IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: *Dwyer v. Interior Health Authority,* 2026 BCSC 567

Date: 20260331
Docket: S33062
Registry: Cranbrook

Between:

Francis Leslie Dwyer and also Francis Leslie Dwyer as Executor for the Estate of Janice Dawn Dwyer, Deceased

Plaintiff

And

Interior Health Authority and Dr. F.W. Green Memorial Home

Defendants

Before: The Honourable Madam Justice Sharma

Reasons for Judgment

The Plaintiff, appearing in person:	F. Dwyer
Counsel for the Defendants:	R. Irving
Place and Date of Trial/Hearing:	Cranbrook, B.C. August 28, 2025
Place and Date of Judgment:	Cranbrook, B.C. March 31, 2026

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I. INTRODUCTION

[1] This judgment addresses the defendants' application to dismiss this claim pursuant to Rule 9-5(1)(a) or Rule 9-6 of the *Supreme Court Civil Rules*, B.C. Reg 168/2009. The defendant the Interior Health Authority ("Health Authority") operates a long-term care facility under the name Dr. FW Green Memorial Home (the "Care Home").

[2] The plaintiff Francis Dwyer brings this claim on his own behalf, but also as executor for the estate of his deceased wife, Janice Dwyer. He represented himself and prepared his own pleadings.

[3] Mr. Dwyer filed the notice of civil claim (NOCC) on August 26, 2024. The Health Authority filed a response to the NOCC on September 20, 2024. Among other things, it asserts that the Care Home is not a separate legal entity and, therefore, it is not a proper party to the litigation.

[4] The NOCC contains an "Introduction" that summarizes the claims. It states, in part:

> In this claim, the plaintiffs allege that the defendant, Green Home, failed to provide adequate mouth care to Janice, denied Francies his right to participate in care planning, disregarded his choice of a palliative diet, and rejected his compassionate request for an end-of-life care plan. The care provided for Janice and the support given to Francis in her final days was disorganized, delayed and appeared, for all purposes, to border on indifference. These distressing events unfolded over two years, marked by failure and omissions.

[5] The Health Authority filed this application on January 22, 2025, and Mr. Dwyer filed his response on March 7, 2025.

[6] Ms. Dwyer suffered from dementia, which is why she was a patient at the Care Home. The allegation at the heart of Mr. Dwyer's claim is that the Care Home failed to respect Ms. Dwyer's wishes about her end-of-life care, wishes she expressed while she had capacity to do so through the completion of an advanced care directive. Because of her condition, she was unable to advocate on her own behalf and relied on Mr. Dwyer to ensure that her wishes would be respected.

[7] Mr. Dwyer submits the Care Home's failure to respect Ms. Dwyer's wishes caused his wife extreme physical discomfort and emotional harm, a claim he brings on behalf of her estate. However, he also says those actions caused him mental anguish, and he seeks damages in his own capacity for that.

[8] The Health Authority submits even if all the facts put forward by Mr. Dwyer—whether in his evidence, pleadings, or statements to Court at the hearing—are accepted as true, there is no possibility of success under any known cause of action. It further submits those facts do not justify recognizing a new duty of care. Thus, its position is that the claim must be struck or, in the alternative, dismissed summarily.

[9] For the reasons expressed in this judgment, I have concluded that not all claims should be struck because it is not plain and obvious that the facts asserted could not be the basis of recognizing a novel duty of care, or could not support Mr. Dwyer's claim for damages, on his own behalf. I conclude that Mr. Dwyer should have the opportunity to amend his claim in order to clarify the legal basis of the relief he seeks.

[10] However, I do agree that any claim brought on behalf of the estate of Ms. Dwyer cannot succeed, and those aspects of the NOCC must be struck.

[11] Because I have determined Mr. Dwyer should be given the opportunity to amend his claim, I decline to rule on the Health Authority's application to dismiss the claim summarily pursuant to Rule 9-6. In my view, justice and fairness require that Mr. Dwyer have the opportunity to amend his claim before he has to respond to an application to summarily dismiss his claim.

II. FACTS

[12] Mr. Dwyer was articulate at the hearing; he spoke eloquently explaining why he started the action. At times he referred to facts that are not in his affidavit, but are mentioned in his application response or the NOCC. In addition, some statements Mr. Dwyer made were not grounded in the evidence or the pleadings.

[13] Counsel for the Health Authority did not object to Mr. Dwyer recounting those facts and did not suggest anything he said was not something that Mr. Dwyer truly believed. However, the Health Authority's position is that many of those facts are not relevant to the legal issues before the Court, or were facts not properly admitted or admissible into evidence, precluding the Court from relying on them.

[14] Where Mr. Dwyer made statements of fact during the hearing which were controversial and not contained in his affidavit evidence, the NOCC, or response to application, I accept those as constituting his submissions. Where any facts he recounted are not relevant to the legal issues I must decide, I accept them as providing background and context to the legal issues raised. Overall, I have no reason to doubt the sincerity of any of Mr. Dwyer's statements.

A. The Notice of Civil Claim

[15] The following facts are listed in the NOCC as "Background":

> a) In the spring of 2015, Ms. Dwyer appointed Mr. Dwyer as her representative pursuant to section 9 of the *Representation Agreement Act*, R.S.B.C. 1996, c. 405 [*Representation Act*] and named their son as the alternate representative. Among other things, the representative was authorized to "do anything that the Representative considers necessary in relation to my personal care and health care".
>
> b) The same day she also signed an advanced care directive (the "Directive"), which stated, among other things:
>
> > PREAMBLE: If I need health care and I am not capable of giving or refusing consent to the health care at the time the health care is required, I GIVE THE FOLLOWING INSTRUCTIONS:
> >
> > I consent to the following health care:
> >
> > …
> >
> > C) As the law might permit, now or at some time in the future; in the event I am left in an irreversible coma and in a vegetative state or suffer from intractable pain with no hope of relief, I'd have the active participation of a physician in ending my life for compassionate reasons.

> …
>
> I do not consent to the following health care:
>
> A) If I am in a terminal condition as defined by my doctors, I do not want my life prolonged and I do not want life sustaining treatment beyond comfort and the relief of pain, which would only serve to delay t-he moment of death.
>
> B) If I am in a terminal condition …I do not want the following:
>
> …
>
> 3 – By force feeding irrespective of any mouth opening or swallowing which may indeed be entirely reflexive and which might wrongly suggest that I want feeding…

c) Throughout 2020, Ms. Dwyer began to display signs of dementia. Mr. Dwyer sought medical help and a diagnosis. Unfortunately, their family physician had retired, and they did not find a replacement. They were limited to attending walk-in clinics, and he alleges that delayed her receiving a definitive diagnosis.

d) On April 4, 2021, Ms. Dwyer was admitted to the Royal Inland Hospital because of debilitating brain seizures. On admission, Mr. Dwyer was asked about and informed the emergency room doctor the existence of the Directive, and provided a copy.

e) In a doctor's report dated April 4, 2021, Ms. Dwyer was described as having a major neurocognitive disorder, and Mr. Dwyer was informed on April 9, 2021, that she had dementia.

f) During the next three months, Mr. Dwyer attended the hospital three times a day to support Ms. Dwyer. He was asked by staff to bathe his wife because she was not complying with the staff's directions.

g) On June 4, 2021, Ms. Dwyer was discharged from the hospital and, as a transitional step, transported to Cranbrook for admission to Joseph Creek Care Home. The discharge notice indicated her diagnosis to be frontotemporal dementia.

h) On or about July 15, 2021, she was admitted to the Care Home on a permanent basis. The Directive was on file at the Care Home's nursing station on July 17, 2021, but the name of her representative was left blank.

i) No doctor nor staff member spoke to Mr. Dwyer about his role as Ms. Dwyer's representative. Nor did they consult him about a care plan as they were required to do so within 30 days.

j) On October 1, 2021, Ms. Dwyer was exhibiting behavioural issues at mealtimes. Ms. Dwyer was a former nurse and unaware that she was ill: she began assisting other residents with their meals.

k) Mr. Dwyer was asked by Joan Tuzon, a registered nurse, if he could time his visits with his wife to be during mealtimes. I infer that was to prevent her from trying to feed other patients.

l) Mr. Dwyer agreed to do so starting on November 1, 2021. Over the course of 13 months, he became acutely familiar with Ms. Dwyer's swallowing issues and food preferences. He continued to visit his wife for every meal until November 30, 2022. He paid for his own meal and dined with her.

m) In January 2022, Mr. Dwyer asked Ms. Dwyer's physician, Dr. Dawson, to elevate Ms. Dwyer's medical orders regarding Ms. Dwyer's status; the doctor agreed, and appropriate form was completed. The doctor signed a "Medical Orders for Scope of Treatment Form" which contained, among other things, the following:

i. Ms. Dwyer was given "M1" status described as "[s]upportive care, symptom management and comfort measures only: allow a natural death. Care is for physical, psychological and spiritual preparation for an expected or imminent death. Do not transfer to higher level of care unless to address comfort measures that cannot be met in current location".

ii. Under part 2, specific interventions, the doctor check “NO” for “Nutritional Support”. Under consultations, he named Mr. Dwyer as Ms. Dwyer’s representative.

