

CANADA / JUDGMENT

McGlone v. Kelly

2002 BCSC 774

COURT

Supreme Court of British Columbia

DECIDED

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Citation:

McGlone v. Kelly, Balfour et al
Date: 20020522
2002 BCSC 774

Docket:

99/4707
Registry: Victoria
IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

TAYLOR MCGLONE (ALSO KNOWN AS TAYLOR FLEMING), AN INFANT
BY HER GUARDIAN AD LITEM, TRACY MCGLONE, TRACY MCGLONE
AND MARC FLEMING
plaintiffs

AND:

DR. PHILIP KELLY, DR. MANVILLE, DR. J. BALFOUR,
DR. J. MATTHEW, NURSE D. GRONEBERG, NURSE D. MARGETTS,
NURSE JOHN OR JANE DOE AND THE
GREATER VICTORIA HOSPITAL SOCIETY AND
NURSE J. MCMILLAN AND NURSE C. STAFFORD
defendants

REASONS FOR JUDGMENT

OF THE

HONOURABLE mr. JUSTICE shabbits

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Nurse D. Groneberg and

Nurse D. Margetts

Catherine L. Woods and

Alex Sayn-Wittgenstein

Date and Place of Trial:

October 22-26, 2001;

October 29-31, 2001;

November 1 & 2, 2001;

November 5-8, 2001;

November 13 & 14, 2001

Victoria, B.C.

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NATURE OF THE PROCEEDINGS

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- [1] Taylor Fleming was born on October 16, 1997. She suffered a brain injury at birth that led her to develop cerebral palsy. She is profoundly disabled. In this action, Taylor and her parents claim compensation for the damages they have suffered from the injury to Taylor.
- [2] The plaintiffs allege that the Hospital Society was negligent in promoting the use of the medication misoprostol to induce labour in post term patients, and negligent in adopting the protocol that guided general practitioners and registered nurses in its facilities in the use of misoprostol.
- [3] The plaintiffs allege that Dr. Kelly was negligent in accepting misoprostol as medication to induce labour in Tracy McGlone, and negligent in the manner in which it was used.
- [4] The plaintiffs allege that Dr. Kelly and three of the registered nurses that cared for Tracy McGlone while she was in labour, did not provide her with adequate care.
- [5] The plaintiffs allege that those acts of negligence caused or materially contributed to the damages that they seek to recover.

CHRONOLOGY OF EVENTS

- [6] Tracy McGlone was born in South Africa on April 29, 1977. She received a high school education there before moving to Canada in October of 1994. She has obtained a Business Administration Diploma from Camosun College in Victoria. She is taking courses two evenings a week with a goal of obtaining accreditation as a Certified Management Accountant. Since January of 2001, Ms. McGlone has been a full-time employee of the Ministry of Health in Victoria.
- [7] Ms. McGlone and Marc Fleming met in the fall of 1996. They entered into, and remain, in a common law relationship. They have two children: Taylor, who was born on October 16, 1997, and Samantha, who was born on April 22, 1999.
- [8] Mr. Fleming was 21 years of age when Taylor was born. He is a journeyman carpenter. He is self-employed.
- [9] Ms. McGlone became a patient of Dr. Kelly after she became pregnant with Taylor. Her family physician did not practice in obstetrics. Dr. Kelly was attending to a friend of Ms. McGlone, who was also pregnant. Ms. McGlone first saw Dr. Kelly on February 25, 1997.

- [10] Ms. McGlone's pregnancy was uneventful. She and Mr. Fleming attended pre-natal classes. Ms. McGlone does not smoke. During her pregnancy, she did not drink either alcoholic beverages or soft drinks.
- [11] On October 14, 1997, Ms. McGlone had an office visit with Dr. Kelly. It was then seven days beyond her expected date of delivery that was October 7, 1997. They discussed, and made tentative arrangements, for the induction of her labour.
- [12] Following the office visit on October 14, 1997, Dr. Kelly left the following Physician's Order at the Victoria General Hospital relating to Ms. McGlone:
- For outpatient prostaglandin E2 October 16, 1997.
- [13] On October 16, 1997, Ms. McGlone and Marc Fleming went to the Victoria General Hospital. She was admitted as an outpatient at 8:10 hours. Nurse J. McMillan initiated electronic fetal monitoring in order to assess the condition of the fetus. She took Ms. McGlone's vital signs at 9:00 hours. Dr. Kelly examined Ms. McGlone.
- [14] Dr. Kelly had intended to attempt to induce labour by using a medication known as Prostin. Prostin is a synthetic analogue of prostaglandin E2. Dr. Kelly was familiar with its use. A registered nurse told Dr. Kelly that misoprostol (Cytotec) was being used at the Victoria General Hospital for induction of labour of post term patients. Misoprostol is a synthetic analogue of prostaglandin E1.
- [15] Dr. Manville, an intern, testified that Dr. Kelly asked her for the protocol for misoprostol induction.
- [16] Dr. Kelly read the Capital Health Region (Victoria General Hospital) protocol relating to the use of misoprostol.
- [17] At 09:00 hours, Dr. Kelly inserted half of a misoprostol tablet (50 micrograms) into Ms. McGlone's vagina. It was kept in place with a tampon. Electronic fetal monitoring continued until just before 10:00 hours.
- [18] Nurse McMillan assessed the fetal heart monitoring strip which had been printing during the monitoring. She assessed it as having a Kubli score of 9 out of 10, which is indicative of reassuring and reactive fetal activity.
- [19] Ms. McGlone was discharged at 10:10 hours in apparent satisfactory condition.
- [20] Ms. McGlone was told to remain active, and to return to the hospital if she went into labour. She was told to otherwise return to the hospital at about 17:00 hours or 18:00 hours. Ms. McGlone testified that she had been instructed by Dr. Kelly to return at about that time, as he would, if necessary, medicate her with the other half of the tablet.
- [21] Ms. McGlone returned to the hospital with Mr. Fleming, and with Ms. K. Griffin, who is her sister.

- [22] Ms. McGlone was readmitted to the hospital at 17:45 hours. She was attended to by Nurse J. McMillan. Nurse McMillan initiated electronic fetal monitoring at 17:49 hours.
- [23] Ms. McGlone's evidence was that after she returned to the hospital, she told Dr. Kelly that she had been experiencing mild contractions, "if anything".
- [24] Dr. Kelly examined Ms. McGlone and decided against administering further induction medication. He artificially ruptured Ms. McGlone's membranes. Although she had been experiencing only mild contractions prior to the rupture of membranes, the rupture of membranes resulted in her going into the first stage of labour.
- [25] Ms. McGlone testified that as soon as her membranes were ruptured, she started to have strong contractions and complained to Dr. Kelly about the pain. Dr. Kelly told Ms. McGlone that labour took a long time, and that he would likely see her again around midnight. He did not think that her condition was cause for concern.
- [26] The nursing note reads as follows: "Returned for further misoprostol. Cervical change allowed ARM by Dr. Kelly. Clear liquor draining + patient started experiencing contractions following ARM."
- [27] After Ms. McGlone's membranes had been ruptured, a difficulty arose with respect to the monitoring of the fetal heart. Ms. McGlone said that discomfort caused her to move about so much that the monitoring was compromised.
- [28] Nurse McMillan testified that the fetal heart monitoring tracing from 18:05 hours on was not satisfactory, and that this was after the rupture of membranes. The strip was providing little information of use to her.
- [29] At 19:30 hours, there was a nursing shift change at the Victoria General Hospital. Tracy McGlone's care was transferred from Nurse McMillan to Nurse Stafford. Nurse Stafford noted that she received Ms. McGlone's care at a time when Ms. McGlone was "working hard with contractions".
- [30] At 19:50 hours, Ms. McGlone requested pain relief. After vaginally examining Ms. McGlone, Nurse Stafford administered Demerol and Gravol. Dr. Kelly had earlier left a written order permitting the administration of that medication.
- [31] Ms. McGlone testified that she became nauseous and drowsy. She said her contractions remained strong and close together.
- [32] Ms. McGlone testified that at the point when she felt she had to push the baby out, her sister Ms. Griffin and Mr. Fleming, who were there with her, called for the nurse.
- [33] Nurse Stafford attended to Ms. McGlone. She performed a vaginal examination at 21:45 hours. She had Dr. Kelly paged at 21:50 hours. Ms. McGlone was then transferred to the labour and delivery room and placed in the care of Nurse Groneberg.

- [34] In October of 1997, Dr. Margaret Manville, a recent medical school graduate, was involved in a family practice residency at the Victoria General Hospital.
- [35] Dr. Manville testified that during the evening of October 16, 1997, she saw Dr. Kelly in the nurses' lounge. She arranged to participate in Taylor's birth.
- [36] Dr. Manville went to the labour and delivery at some time between 22:45 hours and 23:00 hours. She arrived when Dr. Kelly was being paged. When she arrived, Nurse Groneberg was placing an electronic uterine monitor on Ms. McGlone. An electronic fetal monitor was already in place.
- [37] Fetal heart monitoring was instituted with a brief tracing at 22:04 hours, and continuous tracing from 22:46 hours to Taylor's birth.
- [38] Dr. Manning said that Nurse Groneberg told her that there had been quite a bit of a bloody show and that the fetal heart rate had gone down to about 100, although it had recovered quickly. Dr. Manville confirmed that the attending nurses thought that the bloody show was "a lot".
- [39] Dr. Kelly arrived at 10:10 hours.
- [40] Dr. Manville said that when Dr. Kelly arrived, he looked at the show but did not think it was of concern. He commented that, although the heart rate had gone down to a low point, it had recovered very quickly. She said that Dr. Kelly arrived at 22:10 hours. This was 15 minutes after Ms. McGlone had been given into her care. Nurse Groneberg said she reported to Dr. Kelly that Ms. McGlone was 6 cm dilated on anti-partum, but feeling pressure to push. She said that Dr. Kelly conducted a vaginal examination at 22:10 hours and determined that Ms. McGlone was fully dilated.
- [41] The birth summary record notes that the second stage of labour started at 10:20 hours. Nurse Groneberg made no record of contraction activity during the second stage.
- [42] Dr. Manville testified that the sound feature of the fetal monitor was on and operating. This permitted those present to hear the rate at which the fetal heart was beating.
- [43] Dr. Manville said that Nurse Groneberg suggested that Ms. McGlone might have a full bladder, and that that might be affecting the descent of the baby's head. Dr. Manville said that Dr. Kelly asked her to put a catheter in. She was unsuccessful because the presenting part was too low.
- [44] She testified that she attempted to put the catheter in for four or five minutes but she was unsuccessful because the presenting part was too low. It was just at that point that the presenting part of the baby became visible.
- [45] A written note on the fetal heart monitor tracing strip is that the presenting part was visible at about 23:06 hours.

