Holan v. Stanton Regional Health Board et al, 2002 NWTSC 26

Date: 20020321
Docket: CV 08338

IN THE SUPREME COURT OF THE NORTHWEST TERRITORIES

BETWEEN:

EWA KONOPEK-HOLAN,
ADMINISTRATRIX OF THE ESTATE OF WALTER HOLAN

Plaintiff

- and -

STANTON REGIONAL HEALTH BOARD,
DR. WILLIAM McCAY, DR. J.S. McGLYNN and BERTHA HARMAN

Defendants

Action for damages pursuant to the *Fatal Accidents Act* and the *Trustee Act*. Action dismissed.

REASONS FOR JUDGMENT OF THE HONOURABLE JUSTICE J.Z. VERTES

Heard at Yellowknife, Northwest Territories
on December 10-14 & 17-18, 2001

Reasons Filed: March 21, 2002

Counsel for the Plaintiff: Robert A. Kasting

Counsel for the Defendants (Stanton & Harman): Garth Malakoe

Counsel for the Defendant (McGlynn): Jonathan P. Rossall & Arthur von Kursell

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REASONS FOR JUDGMENT

[1] On December 5, 1996, Walter Holan was a patient in the psychiatric unit of the Stanton Yellowknife Hospital. At approximately 5 p.m. that day Mr. Holan left the hospital, on a pass, to go see his son play in a hockey game. He did not return. Mr. Holan's remains were subsequently found on June 6, 1998. The death was ruled a suicide.

[2] The plaintiff in this action is the late Mr. Holan's widow. She brings these proceedings on behalf of herself and their son, now 14 years old. In essence the plaintiff claims that the defendants were negligent because they allowed Mr. Holan to leave the hospital on an unescorted pass when they knew or should have known that there was a risk of suicide. It should be noted at the outset that the claim against Dr. William McCay was discontinued prior to the trial of this action.

[3] For the reasons that follow, I have concluded that the defendants were not negligent and therefore the claim must be dismissed.

Background Facts:

[4] Walter Holan was born in Czechoslovakia in 1944. He came to Canada in 1968. By 1979 he was living in Yellowknife and driving a taxi for a living. He married the plaintiff in 1985.

[5] The late Mr. Holan was by all accounts a serious and hard-working man. He was always looking for ways to improve himself so as to better his family's economic circumstances. He worked very long hours. After a few years he and some fellow taxi drivers bought the company they drove for and then proceeded to set up a car-wash business. These ventures were successful and the businesses were eventually sold. Mr. Holan used the money gained on these sales to invest in new ventures, including some highly speculative ones. He lost quite a bit of money on a venture in California for example.

[6] In 1992 the Holan family moved to eastern Europe. Mr. Holan saw financial opportunities in the emerging economies of the formerly communist countries. The family lived in Czechoslovakia and then in Poland. Unfortunately their various business ventures failed. Mrs. Holan and their son came back to Yellowknife in early 1995 and Mr. Holan followed shortly thereafter. He went back to driving a taxi.

[7] Mr. Holan's emotional state started to deteriorate. He viewed himself as a failure for losing the family's money in bad investments. He was suffering from high stress. He had also developed an addiction to valium (something that was apparently quite easy to obtain on the black market in eastern Europe). He became very depressed. Mrs. Holan described life at this time as "an emotional roller-coaster".

[8] Mr. Holan consulted their family physician, the defendant Dr. McGlynn. He noted Mr. Holan's addiction to valium. He also noted Mr. Holan's depressed state. Dr. McGlynn then saw Mr. Holan regularly. His aim was to wean Mr. Holan off his valium dependency. In this he achieved some success. Dr. McGlynn did not recall Mr. Holan exhibiting signs of a major depressive disorder prior to the fall of 1996.

[9] On November 14, 1996, Mr. Holan admitted himself voluntarily in to the hospital. He was described as agitated with erratic behaviour and suicidal ideation. He showed no evidence of a formal thought disorder but he was admitted to the psychiatric unit for assessment for a "probable" depressive illness and for further detoxification to continue his withdrawal from his valium addiction.

[10] In 1996 there was no resident psychiatrist attached to the hospital so family practitioners, such as Dr. McGlynn, were the ones primarily responsible for the treatment

of any of their patients with psychiatric problems. He was able, however, to refer patients for consultation to Dr. McCay, a psychiatrist from Edmonton who, in 1996, made weekly visits to Yellowknife as a consulting psychiatrist for the hospital. After Mr. Holan was admitted to hospital Dr. McGlynn requested he be assessed by Dr. McCay. This was done on November 19, 1996.

[11] Dr. McCay's diagnosis was "recurrent major depressive disorder-severe" complicated by benzodiazepine (valium) dependency and withdrawal. He commented that Mr. Holan admitted to suicidal thinking but stated that he would not act on those thoughts. He further noted that Mr. Holan displayed no psychotic features and that he was alert and oriented. Dr. McCay recommended anti-depressive medication. He also recommended that Mr. Holan be kept in the hospital until he demonstrated a tolerance for the medication and then he should be assessed weekly on an outpatient basis.

[12] During this first admission, Mr. Holan was initially kept on "high" safety management but then was removed from that category on November 16. The "care plan" shows that on that date passes were authorized "at nurse's discretion". He left the hospital on November 20 on a pass, unescorted, for a few hours to visit his son.

[13] Mr. Holan asked to be discharged on November 21. He was assessed as part of the discharge procedure by both Dr. McGlynn and the defendant Bertha Harman, a registered nurse on duty in the psychiatric ward. Dr. McGlynn testified that he "willingly" granted Mr. Holan's request. Mr. Holan seemed to be doing quite well. Nurse Harman testified that during her assessment she specifically assessed Mr. Holan for suicidal ideation. She was satisfied that he could be discharged. She thought that there was no risk of suicide. Mr. Holan was eager to go home. He seemed confident and looked forward to being with his son. When discharged Mr. Holan was prescribed Zoloft (an anti-depressant) and Desyrel (a sleep-aid).

[14] On November 23, 1996, Mr. Holan was readmitted to the hospital, again on a voluntary basis. The attending physician that day noted that Mr. Holan expressed feelings of not being able to cope at home and of being suicidal. He was thought to be at high risk and therefore readmitted to the psychiatric unit. He was kept on "close" observation under "high" safety management.