[16] In the NOCC, Mr. Dwyer recognizes that the *Limitation Act*, R.S.B.C. 1996, c. 266, applies, and he accepts that his actionable claims must be based on events that occurred after September 2022.

[17] The NOCC lists the following as “Facts”:

a) September 8, 2022: Mr. Dwyer discussed with the dietitian the risks to Ms. Dwyer of choking and aspiration from “lumpy purée and porridge”. He understood the dietitian would give instructions to the kitchen.

b) October 1, 2022: He noticed that variations in the consistency of the food delivered caused Ms. Dwyer to sometimes choke or refuse food. He informed the staff that her diet should be changed to consist only of yogurt, applesauce, and protein drinks. These were foods that Ms. Dwyer enjoyed and were least likely to cause choking. He was of the view that this would provide her with a palliative diet.

c) October 13, 2022: After discussions with the dietitian, Mr. Dwyer signed a managed risk agreement (“MRA”), which specified that the lumpy purée would be stopped.

d) October 25, 2022: A social worker discussed with Mr. Dwyer the issue of palliative care, telling him that he should speak with the Care Home’s manager.

e) November 24, 2022: Mr. Dwyer was asked to sign another MRA about the dietary choices and the risks of malnutrition. He agreed, but only if it was recognized and recorded that the dietary choices would provide a palliative diet because his wife was dying.

f) November 26, 2022: Mr. Dwyer asked staff about the need to provide "mouth care" for Ms. Dwyer, and he was told that he needed to speak with the dentist.

g) November 30, 2022: At a family council meeting, Mr. Dwyer asked who was responsible to look after "mouth care" and whether it was included within the ambit of palliative care. He was told that care aides perform mouth care, but did not receive an answer to his question about whether such care was considered palliative because he was informed that a family council meeting could only address issues about the facility or personal care.

h) December 22, 2022: The dietitian asked if staff could feed Ms. Dwyer purée in the evenings, and Mr. Dwyer refused, explaining the desire to maintain a diet that provided palliative care and did not lengthen Ms. Dwyer's life.

i) January 31, 2023: The Care Home convened a meeting regarding Ms. Dwyer's care. Ms. Dwyer's physician, Dr. Dawson, participated by telephone. At that meeting Mr. Dwyer asked that his wife be given palliative end-of-life care.

j) March 16, 2023: The dietitian again asked if staff could resume feeding Ms. Dwyer purée, and Mr. Dwyer declined. He asked staff to continue to abide by the MRA that he had signed.

k) April 27, 2023: Mr. Dwyer asked Dr. Dawson about a significant decline in Ms. Dwyer's well-being. Dr. Dawson sent a fax to the Care Home asking for copies of a palliative printed order, which Mr. Dwyer described as a form that physicians use to order end-of-life medications. In responding to Dr. Dawson, staff said they were unaware of any significant decline in Ms. Dwyer's condition. However, no one spoke to Mr. Dwyer about that.

l) April 27, 2023: Mr. Dwyer was asked to attend a special family meeting regarding Ms. Dwyer the following day. At the meeting, there was a discussion about quality of life and Ms. Dwyer's impending death, and a new care plan was put into place. Mr. Dwyer asserted this was the only time he was consulted about a care plan for his wife.

m) May 4, 2023: Mr. Dwyer attended a meeting at the Care Home with his son. They were surprised that Dr. Dawson was not in attendance. The meeting was chaired by a nurse who introduced the director of the Care Home and the director of palliative care region, as well as other professionals. At that meeting, staff said they had concerns that Ms. Dwyer was hungry. The dietitian then described the risks of malnutrition. Mr. Dwyer stated that Ms. Dwyer had choked more than 30 times. He also reviewed the reasons he had asked for a palliative diet for her, and asked that there be a plan to provide her with end-of-life palliative care. The meeting ended without there being any agreement on any issue.

n) May 5, 2023: Care Home staff directed that Ms. Dwyer would get a varied diet of textured food.

o) May 6, 2023: Mr. Dwyer left for England for a period of respite after taking care of his wife for two years.

p) May/June 2023: Records indicate that from June 13, 2023, until her death on July 14, 2023, Ms. Dwyer steadfastly refused to be fed.

q) June 16, 2023: A care plan stated that staff should discuss the option of a dental appointment with the family.

r) June 21, 2023: A fax was sent from staff to Dr. Dawson asking whether there is something that can be put on Ms. Dwyer’s gums because the staff cannot tell how much pain she is in.

s) June 28, 2023: A fax from the nurse to Dr. Dawson describing that Ms. Dwyer's teeth and gums appeared to be swollen and bleeding, and that she clamps her mouth shut.

t) July 11, 2023: Mr. Dwyer phoned the Care Home and left a message advising that Ms. Dwyer was dying and that they needed to discuss end-of-life care. That call was not returned. That same day, he visited the Care Home and had a personal interaction with other staff, asking for a care plan, but none was made.

u) July 12, 2023: The care plan developed on that date had a notation that Ms. Dwyer was not currently eating, but stated that she should be given purée diet and all available food with texture. It further stated that the patient might refuse meals and food, but they should be continued to be offered. Mr. Dwyer said this care plan was not a palliative care plan, noting, for instance, that it suggested gardening or concerts as activities for her, as long as it could be tolerated.

v) Later that day, staff acknowledged that Mr. Dwyer had requested notification be sent to Dr. Dawson about Ms. Dwyer's condition. Another note said that around 10 p.m., Mr. Dwyer expressed concerns that Ms. Dwyer would need pain management for palliative symptoms.

w) July 13, 2023: Mr. Dwyer noticed that Ms. Dwyer had muscle spasms that caused her to cry out in pain, but that she was otherwise peaceful. He asked staff for palliative medications, and they responded they would have to fax the doctor. Ms. Dwyer was administered some morphine at about 3:15 p.m.

x) July 14, 2023: At about 1:30 a.m., medication was administered that was meant to reduce Ms. Dwyer’s “death rattle”. Mr. Dwyer notes there is still no discussion with him about providing her with comfort care.

y) Ms. Dwyer died on July 14, 2023, at 5:43 a.m.

[18] Under Part 2, “Relief Sought”, Mr. Dwyer lists a number of headings including duty of care, proximity, and consequences.

[19] He alleges that the Health Authority owed him a duty of care because of:

a) his role under the *Representation Act;*

b) his designation as an essential caregiver;

c) the requests made of him by the Care Home that he bathe Ms. Dywer and supervise her meals; and,

d) his devotion and involvement in all aspects of Ms. Dwyer's care.

[20] Mr. Dwyer alleges he meets the test of proximity because he was at the Care Home with Ms. Dwyer five hours a day for 704 consecutive days, and that the Health Authority should have foreseen the impact the Care Home’s actions or inactions would have on his emotional health, given his role in the care of his wife.

[21] He alleges that by ignoring his compassionate representation of his wife, the Health Authority and Care Home were negligent, thereby causing him to suffer acute emotional distress and lasting psychological impacts that extended well beyond the everyday adversities of life.

[22] He claims general damages, special damages, punitive and aggravated damages, and costs.

[23] He relies on:

a) the *Representation Act*;

b) the *Community Care and Assisted Living Act,* S.B.C. 2002, c. 75 [*CCAL Act*] and its regulations; and,

c) the *Health Care (Consent) and Care Facility (Admission) Act*, R.S.B.C. 1996, c. 181 [*Consent Act*].