- [46] Dr. Manville said that the fetal heart pattern was unlike any that she had seen before. Dr. Manville's experience was limited. She was a recent medical school graduate. She had started an eight-week obstetrical rotation at Victoria General Hospital in late August of 1997. Dr. Manville had had some earlier obstetrical experience, as a four-week rotation during her fourth year of medical school, which permitted her to participate in about 20 deliveries at the B.C. Women's Hospital. Dr. Manville testified that those other births had all involved fetal hearts with a more consistent baseline, and less frequency of heart fluctuations, and with less dramatic range of fluctuations.
- [47] Dr. Manville said that notwithstanding her observation that this birth was different from the others, she thought that Ms. McGlone's labour was going well. She said that Ms. McGlone had frequent strong contractions, with the fetal heart rate ranging between 180 and 100 beats per minute. She said that there were accelerations coincident with contractions, and good variability in the fetal heart rate.
- [48] Dr. Manville did not time the contractions, but expressed the opinion that they seemed to be coming every two minutes. She said that she and Nurse Groneberg told Ms. McGlone not to push between contractions, although both of them felt Ms. McGlone's abdomen and concluded that it was relaxing between contractions.
- [49] Dr. Manville She said that when the presenting part started to crown, Dr. Kelly, Nurse Groneberg and she all expected the delivery to be imminent. A note on the fetal heart monitor tracing strip is that the presenting part was starting to crown at about 23:14 hours.
- [50] Dr. Manville said that about seven minutes before delivery, one of the nurses suggested an episiotomy could be done, and that in response to that Dr. Kelly asked her to put in some freezing, which she did.
- [51] An episiotomy was not done.
- [52] Within the birth summary record, the birth is noted as having been normal rather than abnormal, and there is the comment: "unexpectedly flat baby".
- [53] Dr. Manville said that she was surprised, and shocked, by the condition of the baby.
- [54] Dr. Manville testified that as soon as the baby was born, she took cord gases and cord bloods from the umbilical cord, and then delivered the placenta. She then sutured some labial tears.
- [55] Dr. Manville said that the umbilical cord was wrapped once around Taylor's neck, but it pulled off easily and was not a concern.
- [56] Ms. McGlone was then taken in a wheelchair to the special care nursery where she first saw Taylor, who was being treated.

[57] Ms. McGlone testified that Samantha was born on April 22, 1999. She said that that birth was completely different from that of Taylor's. Samantha's labour was induced with artificial rupture of membranes, but without medication. Ms. McGlone said her labour during Samatha's birth was neither as intense, nor were the contractions as strong or as close together, as with Taylor's, and she was not sedated.

THE NATURE OF TAYLOR'S INJURIES

[58] Taylor was assessed by Dr. Maureen O'Donnell, a specialist in developmental pediatrics. Her opinions as to Taylor's present and future state are set out in her detailed report of August 3, 2001.

[59] Dr. O'Donnell's opinions include these conclusions in the portion of her report captioned "Diagnoses".

[60] She said Taylor is a child with severe cerebral palsy, significant cognitive impairment, severe communication delay, visual impairment and multiple associated medical conditions.

[61] She notes that Taylor has spastic cerebral palsy in a quadriplegic topography. Taylor has marked motor impairment involving her oral motor function, and her swallowing, and poor trunk and head control. She has severe motor impairment of all four limbs, with the consequence of no purposeful movement, no trunk support and no ability to lift her own head in prone.

[62] She has very significant cognitive impairment with no improvement expected.

[63] She has extremely limited communication skills, at the level of a young infant. She cries or moans when in distress, and smiles or laughs when content.

[64] Her associated health problems are numerous. They include sleep disruption. In Dr. O'Donnell's opinion, Taylor's intellectual function is so limited that it is improbable that Taylor will ever be distressed by her disability.

[65] Taylor was assessed by Dr. Michael Joschko, a registered psychologist, who prepared a report dated August 3, 2001. Dr. Joschko's conclusions and opinions include this:

Taylor is an almost entirely passive recipient of her environment - she is not a child who tries to interact with her environment. Taylor responds only minimally to the physical contact and verbal stimulation provided by her caregivers. The ability to make choices is necessary to develop cognitive skills and abilities. Unfortunately, there is no indication that Taylor attempts to initiate interactive communication even with those who might understand her vocalizations, or that she is capable of reliably making a movement to indicate a choice.

At this point, she does not show any indication that she will profit from cause and effect training. She cannot consistently or reliably hit an electronic switch, nor can she use gestures, eye gaze, pointing, or vocalization to communicate. The ability to make choices is necessary to develop cognitive skills and abilities. It is very unlikely that Taylor will ever be able to reliably use a

switch to make choices. Therefore, it is extremely doubtful that Taylor will be able to learn to use a switch system to communicate in a reliable way, and she may even be unable to learn to signal simple "yes" or "no" responses. It is more probable than not that she will never learn to reliably communicate any of her needs beyond smiling or vocalizing in response to some enjoyable stimulation, or crying when uncomfortable.

Taylor is still very young and she shows some reactions to events in her surroundings. She has shown some tentative indications that she may be able to press a very large switch with prompting and hand over hand assistance from an adult. Consequently, she may show improvements in some of her skills and abilities. It is my opinion, however, that any improvements she shows will be quite minimal and that she will not "catch up" or develop at the same rate or to anywhere near the same level as other children her age.

Taylor's cognitive and learning problems will be permanent and no amount of therapy could be expected to help her overcome them. She will not learn to develop or communicate abstract thoughts and concepts, nor will she become literate or learn any academic skills.

Because of her severe physical, sensory, and mental impairments, Taylor is physically and psychologically isolated from the people in her environment. She exists in an infantile state and she most likely will remain unable to appreciate the nature of her differences and deficits.

[66] Taylor was assessed by Dr. George Hahn, a specialist in Paediatric Physical Medicine and Rehabilitation. His report is dated July 8, 2001.

[67] Dr. Hahn diagnosed microcephaly secondary to limited brain growth. He noted cerebral palsy of quadriparetic type with no fine motor ability and extremely limited gross motor function. He found profound developmental (cognitive, social, language, adaptive) delay, cortical blindness and hearing loss. He diagnosed numerous associated medical problems.

[68] Dr. Hahn's opinion is that Taylor has become slowly and steadily more responsive to outside stimuli, although his expectation is that Taylor will always remain profoundly, multiply developmentally delayed. He said she attends to lighted stimuli briefly, smiles to familiar intonations, and calms to music and attention.

[69] I accept those assessments as factual.

THE CAUSE OF TAYLOR'S INJURIES

[70] Dr. Max Pearlman is a staff neonatologist at the Hospital for Sick Children in Toronto and a professor of pediatrics at the University of Toronto. He is a paediatrician with expertise in the diagnosis, treatment and prognosis of medical conditions of the newborn infant.

[71] Dr. Pearlman's opinion is that birth asphyxia was the most likely cause of Taylor's injuries. His opinion is that Taylor's injuries are typical of a child injured by severe intrapartum birth asphyxia. He noted as follows:

1. Disabilities and major physical findings of Taylor McGlone.

Taylor is a profoundly disabled child with the following:

- Cerebral palsy (spastic quadriplegia) associated with microcephaly.
- Severe developmental delay, already evident at 4 months of age.
- Seizure disorder described as non-epileptiform myoclonus.
- Visual impairment (cortical).
- Hearing deficit (sensorineural) - hearing-aided.
- Severe feeding problem.

Comment:

Of the possible causes of this aggregation of disabilities, birth asphyxia causing hypoxic ischemic encephalopathy (HIE) is the most likely. Other conditions including viral or bacterial infections of the brain and its coverings, metabolic diseases (congenital or acquired), shock due to acute infections or to massive blood loss and physical birth trauma can be excluded with a high degree of confidence.

[72] Birth asphyxia causing hypoxic ischemic encephalopathy is the most likely cause of Taylor's injuries. I find that that has been established on a balance of probabilities.

THE TIMING OF TAYLOR'S INJURIES

[73] Dr. Pearlman paediatrician wrote this in his report:

Timing of the injury

A number of terms are defined below and illustrated by the appended Figure 3:

1. "Timing" refers to when the causative event started (e.g., 2 hours before birth, 15 minutes before birth).
2. The term "insult" is used here to mean the causative event "asphyxia" (asphyxia is used here in its pathophysiological sense* (it does not mean that brain injury has occurred), "insult" applies to the conditions that may lead to hypoxic ischemic brain injury;
3. In contrast the term "injury" refers to the brain injury itself (often referred to as the outcome in distinction to the cause); the injury may be transient (e.g., HIE without severe adverse long term outcome), or permanent.
4. "Time-course" refers to the time period or episode during which the event occurred, e.g., "prolonged partial" usually refers to a period of about 0.5 to 4 hours, "acute near-total" refers to an episode of less than 30 minutes.

Timing is determined by extrapolation backwards in time of abnormal findings at birth and during the first hours and days after birth. In the case of Taylor McGlone the following features enable fairly accurate timing of injury:

Time courses of Apgar scores and of resuscitation: The absence of gasping in at least the first few minutes after birth, the failure to establish normal breathing until 30 minutes of age, and the need for endotracheal intubation and artificial breathing indicate the existence of severe asphyxia at birth, sufficient to cause brain damage.

Time course of the base deficit values after birth: The first measurements in cord blood and at 51 and 92 minutes of age reflect the severity of the asphyxia present at and after birth. These values are consistent with the criteria of the Society of Obstetricians and Gynaecologists of Canada (SOGC) and the Consensus Statement of the International Cerebral Palsy Task Force (supported by the SOGC) for defining neonatal asphyxia (16mmol/l or greater at birth).

Time course of the encephalopathy: The age of onset of seizures and the subsequent brain illness are typical of an insult occurring during the very few hours preceding birth. The reported findings on imaging of the brain are typical of an insult that occurred close to the time of birth (expressed in terms of a day rather than minutes of hours).

Time courses of kidney, liver and hematological manifestations are typical of the occurrence of an acute insult during the day preceding birth.

In summary, extrapolation backwards of the above phenomena intersect at a time point just prior to birth. The coarser tools (dysfunction of systems/organs other than the nervous system) point to hypoxic ischemic injury during the last hours up to the last day of the pregnancy; the finer tools (resuscitation, Apgar score, blood gases) indicate that the events that led to the brain damage occurred during the hour or two prior to birth or shortly afterwards. The actual brain damage probably occurred near to the end of this period.

Had the brain damage occurred several weeks or more prior to birth, the infant would probably have been born with a reduced head size, and limb muscle contractures, and her CT examinations at days 1 and 6 would have shown marked permanent changes.

[74] Dr. Pearlman's opinion is that the insult which caused the brain injury started with hypoxia (lack of oxygen) during a period between several hours and 30 minutes before birth, and that the hypoxia worsened to point that it caused severe asphyxia which intensified until brain damage occurred. His opinion is that the brain damage probably occurred no more than 10 to 15 minutes before birth, as it would not have been otherwise possible to resuscitate the infant.

[75] Dr. Alfonso Solimano is a consultant in Neonatal-perinatal medicine, practising in Vancouver. He prepared a written opinion about causation, and the nature and timing of the brain injury that led to Taylor's injuries.

[76] Dr. Solimano's opinion is that Taylor suffered an episode of near total intrauterine asphyxia, which occurred in the last 10 to 30 minutes before birth

[77] I accept that opinion evidence.

[78] I find that Taylor's injuries were caused by near total intrauterine asphyxia, which occurred in the last 30 minutes before her birth.

MISOPROSTOL

[79] Taylor McGlone's birth followed induction of her mother's labour at Victoria General Hospital by the administration of misoprostol.

[80] The plaintiffs' claim that it was negligent of the defendant society to accept and promote the use of misoprostol for the induction of labour, and that the protocol established by the society was inadequate. They submit that it was negligent of Dr. Kelly to have accepted misoprostol for the induction of Ms. McGlone's labour. They submit that the dosage of the misoprostol administered, and the subsequent monitoring of Ms. McGlone was below an acceptable standard. They submit that the use of misoprostol led to tachysystole, followed by hyperstimulation of the uterus, which in turn caused asphyxiation of the fetus.

[81] In alleging negligence in the use of misoprostol, the plaintiffs relied in part on the opinion of Dr. N.D.J. Braithwaite, a specialist in obstetrics and gynaecology.

[82] Dr. Braithwaite's opinion is that the decision to attempt to induce the birth was appropriate. In his opinion, the use of misoprostol was not appropriate. He noted that misoprostol was not then approved by the U.S. Food and Drug Administration for the ripening of the cervix, nor for induction of labour, and that it was not then accepted by the Canadian Society of Obstetricians.

[83] Dr. Braithwaite referred to literature, including American College of Gynaecologists, Committee Opinion 228, published November 1999, and American College of Gynaecologists, Practice Bulletin No. 10, published in 1999.

