COURT OF APPEAL FOR BRITISH COLUMBIA

Citation: *Sheoran v. Interior Health Authority,* 2023 BCCA 318

Date: 20230808
Docket: CA48194

Between:

Dr. Rajeev Sheoran

Appellant
(Plaintiff)

And

Interior Health Authority

Respondent
(Defendant)

Before: The Honourable Mr. Justice Willcock
The Honourable Madam Justice Fisher
The Honourable Madam Justice DeWitt-Van Oosten

On appeal from: An order of the Supreme Court of British Columbia, dated March 4, 2022 (*Sheoran v. (British Columbia) Interior Health*, 2022 BCSC 335, Kelowna Docket 112454).

Counsel for the Appellant:	D.G. Cowper, K.C. G. Cameron I.A. Mills
Counsel for the Respondent:	L.J. Zivot S.R. Gersbach V. Shih (Articled Student)
Place and Date of Hearing:	Vancouver, British Columbia March 29, 2023
Place and Date of Judgment:	Vancouver, British Columbia August 8, 2023

Written Reasons by:
The Honourable Mr. Justice Willcock

Concurred in by:
The Honourable Madam Justice DeWitt-Van Oosten

Concurring Reasons by (p. 37, para. 100):
The Honourable Madam Justice Fisher

Summary:

Majority (per Mr. Justice Willcock and Madam Justice DeWitt-Van Oosten):The appellant is a psychiatrist who suffered devastating injuries when he was assaulted in a hospital interview room. He appeals the dismissal of his negligence action against the respondent, the agency responsible for the management and operation of the hospital, for failing to address the risk of violence posed by patients. Held: Appeal dismissed. The trial judge did not err in refusing to define the standard of care in the absence of expert evidence. The risk of harm to the appellant had to be balanced against the value of treating a mentally-ill patient. To fail to take account of professional standards of care in this context is to address safety in the workplace while ignoring the nature of the work. It was open to the trial judge to dismiss certain negligence claims on the basis that, even if he accepted the standard of care propounded by the appellant, the facts could not support a claim. The trial judge's inability to define all aspects of the standard of care in this case did not preclude him from making findings with respect to factual causation.

Concurring reasons (per Madam Justice Fisher): The judge did not err in concluding that the evidence was insufficient to establish what the respondent was required to do to ensure the hospital was a reasonably safe work environment. The appeal should be dismissed on that basis alone. This is not a case where the judge set out to conduct a causation analysis. If he did, such an analysis would be an error of law, as causation is to be assessed only after finding a breach of the standard of care. To the extent the judge's findings are construed as a causation analysis, there is disagreement with the majority that he assessed causation on the basis of the standard of care propounded by the appellant. The appellant asserted that the standard of care required the respondent to implement various policies that together would mitigate the risk of harm to physicians but the judge considered only whether the lack of one measure or another, in isolation, would have prevented the assault.

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Introduction

The negligence claim

[1] On December 5, 2014, the appellant, Dr. Rajeev Sheoran, suffered devastating injuries when he was assaulted in an interview room in the Inpatient Psychiatry Unit (IPU) of the Penticton Regional Hospital while caring for an involuntary patient, Gregory Nield. He alleges the injury was contributed to by the negligence of Interior Health Authority (IHA), the agency responsible for the management and operation of the hospital, in failing to address the risk of violence posed by patients such as Mr. Nield.

[2] He appeals the dismissal of his action in negligence against IHA. He says the trial judge applied an inappropriate standard of care by asking whether IHA acted in accordance with medical standards of care in its management of its psychiatric facilities. While that standard is appropriate when determining what care is owed to patients, it is not appropriate when determining whether IHA exercised reasonable care to protect the physicians and staff in the hospital. He contends this case highlights the importance of distinguishing between the duties a health authority owes to its patients from the duties it owes to employees and staff members.

The contractual defence

[3] IHA argued that a contract between it and the appellant required him to obtain coverage from WorkSafeBC. He had not done so, but IHA contended the contractual obligation amounted to an agreement with respect to allocation of risk. The trial judge observed that only physicians on sessional contracts were obliged by IHA to register with WorkSafeBC. Many physicians working in its hospitals have no such obligation. He held the covenant to obtain WorkSafeBC coverage could not be viewed as an agreement to allocate risk, “when two physicians working side by side, one with a sessional contract and the other without, would be subject to different rules”. The respondent says he erred in doing so.