B. Application Response

[24] I summarize below information from Mr. Dwyer's response to the application, some of which, to varying degrees, overlaps with what is in the NOCC:

a) Mr. Dwyer asserts that in relation to Ms. Dwyer, he was a volunteer in the legal sense as well as a legal representative. He says that volunteers are owed a duty of care. His description of this in the response is similar to his allegation in the NOCC that he was owed a duty as Ms. Dwyer's caregiver.

b) In both the NOCC and response, Mr. Dwyer says that as his wife's legal representative, he meets the requirements to establish a *prima facie* duty of care. In the response, he specifically ties this claim to the direct and close relationship he says that he had with the dietitian at the Care Home, who was aware of his role.

c) Alternatively, he asserts there could be a duty of care because he was embedded within the Care Home carrying out care functions and should have been declared, or seen to be akin to, an essential caregiver. This is stated in both the response and NOCC.

d) Mr. Dwyer contends that he brings his claim against the Healthy Authority (and Care Home) as a whole, rather than individual doctors, nurses, or other professionals involved in Ms. Dwyer's care. For that reason, he says any statutory immunity contained in the legislation is inapplicable. He also raises the notion of the Healthy Authority's vicarious liability for the actions or omissions of its employees.

e) Mr. Dwyer concedes that statutory breach, alone, is not proof of negligence. However, he argues that statutory breach, in combination with other acts or omissions, could cumulatively amount to negligence and does so here.

f) Mr. Dwyer argues that none of the actions of the defendants constitute "policy decisions" made by public authorities that are immune from negligence. He maintains that the impugned decisions outlined in the NOCC are not operational decisions made by low-level employes, because directors and managers within the Health Authority were present and endorsed the decisions complained of in the NOCC.

C. Response to Civil Claim

[25] The Health Authority specifically denies the assertion of facts in the NOCC.

[26] The Health Authority pleads that the care provided to Ms. Dwyer was in accordance with the standard expected in similar facilities in similar communities. It also asserts that at all times, the diet and end-of-life care provided to Ms. Dwyer was in accordance with her best interests and given in good faith in adherence to the applicable policies.

[27] Regarding the legal basis of its response, the Health Authority alleges that the claims in the NOCC rely on causes of action that are neither recognized nor capable of being recognized at law. For that reason, its position is that the entire NOCC should be struck.

[28] It also asserted that the facts occurred in the context of a specific regulatory scheme and the governing statutes do not give rise to an independent cause of action. In addition, the Health Authority specifically relies on s. 4 of the Schedule to the *CCAL Act*, which precludes any cause of action for violation of that Schedule. It also relies on the immunity provided by s. 33 of the *Consent Act*, which states:

> 33(1) No action may be brought or continued against a person for any act or omission in the performance of a duty or the exercise of a power or function under this Act if the person has acted in good faith and used reasonable care.

[29] Regarding the claim of negligence based on inadequate care provided to Ms. Dwyer, the Health Authority pleads that at all times, her care was rendered with the care, skill, and diligence meeting the standards of prevailing practice. In any

event, it submits any deficiency in that care was not the proximate cause of any suffering experienced by Ms. Dwyer. It also asserts that its policies and procedures relating to care and treatment met the applicable standard of care.

[30] Furthermore, and in the alternative, the Health Authority submits a claim by her estate for damages based on inadequate care allegedly provided to Ms. Dwyer was extinguished upon her death.

[31] The Health Authority denies that it owed any duty of care to Mr. Dwyer in his capacity as Ms. Dwyer's spouse, but in the alternative, if it had that duty, it met the applicable standard. In the further alternative, the Health Authority pleads that even if a duty was owed and was breached, it denies that Mr. Dwyer suffered any damage as a result.

III. LEGAL PRINCIPLES

A. Rule 9-5(1)(a)

[32] The Health Authority submits that the NOCC should be dismissed pursuant to Rule 9-5 (1)(a) as the pleading discloses no reasonable cause of action and has no prospect of success.

[33] The Health Authority acknowledges there is a high standard it must meet under this test. Pleading should only be struck if it is certain to fail and the case is "perfectly clear": *FORCOMP Forestry Consulting Ltd. v. British Columbia*, 2021 BCCA 465 at para. 21.

[34] As stated in *Nevsun Resources Ltd. v. Araya*, 2020 SCC 5 at para. 143, the court is required to read a claim generously and to accommodate inadequacies in form that are merely the result of drafting deficiencies.

[35] In *British Columbia v. Taylor,* 2024 BCCA 44, the Court of Appeal held:

> [27] The test for striking a pleading under R 9-5(1)(a) is well settled. A claim will only be struck if it is plain and obvious, assuming the facts pleaded to be true, that the pleading discloses no reasonable cause of action: *Levy v British Columbia (Crime Victim Assistance Program),* 2018 BCCA 36 at paras 14, 32; *Atlantic Lottery Corp. Inc. v Babstock*, 2020 SCC 19 at para 14.

> [28] The approach must be generous and err on the side of permitting novel but arguable claims to proceed to trial. Courts ought to be cautious in striking claims, particularly "novel ones that may not yet be embedded in existing legal rules, lest it stunt the growth of the law": Levy at para 32.

(See also *James McCallum & Associates Ltd. v. Courchene*, 2025 BCCA 82 at para. 9.)

[36] Furthermore, where pleadings are deficient, the court can dismiss the matter entirely or grant leave to amend the pleadings to rectify the deficiency. Whether to do so involves an exercise of discretion: *Kindylides v. Does*, 2020 BCCA 330 at para. 22.

B. Summary Judgment under Rule 9-6

[37] In the alternative, the Health Authority submits that summary judgement should be granted against the plaintiff under Rule 9-6.

[38] Rule 9-6 permits challenge to a claim based on the limited review of affidavit evidence. The bar on such an application is also high and requires the defendant to convince the court that the plaintiff is bound to lose or the claim has no chance of success: *Tosen* v. *Gumtree Catering*, 2023 BCSC 121 at para. 21.

[39] A court can consider evidence on a summary dismissal, but it is not a summary trial. The presiding judge can only weigh evidence to the extent it is incontrovertible: *Beach Estate v. Beach*, 2019 BCCA 277 at para. 49.

C. Relevant Statutory Provisions

[40] Both parties refer to a number of statutes that are implicated in this case, which I identify and describe below.

[41] The first is the *Representation Act*, whose purpose is to provide a mechanism for adults to make advance health care decisions, and to avoid the need for court to intervene to appoint someone to make decisions on behalf of someone who becomes incapable of doing so: s. 2.

[42] An incapable adult may assign another adult to be their representative pursuant to the procedure set out in either s. 7 or s. 9. A representative may make decisions on behalf of the incapable adult about personal care, minor financial affairs, health care as defined in the *Consent Act* (excluding health care prescribed under s. 34(2)(f)), and obtaining legal services and instructing counsel: s. 7(1).

[43] The second is the *CCAL Act.* In *Health Authority v. Turner*, 2005 BCSC 1540, the court described this legislation as being "directed towards ensuring that those responsible for the care of others ..., do so in a safe and secure environment" (para. 7) and "ensuring that those facilities are safe and the operators of them appropriately qualified" (para. 9). The Health Authority described the legislation as setting out a framework for regulating community care facilities, assisted living residences, and the rights of adult persons in care. It is not clear to me there is an appreciable difference between those descriptions.

[44] Section 7(1) sets out the standards that licensed operators of community care facilities must maintain, including that they must:

> (b) operate the community care facility in a manner that will promote
>
> (i) the health, safety and dignity of persons in care, and
>
> (ii) in the case of adult persons in care, the rights of those persons in care;
>
> (c.2) make the rights of adult persons in care known, orally and in writing, to persons in care and their families and representatives;

[45] To the extent the Health Authority's position is that s. 7(1)(c.2) imposes a duty on family members and representatives to be aware of adult persons' rights in care, I disagree. The sections create a duty on the licensee to inform families and representatives of those rights.

[46] The Schedule to the *CCAL Act* sets out the rights of adult persons in care. It does not assign any rights to family members or representatives, save for setting out an avenue for "a person acting on the person [in care]'s behalf" to file a complaint to the Patient Care Quality Review Board: *CCAL Act*, Schedule, s. 2.

[47] Finally, the *CCAL Act* contains a statutory immunity provision protecting individuals carrying out duties and exercising powers under the legislation: s. 32(1). Notably, s. 32(3) expressly preserves the vicarious liability of the government, health authority, and employer for acts or omissions of individuals protected under the s. 32(1).

