COURT OF APPEAL FOR BRITISH COLUMBIA

Citation: *Kemp v. Vancouver Coastal Health Authority Ltd.* ,
2017 BCCA 229

Date: 20170613
Dockets: CA43033; CA43045

Docket: CA43033

Between:

Brenlee Kemp on her own behalf and as Executrix of the Estate of Shannon Jean Kemp, deceased

Appellant
(Plaintiff)

And

Vancouver Coastal Health Authority Ltd., dba Vancouver General Hospital, Riyad B. Abu-Laban, David Sweet, Steven Sutcliffe, Dean Chittock

Respondents
(Defendants)

- and -

Docket: CA43045

Between:

Brenlee Kemp on her own behalf and as Executrix of the Estate of Shannon Jean Kemp, deceased

Respondent
(Plaintiff)

And

David Sweet

Appellant
(Defendant)

And

Vancouver Coastal Health Authority Ltd., dba Vancouver General Hospital, Riyad B. Abu-Laban, David G. Brough, Larry Dian, Tania E. Fitzpatrick, Ruth I. Schmalz, Steven K. Wong, Steven Sutcliffe, Dean Chittock

(Defendants)

Before: The Honourable Madam Justice Newbury
The Honourable Madam Justice D. Smith
The Honourable Mr. Justice Willcock

On appeal from: An order of the Supreme Court of British Columbia, dated July 29, 2015 (*Kemp v. Vancouver Coastal Health Authority*, 2015 BCSC 1319, New Westminster Registry Docket S120608).

Brenlee Kemp on Her Own Behalf and as Executrix of the Estate of Shannon Jean Kemp, Deceased:	B. Kemp
Counsel for Dr. Abu-Laban, Dr. Sweet, Dr. Sutcliffe and Dr. Chittock:	M.G. Thomas A. Atkinson
Counsel for the Vancouver Coastal Health Authority:	E.J.A. Stanger
Place and Date of Hearing:	Vancouver, British Columbia April 3, 2017
Written Submissions on Application for Re-Hearing Received:	June 2, 2017
Place and Date of Judgment:	Vancouver, British Columbia June 13, 2017

Written Reasons by:
The Honourable Madam Justice Newbury

Concurred in by:
The Honourable Madam Justice D. Smith
The Honourable Mr. Justice Willcock

Summary

Plaintiff, as executrix of her mother's estate, made claims in negligence and battery against hospital, staff, and physicians in relation to mother's death in emergency department following failed resuscitation attempt, and in relation to previous hospital visit. Plaintiff also claimed for own nervous shock. Hospital and four physicians involved in emergency care applied for summary dismissal.

Trial judge decided case against these defendants was suitable for summary trial. She dismissed negligence claims against hospital and four hospital doctors, but ruled claim in battery against Dr. S., the doctor who tried resuscitation (related to whether patient was "full code"), should go to full trial. Plaintiff appealed summary dismissals; Dr. S. appealed order directing that battery claim should proceed to trial.

Held: plaintiff's appeal dismissed; Dr. S.'s appeal allowed. Regarding plaintiff's appeal, judge did not err in Rule 9-7 analysis. No palpable and overriding errors of fact shown. Judge was entitled to decide which evidence she preferred. "Fresh evidence" plaintiff sought to adduce, in form of a fourth letter of opinion from expert and various other documents, did not meet Palmer *criteria. Regarding Dr. S.'s appeal, evidence demonstrated he had implied consent, and perhaps express consent, to make efforts he did at resuscitation. Consequently, Dr. S. could not have committed battery and plaintiff could not advance nervous shock claim based on that tort. Further, because judge accepted that none of the defendant doctors had caused or contributed to death of mother, judge was bound to dismiss plaintiff's claim under* Family Compensation Act *based on battery.*

Application to 're-open' appeal was also dismissed.

Reasons for Judgment of the Honourable Madam Justice Newbury:

[1] In the first of these two appeals (CA43033), the plaintiff Brenlee Kemp appeals the dismissal of all but one aspect of her claims against Vancouver General Hospital (operated by the defendant health authority) and four doctors who were on duty at VGH on the afternoon of June 28, 2007. Ms. Kemp's claim was for battery and for negligence in the defendants' care and treatment of her mother, (Mrs.) Shannon Kemp, who died in the Emergency Department on that day when resuscitation efforts failed. No single cause of death has been conclusively identified. Mrs. Kemp was 88 years old.

[2] The plaintiff sued as her mother's executrix, alleging her mother had received negligent care. The plaintiff also sued on her own behalf, seeking damages for the

infliction of nervous shock she suffered when she saw her mother immediately after her death. The defendant physicians had been led to believe the case was 'full code' – i.e., if the patient was apparently near death, full efforts were to be made to resuscitate her. Such efforts were made, and the daughter alleged that to her shock, her mother had been intubated; was bruised; and had a broken nose, dislocated jaw and cut lip. The plaintiff believes that her mother was fully conscious of, and suffered terribly as a result of, the tube being forced down her throat. According to her psychologist, the plaintiff feels extreme guilt and suffered trauma amounting to PTSD from the memory of what she saw.

[3] In addition to the four doctors on duty at VGH on June 28, 2007, the plaintiff sued various other doctors who had treated Shannon Kemp in the months leading up to her death. The respondents on this appeal applied in 2011 for summary judgment dismissing the action as against them only. This application succeeded, except with respect to the claim of battery (based on an allegation of lack of consent to treatment) asserted against the defendant Dr. Sweet. His challenge to that aspect of the trial judge's order forms the basis of the second appeal (CA43045). The claims against the remaining defendants are still to be tried.

The Litigation History

[4] The procedural history of Ms. Kemp's action is important to one of the main issues on the first appeal, namely whether a summary trial was appropriate. It is a striking fact that seven years elapsed between Shannon Kemp's death and the start of the summary trial which resulted in the order under appeal. As the (summary) trial judge, Madam Justice Arnold-Bailey, recounted at para. 9 of her reasons, the plaintiff had encountered considerable difficulty in retaining a lawyer. Once Mr. Alan Ross was retained, there were various attempts to amend her pleadings, which occupied much court time and increased costs of counsel. An application for summary trial was first scheduled for July 12, 2011 but had to be adjourned; a second summary trial scheduled for September 7, 2011 was adjourned; a full trial (with jury) scheduled for February 13, 2012 was adjourned; a third summary trial

was scheduled for October 16, 2012 and had to be adjourned; a fourth was scheduled for February 18, 2013 and had to be adjourned; a fifth was scheduled for July 10, 2013 and a sixth for November 18, 2013, but both had to be adjourned.

[5] Ms. Kemp filed an Amended Notice of Civil Claim ("NOCC") on December 23, 2013. A second full trial was then scheduled for March 3, 2014 but was adjourned, as was the seventh summary trial scheduled for May 29, 2014. The defendants state in their factums that Ms. Kemp sought or caused the adjournment of the first, second, third, fifth, sixth and seventh summary trials.

[6] The eighth summary trial commenced on the scheduled date of July 22, 2014, but the plaintiff did not complete her submissions in the three days allotted. On July 24, 2014, the summary trial was adjourned to January 28, 2015 for three additional days. At that time, Ms. Kemp was permitted to adduce additional evidence. The trial continued on January 28; on the 29th, the plaintiff sought to file a second amended NOCC, but was unsuccessful. The trial completed on January 30, 2015.

[7] On July 29, 2015, the summary trial judge below issued lengthy and detailed reasons, indexed as 2015 BCSC 1319.

[8] Mr. Ross filed the plaintiff's notice of appeal on August 21, but ceased acting on June 1, 2016. Ms. Kemp was diagnosed with a serious illness in August 2016 and underwent treatment over the late months of that year. The hearing of the appeal was therefore adjourned twice at her request; but finally, a judge in chambers in this court ordered peremptorily that the appeal was to be heard on April 3, 2017.

[9] On the last day of the week prior to the scheduled appeal, Ms. Kemp applied for another adjournment but I, as the chambers judge, dismissed that application. Ms. Kemp purported to renew her application in a different form at the start of the appeal hearing, but again it was not granted. Although Ms. Kemp was appearing on her own behalf, she had filed her factum and reply factum, both of which had been prepared and signed by Mr. Ross as counsel. We proceeded with the appeal despite her protestations that she needed more time than the day allotted.

[10] Among other things, Ms. Kemp sought at the hearing to introduce as fresh evidence the Second Amended NOCC she had sought to file late in the trial, and a report by Dr. A. Lawson ("Lawson #4") dated July 27, 2015 opining on the cause of death of her mother. (One report of Dr. Lawson, #1, was already in evidence at trial; the trial judge ruled #2 and #3 inadmissible.) In accordance with our usual practice, we reserved judgment on the admissibility of these items, not all of which were "fresh evidence" or even "evidence" in any event.

Application to Re-Open

[11] Finally, after the appeal had been heard and judgment reserved, Ms. Kemp was able to retain another lawyer, Mr. Dickson. He wrote to the Court on April 6, 2017 requesting that the appeal be re-opened in order to avoid a miscarriage of justice. We requested more specific information regarding the nature of the argument in support of a re-opening.

[12] By memorandum filed June 2, 2017, Mr. Dickson submitted that the appeal should be re-opened so that he could make argument addressing what he sees as the central issues in these appeals, namely:

> a. Whether the July 22, 2015 report of Dr. Lawson [referred to in these reasons as "Lawson #4"] should be admitted as fresh evidence; and
>
> b. Whether the chambers judge [sic] erred in summarily dismissing most of the claims against the Respondents.

He emphasized that this court is often the one of last resort in the province, and wrote:

> While this Court has considerable experience in hearing from unrepresented parties, the nature of these appeals requires detailed oral submissions. This is because a key issue in these appeals is whether the matters dismissed by the chambers judge were suitable for summary trial proceedings. That issue turns, to a considerable degree, on a detailed understanding of the evidentiary record before the chambers judge and knowledge of the law of negligence and battery, and the legal framework for determining the suitability of summary trial procedures for adjudication of these issues. In sum, it is complicated ground for counsel to traverse, let alone a lay litigant in the Appellant's circumstances.

[13] With respect to the admission of Lawson #4, I have dealt with that at the end of these reasons under the rubric of Ms. Kemp's application to have that evidence admitted as fresh evidence. (See paras. 89–95 below.)

