CITATION: Hemmings v Peng, 2022, ONSC 2674
COURT FILE NO. CV-11-424715
DATE: 20220503

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:	
SOPHIA KENESHA HEMMINGS, by her Litigation Guardian, Rosalie Brown, ROSALIE BROWN personally, SAMANTHA CAMILE GAYLE and MOSES HEMMINGS, minors by their Litigation Guardian, Rosalie Brown, and SAMANTHA HEMMINGS Plaintiffs	*Amani Oakley, Duncan Embury and Michelle Kudlats,* lawyers for the Plaintiffs
– and –	
CAROL YUEN-MAN PENG, SHARON ROSE O'BRIEN, NINA ELIZABETH NALINI VENKATARANGAM, RITIKA GOEL, NEIL THOMAS JAMENSKY, ANDRES BARTOLOME UMOQUIT, JENNIFER LAI-YEE TSANG, LLOYD GREGORY PADMORE, STEPHANIE SLADDEN, NORA DJIZMEDJIAN, YOUYI JIAN and THE SCARBOROUGH HOSPITAL Defendants	*Darryl Cruz, Dorothy Charach and Natalie Kolos,* lawyers for the Defendants, Carol Yuen-Man Peng, Sharon O'Brien, Neil Thomas Jamensky and Lloyd Gregory Padmore *Mary Lynn Gleason, Daniel Girlando and Chloe Richardson*, lawyers for The Scarborough Hospital **HEARD: SEPTEMBER 21, 24, 27, 28, OCTOBER 1, 4, 5, 6, 7, 8, 12, 13, 14, 15, 18, 19, 20, 21, 22, 25 26, 29, NOVEMBER 1, 2, 3, 4, 8, 9, 10, 12, 15, 16, 17, 18, 19, 22, 23, 24, 25, 26, 29, 30 and DECEMBER 1, 20, 21, 22, 2021**

REASONS FOR DECISION

G. DOW, J.

[1] This action arises from the pregnancy of the plaintiff, Sophia Hemmings culminating in her cardiac arrest while in the labour and delivery operating room at the Scarborough (General) Hospital on April 20, 2009. The other plaintiffs are her mother, Rosalie Brown, her sister, Samantha Hemmings, the child born that day, Moses Hemmings and the first child of Sophia Hemmings, being Samantha Camile Gayle.

[2] The plaintiffs claim damages for negligent treatment and care. The quantum was agreed upon at the outset of the trial and, given the individuals under a disability, approved at that time by Justice D. Wilson as the civil trial team leader.

[3] The defendant physicians are her initial treating obstetrician, Dr. Lloyd Gregory Padmore, the obstetricians at the Scarborough Hospital who monitored her care on April 19 and April 20, 2009, being Dr. Carol Yuen-Man Peng and Dr. Sharon Rose O'Brien and the anesthetist in the operating room on April 20, 2009, Dr. Neil Thomas Jamensky. The action against Dr. Andres Bartolome Umoquit, Dr. Jennifer Lai-Yee Tsang, Dr. Nina Elizabeth Nalini Venkatarangam and Dr. Ritika Goel did not proceed to trial.

[4] The Scarborough Hospital has admitted its vicarious liability for the actions of the nurses it employed and thus the action as against the defendants Stephanie Sladden, Nora Djizmedjian and Youyi Jian did not proceed to trial.

[5] The trial proceeded virtually with all counsel, parties and witnesses attending and appearing by way of ZOOM software.

Background

[6] It is undisputed that the following events occurred beginning with Sophia Hemmings having attended at the Woburn Clinic on August 1, 2008 seeking "family planning" from her family physician. Dr. E. Williams. The Woburn Clinic is at 4129 Lawrence Avenue East, Scarborough and was a facility where nine doctors practiced under the name "Woburn Medical Dental Centre (as indicated on a prescription script of Volume 12, Tab 4 E, page 4-0212a which was part of 12 volume Joint Brief of Documents marked as Exhibit 1). The Woburn Clinic file for Samantha Hemmings (marked as part of Exhibit 1) indicated that she began attending there in or about May 2002.

[7] Ms. Hemming's request for "family planning" (as it was described by her physicians) or contraception was the result of having commenced a relationship and having unprotected sex. Sophia Hemmings was referred by Dr. Williams and seen that same day, August 1, 2008 by Dr. Padmore, an experienced obstetrician, who examined her and ordered a multitude of tests, not including the regular blood test for pregnancy known as *beta* HCG The *beta* HCG test, which measures a rapidly increasing hormone in the blood in the first trimester of pregnancy, was not requisitioned by Dr. Padmore until his fourth examination

of Sophia Hemmings on September 30 and confirmed she was pregnant. She was advised of same on or about October 4, 2008.

[8] An ultrasound performed on October 4 estimated the pregnancy to be at 12 weeks thus having conceived in the latter part of July or shortly before the visit on August 1, 2008. Under cross-examination, Dr. Oppenheimer, the defendant doctors' obstetric expert, estimated the date of conception to be on or about July 25, 2008 (trial transcript page 5531). This was Sophia Hemmings' second pregnancy having given birth without complications 12 years earlier at age 16 in 1996 while living in her country of birth, Jamaica. Sophia Hemmings was unable to afford to bring her eldest child to Canada and support was apparently limited to phone calls (trial transcript, pages 9-10).

[9] Sophia Hemmings came to Canada in or about 1997 or 1998. Sophia Hemmings did not want to get pregnant. Dr. Padmore was aware of that fact (Exhibit 40, Tab 7 QQ.327-328 and Tab 22, Q.558, plaintiffs' read in of Dr. Padmore's examination for discovery evidence) and termination of the pregnancy was not raised by Dr. Padmore.

[10] Sophia Hemmings was morbidly obese when she got pregnant given her height, at about 70 inches, and weight, at about 279 pounds. This placed her Body Mass Index (BMI) at 40. Morbid obesity in pregnancy is subject to a multitude of increased health risks to the mother and fetus, including cardiac arrest (Exhibit 40, Tab 39, Q. 728) as admitted by Dr. Padmore and other medical experts during the trial. Other increased risks agreed to by Dr. Padmore included difficult or failed labour (Exhibit 40, Tab 33, QQ. 715-716), a caesarian section (Exhibit 40, Tab 33, Q. 717), maternal or fetal death (Exhibit 40, Tab 40, Q. 725, Tab 32, Q. 704), shoulder dystocia (Exhibit 40, Tab 40, Q. 729), macrosomia (Exhibit 40, Tab 41, Q. 738), anesthetic complications (Exhibit 40, Tab 41, Q. 738) and cephalopelvic disproportion (Exhibit 40, Tab 41, Q. 739). Dr. Padmore admitted not discussing these risks with Sophia Hemmings (Exhibit 40, Tab 44, Q. 743). Dr Padmore also decided to handle the pregnancy without discussing the option of referral to a level 3 hospital (Exhibit 40, Tab 48, Q. 767-768 and Tab 49, QQ. 779-780) with Sophia Hemmings. A blood test conducted on August 1, 2008 revealed lower than normal hemoglobin or iron in the blood at 9.7. This is also called anemia.

[11] The Province of Ontario has three levels of maternal fetal care available with the Scarborough Hospital having level 2 or community hospital resources. The Province of Ontario through the Ministry of Health and in conjunction with the Ontario Medical Association had created and put in use an Antenatal Record 1 and Antenatal Record 2 to be completed by the attending physician upon awareness of and during the pregnancy. There existed not only a 35 page guide prepared by the Ontario Medical Association (Exhibit 50) and released in January, 2006 but also "A Guide to Pregnancy Assessment" categorizing pregnancies as having no predictable risk, at risk, and at high risk on the back of the Antenatal Record 1 form. Dr Padmore's view was the form was "self explanatory" (Exhibit 40, Tab 55, QQ.866-868). The Antenatal Records were forwarded to the hospital where the

birth was to occur, the Antenatal Record 1 at about 20 weeks and the Antenatal Record 2 at 36 weeks.

[12] As indicated, an ultrasound was conducted on October 4, 2008. This was likely the most accurate for a due date. It estimated a birth date of April 12, 2009 although it appears April 17, 2009 was recorded on the sonographer's handwritten note (Volume 12, Tab 4E, pages 4-111a and 4-112a).

[13] The only "Identified Risk Factor" recorded on the Antenatal Record 2 was an apparent entry by Dr. Padmore to manage weight. Similarly, the only entry under "Plan of Management" noted by any physician during the entire pregnancy was "GBS neg", or a test for a type of bacteria in the vagina.

[14] On January 31, 2009, Sophia Hemmings was transported by ambulance to the Scarborough Hospital with abdominal pain which was investigated and she was discharged with advice to arrange an earlier appointment with Dr. Padmore.