[48] The third is the *Consent Act*, which codifies a patient's right to give or refuse consent to medical treatment in healthcare settings and admission to health facilities: *R. v. E.Z.O.*, 2023 BCCA 122 at para. 22. Part 2.1 covers the creation and application of advance directives, defined in the statute as a "written instruction made by a capable adult that gives or refuses consent to health care for the adult in the event that the adult is not capable of giving the instruction at the time the health care is required": *Consent Act*, s. 1. Among the issues addresses about advanced care directives in that part are: who may make one (s. 19.1); their scope (s. 19.2); potential conflicts with representative agreements (s. 19.3); procedural requirements (ss. 19.4-19.6): and, withdrawal of health care (s. 19.9).

[49] Relevant to the asserted facts in this case, a health care provider must not provide health care to an adult if the adult has refused consent to that health care in the advance directive (s. 19.7(b)), provided the circumstances described in s. 19.8 do not apply. I do not find (and the Health Authority did not argue) that any of the circumstances listed in that section apply to the facts of this case.

[50] The *Consent Act* does address, to a limited extent, the rights of family members. For example, s. 8(b) states that a person in care has the right to involve family members in consent decisions:

> 8. When seeking an adult's consent to health care or deciding whether an adult is incapable of giving, refusing or revoking consent, a health care provider…
>
> > (b) may allow the adult's spouse, or any near relatives or close friends, who accompany the adult and offer their assistance, to help the adult to understand or to demonstrate an understanding of the matters mentioned in section 7 [how incapability is determined].

[51] The *Consent Act* also addresses the legal status of personal guardians, representatives, and substitute decision-makers. Those terms are defined in the statue: personal guardian is a committee appointed under the *Patients Property Act*, R.S.B.C. 1996, c. 349; representatives are those appointed as such under an agreement made under the *Representation Act*; and, substitute decision-makers is defined in s. 16 of the *Consent Act*. Each role involves that person's authority to make decisions on behalf of a person in care.

[52] Section 11(b) allows consent to be obtained from the personal guardian or representative of an adult in care, but not the substitute decision-maker. However, this consent is not absolute; the *Consent Act* authorizes the provision of emergency health care despite the refusal of a personal guardian or representative where (s. 12.2):

> a) in their opinion, it is necessary to provide the health care without delay in order to preserve the adult's life, to prevent serious physical or mental harm or to alleviate severe pain; and
>
> b) the personal guardian or representative did not comply with their duties under this or any other Act.

[53] Healthcare providers may not provide emergency healthcare; however, they may do so where the provider has reasonable grounds to believe that the patient "expressed an instruction or wish applicable to the circumstances to refuse consent to the health care": *Consent Act*, s. 12.1.

[54] Sections 16–19 set out the appointment, authority, and duties of temporary substitute decision-makers. Substitute decision-makers must abide by the duties set out in s. 19, including:

> (3) When deciding whether it is in the adult's best interests to give, refuse or revoke substitute consent, the person chosen under section 16 must consider
>
> (a)the adult's current wishes, and known beliefs and values,
>
> (b)whether the adult's condition or well-being is likely to be improved by the proposed health care,

> (c)whether the adult's condition or well-being is likely to improve without the proposed health care,
>
> (d)whether the benefit the adult is expected to obtain from the proposed health care is greater than the risk of harm, and
>
> (e)whether a less restrictive or less intrusive form of health care would be as beneficial as the proposed health care.

[55] Like the *CCAL Act*, the *Consent Act* contains a statutory immunity clause: s. 33(1). In contrast to the *CCAL Act*, the *Consent Act* does not expressly preserve the vicarious liability of the authority or other employer.

IV. SHOULD THE CLAIM BE STRUCK?

[56] The Health Authority submits it is plain and obvious that the claims in the NOCC do not disclose a reasonable cause of action. It asserts that the material facts in support of the claim have not been pleaded, are inadequate, and are bound to fail.

[57] I start by noting that the Health Authority only seeks to strike the claim on the basis of s. 9-5(1)(a). In other words, this is not a case where a defendant seeks to strike a claim because it is prolix, confusing, or difficult to follow; because it is scandalous, frivolous or vexatious (9-5(1(b)); or, because it is an abuse of the court's process (9-5(1)(d)). Importantly, the facts in the pleadings must be taken as true.

[58] I agree with the Health Authority that a claim for damages for pain and suffering brought on behalf of Ms. Dwyer's estate cannot succeed: this conclusion is explained below at paras. 131–135.

[59] However, I do not agree that a claim brought by Mr. Dwyer in his capacity as Ms. Dwyer's representative and/or substitute decision-maker is bound to fail. In particular, I find that there are sufficient facts pleaded, when taken as true, that could support the recognition of a novel duty of care owed to a substitute decision-maker regarding end-of-life care.

A. Mr. Dwyer's Claim for Negligence

[60] To succeed in a claim in negligence, the Supreme Court of Canada in *Mustapha v. Culligan of Canada Ltd*., 2008 SCC 27 at para. 4, stated that a plaintiff must demonstrate four things:

a) the defendant owed the plaintiff duty of care;

b) the defendant's behaviour breached the standard of care;

c) the plaintiff sustained damages; and

d) damage was caused in fact and law by the defendant's breach.

[61] Before turning to my analysis, it is important to fairly characterize the claim that Mr. Dwyer wants to proceed to trial.

[62] At the hearing, Mr. Dwyer explained that he wanted to be represented by counsel, and sought to retain a lawyer, but was unable to find one willing to take on his case. I am mindful of my duty to ensure that Mr. Dwyer is not unfairly prejudiced by reason of his self-representation, although that does not require the Court to extend to self-represented litigant unlimited leniency: *Shehzad v. Langara College*, 2026 BCCA 84 at para. 23. I also rely on statements included below about the nature of the Court's duty to self-represented litigants.

[63] Reading his claim generously, and taking into account Mr. Dwyer's evidence in this affidavit and narration of events in court (to the extent those were not controversial), Mr. Dwyer alleges that the Care Home failed to respect the Directive and MRA regarding Ms. Dwyer's end-of-life care. In that light, the following facts are central to the claim he wants to bring:

a) His wife made her wishes about end-of-life care known in the Directive.

b) As a former registered nurse, she was well versed with issues regarding care to patients, and adamant about not wanting her life unnecessarily prolonged.

c) Ms. Dwyer's doctor was aware of that Directive and what it meant.

d) The Care Home was aware of the Directive.

e) As both her substitute decision-maker and her spouse, Mr. Dwyer was aware of the Directive and its contents.

f) As someone who was recruited by the Care Home to provide personal care for Ms. Dwyer, and someone who was present for all of her meals, Mr. Dwyer had the most knowledge of her food preferences and any physical issues she experienced while eating (such as choking caused by food that was "lumpy").

g) The Directive clearly articulated that Ms. Dwyer did not want to be force fed if it unduly prolonged her life.

h) The MRA clearly conveyed Ms. Dwyer's doctor's order that she not be provided with nutrition in order to allow for a natural death.

i) Despite the foregoing, the Care Home introduced a diet of "lumpy puree", based on a concern for malnutrition.

j) The Care Home also refused to follow Mr. Dwyer's recommendations and requests for food that aligned with Ms. Dwyer's preferences and Directive.

k) In addition to unduly prolonging her life and causing her pain, the failure to respect Ms. Dwyer's clear wishes about her end-of-life care caused Mr. Dwyer to suffer emotional anguish.

[64] Thus, the focus of Mr. Dwyer's complaint is the failure to abide by and respect what he says were his wife's clear and express wishes for the care she wanted towards the end of her life. He asserts that having entrusted him to advocate on her behalf, but also because of the knowledge he had of his wife's condition given his recruitment as a volunteer to provide care to Ms. Dwyer, the Care Home's failure to

follow his directions and instructions regarding her diet were not in keeping with its duty to Ms. Dwyer, or to him as substitute decision-maker, causing him to suffer.

[65] The Health Authority submits that it owed no duty to Mr. Dwyer in his role as a spouse or as family member of a patient, nor can he establish that this is an appropriate case in which to recognize a novel duty of care on that basis.

[66] The Health Authority recognizes that Mr. Dwyer contends he was owed a duty of care because he was Ms. Dwyer's substitute decision-maker and was a volunteer recruited by the Care Home to provide direct, personal care to Ms. Dwyer. The Health Authority notes that no authority is cited to establish its staff might owe a duty of care in those circumstances, which raises the issue of whether Mr. Dwyer can establish that he has an arguable case to recognize a novel duty of care.