[14] With respect to Mr. Dickson's more general argument that the trial judge erred in deciding almost all aspects of the case before her summarily, counsel contends that Ms. Kemp was simply unable to present adequate oral argument in support of her appeal at the hearing on April 3, 2017. He notes that the summary trial judge determined there was "no reliable evidence adduced by the appellant regarding various issues on which there was conflicting evidence" – including for example on whether the defendant doctors had breached their standard of care "by administering certain treatments and whether the resuscitation techniques had caused Shannon Kemp's death." This does not mean the Court did not consider the evidence proffered by the plaintiff, but that the Court did not find it to be reliable or cogent.

[15] The arguments advanced in Mr. Dickson's memorandum simply restate arguments that were made by Ms. Kemp either in her factum (prepared by her earlier lawyer) or in her oral submissions at the hearing of the appeal. Although not represented at the hearing, Ms. Kemp showed herself to be intelligent and articulate. As far as the trial judgment is concerned, it is clear the court below focused on the questions of standard of care and causation (as stated in para. 110 of the judge's reasons). As she also noted, however, the onus of proof was on Ms. Kemp to "adduce expert evidence with regards to the alleged negligent acts or omissions causing or materially contributing to her mother's death." She proceeded to carry out a "rigorous analysis" – 115 pages – of all the evidence before her, and as will be seen, made detailed findings of fact and law. With respect to the events of June 28, 2007, she carefully reviewed all the evidence before her, including that of the plaintiff's experts.

[16] I will deal with the trial judge's analysis at greater length below, but at this point I will say I am not satisfied Mr. Dickson has shown the "exceptional

circumstances of a compelling case in law", or that the trial judge "overlooked or misapprehended evidence" such that the extraordinary step of re-opening the appeal is merited: see this court's recent decision in *Turkson v. TD Direct Investing, a Division of TD Waterhouse Canada Ltd.* 2017 BCCA 213 at paras. 5–7. With the exception of the new suggestion that Mrs. Kemp's death was caused by an abdominal injury inflicted in the course of the resuscitation attempt (as to which see paras. 89-95 below), Ms. Kemp touched on all the points at the hearing of the appeal that Mr. Dickson now seeks to elaborate upon; those points were fully considered by the court below; and are considered anew in these reasons.

[17] Being satisfied that no miscarriage of justice would ensue, I would dismiss the application to re-open this appeal.

The Summary Trial Judge's Reasons

[18] Given the length and detail of the summary trial judge's reasons, I will not even attempt to recount all the facts she found or her detailed analysis of the plaintiff's claims. Instead, I will concentrate on those issues or groups of issues that are most important to the appeal, beginning with whether a summary trial was appropriate.

[19] Arnold-Bailey J. began her reasons by explaining some of the difficulties encountered at trial with evidentiary matters. She noted that the plaintiff had raised various objections to evidence relied on by the defendants, which objections were not timely and were made in a "piecemeal" fashion. In order to avoid yet another adjournment of the trial, the Court had directed counsel for the plaintiff to prepare written submissions setting out his objections to the evidence before the Court; counsel for the defendants to prepare written responses; and the plaintiff then to file further responses. The Court read and considered these submissions and directed that a binder be prepared and marked for identification, containing clean copies of the submissions. (At para. 18.)

[20] The Court then set out the bases on which various items would be admissible and the purposes for which they would be admitted. In the judge's words:

> Insofar as counsel for the Plaintiff objected to the admissibility of certain factual underpinnings for expert reports relied upon by the VCHA or the Defendant Physicians, the Plaintiff, her previous counsel acting as agent and her present counsel had the majority of those opinions for a considerable time and did not previously voice any objection to them. With the exception of the Seymour Medical Clinic records, generally speaking, the factual basis for the opinions expressed by experts is in evidence. The ultimate weight to be attached to such opinions is a matter for the Court.
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> The Plaintiff's materials also fall prey to having objections raised about certain of their contents, particularly with regards to hearsay and opinion evidence. However, I decline to redact portions of her affidavits or exclude them. Rather, where the Plaintiff provided potentially inadmissible opinion evidence (not being a physician or a medical specialist), the Court has regarded it as evidence of the Plaintiff's observations and as part of the narrative she places before the Court, as opposed to accepting her opinions on medical matters as evidence admissible for their truth. I also note that the Plaintiff's objections to certain facts as referred to in the expert opinions relied upon by the defendants being unproven is somewhat specious, as the Plaintiff herself at many places in her affidavits provides details about her mother's prior health and medical conditions as she perceived them, as do the experts upon whose opinions she relies upon to defend against these applications, namely Ms. Rohrback and Dr. Lawson.
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> It is my overall view that the objections raised by the Plaintiff to the evidence tendered by the VCHA and the Defendant Physicians, are not valid and are without merit. I accept counsels' submissions on behalf of the VCHA and the Defendant Physicians with regards to the Plaintiff's objections. [At paras. 19–21.]

[21] The judge noted that the records of VGH with respect to Mrs. Kemp were admissible by agreement between the parties. She rejected the plaintiff's submission that the defendant physicians, none of whom had any independent recollection of having treated Mrs. Kemp, should not be permitted to rely on their notes contained in the hospital records. (At para. 26.) In particular, the judge noted that Dr. Abu-Laban had made his notes contemporaneously with his treatment of Mrs. Kemp, and had had an obligation to make such notes. The judge ruled:

> To the extent that Dr. Abu-Laban and other physicians who swore affidavits in these applications had no memory of treating Shannon Kemp and had to rely on records made contemporaneously or immediately after the fact, such that their evidence amounted to past recollection recorded, I am satisfied that their evidence meets the criteria for admissibility referred to in *R. v. Meddoui*

> (1990), 61 C.C.C. (3d) 345 at 352, (Alta. C.A.); and *R. v. R.(J.)*, [2003] O.J. No. 3215 (Ont. C.A.). [At para. 28; emphasis added.]

[22] The Court summarized the plaintiff's evidence, beginning at para. 31. Several affidavits of Ms. Kemp were before the Court but her Affidavit #10, sworn May 23, 2014, was the most detailed: see paras. 33–50. Further evidence from the plaintiff was summarized in Affidavit #7 (see para. 53) and in Supplementary Affidavit #12, sworn July 18, 2014, summarized at para. 54. The plaintiff had filed expert opinion reports from Dr. Grant Stiver; Dr. Williard Johnston; Dr. Lawson; Dr. Robert Ley (the plaintiff's psychiatrist); and Ms. Rohrback, a nurse. The judge noted at para. 57 that all the admissible evidence would be considered not only on the claims before the Court, but also in the determination of whether the matter should proceed by summary trial.

Summary Trial Ruling

[23] After recounting the parties' respective positions concerning the suitability of a summary trial, the judge reviewed the relevant law, noting in particular that:

> … in this day and age the court must engage in very close scrutiny of the nature of the conflicts in evidence and/or the alleged inter-linking of issues to do justice, as the court is to pay heed to the interests of all parties, including those who seek judgment by way of summary trial. The object of the *Rules* as stated at Rule 1-3(1) is "to secure the just, speedy and inexpensive determination of every proceeding on its merits." To secure such an object, according to Rule 1-3(2), proceedings must be conducted in ways "so far as is practicable … that are proportionate to (a) the amount involved in the proceeding, (b) the importance of the issues in dispute, and (c) the complexity of the proceeding." [At para. 80.]

[24] The judge referred to *Gichuru v. Pallai* 2013 BCCA 60, in which D. Smith J.A. for this court noted the factors identified by Chief Justice McEachern in the seminal decision of *Inspiration Management Ltd. v. McDermid St. Lawrence Ltd.* (1989) 36 B.C.L.R. (2d) 202 (C.A.). These factors included the amount involved, the complexity of the matter, its urgency, any prejudice likely to arise due to delay, the cost of going to trial in relation to the amount involved, and the course of the proceeding. Smith J.A. continued in *Gichuru*:

> To this list [have] been added other factors including the cost of the litigation and the time of the summary trial, whether credibility is a critical factor in the determination of the dispute, whether the summary trial may create an unnecessary complexity in the resolution of the dispute, and whether the application would result in litigating in slices: *Dahl v. Royal Bank of Canada et al.,* 2005 BCSC 1263 at para. 12, upheld on appeal at 2006 BCCA 369. [At para. 31, quoted at para. 76 of the trial judge's reasons.]

[25] The judge also noted the comments of the Supreme Court of Canada in the more recent case of *Hryniak v. Maudlin* 2014 SCC 7, decided on an appeal from Ontario. Speaking for the Court, Karakatsanis J. stated:

> Ensuring access to justice is the greatest challenge to the rule of law in Canada today. Trials have become increasingly expensive and protracted. Most Canadians cannot afford to sue when they are wronged or defend themselves when they are sued, and cannot afford to go to trial. Without an effective and accessible means of enforcing rights, the rule of law is threatened. Without public adjudication of civil cases, the development of the common law is stunted.
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> Increasingly, there is recognition that a culture shift is required in order to create an environment promoting timely and affordable access to the civil justice system. This shift entails simplifying pre-trial procedures and moving the emphasis away from the conventional trial in favour of proportional procedures tailored to the needs of the particular case. The balance between procedure and access struck by our justice system must come to reflect modern reality and recognize that new models of adjudication can be fair and just.
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> Summary judgment motions provide one such opportunity […]
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> In interpreting these provisions, the Ontario Court of Appeal placed too high a premium on the "full appreciation" of evidence that can be gained at a conventional trial, given that such a trial is not a realistic alternative for most litigants. In my view, a trial is not required if a summary judgment motion can achieve a fair and just adjudication, if it provides a process that allows the judge to make the necessary findings of fact, apply the law to those facts, and is a proportionate, more expeditious and less expensive means to achieve a just result than going to trial.
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> To that end, I conclude that summary judgment rules must be interpreted broadly, favouring proportionality and fair access to the affordable, timely and just adjudication of claims. [At paras. 1–5, quoted at para. 81 of the trial judgment.]

