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FROM: Justice W. U. Tausendfreund

PAGES: 36 pages

DATE: February 14, 2012

RE: Wendy Durnin, Alecia Fisher, by her Litigation Guardian, Wendy Durnin,
and Darrell Fisher -and- Victoria Hospital

MESSAGE: Kindly see attached Reasons for Judgment by The Hon. Mr. Justice W. U.
Tausendfreund released February 14, 2012.

ORIGINAL TO FOLLOW BY MAIL: Yes () No(x)

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CITATION: Durnin, et al., v. Victoria Hospital, 2012 ONSC 320
COURT FILE NO.: 31469F
DATE: 2012/02/14

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

WENDY DURNIN, ALECIA FISHER, by
her Litigation Guardian, Wendy Durnin, and
DARRELL FISHER

Plaintiffs

- and -

VICTORIA HOSPITAL

Defendant

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)
) Lorenzo Girones and Andrea Girones, for
) the Plaintiffs
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)

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)
) Deborah Berlach and Emily McKernan, for
) the Defendants
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) **HEARD:** October 3, 4, 6, 12, 13, 14, 18,
) 19, 20, 24, 25, 27, 2011
) **Written submissions filed:** December 15,
) 2011

TAUSENDFREUND, J.

Overview

[1] This case is about the clinically compromised birth of Alecia Fisher on February 4, 1991. The parties agree that Alecia suffered an intrapartum asphyxial exposure that is the cause of her neurological injuries.

[2] The central issue of liability is when this asphyxial process should and/or could have been detected. The plaintiffs' focus in this case is limited to the actions of the nurses for whom the defendant hospital as their employer is responsible.

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[3] The parties have agreed on the measure of damages, subject to court approval.

Facts

[4] The plaintiff mother, Wendy Fisher, as she was then known, was expecting her second child. Her pregnancy had been normal and uneventful. She was considered by her family physician and her obstetrician to be a low-risk patient.

[5] Wendy Fisher saw her obstetrician, Dr. Maynard at about 2 p.m. on February 4, 1991. He told her that she would deliver her baby in about five hours that day. Dr. Maynard noted in Ms. Fisher's Antenatal Record #2 that she was then 4 cm dilated and effaced.

[6] Ms. Fisher's contractions started later that afternoon and by 4 p.m. were repeating regularly every 10 minutes. Her husband drove her to Victoria Hospital in London. She was admitted at 16:37. At the time of her admission, Ms. Fisher presented with a neurologically intact fetus. Ms. Fisher provided her Antenatal Records #1 and #2 to Nurse Disley who saw her upon admission. Nurse Disley recorded a Fetal Heart Rate (FHR) of 132 – 144 at 16:45. Ms. Fisher told Nurse Disley that she was experiencing regular painful contractions every 10 minutes and asked for an epidural. It was not then provided.

[7] An Intern, Dr. Sabga saw Ms. Fisher at 18:00 hours. He noted that she was 4 – 5 cm dilated. He told her that it was too early for an epidural. Nurse Disley recorded the FHR at 18:00 as 132. At 18:30 Nurse Disley obtained a blood sample but did not record the FHR.

[8] The next medical caregiver for Ms. Fisher was Nurse Stephens who recorded her FHR at 19:30 as 120 -144. Ms. Fisher again asked for an epidural based on her then still regular and painful contractions. Nurse Stephens told her that it was far too early and that she could guarantee that Ms. Fisher would have her baby "around midnight". Nurse Stephens recorded the FHR at 19:55 as 140. At 20:00 hours Dr. Sabga noted that Ms. Fisher was 5-6 cm dilated and 75% effaced. Ms. Fisher described her painful contractions as of that time to be acute and unbearable. She again asked for an epidural. Dr. Sabga told her that her contractions were then not strong enough.

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[9] Nurse Stephens recorded Ms. Fisher's FHR at 20:00 as 140 – 144 and at 20:35, Nurse Wanless recorded it as 140.

[10] At or about 21:00 the Labour and Delivery nursing staff had difficulty tracking the fetal heart. Ms. Fisher was repositioned and at 21:03 the FHR was 60 beats per minute. An ultra sound at 21:05 revealed a "barely fluttering heart". Doctors were notified and Alecia was born at 22:00 hours. Unfortunately, Alecia was delivered with severe brain injuries which have left her as a spastic quadriplegic with a component of flailing upper limbs.

[11] The plaintiffs do not challenge, but concede that the medical care provided to Ms. Fisher post 21:00 and leading to Alecia's delivery met the expected standard of medical care.

[12] Nurse Stephens testified that she recorded the FHR based on her then practice, namely counting in five second increments for one minute and then multiplying each count by 12. She started her shift that evening at 19:00 hours but did not record Ms. Fisher's FHR for the first time until 19:30. The FHR of 120 – 144 which she recorded at 19:30, she did not perceive to be out of the expected ordinary range.

Analysis

[13] As already noted, damages are admitted. As well, the standard of medical care provided post 21:00 is not challenged. These reasons will address the issue of liability based on the standard of care provided to Ms. Fisher and the fetus by the defendant hospital and its nursing staff on February 4, 1991 from the time of her admission at 16:37 to 21:00. The question of causation will follow.

Nurses' Standard of Care

[14] To succeed in a negligence action against a physician or a nurse, the plaintiffs must establish that the treatment rendered by the physician or nurse fell below the standard of care

expected of that type of professional.¹ As stated by the Ontario Court of Appeal in the frequently cited decision of *Crits and Crits v. Sylvester et al.*, [1956] O.R. at p. 143:²

Every medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He is bound to exercise that degree of care and skill which would reasonably be expected of a normal, prudent practitioner of the same experience and standing...

[15] In *ter Neuzen v. Korn*³, the Supreme Court of Canada defined the standard of care owed by the physician to the patient as follows:

It is well settled that physicians have a duty to conduct their practice in accordance with the conduct of a prudent and diligent doctor in the same circumstances. In the case of a specialist, such as a gynecologist and obstetrician, the doctor's behaviour must be assessed in light of the conduct of other ordinary specialists, who possess a reasonable level of knowledge, competence and skill expected of professionals in Canada, in that field. A specialist, such as the respondent, who holds himself out as possessing a special degree of skill and knowledge, must exercise the degree of skill of an average specialist in his field.