1. The Test for Establishing a Novel Duty of Care

[67] In *Waterway Houseboats Ltd. v. British Columbia*, 2020 BCCA 378 [*Waterway Houseboats*], the Court of Appeal noted that the determination of the existence of a duty of care in the context of a regulatory scheme requires an extra layer of analysis within the negligence framework. At para. 200, the Court of Appeal sets out the duty of care test, citing *Anns v. Merton London Borough Council*, [1978] A.C. 728 (U.K.H.L.); *Cooper v. Hobart*, 2001 SCC 79; and *Carhoun & Sons Enterprises Ltd. v. Canada (Attorney General)*, 2015 BCCA 163, which they then clarify, at para. 243, in the context of government regulator.

[68] The test is comprised of the following questions:

a) Is there a sufficiently analogous precedent that definitively determined the existence or non-existence of a duty of care in the circumstances? If so, the inquiry ends.

b) If not, was the harm suffered by the plaintiff reasonably foreseeable?

c) If so, is there a sufficiently proximate relationship between the plaintiff and the defendant to justify imposing a *prima facie* duty of care, taking into account:

i. stage one – whether the legislative scheme shows an intention to impose or preclude a private law duty of care; and

ii. stage two – if the legislative scheme is not determinative, whether specific interactions between the regulator and the plaintiff give rise to a duty of care.

d) Are there residual policy considerations that negate a *prima facie* duty of care?

[69] The Health Authority submits existing case law is persuasive and/or binding in precluding Mr. Dwyer's ability to establish a novel duty of care. It also submits that Mr. Dwyer cannot demonstrate sufficient proximity because the relevant statutes prioritize the interest of the person in care over the substituted decision-maker or representative, and imposing a duty of care would create the possibility of conflicting duties of care.

2. Analogous Precedents

[70] The Health Authority relies on what it says is a long line of authority confirming that a novel duty of care will not be recognized if, by doing so, healthcare professionals may be faced with conflicting duties of care.

[71] I first discuss the most relevant cases relied on by the Health Authority.

a. Syl Apps Secure Treatment Centre v. B.D.

[72] In *Syl Apps Secure Treatment Centre v. B.D*., 2007 SCC 38 [*Syl*], the Court considered a claim for damages brought by parents and other relatives of a child who was eventually made a permanent ward of the state. The child was initially removed from her parents based on a letter written by the child alleging physical and sexual abuse by her parents. Her parents were never charged with an offence.

[73] The child was placed in a foster home then transferred to several psychiatric facilities and finally, placed a treatment centre where she consented to be made a permanent ward of the state.

[74] The family alleged that the treatment centre based the child's treatment on the assumption that the allegations of abuse were true, which amounted to negligence causing the child's alienation from her family, thus depriving them of a relationship with her. This was recognized to be the assertion of a novel duty of care, so the Court applied the *Anns/Cooper* framework.

[75] The Court found the governing legislation did not give rise to a proximate relationship between the treatment centre and/or social workers and the family because its paramount purpose was to promote the best interests, protection, and well-being of children (para. 48). It further stated that if a duty of care to family members was imposed on the treatment center and social workers, it would create "a genuine potential for 'serious and significant' conflict with the service providers' transcendent statutory duty to promote the best interests, protection and well-being of the children in their care" (para. 41).

[76] The context in which those conclusions were drawn is relevant. This was a case about a child in care. When children are placed in care, there has typically been a judicial determination that the child is in need of care because of deficiencies in the care provided by the parents.

> 49 … A child in care generally involves "situations in which the care parents provide is considered so inadequate that direct interference by the state is justified to protect children . . . [S]tate interference through removal of a child from parental care will only be justified if it is proven that there is a significant risk to the child" (N. Bala, "Child Welfare Law in Canada: An Introduction", in N. Bala et al., eds., *Canadian Child Welfare Law* (2nd ed. 2004), 1, at pp. 1-2). The finding that R.D. was a child in need of protection, for example, was made pursuant to s. 37(2)(f) and (h) of the Act. According to the wording of the Act when the order was made, such a finding meant that "the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, services or treatment to remedy or alleviate" the harm or condition in question.

[77] While that does not extinguish any role for the family, the Court recognized that in those circumstances, conflict between the family and the state is inevitable, even if sometimes treating a child in care can be done in a way that meets with the family's satisfaction in the long term (para. 43). Thus, the conflict was an inexorable and direct result of the purpose of the statutory scheme, which underlay the claim.

b. Lavery v. Community Living British Columbia

[78] *Lavery v. Community Living British Columbia*, 2022 BCSC 739, also addressed a dispute about care given to a child. The Health Authority relies on this case, and submits it is binding precedent that no duty of care is owed to family members of a person in care in the community. In my view, that assertion overstates the holding from this case.

[79] In *Lavery*, a mother brought a claim in her personal capacity and as executor of her late daughter's estate in negligence and breach of statutory duty. Her daughter had severe physical and developmental disabilities and had been residing in residential care operated by Community Living British Columbia (CLBC). The plaintiff mother characterized the duty of care as follows (at para. 9):

> a) CLBC owed her a duty not to reduce the number of nursing hours provided to [her daughter];
>
> b) CLBC owed her a duty in addressing the concerns she raised regarding [her daughter]'s care; and,
>
> c) CLBC owed her a duty to prevent [her daughter]'s death.

She alleged that CLBC had a statutory duty to "work with parents, guardians, and families of disabled adults to provide care to adults with disabilities".

[80] In *Lavery*, the daughter was nonverbal, and the mother said she assumed responsibility for communicating her daughter's needs, which she argued placed her in a relationship of proximity with CLBC that gave rise to the duty of care:

> [46] The plaintiffs submit that CLBC was in a relationship of proximity to Ms. Lavery such that a duty of care existed. Ms. Lavery states that her level of involvement with the defendants as Katrina's "voice" under a representative agreement establishes the requisite proximity.

[81] The court held that the governing statue was exhaustive with respect to CLBC's duties:

> [68] The mere fact that Ms. Lavery interacted with CLBC does not ground a duty of care. Negligence simply does not cover every interaction that a person has with a statutory body (*Dawson v. Vancouver Coastal Health Authority*, 2021 BCSC 2060 at para. 29). Given the above authorities, the law is clear there is no duty of care owed by CLBC to the plaintiff Ms. Lavery. Ms. Lavery seeks to expand on what is in the Act, yet the Act is the source of CLBC's authority and obligations and does not create a private law duty of care. The duty of care argument fails as there is no relationship of proximity.
>
> …
>
> [70] The existence of a duty of care to Katrina does not raise a presumption there is a duty owed to her mother, no matter how close Katrina and Ms. Lavery's relationship was. A duty of care being owed to a child does not result in a prima facie duty being owed to their parent because of the potential for conflicting duties. While there is no doubt that Ms. Lavery spoke for and advocated on her daughter's behalf, this does not establish the proximity necessary to give rise to legal liability. Any duty of care owed by CLBC to Katrina and the alleged duty of care to her mother could potentially conflict (see Wawrzyniak at paras. 370-371).
>
> [Emphasis added.]

[82] Accordingly, Justice Punnett, at para. 55, declined to find a duty of care existed:

> The plaintiffs' allegations relate to a failure to address Katrina's medical needs causing her death. However, there is no duty of care owed to parents of a child receiving medical treatment, nor does such a duty exist in other situations.
>
> [Emphasis added.]

[83] The "other situations" to which Justice Punnett referred (in paras. 55–56) were all cases brought by parents regarding care given to their child, including *Syl*, which I have already discussed, and *Elkow v. Sana*, 2006 ABQB 851 (school board's duty to a parent of a child).

c. Alafi v. Lindenbach

[84] The Health Authority also relies on *Alafi v. Lindenbach*, 2022 ONSC 1435 [*Alafi 2022*], where parents brought a claim for negligence against a midwife organization and three of its employees regarding care provided during the delivery

of their daughter and the days that followed. The Health Authority argues the case defeats Mr. Dwyer's assertion of recognizing a novel duty of care.

[85] The Ontario Court issued two decisions on the defendants' motion to strike the claim: *Alafi 2022* and *Alafi v. Lindenbac*h, 2023 ONSC 831 (*Alafi 2023*). This was a case about decisions and actions made by midwives during and after a child's birth. During the child's delivery, a midwife communicated with the Children's Aid Society, which apprehended the infant immediately after birth. The child was then administered with a medication without the parents' consent. Although the child was later returned to the parents, they were ordered to attend all medical appointments and follow all recommendations from medical professionals.