[15] On February 3, 2009, Sophia Hemmings was transported by ambulance to St. Michael's Hospital, (which was a level 3 maternal fetal facility with resources available for the most serious or highest risk types of pregnancies), with bilateral leg weakness such that she could not stand. Upon investigation at St. Michael's Hospital, Sophia Hemmings was found to have abnormally low potassium in her blood (or hypokalemia). The potassium was replaced through intravenous and then oral supplements. The February 6, 2009 consulting note of the supervising obstetrician Dr. H. Berger written by Dr. A. Martin requested they be contacted before she was discharged. Referrals to specialists in nephrology and internal medicine at St. Michael's after discharge on February 9 included a follow up consulting note dated February 24, 2009 by Dr. Kamel, nephrologist. It was addressed to Dr. Williams and Dr. Padmore and detailed a diagnosis of a rare renal disorder known as Gitelman's Syndrome requiring ongoing care to include potassium rich medication known as K-Dur with her potassium and magnesium levels "to be followed quite closely" (Exhibit 1, Volume 11, Tab 3D, pages 3-036-37). This was in accord with the evidence of Dr. Braithwaite and the article (Exhibit 8) he was asked to review in his cross-examination by the defendant physicians.

[16] On February 14, 2009, Sophia Hemmings was seen by Dr. Padmore who notes in the "Subsequent Visits" portion of the Antenatal Record 2, her having been to St. Michael's Hospital as well as a weight loss of 40 pounds from her last visit on January 24 when she weighed 310 pounds. Dr. Padmore became ill after February 14 and does not return to work until on or about April 16 (Exhibit 40, Tab 85) with he or his office staff arranging for other obstetricians to see his patients including Sophia Hemmings who was seen on March 7, 14, 21 and 28, 2009.

[17] On March 14 and 21, 2009, blood tests conducted indicated an elevated glucose level indicative of gestational diabetes. Further, an ultrasound conducted on March 21 indicated

the fetus size was at or greater than 90% of those at this stage of pregnancy. This is called macrosomia. With large babies, the mother sometimes develops a large amount of amniotic fluid in their womb, a condition called polyhydramnios.

[18] On April 8, 2009, Sophia Hemmings telephoned the Scarborough Hospital's Labour and Delivery Unit at about 8:30 pm regarding having vomited three times earlier in the day. This required and resulted in the creation of a Nursing and Telephone Advice form signed by Nurse Cecelia San Juan. It was only partially completed and the second line, with boxes to check indicating whether the Antenatal Record's 1 and 2 have been reviewed, were left blank. It also stated if the "No" box was filled in, the patient was to be instructed to see "their MD or come to hospital for assessment". Nurse San Juan had no independent recollection of the call many years later when first asked about this incident. Sophia Hemmings did not attend the hospital to be examined that evening.

[19] On April 18, 2009, Sophia Hemmings was seen by Dr. Padmore at his office who arranged an ultrasound that day. The results indicate a fetus between 39 weeks, 6 days to 42 weeks of age, amniotic fluid over the 90th percentile and an estimated weight of 5,206 grams, also "well over the 90th percentile" (Exhibit 1, Volume 12, Tab E, page 4-0156b). Dr. Padmore directed her to attend Scarborough Hospital right away with his consultation request that she be induced (Exhibit 1, Volume 1, Tab D, page 1-06a). He also provided her with other medical records from his file regarding her medical status.

[20] Sophia Hemmings attended Scarborough Hospital where she was assessed by the on duty obstetrician, Dr. Wilcock. The Triage Assessment Record and Outpatient Record referenced the results of her being examined and prostaglandin (a substance that softens the cervix as part of inducing labour) applied.

[21] On April 19, 2009 Sophia Hemmings returned to the Scarborough Hospital and her case is turned over to and she is assessed by the on duty obstetrician, Dr. Peng. A decision is made to begin induction of labour.

[22] On April 20, 2009 at about 8:00 am, care of Sophia Hemmings was turned over to the on duty obstetrician, Dr. O'Brien who monitored the induction and noted that it had failed to progress. Also on April 20, 2009 at about 15:30, as a result of increasing pain from labour, Sophia Hemmings was offered an epidural anesthetic. This resulted in her being assessed for that procedure as well as evaluation of her airway in case a general anesthetic was required. It was conducted by Dr. Jamensky, the on duty anesthesiologist. The epidural becomes a spinal anesthetic as a result of inserting the needle through the epidural space and into the spinal area.

[23] At about 17:30, Dr. O'Brien reassessed Sophia Hemmings and received consent to perform an urgent caesarean section. The reason for this was assessed and recorded by Dr. O'Brien to be cephalopelvic disproportion or the baby's head was too large to pass through

the mother's pelvis (Volume 1, Tab 1P, page 1-034a). As Dr. Jamensky was completing another surgical procedure, the caesarean section did not commence until about 19:00.

[24] After the caesarean section commenced, that is, the initial incision of Sophia Hemmings' skin was made, Sophia Hemmings became "++ panicking, thrashing" as recorded by Dr. Jamensky (Exhibit 1, Volume 1, Tab 10, page 1-032). Dr. O'Brien recorded a "panic attack" in her Operative Report. Efforts were made to calm her including having her sister, Samantha Hemmings enter the labour and delivery operating room. Samantha Hemmings observed her sister to be responsive, to her name being called and advising Samantha that she could not breathe and wanting to sit up. When Samantha Hemmings attempted to take her sister's hand, she was prevented from doing so by the only male (Dr. Jamensky) in the operating room and Samantha Hemmings was told by him that her sister was going to be put to sleep and the baby taken out. Samantha Hemmings was then removed from the operating room.

[25] The intubation of Sophia Hemmings did not proceed as planned. After the general anesthetic drugs had been administered, Dr. Jamensky attempted to insert a tube down Sophia Hemmings throat using a device called a laryngoscope with a "Mac-3' blade on it. He was unable to so. He then made an effort to fill Sophia Hemmings' lungs with oxygen enriched air by use of laryngal airway mask before proceeding with a larger bladed, "Mac-4" laryngoscope which permitted him to insert the tube to its proper position at the top of Sophia Hemmings' lungs and began breathing for her.

[26] Dr. Jamensky observed Sophia Hemmings' blood pressure, pulse and End-tidal CO2 levels drop. During this time the caesarean section was completed and the baby was delivered.

[27] The handwritten records of the cardiac arrest (or Code Blue) team indicated their actions began at 19:43 with Dr. Jamensky having started chest compressions. A pulse and heart rate were recorded again as of 19:48. The next notation of a blood pressure was at 20:04.

[28] The caesarean section was completed and Sophia Hemmings transferred to the Intensive Care Unit where assessment of what occurred and efforts to treat her were made. At a meeting held with family members on May 3, 2009, the Hospital records indicate the family was told that the cardiac arrest was the result of an unrecognized cardiomyopathy (Exhibit 1, Volume 1, Tab T, page 1-082). The discharge record of the Scarborough Hospital dated July 24, 2009 (Volume 1, Tab C, pages 1-003 and 004) described an "EEA arrest, dilated cardiomyopathy, and peritonitis status post-laparotomy (G-tube misplaced) secondary to G-tube misplacement". Sophia Hemmings' admission to hospital was "a prolonged ICU stay and developed complications during this time including eclampsia, seizures, edema, and hypertension". Her current condition was "probably secondary to anoxic brain injury".

Negligence of Dr. Padmore

[29] The potential negligence of this experienced suburban obstetrician can be narrowed (from the fifteen issues identified by his counsel in their written submissions) to the following three issues:

a) the failure to order a *beta* HCG test earlier than on September 30, 2008;

b) the failure to raise termination of the pregnancy with Sophia Hemmings and determine her wishes; and

c) the failure to document the multiple risk factors and a plan of management during the pregnancy while Dr. Padmore was her most responsible physician for obstetric care.

[30] I accept the standard of care to be applied for each of the physicians is that as submitted by counsel for the physicians. That is, the test as stated in *ter Neuzen v Korn*, [1995] 3 S.C.R. 674 at paragraph 34, which, for a specialist, such as an 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". Further, there is "a duty to conduct their practice in accordance with the conduct of a prudent and diligent doctor in the same circumstances". The evidence noted Dr. Padmore, had more than 30 years of experience as an obstetrician in Ontario (after six years of practice in the same specialty in Scotland) as indicated in his *curriculum vitae* (Exhibit 45). He practiced obstetrics in Scarborough, a large, densely populated suburban area in Canada's largest urban centre. He admitted being familiar with obesity in pregnancy and the risks and complications arising from same. This formed a basis for his decision not to refer Sophia Hemmings to a level 3 obstetric hospital but the level 2 community hospital, that is, the defendant Scarborough Hospital. When asked about a need for heightened observation such as available as a level 3 facility, Dr. Padmore evidence was 'I'm not boasting but she had me" (Exhibit 40, Tab 52, QQ. 786-787).