[16] The conduct of a medical professional must be judged in light of the knowledge he or she ought to have reasonably possessed at the time that the alleged act[s] of negligence occurred.⁴

[17] Professional negligence principles are equally applicable to nurses and physicians. Nurses, like physicians, are professionals who possess special training, skill and knowledge. For that reason they are subject to the same standard of care.⁵

[18] Nurses have a duty to use their professional skill and knowledge in making appropriate assessments of patients and to accurately communicate those assessments to physicians. Nurses must exercise the care and skill that is reasonably expected of a prudent and careful nurse in similar circumstances.⁶

¹ *Granger (Litigation guardian of) v. Ottawa General Hospital*, [1996] O.J. No. 2129 at para. 20 and *Latin v. Hospital for Sick Children*, [2007] O.J. No. 13 at para. 29

² *Crits and Crits v. Sylvester et al.*, [1956] O.R. 132 - 151

³ *ter Neuzen v. Korn*, [1995] 3 S.C.R. 674 (S.C.C.) at para. 33 and 34.

⁴ *Ibid* at para. 34

⁵ *Marchand (Litigation guardian of) v. Public General Hospital Society of Chatham*, [1996] O.J. No. 4420 at para. 66; *Granger (Litigation guardian of) v. Ottawa General Hospital*, *supra* at para. 26.

⁶ *Granger (Litigation guardian of) v. Ottawa General Hospital*, *supra* at para. 26.

[19] As stated by Lax, J. in *Latin v. Hospital for Sick Children, supra*:⁷

A hospital may be directly liable for its own negligent conduct as well as vicariously liable for the conduct of its employees when they are acting within the scope of their employment. The law does not require perfection, but it does require the exercise of the care and skill that is to be reasonably expected of a prudent and careful hospital and of a prudent and careful nurse...

[20] Although a departure from a hospital protocol, policy or procedure is not *prima facie* evidence of negligence, it could nonetheless be a factor in determining whether there has been a failure to meet the requisite standard of care. A breach of a hospital protocol, policy or procedure must be viewed in light of what was reasonable and prudent conduct in the circumstances.⁸

[21] In the Labour and Delivery Unit of a hospital, it is the responsibility of the nurses to properly monitor the fetal status and report any resulting concerns to a physician. As noted in *Granger (Litigation guardian of) v. Ottawa General Hospital, supra* at para. 97:⁹

Within the obstetrical team concept, each of the professionals involved has a particular role and one of the responsibilities of the staff nurse is to properly monitor fetal status and report concerns either to a team leader, an intern, a resident or a staff obstetrician.

[22] In assessing the applicable standard of care expected of the nurses in this hospital in 1991, I remind myself of these principles:

- (a) The standard of care is to be assessed at the time and in the circumstances of the alleged negligence, not with the benefit of hindsight.¹⁰
- (b) A medical professional, including a nurse, will not be held liable for a mere error in judgment, provided that the judgment was exercised honestly and intelligently. However, if the error is one that would not have been made by a reasonably competent medical professional, including a nurse, the error amounts to negligence.¹¹

⁷ *Latin v. Hospital for Sick Children, supra* at para. 29

⁸ *Latin v. Hospital for Sick Children, supra* at paras. 60 and 61.

⁹ *Granger (Litigation guardian of) v. Ottawa General Hospital, supra* at para. 97

¹⁰ *Comisso v. North York Branson Hospital*, [2000] O.J. No. 1866 at para. 68

¹¹ *Williams v. Bowler*, [2005] O.J. No. 3323 at paras. 233 – 235; *Matthews Estate v. Hamilton Civic Hospitals*, [2008] O.J. No. 3972 at paras 125 - 127

Experts

[23] The issues to be canvassed on the standard of care exercised by the nursing staff at Victoria Hospital on February 4, 1991 from the time of Ms. Fisher's admission at 16:37 to 21:00 are the frequency and the method of auscultation.¹² That includes the determination of whether Ms. Fisher was in the active phase of labour and if so, as of what time.

[24] Both sides called a number of experts to assist the court with these issues.

Plaintiffs' Experts**Jane Scheufler**

[25] Ms. Scheufler obtained her RN designation from Humber College in 1979 and a Degree from the University of Toronto in Labour Management Relations. For 19 years she worked in the Labour and Delivery Unit of Toronto General Hospital as a staff nurse, educator and interim manager during which time she dealt with more than 3,000 patients. She then worked as a unit administrator of Labour and Delivery at North York General Hospital for two years and is currently employed as a staff nurse in the Labour and Delivery Unit at Credit Valley Hospital in Mississauga. During her career, she performed more than 20,000 FHR auscultations. She was qualified to give opinion evidence on the nursing standards of auscultation in 1991, the manner of auscultation, its frequency and its methodology

Dr. Jon F. R. Barrett

[26] Dr. Barrett obtained his medical degree from the University of Witwatersrand, South Africa in 1983, a PhD in medicine from the University of Newcastle in the U.K. in 1992 and a Fellowship in maternal/fetal medicine in 1994. He is currently the Chief of Obstetrics and Gynecology at York Central Hospital in Toronto. His expertise is in high risk pregnancies, yet he also delivers low risk women at a rate of about 20 per month. Dr. Barrett has been an Associate Professor at the University of Toronto since 2002. He has held a number of appointments, including advisor on maternal health to the World Health Organization and

¹² Auscultation: The manual action of listening to sounds of the fetal heart with a stethoscope or fetone.

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member of Scientific Advisory Committee Health Canada. He is a Fellow of the Royal College of Obstetricians and Gynecologists.

[27] Dr. Barrett was qualified to give opinion evidence in the area of obstetrics and gynecology regarding methods, intervals and purposes of auscultation and particularly on issues of whether between 1800 and 1930 hours there was a developing asphyxial event and whether that could have been detected by auscultation and if detected, what could and should have been done about it, whether there was an injury at 21:00 hours and what actions could and should have been carried out by the nurses following detection of an asphyxial event and if injury could have been detected or diminished.

Dr. Thomas Baskett

[28] Dr. Baskett obtained his medical degree from Queens University of Belfast, Northern Ireland in 1964. His post graduate medical education continued at the Royal Maternity Hospital/Belfast City Hospital from 1964 to 1970. He was an assistant and then Associate Professor in the Department of Obstetrics and Gynecology at the University of Manitoba from 1971 to 1980 and an Associate Professor/Professor and Professor Emeritus at the Department of Obstetrics and Gynecology at Dalhousie University from 1980 to the present. He is a Fellow of the American College of Obstetricians and Gynecologists.

[29] Dr. Baskett was qualified to give opinion evidence on the question of when the active phase of labour began with Ms. Fisher, on when and how auscultation should be carried out in the active phase of labour, and the question of what brought about the intra-partum asphyxiation in the case of Alecia Fisher.

Defendant Hospital's Experts:

Wendy Sinanan

[30] Ms. Sinanan is a registered nurse. She obtained her diploma in nursing in 1975 from the Toronto General School of Nursing, then associated with the Toronto General Hospital. She started to work as a registered nurse with the Toronto General Hospital Labour and Delivery Unit in 1975 until the program was transferred to Mount Sinai Hospital in 2000 where she

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continues to be employed doing labour and delivery work. She has undertaken teaching assignments at Mount Sinai and has taken additional courses and training, including certification for fetal heart monitoring. As a registered nurse, she has participated and assisted in more than 1,000 deliveries.