[86] The midwives brough an application to strike the claim against them. In *Alafi 2022,* the court categorized two types of claims that were pleaded against the midwives: a "scope of practice" claim and a "duty to report" claim. The scope of practice claim consisted of allegations relating to the assessment, monitoring, and care to Ms. Alafi during pregnancy, labour, and the post-partum period, as well as the assessment, monitoring, and care of the child during the post-partum period.

[87] In *Alafi 2022,* the court struck, without leave to amend, Mr. Alafi's scope of practice claims, which included claims based in negligence, negligent misrepresentation, and negligent infliction of mental suffering. The claims based on duty to report were adjourned.

[88] In *Alafi 2022*, the parties agreed that the claim was based on the recognition of a novel duty of care, thus requiring an application of the *Anns/Cooper* analysis (para. 54). The father submitted that his claim as the spouse of one patient and the father of the other, raised a novel issue. His position was that his status (as father and spouse) distinguished his claim from those brought by: a future child of a physician's not-yet-pregnant patient and a patient's offspring (both considered in *Paxton v. Ramji*, 2008 ONCA 697); and, a patient's substitute decision-maker (considered in *Wawrzyniak v. Livingstone*, 2019 ONSC 4900): para. 64.

[89] The court agreed that Mr. Alafi's status as a spouse and father meant he had a more direct relationship with the midwives, but it nonetheless concluded that his status was similar to those from which he sought to be distinguished: all were claims brought by a "non-patient" third-party. The court held that the law was settled that a "scope of practice" claim against health professionals could not be brought by third-party non-patients (para. 73). The claim, therefore, failed at the first stage of the *Anns/Cooper* test because proximity could not be established (para. 72). The court also held that it would at fail stage two because of settled law, and residual policy considerations (para. 73).

[90] *Alafi 2023* considered the duty to report claim against the midwives. However, the plaintiffs re-cast the claim as a "duty to inform the substitute decision-maker". The midwives agreed that such a claim did not fall into a category previously discussed in the caselaw, and that the plaintiffs could meet the foreseeability portion of stage one (paras. 41, 43). However, the midwives argued that no novel duty should be recognized for the same reasons given in *Alafi 2022*, that it was a claim brought by a third-party non-patient (para. 44).

[91] The court dismissed the claim for a slightly different reason. It held that the alleged "duty to inform" was, in reality, the same as healthcare professionals' duty to obtain informed consent, falling within scope of practice, which had to be struck (paras. 62–63). Therefore, all claims described as falling under a "duty to report" were struck without leave to amend (para. 65).

d. Wawrzyniak v. Livingstone

[92] The case that comes closest to the factual matrix before me is *Wawrzyniak v. Livingstone*, 2019 ONSC 4900. The Health Authority relies on this case because it submits it applies the conclusions from *Syl* to the healthcare setting.

[93] *Wawrzyniak* resulted from a 15-day medical malpractice trial. The plaintiff's father was a patient at a hospital. Her father was elderly and suffering from several illnesses. The hospital had a policy to initiate cardiopulmonary resuscitation (CPR) unless a specific instruction not to do so was given by a patient, a substitute

decision-maker or health care provider who had written a medical order precluding the otherwise automatic administration of CPR. As the substitute decision-maker, the plaintiff consented to a "full code" note on her father's file, meaning that CPR would be administered in the event of cardiac of respiratory distress.

[94] At one point, the doctor most responsible for the plaintiff's father assessed him, noted that he was close to death "and would almost certainly not benefit from resuscitation, [and] concluded [CPR] would only cause him suffering and harm" (para. 6). Another doctor who assessed the patient agreed, and as a result, both signed a "do not resuscitate" ("DNR") order for the patient's chart.

[95] They were unsuccessful in reaching the plaintiff to discuss that change in the resuscitation status of her father. She came to the hospital to see her father, unaware that the DNR had been put on his chart. Her father was in respiratory distress, and she sought medical intervention. The doctors were paged and attended immediately, explaining to her that her father "would almost certainly not benefit from resuscitation and CPR would cause suffering" (para. 9). CPR was not administered, and her father died. Naturally, she was upset and angry about that course of events.

[96] The plaintiff sought damages based on loss of guidance, care, and companionship (under the *Family Law Act*, R.S.O. 1990, c. F.3); her severe and lasting mental injuries based on negligence (based only on her capacity as a family member, not as a substitute decision-maker, see para. 343); and breach of fiduciary duty. It was the latter allegation of breach of fiduciary duty that was based on her status as a substitute decision-maker.

[97] The court rejected recognition of this claim based on the potential for an untenable conflict for the physician:

> [407] The defendants submit, citing *Alberta v. Elder Advocates of Alberta Society*, 2011 SCC 24 at para. 29, that while the hallmarks identified in Frame are useful in explaining the source of fiduciary duties, they are not a complete code for identifying fiduciary duties, and that further analysis is required to identify whether a fiduciary duty applies in the circumstances of a given case. They submit that, first, the alleged fiduciary must have given an undertaking of responsibility to act in the best interests of a beneficiary. In

> relation to the required undertaking, the party asserting the duty must be able to point to a forsaking by the alleged fiduciary of the interests of all others in favour of those of the beneficiary, in relation to the specific legal interest at stake. Second, the duty must be owed to a defined person or class of persons who must be vulnerable to the fiduciary because the fiduciary has a discretionary power over them. Third, the claimant must show that the alleged fiduciary's power may affect the legal or substantial practical interests of the beneficiary: *Alberta* at paragraphs 30-35.
>
> [408] With respect to the relationship between a physician and a substitute decision-maker, the physician cannot undertake to put the substitute decision-maker's interests above those of all others. Such an undertaking would, possibly, conflict with the duty of care owed by a physician to his or her patient. The plaintiff does not suggest that the defendants gave up their duty owed to Mr. DeGuerre in favour of a fiduciary duty to act only in the interests of the plaintiff. In this case, the plaintiff was insisting that CPR be administered to her father on a full code basis, and the defendants decided that it be medically inappropriate for them to do so. This is a conflict which makes the imposition on the defendants of a fiduciary duty to act in the best interests of the plaintiff untenable. I find that the plaintiff has failed to show that the defendants undertook to act in her best interests in favour of the interests of their patient, Mr. DeGuerre. This finding is sufficient for me to conclude that the defendants did not owe a fiduciary duty to the plaintiff.

[98] That analysis is consistent with the court's previous conclusions that it should not recognize a duty of care to support a claim for damages for nervous shock owed to the plaintiff as the daughter of a patient because of the potential for conflicts of interest that may arise:

> [370] I accept that recognition of such a duty of care owed by a physician to a family member or substitute decision-maker of an incapable patient would have the potential to put the physician in a conflict of interest because the wishes of the close family member or substitute decision-maker may not align with the physician's medical opinion of what is in the patient's best interests. The imposition of a duty of care owed by a physician to a patient's family members or a substitute decision-maker might influence the physician, in attempting to comply with competing and potentially conflicting duties of care, to act in ways in which he or she would not otherwise act and put the patient at risk of harm. The dissenting decision of Sharpe J.A. of the Court of Appeal for Ontario and the decision of Abella J. of the Supreme Court of Canada in *Syl Apps* are authorities which support the conclusion that where the duty claimed would potentially conflict with the defendant's overarching duty (in this case the duty owed by the defendants to their patient, Mr. DeGuerre), proximity is not made out.
>
> [371] I conclude that proximity is not made out because a duty of care owed to a person in the position of the plaintiff would potentially conflict with the doctors' overarching duty of care owed to their patient. The plaintiff has failed to establish that the defendants owed her a prima facie duty of care to

> be mindful of her interests as her father's daughter who was closely involved with his care or as his substitute decision-maker.
>
> [Emphasis added.]

e. Analysis of Cases

[99] I am not persuaded that the cases relied upon by the Health Authority conclusively rule out Mr. Dwyer's ability to establish a novel duty of care.

[100] I find the features of this case sufficiently distinguish it from the cases cited by the Health Authority. One feature is his emphasis that the actions of the Care Home directly contradicted Ms. Dwyer's Directive. There is a statutory provision requiring healthcare facilities to respect such a directive (*Consent Act*, s. 12.1), and the immunity in that legislation requires that care was provided in good faith and using reasonable care (s. 33). Mr. Dwyer's claim, read generously, challenges both propositions. In my view, that alone distinguishes this case from any other cited to me.