[26] At the same time, the judge observed that in British Columbia, it is accepted that deciding certain issues by summary trial in a larger action can hinder a "just, speedy and inexpensive determination" of a dispute on its merits. One undesirable effect of 'litigating in slices', she noted, may be that the claims against certain

defendants in a lawsuit are dismissed summarily, leaving the remaining defendant or defendants with the option of shifting liability to those former defendants who are no longer at risk: see *Thompson v. Kootenay Lake District Hospital and Health Services Society* (1985) 68 B.C.L.R. 142 (S.C.) at 143–4.

[27] The judge acknowledged that a "head-on" conflict in the evidence that goes to the core issue in the action will generally constitute an impediment to disposition of an action by summary trial: see *Bell v. Levy* 2011 BCCA 417 at para. 64. On the other hand, she said:

> … where one party asserts an absence of evidence on a key ingredient of the claim and the judge on summary trial agrees, the issue may well be amenable to adjudication in this manner, despite the opposing party voicing its disagreement as to the meaning or significance of the presence or absence of such evidence. In such instances, it may not properly be said that there is clear conflict in the evidence going to a core issue: *Bell* at paras. 86–87.
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> Some multi-issue cases have been found to be appropriate for summary trial because they involve an adjudication upon the clear legal requirements of the cause of action for which evidence is required, or although some issues are linked or inter-related, the determination of a primary or fundamental issue serves to completely or substantially resolve the law suit.
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> An example of the former arises in *Shannahan*, a medical negligence case, where the plaintiff failed to produce evidence regarding standard of care and causation, two of the requirements for a finding of negligence. As a result, his case against several hospitals and a number of doctors was dismissed by way of a summary trial.
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> An example of the latter may be found in *KCC 264 Holdings Inc. v. Circadian (Atkins 2010) GP Ltd.*, 2014 BCSC 1183, where, at para. 31, Maisonville J. determined that she was able on the evidence before her to decide the issue of fundamental breach of contract in the negative, which resolved other matters at issue such that any problem of "litigating in slices" disappeared. [At paras. 86–9.]

[28] The judge accepted that in deciding whether the interests of justice may be served by a summary trial, courts must be cognizant of the cost of proceeding to trial "both in terms of time and money, proportionate to the amount at issue in the litigation." This was recognized in *Hyrniak* at para. 60, where "proportionality, timeliness and affordability" were said to be relevant. In all the circumstances, she concluded:

> … this is a case where the interests of justice are served by a [full] assessment of the claims made by the Plaintiff against the four Defendant Physicians and the VCHA in summary trial proceedings as long as the assessment is informed and guided by the legal parameters set out above. The trial in this action, which at present will continue in any event in relation to the five physicians not involved in the present applications, will be a considerably more focused, fair and cost effective one if claims without any realistic prospect of success based on a lack of evidence may be pruned away. This is particularly so given the scope of the action, which names ten physicians (including one M. Doe) as defendants, and spans a time frame of approximately nine months when there were many physicians involved in Shannon Kemp's care (not all of whom have been sued), and during which Shannon Kemp underwent two hospital admissions at VGH and one at UBC Hospital.
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> For these reasons, the Court finds that it is necessary to undertake a rigorous analysis of the claims advanced by the Plaintiff that are challenged by the VCHA and the Defendant Physicians in their summary trial applications, while fully appreciating that there are still a number of issues against other defendants that may well proceed to trial. Therefore, the Plaintiff's application pursuant to Rule 9-7(11) that this action is not suitable for determination by way of summary trial is dismissed. [At paras. 106-7; emphasis added.]

The Causes of Action

[29] The trial judge began her analysis of the case in negligence advanced by the plaintiff, beginning at para. 108 of her reasons. Again, I will only summarize. She rehearsed the general principles of negligence law regarding the onus of proof, standard of care, and causation. The plaintiff does not challenge her analysis of the law in this regard.

[30] With respect to battery, the judge noted that Ms. Kemp had alleged this tort was committed on Mrs. Kemp when Drs. Sweet, Sutcliffe, Chittock and "M. Doe" had performed chest compressions, intubation, and the administration of medications and other treatments in the course of trying to resuscitate her. It was also alleged that Dr. Abu-Laban had administered antibiotic medications to the patient without consent. (At para. 122.)

[31] A patient's consent, of course, constitutes a full defence to conduct that might otherwise constitute battery, as Arnold-Bailey J. explained at paras. 123–6. She also pointed out that as a "personal tort", battery does not survive the death of the

battered person. (At para. 128.) Thus the plaintiff could not advance a claim for battery at common law on her mother's behalf. However, s. 2 of the *Family Compensation Act,* R.S.B.C. 1996, c. 126 permits liability to be imposed where the death of a person has been caused by negligence and the negligent actor would have been liable if death had not resulted. The judge stated:

> The Plaintiff's claims for the torts of battery of her mother she alleges in relation to the VCHA and the Defendant Physicians may only be advanced by the operation of s. 2 of the *FCA*, if she is able to prove that the batteries (allegedly committed during the November 2006 re-catheterization and during the June 2007 treatment and resuscitation efforts) were wrongful acts that caused Shannon Kemp's death. Without proof that the alleged battery caused Shannon Kemp's death, these aspects of the Plaintiff's claim are not actionable at law.
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> Similarly, the Plaintiff may not advance claims on behalf of her mother for aggravated or punitive damages: *Glenn v. Seair Seaplanes Ltd.*, 2012 BCSC 1726 at paras. 10–11.
>
> Therefore, for the Plaintiff's claims in battery, she must prove that the various acts were performed by nursing staff or attending physicians without consent, and that the said wrongful act caused her mother's death. [At paras. 129–31; emphasis added.]

[32] The judge noted that the plaintiff's own claim for damages for nervous shock rested on a finding of negligence, citing this court's decision in *Devji v. Burnaby (District)* 1999 BCCA 599, *lve. to app. dism'd* [1999] S.C.C.A. No. 608, and the Supreme Court of Canada's decision in *Mustapha v. Culligan of Canada Ltd.* 2008 SCC 27 at paras. 8–9.

The Case against the Hospital

[33] The trial judge turned to examine the case against the defendant health authority, focusing on various categories of allegations made by the plaintiff. The first category related to the hospital's treatment of her mother when she had been hospitalized in November 2006. The Court found that these allegations, including that Mrs. Kemp had been re-catheterized without her consent, were without merit: see paras. 165–8.

[34] With respect to Shannon Kemp's admission to the VGH Emergency Department on June 28, 2007, the judge embarked on an examination of each of the particulars stated in the NOCC, beginning with the assertion that hospital staff had not delivered to the responsible physician a letter prepared on June 28, 2007 by Dr. Wong (the internist who sent the two women to Emergency that day) and addressed to Dr. Campana, a doctor at VGH. The trial judge described the letter thus:

> Dr. Wong's letter, dated June 28, 2007, was addressed as "Dear Bruce" in reference to Dr. Bruce Campana. Dr. Wong enclosed notes from his clinic from the previous month or so. In the letter, he makes reference to Shannon Kemp previously having been a high functioning woman with chronic Atrial Fibrillation ("AF") and her prior left hip surgery at VGH the preceding year. He also described Shannon Kemp being followed for MRSA cellulitis, which improved with medications, but that she reacted to various drugs with nausea and vomiting. She had also previously been given high diuretics that had resulted in renal failure. Dr. Wong described Shannon Kemp on June 28 as "a bit confused and dizzy but remains alert and oriented to person." He stated "I can't measure a BP [blood pressure] and can barely palpate a pulse. HR [heart rate] is around 100 in AF. The leg is improved without edema." He then provided information about which medications had been stopped and which ones Shannon Kemp continued to take. He then concludes the letter:
>
> > She obviously needs to stop the BP-active meds but is sufficiently volume deplete that I don't think we can manage her outside any more. I've finally convinced them to go to ER.
> >
> > I have discussed code status outlining poor prognosis in the event of arrest however her daughter is reluctant for a no code status. [At para. 171; emphasis added.]

(I note parenthetically that this letter does not sit comfortably with the plaintiff's statement to us that Dr. Wong had assured her on June 28 that her mother was not seriously ill and that she would be home and comfortable by the end of the day.)

[35] Dr. Abu-Laban, the Emergency physician who first saw Shannon Kemp, deposed that he did not recall whether he had seen Dr. Wong's letter, although it was present among the other hospital records pertaining to Mrs. Kemp, along with the clinical notes that accompanied the letter. It was not possible to say whether any of the defendant physicians had seen or read the letter but, the judge observed, there was "no evidence that the presence or absence of this letter … had any effect

on the treatment provided by the responsible physician, Dr. Abu-Laban". (At para. 173.) In her analysis:

> … there is no evidence of negligence on behalf of the VCHA, either with regard to standard of care or causation, from an alleged failure to deliver this letter with enclosures to the physician in the VGH Emergency responsible to treat Shannon Kemp, and no evidence that any alleged failure to deliver the letter negatively impacted the care provided to Shannon Kemp. [At para. 174.]

[36] As for the allegation that hospital staff had failed to triage Shannon Kemp properly, resulting in a "lengthy delay" in treatment, the Court made detailed findings as to the timing of treatment given to Mrs. Kemp in light of the opinion evidence of Ms. Rohrback, a registered nurse. The judge rejected Ms. Rohrback's opinion that both the hospital and the triage nurse had failed to meet the standards of care expected of them in caring for Mrs. Kemp. In particular, the judge rejected Ms. Rohrback's reliance on the Canadian Emergency Department Triage and Acuity Scale ("CTAS"). In the judge's analysis:

> There is no reference by Ms. Rohrback to any real-world implementation of the CTAS guidelines in a hospital setting. She does not say that another hospital similarly-situated to VGH meets these guidelines as a general standard of care. I also note that in the response affidavit of Lori Korchinski (Affidavit #1 sworn July 18, 2014), the current nursing manager of the VGH Emergency department, she attaches a copy of the current CTAS guidelines as updated since 1999. The CTAS guidelines themselves state at p. 2, "The time responses are ideals (objectives) not established care standards."
>
> I also note that counsel for the VCHA has provided authority that CTAS guidelines have been rejected as evidence of the standard of expected care by a triage Emergency nurse: *Hasselsjo v. St. Joseph's Hospital,* 2010 ONSC 800 at paras. 5–9, 51. [At paras. 184–5.; emphasis added]

[37] The Court did accept that Dr. Abu-Laban had seen Mrs. Kemp at 1340 hours, after she had presented in Emergency at 1308 hours and had been assessed and had her vital signs taken by the triage nurse at 1310 hours. Even if Dr. Abu-Laban's notes were incorrect and he had not seen Mrs. Kemp until 1400 hours, the Court continued, there was no evidence that "delay in triage prior to Shannon Kemp's seeing a physician had any effect on her further decline or her demise. Steps were taken to begin hydrating Shannon Kemp with a saline IV immediately upon Dr. Abu-

Laban giving the orders to do so and, even so, her blood pressure continued to fall." (At para. 187.)