[31] At the outset, consideration of Dr. Padmore's testimony, who gave evidence at this trial, having been retired for five years, included his poor memory of these events which occurred almost twelve years earlier. This was acknowledged by him. To that end, I generally preferred to rely on his examination for discovery evidence, taken years earlier and much of it read in as part of the plaintiffs' case. I do note that many of his positions remained steadfast between his examination for discovery and the trial and were practiced by him during the applicable timeframe, that is 2008 and 2009.

[32] I find Dr. Padmore was negligent in not including a *beta* HCG test as part of the extensive array of blood tests he requisitioned following the initial examinations on August 1, August 26 (for which OHIP was billed but no clinical note exists) or September 2, 2008 (Exhibit 1, Volume 12, Tab 4D, pages 4-100a-101a). I do so because Sophia Hemmings presented to Dr. Padmore seeking contraception as a result of having unprotected sex in the days or weeks before that visit.

[33] It was submitted the failure to conduct a beta HCG test was not below the standard of care because Sophia Hemmings had not missed a period when examined on August 1, 2008. Dr. Padmore's own evidence was that, in his experience, woman equate uterine bleeding with periods which may not be accurate (Exhibit 40, Tab 18, Q.460). This raises whether reliance on a woman's report of when she last had a menstrual period was appropriate or within the standard of care. Adding the *beta* HCG test on the first or second visit to the many other blood tests would have provided more reliable information.

[34] As indicted in the *beta* HCG test result of September 30, 2008 and raised in the cross-examination of Dr. Oppenheimer (trial transcript pages 5570-75), the laboratory results provide (as occurred here) a "Reference Range". For the *beta* HCG test, the non-pregnant result is less than five. Any result of five or greater is considered positive for pregnancy and placed in a weekly and then trimester range. The Reference Range for the first week of pregnancy is 5-50 and the second week is 40-300 (Exhibit 1, Volume 12, Tab 4E, page 4-0110a). By waiting until the fourth visit on September 30 and the assessment of or by Sophia Hemmings having missed a period, her pregnancy was not detected until about 12 weeks.

[35] Dr. Padmore failed to follow his own experience and expertise in relying on the patient's self-evaluation of having had a menstrual period. This was compounded by the fact Dr. Padmore's own brief records included the notation "FUB" or functional uterine bleeding on visits September 2 and September 9, 2008 (Exhibit 1, Volume 12, Tab 4B, page 4-026a).

[36] The conclusion that Dr. Padmore was negligent in failing to include the *beta* HCG test in the variety of tests conducted on his initial visit (or that of September 2 or 9, 2008) was made cognizant of the need to assess his conduct at that time and not by applying current standards to those events. This principle was also submitted by counsel for the defendants' physician as part of the *ter Neuzen v Korn, supra* decision (at paragraph 47).

[37] In this regard, I also rely on the comments and evidence of Dr. Braithwaite regarding Dr. Padmore's finding of bulkiness in the uterus on September 2, 2008 being "pretty suggestive of a pregnancy" (Trial transcript pages 622 and 627). I find Dr. Padmore's decision lacked the prudence or diligence of an obstetrician in these circumstances.

[38] Regarding the second issue of whether Dr. Padmore's failure to raise termination of the pregnancy pits the very purpose of Sophia Hemmings visit to the Woburn Clinic seeking contraception following unprotected sex because she did not want to get pregnant with Dr.

Padmore's unwavering position (and that of the defendant physicians obstetrical experts) that the topic of abortion must be raised by the patient (Exhibit 40, Tab 26, Q. 645-670). I have concluded Dr. Padmore was negligent in this regard. Dr. Oppenheimer acknowledged in his cross-examination that the standard of care should anticipate a range of knowledge and understanding in patients and the need to tailor conversations with the patient based on the patient's education, employment status and knowledge (trial transcript pages 5337-5338). I do so on the basis that as of 2009, the existence of the methods available to terminate the pregnancy varied and gave importance to the timeliness and discovery of whether the patient was pregnant and whether the pregnancy was unplanned or unwanted.

[39] Dr. Padmore ought to have been aware of and followed the Canadian Medical Association (CMA) policy issued in 1998 (Exhibit 46) that abortion was a medical decision to be confidential between the patient and physician. Having sought contraception from Dr. Padmore following unprotected sex and not wanting to get pregnant, Sophia Hemmings was to "be provided with the option of full and immediate counselling service in the event of unwanted pregnancy" (at page 1, bullet point 4).

[40] Further, I agree with and accept the evidence of Dr. Braithwaite during his cross-examination by counsel for Dr. Padmore that relied on the November, 2006 Society of Obstetricians and Gynecologist of Canada (SOGC) Clinical Practice Guideline entitled "Induced Abortion Guidelines" (Exhibit 5, Trial Transcript at pages 646-647). That is, the physician has an obligation to discuss options with a patient that comes to him or her for contraception because she did not want to get pregnant and was or becomes pregnant. Had Dr. Padmore given evidence which was accepted or preferably made a note that she wished to continue with the pregnancy (or adoption) and this was rejected by Sophia Hemmings, the standard of care would have been met. I also rely on the evidence regarding the significant percentage of women that choose to terminate an unintended pregnancy (as referenced in Exhibit 70). I find Dr. Padmore's decision lacked the prudence or diligence of an obstetrician in these circumstances. Dr. Padmore's failure to discuss the option of termination of the pregnancy with Sophia Hemmings when she attended at his office with concerns about having had unprotected sex and wanting contraception was a clear breach of the SOGC guidelines and falls below the standard of care of an obstetrician in these circumstances. Dr. Padmore was negligent in this regard.

[41] I pause at this point, as it will be repeated in these Reasons, regarding the reliance on memory or usual practice instead of notes. I am aware of and accept the authorities which permit health care professionals to give evidence about and rely on their usual practice rather than (the lack of) present recollection. (*Girard and Gagnon v. Windsor Regional Hospital* 2014 ONSC 87 at paragraph 190). Each participant, whether patient or medical practitioner, had the opportunity to record what transpired with sufficient detail to demonstrate what occurred and preserve it for future reference, if required. However, for the medical practitioner and their employer, there was a legal obligation to make a record of what occurred and have it available for effective continuity of care. Those involved in the care of Sophia Hemmings repeatedly failed to take advantage of the forms, protocols, guidelines

and practices in place to demonstrate patient safety was adequately and appropriately protected.

[42] This statement leads to the analysis of the third allegation of negligence on the part of Dr. Padmore, that is, whether the failure to document the multiple risk factors or the plan of management in these circumstances while Dr. Padmore was her most responsible physician for obstetric care fell below the applicable standard of care. Given the many potential risk factors facing this morbidly obese pregnant patient, I have concluded that it did.

[43] The Antenatal Record 1 and 2 were, as Dr. Padmore testified at his examination for discovery "self-explanatory" and required no training (Exhibit 40, Tab 55, Q.866).

[44] Dr. Padmore acknowledged its main purpose was to serve as a communication tool for proper obstetrical care (Exhibit 40, Tab 55, Q.877). Despite that evidence, a 32 page Guide existed as of January, 2006 (Exhibit 50) prepared by the Ontario Medical Association. At pages 23-24 of the Guide, it recognized antenatal care "is often delivered on a shared basis where one clinician provides the bulk of the antenatal care, and another assumes full responsibility for the delivery" as well as "other allied health personnel who provide care need to be aware of any risk factors". This compares with the complete failure to identify a plan of management during the time when Dr. Padmore was her most responsible physician for obstetric care. This would be up until February 14, 2009 or Sophia Hemmings thirty-first week of pregnancy. Dr. Padmore's evidence was the Plan of Management portion of the Antenatal Record 2 pertained to how the baby was to be delivered (Exhibit 40, Tab 69, Q.1091). Further, the Plan of Management developed as the pregnancy developed (Q.1084). I agree with that evidence. The Plan of Management portion of Antenatal Record 2 contains nine lines or, as I conclude, room for some kind of plan to be stated over the first 31 weeks of the pregnancy. There is room to update or alter the plan as required. This conclusion was re-enforced by Dr. Padmore's own evidence of his early awareness that Sophia Hemmings obesity and initial ultrasound resulted in his opinion birth should occur at 38 weeks which would be when the fetus had matured (Exhibit 40, Tab 91, QQ.1574, 1583 and Tab 92, Q.1592). Dr. Padmore's stated clinical judgment was no obstetrician would have "gone past 38 weeks" (Exhibit 40, Tab 93, Q.1612). I am aware that in reaching these conclusions I have accepted portions of the evidence of Dr. Padmore. As I indicated to counsel, juries, as the triers of fact are instructed they can believe all of what the witness has said, part of it, or none of it. I have relied on that direction throughout these reasons.