[15] On November 26, Mr. Holan was again assessed by Dr. McCay at Dr. McGlynn's request. Dr. McCay noted that Mr. Holan was suffering from anxiety attacks and intermittent suicidal thoughts. He diagnosed a recurrent depressive illness.

[16] On November 27, Dr. McGlynn made a notation in the "Physician's Orders" that Mr. Holan may have passes, as required, at nurse's discretion. Mr. Holan was allowed out on that date on an unescorted pass to visit his home. When he returned, however, he was very agitated. Apparently the visit did not go well. As a result Dr. McGlynn directed that "passes be limited for now". He viewed this as a temporary measure, in response to Mr. Holan's reaction to his visit home, and one to be assessed on a day-by-day basis.

[17] Mr. Holan was once again assessed by Dr. McCay on December 3, 1996. Dr. McCay noted that Mr. Holan was very depressed. His mood would fluctuate and he would have suicidal thoughts (although Dr. McCay noted as well that Mr. Holan said he would not act on these thoughts). He recommended a plan of increased medication and close observation.

[18] Over the course of the next two days, as evidenced by the ongoing nurses' notes, Mr. Holan had periods when he would not get out of bed and periods when his mood and attitude were noticeably improved. Nurse Harman made a note on December 4, at 6 p.m., that Mr. Holan stated to her: "I have suicidal ideation, just like everyone else." Then she noted that "patient denies a plan". Nurse Harman testified at trial that Mr. Holan "had some good days and some rough days". She said that his symptoms were always changing but that this was common among their patients.

Events of December 5, 1996:

[19] The nurses' notes for December 5 indicate that Mr. Holan remained in bed for a good part of the day. But, by 5 p.m., it was noted that his affect was "bright" and he was asking to go out on a pass.

[20] Mrs. Holan testified that she saw her late husband at least once on December 5 at the hospital, most likely mid-afternoon. She said that he was lying in bed, unresponsive, apparently depressed. She told the nurse on duty what she had seen.

[21] Nurse Harman testified that the staff had been trying to get Mr. Holan to interact with others more. That day they were trying to get him out of bed to go to a group session. However, he stayed in bed at least most of the morning. At 3 p.m. on December 5 she went to a staff meeting. When she came out just before 5 p.m. she saw Mr. Holan standing with Dr. McGlynn beside a desk where sat Ms. Inward-Jones, another one of the registered nurses on the unit. Dr. McGlynn left and it was then that

Nurse Inward-Jones told Nurse Harman that Dr. McGlynn had said that Mr. Holan could go out on a pass to see his son play hockey.

[22] Dr. McGlynn testified that he has no independent recollection of discussions on December 5 that he may have had with either Mr. Holan or Nurse Inward-Jones. I accept the evidence of Nurse Inward-Jones on these events.

[23] Nurse Inward-Jones testified that she had no interaction with Mr. Holan on December 5 other than noticing that he had been lying on his bed all day. He was not her patient but she understood that he was in hospital because he was suicidal.

[24] Around 3 p.m. Dr. McGlynn told her that he had had a long conversation with Mr. Holan and that Mr. Holan seemed fine. He also said that Mr. Holan can be given a pass to see his son play hockey. Nurse Inward-Jones expressed some reservation that perhaps Mr. Holan was not as well as he let on because of her earlier observation of Mr. Holan lying on his bed all day. Dr. McGlynn said that he felt that Mr. Holan was fine and that he had told Mr. Holan that he could go to the game. Dr. McGlynn, according to Nurse Inward-Jones, did not say anything about Mr. Holan being escorted or unescorted.

[25] Nurse Inward-Jones testified that she took Dr. McGlynn's direction and comments as a "doctor's order". She passed the information on to Nurse Harman.

[26] Nurse Harman has been a registered nurse since 1988 with specialized training in psychiatric nursing. She has impressive credentials and I accept her evidence.

[27] Nurse Harman was the primary nurse for Mr. Holan on December 5. She knew that he had been on "close observation" since his admission; that he had been out on a pass on November 27; that there was a notation to "limit passes for now"; and, that there had been a further assessment by Dr. McCay on December 3. So, when Nurse Inward-Jones told her that Dr. McGlynn had said that Mr. Holan could go out to see his son play hockey, she took Mr. Holan aside to his room to do her own assessment as to whether he was well enough to go out. Her main concern was to see if Mr. Holan was suicidal.

[28] Mr. Holan told her that he had talked with Dr. McGlynn and that Dr. McGlynn had said that he could go out on a pass. He said he just wanted to spend time with his son. Nurse Harman testified that Mr. Holan seemed "quite with it, quite focussed". She detected no signs of confusion or agitation. She asked him if he had any thoughts of killing himself and he said "no". He reassured her that he would come back after his pass

and that he would attend a group session the next day. Nurse Harman was satisfied that he was well enough to go out. This assessment took about 10 minutes. She told Mr. Holan that he was not to consume alcohol or drugs while on the pass. She asked him if he had a ride; he told her he did; and then she let him go. Her shift ended at 7:30 p.m. that evening. She expected Mr. Holan to return to the hospital by 8 or 9 p.m.

[29] Nurse Harman testified that she had no reason to doubt that Mr. Holan was going to see his son play hockey. Mr. Holan had always expressed a great love for his son and talked about him frequently. So, to her, he seemed sincere. She also felt that there was a therapeutic value to Mr. Holan going out on a pass because it would foster family contact and support.

[30] Nurse Harman understood that Dr. McGlynn wanted Mr. Holan to go out on a pass. But she still felt that she had a discretion so that was the reason for her own assessment. Nurse Harman testified that if she had determined that Mr. Holan was suicidal, even though she was aware of Dr. McGlynn's direction, she would not have let him out. If Mr. Holan had insisted she would have called in the doctor. If Mr. Holan still insisted then the options were limited because he was a voluntary patient. She would have had to let him leave (albeit with an acknowledgement that it was against medical advice) or she would have had to have him certified as an involuntary patient (which would have necessitated the involvement of a doctor). All of this, of course, is hypothetical because she had no concerns.