[38] The primary evidence relied on at trial by the plaintiff was a report (#1) of Dr. Lawson, an emergency medicine specialist resident in California, dated May 21, 2014. (As already noted, two "addenda" were excluded from evidence at trial given their lateness.) Dr. Lawson was critical of the care given by the Emergency physicians in "not attending to the patient's hypothermia by warming her"; in not ensuring that she was given "supplement oxygen"; in failing to apprise themselves of material changes in her condition; and in failing to ensure "proper continuous monitoring of the patient's vital signs, including cardiac monitoring and oxygen saturation levels." As well, Dr. Lawson opined that the intensive care physicians called in by Dr. Abu-Laban for consultation fell below the appropriate standard by "initiating treatment without first assessing the patient's status"; by "performing chest compressions on a conscious patient"; by intubating her when she was "conscious and resisting" and without sedating her; and by "ordering 2 grams of Versed, a critically high dose." Dr. Lawson's report ended with the general conclusion that "breaches of the standard of care were the cause of the death of Mrs. Kemp. Further, in my opinion, Mrs. Kemp would not have suffered and died but for those breaches of care." (At para. 193.) For purposes of this appeal, I note that no mention was made of any abdominal injury to Mrs. Kemp.

[39] The judge characterized Dr. Lawson's report as a "non-specific, omnibus-type opinion" that was "conclusory" and based on "speculative facts". He had failed to address the manner of triage or the impact of any alleged delays in triage, nor did he differentiate between the various alleged breaches of care by physicians and triage or Emergency nursing staff. As such, she said, the document did not assist the Court on the question of negligence on the hospital's part. With respect to delays in triage care, the judge made the findings I have already mentioned regarding the times at which Mrs. Kemp arrived at VGH, was first assessed by the triage nurse, and was first seen by Dr. Abu-Laban. He ordered that she be hydrated immediately with a saline IV. An ECG was done at 1413 hours, also in accordance with his orders, by

which time the patient had been placed in a treatment bed. The judge found no evidence that any delay or failure to assess her condition had contributed to or caused her death or that if an earlier ECG had been carried out, it would have resulted in different treatment and a different outcome. (At paras. 188, 190.)

[40] Finally on the issue of delays in triage and initial treatment, the trial judge accepted the expert evidence of Dr. Skinnider, an internal medicine specialist, to the effect that when Mrs. Kemp had presented in Emergency, no clinical features had been recorded to suggest an acute critical illness that required immediate intervention. (At para. 195.) Further, Dr. Skinnider wrote:

> There is no indication that had Mrs. Shannon Kemp been seen any earlier than she was, that if the fluids and IV clindamycin had been given any earlier, that she would have been more likely to have survived. She had been at least one hour into rehydration therapy when she suddenly deteriorated so her fluid status was positive when compared to that on arrival. She had already been on outpatient doxycycline and rifampin as well as being given IV clindamycin at 14:40h, suggesting that she was more than adequately treated for sepsis. As mentioned in a previous opinion, the cause for her death is likely multifactorial with a large part played by her chronic medical state including known congestive heart failure with aoretic stenosis, bradycardia related to medications used to control her atrial fibriolation, renal insufficiency, and significant deconditioning. It is unlikely that any other intervention would have changed the outcome. [Emphasis added.]

The judge concluded on this point that:

> … there is no evidence of breach of an established standard of care with regards to either the nature of treatment provided or delay in treatment (as opposed to missing one 15-minute check as per the CTAS guidelines for Level 2), and also no cogent evidence that any of these alleged breaches contributed to or caused Shannon Kemp's death. [At para. 197.]

[41] Beginning at para. 208, the Court considered what had been done to monitor Mrs. Kemp's condition and to treat her as she deteriorated, then improved upon "extensive medical interventions" (para. 203), and then quickly deteriorated again. Contrary to the opinion of Ms. Rohrback and the plaintiff's allegations, the judge found:

> My finding with regards to the Plaintiff's allegation that the nursing staff, in particular Nurse Waugh, failed to monitor and document Shannon Kemp's urine output while she was being infused with saline, is that there is no

> evidence that nursing staff and attending physicians were not observing the level of the urine in the collection bag as the saline was being administered.
>
> More significantly, in terms of excess fluid collecting in Shannon Kemp's lungs as causing or contributing to her death, as alluded to by Ms. Rohrback, I find that the ultra sound at 1557 hours and the affidavit evidence of Dr. Sweet puts that allegation to rest. It is also worthy to note that Dr. Sweet, according to his notes made at 1608 hours, eight minutes after he called Shannon Kemp's death, indicated that he thought she had died from "a profound septic shock" but he was not sure, and that when he discussed the situation with her daughter (the Plaintiff), she was sure that she did not want an autopsy (Dr. Sweet Affidavit #1, Exhibit "B").
>
> Therefore, with regards to the alleged failure of VGH nursing staff to monitor or adequately monitor Shannon Kemp's vital signs, including her heart rate, oxygen saturation levels and urinary output, the evidence is that either they were monitored and the results were available as needed (including heart rate and urinary output) and, with regards to the period of time when oxygen saturation levels were not recorded, it is more consistent with the available evidence that they were not able to be recorded. [The monitor kept falling off Mrs. Kemp's finger.]
>
> In addition, there is no evidence supporting the over-arching claim that failure to monitor Shannon Kemp's vital signs at any time during her hospital admission to VGH Emergency on June 28, 2007 caused or contributed to her death. [At paras. 230–3; emphasis added.]

[42] With respect to the allegation that the hospital had administered excessive doses of Versed and Atropine to Mrs. Kemp in the course of resuscitating her, the Court found, again on the basis of detailed evidence, that the reference to 2 grams of Versed and 5 milligrams of Atropine had been typographical errors in Nurse Waugh's chart notes in that a decimal point had been omitted. Arnold-Bailey J. added:

> This is patently obvious given that it would have been noticeably cumbersome and virtually physically impossible to administer medications in these quantities (ten pre-packaged dosages of Atropine and 1000 times the usual 2 mg dose of Versed) to Shannon Kemp, or indeed any other patient in the VGH Emergency. [At para. 245.]

[43] The judge concluded that the plaintiff's case against the hospital, including its nursing staff, had not been proven, either in terms of breach of a standard of care or in terms of causation. It also followed that the plaintiff had no legal basis for her claim for damages for nervous shock as against them. (At para. 262.)

The Case against the Doctors

[44] The Court then considered the allegations made against Drs. Chittock, Sutcliffe, Abu-Laban and Sweet individually. Beginning with Dr. Chittock, Arnold-Bailey J. found that there was "simply no evidence that he provided any treatment or care to her". Rather, his role as the "consultant staff critical care physician" was to supervise trainee physicians, including Dr. Sweet. All claims against Dr. Chittock were dismissed.

[45] Dr. Sutcliffe was an internal medicine specialist with whom Dr. Abu-Laban requested a consultation. According to the hospital records, Dr. Sutcliffe reviewed Mrs. Kemp's case with a resident. They concurred she was "suffering from hypovolemic plus or minus septic shock" and was critically ill. (At para. 281.) Although Dr. Sutcliffe made a note that the intensive care unit was resuscitating Mrs. Kemp when he attended, he was not on that "team" and did not participate in the resuscitation. Dr. Sutcliffe later completed the discharge summary, stating the cause of death as "sepsis" and noting that at the plaintiff's request, there was to be "no autopsy". The trial judge concluded that since Dr. Sutcliffe had not been actively involved in Mrs. Kemp's care, there was no basis in law or fact to maintain an action in negligence or battery against him. The claims against him were dismissed. (At para. 285.)

[46] Dr. Abu-Laban is a specialist in emergency medicine who had no independent recollection of treating Mrs. Kemp. He relied on his notes to the hospital chart for purposes of his affidavit evidence and discovery. The judge set out the allegations pleaded against him at paras. 305 and 306, and appeared to accept counsel's summary of these claims as follows:

> Counsel for the Defendant Physicians summarized the claims against Dr. Abu-Laban as that he neglected to treat Shannon Kemp's hypotension in a sustained, focused and timely way; that he administered antibiotics when it was contraindicated and that he directed a blood draw which was not justified and further destabilized Shannon Kemp. [At para. 307.]

[47] The judge's many findings of fact concerning Dr. Abu-Laban's treatment of Mrs. Kemp are distributed throughout the reasons; and as the Court observed at para. 311, the plaintiff's "concerns" about Dr. Abu-Laban had been addressed to a considerable extent in the earlier discussion of Dr. Lawson's report and the allegations made against the hospital. Ms. Kemp takes issue with many of these findings on appeal, but the judge also made one central finding, repeated at various points in her reasons – that in any event, no causal connection was shown between any act or omission of Dr. Abu-Laban (or for that matter, any of the other defendants on this appeal) and Mrs. Kemp's death. With respect to Dr. Abu-Laban, the judge stated:

> In the context of any comments about Dr. Abu-Laban's conduct failing to meet a reasonable standard of care, I simply point out that in the event that the same were to be proven, which they are not, there is no evidence that anything Dr. Abu-Laban did or failed to do caused or contributed to the death of Shannon Kemp. To the contrary, Dr. Abu-Laban appears to have taken the necessary and appropriate steps to treat Shannon Kemp. This is apparent from the opinion of Dr. McFadyen, an expert relied upon by the Defendant Physicians. [At para. 311; emphasis added.]