[31] Ms. Sinanan was qualified to give opinion evidence on the standard of nursing care expected of an obstetrical nurse in 1991.

Dr. Dan Farine

[32] Dr. Farine obtained his medical degree in 1976 from the Sackler School of Medicine, Tel Aviv University, Israel. Between 1977 and 1986 he undertook post graduate research and specialty training, including residency in obstetrics and gynecology at the University of Toronto. He is a Fellow of the Royal College of Physicians and Surgeons of Canada. As of 1988 he has been the staff Perinatologist, Division of Maternal/Fetal Medicine, Department of Obstetrics and Gynecology, Mount Sinai Hospital in Toronto. Since 2001, he has been a Professor of Obstetrics and Gynecology at the University of Toronto.

[33] Dr. Farine was qualified to give opinion evidence in the area of obstetrics, on the active phase of labour, fetal heart surveillance and auscultation and the possible timing of the injury in this case.

Active Phase of Labour

[34] At the time of admission to Victoria Hospital, Ms. Fisher presented as a multiparous mother (more than one pregnancy) with a healthy and neurologically intact fetus, as confirmed by Dr. Farine and others. She was then experiencing regular and painful contractions every 10 minutes. Her pregnancy had been normal and uneventful. At 2 p.m. that day her obstetrician, Dr. Maynard, noted on her Antenatal Record that she was 4 cm dilated and effaced. Dr. Sabga examined Ms. Fisher at 18:00 and found her to be then 75% effaced and 4 - 5 cm dilated. Both Drs. Baskett and Farine stated that "effaced" means a favourable cervix.

[35] The October 1995 policy statement of the Society of Obstetricians and Gynecologists of Canada (SOGC) defined the active phase of labour in a multiparous mother as the presence of

strong regular contractions with the cervix having reached approximately 3 – 5 cm dilation and 70% – 90% effacement.

[36] The Victoria Hospital protocol, in effect as of 1991, indicates that in the active phase of labour the FHR should be monitored every 30 minutes. Reference in the protocol to “active phase” includes the description of 4 cm dilation.

[37] ACOG is the governing body for obstetricians and gynecologists in the United States. It is recognized internationally as a leader in the development and publication of standards with respect to expected obstetrical practice, including the monitoring of FHR. ACOG’s standards for monitoring of FHR in 1991 were adopted by the Nurses’ Association of American College of Obstetricians and Gynecologists (“NAACOG”). NAACOG is the governing body for obstetrical nurses in the United States. It is recognized internationally as a leader in the development and publication of standards with respect to good obstetrical nursing practice, including the proper monitoring of FHR. In 1991, both ACOG and NAACOG standards were equally applicable in Canada as they were in the United States.¹³

[38] Nurse Scheufler stated that NAACOG, ACOG and SOGC all define the onset of “active labour” for multiparous mothers as “cervix – 4 cm dilated with regular contractions”.

[39] Regarding active labour and the frequency of auscultation, Ms. Scheufler’s opinion was:

- (a) based on Ms. Fisher’s 4 cm dilation and regular contractions at the time of her admission, she was by then in the “active phase of labour” as a multiparous mother;
- (b) based on the Victoria Hospital protocol, 4 cm of dilation required auscultation every 30 minutes;
- (c) Ms. Scheufler disagreed with Nurse Disley’s note at 16:55 that Ms. Fisher was then in “very early labour”;

¹³ *Fuong v. Morten*, [2009] O.J. No. 4661 at paras. 24 and 26

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(d) the note in the "Record of Labour" at 18:00 that dilation was then 4 – 5 cm indicated that Ms. Fisher was progressing in her labour which should have alerted Nurse Disley that Ms. Fisher was then in the "active phase";

(e) Dr. Sabga's notes at 18:00 of 4 - 5 cm dilation and contractions initially every 10 minutes and then every 5 minutes confirms continuation of "active labour".

(f) to the extent that the nurses did not auscultate every 30 minutes between 18:00 and 19:30, their failure to do so fell below the expected standard of care;

[40] Nurse Sinanan gave the following opinion on the issue of the start of active labour and the expected frequency of auscultation:

(a) Victoria Hospital protocol in effect in 1991 defined the "active phase" of labour for a multiparous mother as regular contractions, cervix dilation of 3 – 4 cm and 70% - 80% effacement. Yet, in her opinion, Ms. Fisher was in the "early stage" of labour at the time of her admission which called for a frequency of auscultation only once per hour;

(b) At 18:00 Ms. Fisher was as much effaced as needed to deliver and that she was then having regular contractions every 5 minutes;

(c) Ms. Fisher met the SOGC guideline for active labour by 18:00;

(d) Ms. Fisher may have been in active labour by 18:30 and 19:00, but Nurse Sinanan did not have enough information to say with certainty. She was, however, certain that by 19:30 Ms. Fisher was then in active labour.

[41] Even if Ms. Fisher did not start the active phase of her labour until 19:30, based on Nurse Sinanan's opinion that Ms. Fisher was in the "early stage" of labour from the time of her admission to 19:30, that required auscultation once every hour based on the protocol of the defendant hospital. Even by that standard, the nurses failed to auscultate at 19:00.

[42] Dr. Barrett stated the following on the expected frequency of auscultation:

- (a) during the active phase, the FHR should be auscultated at least every 30 minutes;
- (b) there should have been an auscultatory episode at 19:00;
- (c) the nursing care fell below the expected standard in the period between 18:00 and 19:30, based on the failure to auscultate every 30 minutes.

[43] Dr. Baskett opined as follows on the active stage of labour and expected frequency of auscultation:

- (a) based on dilation, effacement and regular contractions as of the time of her admission and her pelvic exam by Dr. Sabga at 18:00, Ms. Fisher was in active or established labour at or before 18:00;
- (b) the failure to auscultate at 18:30 and 19:00 fell below the expected standard of care;

[44] Dr. Farine provided this opinion on the active phase of labour:

- (a) it is difficult to know if Ms. Fisher was in the active phase at the time of arrival at hospital;
- (b) 4 cm dilation may have put her into the active phase, but she probably was not in the active phase as of the time of her admission;
- (c) the term "active phase" is in his view, a "package deal". It includes an assessment of whether contractions are painful.

[45] I note that Ms. Fisher gave voice to her painful contractions at the time of her admission.

[46] Dr. Farine stated further:

At pp. 49 – 51:

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Q. Now at 18:00, if the contractions were as noted by Dr. Sabga every 5 minutes apart, in your opinion was Mrs. Fisher in the active phase of labour?

