as much as "well-being," which is an expressly mentioned factor, can and must be assessed objectively.

[101] Objectivity can be achieved by separating death, which is the end of life, with dying which is an inevitable part of being alive. Being alive begins with birth and ends with death. In between birth and death, dying is an aspect of being alive. As the Board appreciated in its decision *Re EJG,* dying is an inevitable part of life that ends with death and the manner of dying is an aspect of a person's well-being. Justice Brown appreciated these truths with his opening paragraph in *Barbulov v. Cirone,*[24] where he stated:

> 1. Death, for some, is an end; death, for others, is a beginning; death, for all, is the unavoidable outcome of birth, the natural completion of life. Medical treatment and technology can remedy some illnesses one encounters along life's path, but medical treatment cannot alter the inevitability of death. The past half century has seen, however, significant developments in the ability of medical technology to prolong existence, delay death, and create conditions where the final phases of life risk becoming overly medicalized. Consequently, as a person advances closer towards death, issues arise about what medical assistance should be administered. The Ontario *Health Care Consent Act, 1996*, S.O. 1996, c. 2, represents an effort by the Legislature to create a framework for addressing these issues.

[102] Thus, in accordance with the principles of the *Health Care Consent Act, 1996,* the treatment of the withdrawal of life support for the approach of an inevitable death that has been hastened by a tragic event can be, and in the immediate case is, objectively in KHK's best interests. The Board made no error in its decision in the immediate case.

K. Conclusion

[103] For the above reasons, I dismiss the appeal with the automatic stay to be lifted seven days after the release of these Reasons for Decision to allow BH and DK to prepare for the death of their child.

Perell, J.

Released: November 2, 2021

[24] [2002] O.J. No. 450 at para. 1 (S.C.J.)

CITATION: DK v. Gilfoyle, 2021 ONSC 7248
COURT FILE NO.: CV-21-668875
DATE: 20211102

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

DK

Appellant

- and -

DR. ELAINE GILFOYLE, BH, and KHK

Respondents

AND BETWEEN:

BH

Appellant

- and –

DR. ELAINE GILFOYLE, DK and KHK

Respondents

REASONS FOR DECISION

PERELL J.

Released: November 2, 2021