[45] Had such a Plan of Management been noted in the Antenatal Record 2, it would have drawn the attention of those that became Sophia Hemmings most responsible physician. This is particularly the case where, as occurred here, Sophia Hemmings' prenatal care was transferred to others after Dr. Padmore fell ill on February 14, 2009 and at the Scarborough Hospital.

[46] Similarly, there was a failure to document Sophia Hemmings' risk factors aside from her weight. This included her anemia or low hemoglobin. This was an acknowledged concern of Dr. Padmore as he ordered tests to measure it and prescribed her to take iron supplements including folic acid which would assist in the absorption of the iron supplement. While the attendance at St. Michael's hospital for her low potassium was noted as part of the February 14, 2009 visit, no other details were recorded on the Antenatal Record 2. This was a five day stay at a then tertiary or level 3 obstetrical care hospital with nephrology and internal medicine assessments and follow up. The Discharge Summary was forwarded to and in fact in Dr. Padmore's file. The document was stamped to note its receipt by Dr. Padmore's office on February 11 which seems to have precipitated the February 14 examination (Exhibit 1, Volume 12, Tab 4e, pages 4-134a and 134b). While the explanation for this failure was the existence of the Discharge Summary in Dr. Padmore's file, even a simple entry in the Risk Factors portion of the Antenatal Record 2 such as "see St. Mike's Discharge Summary Feb 9 /09" was not made.

[47] Dr. Padmore acknowledged obesity in pregnancy (and various reputable published material marked as Exhibits 15, 16, 17, 18, 19, 20, 25, 26, 31, 55 and 78 detailed) increased the risk of hypertension, diabetes, macrosomia, cesarean section, polyhydramnios, pre-eclampsia and anesthetic complications. All of these conditions or procedures could cause serious harm to the patient. In fact, morbid obesity, or a Body Mass Index of 40 or greater, on its own, placed Sophia Hemmings as "extremely high" risk (to use the classification noted in Table No. 2 on Page 6 of Exhibit 55, a February, 2010 article on which Dr. Davies, the defendant hospital expert obstetrician was a principal author). All of these conditions presented during Sophia Hemmings pregnancy (Exhibit 40, Tab 31, QQ. 703, Tab 33,QQ. 715-717, Tab 35 QQ. 721-722, Tab 39 Q. 728, Tab 40, Q. 729-733 and Tab 41,QQ. 736-739). Dr. Padmore acknowledged being aware of all of these risks as of August, 2008, yet making no record of having any discussions about them with Sophia Hemmings (Exhibit 40, Tab 42, QQ. 740-741, Tab 44, Q. 743). Rather, Dr. Padmore's approach was to be "optimistic" (Exhibit 40, Tab 45, Q. 749) and focus on having a "nice baby" (Tab 45, Q. 748). Dr. Padmore acknowledged these risks were that of Sophia Hemmings and were hers to accept or reject (Exhibit 40, Tab 46, Q. 762). Further, Dr. Padmore's confidence in being able to deal with any complications that arose led him to decide and not discuss with Sophia Hemmings a referral to a level 3 obstetric care facility (Exhibit 40, Tab 48, QQ .767-768, Tab 53, QQ. 796-797).

[48] Dr. Padmore acknowledged several risk factors but failed to note them in his chart, notwithstanding his knowledge that another doctor would likely be the one delivering the baby and that doctor would need to be aware of all of the relevant risk factors in order to make the best decisions for the care of Sophia Hemmings. Dr. Padmore's failure to document these risk factors and test results was a clear breach of his duty of care as her treating obstetrician.

[49] In reaching these conclusions of Dr. Padmore failing to act prudently or diligently in the circumstances, I have reviewed and considered the obstetrical expert evidence of Dr.

Braithwaite and Dr. Oppenheimer. I prefer the opinions of Dr. Braithwaite and his review and analysis of the circumstances of the pregnancy of Sophia Hemmings. Dr. Oppenheimer's willingness to accept Dr. Padmore's lack of documentation of what should have been noted undermine his opinion of Dr. Padmore meeting the requisite standard of care. Further, as noted in his cross-examination, Dr. Oppenheimer made assumptions about information without balancing other information available to him which ought to have been considered. As an example, he relied on the existence of the identity of Sophia Hemmings' partner in the Antenatal Record 1 form as evidence of a stable relationship without considering Sophia Hemmings identification of her sister as next of kin and emergency contact in multiple other medical records.

[50] Further, as part of reviewing the SOGC Clinical Practice Guidelines – Canadian Contraception Consensus as of February, 2004 (Exhibit 71), Dr. Oppenheimer agreed Dr. Padmore's evidence was at times, paternalistic (Trial Transcript pages 5488-5492). Dr. Padmore's communication did not meet "being proactive and counselling" (at page 145, left column of Exhibit 71) for a patient seeking contraception after having unprotected sex because she did not want to get pregnant. These conclusions are based on the facts known at the time or what should have been known or recorded. It is not a judgment reached by the result or what occurred (*Wilson v. Swanson*, [1956] SCR 804 at pages 812-813).

Negligence of Dr. Peng

[51] This would appear to be limited to the 24 hours of care when Sophia Hemmings was turned over to Dr. Peng by Dr. Wilcock in April 19, 2009 at about 8:00 am and continued to about that same time on April 20. The evidence noted Dr. Peng had 13 years' experience of practicing obstetrics at the Scarborough Hospital and any potential negligence should be assessed and narrowed to the following issues:

a) the failure to adequately review the clinical situation presented to her, including reviewing Dr. Padmore's clinical judgment from the material provided and when she spoke to him that day socially; and

b) the steps taken to augment labour and assessment of whether Sophia Hemmings should have been referred to level 3 obstetrical unit.

[52] My evaluation of the evidence does not indicate any breach of the standard of care by Dr. Peng. Dr. Wilcock made the decision to induce labour which Dr. Peng inherited. I agree Dr. Peng had a responsibility and duty to review and assess that decision as part of assuming her care. However, I would also note Sophia Hemmings remained stable and safe during this 24-hour time frame. No decisions about a caesarian section or general anesthetic were made while under her care.

[53] Despite the risk factors present, Sophia Hemmings did not deteriorate while under the care of Dr. Peng. The key risk factors known from the records and information available

was reviewed. I have concluded Dr. Peng's failure to conclude Sophia Hemmings' required level 3 obstetrical care based on her experience dealing with obese pregnant patients did not fall below the requisite standard of care. The evidence presented was not persuasive that any request for referral, made through the proper procedure of calling Criticall (through which such a referral would have been made at this stage of the pregnancy), would have resulted in Sophia Hemmings being transferred to a level 3 care obstetrical hospital.

Negligence of Dr. O'Brien

[54] The evidence noted Dr. O'Brien had eight years' experience at the Scarborough Hospital (preceded by eight years' experience at St. Joseph's Hospital). Any potential negligence should be assessed and can be narrowed to the following issues:

a) the failure to adequately review the clinical situation presented to her, including the decision to perform the caesarean section under spinal anesthetic; and

b) the steps taken to proceed with delivery of the fetus rather than seek transfer to or assistance from a level 3 obstetrical care hospital.

[55] Dr. O'Brien assumed care of Sophia Hemmings at or shortly after 8:00 am on April 20, 2009. Her evidence was steadfast about being able to handle cases such as Sophia Hemmings and Dr. O'Brien testified as if the level of care she could provide was that of a level 3 facility. That, in my view, does not raise the standard of care to which Dr. O'Brien should be held to that at a level 3 facility. It does suggest care at the highest a level 2 facility could provide. I am troubled by her acknowledgment of the need to do an accurate, independent re-assessment of Sophia Hemmings when she assumed care for her, but failure to detail her awareness of Sophia Hemmings' multiple risk factors (such as obesity, macrosomia, hypokalemia, and polyhydramnios). Despite learning of these multiply risk factors during the day, she decided to proceed with the induction for a vaginal delivery.

[56] The key example of this was not becoming aware of Sophia Hemmings' low potassium and the need to supplement it until at least 1400 or six hours after meeting and assessing the patient. There was an inference Sophia Hemmings failed to disclose key information about her health to Dr. O'Brien. This is contrary to histories obtained elsewhere and contained in the medical records such as St. Michael's Hospital on February 4 (Exhibit 1, Volume 11, Tab 3B, pages 3-09 and 3-028).

[57] Dr. Padmore had evaluated Sophia Hemmings as a "good" and "compliant" patient (Exhibit 40, Tab 53, QQ. 795).

[58] The admission by Dr. O'Brien that she did not have the records from St. Michael's Hospital which the evidence indicates was forwarded with Sophia Hemmings by Dr. Padmore is also of great concern. I shall leave my analysis and findings about the record keeping at Scarborough Hospital to my assessment of their negligence below. Given I

accept that Dr. Padmore gave the St. Michael's records to Sophia Hemmings and they were referenced by others at the Scarborough Hospital, the conclusion is Dr. O'Brien failed to review these records.