A.. It is hard to say but, possibly and probably. I mean, I really don't know. ... I didn't say probably, I said possibly, but I mean it's really hard to know. There is a continuum ... I would say that the active phase probably started around 19:30.

...

And at p. 194:

Q. The bottom line in all this issue, sir, about the active phase of labour, is that as you told us earlier, you cannot tell if she was in active labour at 18:00 or whether it began at 19:30?

A. In this specific case, it's true.

[47] Based on the hospital protocol and the above noted Association guidelines, Ms. Fisher's regular painful contractions and the degree of her dilation and effacement, I prefer the evidence of Drs. Barrett and Baskett and Nurse Scheufler to the evidence of Dr. Farine and Nurse Sinanan where it differs on the start of Ms. Fisher's "active phase" of labour. In my view, both Dr. Farine and Ms. Sinanan equivocated on that question. I find that Ms. Fisher was in the "active phase" of labour by at least 18:00 and that she should have been auscultated every 30 minutes, from at least 18:00 forward. To the extent that there was a failure to auscultate at 18:30 and at 19:00 creating a gap of 1.5 hours between 18:00 and 19:30, I find that the actions of the nurses fell below the expected standard of care.

The Method of Auscultation of Nurse Stephens

[48] As already noted, Nurse Stephens described her method of auscultation as follows:

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- She would listen to the FHR with the fetoscope during 12 consecutive intervals of 5 seconds each. She would then multiply each of the results by 12.

[49] The March 1990 NAACOG guideline on fetal heart rate auscultation states:

- “Minimal” recommendations indicate auscultating during a uterine contraction, if possible, and for 30 second intervals following a uterine contraction.
- Count FHR during a uterine contraction and for 30 seconds thereafter to identify fetal response.
- Count FHR between uterine contractions for at least 30 – 60 seconds to identify average baseline rate.
- If distinct differences are noted between counts, recounts for longer periods are appropriate to clarify the presence and possible nature of periodic FHR changes, such as abrupt versus gradual changes.
- In clarifying accelerations, recounts for multiple brief periods of 5 – 10 seconds may be particularly helpful.

[50] The ACOG technical bulletin of September, 1989 states:

...such auscultation is usually performed during a contraction and for 30 seconds thereafter...

[51] AWHONN Study 2000 (Association of Women’s Health, Obstetric and Neonatal Nurses) states:

- Count the FHR after uterine contractions for at least 30 – 60 seconds.
- In clarifying accelerations and decelerations, recounts for consecutive brief periods of 6 – 10 seconds (multiplied by 10 or 6 respectively) may be particularly helpful.

[52] Ms. Scheufler indicated that Nurse Stephens’ counting method should be used only for further clarification and not solely for FHR monitoring.

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[53] Ms. Sinanan agreed that NAACOG indicated that counting for 5 – 10 seconds is a method used to clarify an uncertain situation or to provide more information. Although she stated that a 5 second method of counting was taught in a nursing course, she knew of no study to support Nurse Stephens' method.

[54] Dr. Barrett opined as follows:

P. 151:

I don't believe the monitoring was done in the correct fashion there as described by the nurse... the nurse was counting in 5 second increments, and multiplying by 12, which I don't believe is in accordance to the standard; I don't believe it gives you the baseline accurately...

Dr. Barrett indicated that he had not seen the Stephens' 5 second counting method in his practice, but knew of it as an additional method to clarify accelerations.

[55] Dr. Farine gave this opinion:

- Nurse Stephens' method of counting is an old method – you are likely to miss a few beats using this method, but missing beats here would not concern him as the FHR recorded was in the normal range and missing beats would not substantially change matters to bring it into an area of concern.
- The greatest accuracy of FHR counting is achieved when counting for 60 seconds and not in intervals.

[56] The opinion provided by Dr. Baskett was this:

- Counting in 5 second increments is subject to error.
- He had never heard of anyone using that method.
- The shorter the period of count, the greater the chance of error.

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- This method of counting has never been validated.
- He would be worried about the accuracy of the recordings made by Nurse Stephens based on that method of counting.
- There is a rhythm to the FHR, a familiar sound to an obstetrical nurse, provided the FHR is in the normal range. Listening in 5 second increments would not allow a nurse to detect if she was listening to the familiar sound of an FHR rhythm. The probability is high that this method of counting may lead to an error either on the up – or the down side.

[57] Nurse Stephens recorded the FHR at 19:30 as 120 – 144 using her 5 second incremental method of counting. With respect to that particular result, the physicians opined as follows:

Dr. Barrett:

- These two counts show a difference of greater than 15 beats. That should have called for a recount which was not done.

Dr. Baskett:

- He could not understand why there were two readings. In his view, 120, in the face of the earlier range of 132 – 144 at 16:55 was a little low. He would be worried enough to have caused him to apply electric fetal heart monitoring (“EFM”)¹⁴. In this case, it was a tough call, as 120 was still within the normal range. However, you should always reassure yourself and therefore, EFM should have been applied in this instance.

Dr. Farine:

P. 103

¹⁴ EFM – a procedure in which an electronic device is attached to the mother’s abdomen to monitor the FHR. It produces a continuous monitoring strip plotting the FHR.

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Q. And in your opinion, with a fetal heart rate in the range of 120 – 144 when intermittent auscultation is used as a method of fetal heart rate surveillance, would you expect a nurse to apply the electronic fetal monitor at that time?

A. No.

Q. To clarify what she heard?

A. No.

[58] Nurse Stephens' method of counting at 19:30 in increments of five seconds produced an FHR reading in the range of 120-144. As that difference is greater than 15 beats, I find that Nurse Stephens should have investigated further to either establish a baseline or to determine if she had listened to an acceleration or a deceleration. That could have been accomplished either by a manual recount or by EFM. As she did neither, I find in that regard that Nurse Stephens failed to meet the expected standard of care.