[31] Nurse Harman also testified that when she did her assessment, because Mr. Holan appeared fine, she concluded that he fit the criteria for "general observation". Therefore he did not need an escort. Her assessment, in effect, downgraded Mr. Holan's observation status from "close" to "general". In Nurse Harman's view, the observation category is a nursing decision based on their ongoing assessment of the patient. Nurse Harman, in any event, understood the situation on December 5 to be the same as it had been since Dr. McGlynn's order of November 27: "may have passes at nurse's discretion".

Dr. McGlynn's Practice:

[32] I earlier noted that Dr. McGlynn had no recollection of the specific events of December 5. He therefore testified as to what his routine practice would be in such a situation. Evidence of routine or usual practice is, of course, acceptable evidence: see, for example, *Tetterington v. Wiens* (1995), 165 A.R. 6 (C.A.), leave to appeal refused [1995] 3 S.C.R. viii.

[33] Dr. McGlynn outlined both his general approach to treating patients on the psychiatric unit and on the question of passes. Although Dr. McGlynn was in family practice, approximately 20% to 30% of his patients had some type of psychological or psychiatric disorder and 5% of his patients would require admission to the psychiatric unit. So this was not an unusual situation. If he admitted a patient to the unit then he was responsible for that patient's treatment. However, he depended very much on the nursing staff since they were better informed as to the patient's ongoing condition because they observed the patient all day. He would do a ward round each day if he had patients in the unit.

[34] With respect to passes, Dr. McGlynn's usual practice was to direct that a patient may have a pass at nurse's discretion. He would meet with a patient to discuss each request for a pass. If he approved it he would communicate that to the nurse so that the nurse would do an assessment just before the pass was to be exercised. If the nurse felt that the patient should not go out then he would be called. This procedure applied to each pass even though there was a continuing order for passes at nurse's discretion. If he decided that a patient should have a pass then that meant that he concluded that the patient could be taken off "close observation" status. Every pass, however, would be subject to his assessment and also a nurse's assessment.

[35] Dr. McGlynn testified that his direction for "limiting passes", made on November 28, was one to be assessed on a day-by-day basis. He viewed it as a temporary response to Mr. Holan's problematic visit home on the previous day. Also, considering Dr. McCay's assessments, he would not have let Mr. Holan out on a pass without assessing him first.

[36] Dr. McGlynn stated that, while he cannot recollect his interaction with Mr. Holan on December 5, he would have gone through the same procedure as he usually did. In his view it would have been therapeutically beneficial for Mr. Holan to go out to see his son.

Events After December 5, 1996:

[37] Walter Holan did not return to the hospital. His movements after leaving the hospital are unknown.

[38] Mrs. Holan testified that she took her son to the hockey game. She did not see her husband there. She did not expect to see him because she did not know that he had

been given a pass. She first found out about that when she called the hospital later in the evening to find out how he was feeling. The next day the hospital contacted the police.

[39] In the pre-trial brief filed by plaintiff's counsel, there are references to the hospital not following "its own or any rational search policy" and that the steps it took were "inconsistent with hospital policy". If this was intended to be a separate allegation of negligence on the part of the hospital then the pre-trial brief is the only place it has been mentioned. It was not pleaded in the Statement of Claim and counsel did not refer to it in his closing argument. Suffice it to say that there is no evidence to support an allegation of negligence insofar as what occurred after Mr. Holan's disappearance.

[40] The police conducted numerous inquiries and also made a ground and helicopter search of the area around the hospital. They even contacted Interpol in the event that Mr. Holan had returned to Europe. There was no sign until body remains were found on June 6, 1998.

[41] Mr. Holan's body was found on an island in a small lake close to the hospital. A wallet was found on the body containing Mr. Holan's driver's licence. Because of the condition of the remains positive identification had to be made from dental x-rays. A police officer at the scene located a bottle of liquor next to the body and several empty antihistamine tablet packages. Toxicological examination of liver tissue revealed the presence of an extremely high level of diphenhydramine (an antihistamine medication found in a number of over-the-counter drugs). The toxicologist was of the opinion that the grossly elevated concentration of diphenhydramine was consistent with a probable overdose leading to death. Therapeutic levels of anti-depressant medication were also detected. There were no indications of trauma occurring before death.

[42] Ultimately the Coroner registered a death certificate noting that the death was a suicide caused by acute diphenhydramine toxicity.

Expert Evidence:

[43] The critical questions in negligence actions against doctors and hospitals are normally what is the requisite standard of care and whether there has been a failure to meet that standard. Expert evidence is usually of crucial importance on these questions. In this case there was only one medical expert called to testify and he was called on behalf of the defendants. There was no medical expert called by the plaintiff.

[44] The importance of expert evidence is readily apparent. The test in medical malpractice cases is whether the patient was given the medical care that a competent doctor (and nurse) would give under similar circumstances. In determining whether the care given and actions taken fell within the appropriate standard, the opinions of other professionals become quite relevant. As stated by Rand J. in *Wilson v. Swanson* (1956), 5 D.L.R. (2d) 113 (S.C.C.), at 120:

> . . . The test can be no more than this: was the decision the result of the exercise of the surgical intelligence professed? or was what was done such that, disregarding it may be the exceptional case or individual, in all the circumstances, at least the preponderant opinion of the group would have been against it? If a substantial opinion confirms it, there is no breach or failure.

This is not to say that a court should simply defer to the opinion of an expert. It is simply a recognition that expert evidence will normally be very helpful and influential but always with the caveat that it is the court, and not the expert, that decides whether negligence is established in a particular case.

[45] Dr. Ross Wheeler was qualified as an expert in the field of general medical practice and psychiatric care in the City of Yellowknife, able to give opinion evidence concerning the standard of care required of a family physician caring for a psychiatric patient and the quality of care provided to Walter Holan by Dr. McGlynn and the hospital's nursing staff. Dr. Wheeler was also familiar with the policies and procedures of the hospital having sat on several committees responsible for their implementation. He never had contact with Mr. Holan in a professional capacity.

[46] The thrust of Dr. Wheeler's opinion was that all reasonable steps were taken in Mr. Holan's care and supervision. He did not identify any deviations from accepted and responsible procedures. He did not express any criticisms of the decision-making process used to allow Mr. Holan to leave on an unescorted pass.