[59] Dr. O'Brien's evidence that she did not learn of the low potassium in Sophia Hemmings' blood until 1400 when advised by a resident who had been told by a nurse (trial transcript, page 3505) is problematic for two reasons. First that either came from the nurse's review of the records available or from Sophia Hemmings. Either points to the conclusion Dr. O'Brien failed to obtain this information when she assumed care for Sophia Hemmings as her most responsible physician and while tasked with conducting an independent re-assessment of Sophia Hemmings' condition that morning. Dr. O'Brien admitted the importance of being accurate.

[60] Further, Dr. O'Brien testified being aware there "can be documents that when the patient comes in and is discharged do not make it on the chart when she is admitted" and "sometimes papers after admission end up sitting on the desk and they don't get in the chart" (Trial Transcript, page 3507). This results in Dr. O'Brien knowing where to look for additional information when faced with obvious multiple risk factors and not doing so. This occurred whether or not such information was provided by the patient. The end result was Dr. O'Brien failed to obtain or, if such information was obtained, failed to note it on Sophia Hemmings' chart when the independent re-assessment was conducted. I conclude that failed to meet the applicable standard of care. It was not prudent or diligent conduct in the circumstances.

[61] Regarding the steps taken to proceed with delivery of the fetus rather than seek transfer to or assistance from a level 3 facility, it is clear Sophia Hemmings would not have been transferred to a level 3 facility. The evidence about the process that would have been followed had Dr. O'Brien made the request on April 20, through the use of Criticall, is persuasive in this regard. Sophia Hemmings was already being induced to give birth when Dr. O'Brien assumed her care.

[62] Dr. O'Brien's evidence that she was fully confident in her abilities to safely care for Sophia Hemmings, while incorrect, was a clinical judgment available for her to make. At issue was the decision to proceed with the caesarean section with the regional anesthetic rather than discontinue that method and switch to a general anesthetic. The court can only speculate on the success this manner of delivery of the child as there was insufficient evidence about whether or how it would have avoided an anesthetic complication and subsequent cardiac arrest. There was evidence the safest method of a caesarean section delivery is by regional anesthetic. There was also evidence the least safest method is converting to a general anesthetic after or while a regional anesthetic has been utilized.

[63] The plaintiffs did not put forward Sophia Hemmings' caesarean section ought to have been conducted only by a general anesthetic. Instead, it focused on the decision not to

seek transfer to a level 3 facility. I am not prepared to find it, in all of the circumstances, that Dr. O'Brien fell below the standard of care in this regard.

Negligence of Dr. Jamensky

[64] The evidence noted Dr. Jamensky having practiced anesthesiology at a suburban hospital including three years' experience at Scarborough Hospital (preceded by five years of residency at downtown Toronto teaching hospitals). Any potential negligence should assessed and from the seven issues identified by his counsel to the following issues:

a) the failure to adequately intubate Sophia Hemmings' airway upon being asked to assist in the caesarean section during labour in the evening of April 20, 2008; and

b) the failure to take any or adequate steps to maintain the spinal anesthetic before converting to a general anesthetic.

[65] Dr. Jamensky confirmed his comfort level in administering anesthetic in labour in delivering patients describing Scarborough Hospital as one of the busiest hospitals for surgery in the Metropolitan Toronto area. He also testified that the labour and delivery room where these events occurred had been renovated and was fully equipped with all necessary medication and equipment to conduct whatever was required.

[66] The large nephrology unit at Scarborough Hospital gave him regular experience in providing anesthetic care to those with diabetic and other vascular conditions. He was also "very comfortable" treating morbidly obese patients (trial transcript, page 3891).

[67] Dr. Jamensky agreed with the expert anesthetic evidence that delivery of a baby, whether vaginally or by caesarean section, was best performed under a regional (or as occurred here spinal) anesthetic. It is the safest method for both mother and child. Converting to a general anesthetic was to be avoided if possible as it presents risks including dilating of blood vessels which reduces blood pressure and can depress cardiac function.

[68] Dr. Jamensky's evidence is particularly noteworthy for two significant incidents. The first was his description at trial, for the very first time, of Sophia Hemmings doing "something that I had never seen before, prior to or even since. She actually lifted the entire upper part of her body off the operating room table" (trial transcript, page 4052). This event was not specifically pleaded. There were submissions about this with his counsel relying on there being no onus to disclose this evidence as it was not asked about specifically at his examination for discovery. It was also submitted as having been pleaded sufficiently at paragraph 40 of the physicians' Statement of Defence where Sophia Hemmings started to "panic and began thrashing".

[69] I would be inclined to agree with this submission had the physicians only denied what was being alleged as having not occurred in their pleading. However, that was not

what was pleaded. Rather, the events in the operating room on April 20, 2008 were pleaded in detail as contained in paragraphs 38 to 50 of the physicians' Statement of Defence. "Panic and began thrashing" does not equate to "actually lifted the entire upper part of her body off the operating room table". To that end, it undermines the reliability of Dr. Jamensky's evidence.

[70] This is compounded by the other noteworthy incident being the loss of Dr. Jamensky's second page of notes detailing the events in the labour and delivery operating room on April 20, 2008 made later that evening. This document was referenced in the Scarborough Hospital Operating Room and Anesthetic Record (Exhibit 1, Volume 1, Tab 10, Page 1-032) where the eight lines of "Comments" section begins "@ 1930: PT + + panicking, thrashing" and concludes "(see next page re details)". The evidence at trial was Dr. Jamensky made no separate copy of this document and the Scarborough Hospital was unable to locate it. It was looked for by the Scarborough Hospital when advised of its existence years before trial at the time of examinations for discovery (trial transcript, page 6958). It first came to the court's attention during Dr. Jamensky's examination in chief. Again, the fact that no mention was made of an event "never seen before, prior to or even since" in the first eight lines of the description of the events further undermines the reliability of Dr. Jamensky's evidence.

[71] By comparison, it should be noted at this point that the evidence of Nurse Nora Djizmedjian also references Sophia Hemmings having "lifted her shoulders off the table" (trial transcript, page 3809). The events of that evening were so dramatic for Ms. Djizmedjian that she testified having made notes of the events (trial transcript, page 3822). She took those personal notes home. Unfortunately, Ms. Djizmedjian retired soon after these events and was not able to be located by any of the litigants or their counsel until 2019. Her notes were misplaced in the interim.

[72] A motion at the outset of the trial raised issues of trial fairness and whether Ms. Djizmedjian ought to be permitted to testify. This resulted in the four page "Resolution" document being as Exhibit "A" where the Scarborough Hospital undertook not to call Ms. Djizmedjian.

[73] The trial schedule permitted and I ordered Ms. Djizmedjian to be examined under oath on September 23, 2021 and ruled the defendant physicians, not a party to the "Resolution", could tender her evidence which proceeded November 3 and 4, 2021.

[74] When finally located and questioned about the events of April 20, 2009 several years later, Ms. Djizmedjian was without her notes and relied on her memory of the events. She logically admitted her memory had been affected by the passage of time such that she could be confused about what occurred, certain details were quite vague and that she could not even recall if a cardiac arrest (the other dramatic event that evening) had occurred (trial transcript, pages 4007-4008). This undermines the reliability of Ms Djizmedjian's evidence.

[75] I am reinforced in this conclusion by the contradiction in Ms. Djizmedjian's evidence about the "biggest fear" being Sophia Hemmings might fall off the operating room table (see Trial Transcript, Pages 3809-3810). Despite this, Ms. Djizmedjian left her position at the side of the operating table where she could assist in keeping Sophia Hemmings on the operating table to go to the other side of the room, without being asked, to push the emergency button for extra help. There were others in the room, such as residents, that she could have asked to do this task. Ms. Djizmedjian's evidence, as an experienced operating room nurse, of also being "amazed how fast" Dr. Jamensky intubated Sophia Hemmings contradicts Dr. Jamensky's undisputed repeated efforts the intubation actually required.

[76] Turning to whether Dr. Jamensky met the standard of care in intubating Sophia Hemmings' airway on April 20, 2009 from when he met her to obtain her consent and provide pain relief from labour to his efforts to convert the regional anesthetic to a general anesthetic, I find that he was negligent. As part of his assessment for an epidural anesthetic, Dr. Jamensky completed an Anesthetic Record (Exhibit 1, Volume 1, Tab 1N, Page 1029a-1030a). This included assessment of Sophia Hemmings' airway. Dr. Jamensky testified that he "always, always, always" (trial transcript, page 3913) does this as part of being prepared for if a general anesthetic became necessary and determining his ability to intubate the patient.