[84] Although Taylor's birth was after the publication of these documents, it was Dr. Braithwaite's opinion that the defendant hospital society and Dr. Kelly ought to have known that the use of misoprostol was associated with an increased rate of uterine tachysystole, and that both were negligent in selecting or accepting it for use.

[85] Dr. Jerome Dansereau, a specialist in maternal fetal medicine, was Director of Perinatology Services for the Capital Health Region, which included the Victoria General Hospital, and a member of the Obstetrics Multidisciplinary Care Committee at the time that the decision was made to use misoprostol. Dr. Dansereau testified that the committee consisted of a large number of persons with different areas of expertise. The committee reviewed the available literature. Dr. Dansereau testified that the use of medication in an off-label fashion is a common practice. The committee was aware that the medication was not approved for use for induction. The committee concluded that the use of misoprostol for the induction of a

post-term woman with a healthy fetus was safe and efficacious. They were aware that misoprostol was associated with a higher incidence of tachysystole. They drew the protocol relating to its use.

- [86] The committee that established the protocol was comprised of specialists in obstetrics. They considered much of the same literature that Dr. Braithwaite referred to in his medical legal opinion.
- [87] Dr. Howard J. Pendleton, a specialist in obstetrics, prepared an opinion report dated August 27, 2001. His opinion is that the choice of misoprostol for the induction of labour, and the protocol, were reasonable and appropriate. He agreed with the dosage and monitoring set out in the protocol.
- [88] Dr. Braithwaite acknowledged that his opinion as to the use of misoprostol differed from the opinion of the Obstetrics Multidisciplinary Care Committee.
- [89] The reason why this use of misoprostol was off label, and why this use of misoprostol was not approved, may have had nothing to do with its safety or efficacy. It was suggested that the manufacturer of the medication did not want the adverse public reaction that might be caused by being associated with medication that could be used for abortions, and that the result was that its distribution of misoprostol was not directed to induction of labour or abortion.
- [90] The plaintiffs filed as exhibits much of the literature that they submit dictates against the use of misoprostol. Some of the experts who testified were referred to this literature. Nevertheless, the purpose of the plaintiffs in submitting these exhibits seemed in part to be to invite the Court to make an independent assessment as to the safety of misoprostol as an induction agent. As noted by Mr. Justice Macaulay in *Tekano v. Lions Gate Hospital*, July 26, 1999, Vancouver Registry No. C973422, such matters are complicated and far beyond the experience and understanding of a judge. Such a determination requires expert evidence.
- [91] The plaintiffs have demonstrated that there are differences in opinion as to the use of misoprostol. They have not shown that its use for induction was negligent.
- [92] In my opinion, the defendant society was not negligent in acting on the advice of its Obstetrics Multidisciplinary Care Committee in accepting the use of misoprostol as an induction agent for a post-term healthy woman with a healthy fetus, and in relying on its Committees in establishing the protocol for its use.
- [93] Dr. Braithwaite's opinion was that Dr. Kelly fell below the standard expected of an attending physician in his using medication, (misoprostol), without being completely familiar with its potential risks, complications, and recommended monitoring.

- [94] When he administered misoprostol to Ms. McGlone, Dr. Kelly relied solely upon the information contained within the hospital's protocol. The protocol was prepared for the specific purpose of informing physicians in Dr. Kelly's circumstances of risks, complications and recommended monitoring.
- [95] The protocol adopted by the defendant Society relating to misoprostol was intended to be of application within the Victoria General Hospital. The defendant Society expected that it would be used and relied upon by the general physicians performing deliveries in Victoria General Hospital.
- [96] The evidence of Dr. Douglas W.R. McTaggart, a family practitioner with an active obstetrical practice in North Vancouver, was that when family physicians practice obstetrics in a large community hospital with specialist attending staff, it is common to accept guidance from such specialist staff with respect to the use of medications, equipment and procedures. His evidence was that it was not routine for individual general practitioners to individually research and decide on the application of new procedures.
- [97] After reviewing the protocol for the induction of labour in post-term patients with misoprostol, which had been made available to Dr. Kelly, Dr. McTaggart noted this:
- In my opinion, virtually any competent and conscientious obstetrical general practitioner could have accepted at face value that misoprostal (sic) was a medication equivalent to its predecessors, i.e. non-controversial, and with a risk: benefit profile essentially identical to other known agents.
- [98] He went on to note:
- In my opinion, Dr. Kelly was fully within the standard of care in his use of this agent, and in explaining its use to the patient in terms virtually identical to other similar agents.
- [99] The evidence is that Ms. McGlone's clinical situation accorded with the criteria set out in the protocol for its use to induce Taylor McGlone's birth. Dr. Kelly used the medication in exact compliance with the protocol. In my opinion, the defendant, Dr. Kelly, did not fall below the standard expected of him in his use of misoprostol. Dr. Kelly was not an obstetrician.
- [100] Dr. Braithwaite's opinion that Dr. Kelly ought not to have chosen to use misoprostol rests on his view that the defendant, Dr. Kelly, ought to have independently referred to the available literature, that being the kind of literature to which the committee establishing the protocol referred, and that that review should have reasonably resulted in Dr. Kelly not having selected the use of misoprostol on this occasion.
- [101] In my opinion, Dr. Kelly was entitled to rely upon the protocol to provide him with the information he required for the use of misoprostol and he did not fall below the standard expected of him by not independently reviewing literature and by not consulting with an expert in obstetrics.

- [102] The plaintiffs challenged the appropriateness of a 50 mg dosage being given to Ms. McGlone to induce her labour.
- [103] The dosage suggested in the hospital protocol was that of 50 mg of misoprostol. That was the amount Dr. Kelly used.
- [104] It was Dr. Braithwaite's opinion that the use of a dose in excess of 25 mg is not supported by the literature and for that reason its use in that dosage was below the standard of care expected of Dr. Kelly.
- [105] In my opinion, Dr. Kelly was entitled to rely upon the protocol. His reliance on the protocol was in accordance with what was expected of him as the attending physician.
- [106] Dr. Braithwaite's objection to the dose that was used relates to the use of misoprostol being associated with an increased rate of uterine tachysystole.
- [107] The misoprostol, which was administered to Ms. McGlone, was administered well before her discharge at 10:10 hours.
- [108] Her membranes were artificially ruptured at about 18:00 hours. It was not until about 20:00 hours of October 16, 1997, that Ms. McGlone's labour was such that an issue arose as to fetal distress. Taylor was born at 23:46 hours, 14 or so hours after the administration of the misoprostol.
- [109] Dr. Braithwaite's opinion was that if misoprostol was used at all, and he remained of the opinion that it ought not to have been used, that each dosage be no more than 25 mg of misoprostol, which could be repeated.
- [110] Dr. Braithwaite offered no opinion that a single dose of 50 mg of misoprostol administered before 10:00 hours could have contributed to the fetal distress, while two separate doses of 25 mg each, administered several hours apart, would not have done so.
- [111] In my opinion, it has not been shown that it was negligent of the Committee to adopt dosages of 50 mg and not 25 mg, nor has it been shown that even if the dosage ought to have been 25 mg of misoprostol, that the difference in how the medication was administered was of any relevance.
- [112] It was Dr. Braithwaite's opinion that it was inappropriate for Tracy McGlone to be discharged from hospital following the insertion of the 50 mg tablet of misoprostol within her vagina in the attempt to induce her labour. In advancing that opinion, Dr. Braithwaite referred to the Practice Bulletin No. 10 published in 1999. That publication, of course, followed Taylor McGlone's birth.
- [113] The reason that Dr. Braithwaite was of the opinion that it was inappropriate to have discharged Tracy McGlone, was that she could not then be monitored.

- [114] Tracy McGlone returned to the Victoria General Hospital in the late afternoon of October 16, 1997, and was admitted at about 17:45 hours. Her evidence is that she returned to the hospital only because she had been instructed so to do earlier in the day.
- [115] Following her re-admission to the hospital, an electrical fetal heart monitoring assessment was conducted between 17:49 hours and 18:30 hours.
- [116] The tracing between 17:49 hours and about 18:04 hours. shows that the fetus was in good health. The quality of the tracing between about 18:04 hours to 18:30 hours is poor.
- [117] There is nothing to suggest that the fetus was stressed at that time.
- [118] I am of the opinion that Tracy McGlone's discharge from hospital between 10:10 hours and 17:45 hours is of no relevance to these proceedings.
- [119] Dr. Braithwaite's evidence was that Tracy McGlone ought not to have been discharged from hospital following the administration of misoprostol, that she ought to have been subjected to appropriate monitoring within the facility.
- [120] Even if she had remained in hospital, and been subjected to periodic monitoring, there is no evidence that those actions would have been of any consequence.
- [121] Even if the protocol ought to have required that Ms. McGlone remain within the hospital following its administration to facilitate fetal monitoring, it has not been shown that such monitoring would have had any effect on the course of events. The fetal monitoring from 17:49 hours to 18:04 hours disclosed no fetal distress. Earlier monitoring would not have been of any consequence.
- [122] The plaintiffs' claims with respect to misoprostol rest on their assertion that, had that medication not been used as an induction agent, Ms. McGlone may never have developed tachysystole, or, alternatively, that had the protocol been better, Dr. Kelly and the nursing staff might have earlier identified tachysystole, and possibly intervened in the birthing process in such a manner that Taylor's intrapartum injuries would have been avoided.
- [123] The misoprostol administered to Ms. McGlone did result in her labour. The medication achieved its purpose. Taylor's birth was over 14 hours following the administration of this medication. The weight of the evidence is that the physical presence of misoprostol in Ms. McGlone's system had by then largely dissipated. It is a matter of speculation as to whether the use of the induction agent still played any part in the tachysystole, or in the asphyxia which caused Taylor's injuries.
- [124] Even if the misoprostol was a cause of the eventual tachysystole, and this was not proven, tachysystole is associated with the use of all induction agents. There is no evidence that the same outcome would not have resulted following the use of a different induction agent. The nursing and medical staff were alive to the risk of tachysystole. There is no reason to think that they would have afforded Ms. McGlone different care, had the protocol identified the somewhat higher level of risk of tachysystole associated with misoprostol, than the level of

risk associated with prostaglandin E2. The risk was known; its rate of incidence could not have affected the care given Ms. McGlone.

[125] I am of the opinion that no claim relating to the use of misoprostol has been established.

THE CLAIMS AGAINST THE NURSING STAFF

[126] It is the theory of the plaintiffs that Taylor's injuries originated with the administration of misoprostol, which eventually caused tachysystole, and then caused hyperstimulation of the uterus during the second stage of labour. They ascribe the birth asphyxiation to hyperstimulation of the uterus. They submit that with competent nursing care, and with charting and inter-staff communications of the standard expected of registered nurses, Dr. Kelly, who attended the birth, might have become alive to the complication which caused Taylor's injuries and expedited Taylor's birth. They submit that a material cause of Taylor's injuries was the negligence of the registered nurses.

[127] The issue of standard of care was reviewed by our Court of Appeal in *Belknap v. Meakes*, (1989) 64D.L.R. 4th. 452. At p. 473, the Court cited with approval tests for establishing medical negligence adopted by the House of Lords in *Maynard v. West Midlands Regional Health Authority*, [1948] 1 W.L.R. 634, including this from p.638: "The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care ... ", and this from p. 638: "Differences in opinion and practice exist, and will always exist, in the medical as in other professions. There is seldom any one answer exclusive of all others to problems of professional judgment. A Court may prefer one body of opinion to the other: but that is no basis for a conclusion of negligence."