Causation

[59] Causation is established where the plaintiff proves on a balance of probabilities that the defendant caused or contributed to the plaintiff's injury.¹⁵

[60] The basic test for determining causation is the "but for" test which requires the plaintiff to show that the injuries would not have occurred "but for" the negligence of the defendant.¹⁶ The "material contribution" test may also be applied provided a two-pronged test is met. First, it must be impossible for the plaintiff to prove that the defendants' negligence caused the plaintiff's injury using the "but for" test. Second, it must be clear that the defendant breached a duty of care owed to the plaintiff, thereby exposing the plaintiff to an unreasonable risk of injury and that the plaintiff suffered harm from that injury. Where these two requirements are satisfied, liability may be imposed even though the "but for" test is not satisfied, as it otherwise would offend basic notions of fairness and justice to deny liability by the rigid application of the "but

¹⁵ *Athey v. Leonati*, [1996] 3 S.C.R. at para. 13

¹⁶ *Athey v Leonati*, *supra* at para. 14 and *Resurfice Corp. v. Hanke*, [2007] S.C.J. No. 7 (S.C.C.) at paras. 21, 23.

for” test.¹⁷ To state it more succinctly, the “but for” test may be relaxed where it is impossible to determine the precise cause of the injury in the face of multiple causes for the harm.¹⁸

Causation in Medical Negligence Actions

[61] Causation need not be determined by scientific precision. It is “essentially a practical question of fact which can best be answered by application of ordinary common sense”.¹⁹

[62] On the question of whether clear scientific evidence is required to support a finding of causation in medical malpractice cases, the Ontario Court of Appeal in *Fisher v. Atack*²⁰ stated:

54. ...in medical malpractice cases, an expert capable of providing a firm opinion that supports the plaintiff’s theory of causation is not required: *Snell at p. 330*. Rather, the trial judge is entitled to consider all the facts and circumstances established by the evidence at trial, and where appropriate, to draw an inference of causation through the application of reason and common sense. This approach has been termed “the robust and pragmatic approach”...

...

56. However, ...the robust and pragmatic approach does not shift the burden of proof away from the plaintiffs. Rather, the plaintiff must still “provide an evidentiary foundation for finding that there is a substantial connection between the injury and the defendant’s conduct: *Barker v. Montfort Hospital* (2007), 278 D.L.R. (4th) 215, at para. 54.

...

58. ...just as the robust and pragmatic approach cannot be used as a substitute for evidence, it cannot be used as a substitute for reviewing and making findings about relevant evidence.

Application of Causation Principles to the Evidence

[63] In addition to Drs. Barrett, Baskett and Farine whose qualifications I already noted, these three physicians also testified on the question of Alecia’s injuries and their timing: Drs. Armstrong and Marrin called by the plaintiffs and Dr. McMillan by the defendant hospital.

¹⁷ *Resurfice Corp. v. Hanke*, *supra* at paras. 22, 25

¹⁸ *Grass v. Women’s College Hospital*, [2003] O.J. No. 5313 at para. 95

¹⁹ *Snell v. Farrell*, [1992] S.C.R. 311 at para. 29

²⁰ *Fisher v. Atack*, [2008] O.J. No. 4481 at para 54-58

Dr. Derek Armstrong

[64] Dr. Armstrong is a paediatric neurologist who has carried on a diagnostic and interventionist practice at the Hospital For Sick Children in Toronto since 1984. He is an Associate Professor at the Department of Radiology, University of Toronto where he has taught since 1984.

[65] Dr. Armstrong was qualified to give opinion evidence as a paediatric neurologist on the issue of the nature, extent and the cause of Alecia's brain injury.

Dr. Michael Marrin

[66] Dr. Marrin is a neonatologist and Associate Professor of Paediatrics at McMaster University. He had obtained his neonatal fellowship at McMaster University. Since 1986 he has taught as a member of the Faculty of Medicine at McMaster University. From 1994 to 2001, he was the Clinical Director of the Neonatal Intensive Unit at McMaster Children's Hospital. In addition to his clinical work in neonatology, he was the Director of the Neonatal-Perinatal Medicine Fellowship Program.

[67] Dr. Marrin was qualified to give opinion evidence on the cause of Alecia's injury, the likely timing of that injury and whether earlier intervention would have avoided or diminished the impact of her injury

Dr. Douglas D. McMillan

[68] Dr. McMillan is a Fellow of the American Academy of Paediatrics and the Royal College of Physicians and Surgeons. He was a Professor of Paediatrics at the University of Calgary and Chief of the Division of Neonatology and Department of Paediatrics at Foothills Provincial General Hospital in Calgary. Since 2004, he has been Chief of the Division of Neonatal-Perinatal Medicine and Professor of Paediatrics at Dalhousie University.

[69] Dr. McMillan was qualified to give opinion evidence on the topic of neonatology and the nature and timing of the medical insult to Alecia and her resulting injury.

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[70] The parties agree that Alecia suffered an intrapartum asphyxial exposure which is the cause of her neurological injuries. I also repeat that the plaintiffs concede that the medical care provided to Ms. Fisher and her then fetus post 21:00 and leading to Alecia's delivery at 22:00 hours met the expected standard of medical care.

[71] The medical experts here agreed that FHR monitoring generally, and including this instance, was to ensure fetal well-being during labour and delivery and, if required, to intervene in a timely fashion to prevent possible harm that might result from oxygen deprivation.

Dr. Armstrong - Opinion

[72] A summary of the evidence given by Dr. Armstrong on the injuries to the fetus is the following:

- All parts of Alecia's brain were permanently injured.
- Those injuries are consistent with the diagnosis of cerebral palsy caused by oxygen deprivation resulting from decreased blood supply.
- The ultrasound taken the day before Alecia's birth showed a healthy brain and the further ultrasound taken six hours before birth showed no injury.
- The injury was caused by a prolonged partial or moderate asphyxia lasting an hour or more.
- The injury occurred on the day of birth and not before and occurred close to the time of birth.
- Essentially all parts of Alecia's brain were affected resulting in permanent brain injury.
- Alecia's brain injury is consistent with the occurrence of hypoxia-ischemia which in a fetus is oxygen deprivation to the brain caused by a decreased flow of oxygenated blood.
- Alecia's brain injury is due to a hypoxic-ischemic event and her injury represents a typical pattern for hypoxia-ischemia in a term fetus. The injury pattern indicates that it

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occurred at one time as an acute injury. There was no prior in-utero event that caused this injury.

- Prolonged partial asphyxia is typically present for hours and is of moderate degree of decreased oxygen. Sudden profound asphyxia is measured in minutes and is due to a profound or severe or near complete deprivation of oxygen. These are two different types of asphyxia. The resulting injuries from each of these two types of asphyxia are different. Alecia had injuries reflecting both types of asphyxia.
- The post 21:00 FHR drop to a rate of 60, the decrease to a barely fluttering state followed by a still worrisome range of 60 to 90 is a significant reduction of the FHR to less than half of what it should be. This is consistent with sudden profound asphyxia leading to Alecia's brain injuries.

Dr. Barrett – Opinion

[73] A summary of Dr. Barrett's evidence is as follows:

- Labour is a time of stress for the fetus as there is no blood flow during contractions. During that time, the fetus relies on its resources. The body continues to metabolize and in the absence of oxygen, lactic acid builds up. The amount of lactic acid is measured by the "pH" level.
- The "buffer" is the ability of the fetus to deal with the build-up of lactic acid. If the buffer is overwhelmed, then the pH falls. Acid is toxic to the body tissue and acid can damage the baby's brain.
- "Acidosis" is a condition of acid accumulation. That condition can be detected by FHR patterns. Detection of acidosis is the only reason for auscultation.
- The normal pH of a fetus should be in the range of 7.3 to 7.4. Damage can start at 7.2.