[48] The judge reproduced lengthy passages from the report of Dr. McFadyen, an emergency medicine physician, provided on behalf of Dr. Abu-Laban. He addressed each allegation made by the plaintiff against Dr. Abu-Laban, finding no evidence to substantiate the claim that the Emergency doctor had fallen below a reasonable standard of care. In particular, Dr. McFadyen opined that Dr. Abu-Laban had obtained a thorough history and physically examined Mrs. Kemp; that he had not failed to note or act upon Mrs. Kemp's drug allergies or prescribed any medication contraindicated for her; that the tests he had ordered were "entirely appropriate to investigate her presentation"; that appropriate investigations and concurrent treatment with intravenous fluid were appropriate; that he had been "conscientious in confirming with [Mrs.] Kemp's alternate decision maker that the family's wish was for aggressive resuscitation"; that he had acted appropriately to treat dehydration; and finally, that the care provided by all of the physicians, including Dr. Abu-Laban, had been "appropriate in the circumstances".

[49] Given this detailed opinion evidence and its contrast with Dr. Lawson's opinion, the Court concluded that the plaintiff had not established her claim that Dr. Abu-Laban had failed to meet a reasonable standard of care or that he had caused or contributed to Mrs. Kemp's death. The claim in negligence against Dr. Abu-Laban was dismissed. (At para. 315.)

[50] The claim of battery against Dr. Abu-Laban rested on the assertion that he had wrongly prescribed antibiotics for Mrs. Kemp. The judge found it unnecessary to reach a specific finding on this point, again because in any event, causation was not proven. Dr. Lawson's report #1 did not suggest any specific cause(s) of Mrs. Kemp's death. In the Court's words:

> … in the Plaintiff's Affidavit #10 at paras. 58 and 61, she states that she advised Dr. Abu-Laban that her mother did not have sepsis, did not require antibiotics and that no further antibiotics were to be administered to her mother. This evidence is specifically rejected by Dr. Abu-Laban in his Affidavit #3 at paragraphs 2–5.
>
> However, in any event, I accept the submission made by counsel for the Defendant Physicians that it is unnecessary to resolve this conflict in the evidence for the purposes of this application. This is because the Plaintiff has not provided any expert evidence to establish that the administration of the antibiotics to Shannon Kemp as prescribed by Dr. Abu-Laban caused her any harm. As previously stated, the Plaintiff may not maintain an action in battery in relation to her mother under the *FCA* unless she can prove that the battery caused her mother's death, which, with regards to the administration of antibiotics to Shannon Kemp by Dr. Abu-Laban, she has failed to do.
>
> Dr. Lawson, upon whose expert opinion the Plaintiff relies regarding the conduct of the emergency physicians, which includes Dr. Abu-Laban, does not indicate anywhere in his report that the administration of antibiotics Clindamycin and Ciprofloxacin had any effect on Shannon Kemp, adverse or otherwise. He does however, reference them being administered to her at 2:40 p.m. in his summary of assumed facts (at p. 2 of his report), so they were obviously among the facts he did consider. [At paras. 316–8; emphasis added.]

[51] The plaintiff also adduced expert evidence from Dr. Poryako, a critical care physician and anesthesiologist, who opined that the antibiotics administered to Mrs. Kemp (which did not include any antibiotics to which she was known to be allergic) had not caused her any material harm. The trial judge continued:

> Counsel for the Plaintiff raised the issue of 'red man syndrome' as a possible cause of Shannon Kemp's death. It is a life threatening anaphylactic reaction

> to certain antibiotic medications, including Clindamycin and Ciprofloxacin, the two antibiotics prescribed to Shannon Kemp by Dr. Abu-Laban. That issue is also discussed at p. 9 of Dr. Porayko's report in the context of the Plaintiff's allegation that those physicians failed to "heed the advice of the Plaintiff that Shannon Kemp was having an adverse reaction to medications being administered", where Dr. Porayko states as follows:
>
> > Life threatening anaphylactic reactions to vancomycin, clindamycin and ciprofloxacin are very uncommon, particularly in the elderly [footnote omitted]. The 'red man syndrome' caused by overly rapid administration of vancomycin can be life-threatening [footnote omitted]; however, the bright red flushing phenomenon and urticaria is nearly invariably obvious and was not noted in any of the clinicians' records.
> >
> > The other cardinal signs of anaphylaxis were not recorded in observations of any of the clinicians involved, including rash, diarrhea or bronchospasm.
>
> There is no evidence that Shannon Kemp had this reaction or suffered any other adverse effect as a result of the antibiotics prescribed by Dr. Abu-Laban and no evidence that anything related to the administration of the antibiotics clindamycin and ciprofloxacin to her played any role in her decline or demise. [At paras. 320–1; emphasis added.]

In the result, the Court also dismissed the claim in battery against Dr. Abu-Laban.

[52] I turn last to Dr. Sweet. As of June 28, 2007, he had completed all the requirements for certification as a critical care specialist. He was the intensive-care physician called in by Dr. Abu-Laban and from 1507 hours onwards was responsible for all decisions made for the treatment of Mrs. Kemp. He did not recall having discussed her resuscitation status with her daughter, but as seen above, there was a letter from Dr. Wong on file indicating she was 'full code'.

[53] Ultimately, Dr. Sweet was the leader of the unsuccessful attempt at resuscitation. The team had intervened to revive Mrs. Kemp once by means of medication and her blood pressure had improved. However, her condition deteriorated again and resuscitation became necessary. Dr. Sweet denied the plaintiff's statement that he would have told the plaintiff that "[i]t's now a surgical problem" – no surgery was ever suggested for the patient – and deposed that he had not observed any "fluid" entering her abdomen. (At para. 291.) He denied

initiating CPR on the patient once she had regained a pulse, and deposed that the nurse's notation of 2 grams of Versed was a recording or typographical error.

[54] The trial judge returned to Dr. Lawson's report #1, again noting that it was a "broad, conclusory opinion based upon speculative facts" and thus of "no assistance" to the Court. Further:

> It is also clear that given the highly specialized nature of the treatment provided to Shannon Kemp by Dr. Sweet that a cogent, specific expert opinion regarding alleged breaches in the standard of care is required for the Plaintiff to prove that Dr. Sweet was negligent in terms of breaching a reasonable standard of care. This is not one of those rare instances in medical malpractice cases where the nature of the actions themselves supports such a finding. [At para. 298; emphasis added.]

[55] The judge reproduced two additional passages from the report of Dr. Porayko, who addressed one by one the allegations pleaded against Dr. Sweet in the NOCC. With respect to the alleged battery, this expert opined:

> Legal Basis Item #12
>
> *The chest compressions, forced catheterization and intubation, administration of medications and other treatments referred to did not have Shannon Kemp's, or the [Plaintiff's] consent, and they constituted battery.*
>
> Consent was obtained for the full spectrum of resuscitative efforts as documented by Dr. Wong's letter … the CTU resident's record … and Dr. Abu-Laban's consult … . There is no evidence of refusal of care by the patient or her surrogates in the records. The patient's 'pushing' on the endotracheal tube … is very commonly seen during resuscitations and most likely represented an unconscious reflex to airway stimulation after brain reperfusion during CPR. The observed activity was almost certainly not a conscious effort by the patient to indicate that further resuscitation was not desirable.
>
> …
>
> These historical points indicate that the patient likely had NYHA [New York Heart Association] Class II to III congestive heart failure that would imply an EFFECT heart failure prediction score [footnote omitted] of over 250. This places her definitively in the 'very high risk' group for both 30 day and 1 year mortality events.
>
> Several patient complaints in the weeks leading up to her death suggest that the evolving multiple organ failure process was either subacute or acute on chronic. On June 14, [2007] she was fatigued at rest, anorexic and could not walk unassisted …. She complained of a cough persisting for the previous week, suggesting a respiratory tract infection or decompensated heart failure and her renal function had deteriorated dramatically ….

> Conclusion:
>
> …
>
> The records provided describe an extraordinarily comprehensive resuscitative effort that meets or exceeds the standards of care for a critical care physician practicing in a quaternary care hospital in 2007. [At para. 302; emphasis added.]

[56] The Court concluded that the claim of negligence against Dr. Sweet must be dismissed:

> Based on the foregoing and given the flaws in Dr. Lawson's opinion, particularly in view of the finding that 2 mg and not 2 gm of Versed was administered to Shannon Kemp, and in the face of the evidence of Dr. Sweet and Dr. Porayko, there is no cogent evidence to support a claim of negligence against Dr. Sweet; accordingly, that claim is dismissed. [At para. 303; emphasis added.]

[57] With respect to the claim of battery, however, the judge ordered that since there were conflicts in the evidence as to whether Mrs. Kemp "was or continued to be 'full code' during the resuscitation", it must proceed to trial. (At paras. 304, 327.) This finding is the focus of Dr. Sweet's appeal in CA43045, to which I shall return below.

The Main Appeal

[58] At the hearing of her appeal, Ms. Kemp did not focus on the grounds of appeal stated in her factum (prepared by her previous counsel), but on other arguments, primarily founded in "fresh evidence" she sought to have admitted. It is necessary, however, to address the grounds stated in her factum before addressing the others.

[59] The grounds of appeal stated in the plaintiff's factum generally raise questions of fact, but issues of law do arise from the judge's dismissal of her application under Rule 9-7(11) of the *Civil Rules*. Rule 9-7 (which is very similar to its forerunner, Rule 18A of the former *Supreme Court Rules)* deals with summary trials. It was under this rule that the defendants applied to have Ms. Kemp's claims dismissed after summary trial. Rule 9-7(15)(a) states that on the hearing of a

summary trial application, the Court may grant judgment in favour of any party, either on an issue or generally, unless:

> (i) the court is unable, on the whole of the evidence before the court on the application, to find the facts necessary to decide the issues of fact or law, or
>
> (ii) the court is of the opinion that it would be unjust to decide the issues on the application.

Subrule (11) provides that on an application by the opposing party, the Court may:

> (a) adjourn the summary trial application, or
>
> (b) dismiss the summary trial application on the ground that
>
> (i) the issues raised by the summary trial application are not suitable for disposition under this rule, or
>
> (ii) the summary trial application will not assist the efficient resolution of the proceeding.

[60] I begin by noting that the standard of review applicable to a trial court's decision to proceed summarily is not to be interfered with lightly. As stated by Levine J.A. for the Court in *Harrison v. British Columbia (Children and Family Development)* 2010 BCCA 220, *lve to app. dism'd* [2010] S.C.C.A. No. 293:

> Appellate interference will be justified if the trial judge's determination that judgment should not be granted under R. 18A is "clearly wrong": *McGregor v. Van Tilborg,* 2005 BCCA 217 at para. 21. If all of the facts necessary to support the defendant's application for dismissal could have been found in the evidentiary record, and it would not have been unjust for the trial judge to have done so, this Court will be entitled to substitute its opinion and dismiss the action: *Pearlman v. American Commerce Insurance Company*, 2009 BCCA 78 at para. 36. [At para. 42.]