Background

[4] The appellant first met Mr. Nield on November 24, 2014, when he assessed him in the hospital emergency room as the on-call psychiatrist. Mr. Nield had been using psilocybin mushrooms, had not been sleeping, had mood swings, was erratic and confrontational. The appellant thought Mr. Nield was demonstrating hypomania and elation. He tried to persuade him to be admitted to the hospital, but Mr. Nield refused and was discharged with prescribed medication.

[5] The appellant next saw Mr. Nield in the hospital emergency room on November 26 at the request of his general practitioner, Dr. Kyle Stevens. He shared Dr. Steven's opinion that Mr. Nield needed to be admitted to hospital involuntarily under the *Mental Health Act*, R.S.B.C. 1996, c. 288.

[6] The IPU staff were advised by Mr. Nield's family at the time of his involuntary admission that he was a mixed martial arts fighter, highly skilled in Brazilian jiu-jitsu, and that the staff needed to be careful because he could get angry and hurt someone. On the evening of his admission, Mr. Nield climbed over a fence around a patio outside the IPU but he was returned to the ward by his father-in-law.

[7] The appellant saw Mr. Nield regularly in the IPU between the date of his involuntary admission and the December 5 assault.

[8] When the appellant assessed Mr. Nield on November 27, he demonstrated a flight of ideas and pressure of speech, consistent with psychosis or schizophrenia. When he saw Mr. Nield on November 28, Mr. Nield was unimproved.

[9] Mr. Nield again eloped from the IPU on that date, by climbing over a fence. He returned by climbing back over the fence.

[10] On November 29, Mr. Nield advised a psychiatric nurse that he was "losing touch with reality" and paranoid. The nurse called for security to assist with calming Mr. Nield. The on-call psychiatrist, Dr. Agbodo, prescribed a change in medication

and authorized the nurse to put Mr. Nield into the IPU's seclusion room if the nurse felt it necessary.

[11] On November 30, on an assessment by Dr. Agbodo, incidents of violence in Mr. Nield's distant and more recent past were noted. Mr. Nield said to a nurse: "I just hope I do not have to hurt anyone to get out of here", but this was not recorded in Mr. Nield's chart.

[12] On the evening of December 1, Mr. Nield's mood changed rapidly from settled to agitated. He expressed concern about becoming paranoid and that he might hurt others. He again left the IPU without permission by climbing over the fence. The RCMP were called, but he climbed back over the fence before he could be apprehended.

[13] On December 2, the appellant saw Mr. Nield and formed the impression there had been some improvement over the previous day. Mr. Nield was permitted to leave the hospital to visit his family.

[14] When he returned on December 3, his presentation was calmer. He was doing better at managing his level of agitation with frequent use of the gym, and was generally slightly better until the evening when he became agitated again. He refused to take his medications and encouraged other patients to refuse theirs as well. He got into an altercation with another patient, putting him into a headlock, but the situation ended quickly and no one was hurt.

[15] On December 4, Mr. Nield was observed to be irritable and angry and was demonstrating all of the symptoms of hypomania. When he met the appellant on that date he was agitated, the insight he had displayed had gone, he was not taking his medication and he was confrontational. He saw an occupational therapy student in the afternoon. The student noted that he thought Mr. Nield posed a threat to staff because of his martial arts training. In the evening, Mr. Nield agreed to take his medications and later apologized to the nurses for his behaviour and attitude.

[16] On December 5, a nurse advised the appellant that Mr. Nield was doing much better and asked the appellant to come in to the IPU to reassess him. Mr. Nield was seeking a day pass. Later in the day (2:00 PM) the same nurse noted that Nr. Nield was "feeling hyper" but this information was not verbally communicated to the appellant. At about 4:00 PM, the appellant accompanied Mr. Nield into a treatment room (also referred to as the interview room) to conduct an assessment. Nurses who were present at the nursing station testified that Mr. Nield approached the appellant in a calm manner and asked politely to speak with him. As they sat across from each other, Mr. Nield leaned down as if he had dropped something and, without warning or any apparent precipitating event, he punched the appellant in the face. The appellant was reaching for a panic button when he was hit again and lost consciousness. When a nurse, having heard a loud banging noise, went to the room to see what was happening, Mr. Nield left the room, saying, "I think he might be dead". The plaintiff was unconscious, slumped onto the desk in the corner of the room, seated on a chair, and there was a lot of blood. His jaw was broken in two places and his right eye was badly injured.