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- Here the pH reading was 6.84. This indicates a large build-up of acid, as the “buffer” of the fetus was overwhelmed. It indicates that a very significant asphyxial insult has occurred.
- The “base deficit” signals that neutralizing bicarbonates are being depleted by the build-up of lactic acid.
- If bicarbonates are depleted, it is almost inevitable that the fetus has sustained acidosis. A level of bicarbonates below -16 minimols (a thousand’s of a litre) per litre is in the range of acidosis. Here, the level of -22.9 reflects a significant base deficit.
- The combination of a pH reading of 6.84 and a base deficit of -22.9 is symptomatic of a very significant and prolonged severe insult of asphyxia.
- The clinical picture of this fetus does not reflect a sentinel event that may have caused this sudden profound or acute asphyxia process.
- This was an acute partial asphyxia which developed over some hours leading to the progressive accumulation of acid, as the capacity of the fetus to buffer was gradually overwhelmed.
- Had auscultation occurred in the period between 18:00 and 19:30, it would probably have shown either further decelerations of the FHR or other abnormalities associated with the progressive development of acidosis.
- Had auscultation been properly carried out between 18:00 and 19:30, signs of acidosis and the developing asphyxia would have been detected. That would have allowed the medical staff to deliver the baby at an earlier time and thus have prevented the eventual damage. Essentially, the nurses should at that time have done what they did at 21:00 when faced with a suspicion of an abnormal FHR, namely attempt to monitor further, call for help and apply an external fetal monitor.

Dr. Baskett - Opinion

[74] A summary of Dr. Baskett's evidence is as follows:

- This fetus was neurologically intact at the time of admission to the hospital.
- The entire clinical picture clearly indicates that the culprit of this hypoxic insult was intermittent cord compression or cord entanglement.
- Cord entanglement means that the umbilical cord which carries the blood and oxygen from the mother to the fetus is impaired by physical obstruction. Here, the cord entanglement was the result of the cord being wrapped around the neck of the baby either once or twice. Whether it was once or twice had no physiological impact.
- Cord compression leading to fetal heart abnormality can be picked up by auscultation, as it leads to the most profound type of bradycardia.
- Cord entanglement could have happened four to five times between 18:00 and 19:30.
- The fact that the 20:35 auscultation indicated an FHR in the normal range of 140 does not diminish his opinion that there was cord entanglement, as the nurse on that occasion would have listened at a time in between episodes of cord compression and have obtained a normal heart rate.
- Had the nurses listened to the fetal heart rate between 18:00 and 19:30 and detected cord compression during that time, they then should have undertaken the course of action they did post 21:00 hours. They would have repositioned Ms. Fisher to try and relieve the presumed cord compression, have given her oxygen, and have sped up the IV. They would have called the obstetrician and alerted the OR. Had the obstetrician then detected an episode of prolonged deceleration or repeated profound variable decelerations, the obstetrician would undoubtedly have then opted for Caesarean section. That would have avoided the events of post 21:00 and all subsequent episodes of hypoxia.

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- It is probable that one or more episodes of cord compression occurred between 18:00 and 19:30 when no auscultation was carried out by the nursing staff. Each such episode would have produced FHR changes detectable by auscultation. In addition, the unusual manner of auscultation carried out by Nurse Stephens at 19:30 may have missed a deceleration resulting from a cord compression.

Dr. Marrin - Opinion

[75] A summary of Dr. Marrin's evidence is as follows:

- On February 4, 1991 between 2:00 p.m. and the time of Ms. Fisher's admission to Victoria Hospital at 4:45 p.m., there were no signs of abnormality. Alecia was then probably a healthy fetus.
- The elevation of the lymphocytes and the nucleated red blood cells suggest that the fetus was experiencing some degree of hypoxia in the period ranging from one to a few hours before birth.
- Based on the "barely fluttering" heart and the fetal bradycardia detected at 21:05 hours and the sensitivity of FHR changes for even mild degrees of fetal hypoxia-ischemia, it is likely that some concerning features of the fetal heart would have been detected by auscultation in the few hours before 21:00 hours.
- The lasting brain injury of the type Alecia sustained is the result of a partial prolonged hypoxic-ischemic process that evolved probably over a period of two to three hours or longer. The probable cause is repetitive cord compression.
- The observations by the nurses of a "barely fluttering heart" at or about 21:00 hours is the result of a hypoxic-ischemic process that had evolved over two hours or more.
- Alecia's injury probably evolved over the hour following 21:00 hours to her birth at 22:00 hours. Alecia's brain injury was the result of the hypoxic-ischemic event which occurred at least during the last few hours of pregnancy which in the last hour reached a sufficient cumulative degree of severity to cause lasting injury to Alecia's brain.

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- Based on the “barely fluttering heart” and the bradycardia of 60, both detected minutes post 21:00 and in the absence of any evidence associated with a prior more acute profound asphyxial process, it is probable that there was a significant fetal acidosis developing in the hours before. Appropriate intermittent auscultation would likely have detected features in the FHR that would have prompted the institution of electronic monitoring. This would have afforded the opportunity to prevent injury that developed following 21:00 hours.
- Given the degree of abnormality of the FHR at or about 21:00 hours, and the fact that decelerations of the FHR are a sensitive indicator of a fetus becoming mild to moderately hypoxemic, had regular intermittent auscultation been undertaken at intervals of 30 minutes prior to 21:00, it would have detected some abnormality and would then have prompted the institution of more sophisticated monitoring such as EFM.
- Given that more subtle abnormalities of fetal heart rate can be detected on electronic monitoring versus intermittent auscultation, it is probable that there would have been changes detected that would have afforded the opportunity to pre-empt the injuries which occurred post 21:00.
- The bulk of Alecia’s neurological injuries evolved over the last hour of pregnancy. Had she been delivered based on an alarming degree of abnormality likely identified by EFM in the pre- 21:00 period, measures could have been taken to deliver her instrumentally, or by Caesarean section. Had she been delivered before 21:00 or even at 21:00 hours, it was probable that her brain injuries would have been prevented or very substantially ameliorated.
- The partial prolonged asphyxia probably started at a time when no auscultation was carried out. The asphyxial event could have started at 20:00 hours but it is more probable that it started earlier.

Dr. Farine - Opinion

[76] The following is a summary of the evidence given by Dr. Farine:

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- Q. Dr. Farine, were you able to come up with an opinion as to the possible time of insult or stress, distress and injury?