[47] Dr. Wheeler testified that in 1996 most psychiatric services in Yellowknife were delivered by family practitioners due to the lack of a full-time psychiatrist working out of the hospital. When a patient was referred to the psychiatric unit then treatment would be at the direction of the physician but in consultation with nursing staff on the unit.

[48] With respect to passes, the general policy was that there would be no pass issued for the first 24 to 48 hours after admission. This provides an opportunity for evaluation of the patient. After that it was a matter of assessment by the treatment team. Passes

were authorized by doctor's orders but subject to a nurse's discretion based on her assessment at the time when the pass was to be exercised. That assessment would consist of questions and answers focussing on whether the patient exhibited any signs of confusion, mood disturbance or suicidal ideation. In his opinion, a pass is a clinical therapeutic tool; it is a way of integrating the patient with family and community and also a way of building trust and self-confidence in a patient.

[49] In this particular case, Dr. Wheeler expressed the opinion that Dr. McGlynn's direction that Mr. Holan could go out to see his son on December 5 was a "verbal order". Nurse Harman then did the appropriate assessment. All indications were that Mr. Holan was making an effort and wanted to get better so that would have reinforced the veracity of what he told Nurse Harman. The experience with the pass on November 27 would have also reinforced the assessment done on December 5. The fact that Mr. Holan came back to the hospital that time after encountering stress showed that he could exercise good judgment about his care.

[50] Dr. Wheeler also stated that the question of an escort did not need to be specifically addressed on December 5 given Mr. Holan's clinical history. He had been out on unescorted passes previously. Also, as a doctor, he would not necessarily have expected the nurse to arrange an escort if he had ordered a pass. That was something within the nurse's general discretion.

[51] In Dr. Wheeler's opinion, the course of treatment was appropriate. In particular, it is important to keep in mind the context. Mr. Holan was a voluntary patient. There was nothing in his history or the clinical record that would have suggested a need for certification as a danger to himself or others. He certainly had mood swings but this was common in patients with a depressive order. In his opinion, there was nothing that should have led either Dr. McGlynn or Nurse Harman to think that Walter Holan was at risk to commit suicide when he left the hospital on December 5.

Hospital Policies:

[52] One of the key points of argument in this case is the importance of certain hospital policies with respect to the controls exercised over psychiatric patients. The position advanced on behalf of the plaintiff was that Dr. McGlynn and Nurse Harman breached hospital policy by allowing Mr. Holan to leave on an unescorted pass. The argument is that the policy sets the requisite standard of care and breach of it amounts to negligence.

[53] There are two pertinent policies. First, there is the policy entitled "Patient Passes: Psychiatry" under the category of "Nursing". This policy states:

> Passes outside of the Hospital may be granted to patients under certain circumstances:
>
> 1. as part of a therapeutic activity program
>
> 2. to facilitate community reintegration
>
> 3. to attend appointments with services in the community (ie. dental, ophthalmologic, social services, A.A., etc.)
>
> 4. to foster social supports (ie. family)
>
> Passes will not normally be granted until at least twenty-four hours after admission. Unit routine is not until 48 hrs. after admission.
>
> Passes are not to interfere with attendance of unit activities and programs.
>
> Attending physician must authorize passes by written order.
>
> Authorized passes will be granted at the discretion of the patient's nurse on shift.

[54] Second, there is the policy entitled "Observation Levels - Psychiatry" also under the category of "Nursing". By this "policy statement" (as it is labelled), psychiatric patients were subject to three different levels of observation by staff: general, close (which meant observation every 15 minutes), or constant (which meant continuous observation). It provides in part as follows:

> All patients admitted to Psychiatry will be placed on close observation (15 minutes checks) for twenty-four hours unless they require constant observation as specified by the attending physician's written orders or by the nurse in the Nursing Care Plan.
>
> Following the first twenty-four hours post-admission, the psychiatry patient will be placed on general observation unless otherwise specified by the attending physician's written order or by the nurse in the Nursing Care Plan.

[55] Attached as an appendix to this policy statement were specific details on each level of observation. For example, under the classification of general observation, the indications listed are that the patient (a) has been in hospital for a minimum of 24 hours,

and (b) is displaying responsible and predictable behaviour. That patient may leave hospital property with a written pass. Under the classification of close observation, the indications listed include (a) newly admitted to the unit, or (b) displays some disorganization, confusion, suicidal or homicidal ideation. Such a patient may have an ordered pass to leave the hospital but accompanied by a responsible person.

[56] Plaintiff's counsel noted that these policy statements do not differentiate between voluntary and involuntary patients nor do they apply only to some medical staff. In this case, Mr. Holan was placed on close observation. The policy provides that there must be an escort for any passes. Thus there was a breach of this policy, which counsel described as a "rule", and the breach amounts to negligence.

[57] The position of the defendants is that these policies are guidelines which are not meant to over-ride or replace medical judgment. This was the opinion of Dr. Wheeler and it was a view shared by Dr. McGlynn and the hospital's director of operations, Donna Zaozirny.

[58] Ms. Zaozirny's evidence (as read-in from her examination for discovery) was to the effect that policies provide "the guidelines, some standards, rules and regulations for various things" done in the hospital. They are developed by committees and approved by the senior management of the hospital and a medical advisory committee. Physicians are expected to comply with all hospital by-laws, rules, regulations and policies. This is confirmed by the document provided to each physician upon his or her appointment or reappointment to the medical staff. However, as Ms. Zaozirny related it, the physician is ultimately responsible for the care of his or her patient. This is confirmed by the Medical Staff By-Law of the hospital:

> Every patient in the Hospital shall be in the care of a Member of the Medical Staff who is a physician and who **shall be responsible for** the overall care of the patient. (Emphasis added)

and by the General By-Law of the Board of Management of the hospital:

> Subject to the provisions of Territorial Ordnances and regulations, these By-Laws, Rules and Regulations, and the Medical Staff By-Laws, Rules and Regulations, a physician appointed to the Medical Staff **shall have full authority and responsibility** in prescribing for the care of patients admitted to his services. (Emphasis added)

[59] Dr. McGlynn acknowledged that a physician had to do his or her job in a manner consistent with hospital policies. However, he viewed his medical decisions as the patient's physician to be paramount. His medical decisions, in his opinion, took precedence over hospital policies if those policies clashed with his opinion as to the best treatment for the patient.