[17] The appellant had to undergo surgery to repair those injures. He has since suffered from both depression and post-traumatic stress disorder. His life has been dramatically affected by the injuries Mr. Nield inflicted upon him.

[18] The only significant conflict in the evidence at trial was whether the appellant had asked a nurse to accompany him into the interview room when he assessed Mr. Nield on December 5. The judge resolved this dispute against the appellant, holding that he did not ask a nurse to accompany him, that none of the nurses refused to do so and that he chose to proceed with the interview unaccompanied.

[19] The appellant attributed the assault to IHA's failure to discharge its duty to take reasonable care to ensure the workplace was as safe as reasonably possible. He alleged IHA "invited" him to conduct a high risk assessment of Mr. Nield when it knew or ought to have known that its facilities were unsafe and inadequate for such assessments; IHA failed to make adequate inquiries into the threat posed by

Mr. Nield, including failing to conduct a psychiatric intake assessment and risk assessment; IHA failed to take precautions such as providing staff members with individual panic buttons or personal alarms. The pleadings, which allege that the respondent is vicariously liable for the negligence of the nursing and security staff, do not identify the failure to transfer the patient to a tertiary care facility as negligence but that allegation was made at trial, as were the following specific allegations:

Failing to undertake a violence risk assessment of the IPU

[20] A violence risk assessment of the workplace is a statutory requirement under the *Occupational Health and Safety Regulation*, B.C. Reg. 296/97 [*OHS Regulations*], enacted pursuant to the *Workers Compensation Act*, R.S.B.C. 2019, c. 1. The appellant contended such an assessment would have led to the adoption of coordinated policies and procedures to identify high-risk patients, to create spaces to safely assess those patients, and to manage them using a process such as a behavioural care plan. Certain of the obligations of the IHA under WorkSafeBC policies were addressed by a witness, Annie Strauss, who was qualified as an Occupational Safety Officer with a specialty in health care inspections and formerly employed by the Workers Compensation Board. Ms. Strauss identified the following obligations arising from the requirement to do a risk assessment:

> (1) An employer must inform workers who may be exposed to the risk of violence of the nature and extent of the risk.
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> (2) The duty to inform workers includes a duty to provide information related to the risk of violence from persons who have a history of violent behaviour and whom workers are likely to encounter in the course of their work.
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> (3) The employer must instruct workers who may be exposed to the risk of violence in
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> > (a) the means for recognition of the potential for violence,
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> > (b) the procedures, policies and work environment arrangements which have been developed to minimize or effectively control the risk to workers from violence,
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> > (c) the appropriate response to incidents of violence, including how to obtain assistance, and

> (d) procedures for reporting, investigating and documenting incidents of violence.

[21] At paras. 140–161 of the reasons for judgment, the trial judge describes the IHA's slow and inadequate response to WorkSafe directives.

Failing to use the Aggressive Behaviour Assessment Scale ("ABAS")

[22] An ABAS score on a scale of one to five, with five being the highest score, is the measured result of an assessment by a registered nurse, a registered psychiatric nurse, or a licensed practical nurse, and requires the person completing the form to assess observed behaviours; communication; physical ability to inflict harm; and threat of violence. The ABAS assessment had been adopted and mandated for use throughout the IHA as part of an "aggressive behaviour toolkit" designed to identify risks of aggression and violence. The ABAS assessment was not being used in the IPU during Mr. Nield's admission. The appellant argued that in the absence of formal methods of assessing risk in an objectively quantifiable manner the clinical staff had incomplete information to use in making decisions regarding matters of safety.

Failing to adopt a policy requiring medical staff to be accompanied or in a public area or surveyed area when assessing high-risk patients

[23] As I have noted, the appellant's evidence that he asked a nurse to accompany him into the interview room was rejected. The appellant was found to have elected to conduct the assessment of Mr. Nield alone, in the closed interview room. However, the appellant submitted IHA should not have permitted physicians to see high-risk patients alone in closed rooms in the IPU and that the interview room was ill-suited for this purpose.