A. In a general sense, yes; in specifics, no. In other words, I knew that the pH at birth was low which suggested that this happened not that long before. It could have been a few minutes, it could have been an hour – it could have been a few hours or even a day or two... I think it's a bit difficult to time it unless it was a sentinel event to a very precise time. I think it's very difficult because you have to assume lots of things that may not be correct... I do not know when the insult really happened, and I am not sure that it's that easy to define.

...

- Q. Dr. Farine, you have read reports for this trial that suggest that something occurred or may have occurred somewhere between 18:00 and 19:30. ...do you agree based on the clinical record that you have reviewed that that's when something may have occurred for Alecia?

A. It could have happened, but I'm not sure. I mean I think it was not likely to happen at that time – transcript Pp. 91 – 92.

- There was no sentinel event.
- I don't really know when the insult occurred... – transcript p. 98.
- Assuming that there was intermittent cord compression which started at some point between 18:00 and 19:30, intermittent auscultation probably would not have picked up the fetus' response to that intermittent cord compression. – transcript p. 98.

- Q. ...did you come to any conclusion based on this record as to when the insult, as opposed to the injury, occurred?

A. Not really, I mean I knew that it happened sometime in the 24 hours... before the delivery occurred but in terms of pin-pointing it, I couldn't, but because of the

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contraction pattern and also because of the other things I mentioned earlier, it was unlikely to happen at that time ... the 18:00 to the 19:30. – transcript p. 102.

- Q. I am going to ask you to look at the fetal heart rate that's documented at 19:30, which is documented at 120 – 144, ...do you have any concern even with the counting method of Ms. Stephens with that fetal heart rate?

A. No.

- Q. In your opinion might that fetal heart rate suggest a deceleration?

A. No.

- Q. And in your opinion, with that fetal heart rate, would you have expected that the nurse took other actions to verify or clarify that fetal heart rate?

A. No.

- Q. And why not?

A. Because there was nothing that would suggest to her that she has to.

- Q. And in your opinion, with a fetal heart rate in the range of 120 – 144 when intermittent auscultation is used as a method of fetal heart rate surveillance, would you expect a nurse to apply the electronic fetal monitor at that time?

A. No.

- Q. To clarify what she heard?

A. No. – transcript p. 103

Dr. McMillan - Opinion

[77] The following is a summary of Dr. McMillan's evidence:

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- Q. Dr. Marrin gave evidence for this court that if the process had been going on for less time as opposed to more time, he would have expected the blood results or the cord blood gases, and particularly the base excess to be worse. Do you agree with that statement?

A. I can't, I can neither agree nor disagree with that statement. I don't know on what basis how he would be able to tell that.

- Q. Now, was there anything that you saw from your review of the record that would indicate to you that this process, and you said you're not sure of the process, but you think it could be cord compression, started between 18:00 and 19:30?

A. Nothing would suggest that at all on there... There isn't any, I don't know a way of determining that. I think it is unlikely, but I cannot absolutely 100 percent rule that out.

- Q. And why do you think it's unlikely?

A. Well, because the baby, after 19:30 had four other auscultations in which there appeared to be no concern at all.

- Q. And why is that of clinical significance to you in reviewing this case for coming to your opinion?

A. Well, it suggests to me that there was no, no evidence that there was anything out of the ordinary... for this baby until close to the 21:00 time...

...

- Q. And is there anything in Alecia's condition after birth which you've reviewed with us that would suggest to you or indicate to you that this process could have started between 18:00 and 19:30 and continued until her birth?

A. Nothing. I can't time it into any of those time regions. - transcript - Pp. 30 - 32.

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- FHR may return to normal after an acute bradycardic event.
- Is unable to comment on whether or not there was a bradycardia between 18:00 and 19:30 as no one listened to the fetal heart during that time.
- The fact that the FHR returned to normal values after 19:30 is an indication that it was at least a partially reversible process.
- If intervention had taken place prior to 21:00, it is possible the process could have been completely reversed.
- A cord compression between 18:00 and 19:30 could cause a bradycardia in that time period.
- Recovery of the FHR to normal values does not preclude the occurrence of an earlier problem.
- Agrees that the acute event of post 21:00 was preceded by a partial prolonged event.
- Asphyxial exposure almost certainly started during the last hours of delivery.
- He can neither agree nor disagree with the proposition that the prolonged event has to be greater than 60 minutes in duration and the acute event less than 30 minutes in duration.
- Absence of FHR monitoring during labour does not necessarily mean the absence of an undetected event during that time.

Assessment and Finding

[78] On the question of causation, I heard and considered opinions of six physicians. These opinions can be grouped into two camps. Drs. Armstrong, Barrett, Baskett and Marrin are in one such camp and Drs. Farine and McMillan in the other. Not surprisingly, the first group of doctors was called by the plaintiffs and the second by the defendant. It is apparent from my above noted summary that there is a divergence between these two groups of opinions.

[79] Absent consensus, I must distinguish between these two sets of opinions. In doing so, I remind myself of these principles:

(a) It is my role as the trier of fact and not the expert witnesses, to decide the question of causation.²¹

(b) Considering the issue of causation, the trier of fact may draw reasonable inferences from the evidence, based on common sense.²²

(c) The trier of fact must consider all of the evidence, including the expert testimony and may conclude on all of the evidence that the injury to the plaintiff was caused by the wrongdoing of the defendant, even if:

- None of the experts testifying conclusively states this to be the case;
- There is no consensus among the experts as to the respective likelihood of various potential causes of the injury²³

[80] Dr. Farine stated that an insult may have occurred in the time between 18:00 and 19:30, but he could not be certain. His evidence in that regard was:

“It could have happened, but I’m not sure.”

“I think it was not likely to happen at that time.”

“I don’t really know when the insult occurred.”

In support of his position that an insult likely did not occur during that 1.5 hours between 18:00 and 19:30, he gave two reasons:

(a) He referred to the earlier trial in this matter which then involved a number of physicians as defendants, in addition to this defendant hospital. Dr. Farine noted

²¹ *Cameron v. Loudon*, [2000] O.J. No. 858 at para. 157 and *Snell v. Farrell*, *supra* at para. 36

²² *Cameron v. Loudon*, *supra*, at para. 157

²³ *Cameron v. Loudon*, *supra*, at para 157

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that during that earlier trial none of the experts called ever suggested that an insult may have occurred during this time period of 18:00 to 19:30.

(b) The fact that there were normal auscultations after this time period.

[81] There is no evidence before me to suggest that the opinions elicited from the experts at the earlier trial are the result of either the identical theory now advanced by the plaintiffs or the same questions as put to the experts in that earlier trial. For at least those reasons, in my view the opinions advanced by the experts in that earlier trial are neither binding nor applicable on the issues before me. For these reasons, I will not consider those opinions.