[128] In *Tekano v. Lions Gate Hospital et al*, July 26, 1999, No. C973422, Mr. Justice Macauley considered the issue of the standard of care of nurses. He said this at p.52:

Nurses will be held to the standard of care expected of a registered nurse of average competence. As with physicians, nurses will not generally incur liability in negligence for errors in judgment: *Heidebrecht v. The Fraser Burrard Hospital Society* (October 10, 1996) Vancouver No. C933456 (BCSC) at 46. Generally, expert evidence is required to establish the standard of care expected of a registered nurse of average competence. As Henderson J. stated in *Heidebrecht*, *supra*, at 45:

Nursing is an independent profession with its own practices, procedures and standards of competence.

It is clear, however, that nurses are not responsible for diagnosis, nor are nurses free to depart from a physician's instructions absent 'clear and obvious' neglect or incompetence. In *Serre v. de Tilly* (1975), 58 DLR (3d) 362 (Ont. HC), the court considered the liability of nurses who, in accordance with a physician's instructions, discharged a patient. The patient later died. In dismissing the action against the nurses, the court stated at p. 367:

... diagnosis is surely not a function of the nurse; unless there were clear and obvious evidences of neglect or incompetence on the part of the family doctor, it would be unthinkable that the hospital or its agents should interfere with or depart from his instructions.

In my view, the two nurses met the standard of care throughout.

[129] In my opinion, the trial evidence did not establish the comprehensive theory of nursing staff negligence advanced by the plaintiffs. It is a matter of speculation whether the administration of misoprostol caused the tachysystole experienced by Ms. McGlone. If it did, it is not known whether the same effect would have resulted from the administration of a different induction agent, since tachysystole is also associated with the medication which the plaintiffs say ought to have been used. It is not known whether there was hyperstimulation of the uterus. The birth asphyxiation occurred long after Dr. Kelly had arrived and taken charge of Ms. McGlone; there is scant evidence that the nursing staff could have observed or reported anything which occurred before Dr. Kelly took charge of his patient that would have affected the obstetrical care he afforded Ms. McGlone. Dr. Kelly had ample opportunity, after his arrival at 20:10 hours, to independently assess Ms. McGlone's condition and progress. In my opinion, it is a matter of speculation whether there was anything the nursing staff could have noted or recorded before his arrival which might have alerted Dr. Kelly to concerns of which he was not aware.

[130] The negligence claims against each of the nurses must be considered by examining whether the care each of them accorded Ms. McGlone was below the standard of care required of that nurse, and not by determining that if each of them had acted differently, the overall result would have been a different outcome.

THE CLAIM AGAINST NURSE McMILLIAN

[131] Jeanette Anne McMillan graduated from the Guelph General Hospital School of Nursing in 1973. After nursing in a number of communities, she started working in the labour and delivery unit of the Victoria General Hospital in about 1983. She worked as a labour and delivery nurse from that time until after Taylor's birth.

[132] In 1990, Nurse McMillan started to teach pre-natal education in Victoria. Tracy McGlone and Marc Fleming received pre-natal instruction from Nurse McMillan.

[133] On October 16, 1997, Nurse McMillan came on shift at 07:30 hours. Her shift was 12 hours in length. Nurse McMillan's evidence was that she cannot recall the events surrounding the induction of Tracy McGlone's labour with misoprostol, but that she was comfortable in relying on the hospital chart in relating what occurred.

[134] Nurse McMillan identified an assessment form that she completed while interviewing Tracy McGlone following Ms. McGlone's admission to the hospital, and before the first of the three electronic fetal heart monitoring assessments commenced.

- [135] Nurse McMillan testified that she took Tracy McGlone's vital signs at 09:00 hours, and that Dr. Kelly performed a vaginal examination. She said that Dr. Kelly administered 50 milligrams of misoprostol to Ms. McGlone at 09:00 hours.
- [136] Nurse McMillan testified about the fetal heart monitoring which she had effected that morning, and about assessing the fetal heart monitoring strips at 9 out of 10, using the Kubli score.
- [137] Nurse McMillan testified that Ms. McGlone was discharged at 10:10 hours and that the note that she then made read in part; " . . . ambulatory, in apparent satisfactory condition following reactive monitor strip."
- [138] Nurse McMillan testified that she would have given Ms. McGlone instructions as to when she was to return to the hospital.
- [139] One of the experts who testified at this trial was Dorothy Christina Tier. Nurse Tier is a registered nurse employed at B.C. Women's Hospital as a peri-natal clinical educator. She was qualified as an expert in fetal health surveillance, including the interpretation of fetal monitoring, and on nursing standards of care. She has been published in a number of journals, including The Canadian Nurse, Journal of Nurse Midwifery, and has contributed to a book entitled, Decision-Making in Obstetrical Nursing.
- [140] Nurse Tier's opinion was that when Tracy McGlone was admitted for induction, there was a complete and thorough assessment of her status and that of the fetus, and that she agreed with Nurse McMillan's Kubli scoring. Nurse Tier was of the opinion that the care accorded to Tracy McGlone during her morning admission was acceptable and prudent.
- [141] Nurse McMillan again attended to Ms. McGlone on her re-admission to the hospital. Nurse McMillan's note at 17:45 hours reads in part: ". . Cervical change allowed ARM by Dr. Kelly. Clear liquor draining." . . .
- [142] The second strip was run from 17:49 hours to 18:30 hours. Nurse McMillan turned over Ms. McGlone's care to Nurse Stafford at 19:30 hours.
- [143] Nurse Tier testified that there is a possibility that there will be a hyperactivity of uterine action following artificial rupture of membranes. She testified that it was for that reason she considered the tracing after 18:05 hours inadequate. Nurse Tier testified that she would expect to have a cardiotocograph applied to assess the fetal well-being and that, in addition, what can be seen on the second fetal monitoring tracing from 18:05 hours to 18:30 hours was of concern, inasmuch as it revealed markedly decreased variability of fetal heart activity and evidence of a lot of uterine activity after 17:50 hours. Nurse Tier testified that, in her opinion, Nurse McMillan ought to have repositioned the transducer to get adequate data after 18:05 hours and, if auscultation was the means of assessment, that Ms. McGlone ought to have been assessed every 15 minutes with the results of the assessment recorded.

- [144] Nurse McMillan testified that she was satisfied with the status of the fetus. Because the electronic fetal heart was not providing information of use to her, she discontinued monitoring at 18:30 hours.
- [145] Nurse McMillan testified that there was no requirement for fetal monitor recording at all after rupture of membranes, and that the only reason any such monitoring was done was for her own satisfaction. She said she did assess by auscultation.
- [146] Another expert witness was Dr. Howard John Pendleton. He is an obstetrician and gynaecologist who has lectured to nurses and who is a past president of the medical staff at Grace Hospital. He was head of the Department of Obstetrics and Gynaecology at B.C. Women's Hospital from 1993 until 1998.
- [147] Dr. Pendleton disagreed with Nurse Tier's interpretation of the second fetal heart-monitoring strip. He agreed that Nurse McMillan ought to have been charting the results of auscultation, but he did not agree that there was any evidence of concern for the condition of the fetus which Nurse McMillan ought to have noted.
- [148] Dr. Braithwaite said that the second tracing was a cause of concern; Dr. Michael J. Farmer, a general practitioner who practices obstetrics in Vancouver, disagreed.
- [149] Nurse McMillan left no notes as to her involvement with Ms. McGlone between 18:30 hours and 19:30 hours. She testified that she was not concerned about the fetal heart, or contraction activity, and that she probably inadvertently failed to record her findings on palpitation and auscultation because of an inadvertent omission to transcribe her notes from her worksheet to the chart kept at the nursing station.
- [150] Other than the arguably equivocal fetal heart monitoring strip, there is no evidence that there were signs of fetal distress or abnormal uterine activity that Nurse McMillan ought to have recorded, or brought to the attention of Nurse Stafford, the nurse to whose care Ms. McGlone was transferred at 19:30 hours.
- [151] It has not been shown that the inadequacies in the charting are of any significance or relevance to the claims advanced by the plaintiffs. Even though Nurse McMillan did not leave a written record of her involvement with Ms. McGlone after 18:30 hours, there is no evidence that there was anything of significance or relevance that she ought to have noted.
- [152] There is no evidence that Nurse McMillan was negligent. The action against Nurse McMillan is dismissed.

THE CLAIM AGAINST NURSE STAFFORD

- [153] Catherine Margaret Stafford received her registered nursing designation in England in 1971. She trained as a midwife in 1975, and practised as a midwife in England until 1978. After some years of travel and nursing, she started work as an obstetrical nurse at the Victoria General Hospital in 1987. She was still there when Taylor was born.

- [154] On October 16/17, 1997, Nurse Stafford worked the 19:30 to 07:30 hour shift assigned to antepartum. She received Ms. McGlone's care at 19:30 hours on October 16, 1997.
- [155] Nurse Stafford testified that her practice was to review the chart and monitoring strips when receiving a patient in labour; she said she would have done that on this occasion.
- [156] She assessed Ms. McGlone at 19:45 hours, when she determined by auscultation that the fetal heart rate was 140, and that the contractions were moderate.
- [157] At 20:00 hours, Nurse Stafford administered 100 milligrams of Demerol and 50 milligrams of Gravol to Ms. McGlone. This was done at Ms. McGlone's request, but pursuant to an order that Dr. Kelly had left.
- [158] Nurse Stafford testified that she had no concerns about Ms. McGlone at 20:00 hours.
- [159] Nurse Stafford auscultated again at 20:30 hours. She said the 30-minute interval was routine for that stage of labour.
- [160] Nurse Stafford then went on a break. Ms. McGlone was examined twice in her absence by others, once at 20:55 hours and once at 21:15 hours.
- [161] After Nurse Stafford returned to the ward, she determined that Ms. McGlone was in transition from the first stage of labour to the second stage of labour. The charting on the partogram by Nurse Stafford resumes at 19:30 hours. Her note at 19:30 hours reads: "Strong urge to push."
- [162] Nurse Stafford performed a vaginal examination. She testified that she did not have "concerns", that the fetal heart was "good", and that Ms. McGlone was entering or approaching transition.
- [163] Dr. Kelly was paged, and Ms. McGlone's care was turned over to Nurse Groneberg.
- [164] The claims against Nurse Stafford are advanced on the theory that she did not auscultate or examine with sufficient frequency, that she failed to notice signs of tachysystole, and that she failed to provide Nurse Groneberg with adequate information as to the pattern of labour.
- [165] Nurse Stafford testified that no concerns were identified to her when she took over Ms. McGlone's care, and that her normal practice was to review the chart and fetal monitoring strips when she took over the care of a patient. She believed that she had done that on this occasion. She said that she would have immediately assessed the fetal heart, and palpated Ms. McGlone's contractions. She said she monitored the fetal heart as required and transferred Ms. McGlone to labour and delivery when Ms. McGlone was in transition to the second stage of labour. She testified that she had Dr. Kelly paged, and that she made a report to Nurse Groneberg. She testified that she had no concerns about Ms. McGlone while she had care of her.

- [166] In my opinion, the plaintiffs have not shown that the care accorded to Ms. McGlone by Nurse Stafford was anything less than that which was reasonably required of her. The plaintiffs have not shown that anything that Nurse Stafford could have observed or recorded or said to other caregivers could or would have made any difference in the outcome of this birth.
- [167] Furthermore, there is only speculation that anything that occurred while Ms. McGlone was in Nurse Stafford's care played any part in the complications that led to Taylor's injuries. The birth asphyxia occurred after Ms. McGlone left Nurse Stafford's care.
- [168] The action against Nurse Stafford is dismissed.