[60] While Dr. McGlynn's evidence may strike one, at first blush, as a tad arrogant, it is in my opinion an accurate description of not only the way things are but also the way things should be. In my opinion the hospital's policies are guidelines; they do not set inflexible rules; and, they are subject to the exercise of discretion, by both doctors and nurses, depending on the needs of the patient. And it cannot be any other way. We cannot expect medical professionals to exercise competent and prudent judgment and then bind their hands to rigid policies.

[61] While, in my view, breach of a hospital policy does not amount to *prima facie* negligence, the policy could nonetheless be a factor to consider in determining what is the requisite standard of care and whether there has been a failure to meet it. This is no different than the general law with respect to the civil implications of a statutory violation.

[62] In *Canada v. Saskatchewan Wheat Pool*, [1983] 1 S.C.R. 205, the Supreme Court of Canada held that mere breach of a statute does not itself give rise to civil liability. It may, however, be an element of negligence. The civil consequences of a breach of statute are subsumed in the law of negligence although the statute may be examined to see if it sets up a useful standard of reasonable care. Since that is the application of a statute breach in the tort context, I fail to see how a policy breach could lead to more strict consequences.

[63] The requirements of a policy, such as the hospital polices in this case, are indicia of what the standard of care may be but they are not determinative of it. That is also the conclusion of the few cases on this point referred to by counsel: *Levesque v. Health Sciences Centre* (1996), 108 Man.R. (2d) 145 (Q.B.), affirmed on appeal (1997), 115 Man.R (2d) 228 (C.A.); *Croutch v. B.C. Women's Hospital & Health Centre*, [2001] B.C.J. No. 1430 (S.C.). Even the case referred to by plaintiff's counsel supports this conclusion: *DeJong v. Owen Sound General Hospital*, [1996] O.J. No. 809 (Gen.Div.), affirmed on appeal (November 22, 1999). There the trial judge noted the failure to follow certain policies as part of several factors leading to the finding of negligence. However, the trial judge also noted that a policy is not mandatory even though it may set out relevant considerations.

[64] All of this begs the question as to whether there were, in fact, violations of any policies. In my opinion, based on the evidence, there were none.

[65] The "Patient Passes" policy, quoted above, directs that "attending physicians must authorize passes by written order" and that "authorized passes will be granted at the discretion of the patient's nurse". That is what happened here. There was a written physician's order, as of November 27, to the effect that Mr. Holan may have passes at nurse's discretion. That was superseded on November 28 by Dr. McGlynn's direction to limit passes "for now". On December 5, Dr. McGlynn gave a verbal direction to Nurse Inward-Jones that Mr. Holan could go out on a pass. This, in my opinion, is the equivalent of reinstating the earlier order of passes at nurse's discretion. The fact that this was not written on a chart is not significant. This was also the opinion of Dr. Wheeler.

[66] Nurse Inward-Jones testified that she took Dr. McGlynn's direction as an "order" that was not subject to nurse's discretion. But that is not how Dr. McGlynn meant it nor, more importantly, how Nurse Harman interpreted it. She still proceeded to do an assessment of Mr. Holan because the pass, while "ordered", was still in her view, and in the view of Dr. McGlynn, subject to "nurse's discretion". This was in conformity with the policy.

[67] The "Observation Levels" policy, also quoted above, provided that a patient (after the first 24 hours) will be placed on general observation unless otherwise specified by a physician's order or by the nurse in the Nursing Care Plan. In this case Dr. McGlynn did not make any specific order. Dr. McCay, in his consultation report on December 3, recommended close observation. The nurses had Mr. Holan on close observation right up to December 5.

[68] There is a distinction that must be maintained between the policy respecting passes and that respecting observation levels. As Dr. Wheeler explained, observation status determinations are generally made by nurses on an ongoing basis. If a doctor gives an order for passes that does not necessarily determine a particular observation status. That is left to the nurses based on their ongoing assessment of the patient. And it may change from day to day. This was the procedure used with respect to Mr. Holan's status.

[69] What happened on December 5 was, in effect, as the medical witnesses testified, a re-assessment of Mr. Holan's condition both with respect to observation status and his ability to go out on an unescorted pass. Implicit in Nurse Harman's exercise of her discretion was a downgrading of the observation status from close to general. In my

opinion it was not necessary for Nurse Harman to first make a formal and distinct decision as to observation status and then another one as to the pass. The fact that she granted the pass, based on Dr. McGlynn's authorization, was in effect the change of Mr. Holan's status to general observation. The policy allows unescorted passes for patients on general observation. Hence there was no breach of the policy.

[70] Plaintiff's counsel argued that this point about a reclassification of Mr. Holan's observation status is nothing more than *ex post facto* justification for granting him an unescorted pass. In my opinion, however, there was no need for Nurse Harman to go through some formal step-by-step procedure. She was dealing with a human being who wanted to go out to see his son. It was a fluid, highly dynamic, situation, as it must have been all the time on that ward. The point is that the granting of the unescorted pass was to the same effect as if Nurse Harman formally reclassified Mr. Holan as being on general observation status. Thus my conclusion that, in sum and substance, there was no breach of hospital policy.

[71] The real question, nevertheless, is whether Mr. Holan should have been let out on an unescorted pass at all.

Standard of Care:

[72] Unquestionably a doctor and the medical staff of a hospital, such as nurses, owe a duty of care to a patient. The standard of that care is well-recognized in the jurisprudence. Every medical practitioner must bring to his or her task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He or she is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of similar experience and standing: as per Schroeder J.A. in *Crits v. Sylvester* (1956), 1 D.L.R. (2d) 502 (Ont.C.A.), at 508, affirmed [1956] S.C.R. 991. Whether a defendant has met the requisite standard of care in a particular case is a question of fact.

[73] In this case the particular allegation of negligence is that Dr. McGlynn and the hospital staff failed to take reasonable care to ensure that Mr. Holan did not inflict injury to himself. A duty to supervise and protect a patient will arise when the doctor and hospital staff know, or ought to have known, of the risk of suicide or self-injury. But, as Picard and Robertson note in their text, *Legal Liability of Doctors and Hospitals in Canada* (3rd ed., 1996), a "hospital is not an insurer against all hazards and will not be liable if the event in which the patient is injured was not foreseeable" (at 377).