[101] I add that interrelated to that is Mr. Dwyer's contention that he was recruited to provide direct care to his wife and, as such, had the best knowledge of her preferences and tolerance for different types of food. Also, he was her legal representative empowered to advocate for her end-of-life care. In that context, his direct observations while feeding her, combined with his knowledge of her, clearly expressed preference for end-of-life care, demanded that his instructions and directions ought to have been respected. He alleges failure to do so was negligence.

[102] For the reasons explained below, I find the juridical basis of the cases brought to my attention are distinguishable from these facts, such that none are either binding or persuasive precedents precluding Mr. Dwyer's claim in negligence

[103] The Health Authority submitted *Lavery* was a binding precedent that precluded his claim. However, in that case the mother brought her claim under the *Family Compensation Act*, R.S.B.C. 1996, c. 126, which is not a statute involved in this case. Certainly, that legislation has no application to that aspect of Mr. Dwyer's claim seeking relief as a substitute decision-maker. More importantly, in *Lavery*, in

the mother's status and relationship to the organization and how that related to the claims she wanted to raise, was ambiguous. Thus, I am not persuaded that this case defeats the potential duty of care that Mr. Dwyer wants to establish.

[104] *Syl* is not a case similar enough to Mr. Dwyer's situation because it involves a claim by family members about the care of a child who was removed from their care. Cases about children in care involve the inherent and inescapable conflict between those obliged to provide care in the child's best interests, and parents who had already been found incapable or unwilling to do so. I am not persuaded that overarching principle can be translated to the situation of the end-of-life care dictated in an advanced directive.

[105] The Health Authority relies on *Alafi 2022* because it applied *Syl* to the health care setting, and stated the broad proposition that no duty of care owed by healthcare professionals to third-party non-patients (see para. 73).

[106] *Alafi 2022* also involved the inherent conflict that arises when a child is found to be in need of protection and removed, in this case temporarily, from parents' care. In my view, that contextual element cannot be separated from the broad conclusion stated at para. 73.

[107] In addition, I am not bound by an Ontario court's conclusion that *Syl* should be extended to the healthcare setting, although I agree it requires careful consideration. These comments apply equally to *Wawrzyniak,* which I noted involves facts closer to Mr. Dwyer's situation.

[108] Also, with regard to the facts in *Wawrzyniak*, apart from anything else, I find it reasonable that there could be a material difference between a case where substitute decision-maker wants medical care to be provided to prolong a patient's life in the face of medical decision that such treatment would cause suffering and the facts in this case.

[109] Moreover, it is unclear if the conclusion at para. 73 of *Alafi 2022* is an accurate statement of the law in Ontario, and on that point, *McKee v. Shahid*, 2024

ONSC 4258, is helpful. The issue in that case was whether to strike a claim brought by a patient's parents against a psychiatrist. In reviewing the jurisprudence on the existence of a duty of care to third-party non-patients (including *Syl* and *Wawrzyniak*), the court concluded that the case law did not categorically foreclose the possibility that a duty of care could be found to exist in that context:

> [56] To be more precise, Corthorn J. concluded that healthcare professionals do not owe a duty of care to non-patient third parties, on the basis of jurisprudence that included Syl Apps, as above, Paxton v. Ramji, as above, and Wawrzyniak v. Livingstone, 2019 ONSC 4900.
>
> [57] Further support for Justice Corthorn's conclusion is offered by the decision in *Ovari v. Brant Community Healthcare System*, 2023 ONSC 6933 (CanLII), 2023 ONCS 6933, where Broad J. held, at para. 40:
>
> > It is clear from the jurisprudence that a healthcare professional does not owe a duty of care to a non-patient third party, including a close family member or substitute decision-maker, as the recognition of such a duty would have the potential to put the professional in a conflict of interest because the wishes of a close family member or substitute decision-maker may not align with the healthcare professional's medical opinion of what is in the patient's best interests [citation omitted]
>
> [58] I do not agree that appellate jurisprudence goes so far as to categorically preclude the recognition of a duty of care between a physician and a non-patient third party. …
>
> [Emphasis added.]

[110] One case the court reviewed that may be of note was *Paxton*, where the trial judge concluded that there was no duty of care, failing at the proximity stage, but did not strike the claim:

> [70] Despite having the benefit of *Syl Apps*, Feldman J.A., for a unanimous panel, did not conclude that it was settled law that a duty of care could never be owed by a physician to a non-patient third party. Indeed, to the contrary, she held, at para. 53:
>
> > Having reviewed these authorities, I believe it is fair to say that there is no settled jurisprudence in Canada on the question of whether a doctor can be in a proximate relationship with a future child who was not yet conceived or born at the time of the doctor's impugned conduct.
>
> [Emphasis added.]

[111] The court in *McKee* ultimately struck the claim, but allowed the plaintiff to re-plead:

> [132 … Having said that, this is a very serious case, involving the tragic killing of a father by his mentally ill son. The claim raised by the plaintiff is a novel one and the law is not clear on its constituent elements. It is, in my view, in the interests of justice that the plaintiff be permitted to amend the claim and continue to litigate it on its merits.

[112] I also find it relevant and significant that the conclusions in *Wawrzyniak* were reached after a trial had taken place, and the court heard all evidence. Notably, the conclusion whether to recognize a novel duty of care took place in the context of the court making the following conclusions about the doctor's conduct (para. 12):

a) the doctor's clinical judgment that the plaintiff's father was close to death and administering CPR would "almost certainly not benefit him and would only cause suffering and harm" were decisions that met the applicable standard of care;

b) by the doctors' decision not to administer CPR and to place a DNR on the patient's chart met the applicable standard of care;

c) the doctors did not breach the applicable standard of care by failing to obtain consent not to administer CPR; and

d) the doctors did not fail to meet requisite standard of care by, before writing DNR, not informing the plaintiff of their conclusion that CPR would not benefit the patient nor in way that was communicated to her.

[113] Thus, it was only after a trial was held and drawing the preceding conclusions that the court determined that *Syl* could be applied in the healthcare setting.

f. Conclusion

[114] I do not agree with the Health Authority that the case law in British Columbia is settled to the extent that a third-party non-patient can never succeed in establishing the recognition of a novel duty of care owed to that party by a

healthcare facility or professional. Certainly, given the material facts in this case, I am not satisfied that previous case law establishes that Mr. Dwyer cannot establish he was owed a duty of care.

3. Proximity

[115] The Health Authority did not dispute that Mr. Dwyer could establish foreseeability, but contends he cannot, for policy reasons, establish proximity.

a. Breach of Statute

[116] The Health Authority questioned what purpose is served by Mr. Dwyer's reference to statues in the NOCC. It submits that a breach of a statute is not determinative on the issue of negligence and, at most, it may be evidence of a breach: *R. v. Saskatchewan Wheat Pool*, [1983] 1 S.C.R. 205, 1983 CanLII 21.

[117] The Health Authority also argues that Mr. Dwyer's claims based on breaches of statute are barred by the *Health Authorities Act,* R.S.B.C. 1996, c. 180, as well as the *CCAL Act*. The Health Authority is a designated regional health board established pursuant to the *Health Authorities Act*. Employees have statutory immunity against being sued in respect of good faith actions or omissions done in the course of their employment pursuant to s. 14(1) of that Act. This immunity is similar to s. 33 of the *Consent Act.*

[118] However, based on a generous reading of the claim and taking into account Mr. Dwyer's submission in Court, I do not discern that he seeks relief on the basis of any breach of statute alone. Instead, he raises the statutory provisions as providing context for what he says was the overriding failure to respect his direction about end-of-life care as Ms. Dwyer's substitute decision-maker.

[119] The Health Authority also raises the statutory provisions in support of its position that Mr. Dwyer cannot establish proximity, for policy reasons. It submits that the Care Home's statutory duty to Ms. Dwyer required it to act in Ms. Dwyer's best interests and its ability to do that would be jeopardized if it also had to consider the impact of their actions on family members. That potential for conflict is certainly one

of the main bases upon which most of the cases cited by the Health Authority refused to recognize a novel duty of care owed to patient's family members.

[120] I do not find that line of reasoning persuasive. Specifically, I find the context of providing end-of-life care such as feeding (as opposed to medical interventions) raises a novel question as to whether the patient (herself, or by proxy, her representative) or the Care Home are in the best position to determine the specific of end-of-life care. It may be that in years past, there was a consensus in society that, in general, medical or health care professionals were best placed to know what accords with a patient's best interest. In that context, it might have been true that there was a "clear answer" whether giving Ms. Dwyer "lumpy" food met or did not meet the requisite standard of care, or be in her best interest.