[82] With respect to the second reason advanced by Dr. Farine, I note that the opinion at least of Dr. McMillan is that recovery of the fetal heart rate did not necessarily mean resolution of a presumed prior fetal insult.

[83] I note that the opinions of both Drs. Farine and McMillan on several occasions were equivocal on the question of the timing of the insult. Their respective responses, as I have noted above, included:

- "It could have happened."
- "It could happen, but not likely."
- "I don't know a way of determining that. I think it is unlikely, but I cannot absolutely 100 percent rule that out."
- "I can neither agree nor disagree with that statement."

[84] Particularly on the question of timing, Drs. Barrett, Baskett and Marrin all supported their respective opinions.

[85] To the extent that the opinions advanced by Drs. Farine and McMillan differ from those of the other four physicians, I prefer and accept the opinions of Drs. Armstrong, Barrett, Baskett and Marrin.

[86] Applying the principles of causation noted above, I find the following:

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- (a) The umbilical cord had wrapped itself around the fetus causing the umbilical cord to compress. That periodically interrupted the flow of blood causing a hypoxic-ischemic condition that deleteriously affected the fetus.
- (b) Ms. Fisher was in the active phase of labour by at least 18:00 hours and as of then should have been auscultated every half-hour.
- (c) Based on Nurse Stephens' method of auscultation, and her failure to verify the 19:30 FHR of 120 – 144 and/or her failure to then apply EFM, I find that it had the effect of extending the failure by the nursing staff to auscultate beyond the period of 18:00 to 19:30, namely to 19:55, a total of 1 hour and 55 minutes between 18:00 and 19:55.
- (d) The bradycardic event evident as of 21:00 hours was the result of a prolonged partial asphyxia which had its genesis in the time period of at least two to three hours prior to 21:00.
- (e) This prolonged partial asphyxial event impacted the fetal heart rate causing it to periodically drop to a range which would have alerted the nurses had they listened to the FHR by auscultation in the time of 18:00 to 19:55. Should I be incorrect in my assessment of the effect of Nurse Stephens' auscultation at 19:30, I find that a probable periodic drop of the FHR could have been detected had the fetus been auscultated between 18:00 and 19:30.
- (f) In that event, the nurses could and probably would then have initiated the steps they followed post 21:00 hours with the result that Alecia would then have been born earlier, either vaginally or by C-section and either without or with at least substantially reduced injuries.
- (g) The hypoxic-ischemic event probably started shortly after 18:00. It presented itself periodically and probably would have been detected, but for the nurses failure to auscultate between 18:00 and 19:55. The prolonged partial asphyxia was an indolent process which evolved into a sudden profound asphyxial event at or about 21:00. It was then that the moderate degree of decreased oxygen lunged into a state of near complete

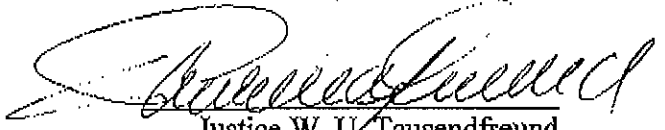
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deprivation of oxygen. It was that heightened degree of oxygen deprivation that caused Alecia's neurological injuries. That could have been avoided entirely or at least diminished, but for the negligence of the nurses in failing to auscultate between 18:00 and 19:55, or in the alternative, between 18:00 and 19:30.

(h) The neurological injuries Alecia sustained would not have happened or would have been substantially reduced, but for the negligence of the nurses in failing to auscultate between 18:00 and 19:30 and alternatively, their failure to verify the 19:30 FHR and/or to then apply EFM.

[87] The plaintiffs' claim against the defendant hospital is allowed.

[88] If required, the parties may make written submissions on costs within 30 days.



Justice W. U. Tausendfreund

Released: February 14, 2012

APPENDIX "A"

1. Granger (Litigation guardian of) v. Ottawa General Hospital, [1996] O.J. No. 2129 at para. 20; Latin v. Hospital for Sick children, [2007] O.J. No. 13 at para. 29
2. Crits and Crits v. Sylvester et al., [1956] O.R. 132 – 151
3. ter Neuzen v. Korn, [1995] 3 S.C.R. 674 (S.C.C.) at para. 33
4. ter Neuzen at para. 34; Ibid at para. 34
5. Marchand (Litigation guardian of) v. Public General Hospital society of Chatham, [1996] O.J. No. 4420 at para. 66; Granger (Litigation guardian of) v. Ottawa General Hospital, supra at para. 26
6. Granger (Litigation guardian of) v. Ottawa General Hospital, supra at para. 26
7. Latin v. Hospital for Sick Children, supra at para. 29
8. Latin v. Hospital for Sick Children, supra at paras. 60 and 61.
9. Granger (Litigation guardian of) v. Ottawa General Hospital, supra at para. 97
10. Comisso v. North York Branson Hospital, [2000] O.J. No. 1866 at para. 68
11. Williams v. Bowler, [2005] O.J. 3323 at paras. 233 – 235; Matthews Estate v. Hamilton Civic Hospitals, [2008] O.J. No. 3972 at paras 125 – 127
12. Auscultation: The manual action of listening to sounds of the fetal heart with a stethoscope or fetone
13. Vuong v. Morten, [2009] O.J. No. 4661 at paras. 24 and 26
14. EFM – a procedure in which an electronic device is attached to the mother's abdomen to monitor the FHR. It produces a continuous monitoring strip plotting the FHR.
15. Athey v. Leonati, [1996] 3 S.C.R. at para. 13
16. Athey v. Leonati, supra at para. 14 and Resurfice Corp. v. Hanke, [2007] S.C.J. No. 7 (S.C.C.) at paras. 21, 23
17. Resurfice Corp, v. Hanke, supra at paras. 22, 25
18. Grass v. Women's College Hospital, [2003] O.J. No. 5313 at para. 95
19. Snell v. Farrell, [1992] S.C.R. 311 at para. 29

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20. Fisher v. Atack, [2008] O.J. No. 4481 at para. 54
21. Cameron v. Loudon, [2000] O.J. No. 858 and Snell v. Farrell, supra, at para. 36
22. Cameron v. Loudon, supra, at para. 157.
23. Cameron v. Loudon, supra, at para. 157

CITATION: Durnin et al v. Victoria Hospital, 2012 ONSC 320
COURT FILE NO.: 31469F
DATE: 2012/02/14

**ONTARIO
SUPERIOR COURT OF JUSTICE**

B E T W E E N:

WENDY DURNIN, ALECIA
FISHER, by her Litigation Guardian,
Wendy Durnin, and DARRELL
FISHER

Plaintiffs

-and-

VICTORIA HOSPITAL

Defendant

REASONS FOR JUDGMENT

Tausendfreund J.

DATED: February 14, 2012