Failing to transfer Mr. Nield to a more secure, tertiary care facility

[24] A patient considered to be refractory, or resistant to, treatment at the IPU might be transferred to a tertiary unit, in this case the Hillside Centre, a tertiary facility in Kamloops, with a higher level of security and higher nurse to patient ratio than the Penticton IPU. However, the care model in effect during Mr. Nield's admission required, as a matter of standard practice, that all IHA patients remain in

a secondary unit for two weeks before they could be considered for transfer. The appellant says this policy does not adequately protect the medical staff at the secondary care hospital.

Failing to establish better communication between team members

[25] The appellant contended the existing communication protocols in the IPU were inadequate, specifically that information suggesting an elevated risk of violence was not sufficiently documented and communicated. The judge (at para. 269) described this as an allegation "that IHA was required to have a policy that certain types of observations would be charted twice, once in the regular patient chart and again on a standalone document relating to behaviour to address concerns of aggression and violence."

Judgment at Trial

[26] The trial judge concluded IHA was required by *OHS Regulations* to have conducted a violence risk assessment prior to 2014. Following the assault, WorkSafeBC had issued an order that required IHA to conduct such an assessment. However, that order was made without considering the adequacy of the violence prevention measures that were in effect in the IPU. Its issuance therefore did not speak to substantive deficiencies in the existing program for identification of the risk of violence at the time of the assault The judge concluded:

> [204] Although the plaintiff argues that if a violence risk assessment had been conducted earlier, there would have been policies and procedures in place that would have identified Mr. Nield as a high risk patient, the fact is that the risk posed by Mr. Nield was well-known on the ward. The plaintiff knew that Mr. Nield was a trained fighter since he first met him on November 24, 2014. Although his very recent history of violence, including a bar fight from the preceding week, was not identified until Mr. Nield was assessed by Dr. Agbodo on November 30, it was known by both the plaintiff and other members of the clinical team by December 1 or 2 because it was outlined in some detail in Dr. Agbodo's report that was placed on the file. Similarly, the plaintiff and the other members of the clinical team were also aware of his elopements and the incident with a co-patient.
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> [205] I am satisfied that the entire care team, including but not limited to the plaintiff, was well aware that Mr. Nield constituted a significant risk, and that nothing that would have flowed from a violence risk assessment, even if one had been conducted earlier, would have changed anything.

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> [209] The decision of how and where to meet with a patient is one of clinical judgment. There are a number of factors that are taken into consideration; for example, the plaintiff testified that in his opinion, patient privacy is very important in a therapeutic relationship because the physician wants the patient to feel comfortable.

[27] In part, the conclusion that a violent risk assessment would not have made any difference in this case hinged upon the judge's conclusion the appellant knowingly undertook the risk entailed in a private, unaccompanied interview in order to effectively treat his patient. Without expert opinion, the judge was not prepared to second-guess the decision about how and where to meet the patient:

> [211] All of the other psychiatrists who testified at the trial confirmed that it is a matter of personal judgment as to whether or not they would meet with a particular patient alone.
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> [215] The plaintiff's claim against IHA is that IHA ought to have had a policy whereby nobody would ever meet with Mr. Nield alone. In effect, the plaintiff is suggesting that the assault would not have occurred if IHA had a policy that would have overridden his own clinical judgment. However, he presented no expert evidence on the standard of care that provided a single example of a hospital or health authority with such a policy. As such, the evidence falls far short of establishing that IHA was required to have such a policy.

[28] For essentially the same reason, he concluded the failure to adopt the ABAS was immaterial in this case. The ABAS was solely about identifying high-risk patients, and thus would not have provided new information about Mr. Nield:

> [222] … [B]ecause Mr. Nield was known by the entire clinical care team, including the plaintiff, to be a high risk patient, completing the ABAS form would have provided no new or additional information.

[29] The judge was not prepared to set a standard of care that would require IHA to prevent physicians from conducting unaccompanied interviews of high-risk patients. He wrote:

> [187] If safety of others was the sole consideration, psychiatric wards would resemble prisons, where patients are confined in a manner to preclude the possibility of physical interaction with others. The more modern approach to psychiatry uses a therapeutic model of treatment.