[61] The grounds of Ms. Kemp's appeal relevant to Rule 9-7(11) are that the court below erred as follows:

> 42. In considering BK's [Ms. Kemp's] application under Rule 9-7(11), the summary trial judge made palpable and overriding errors of fact which she weighed against the plaintiff.
>
> 43. In considering BK's application under Rule 9-7(11), the summary trial judge weighed, against the plaintiff, considerations which were irrelevant to the judicial exercise of discretion thus constituting an error of law.

> 44. In dismissing BK's application under Rule 9-7(11) the summary trial judge addressed only part of the action (which action involved "connected" claims) and thereby fragmented the hearing of the action and made necessary an adjournment of the scheduled trial.

Similar or related objections were advanced in the plaintiff's oral submissions at the hearing of the appeal.

[62] In my view, the judge did not err as alleged. The past history of the litigation was clearly relevant to her determination under Rule 9-7. I see no error in her characterization of the protracted procedural history of the matter before her, including her findings at paras. 32, 99 and 104. The fact that certain allegations of negligence were not raised until shortly before trial, the fact that the four doctors were not added as defendants until 2011, and the difficulties and delays encountered in connection with applications to amend Ms. Kemp's pleadings – all supported the trial judge's concern that the plaintiff might not have had a "serious intention of actually resolving this matter". (At para. 105.) And, contrary to what her factum suggests, counsel for Ms. Kemp provided particulars shortly before the summary trial commenced and those particulars did materially change the case against the defendants.

[63] Ms. Kemp also challenged the judge's reference to proportionality in connection with the "amount involved" in this case. Ms. Kemp contends that given the degree of her mental distress, her damages could well be "in the six figures." Although it is clear Ms. Kemp has had a severe and long-lasting reaction to the circumstances of her mother's death, the fact is that damages for nervous shock have not often resulted in large damage awards in Canadian law: see the discussion of "control mechanisms" in *Devji v. Burnaby (District)* and see *Mustapha v. Culligan of Canada Ltd.*, *supra*, both referred to by Arnold-Bailey J. at paras. 133–4.

[64] I agree with the court below that the delays encountered from the time of the filing of the plaintiff's claim, the principle of proportionality, the unlikelihood of a large award of damages, and the unlikelihood that Ms. Kemp's case would get stronger as time passed, all fell to be considered in the "interests of justice" inquiry described in

Hryniak, supra. I would not accede to the second ground of appeal regarding summary trial.

[65] Nor do I agree that the trial judge was "clearly wrong" in addressing only part of the action and fragmenting the hearing of the action, necessitating the adjournment of the scheduled (full) trial. In this case, there was a natural distinction between the four defendant physicians said to have been involved in Mrs. Kemp's treatment in Emergency on June 28, 2007, and the collection of doctors who had cared for her over the months prior to that date. The summary trial had a specific focus – the events of that date in the Emergency ward – and findings made in this trial are very unlikely to affect findings in respect of earlier conduct by other doctors.

[66] At the end of the day, this case had been delayed substantially by the accumulation of adjournments granted by the Court, largely to accommodate Ms. Kemp. In this court, she expressed disappointment, if not outrage, at the fact she had not been given the opportunity to cross-examine the four doctors directly, or to be cross-examined herself. Obviously, she continues to harbour a sense of anger over what she perceives as the unnecessary death of her beloved mother at the hands of doctors who, several years later, have no independent recollection of treating Mrs. Kemp.

[67] But the legal system does not exist to allow litigants to be cross-examined for cross-examination's sake; and the judicial system can no longer afford, if it ever could, the resources required to provide a "perfect" trial. Here, extensive examinations for discovery of various defendants were carried out, and it was of course open to the judge to require the appearance of any witness she felt necessary to be cross-examined in open court. (See Rule 9-7(12)(b).) The judge was able to decide almost all the issues before her and, while this was a large trial to be heard summarily, her "rigorous" approach to the evidence ensured an adjudication that was, in the words of the Court in *Hryniak*, "fair and just." The judge's reasons are set out with admirable clarity and it seems unlikely that, had a full trial been held, her conclusions would have been different. We may also assume

that proceeding summarily saved much in terms of judicial resources and counsel's time.

[68] I would not accede to the assertion that the Court erred in proceeding by summary trial.

Errors of Fact re Conduct of Hospital or Hospital Employees

[69] With respect to the trial judge's finding that negligence on the part of the hospital or employees thereof had not been proven, Ms. Kemp's factum asserts various errors. First, she says the judge erred in holding that the plaintiff had failed to provide evidence of the required standard of care with respect to the timeliness of "checks" in triage. On this point, the plaintiff relied, and continues to rely, on the opinion of Ms. Rohrback to the effect that the CTAS required that the patient be seen by a physician or had a re-assessment done at 15-minute intervals.

[70] Based on the hospital records, the trial judge found at para. 176 that Mrs. Kemp had arrived at Emergency at 1308 hours and was assessed by a triage nurse at 1310 hours, when her vital signs were taken. The judge observed:

> The presenting complaint was recorded as "low BP/dehydration". Atrial Fibrillation and surgery on her left hip were noted. It was also noted, "Told by GP to come to ER because she is dehydrated + unable to get a pulse or BP. Pt drowsy. Confused. Dizzy. Weak pulse." Her present medications were listed and an allergy to "penicillin/sulfa" was noted. Her blood pressure was 86/39.
>
> At 1315 hours, the triage nurse noted that there were no beds available in acute, and the patient was waiting on a "STR" at triage with family (hospital records, p. 43).
>
> …
>
> The hospital records contained notes made by Dr. Abu-Laban that he saw Shannon Kemp at 1340 (hospital records, p. 8). This handwritten notation time has been overwritten, but it is clearly "1340" with the "40" having possibly been written over a "20". Using the later of the two times (which favours the Plaintiff in terms of her allegation of delay), 1340 hours, there is no other evidence that contradicts the timing of these notes. [At paras. 176–8.]

[71] At para. 181, the judge recounted the plaintiff's evidence concerning her mother's time in triage. Ms. Kemp estimated that Dr. Abu-Laban had first attended on her mother at approximately 1415 hours, after which the saline IV was administered through to 1440 hours, when the nurse attached a bag of antibiotic medication to the right IV. The plaintiff deposed that at this time, her mother did not appear to be in distress. (At para. 181.) With the exception of the question of the time Dr. Abu-Laban first attended the patient, the judge noted that Ms. Kemp's evidence as to the sequence of events was "generally consistent with the timing outlined in the hospital records."

[72] It will be recalled that the trial judge accepted the hospital's argument that the CTAS guidelines were, as they themselves stated, "ideals (objectives) not established care standards." (At para. 184.) Even if the 15-minute "objective" was accepted as a standard, and even if 30 minutes had elapsed between 1310 and 1340 hours when Dr. Abu-Laban may have first seen the patient, the Court found there was no evidence that such delay caused or contributed to the patient's demise. This was also the case, the Court said, even if Dr. Abu-Laban's notes were assumed to be incorrect and he had not seen the patient until 1400 hours.

[73] I am not persuaded that the judge made any clear and palpable error in her analysis of the timing of attendances on Mrs. Kemp in triage.

[74] Another error of fact alleged is that the judge was wrong to find that Dr. Abu-Laban first attended on Mrs. Kemp at 1340 hours rather than 1400 hours, as the plaintiff recalled. Ms. Kemp points out that in discovery, Dr. Abu-Laban agreed that it was likely he first saw Mrs. Kemp at 1400 hours. (As earlier mentioned, Dr. Abu-Laban had no independent recollection and he evidently based his answer in discovery on the hospital chart to which his attention had been drawn.)

[75] It is clear from Dr. Abu-Laban's notes to the chart, however, that he saw her prior to 1400 hours, at a time that appears to be 1320 but is not completely clear. As we have seen, the trial judge addressed this issue at paras. 178–82, and found that he had seen Mrs. Kemp at 1340 hours. (See para. 187.) In the interval, the nurses

had orders to hydrate Mrs. Kemp with the IV. Her blood pressure still continued to fall. There was no evidence that it was possible to carry out an ECG review in triage, but one was performed at 1413 hours in accordance with Dr. Abu-Laban's order, made at 1400 hours, and a consultation with an internist was requested.

[76] Again, no error has been shown in the Court's findings regarding the time at which Dr. Abu-Laban's first attendance took place; nor the finding that even if he had first attended at 1400 hours, the resulting delay would not have caused or contributed to Mrs. Kemp's death. It was open to the Court to accept the expert evidence of Dr. Skinnider on the latter point, which evidence was set out at paras. 195–6 of the reasons.

[77] This brings us to an error alleged by the plaintiff in connection with her case against the hospital. In her submission, the Court erred in accepting Dr. Skinnider's opinions because they were "premised" on the records of Dr. Wong, Dr. Brough and his locum, Dr. Schmalz, and the records of the UBC and VGH hospitals concerning prior treatment of Mrs. Kemp. Dr. Skinnider assumed these records to be true for purposes of his report of December 6, 2012. Some months later, on May 12, 2014, he provided another letter intended as an addendum to the December 6 letter. It was the latter letter from which the trial judge quoted at length at paras. 195–6. The second letter did not mention the records of Drs. Wong, Brough and Schmalz, but for purposes of this appeal we may assume that Dr. Skinnider was still assuming those records were true.

[78] Contrary to the plaintiff's argument, the records of these doctors were in evidence: see Respondent's Appeal Book, pages 1 and 114. In fact, counsel for Ms. Kemp took the position at one point that the clinical records of the doctors who worked at Seymour Medical Clinic (including Brough, Schmalz and Wong) were not admissible because the defendants had not provided affidavit evidence confirming that the records were kept in accordance with the requirements in the *Evidence Act*, R.S.B.C. 1996, c. 124 concerning business records. Affidavit evidence to this effect was then obtained by the defendants from Drs. Dian, Fitzpatrick and Schmalz;

Drs. Brough and Wong were unavailable at the time, but Dr. Brough provided an email to this effect which was attached to an affidavit. Mr. Ross' uncertainty as to whether he would pursue his objection led to an adjournment of the summary trial and Mr. Ross ultimately turned his attention to other matters. The records went in without objection.