THE CLAIM AGAINST NURSE GRONEBERG

- [169] Diane Lynn Groneberg graduated in nursing from St. Joseph's Hospital in Hamilton in 1969. She has worked as an obstetrical nurse since 1976, and at the Victoria General Hospital since 1983. On October 16/17, 1997, Nurse Groneberg was working in labour and delivery on the night shift from 19:30 hours to 07:30 hours.
- [170] Nurse Groneberg received the care of Ms. McGlone from Nurse Stafford at 21:55 hours. Nurse Groneberg could not remember what Nurse Stafford said to her at the time of the transfer, but said that it was customary that a report be made, and that she believed that that had occurred. She said that Nurse Stafford identified no concerns to her, although she could not recall what Nurse Stafford had said to her.
- [171] Nurse Groneberg could not recall reviewing the earlier fetal heart monitoring strips, although she said her normal practice was to do so.
- [172] Nurse Groneberg did not then have care of any patient other than Ms. McGlone.
- [173] When Nurse Groneberg first received Ms. McGlone into her care, she assessed the fetal heart by auscultation. She noted that the fetal heart rate decreased to 100 during contraction, and then recovered to 120 within seconds, following the completion of a contraction. Nurse Groneberg testified that that was not a concern to her. She said that it was normal, at that stage of labour, due to head compression or cord compression, for the fetal heart to be down briefly during a contraction.
- [174] Nurse Groneberg said she implemented electronic fetal monitoring so that she would have her hands free to help Ms. McGlone with pushing. The fetal heart rate could be heard with that equipment.
- [175] Dr. Manville arrived in the labour and delivery room just as the instrument to record electronic uterine activity was being put in place. It was Dr. Manville's understanding that the electronic monitoring was being introduced because of concerns with fluctuations in the fetal heart, and because of nursing concerns with the amount of the bloody show and clotting.

- [176] Dr. Kelly arrived at about 20:10 hours, 15 minutes after Nurse Groneberg received Ms. McGlone into her care. Dr. Kelly examined Ms. McGlone at 22:20 hours. He then left the room to change. He did not return until after he was called following the re-implementation of fetal heart monitoring at 22:49 hours.
- [177] Nurse Groneberg had received Ms. McGlone into her care at 21:55 hours. Ms. McGlone went into the second stage of labour at 22:20 hours. Nurse Groneberg made no record of the contraction pattern for that period of 25 minutes.
- [178] Nurse Groneberg said that the expected standard with regard to auscultation of the fetal heart during first stage of labour was that it should be taken every 15 to 30 minutes. She said she was listening more than every 15 minutes, even though there is no record of that. She said that because Ms. McGlone's uterus was resting in between contractions, she did not have concerns about the contraction activity.
- [179] She said that oxygen by mask was introduced to Ms. McGlone at 22:44 hours. She said oxygen was delivered as a matter of routine if the fetal heart went down to 100.
- [180] Nurse Groneberg's nursing notes made at 22:44 hours include note of initiating oxygen because the fetal heart had dropped below 100 at least three times.
- [181] The drops in the fetal heart rate, and the more than normal bloody show, were of concern to her.
- [182] Nurse Groneberg's note of 22:46 hours reads:
- EFM on continuous short frequent FHR fluctuating between 100 - 180. A little more than normal show and clots per vagina. Good variability.
- [183] Nurse Groneberg agreed that when the presenting part was crowning partially, that the fetal heart rate was 90 to 100, and that was a concern to her. Nurse Groneberg said it was not unusual for a baby's head to sit in the perineum for 16 minutes. Nurse Groneberg said that Dr. Kelly did have scissors in his hand with which to perform an episiotomy, but he never decided that one was necessary.
- [184] She agreed that she did not bring any concerns that she may have had with respect to the contraction pattern and with respect to oxygen getting to the baby, to Dr. Kelly's attention.
- [185] Nurse Groneberg testified that the strip did cause her some concern, from about 23:20 hours. She said that the fetal heart was being recorded as going from 190 down to 110, then back up, and down to 120, but not picking up very clearly either, and it was a pattern that she would have called "like a gasping reaction where the baby is recovering. It's dropping and then it recovers again."
- [186] Nurse Groneberg was alone with Ms. McGlone for only about 15 minutes before Dr. Kelly's arrival. Dr. Manville was also present. Nurse Groneberg's involvement was almost entirely that of support to a supervising physician. Nurse Groneberg drew the concerns that she had

about events that had occurred when Dr. Kelly was not present to Dr. Kelly's attention; the concerns she had about matters occurring when he was there were as evident to Dr. Kelly as they were to Nurse Groneberg. Nurse Groneberg did not chart the results of the auscultations during the last part of the first stage of labour, but there is no reason to think she did not auscultate, or that she had concerns that she did not report to Dr. Kelly. Since Nurse Groneberg was in the labour room and doing nothing other than attending to Ms. McGlone, in my opinion it is inconceivable that she would not have been doing what she says she was doing, that of assessing the progress of the labour and of assisting Dr. Kelly. There is evidence that it was the nurses that suggested an episiotomy. Nurse Groneberg's duty was to defer to Dr. Kelly, the supervising physician. The course of the delivery was under his direction and control, and not at the direction of Nurse Groneberg.

[187] I am of the opinion that it has not been shown that Nurse Groneberg's care of Ms. McGlone was below the standard required of her.

[188] The action against Nurse Groneberg is dismissed.

DR. KELLY'S OBSTETRICAL CARE OF MS. McGLONE

[189] Dr. N.D.J. Braithwaite's opinion is that Dr. Kelly fell below the standard expected of an attending physician in his failure to recognize potential fetal compromise and appropriately expedite delivery.

[190] Dr. Braithwaite's opinion is that Dr. Kelly ought to have recognised potential fetal compromise from the nursing notes and from the fetal monitor tracing, and expedited delivery by outlet vacuum delivery, low forceps, or by performing an episiotomy.

[191] Dr. Braithwaite's opinion is that Dr. Kelly could have performed a low forceps or vacuum delivery as early as 23:06 hours, or could have performed an episiotomy to effect delivery at 23:14 hours, that being the time of the crowning, that being 32 minutes before the birth.

[192] Dr. Braithwaite's opinion is that since the delivery could have been effected at those times without risk to either the mother or her child, given the risk of not acting, the failure to then deliver was below the standard expected of the attending physician.

[193] Dr. Braithwaite's opinion that Dr. Kelly ought to have recognized that something was wrong rests on an interpretation of the electronic fetal monitoring strip recorded between 22:46 hours to the birth at 23:46 hours and on the nursing reports of "abnormal labour activity".

[194] Dr. Braithwaite testified that, even though Dr. Kelly was not an expert in obstetrics, the available tracing is so obviously abnormal, that Dr. Kelly ought to have at least recognized that there was a problem that had to be addressed.

- [195] Dr. Kelly did not seek the attendance of an obstetrician; he did not perform a low forceps or outlet vacuum delivery which could have resulted in Taylor McGlone being born 40 minutes sooner than she was, nor did he perform an episiotomy, which could have effected delivery about 32 minutes sooner than it occurred. Those circumstances satisfy me that Dr. Kelly did not recognize that the fetus was in distress.
- [196] In my opinion, the issue as to Dr. Kelly's liability relates to whether his obstetrical care of Ms. McGlone fell below the standard expected of him.
- [197] There is ample evidence that the fetus was in distress. Dr. Braithwaite's evidence that the fetus suffered a catastrophic peri-partum asphyxic insult is evidenced by the blood gas results, Taylor's clinical neo-natal course, her subsequent ancillary test findings (EEG, CT and MRI) and her long-term neurological deficits.
- [198] Dr. Braithwaite is of the opinion that the available tracing from the fetal heart monitor shows significant and progressive fetal heart rate abnormalities.
- [199] The evidence advanced on behalf of Dr. Kelly is that those readings are inconclusive, and that fetal heart monitoring strips cannot be determinative of fetal distress.
- [200] Dr. Michael J. Farmer is affiliated with the British Columbia Women's Hospital, and his training and expertise in obstetrics is greater than that of most family practitioners that involve themselves in maternity care. Dr. Farmer's opinions are within his report of March 19, 2001.
- [201] It is Dr. Farmer's opinion that Dr. Kelly's obstetrical care and decision-making in respect of matters surrounding the birth of Taylor McGlone were below that of what would be expected of a reasonably competent general practitioner practising maternity care in 1997 in a similar setting and situation.
- [202] Dr. Farmer's opinion is that by 23:15 hours, there was obvious deterioration in the fetal heart recording, and delivery was indicated immediately; he wrote that by 23:10 hours "the fetus needed to be delivered urgently."
- [203] Dr. Farmer's opinion is that the baby could have been delivered by episiotomy or with a forceps delivery or by vacuum extraction 36 minutes before it was.
- [204] It is Dr. Farmer's opinion that during the ensuing 36 minutes, until delivery, the fetal heart strip continued to record non-reassuring tracings consistent with hypoxia and, likely, acidemia. His opinion is that during each waiting minute, the fetus became more hypoxic and the fetal blood PH dropped.
- [205] Dr. Farmer described the tracing taken from the external fetal electronic monitoring, which commenced at 10:49 hours, as being "a very non-reassuring strip". He advanced reasons why he said the strip was "ominous". He said that the fetal heart strip was "very unusual, very concerning."

- [206] Dr. Douglas W.R. McTaggart is in family practice in North Vancouver. He has an active obstetrical practice. He gave expert evidence in this proceeding.
- [207] It is Dr. McTaggart's opinion that Dr. Kelly met the standard of care expected of him in his management of Tracy McGlone's labour and delivery.
- [208] In arriving at that opinion, Dr. McTaggart said that, once delivery is imminent, proceeding with the delivery is usually appropriate management, and is usually effected more by short-term clinical observation than by detailed fetal heart strip analysis. He said that lacking significant clinical grounds to become apprehensive, most obstetrical general practitioners would not likely feel a need to engage in detailed analysis of the fetal heart rate strips, with or without scalp electrodes. His opinion is that detailed analysis of fetal monitoring strips is usually of greater consequence earlier in labour when delivery may be up to hours away.
- [209] It was Dr. McTaggart's opinion that a scalp electrode would not likely have produced information materially different to that obtained by external monitoring and intermittent auscultation. Dr. Farmer's opinion was that Dr. Kelly ought to have applied an internal fetal electrode.
- [210] Dr. McTaggart noted that the artificial rupture of membranes resulted in Dr. Kelly noting a clear liquor. His opinion was that Ms. McGlone's presenting history, and the results of the earlier fetal monitoring was such, that there was no indication as second stage commenced, that significant problems need be suspected.
- [211] Dr. McTaggart's analysis of the available records itemized in his report of August 24, 2001, led him to conclude that during Ms. McGlone's second stage of labour, she was experiencing strong and quite frequent contractions which resulted in the fetal heart rate falling frequently to a rate of about 100 beats per minute, and occasionally to 90 beats per minute, with, in each instance, a quite rapid return to a higher rate. He said that, in developing any index of suspicion, most general practice physicians are more attuned to a prompt fetal heart recovery to normal range than they are to the existence of drops of 90 to 100. He said that given that most obstetrical general practitioners would not find the drops in recovery unusual, they would not likely develop apprehension of significant problems.
- [212] It was with those observations that Dr. McTaggart noted:
- ... in my opinion most obstetrical general practitioners would likely regard the strips of confirmation of what they were clinically observing, i.e. dips of an anticipated degree, followed by reassuring recoveries.