[77] Regarding Dr. Jamensky's decision to convert to a general anesthetic, I find that Dr. Jamensky fell below the requisite standard of care and was negligent. He made the decision to convert to general anesthesia before all reasonable options had been attempted let alone exhausted. This included the use of a family member as part of attempting to calm the patient. I accept Samantha Hemmings evidence that her sister was responsive while she was in the operating room. While the level of agitation or panic is in dispute, the substance of Samantha Hemmings' evidence was being told by Dr. Jamensky that he was "going to" or had made the decision to put Sophia Hemmings to "sleep", that is, under general anesthetic, before Samantha Hemmings had been given a fair opportunity to calm her sister. I prefer and rely on the expert opinion evidence of Dr. Goldszmidt of needing to do everything available to avoid converting to a general anesthetic because of the dangers and risks (trial transcript pages 1715-1716). I reject the submission of Dr. Jamensky's decision to convert to a general anesthetic was only hasty which implies it was an exercise of clinical judgment that meets the requisite standard of care.

[78] In addition, I rely on the medical evidence that Dr. Jamensky did not wait for the peak effect of the relaxant or sedative, Versed/Midazolam he had administered (see trial transcript at page 4072). Further, this decision was made in the absence of fetal distress or the need to proceed quickly. Thus, it fell below the standard of care to take all reasonable steps before converting to a general anesthetic. I find it lacked the prudence or diligence of an anesthesiologist in these circumstances.

[79] Having found Dr. Jamensky negligent in his administrating of the general anesthetic, it is not necessary to deal with whether he had informed consent to do so in detail. I also

agree with the expert evidence that Dr. Jamensky ought to have made an attempt and noted that he summarily explained the additional risks of converting to a general anesthetic before doing so.

[80] Dr. Jamensky assessed and recorded Sophia Hemmings airway on the four-category scale used for this purpose (known as the Mallampati scale) to be Grade II, Grade I being the most open or easiest. Dr. Jamensky assessed and recorded the ability to intubate Sophia Hemmings on the three level scale in the middle or "moderately difficult".

[81] However, after Dr. Jamensky decided to use a general anesthetic, I find his ability to do so was not easy or even moderately difficult. The evidence is clear Sophia Hemmings was agitated if not panicking and thrashing. The steps necessary to intubate required filling the patient's lungs with oxygen. This was to be done by placing a mask over the patient's mouth and having her take several deep breaths of air enriched with oxygen. The intent is have this oxygen in the lungs to be processed while the medication, in this case propofol and succinyl choline renders the patient unconscious and unable to breath on their own. While unconscious and not breathing, Dr. Jamensky was required to insert the tube which will carry oxygen to the spot where it can fill both lungs using the laryngoscope. The tube must be inserted through the vocal cords. The uncontested expert anesthetic evidence is to have the first effort be the best as the patient's lungs are processing the available oxygen, a process called desaturation.

[82] As stated above, Dr. Jamensky's first attempt failed. An effort was made to add oxygen to Sophia Hemmings' lungs with a laryngal airway mask before the second attempt with a larger blade on the laryngoscope succeeded.

[83] I find, as Dr. Goldszmidt testified, these events distracted Dr. Jamensky from Sophia Hemmings' falling blood pressure and cardiac function. Dr. Jamensky's conduct was not prudent or diligent in these circumstances.

[84] This leads to determining what was the cause of Sophia Hemmings' cardiac arrest. The plaintiffs' theory and submission was that it was caused by the actions of Dr. Jamensky. The defendants' theory and submission was that it was the result of an Amniotic Fluid Embolism (or AFE). It was not disputed Amniotic Fluid Embolism can occur when amniotic fluid enters the blood stream of the mother. This was submitted by counsel for the defendant physicians and I accept it to be an "extraordinarily rare event" (Defendant Physicians Written Submissions at paragraph 453). Only a few of the many medically trained witnesses at this trial had actually witnessed such an event. It results in sudden cardiorespiratory collapse.

[85] Dr. O'Brien had previously witnessed an AFE in the mid-1990s and described it as "like being struck by lightning. It happens very suddenly verses a slow change in condition" (trial transcript, Pages 3443 - 3444). I have concluded that was not what occurred here. Sophia Hemmings was panicking and thrashing for several minutes right after the initial

incision through the skin made by Dr. O'Brien. She described her inability to breathe and wanting to sit up. She had not arrested before Dr. Jamensky made the decision to convert her to a general anesthetic. She had not arrested before when her sister was brought into the labour and delivery operating room and briefly spoke with her, repeating that she could not breathe and asking to sit up.

[86] It does not appear that Sophia Hemmings had arrested during the eight to eleven minutes estimated by Dr. O'Brien it took her to resume and complete delivery of the baby.

[87] I am reinforced in this conclusion by the expert evidence and literature on Amniotic Fluid Embolism (Exhibits 6, 12, 13, 29 and 98). That is, about 83 percent of Amniotic Fluid Embolism cases are accompanied by significant coagulopathy or disseminated intravascular coagulation. This is significant bleeding from surgical and other sites in the body. That did not occur here. Dr. O'Brien's evidence, which I accept, was that there was "no excessive bleeding" (trial transcript, pages 3646). This reduced the likelihood of an extraordinarily rare event becoming an even much less likely possibility. That is, 17 percent of an extraordinarily rare event.

[88] Amniotic Fluid Embolism is also what is known in the medical field as a diagnosis of exclusion. This means it is something for which there is no other identified cause. That is, it is reached by excluding other likely possible causes. There is a concern in the medical literature that it is often over diagnosed (See Exhibit 12, 3rd sentence). That 2016 Special Report article from the American Journal of Obstetrics & Gynecology was referenced by Dr. Barrett and, as part of his expert opinion and evidence, which I accept, that Sophia Hemmings' cardiac arrest was the result of anesthetic accident or complication (Trial Transcript, Pages 964-965). This conclusion is also consistent with Table 4 of Exhibit 12 which lists a variety of conditions that have some common characteristics. What is known about what occurred to Sophia Hemmings more closely resembled anesthetic complication than Amniotic Fluid Embolism. This conclusion also deals with the defence submission about the failure by the plaintiffs to address or deal with the issue of a cardiomyopathy with appropriate cardiology expert evidence. I agree with the plaintiffs' submission that the conclusion of an anesthetic complication as the reason for the cardiac arrest obviates the determination of this issue.

[89] There is an inconsistency with the recorded times in the Scarborough Hospital records. The cardiopulmonary resuscitation records (or CPR) were created as the events are occurring with a nurse on the resuscitation or "Code Blue" team tasked with making that record. However, the recording of administrating a drug such as epinephrine when blood pressure had returned should not and I have concluded would not have been done. I accept the submission of counsel for the defendant physicians that this is not surprising. I reject the submission of counsel for the defendant physicians that the Anesthetic Record is the "only" place to look for vital signs given it was prepared after the events had occurred by Dr. Jamensky. As noted, those record are incomplete and undermine the reliability of Dr. Jamensky's evidence. Rather than conclude either of the records are or are not accurate, I

prefer to rely on the sequence of known events. That is, spinal anesthesia was followed by an initial incision, followed by agitation, administering Midazolam, a decision made to convert to a general anesthetic, sister Samantha Hemmings' presence and observations in the operating room, administering the general anesthetic, the difficult airway and delay in intubation, the birth, dropping blood pressure and pulse, cardiac arrest and then efforts to revive Sophia Hemmings. The cardiac arrest occurred before Dr. Jamensky began performing chest compressions.

[90] It is unclear and unnecessary to match the events which occurred with the time of day. The birth must have also likely occurred while or after Dr. Jamensky had administered the general anesthetic and Sophia Hemmings was no longer moving. Dr. Jamensky was dealing with her high airway pressure, inserting a suction catheter and then a bronchoscope to verify the tube placement in Sophia Hemmings' throat. Dr. Jamensky was also dealing with dropping end-tidal CO2, blood pressure and cardiac function caused by the general anesthetic, in combination with the spinal anesthetic. My conclusion was that Dr. Jamensky's decisions were not errors of judgment, but rather conduct below the standard of care for an anesthesiologist possessing a reasonable level of knowledge, competence and skill in his field or specialty.

Negligence of Scarborough Hospital

[91] Before proceeding to whether the Scarborough Hospital was negligent, I need to address submissions made of spoliation or drawing an adverse inference as a result of matters which arose shortly before and during the trial. At the outset of the trial there was a motion by the plaintiffs regarding late disclosure of information obtained by counsel for the Scarborough Hospital in February and March, 2020. It was from nurses in the employ of Scarborough Hospital in April, 2009. The action as against the nurses named in the Statement of Claim was discontinued on the basis that Scarborough Hospital acknowledged its vicarious liability for their actions. This occurred in or around March, 2019.