[74] There are two further points to be noted. First, it is important to distinguish between negligence and an error in judgment. This is particularly so where, as here, the alleged negligence is the assessment of the risk that the patient may commit suicide. As many cases note, medical practitioners are not expected to be infallible in their predictions as to human behaviour. This was explained by Huddart J.A., on behalf the majority, in *Ganger v. St. Paul's Hospital*, [1998] 3 W.W.R. 329 (B.C.C.A.), at paras. 157-158:

> In a case such as this it is important to distinguish an error in judgment from breach of a duty of care. All who are called upon to predict human behaviour recognize the near impossibility of doing so with any confidence. If an attempt at suicide may be said to establish an error in judgment on the part of anyone charged with assessing the risk of that very event who does not anticipate it, then errors in judgment are endemic in the assessment of the risk of suicide. The evidence is clear that an error in the assessment of the risk of an attempt at suicide is as likely as not. Even the best judgment of a skilled psychiatrist will frequently be wrong.
>
> This point was made eloquently by the court in Fiederlein v. City of New York Health and Hospitals Corporation, 437 N.Y.S. 2d 321 at 324 (App. Div. 1981). There, the patient committed suicide while on a pass outside the hospital; the patient had been awaiting transfer to a psychiatric institute when the pass was granted. In overturning a jury verdict in favour of the plaintiff, the court observed:
>
> > The prediction of the future course of a mental illness is a professional judgment of high responsibility and in some instances it involves a measure of calculated risk. If a liability were imposed on the physician . . . each time the prediction of future course of mental disease was wrong, few releases would ever be made and the hope of recovery and rehabilitation of a vast number of patients would be impeded and frustrated. This is one of the medical and public risks which must be taken on balance, even though it may sometimes result in injury to the patient or others.

[75] The second point is that the focus of this inquiry must be on whether the actions of the doctor and the hospital staff at the time reveal a lack of reasonable care; the focus should not be narrowed to the result of those actions. This was expressed by Hall J. in *University Hospital Board v. Lepine* (1966), 57 D.L.R. (2d) 701 (S.C.C.), at 718-719:

> The question of whether there was or was not negligence in a given situation has been dealt with in many judgments and by writers at great length. One principle emerges upon which there is universal agreement, namely, that whether or not an act or omission is negligent must be judged not by its consequences alone but also by considering whether a

> reasonable person should have anticipated that what happened might be a natural result of that act or omission. As was said by Lord Thankerton in Glasgow Corp. v. Muir, [1943] A.C. 448 at pp. 454-5:
>
> > The court must be careful to place itself in the position of the person charged with the duty and to consider what he or she should have reasonably anticipated as a natural and probable consequence of neglect, and not to give undue weight to the fact that a distressing accident has happened.

The point is that the subsequent harm may show, in hindsight, error in judgment, but that is not proof of negligence.

[76] In this case, on December 5, 2001, both Dr. McGlynn and Nurse Harman exercised their clinical judgment based on their independent assessments of Mr. Holan's mental state at the time. They were examining specifically for the risk of suicide. In my opinion, and in the opinion of Dr. Wheeler, they were taking the necessary and appropriate steps for his safety.

[77] Dr. McGlynn had been treating Mr. Holan for at least a year. He was aware of Mr. Holan's clinical history, including his valium addiction. He was aware of the problems and stresses that Mr. Holan had been facing. He knew that Mr. Holan had recently been on an unescorted pass that had not gone well. But he also knew that Mr. Holan had returned to the hospital on his own at that time. Dr. McGlynn had, on at least three occasions within the previous month, sought the specialist advice of Dr. McCay. All of this went into the decision to allow Mr. Holan out on a pass on December 5. More significantly, however, Dr. McGlynn assured himself that Mr. Holan could go out on a pass that day by talking to him directly.

[78] Nurse Harman was also aware of Mr. Holan's clinical history. She was aware of the latest consultation report of Dr. McCay. She also knew that Dr. McGlynn had apparently assessed Mr. Holan and had concluded that Mr. Holan could go out on a pass. She too was aware of the previous pass and the fact that Mr. Holan had returned to the hospital when things were not going well. All of this was clearly documented on the nursing plan and other patient charts.

[79] It is also important to recognize that all of this was in the context of Mr. Holan being a voluntary patient who could discharge himself at any time. No one gave consideration to having him certified because, as Dr. Wheeler noted, there was nothing in Mr. Holan's history or behaviour that would have justified such a step.

[80] Finally, it is important to recognize, as both Dr. McGlynn and Nurse Harman did, that the ostensible reason for the pass - going to see his son play hockey - was considered a valuable therapeutic aid in Mr. Holan's treatment. The fact that Mr. Holan may have misled them as to his purpose is not something that either Dr. McGlynn or Nurse Harman can be blamed for. In any event, we do not know what happened to Mr. Holan after he left the hospital. All sorts of things may have intervened.

[81] The important thing is that both Dr. McGlynn and Nurse Harman were aware of the risk of suicide and specifically wanted to assess Mr. Holan from that perspective. Nurse Harman did not notice any suicidal ideation or confused thinking at the time. In my opinion, while one can say that there was always a risk of suicide, that occurrence was not a reasonably foreseeable one on December 5, 1996.

[82] The question of an escort comes under the same examination as the decision to allow Mr. Holan out on a pass. That was part of Nurse Harman's assessment. There was no evidence that the presence of an escort would or could have prevented what happened. Dr. Wheeler stated that an escort is no assurance of safety. Here, though, once again it is a question of the exercise of careful judgment in light of all the circumstances. I find no negligence for failure to require an escort on the pass.

[83] In the situation as it existed on December 5, Dr. McGlynn and Nurse Harman were exercising their clinical judgment. Subsequent events show that they may have been in error in their decision to let Mr. Holan leave the hospital. However it is only hindsight that shows this to be an error. And if it was an error then it was an error in judgment, not a breach of the standard of care imposed on the defendants in this situation.

[84] For these reasons, the claim against all defendants is dismissed. I realize that Mr. Holan's death was, and continues to be, a great tragedy for his family. But there is no basis for a finding of negligence in this case.