- [213] Dr. Stephen Hudson, a specialist obstetrician gynaecologist, prepared a report dated August 21, 2001. His opinion is that the fetal heart strip was difficult to interpret. He said that although "In retrospect this baby must have been distressed during the second stage of labour", the interpretation of this strip was difficult, and "In this particular case the patterns could easily have been interpreted as reassuring accelerations rather than distressing decelerations."
- [214] Dr. Hudson noted that the strip showed a pattern of changes in the heart rate, or variability, which is a reassuring feature of the strip.
- [215] A submission advanced on Dr. Kelly's behalf is that since the heart strip in question permitted an innocent interpretation, his failure to recognise potential fetal compromise was at worst an error in judgement.
- [216] Dr. Howard J. Pendleton has extensive experience, both as a practitioner and as a teacher.
- [217] Dr. Pendleton's testimony was that the fetal heart strip did not indicate to him a need to intervene. He said the heart strip was difficult to interpret, but that, in his opinion, it did not have the troublesome features of no variability or late decelerations.
- [218] Dr. Kelly's evidence was that the rises in the fetal heart rates were accelerations in response to contractions. His evidence was that he had been considering the total clinical picture presented to him, and continuing to review the strip. He said that those reviews satisfied him that it was not "a hyperstimulation situation."
- [219] He said he was aware that there were fluctuations in the fetal heart rate, although he didn't consider that they were extreme. He said this:
- I looked at these, looked at the relationship to the contractions and pushing efforts, and felt that the baby was responding appropriately to those maternal efforts.
- [220] He added this:
- But in second stage, it is not unusual to see transient rises to that kind of level. Once again, it - I felt that this was an appropriate response to the stimulation of the expulsive efforts of the mother.
- [221] His evidence was that the fetal heart monitoring strip was reassuring because it was reactive, by which he meant that the fetal heart rate was reacting to the contractions of labour. Dr. Kelly said that he continued to monitor the strip and continued to be reassured that the strip was within an acceptable or normal range, given the progress in the second stage.
- [222] In cross-examination, Dr. Kelly was directed to tracings on Exhibit 11 which do not bear out his evidence that the rapid accelerations in the fetal rate were associated with or caused by contractions of the uterus.

[223] At a location identified on the exhibit as "pages left, 60", the tracing of the fetal heart rate shows that it rose from a rate of about 120 beats per minute to about 162 beats per minute. Dr. Kelly agreed that this was not a reaction to the "influence of a contraction."

[224] He was referred to the place on Exhibit 11 at the location where the marking "pages left - 59" pp is visible. Just to the right of that entry, the tracing shows the fetal heart beat rose from 140 beats per minute to 180 beats per minute, and that that acceleration was not associated with a contraction.

[225] There is a rise in the fetal heart rate from about 115 beats per minute to 180 beats per minute at the portion of the tape identified as being at about 23:11 hours. There was no uterine contraction activity at that time.

[226] There are other rises shown on the fetal heart tracings that are not coincidental in time to uterine contractions. One is to the right portion of the tracing at "pages left - 56", another to the right of "pages left - 55", and an increase at about 23:21 hours.

[227] Dr. Kelly was asked whether he noticed that these rises in the fetal heart rate were not in response to contractions. He replied:

The ones that you mentioned, I certainly did not notice.

[228] The explanation offered by Dr. Kelly was this

When I was looking at the strip, I was looking at the strip in its entirety, the visible entirety. And you look at the total picture rather than every individual, single movement. I think some of these rises are very steep. And I am sure you can put different interpretations on them. Overall, I felt the strip was reassuring through this period of time.

[229] Dr. Kelly was asked whether he would agree that the rises in the fetal heart rate to which he was referred were not in response to contractions. He said,

On the examples that we have - that you have led me through, I would agree.

[230] Dr. Kelly later added this:

I don't know that my mind was picking up every single little nuance at that very moment in the manner in which you are trying to suggest.

[231] Dr. Kelly agreed that after the point of time that somebody entered on the strip "pp starting to crown", that the head would be low enough for a forceps delivery. He agreed that at that point of time, he could also have done a vacuum delivery. He also agreed that an episiotomy could then have been effected. He testified that he did not do any of these things because "I did not feel any clinical reason to intervene with any of those procedures."

[232] Dr. Pendleton's opinion that a reasonably competent physician could have acted as had Dr. Kelly, was premised on the assumption that the attending physician was observing and interpreting the data being produced and recorded by the fetal heart monitoring equipment. His evidence that a reasonably competent physician could have come to the conclusion that the accelerations which were not related to contraction were not of concern, does not address Dr. Kelly's lack of attention.

[233] The submissions advanced on behalf of Dr. Kelly made reference to *Kehler v. Myles*, [1986] A.J. No. 1021, a judgment cited with approval by Shaw, J. in *Morrison v. Hicks*, (1989) 49 C.C.L.T. 167, wherein the court said this:

Although the experts for the plaintiff were critical of Dr. Myles' cervical assessment, they analysed the case from an after-the-fact perspective knowing the ultimate outcome of the case. In *Chelan v. Bell* supra Riley, J. issued a caution that the court should never lose sight of the importance of seeing the matter through the eyes of the attending physician. I agree with and adopt the words found at page 155 of this judgment:

Where the experts disagree but some of them support the treatment given, then surely the treatment given by the general practitioner should not be criticized, and one must always keep in mind the importance of viewing the treatment and seeing matters through the eyes of the attending physician.

[234] It is this very analysis which, in my opinion, renders Dr. Kelly liable in negligence.

[235] The issue is not whether Dr. Kelly could have made an honest error of judgment in interpreting the strip, or whether he could have come to the conclusion that the data which was produced by the fetal heart monitoring equipment did not suggest intervention, but the issue is that he was not paying attention and did not even notice that significant accelerations in the fetal heart beat were not associated with the contractions of labour.

[236] The standard of care of application to Dr. Kelly required that he observe and consider the information available to him from the fetal heart monitoring.

[237] Dr. Pendleton, in cross-examination by counsel for the plaintiffs, testified as follows:

Q. . . . So, Doctor, all I'm suggesting to you is that given the strip, which I think you've acknowledged is abnormal, that you would sit down and watch closely.

A. Yes, I would.

...

Q. The question was -

A. All right.

Q. - - you've agreed that this strip would require close watching?

A. Yes. All fetal hearts require close watching all through the second stage and close to it.

Q. Would it not - is it not also imperative that a strip that is difficult to interpret, which you've agreed it's difficult to interpret, that there could be an alternative interpretation to what you're giving it? That's something that you would - you would have in your mind, correct?

A. Is there an alternative inter - interpretation?

Q. You're having a diffi -you've got a strip that you're finding difficult to interpret.

A. Yes.

Q. It's different.

A. It's different. Yes.

Q. And I'm sure you've taught fetal heart monitoring a lot.

A. I have.

Q. And you teach all the basics, what to watch for?

A. That's correct.

Q. And do you also teach your students that if you can't interpret it, don't jump to a conclusion?

A. You teach the students to listen and to look at the patient and to watch the strip.

Now, if you hear with your ear a perfectly normal heart rate and accelerations, that's fine. It helps you to interpret the strip. If you hear a very high heart rate with significant decelerations, again, you watch the strip. But everybody who runs a strip watches it all the time. There's no point in running it if you don't look at it.

Q. Um-hum.

A. So the answer is, yes, you pay attention to it with detail, and you teach people to look for changes that occur in that strip.

[238] Had Dr. Kelly been paying attention to the fetal heart monitoring data, he would have noticed significant rises in the fetal heart that were not in response to uterine contractions, and that the problematic nature of the strip required explanation or consultation by a specialist or immediate delivery of the baby.

[239] There is much evidence that the strip and fetal heart was problematic, even if the strip did permit a possible innocent explanation.

[240] Dr. Manville was of limited experience. She had participated in about 20 births. She testified as follows:

Q. Now, you talked about the fetal heart strip in this situation, and you were also hearing it in the room. Is that correct?

A. Yes.

Q. Because where you were sitting, you couldn't see it?

A. Yes.

Q. Correct?

And I'm correct, am I not, that that was because others that you had heard had a more consistent baseline?

A. Yes.

Q. And the frequency of the heart fluctuating, the - in this case, the fluctuations of the heart between 100 and 180 were occurring more frequently than you had experienced?

A. Yes.

Q. And the range of the fluctuations was greater than you had ever experienced?

A. What do you mean by "range"? Sorry.

Q. The range from the low of 90 to 100 to a high of 180, 190?

A. I'd seen heart rates of 100 and 90 before, and I'd seen heart rates of 180 before, but occurring in such close time frame, I hadn't seen that before.

[241] Both Nurse Tier and Nurse Groneberg likened the fetal heart pattern before birth to "gasping".

[242] Dr. Farmer said the strip showed an "ominous" pattern, and Dr. Braithwaite said that even if one could not interpret the strip, it was so obviously abnormal that Dr. Kelly should have become alive to the need for action.

[243] There is expert evidence that the strip was difficult to interpret, and could have resulted in an innocent interpretation. Nevertheless, it was, in my opinion, negligent of Dr. Kelly not to have noticed that there was a fetal heart pattern inconsistent with his assumption as to what was happening. Dr. Kelly was not interpreting the strip and fetal heart in the manner that could lead to an innocent interpretation. He was not paying sufficient attention to it.

[244] The brain damage that caused Taylor's injuries occurred within 30 minutes, and probably within 15 minutes, of her birth. All of the troubling features of the strip which Dr. Kelly referred to as "nuances" occurred well before the 15-minute window before birth; and at least three were before the head started to crown at 23:14 hours.

[245] I am of the opinion that Dr. Kelly was negligent in not paying adequate attention to the data being produced by the fetal heart monitoring equipment and in not noticing that rapid accelerations in the rate of the fetal heart were not associated with uterine contractions, and that Dr. Kelly's negligence was a material cause of Taylor's birth not being expedited and her being injured at birth by asphyxiation.

NON-PECUNIARY DAMAGES

[246] Taylor's injuries are referred to in these reasons under the heading "The Nature of Taylor's Injuries".

[247] Taylor's injuries are catastrophic. If the assessment of her non-pecuniary damages were based on severity of injury alone, the appropriate assessment would be the maximum amount permitted at law. That maximum was fixed in the sum of \$100,000 in January of 1978. The expert evidence before me is that the Consumer Price Index published by Statistics Canada as the measure of change, the current dollar value of the sum of \$100,000 in January 1978 is \$281,818. That is the maximum amount currently permitted in British Columbia for the assessment of non-pecuniary damages.

[248] A functional approach is used in determining the appropriate award for non-pecuniary damages. In *Andrews v. Grand & Toy Alberta Ltd.* (1978), 33 C.C.L.T. 225 (S.C.C.) Mr. Justice Dickson of the Supreme Court of Canada said this at 253:

If damages for non-pecuniary loss are viewed from a functional perspective, it is reasonable that large amounts should not be awarded once the person is properly provided for in terms of future care for his injuries and disabilities. The money for future care is to provide physical arrangements for assistance, equipment and facilities directly related to the injuries. Additional money to make life more endurable should then be seen as providing more general physical arrangements above and beyond those relating directly to the injuries. The result is a co-ordinated and interlocking basis for compensation, and a more rational justification for non-pecuniary loss compensation.

[249] In *Lindal v. Lindal* (1981), 34 B.C.L.R. 273 Mr. Justice Dickson said this:

The Court adopted the third approach, the "functional", which rather than attempting to set a value on lost happiness, attempts to assess the compensation required to provide the injured person with reasonable solace for his misfortune. Money is awarded; not because lost faculties have a dollar value, but because money can be used to substitute other enjoyments and pleasures for those that have been lost . . .

Thus the amount of an award for non-pecuniary damage should not depend alone upon the seriousness of the injury but upon its ability to ameliorate the condition of the victim considering his or her particular situation.

[250] In *Wipfli v. Britten* (1984), 56 B.C.L.R. 273, the British Columbia Court of Appeal fixed non-pecuniary losses at about 50% of the maximum then permitted. In doing so, it said this at 301:

It is important to note that he is not unconscious. But he cannot walk or talk. He cannot respond or communicate in any meaningful manner. He is mentally retarded to some degree. However, he does occasionally exhibit some emotions, such as pleasure, and I accept the evidence of Mrs. Wipfli that he appears to like music and he appears to like watching television. There was some evidence from some of the experts that his condition may improve to a limited degree and from that I draw the inference that in the future he may derive enjoyment not only from music and television, but from a variety of other activities. As medical science develops in the future, there may be a number of advances that will "ameliorate the condition" of Joseph Wipfli.