[79] Both the *Evidence Act* (see s. 42) and the common-law exception to the hearsay rule for business records support the admissibility of the records of Drs. Wong, Brough and Schmalz. Dr. Skinnider was clearly entitled to rely on them in his opinion, provided he indicated what records he had reviewed and assumed to be correct. This he clearly did.

[80] Again, the trial judge was entitled to prefer the evidence of Dr. Skinnider over the general, conclusory opinion of Dr. Lawson. Dr. Skinnider's report was obviously more helpful, particularly on the issue of the effect of any delays in treating Mrs. Kemp. The judge did not err in accepting his opinion evidence.

Errors re Dismissal of Claims against Drs. Chittock, Abu-Laban, and Sweet

[81] In her factum, Ms. Kemp asserts that the trial judge also erred in accepting Dr. Sweet's evidence over her own "sworn and unchallenged" evidence. Essentially, the complaint is that the judge did not believe Ms. Kemp was correct in her recollection that at one point, Dr. Sweet told her "It's a surgical problem now. It's no longer our problem". He categorically denied saying this or anything like it.

[82] More significantly, the plaintiff also insists that Dr. Sweet should have noticed that fluid had entered her mother's abdomen. As the defendant doctors point out in their factum, Dr. Sweet deposed that if he had observed fluid entering Mrs. Kemp's abdomen (as the ultrasound would have shown), he would have documented that finding. Again, the trial judge considered Dr. Sweet's evidence in considerable detail at paras. 286–97. She then referred to Dr. Lawson's report #1, which unlike #3 and #4 did not advance abdominal injury as one of the likely causes of death. The judge stated:

> As previously commented upon, the Court does not find Dr. Lawson's non-specific, omnibus-type of opinion regarding the alleged breaches of the standard of care by the intensive care physicians (namely Dr. Sweet) to be of assistance to the Plaintiff in proving this aspect of her claim. It is a broad, conclusory opinion based upon speculative facts and as such does not assist the Court. It is also clear that given the highly specialized nature of the treatment provided to Shannon Kemp by Dr. Sweet that a cogent, specific expert opinion regarding alleged breaches in the standard of care is required for the Plaintiff to prove that Dr. Sweet was negligent in terms of breaching a reasonable standard of care. This is not one of those rare instances in medical malpractice cases where the nature of the actions themselves supports such a finding.
>
> In addition, Dr. Lawson's opinion does not assist the Plaintiff in proving that the actions of Dr. Sweet caused or contributed to Shannon Kemp's death. [At paras. 298–9; emphasis added.]

[83] The trial judge did accept the opinion evidence of Dr. Porayko, which provided a very detailed consideration of the plaintiff's allegations concerning the treatment provided by Dr. Sweet, including his efforts at resuscitation. In my opinion, it is hardly surprising that the trial judge accepted Dr. Porayko's evidence on this point as well. Certainly she was entitled to decide which evidence was of assistance and which was not. In my opinion, she has not been shown to have been in error, let alone clearly and palpably wrong, in her characterization of Dr. Lawson's report or in her acceptance of Dr. Porayko's opinion.

[84] Nor can it be said the trial judge's acceptance of the report of Dr. McFadyen concerning Dr. Abu-Laban's care of Mrs. Kemp was erroneous. His opinion dealt in particular with the question of Mrs. Kemp's "code" status (to which I will return below) and the administration of two antibiotics in the face of the patient's history of allergy to penicillin and sulfa drugs. The Court again contrasted the detailed evidence of this expert with that of Dr. Lawson, concluding that the plaintiff had not established "an evidentiary basis to support her claim that Dr. Abu-Laban failed to meet a reasonable standard of care, or that anything he did or failed to do caused or contributed to Shannon Kemp's death." (At para. 315.) I see no error in the judge's reasoning on this point.

Dismissal of Claims for Nervous Shock

[85] Ms. Kemp asserts in her factum that the trial judge erred in law in dismissing her claims for damages for nervous shock caused by her having witnessed the (alleged) battery of her mother by Dr. Sweet. I will return to this submission later in these reasons under the rubric of Dr. Sweet's separate appeal.

[86] Finally, Ms. Kemp's factum contends that the summary trial judge erred in dismissing her application at trial to have Dr. Lawson's addendum of January 21, 2015 ("Lawson #2") or alternatively, his July 21, 2014 addendum ("Lawson #3") , introduced into evidence. At the hearing in this court, Ms. Kemp also sought to have yet another report, dated July 27, 2015, of Dr. Lawson ("Lawson #4") admitted as fresh evidence – which application was of course also repeated in Mr. Dickson's application to re-open the appeal.

[87] As the defendant physicians note at para. 82 of their factum, counsel for Ms. Kemp sought on January 28, 2015, the fourth day of a six-day trial, to introduce Lawson #3 or alternatively, Lawson #2, into evidence. One may assume that counsel for Ms. Kemp had had Lawson #2 in his possession for some time. Its opening paragraph stated:

> At your request I provide the following addendum to my report of May 21, 2014. To address criticism that the last sentence of point 1 of my report and the second to last paragraph require further explanation.

Similarly, the opening paragraph of Lawson #3 stated:

> At your request I provide the following addendum to my report of May 21, 2014 to address criticism that the last sentence of point 1 of my Discussion and Opinion and the second to last paragraph require further explanation.

The last sentence of point 1 of the doctor's Discussion and Opinion in his original report #1 (admitted at trial) dated May 21, 2014 stated:

> In my opinion, had Mrs. Kemp received prompt and proper treatment – begun within, say, 30 minutes of Dr. Wong's examination – I am confident that she would have survived.

(I note that almost two hours elapsed between when the Kemps left Dr. Wong's office at 1115 hours (the time assumed by Dr. Lawson) and their arrival at VGH at 1308 hours.) As we have already seen, the penultimate paragraph of Lawson #1 stated:

> It is my opinion that the breaches of the standard of care were the cause of the death of Mrs. Kemp. Further, in my opinion, Mrs. Kemp would not have suffered and died but for those breaches of care.

[88] Arnold-Bailey J. ordered on July 28, 2012 that with the exception of certain interrogatories and answers, none of the parties was to 'advance' any more evidence without leave. She declined to accept Lawson #2 or #3 into evidence on January 28 and the defendants prepared a separate order to this effect, which was entered March 25, 2015. No appeal was taken from that order and the trial judge's reasons for dismissing the application were evidently not transcribed. If one had to guess at the Court's reasons for exclusion, it might well be that it was too late in the trial to permit the plaintiff to introduce opinion evidence of which the defendants had had no prior notice.

[89] Turning then to the fresh evidence application in respect of Lawson #4, the fact that the letter is dated July 27, 2015 (two days before judgment was pronounced below) indicates that Ms. Kemp had this document for many months before the hearing of her appeal, but presumably chose not to provide it to Mr. Thomas or Mr. Stanger. She offered no explanation for failing to do so.

[90] Comparing Lawson #4 with Lawson #1, we see that in both documents, Dr. Lawson had been directed that wherever the facts put in evidence by the plaintiff added to or conflicted with what was in the hospital records, he was to assume the correctness of the "Kemp Facts". These included the "fact" that "[a]fter giving his orders, the ER physician did not follow up until 3:20 p.m." Obviously, the fact that the court below found other facts limited the usefulness of the opinion substantially.

[91] Dr. Lawson's statement of the Assumed Facts and his statement of what he was instructed to assume (at pages 2 and 3 of the letters), appear to be the same in

both Lawson #1 and #4. Under his "Discussion and Opinion" in #4, however, he states his conclusions under the headings "Dr. Wong", "Dr. Abu-Laban", and "Drs. Sweet and Chittock". In Lawson #4, the breaches of the standard of care previously described as the fault of "the emergency physicians" are now ascribed to Dr. Abu-Laban. There is also a new section on the patient's declining blood pressure in which the following appears:

> Mrs. Kemp should not have been left waiting from 1:10 p.m. until 2:00 p.m. before seeing a physician, and that physician should then have addressed the declining blood pressure aggressively. The 800 ml. of normal saline infused between 2:00 p.m. and 3:00 p.m. was clearly insufficient given the unstable and declining blood pressure throughout that period. Had the hypotension been treated appropriately – i.e., with additional fluid and vasopressors – Mrs. Kemp would not have reached the state where aggressive resuscitative measures (i.e., chest compressions and intubation) had to be contemplated, let alone undertaken.

[92] With respect to Drs. Sweet and Chittock, page 5 of Lawson #4 repeats para. 4 of the "Discussion and Opinion" section of Lawson #1 and then adds a new section entitled "Consideration of Aggressive Measures" and "Aggressive Resuscitative Measures Employed". There is a new paragraph under the heading "Overview Opinion" which states:

> In overview, Mrs. Kemp's death was due to multifactorial error. It was caused by a combination of the inadequate management of her progressive hypotension and the resulting aggressive resuscitative measures which ought to have been unnecessary. Those resuscitative measures culminated in a catastrophic and ultimately fatal abdominal injury which was not identified until too late. [Emphasis added.]

Lawson #4 also has attached to it a "Statement of Background Facts" which would appear to be Ms. Kemp's version of relevant medical events relating to her mother, up to Dr. Wong's recommendation that she go immediately to Emergency on June 28, 2007.

[93] The criteria for the admissibility of "fresh evidence" on appeal are well known: *Palmer v. The Queen* [1980] 1 S.C.R. 759. As stated in *Winskowski v. Coldstream (District)* 2013 BCCA 234 at para. 43, an appellate court must consider:

a) whether, with due diligence, the evidence could have been adduced at trial;

b) whether the evidence is relevant, meaning whether it bears upon it decisive or potentially decisive issue at trial;

c) whether the evidence is credible, meaning reasonably capable of belief; and

d) whether if believed, the evidence could, when taken together with other evidence, be expected to have affected the result at trial.

This court has made it clear on many occasions that the overarching consideration is always in the interests of justice.