[85] I should explain, as a final point on this issue, that in coming to my conclusions I have not taken into account what is commonly referred to as the "locality rule". That rule protected doctors from tort liability if they merely lived up to the standard of the profession in their own or a similar community. In other words, someone in a rural or small-town practice did not have to be as proficient as an urban or big-city physician. I agree with the Hon. Allen Linden, author of *Canadian Tort Law* (7th ed., 2001), when he writes that the locality rule should be abandoned (at 162). There is no rationale for such differentiation now that there is standardized medical education in Canada and high-

speed communication technology. The courts should not countenance a principle that permits an inferior brand of medicine for Canadians living outside of major urban centres.

[86] The locality rule was not an issue in this case although Dr. McGlynn's counsel did make references to the standard of care as being that of a family practitioner providing psychiatric services in Yellowknife in 1996. I did not understand Dr. Wheeler, however, to differentiate between what he regarded as careful and prudent practice in Yellowknife or anywhere else. I approached this issue on the same basis.

Damages:

[87] While it is not necessary to decide damages, having regard to my conclusion on liability, I will discuss them briefly since counsel expended a great deal of effort on them at trial (and in case I am wrong on the liability issue). The objective in any wrongful death case is to compensate the surviving family members for their pecuniary losses attributable to the death.

[88] In this case the plaintiff advanced claims under several different heads of damages. I will address the major ones individually:

1. Loss of Financial Support:

[89] The plaintiff claims damages under both the *Fatal Accidents Act*, R.S.N.W.T. 1988, c.F-3, and the *Trustee Act*, R.S.N.W.T. 1988, c.T-8. As has been noted in other cases, the two claims co-exist but overlap. This was explained by Richard J. in *Stewart Estate v. Stewart Estate*, [1994] N.W.T.R. 276 (S.C.), at 280-281:

> Consequent upon such allegations of negligence causing death, two types of court action often emerge. The first is sometimes termed a "dependants action", in which the spouse, children and/or parents of the deceased person sue the alleged wrongdoer for losses suffered by them as a result of the death. This type of court action was not permitted, historically, at common law; rather it is an action that was created by statute, by the legislators. In this jurisdiction the dependants action was created by the enactment of the Fatal Accidents Act . . .
>
> The other type of court action which regularly flows from allegations of negligence causing death is what is described as an "estate action". In this action the representatives of the deceased person's estate pursue against the alleged wrongdoer the claim that the deceased person would have been entitled to pursue, for losses and injuries suffered by the deceased

> personally. Here too, it is not the common law but rather statutory law which permits the continuance of such a remedy notwithstanding the injured party's death. In most Canadian jurisdictions the statute is appropriately entitled the Survival of Actions Act. In the Northwest Territories the statutory provisions are found in sections 31-33 of the Trustee Act. . . .

[90] In recent years there has been quite an extensive examination of these two types of claims in Alberta and how to calculate each claim without duplication: *Duncan Estate v. Baddeley (No.1)* (1997), 196 A.R. 161 (C.A.); *Brooks v. Stefura* (2000), 192 D.L.R. (4th) 40 (Alta.C.A.); *Duncan Estate v. Baddeley (No.2)* (2000), 192 D.L.R. (4th) 53 (Alta.C.A.). Counsel took me through various aspects of these cases. What counsel did not do was make a specific comparison as between the legislation in Alberta and in this jurisdiction to determine if the same principles apply. I do not know if they do but that analysis can await a more appropriate case.

[91] The essence of the *Fatal Accidents Act* claim is compensation for the loss of income or support to the survivors of the deceased. The essence of the *Trustee Act* claim is to compensate for loss of future working capacity (the "lost years" claim). But the actual calculation of the claims appears to be the same. The loss is determined by discounting to present value the expected lifetime net income stream of the deceased: see Cassels, *Remedies: The Law of Damages* (2000), ch.5. This is usually calculated by using the deceased's projected income after (a) deducting the income tax that would have been paid on that income; (b) deducting the deceased's personal living expenses; and (c) applying various contingencies that are appropriate to the deceased (such as the prospect of unemployment, sickness, etc.) and to the survivors (such as the possibility of remarriage for the surviving spouse).

[92] It is important to quantify these matters as fairly and realistically as possible and therefore the evidence of experts is of great importance. As noted in *Keizer v. Hannah*, [1978] 2 S.C.R. 342 (at 351): "An assessment must be neither punitive nor influenced by sentimentality. It is largely an exercise of business judgment."

[93] The plaintiff's economics witness, Mr. Roy Ellis, was qualified as an expert over defence counsels' objections. I qualified him because, even though his expertise in the field of income loss analysis is somewhat limited, he still met the essential requirement for qualification, that being that he possessed special knowledge going beyond that of the trier of fact. The shortcoming in his expertise, however, is that it is concentrated in the areas of economic modelling and statistics. Accordingly, where there was a conflict, I

preferred the evidence of the defendant's expert, Mr. Ron Galagan, who has had far more experience in assessing these types of claims as a forensic and litigation accountant.

[94] The major deficiency in the analysis put forward by Mr. Ellis is that it is based on assumptions that have no, or little, factual foundation in the evidence. He based his calculations on a "statistical" man as opposed to the evidence as to the real Walter Holan. Mr. Ellis acknowledged that his report was a statistical model for a person of a certain age making a certain income. Thus, in my opinion, the income figures were arbitrary and the assumptions unrealistic. Admittedly there was very little information for him to work with. The tax returns that were placed in evidence were only for a few years when Mr. Holan was reporting significant income from the sale of his Yellowknife business interests. But this is a mere snapshot of his best years financially. They bear no relation to the long-term financial history. Mr. Ellis also did not apply any contingencies to his projections. This is contrary to accepted damage assessment practice: see *Andrews v. Grand & Toy Alberta Ltd.* (1978), 83 D.L.R. (3d) 452 (S.C.C.), at 470.

[95] One of the problems that plaintiff's counsel was confronted with in this case was the need to establish the probability that Mr. Holan earned more income, and would have earned more income, than the available records suggest. There was some evidence from Canada Pension Plan contribution data that Mr. Holan's reported net earnings from employment varied from approximately $4500 in 1982 to $15,000 in 1988 and back down to $3500 in 1995. Witnesses were called, however, to support the argument that the real income for a taxi driver such as Mr. Holan would have been in the range of $30,000 to $50,000 per year.