[251] Taylor's father, Mr. Marc Fleming, testified at the trial. He was asked whether it was accurate to say that Taylor cannot distinguish between family and strangers. He responded that it was hard to say whether that was so. He said that he believed that Taylor knows his voice. He said that if he comes home and talks to her, he thinks, by the expressions on her face and her reaction, that she knows his voice.

[252] Mr. Fleming gave evidence that Taylor has a repetitive arm motion, and that it is with that motion that she has hit or pressed a switch to activate some music. Mr. Fleming did give evidence, however, that he did not "really think it's a voluntary movement. It is just where her hand lands, and she hits the switch."

[253] Taylor's mother, Tracy McGlone, testified that Tracey can recognize familiar voices, like those of her immediate family. She described how Taylor displays pleasure or displeasure with her immediate surroundings. She spoke of her hopes for Taylor's future.

[254] A helpful description of Taylor's status was provided by Ms. Jennifer Clarke, whose family cares for Taylor on respite weekends. Ms. Clarke said that Taylor responds to being outside and experiencing the wind and movement, by smiling or giggling. She said that Taylor will giggle if she is tickled, or if she hears music. Taylor will fuss or cry when she is uncomfortable or upset. Ms. Clarke said that Taylor requires constant care, and cannot do anything for herself.

[255] I was referred by counsel for the plaintiffs to a number of cases in which plaintiffs who suffered catastrophic injury were awarded non-pecuniary damages near the maximum amount permitted.

[256] In *Brimacombe v. Mathews* (1999), B.C.J. No. 190, Mr. Justice Hutchison awarded the maximum non-pecuniary damages for an infant plaintiff who was catastrophically injured at birth. Mr. Justice Hutchison found that that plaintiff would be able to derive solace from the provision of the non-pecuniary award. He found that that the plaintiff was not in the same category as the plaintiff in *Wipfli v. Britten* (*supra*).

[257] In *Dube (Litigation guardian of) v. Penlon Ltd.*, [1994] O.J. No. 1720, Mr. Justice Zuber of the Ontario Court of Justice fixed non-pecuniary general damages at \$245,000. In doing so, he said this at paragraph 34:

It is, I think, appropriate at this point to say something about the purpose of this amount. It is a sum awarded only after the plaintiff is properly provided for in terms of future care. This additional money can make life more endurable and can provide for physical arrangement and devices not related directly to the injuries (again, see *Andrews v. Grand and Toy*, (supra). Thus in the course of these reasons when some claim or item is not shown to fall within future care expenses and is disallowed, that is not the end of the matter. If the expense or item claimed can be of some benefit to Jordan, obviously resort may be had to this non-pecuniary general damage fund.

[258] In a number of cases relating to catastrophic injury, non-pecuniary damages were assessed at the upper limit as established by the Supreme Court of Canada in *Andrews v. Grand & Toy Alberta Ltd.* supra; in a number of other cases, non-pecuniary damages were assessed in a lower amount. Each assessment is dependent on its facts.

[259] Dr. Joschko's report included the following:

Other than smiling, making pleasant vocalizations, or becoming calm when being held, touched, or moved, Taylor did not appear to interact with her caregivers during the morning I observed her. During the time I observed her, Taylor did not appear interested in what was happening around her, nor did she appear aware of, or interested in, her sister's or mother's presence unless they initiated an interaction with her. She did not react at all to the very loud sound of sirens coming through the open patio door.

[260] I am of the opinion that the solace that could be provided Taylor with a non-pecuniary damage award is limited, not only because of her prognosis, but also because of her life expectancy is 14 years from the date of this trial. Nevertheless, the reports of both Drs. Hahn and Joschko suggest that there is some room for optimism. Taylor's condition may improve to a limited degree. Taylor might derive enjoyment and a degree of solace from improvements to her environment, and from additional care, equipment, and facilities which are not medically required, or not even yet available.

[261] I assess non-pecuniary damages at \$125,000.

PAST PECUNIARY DAMAGES

1. Special Damages

[262] The parties are in agreement that between March and December of 1998, Ms. McGlone paid \$817.00 for childcare for Taylor, that being the amount paid for Taylor's care above Ministry payments. These payments were required only because Taylor was disabled. Ms. McGlone is entitled to recover those payments as special damages.

- [263] In the same time period, Ms. McGlone paid an additional sum of \$834.00 for childcare. These expenditures would have been incurred even if Taylor had not been injured. This claim is not allowed.
- [264] Ms. McGlone is entitled to recover \$11,016.05 already spent for equipment for Taylor's care, and \$990.00 spent for massage treatments and user fees for Taylor's care. These amounts were paid by Pacific Blue Cross pursuant to benefits coverage for Taylor through Ms. McGlone's policy. The defendants concede that they are recoverable under the principles of law set out by the Supreme Court of Canada in *Cunningham v. Wheeler* [1994], 1 S.C.R. 359.
- [265] Ms. McGlone seeks to recover the sum of \$11,000.00 paid by her for the purchase of a van. She submits that a van was necessary to transport Taylor, and that the purchase price of the van is recoverable as special damages. In my opinion, it is more likely than not that Taylor's family would have already acquired a second vehicle, even if she had not been injured. It has not been shown that the purchase of this vehicle was a result of Taylor's injuries.

2. The In-Trust Claim, and the Claims of Taylor's Parents for Past Loss of Income

- [266] An in-trust claim is advanced for the past domestic and nursing services provided to Taylor by her parents, and by her maternal aunt, Ms. K. Griffin.
- [267] The principles applicable to such a claim were set out by Madam Justice Sinclair Prowse in *Brito v. Woolley* (2001), B.C.S.C. 1178 at paragraph 392, where she said:

Such a claim is recoverable, provided that the claim services are outside the normal duties of parents, that these services were needed because of his injuries, and that someone outside of the family would have been required to perform these services had his parents not done them: *Crane v. Worwood* (1992) 65 B.C.L.R. (2d) 16 (S.C.); *Feng v. Graham* (1988) 25 B.C.L.R. (2d) 116 (C.A.)

- [268] Ms. McGlone also advances a loss of income claim amounting to \$20,811. She claims for a partial loss of income from March 30, 1998, to July 31, 1998, because the demands of caring for Taylor precluded full-time employment. She also claims for loss of income from November, 1999, to August, 2000. This included three months when Ms. McGlone became seriously ill due to the stress.
- [269] Although Dr. Kelly concedes that Ms. McGlone is entitled to an in-trust award, he submits that it must be restricted to the reasonable value of the services provided. He submits that there is no juridical basis for the claim relating to Ms. McGlone's stress leave in the summer months of 2000.
- [270] I agree with the defendants' submissions that care must be taken to ensure that the claims relating to past care and past loss of income do not result in duplication, or double recovery for losses.
- [271] The evidence of Ms. K. Griffin was that on occasion her care of her niece, Taylor, did result in reduction of her income as a flight attendant. Ms. Griffin would not have lost that income had Taylor not required special care. However, most of the care that Ms. Griffin afforded

followed Ms. Griffin's engagement as a paid caregiver. If Ms. Griffin had not been involved in that care, the same care would have been provided to Taylor by others, at the same rate as was paid to Ms. Griffin. Notwithstanding the wish of both Ms. McGlone and Ms. Griffin that Ms. Griffin be hired to care for Taylor, the monetary value of those services is the cost of the services had they been provided by outside caregivers, and not the amount of income that Ms. Griffin would have earned had she continued employment as a flight attendant. See *Cran v. Worwood* (1992), 65 B.C.L.R. (2d) 16 (S.C.). Ms. Griffin has provide Taylor with injury related care at times when she was not being paid as a caregiver. She is entitled to the benefit of an in-trust claim relating to those services.

[272] Mr. Fleming's evidence is that his involvement with Taylor's care has been secondary to the involvement of Ms. McGlone. In my opinion, Mr. Fleming's involvement with Taylor has been about the same as it likely would have been, had Taylor not been injured. I am of the opinion that the evidence does not demonstrate that Mr. Fleming afforded Taylor any care that would attract an in-trust claim for his benefit.

[273] Ms. McGlone has provided extensive nighttime care for Taylor. On most nights since her birth, Taylor has been at home with her parents, and it has been Ms. McGlone who has been required to attend to her. Ms. McGlone has missed time from work in order to care for Taylor. All of Ms. McGlone's time off work did not relate to Taylor's at-birth injury, but much of it did directly relate to Taylor's extra need of attendant care. Ms. McGlone has, on an ongoing and virtually daily basis, attended to Taylor's needs. Taylor can do nothing for herself. It is Ms. McGlone who has been required to regularly attend to her.

[274] I assess Ms. McGlone's in trust claim and her past income loss claim in the global amount of \$30,000. I assess the in-trust claim for Ms. Griffin at \$7,500.

AGREEMENT OF FACTS RELATING TO FUTURE PECUNIARY DAMAGES

[275] The parties are in agreement that Taylor's life expectancy is 14 years from the date of this trial. Taylor has been cared for with the assistance of benefits received from the Ministry of Children and Families. The parties agree that benefits available from the Ministry of Children and Families will no longer be available after this award. The parties have agreed as to the quantification of some of the damages claimed by the plaintiffs, and as to the hours of respite care required. They have agreed as to the hours of attendant care required, and as to the appropriate deduction for non-disability related costs of childcare. These reasons relate to the matters that have not been the subject of agreement.

FUTURE DAMAGES

1. Agreement as to Quantification of Damages

[276] The parties have agreed to the quantification of damages set out in the following table.

ITEM

COMMENCING IN YEAR

COST OF ITEM

PRESENT VALUE

Accommodation

2001

115,000.00

109,173.00

Rehabilitation Case Manager

Year Two and ongoing thereafter

2002

4,320.00

36,871.00

Travel costs for caregiver

2001

500.00

4,742.00

Psychological Consultant

2001

1,250.00

11,855.00

Psychological Consultant:

Contingency fund lump sum

2001

7,200.00

6,835.00

Massage Therapist

2001

1,800.00

17,072.00

Occupational Therapist

2001

2,040.00

19,348.00

Physiotherapist

2001

3,060.00

29,022.00

Nutritional Program:

Years 4 - 6

2001

13,241.99

23,885.00

Nutritional Program:

Years 7 - 9

2003

13,423.99

27,979.00

Nutritional Program:

Years 10 - 12

2006

13,663.99

20,767.00

Nutritional Program

Years 13 - 15

2009

13,781.99

15,273.00

Nutritional Program

Years 16 - 18

2012

13,706.99

11,071.00

Syringe 5 cc

2001

9.07

86.00

Syringe 10 cc

2001

58.37

554.00

Feeding tube sets

2001

1,772.87

16,814.00

Drainage bags for gastric secretions

2001

196.99

1,868.00

Kangaroo (pet) feeding pump and case

mid-2002

1,245.00

3,434.00

Kangaroo pump backup

mid-2006

556.00

607.00

Annual maintenance of infusion pumps

2001

200.00

1,897.00

Diapers

2001

1,607.28

15,244.00

Diaper wipes

2001

416.00

3,945.00

Pulmo-aide

2004

165.00

279.00

Nebulizer supplies

2001

17.96

170.00

Reusable washable underpad

2001

46.00

436.00

Disposable gloves

2001

88.44

839.00

Filters for re-infusion of gastric juices

2001

62.66

594.00

Gauze

2001

138.12

1,310.00

Micropore tape and waterproof tape

2001

59.28

562.00

Mic-key button

2001

1,106.16

10,491.00

J-tube button

2001

1,106.28

10,492.00

Adapted clothing

2001

250.00

2,371.00

Additional towels

2001

150.00

1,423.00

Knee/Ankle/Foot Orthoses

2001

3,460.00

15,982.00

KAFO Clips

2001

100.00

350.00

KAFO Medial Joint Adapters

2004

500.00

1,275.00

Thumb/wrist Splints (first future replacement in 2001-2002 period)