[94] Ms. Kemp made no attempt in her oral submissions to address the four *Palmer* criteria, but asserted that a "catastrophic abdominal injury" had led to cardiac arrest, along with the "overdose" of Versed, improper monitoring of the IV by a nurse, the administration of antibiotics without consent, and a failure to sedate Mrs. Kemp before she was intubated. According to the plaintiff, all her mother required when she went into the hospital was "fluids" and "gentle supportive care"; instead she got antibiotics to which she reacted, and "aggressive" resuscitation which she should not have needed.

[95] All of these allegations were dealt with in one form or another by the trial judge. Quite aside from the failure to satisfy the 'due diligence' criterion, it seems very unlikely the result would have been different if Lawson #4 had been admitted. The only substantive difference between Lawson #1 and #4 is the reference to "abdominal injury" (allegedly due to resuscitation efforts) as a cause of death. To the extent this is new, it is simply too late: litigants are required to be ready for trial, even summary trial, and Ms. Kemp had years in which to obtain the best expert evidence she could. Moreover, Lawson #4 still does not single out one cause, but like #1 refers to "multifactorial" errors. All of the 'factors' referred to were addressed in the defendants' evidence by other experts, which evidence was accepted by the trial

judge. Finally, it would be difficult for a judge to place confidence in any of the constantly changing opinions of Dr. Lawson, all based on the plaintiff's version of the facts. I would not admit the report.

[96] Ms. Kemp also sought to introduce as fresh evidence an article entitled "Disclosing Errors and Adverse Events in the Intensive Care Unit" by D. Boyle, D. O'Connell, F.W. Platt and R.K. Albert, in (2006) 34:5 *Crit. Care Med* 1532–7. It explores the "problem" of non-disclosure of medical errors and suggests a "standard framework" to be used by physicians for discussing errors and adverse events with patients.

[97] In seeking to have this evidence admitted, Ms. Kemp of course assumes that the defendant doctors failed to disclose errors on their part. Whether Ms. Kemp intends to suggest that this is deliberate or not, this is an entirely new allegation that should have been made many years ago. It is simply not in the interests of justice to introduce it in this court at this late date. Further, the article itself is not "evidence" but simply a summary of research into an area of medical practice in the United States that may or may not be relevant to practise in this province.

[98] Also of questionable relevance is an article from *The Province* newspaper detailing the experience of a woman whose father died in a care facility after choking to death while being fed by a caregiver. I fail to see any relevance to this case, since Ms. Kemp was present with her mother at the hospital at all times and was standing right outside the curtained area when the resuscitation was being attempted. At that time, she "begged" the doctors to help her mother.

[99] Another item sought to be submitted as fresh evidence in this court was a draft Second Amended NOCC, which the trial judge had refused to admit into evidence at trial. This is obviously not "fresh evidence" and it is much too late for the many new allegations in this draft pleading to be tried or re-tried. Nor is it in the interests of justice that the defendants be put through such a proceeding.

[100] The balance of the items contained in the book handed up by Ms. Kemp to this court at the hearing of the appeal are conclusory or irrelevant and must also be excluded.

Disposition

[101] For the foregoing reasons, I would dismiss the main appeal and the allegations of negligence against the Vancouver Coastal Health Authority and the respondent physicians; her battery claim against Drs. Chittock, Sutcliffe, and Abu-Laban; including her prayer for damages for nervous shock. I would also dismiss the negligence claim against Dr. Sweet.

CA43045 – Dr. Sweet's Appeal

[102] In the second appeal, Dr. Sweet appeals that aspect of the trial judge's order that directed that Ms. Kemp's claim of battery arising out of the failed resuscitation of her mother "based on lack of informed consent or withdrawal of consent", should proceed to trial. The judge said this was due to "conflicts in the evidence as to whether Shannon Kemp was or continued to be 'full code' during the resuscitation." (At para. 304.) Dr. Sweet submits that it is unnecessary to resolve any conflict in the evidence on this issue because if he did not have express consent, he had implied consent to resuscitate the patient. I agree with counsel that the question of whether consent may, in law, be implied is a question of law to which a standard of correctness applies. Of course whether it may be implied on the particular facts of a case is likely an issue of fact or mixed fact and law.

[103] The line between express and implied consent is a blurry one, particularly in this case, where the plaintiff was present during Dr. Sweet's resuscitation efforts and deposes that when two of the physicians came out from behind the curtain, she "pleaded with each of them that my mother was strong and I begged each of them to help her." Very arguably, this constituted express consent. (The parties do not dispute that Ms. Kemp stood in a position of being able to grant or withdraw consent on behalf of her mother.) Further, as Dr. Sweet's factum emphasizes, Ms. Kemp did

not express any objection concerning the resuscitation efforts that were taking place in close proximity to her, and she has not suggested in any of her affidavits that her mother should not have been treated as 'full code'.

[104] Dr. Sweet submits that even if one were to accept that there was a conflict on the evidence regarding express consent, the law is clear that where a physician reasonably infers a patient is consenting or has consented to particular treatment, consent may be inferred. As pointed out in *Glaholt v. Ross* 2011 BCSC 1133 at paras. 186, the *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181 codifies this common law principle. Section 9(1) thereof provides that consent to health care may be "expressed orally or in writing or may be inferred from conduct." The Court in *Glaholt* also cited a passage from the judgment of Mr. Justice Linden in *Allan v. New Mount Sinai Hospital* (1980) 109 D.L.R. (3d) 634 (Ont. H.C.J.), *rev'd on other grounds* (1981) 125 D.L.R. (3d) 276 (Ont. C.A.) that:

> Whether a doctor can reasonably infer that a consent was given by a patient, or whether he cannot infer such consent, and must respect the wishes of the patient, as foolish as they may be, always depends on the circumstances. [At 641.]

[105] The trial judge correctly stated this principle at para. 124 of her reasons, paraphrasing a passage from Picard J.A. and Gerald Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 4th ed. (2007) to the effect that "[c]onsent or implied consent to medical treatment negates the commission of the tort of battery; … consent may be oral or written, but it does not necessarily have to be explicit; consent may also be implied from the words or conduct of a patient". The plaintiff has not sought to persuade us that this is not a correct statement of the law.

[106] In support of his submission that the trial judge erred in failing to find implied consent, Dr. Sweet notes the fact that Dr. Wong's letter indicating that the patient's daughter was "reluctant for a no code status" had been brought to the hospital by the plaintiff; Dr. Abu-Laban's evidence that a note in the file that "pt. [patient] is full code as per discussion [with] daughter" would indicate that he had spoken with the plaintiff about her mother's condition and determined that full resuscitative efforts were to be

provided should the mother's condition deteriorate; that at 1410 hours, Dr. Abu-Laban requested a consult with an internist "stat"; that Dr. Abou Mourad (a resident in internal medicine) assessed the patient at 1435 hours and noted "ER consulted CTU. I saw her + immediately contacted ICU since daughter insisted that she is functional + is full code."; that Dr. Sweet was then called "stat" to Emergency to assist with resuscitation by an ICU resident; and that on his arrival, Dr. Sweet noted the patient was "full code" and that he undertook the first 'intervention' while the plaintiff was standing nearby. At no point did the plaintiff object.

[107] When the second resuscitation became necessary at 1542 hours, a second attempt was made while Ms. Kemp waited on the other side of a curtain. Unfortunately, despite Dr. Sweet's efforts, Mrs. Kemp had no palpable pulse at 1557 and no cardiac movement was detected in an ultrasound. He pronounced her dead at 1600 hours.

[108] In response to the doctor's argument concerning implied consent, Ms. Kemp in her factum submits that she was nearby at all times and thus available for express consent to be sought. She does not say she would have told the doctors to stop their efforts; rather she says her desperate pleas to the doctors to "help" her mother did not constitute *carte blanche* to initiate "an aggressive, unnecessary and physically injuring resuscitative effort."

[109] With respect, there is no evidence that would support the proposition that Mrs. Kemp did not require resuscitation, nor that a "gentle" resuscitation – if there be such a thing and if such had been requested – would have been successful. 'Full code' means full resuscitative efforts; indeed, there was no evidence that some lesser standard of effort would have been recognized. Dr. Sweet also stated in discovery that injuries such as the tearing of a lip and even the breaking of a tooth "can happen" in the intubation of a patient, but that if the patient's nose been fractured or her jaw dislocated as alleged by the plaintiff, he would have documented it. The same was true of the possibility of Mrs. Kemp's abdomen being grossly distended.

[110] In her respondent's factum, Ms. Kemp takes issue with various findings of fact made by the trial judge relevant to implied consent. She contends, for example, that Dr. Sweet simply "assumed" that Mrs. Kemp was 'full code' and did so at his risk. With respect, Dr. Sweet was entitled to assume the veracity of what he was told by Dr. Abu-Laban and what he read in the patient's chart. Moreover, Mrs. Kemp was by this time deteriorating rapidly and it was simply not possible for him to carry out an interview with the patient's daughter or to embark on advising her as to the meaning of 'full code'. He reasonably understood that he was to use his best efforts to resuscitate the patient. He succeeded in the first attempt, but not the second.

[111] In all the circumstances, I am satisfied that Dr. Sweet had implied consent, and perhaps express consent, to make the efforts he did at resuscitation. Given this, Dr. Sweet cannot be said to have committed battery of Shannon Kemp and the plaintiff may not advance a claim for mental shock or distress based on that tort.

[112] There is also another reason why the judge's conclusion must, with respect, be set aside as wrong in law, and that is the trial judge's earlier finding that there was no evidence "that anything [Drs. Sweet or Abu-Laban] did or did not do caused or contributed to [Mrs. Kemp's] death." (At para. 324.) The judge had already agreed with the proposition that s. 2 of the *Family Compensation Act* could be invoked only if the alleged battery caused Mrs. Kemp's death: see paras. 129–31, quoted above. Given this, the trial judge was bound in law to dismiss the claim of battery asserted against Dr. Sweet.

Disposition

[113] In the result, I would dismiss the plaintiff's appeal in CA43033 and allow Dr. Sweet's appeal in CA43045, resulting in the dismissal of all claims against the hospital and all four physicians. As mentioned earlier, I would also dismiss Ms. Kemp's application to re-open the appeal after the hearing thereof.

[114] We are grateful to counsel for their helpful submissions.

"The Honourable Madam Justice Newbury"

I AGREE:

"The Honourable Madam Justice D. Smith"

I AGREE:

"The Honourable Mr. Justice Willcock"