[92] As referenced earlier, this motion led at the opening of trial to a four page "Resolution" (marked as Exhibit A) where, as part of the Resolution, the plaintiffs confirmed "the sole remaining issue between the Plaintiffs and the Hospital is in relation to what will be referred to in the evidence as the April 8, 2009, telephone call". The Scarborough Hospital undertook not to call the nurses originally named in the Statement of Claim or the April, 2009 Head of the Scarborough Hospital Department of Obstetrics, Dr. Wilcock. This Resolution was not binding on the defendant physicians who successfully argued before me their right to examine and call Ms. Djizmedjian.

[93] As part of dealing with the evidence of nurse Cecelia San Juan, as the charge nurse on duty at the Scarborough Hospital Obstetrics Department who took the April 9, 2009, 20:30 telephone call, it was brought to my attention on or after November 19, 2021, when the Hospital began calling evidence in its defence, that undertakings given at the examination for discovery of the Scarborough Hospital's representative (Pamela Marshall)

on June 17, 2016, subsequently fulfilled, were incorrect. This dealt with the non-existence of hospital policies and protocols regarding how such telephone calls were to be handled.

[94] The letters from counsel for the Scarborough Hospital fulfilling these (and other) undertakings were dated June 2, 2017 and September 1, 2017 (Exhibits O and N). I ordered the earliest versions available of the Scarborough Hospital's policy and procedure for telephone advice and practice protocols be produced. They were relied on and marked as Exhibits 94 and 95. In summary, the Scarborough Hospital maintained from June, 2016 until after the plaintiffs had closed its case and apparently after it began calling evidence at trial that no policies or practice protocols for completing the Labour and Delivery Phone Advice Form existed. This was incorrect as the policy and procedure form and practice protocol forms both referred to original dates of earlier versions predating April, 2009. Those earlier versions could not be located. However, it appears the versions in place in 2009 were requested in the action prior to the revised versions being put into practice, which, it was inferred, resulted in disposing of the 2009 version.

[95] This resulted in submissions at the conclusion at the trial of spoliation and adverse inference. Counsel for the Scarborough Hospital relied on the recent statement by my colleague, Justice Vermette, in *Mann Engineering Ltd. v. Desai*, 2021 ONSC 7580 (at paragraph 132) that a finding of spoliation has four elements, one of which is the missing evidence must have been "destroyed intentionally". This is a more onerous test than that relied that in the *Lamont Health Care Center v. Delnor Construction Ltd.* 2003 ABQB 998 (at paragraph 49) decision which cited the Privy Council reasons from *The Ophelia*, [1916] 32 T.L.R. 502 which included unintentional acts resulting in the destruction of evidence.

[96] Here, it appears the earlier version of the telephone advice policy and protocols were not kept despite the existence of this litigation. However, I am unable to conclude this evidence was destroyed as required by the fourth element of the test "in order to affect the outcome of the litigation". Fortunately, the existence of the subsequent policy and protocols and other actions (or inaction) by Ms. San Juan is sufficient to determine this issue of whether the Scarborough Hospital was negligent and not specially rule on spoilation or adverse inference.

[97] Counsel for the Scarborough Hospital sensibly acknowledged Ms. San Juan failed to complete the Labour and Birth Nursing Telephone Advice form (Exhibit 1, Volume 5, Tab 1a, Page 1-01543a) as required. It was admitted by Ms. San Juan that she had no independent recollection of the phone call. She was not asked about the phone call until years later. Any potential negligence on her was assessed through her background and training. This involved 19 years experience at the Scarborough Hospital as well as promotion to charge nurse. Evidence was tendered from Dr. Peng that she was respected in the unit and that Dr. Peng previously supported her being the "Nurse of the Year".

[98] It is clear that the Scarborough Hospital had considered and addressed how to make its resources available and deal with telephone calls from pregnant women who were

scheduled to give birth in their Labour and Delivery Department. After identifying the individual and the date of the call on the printed Labour and Birth Nursing Telephone Advice form, the first (and I infer from that position) most important duty of the nurse taking the call was to review the Antenatal Record 1 and Antenatal Record 2. Nurse San Juan failed to complete this part of the form. The importance of doing so is emphasized by the direction printed on the form that if it has not been reviewed then the nurse is to "instruct the patient to go to their MD or come to the hospital for assessment". This is reinforced by inclusion in the versions of the Scarborough Hospital policy and procedure (Exhibit 94) and Telephone Advice Practice Protocol (Exhibit 95) of that requirement. It is further reinforced by Ms. San Juan's admission of not being aware of this policy and protocol. This conduct did not meet the College of Nurses' standards for documentation of patient contact (Exhibits 85 and 86).

[99] Indeed, in the absence of any memory of the call, Ms. San Juan relied on her usual practice which did not include any awareness of these requirements. I agree with the plaintiffs' submissions Ms. San Juan, whose actions the Scarborough Hospital is vicariously liable, had a duty to review the Antenatal Record 1 and 2 and failed to do so. The entirety of this conduct by both the Scarborough Hospital and Ms San Juan falls below the standard of care. It was not prudent or diligent in these circumstances.

[100] The Scarborough Hospital attempted to avoid this finding of negligence based on Ms. San Juan's normal practice of conducting a "focused" assessment. To that end, it was somehow sufficient and met the standard of care to confirm to that if the fetus was moving well and there was no fever or diarrhea as part of having vomited three times that day, no further action was required aside from monitoring of symptoms and either calling her doctor or calling back in an hour if things did not improve. I disagree. This contradicts the Scarborough Hospital's own direction as set out in its form.

[101] Further, Ms. San Juan's evidence that she "always" (trial transcript, page 6370) takes her time is persuasively contradicted by two glaring failures. First, there is inconsistency in the due date Ms. San Juan recorded on the form (April 12 or four days after the call) and the 38 weeks of gestation recorded. This ought to have raised concerns. Second, the failure to even check off boxes or circle the final statement on the form being "she is comfortable with staying home for now" undermines any reliance on Ms. San Juan's usual practice.

[102] In addition, the records created by the Scarborough Hospital, such as the Labour and Birth Nursing Telephone Advice form and the January 31, 2009 emergency records (Exhibit 1, Volume 4, Tab IIA, Pages 1-01525-01541) were not referenced as reviewed by Doctors Peng, O'Brien or Jamensky. In addition, there is inconsistent evidence about the availability of the records Dr. Padmore provided to Sophia Hemmings to bring to the hospital with her on April 18.

Causation

[103] Can the cardiac arrest, which the parties agreed caused the anoxic brain injury to Sophia Hemmings (Exhibit 28), be attributed to any of the defendants who have been found to be negligent in their treatment and care of Sophia Hemmings? That is, but for the breach of the applicable standard of care, would Sophia Hemmings have suffered an anoxic brain injury?

[104] It was submitted by the defendant physicians and I accept the description given in *Clements v. Clements*, 2012 SCC 32 that the plaintiffs "must show on a balance of probabilities that "but for" the defendants negligent act, the injury would not have occurred" (at paragraph 8). I would also accept that the "but for" causation test must be applied in a "robust common-sense fashion". There is no need for scientific evidence of the precise contributions the defendant's negligence made to the injury" (at paragraph 9). This test must be applied to each defendant in the circumstances as there were not the exceptional circumstances where the number of negligent acts by multiple acts makes it impossible to determine which caused or contributed to the injury and damages (*Clements v Clements, supra*, at paragraph 13).

[105] Further, it was also submitted by the defendant physicians and I accept that causation be determined by applying what was reasonably foreseeably to the reasonable person on the balance of probabilities. Or, as stated in *Mustapha v. Culligan of Canada Ltd.* 2008 SCC 27 what the reasonable person "would not brush aside as far-fetched" (paragraph 13).

[106] For Dr. Padmore, this includes his decision to not include a *beta* HCG test in the extensive array of blood test he requestioned following his initial examination on August 1, 2008. Dr. Padmore did not raise the multitude of risks of the pregnancy to Sophia Hemmings given her morbid obesity. He failed to determine if the pregnancy was unplanned or unwanted. I am satisfied on the balance of probabilities had he conducted this basic test for pregnancy, the pregnancy would have been discovered weeks if not months earlier.

[107] I am reinforced in this conclusion by the other missed signs of pregnancy noted before September 30, being uterine bleeding and bulkiness of the uterus. I am satisfied a reasonable person would not find it at all "far-fetched" (to quote *Mustapha v. Culligan of Canada Ltd., supra*) that with the earlier detection of the pregnancy, explanation of the multitude of risks morbid obesity posed to the pregnancy, raising whether the pregnancy was unplanned or unwanted and the various options to terminate the pregnancy, Sophia Hemmings would have chosen to terminate the pregnancy. That is, I am persuaded that had Sophia Hemmings been advised earlier on about the multitude of risks associated with her pregnancy and her options to terminate the pregnancy by Dr. Padmore, she would have chosen to do just that. After all, she attended at the Woburn Clinic where Dr. Padmore practiced because she had unprotected sex and did not want to become pregnant. In this regard, I have taken the three step approach described in *Sacks v. Ross* 2017 ONCA 773 at paragraphs 98-99 referenced below.