2001

150.00

1,086.00

Floor mat, one

2002

295.00

252.00

Side lyer, with wedges

2009

745.00

467.00

Body roll barrel

2002

475.00

623.00

Long sitter (first future replacement in 2004-2005 period)

2004

300.00

603.00

Easy-stand hydraulic standing frame

2008

4,000.00

2,785.00

Easy-stand hydraulic standing frame maintenance

2008

20.00

91.00

Joerns 2001 Bed

2012

2,784.81

1,271.00

Two slings re ceiling track system

2002

500.00

2,246.00

Rifton Blue Wave Bath Chair

2006

550.00

308.00

Shower/commode chair

2002

1,200.00

1,748.00

Adult bath chair

2012

500.00

149.00

Orthopedic lounge chair - pediatric

2001

4,000.00

3,797.00

Orthopedic Lounge chair - adult

2011

4,500.00

2,283.00

Wheelchair table

2001

498.75

473.00

Manual wheelchair, pediatric - maintenance

2001

200.00

778.00

Wheelchair seating, pediatric - maintenance

2001

300.00

1,166.00

Manual wheelchair, pediatric

2006

4,050.00

2,271.00

Manual wheelchair, pediatric maintenance

2006

200.00

459.00

Wheelchair seating, pediatric

2006

2,671.00

1,498.00

Wheelchair seating, pediatric - maintenance (10)

2006

200.00

459.00

Adult wheelchair (3)

2011

6,500.00

4,911.00

Adult wheelchair - maintenance

2011

300.00

990.00

Adult wheelchair seating (3)

2011

4,000.00

3,022.00

Adult wheelchair seating - maintenance

2011

200.00

660.00

Annual Pharmacare deductible

2001

800.00

7,587.00

Sodium bicarbonate

2001

683.16

6,479.00

Prescription creams

2001

88.56

840.00

Cellular phone

2001

359.40

3,409.00

Membership in Cerebral Palsy Association

2001

25.00

237.00

Lost earnings

2001

293,000.00

293,000.00

TOTALS:

\$770,864.00

2. Transportation

- [277] Taylor is wheelchair dependent. A vehicle is required to transport her to activities and to medical and dental appointments and for therapy. A wheelchair accessible van is the type of vehicle best suited for that purpose.
- [278] The defendants submit that the "second vehicle" in Taylor's family ought to be adapted to accommodate Taylor's transportation by wheelchair, and made available for her transportation. They submit that the cost of adaptation of a van is the measure of damages relating to her transportation needs.
- [279] The anticipated level of use and mileage of a van whose use was shared between the family and Taylor's needs would require that the van be replaced after eight years. After eight years, a replacement van would be required, with a need for funding of a second lift. A van dedicated to Taylor's transportation needs would not require replacement for 21 years.
- [280] Janice K. Landy, an expert in rehabilitation management, prepared an opinion report relating to Taylor's medical and rehabilitative needs. Ms. Landy recommended funding for the purchase of an adapted vehicle dedicated to Taylor's care.
- [281] A shared use van would require the family, and probably Ms. McGlone, since it would likely be "her" vehicle that would be shared with Taylor's needs, to accept a van for personal transportation. Ms. McGlone would be required to defer to the predetermined pattern of replacement after eight years, and she would be required to make the van available for Taylor's transportation needs while Taylor was being cared for by others. Ms. McGlone's access to the van would necessarily be secondary to Taylor's needs.
- [282] Mrs. McGlone may not want a van for personal transportation. She may wish to replace her personal vehicle sooner than every eight years. She may wish to have use of a vehicle for her own daytime use, particularly since she is employed outside the home. The shared vehicle proposal would likely require her to use public transportation to go to work.
- [283] I accept Ms. Landy's recommendations. Taylor is wheelchair dependant. She will require transportation while she is being cared for by others than her parents, and a vehicle is needed for her care.
- [284] There are other advantages to the purchase of a van reserved for Taylor's needs. Provision for replacement of a van dedicated to Taylor's use would not be necessary. That is because the van would not require replacement within her agreed life expectancy. A van selected for shared use would likely require wheelchair modification costs higher than would be required for a van selected on the basis it was most suitable for modification for wheelchair use.

[285] I am of the opinion that provision must be made for transportation for Taylor in such a fashion that her mother is not required to purchase a vehicle, and to then give up its use to Taylor's needs during working hours. Ms. McGlone should be free to decide whether she wishes to purchase a vehicle for her own use, and, if so, she should be free to select the vehicle, and to decide when it will be replaced.

[286] I assess the capital cost of Taylor's transportation needs in the sum of \$42,000, that being the cost of a wheelchair accessible van dedicated for her use. I allow the annual cost of insurance for the van in the sum of \$900 per year commencing 2003.

3. Daytime Attendant Care

[287] The parties have agreed as to the hours of attendant care required, and as to the appropriate deduction for non-disability related costs of child care. They have not agreed as to appropriate hourly rate for daytime attendant care.

[288] Taylor's care has been provided to her by JLM Services, an agency utilized by the Ministry of Children and Families. The cost of that care approximates \$13.20 an hour. This agency hired Ms. Griffin, Taylor's aunt, to provide much of the care. The agency has other employees who are equally qualified to care for Taylor.

[289] Ms. McGlone has expressed dissatisfaction with the services received from JLM. Ms. McGlone is grateful for the care that her sister, Ms. Griffin, has afforded Taylor, but she is concerned that if JLM's usual caregiver is ill, or not available, that JLM does not have sufficient personnel to provide a replacement caregiver on short notice.

[290] Taylor's medical needs require that she be attended to by trained and competent caregivers. Dr. Maureen O'Donnell, who has a specialty in developmental pediatrics, assessed Taylor and made recommendations for her care. Her opinion is that although Taylor will require the continuous care of a caregiver for all aspects of her activities of daily living, the daytime caregiver does not need medical/nursing training, but will require specific training from a nurse consultant. A needs assessment was performed by Dr. George Hahn, who has specialty training in both pediatrics and physical medicine. Dr. Hahn's opinion is that Taylor is in need of "a roster of well trained uncertified caregivers", and that there was a need for "caregiving agency supervision and management of caregivers."

[291] The plaintiffs submit that care ought to be provided by an agency larger than JLM. Ms. Landy recommended two specific agencies, whose hourly rates are \$29.33 and \$24.95 per hour.

[292] The defendants called evidence to show that the use of live-in caregivers is not uncommon. Such caregivers are available through Nanny agencies. There is a federal visa program that accommodates the employment of non-Canadians as live-in caregivers in Canadian homes.

- [293] The advantages of using the type of agency recommended by Ms. Landy is that they typically have a pool of personnel who can provide backup care should the designated caregiver be unavailable. They supervise the staff and provide scheduling and payroll services.
- [294] The disadvantages are that there is less consistency of care. It is more likely that the caregiver would change from time to time. Ms. McGlone would probably have less say in the selection. Caregivers who are employed by the agencies recommended by Ms. Landy are not paid more than those who are employed by a smaller agency such as the one that has been caring for Taylor. The difference in charges relates to agency charges. It is erroneous to assume that the higher cost agencies attract better-qualified caregivers because of a different pay schedule.
- [295] I am of the opinion that Taylor needs the kind of care recommended by Drs. O'Donnell and Hahn. The agencies recommended by Ms. Landy seem to me to be particularly suited for the provision of care that requires active and ongoing management. Those agencies can respond to changes in daily needs. They are in a position to provide short-term care, and care which might change in terms of need.
- [296] The care that Taylor requires is known. It does not change from day to day. Taylor requires daily care by a capable caregiver; a need which in my opinion is best served with the employment of a caregiver who regularly cares for her. That, in effect, is what the Ministry has done with the arrangements with JLM and Ms. Griffin. There must be a plan and arrangements to provide substitute care providers, as needed, and provisions are required for management and payroll functions. The evidence at trial was that there are competent caregivers available in Victoria, both for primary and backup care, at rates far lower than the \$25 to \$30 range. I am of the opinion that Taylor's particular needs are not ones that would be best met with care by a large agency.
- [297] I assess the daytime hourly rate required at \$20 per hour. That rate is to include all aspects of Taylor's daytime care, including the cost of primary and backup care, including benefits, and supervision, management, payroll and training costs.

4. Respite Care

- [298] The parties have agreed that the following respite care is required: "To age 18: 2 weekends (48 hrs)/mo x 12 mo + 10 hrs/wk x 28."
- [299] They have not agreed as to the cost of respite care.
- [300] Respite care is being provided by Jennifer Clarke, with the assistance of her family. This arrangement has involved the Ministry of Children and Families, who have been funding respite care. Ms. Clarke is paid \$120.00 per 24-hour period of time, or \$240.00 per weekend. The defendants submitted that that is the measure of the cost of the care.

- [301] The plaintiffs are satisfied with the care afforded Taylor by Ms. Clarke and her family. It is their expectation that Ms. Clarke will continue to provide respite care. She is prepared to provide that care. But, it was their submission that since it was uncertain that Ms. Clarke would be able to provide this care as Taylor grows, provision ought to be made to fund respite care at agency rates. Ms. Landy recommended two agencies, with hourly rates of \$29.33 and \$24.95 per hour.
- [302] I am of the opinion that the best measure of the cost of respite care is the amount presently being paid for the care. There is no reason to conclude that if Ms. Clarke becomes unavailable to provide respite care, that another caregiver would not be available at the same rate. The rate being paid Ms. Clarke is the governmental rate paid others, and it is the rate the plaintiffs paid Ms. Clark for unfunded respite care.
- [303] I assess the cost of weekend respite care at \$240.00 per weekend.
- [304] The evidence of Maureen Simpson, an expert in rehabilitative nursing, was that the cost of daycare respite providers in Victoria varied, but that adequate care could be arranged for \$8 to \$10 an hour. I accept that evidence.
- [305] I would assess the cost of each of the 10-hour blocks of respite care at \$100, for a total of \$2800 per year.

5. Nighttime Care

- [306] Taylor often wakes up during the night. She may, on occasion, wake up more than once. Ms. McGlone gets up to attend to Taylor. This can take anywhere from a few minutes to as long as an hour.
- [307] Dr. Hahn listed as a "Care Requirement" the "need for mother to have uninterrupted sleep". Dr. Hahn did not say there was a need for an awake nighttime caregiver. His opinion was that a live-in caregiver might not be required. Dr. O'Donnell said that an awake caregiver was not required. I prefer those opinions to Ms. Landy's opinion that an awake caregiver is needed. In my opinion, the evidence does not establish any medical need for a person to be present, and awake, to attend to Taylor should she wake up. Taylor has not thus far received such care; I see no reason why it should be instituted now.
- [308] I am satisfied that sleep disruption has been an ongoing problem for Ms. McGlone. I am of the opinion that the evidence demonstrates that the scope of this difficulty has varied a good deal. There have been periods of time when the provision of nighttime care would not have been reasonably required at all, including times when Taylor was not given to waking up. There have been other periods of time when the pattern of disruption was such that provision ought to have been made to deal with it. My opinion is that this issue is best addressed with the provision of nighttime care of adequate frequency to address particularly trying times. None of the medical practitioners recommend nighttime care unless the disruption of sleep of Ms. McGlone is excessive. Ms. Simpson has recommended provision for two nights of care per month, at a yearly cost which she estimates at about

\$3100.

[309] I assess the cost of needed nighttime care at \$7000 per year. This sum is sufficient for eight hours of nighttime care once a week, or, alternatively, adequate to employ a live-in nighttime attendant.

REMAINING ISSUES

[310] A number of issues may require further submissions. They include a management fee, an income tax gross-up, interest, taxes and costs.

SUMMARY

[311] The plaintiffs shall recover judgment against the defendant Dr. Philip Kelly. The actions against all other defendants are dismissed.

"S.J. Shabbits, J."

The Honourable Mr. Justice S.J. Shabbits

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