[96] The difficulty of basing a lost income claim on unreported or undocumented income has been the subject of comment before. In *Audet v. Frenette* (1988), 89 N.B.R. (2d) 336 (C.A.), Ayles J.A. stated that it would be against public policy to allow a plaintiff to recover damages for lost income on the basis of money never formally acknowledged or reported on a tax return. On the other hand, the British Columbia Court of Appeal, in *Iannone v. Hoogenrood*, [1992] B.C.J. No.682, held that to deny recovery because income is unreported on the basis of public policy confuses the concepts of the right to recover on a cause of action and the burden of proof upon a plaintiff. The cause of action does not arise from the failure to report income so public policy does not bar it. The cause of action arises from the alleged negligence of the defendants.

[97] I prefer the British Columbia view on this issue. And that highlights the problem in this case. The plaintiff has failed to prove the lost income claim, not because it was unreported but because of a lack of evidence. The lost income claim is based on

speculation and assumptions not supported by the evidence. There were sources of evidence but these were untapped by Mr. Ellis because his instructions were simply to prepare a model based on the assumptions provided by counsel. I agree with an observation made by Mr. Galagan in his testimony. There is not enough evidence to do a reasonable income loss calculation. Any award I would make would be mere guesswork.

2. Loss of Care, Guidance and Affection:

[98] This is a claim on behalf of Mr. Holan's son. This type of claim has been recognized as compensable under the rubric of pecuniary loss even in the absence of any statutory provision for it: *Orden Estate v. Grail*, [1998] 3 S.C.R. 437. In my opinion, earlier case law from this jurisdiction (*Stokes v. Levesque*, [1996] N.W.T.R. 182) which did not recognize this claim as a valid head of damage in the absence of statutory authorization must now be interpreted consistently with the common law reform sanctioned in the *Orden* case. I would have assessed damages under this head at $30,000.00 recognizing that it is somewhat arbitrary.

3. Loss of Expectation of Life:

[99] This is a claim under s.31(1) of the *Trustee Act*. That section is in the same form as the statute under consideration in *Crosby v. O'Reilly*, [1975] 2 S.C.R. 381, where an award on this type of claim was upheld. The Supreme Court then considered it an anomaly but the legislature has not deemed it necessary to change the legislation. As the Court noted then, this provision dates back to the *Trustee Ordinance* of the Northwest Territories enacted in 1903. It is likely that this jurisdiction is the last one in Canada to still recognize this head of damage.

[100] The damages under this head are awarded for shortened expectation of life. It was described as a somewhat conventional figure not susceptible to mathematical calculation. I would have awarded $30,000.00 to the estate on this claim.

4. Loss of Inheritance:

[101] This is a claim brought on behalf of the deceased's son. It is by nature highly speculative and any award is largely arbitrary. It is also usually awarded where the sole beneficiary of the estate was one person and the surviving child would not benefit from the estate: see *Kwok v. British Columbia Ferry Corporation* (1987), 20 B.C.L.R. (2d) 318 (S.C.), affirmed (1989), 37 B.C.L.R. (2d) 236 (C.A.).

[102] In this case there was no evidence as to any peculiar estate planning done by the deceased nor was there evidence of asset accumulation or of active steps to build an estate. In my opinion, there was insufficient evidence to support any award under this claim. In any event, there is overlap between this claim and that under the "lost years" approach.

5. Loss of Household Services:

[103] The non-monetary contribution to the family's welfare by the deceased is a recognized head of damage: *Coco v. Nicholls* (1981), 31 A.R. 386 (C.A.). The measurement of the value of lost household services is usually done on a "replacement cost" basis. This requires evidence regarding the actual contribution of the deceased to the household and evidence as to the value of unpaid services commonly provided by persons in the position of the deceased.

[104] The evidence was that Mr. Holan spent most of his time working. He did not do any cooking or cleaning and he was not a "handyman" around the home. He did spend a lot of time with his son when he could. He also drove his wife wherever she had to go (but it seems to me that was mainly because he was driving taxi and could do it at any time).

[105] The plaintiff also placed in evidence a statistical model prepared by her expert economist as to a calculation of this loss. Mr. Ellis acknowledged that he had no specific data as to Mr. Holan's household circumstances in the past. So he developed his analysis on the assumption that Mr. Holan fit the statistical averages. Those statistical averages were that Mr. Holan would have spent between 3.1 and 3.4 hours per day on household and related services. Using average hourly wage rates, and discounting for work done solely for his benefit, Mr. Ellis estimated a total loss (pre-and post-trial) in excess of $235,000.00.

[106] These calculations were challenged by Mr. Galagan. He questioned the assumption that Mr. Holan would devote at least 3 hours per day since it did not coincide with other data he had seen and that was widely accepted. That data shows that the average Canadian male spends only 1 hour per week on household services. Furthermore, the entire calculation is based on a statistical model without reference to what actually happened in the Holan household.

[107] I agree with the criticisms voiced by Mr. Galagan. All of the evidence presented to me drew a picture of the late Walter Holan as a man obsessed by work and getting ahead financially. This is not meant as a criticism. But, as a result, there would have been little time for him to spend on household services. There was also no evidence that all the time he spent with his son should be categorized as some type of compensable "childcare". It seems to me that it was the quality time that every parent tries to have with his or her child. There is a lack of evidence to support any precise calculation under this head of damage. The best that I could have done would have been to award some arbitrary amount, such as $25,000.00, for this claim.

Conclusion:

[108] As I stated above, this action is dismissed. Ordinarily costs follow the event. If costs are demanded in this case, and if counsel cannot agree, they may make arrangements through the clerk to make further submissions.

J.Z. Vertes
J.S.C.

Dated this 21st day of March, 2002.

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CV 08338

IN THE SUPREME COURT OF THE
NORTHWEST TERRITORIES

BETWEEN:

EWA KONOPEK-HOLAN,
ADMINISTRATRIX OF THE ESTATE
OF WALTER HOLAN

Plaintiff

- and -

STANTON REGIONAL HEALTH BOARD,
DR. WILLIAM McCAY, DR. J.S. McGLYNN
and BERTHA HARMAN

Defendants

REASONS FOR JUDGMENT OF
THE HONOURABLE JUSTICE J.Z. VERTES