[121] However, we must recognize that societal attitudes and the law has made significant advances with regard to end-of-life care and decision-making. In an era where Parliament has come to accept the legitimacy and sacredness of people being able to, if they choose, have medical assistance in dying, it is not clear the same principles applicable to providing medical care must be applied in the same way to end-of-life care.

[122] For that reason, I am not persuaded that imposing a duty on health care professionals to follow a substitute decision-maker's direction about end-of life care, when an advance directive exists, necessarily leads to conflicting duties of care in today's society. Certainly, I am unable to draw the conclusion based on the pleaded facts in this case, at this stage of this litigation.

[123] From a policy perspective, the reasonability and justification to avoid conflicting duties of care is based, at least in part, on a presumption of the superiority of health care providers' assessment of what is best for a patient. It is not clear to me that presumption remains reasonable and defensible with regard to end-of-life care, given the acceptance that people have greater autonomy over the timing and manner of their death. In *Carter v. Canada(Attorney General)*, 2015 SCC 5, the Court stated "the law has come to recognize that, in certain circumstances, an

individual's choice about the end of her life is entitled to respect" (para. 63) and s. 7 of the *Charter* "recognizes the value of life, but it also honours the role that autonomy and dignity play at the end of that life" (para. 68).

4. Conclusion

[124] For all those reasons, I do not find it is plain and obvious that Mr. Dwyer could not establish the recognition of a novel duty of care in order to pursue a claim of negligence against the Care Home based on the constellation of facts in this case.

B. Damages for Mr. Dwyer's Emotional Distress

[125] With regard to the claim for emotional distress, the Health Authority conceded that the law is in a state of evolution. Despite that, it maintains that Mr. Dwyer cannot establish a duty of care was owed to him given the prevailing law within the applicable statutory scheme. That aspect of the Health Authority's position is not persuasive for the reasons I have stated above.

[126] However, the Health Authority also submits that since Mr. Dwyer's claim relates facts that occurred over an extended period of time, which he says amounted to negligent conduct, the allegation lacks the immediacy required to support a claim for psychological injury. Such claims require there be a distinct, traumatic experience in order to establish proximity for a claim of nervous shock: *Lavery* at paras. 87, 96–97; *E.B. v. British Columbia (Child, Family and Community Services),* 2021 BCCA 47 at paras. 59–63.

[127] It is not entirely clear to me that Mr. Dwyer intended to tie the emotional distress he said he suffered, to what happened over the entire time he was providing care to his wife. A possible interpretation is that the events surrounding the reintroduction of a diet of lumpy puree in the face of her Directive and MRA grounds the claim. The NOCC could benefit from clarity on that point.

[128] Also, the Health Authority acknowledges developments in the case law that may be favourable to Mr. Dwyer's position. For instance, in *Bevan v. Husak,* 2024 BCCA 323, the Court of Appeal allowed an appeal of an order striking a claim for

negligent infliction of mental distress. The plaintiff was a mother whose daughter was sexually assaulted by the defendants. The Court of Appeal held that it was at least arguable the defendant owed a duty of care to the plaintiff because he had assured her he would keep her daughter safe (para. 102). The court also noted that the claim, "While novel, given the evolving state of the law and widely-known harm associated with sexual assault … it cannot be said that a claim of this sort has no prospect of success whatsoever" (para. 103).

[129] I would say given the evolution in the law regarding the court's attitude about people's control over the manner of their death, leads to the same conclusion regarding Mr. Dwyer's claim.

[130] For those reasons, I am unable to say that Mr. Dwyer's claim for damages for emotional distress has no chance of success.

D. Claim for Damages Brought on Behalf of the Estate

[131] With regard to the claim brought in his capacity as executor of Ms. Dwyer's estate, the Health Authority says it is not entirely clear which allegations of negligence are alleged to have caused Ms. Dwyer to suffer injury. For that reason, the pleadings are inadequate because they do not set out material facts to support a cause of action.

[132] However, the Health Authority does acknowledge that Mr. Dwyer's application response contains an allegation that the failure to manage Ms. Dwyer's oral health caused her physical pain and prolonged emotional distress. Even if such a claim was properly pleaded, the Health Authority's position is that a claim seeking damages for pain and suffering on behalf of a deceased person is precluded by legislation.

[133] In my view, reading the NOCC generously, the claim may be the Health Authority's failure to abide by the Directive and MRA, thereby possibly prolonging her life, caused her to suffer emotional distress.

[134] Even if that is the case, I agree the claim has no prospect of success because of s. 150(4) of the *Wills, Estate and Succession Act*, S.B.C. 2009, c. 13 [*WESA*], which precludes the ability to seek damages on behalf of a deceased person in respect of a nonpecuniary loss:

> (2) Subject to this section, the personal representative of a deceased person may commence or continue a proceeding the deceased person could have commenced or continued, with the same rights and remedies to which the deceased person would have been entitled, if living.
>
> …
>
> (4) Recovery in a proceeding under subsection (2) does not extend to
>
> (a) damages in respect of non-pecuniary loss …

[135] Thus, any claim that Mr. Dwyer seeks to bring on behalf of Ms. Dwyer's estate for damages for her mental distress or physical pain she suffered, is foreclosed by s. 150 of *WESA*.

V. CONCLUSIONS

[136] For the reasons cited above, I find:

a) The portions of the NOCC asserting a claim for damages on behalf of Ms. Dwyer's estate have no prospect of success and are struck pursuant to Rule 9-5(1)(a).

b) The portion of the claim in which Mr. Dwyer seeks damages against the Care Home for its failure to follow the Directive and MRA regarding Ms. Dwyer's end-of-life care is not bound to fail and can proceed.

c) The portion of the claim seeking damages for Mr. Dwyer's emotional distress can proceed.

[137] In my view, it is in the interest of justice to permit Mr. Dwyer to amend his claim to provide clarity for the claims I have identified can proceed.

[138] In particular, in my view, it would be contrary to the interest of justice to not allow him to rectify any flaws in his pleadings based on the absence of facts which

he stated at the hearing. This is based on guidance from the Court of Appeal and the Supreme Court of Canada, as I discussed in *Rahman v. Windermere Valley Property Management Ltd.*, 2025 BCSC 1221:

> [16] … Among other things, the Court of Appeal referred to courts' duty to self-represented litigants, citing *Charbonneau Estate v. Charbonneau,* 2021 BCCA 206 at para. 42, before continuing as follows:
>
> > [32] These statements align with the guidance in *Pintea v. Johns*, 2017 SCC 23 where the Court endorsed the *Statement of Principles on Self-Represented Litigants and Accused Persons* (2006) authored by the Canadian Judicial Council: at para. 4. The Statement of Principles provides, among other things, at 4 that:
> >
> > > 1. Judges and court administrators should do whatever is possible to provide a fair and impartial process and prevent an unfair disadvantage to self-represented persons.
> > >
> > > 2. Self-represented persons should not be denied relief on the basis of a minor or easily rectified deficiency in their case.
> >
> > …
> >
> > [34] A trial judge has a duty to assist self-represented litigants in presenting their cases properly in order to provide a fair and impartial process and prevent unfair disadvantage to self-represented parties: *Burnaby (City) v. Oh*, 2011 BCCA 222 at paras. 35–36, leave to appeal to SCC ref'd, 34373 (8 December 2011), citing *Davids v. Davids*, [1999] O.J. No. 3930 at para. 36, 1999 CanLII 9289 (C.A.); *Williams v. Unrau Williams*, 2004 BCCA 577 at para. 27; *Morwald-Benevides v. Benevides*, 2019 BCCA 1023 at paras. 34–35. Of course, this duty is limited as it engages a delicate balance between the judge's duty to ensure a fair process and their duty to remain neutral both in appearance and reality: *Burnaby (City)* at paras. 35–36; *Child & Family Services of Winnipeg v. J.A. et al.*, 2004 MBCA 184 at paras. 32–35, leave to appeal to SCC ref'd, 30736 (30 June 2005).
>
> [Emphasis added in *Rahman*.]

[139] As noted, I also find it would not be keeping with the interest of justice to assess the Health Authority's application to summarily dismiss Mr. Dwyer's claim before he has had a chance to amend it. I dismiss it for that reason, but nothing stated here should foreclose the possibility of the Health Authority to bring such an application after the amendment of the pleadings.

COSTS

[140] Because he was successful, Mr. Dwyer is entitled to the costs of this application.

"Sharma J."