[108] The procedures to terminate the pregnancy at that time would not have involved a general anesthetic and the cardiac arrest would have been avoided. In this regard, I rely on the methods available for termination as of 2008 as set out in the article "Induced Abortion Guidelines" marked as Exhibit 5.

[109] I am reinforced in this conclusion by the common sense reality that it was clear by her attendance at the doctor's office for contraception, Sophia Hemmings had unprotected sex and did not want to get pregnant. Further, Sophia Hemmings' financial circumstances were such that she had been unable to have her other child come to Canada. Her support of that child was limited to telephone calls when they could be afforded.

[110] In addition, the relatively recent nature of her relationship with the father and her reliance on her sister in various records as the emergency contact also support the conclusion that pregnancy was not only unplanned but unwanted.

[111] Alternatively, or with regard to Dr. Padmore's negligence in failing to document the multiple risk factors presented in Sophia Hemmings pregnancy, was it reasonably foreseeable Sophia Hemmings would suffer a cardiac arrest arising from an anesthetic complication? The multitude of risk factors for morbidly obese women were known to Dr. Padmore. As stated, these included a macrosomic fetus, polyhydramnios, shoulder dystocia and difficult or failed labour. Each of these occurred. In addition, there was a higher risk of cephalopelvic disproportion which was Dr. O'Brien's stated reason for conducting an urgent cesarean section. It was acknowledged by Dr. Padmore and the experts that morbid obesity increased the risk of anesthetic complications. That is what occurred and led to the cardiac arrest. To that end, the conclusion Dr. Padmore failed to document as risks or set out a preliminary plan of management resulted in the cardiac arrest being reasonably foreseeable.

[112] This conclusion is reinforced by Dr. Padmore's own assessment that pregnancy in these circumstances ought not to have gone beyond 38 weeks.

[113] For Dr. Peng, having found that her conduct met the standard of care, causation need not be addressed.

[114] For Dr. O'Brien, her negligence was limited to the failure to adequately review the clinical situation presented to her and appreciate the multiple risk factors of Sophia Hemmings' pregnancy and labour. A method of delivering Sophia Hemmings' child had been determined. Dr. O'Brien inherited the decision to induce the labour. After it failed to progress, caesarean section with the already in place regional anesthetic was the safest way to proceed. It could not be anticipated by Dr. O'Brien that Dr. Jamensky's efforts would result in an anesthetic complication and cardiac arrest.

[115] Thus, the "robust common sense" approach directed by *Clements v Clements, supra* (at paragraph 9) results in Dr. O'Brien's negligence not being attributable to the cardiac

arrest which occurred. That is, "but for" Dr. O'Brien's failure to adequately assess the clinical situation presented to her, it cannot be concluded that cardiac arrest would have been avoided.

[116] For Dr. Jamensky, his negligence, both in failing to adequately assess Sophia Hemmings' airway and his failure to take sufficient or adequate steps before converting to general anesthetic were the direct cause of Sophia Hemmings' cardiac arrest. That is, and mindful of Dr. Westcott and his agreement with Dr. Barrett, that without the administering of a general anesthetic the cardiac arrest would not have occurred, causation has been made out.

[117] For the Scarborough Hospital, the negligence of Ms. San Juan was in her handling of the April 8, 2019 phone call and in the Hospital's failure to assemble the records detailing Sophia Hemmings' pregnancy. As stated in *Clements v Clements, supra* "scientific proof" is not required but a "robust and pragmatic" approach is to be taken (at paragraph 46). I was directed to this statement of the law by counsel for the defendant hospital.

[118] I was also directed to the process to follow as stated in *Sacks v Ross*, 2017 ONCA 773. First the trier of fact must determine what likely happened (which is set out above). Second, the trier of fact must consider what likely would have happened had the defendants not breached the standard of care. Here, had Ms. San Juan been guided by the Labour and Birth Nursing Telephone Advice form contents, she would have instructed Sophia Hemmings to see her doctor (which could not have occurred given it 8:30 pm in the evening) and thus advised her to come to the Scarborough Hospital for assessment. At issue is what would have happened had Sophia Hemmings attended and being assessed.

[119] To that end, I propose to follow what is set out in *Sacks v Ross, supra* (at paragraphs 47 and 48). First, she would have been seen by an obstetrician on duty. A more fulsome history would have been obtained revealing the multitude of risks in Sophia Hemmings' pregnancy. Being at least 38 weeks gestation, the fetus was mature but less macrosomic and with less polyhydramnios than on April 20, 2009. Aware of the multitude of risk factors, I find on the balance of probabilities a decision to induce labour would have been made. Alternatively, given she was not full term, an urgent caesarean section would have been performed.

[120] I have concluded that this is not "far-fetched" and merely the application of "robust common sense". But for the negligence of the Scarborough Hospital, Sophia Hemmings would not have suffered the damages that occurred.

[121] The liability of the defendant Scarborough Hospital has been established. I am reinforced in this conclusion by the evidence of Dr. Padmore, which bears repeating, that is, no obstetrician would have "gone past 38 weeks" (Exhibit 40, Tab 91, QQ. 1572 and 1583, Tab 93, Q. 1612).

Apportionment

[122] The defendants, Dr. Padmore, Dr. Jamensky and Scarborough Hospital have been found to be negligent in their treatment and care of Sophia Hemmings. Further, these defendants' actions have been found to have caused the anoxic brain injury and damages suffered by the plaintiffs. Under the *Negligence Act*, R.S.O. 1990 c. N. 1, Section 3 and the directions set out in *Sacks v. Ross, supra* (at paragraphs 99 and 100) the next step is to allocate fault among the negligent defendants. This is not a case where it was clear one defendant's negligence caused a certain outcome. Rather, as is usually the case when medical treatment is rendered over the course of time, such as in this pregnancy, it is difficult, if not impossible to parse out the damages that flow from the negligent acts. It is clear that the negligence of Dr. Padmore, Dr, Jamensky and the Scarborough Hospital all caused and contributed to the tragic outcome suffered by Sophia Hemmings and her family. As a result, I conclude they are equally responsible. That is, Dr. Padmore, Dr. Jamensky and Scarborough Hospital are all one-third responsible for the damages as agreed on by the parties at the outset of the trial and approved with regard to the persons under disability by Justice D. Wilson.

Costs

[123] At the conclusion of the trial, I requested the parties prepare and forward to me on or before January 17, 2022 the costs they would be seeking in the event that they were successful. The partial indemnity claims of the plaintiffs was $4,145,201 for fees, plus HST of $538,876.13 and disbursements of $602,052 inclusive of HST.

[124] The defendant, Scarborough Hospital submitted a claim for $794,094.50 for partial indemnity fees, plus HST of $103,355.79 and disbursements of $217,901.73 inclusive of HST.

[125] The defendant physicians submitted a claim for $1,362,482.40 for partial indemnity fees, plus HST of $177,122.71 and disbursements of $436,517.11 inclusive of HST.

[126] I urge the parties to agree on costs. If that cannot be accomplished on or before June 10, 2022, the parties shall contact me on that date with a short list of mutually agreeable dates for a one day hearing. After that and one week before the hearing date assigned, the parties shall have exchanged and provided to me their written submissions in support of their positions, to not exceed 10 double-spaced pages in a readable font, excluding any Offers to Settle or authorities being relied upon.

Mr. Justice G. Dow

Released: May 3, 2022

CITATION: Hemmings v Peng, 2022, ONSC 2674
COURT FILE NO. CV-11-424715
DATE: 20220503

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

SOPHIA KENESHA HEMMINGS, by her Litigation Guardian, Rosalie Brown, ROSALIE BROWN personally, SAMANTHA CAMILE GAYLE and MOSES HEMMINGS, minors by their Litigation Guardian, Rosalie Brown, and SAMANTHA HEMMINGS

Plaintiffs

– and –

CAROL YUEN-MAN PENG, SHARON ROSE O'BRIEN, NINA ELIZABETH NALINI VENKATARANGAM, RITIKA GOEL, NEIL THOMAS JAMENSKY, ANDRES BARTOLOME UMOQUIT, JENNIFER LAI-YEE TSANG, LLOYD GREGORY PADMORE, STEPHANIE SLADDEN, NORA DJIZMEDJIAN, YOUYI JIAN and THE SCARBOROUGH HOSPITAL

Defendants

REASONS FOR DECISION

Mr. Justice G. Dow

Released: May 3, 2022