> [188] In *Worth v. Royal Jubilee Hospital*, [1980] B.C.J. No. 1336, 1 A.C.W.S. (2d) 401 (C.A.) [*Worth*], the Court addressed the standard of care required of a hospital caring for psychiatric patients on an open ward in similar circumstances. ...
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> [189] … The Court of Appeal affirmed the trial judge's finding that the hospital was not negligent. In concluding that the hospital's supervision of the appellant and its security were adequate, Mr. Justice Seaton observed:
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> > [62] Whenever a risk is taken in a medical situation there will be some who will be affected adversely, but that does not make the institution liable unless the exposure of patients to the risk was not reasonable. In this case the evidence shows beyond question that the exposure was justified. The openness of the institution, the freedom to walk about and the general feeling that this was not a prison but a hospital, had a therapeutic effect that fully justified accepting the rather minor risk that suicidal or escaping patients would injure themselves.
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> [191] In his concurring reasons, Mr. Justice Craig reasoned that:
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> > [53] The argument that the hospital premises, specifically the fence of the roof gardens, were not reasonably fit is really part of the argument that the hospital provided a lower standard of care than it was bound to provide. Again, we must determine what is reasonable by considering the circumstances. One or more of the witnesses who are involved with this type of institution emphasized that probably something always can be done to make a mental institution more suicide proof or more escape proof but that, eventually, the result is an institution which, physically and administratively, resembles a maximum security prison and that for all but the most seriously mentally disordered such a setting would be harmful rather than therapeutic. This is not to say, of course, that hospital authorities may provide premises which are below reasonable standard merely because the changes which might be necessary to bring the premises up to standard would be considered non-therapeutic.

[30] Nor was the trial judge prepared to fault IHA for failing to transfer Mr. Nield to a tertiary care facility before the assault occurred. He was unable to find support for the submission that IHA's psychiatric services model was deficient (because it did not allow exceptions from the rule that transfers would not be considered until the patient had been in a secondary care facility for two weeks), in the absence of evidence of the model employed by other health authorities, or some expert evidence of the standard of care that might be expected.

[31] Further, he concluded (at para. 228) that even if the policy allowed for exceptions, “it is not apparent on the facts of this case that such an exception would have made a difference on these facts.” There was evidence in the hospital record and from the testimony of the medical team that Mr. Nield “had ... gained some insight into his condition and was intending to comply with his medication regime with a view to ultimately obtaining his discharge.”

[32] Not only did the appellant fail to establish that the standard of care called for IHA to provide for the early transfer of violent patients in exceptional cases to tertiary care facilities, the judge concluded a case for transfer was not made out on the facts. He held:

> [230] The only distinguishing feature of Mr. Nield's presentation was that if he were to become violent, the consequences could be catastrophic. In the absence of evidence that would suggest that the ability to inflict serious harm is generally managed differently, or that Mr. Nield would therefore have been transferred to another facility based upon his presentation while he was at the IPU, I cannot conclude that IHA has failed to meet its duty of care.

[33] While some deficiencies in charting and communication were noted, they were considered to be inconsequential. The judge reviewed in detail the observations and information available to each member of the clinical team during the course of Mr. Nield’s admission and concluded the appellant was aware of all material information with respect to the risk of violence when he entered the interview room with Mr. Nield on December 5.

[34] The judge accepted IHA’s contention that, for the most part, the appellant, as Mr. Nield's most responsible physician, was more aware than anyone of the risk of violence posed by Mr. Nield and he had all the available and necessary information to make a clinical decision about whether to meet with Mr. Nield alone. He held:

> [265] … [T]here are some difficulties with the plaintiff’s position that IHA failed to meet the required standard of care in this regard. The conditions of inpatients in the psychiatric unit wax and wane, and there was no evidence to support the suggestion that there was anything inherently unusual with regard to Mr. Nield. With regard to Mr. Nield specifically, he had previously shown improvement, only to regress.

> [266] There was no expert evidence regarding what a reasonably prudent nurse would have done when Mr. Nield indicated that he was feeling "hyper" and was going to go to the gym, something he had done on many prior occasions when feeling agitated. Nurses have several patients, and Nurse Ireland was off shift at 3:00 PM. Absent evidence that this particular piece of information warranted special attention, I cannot conclude that Nurse Ireland did anything other than act appropriately by charting his observations, or that he was required to do anything further.

[35] He rejected the proposition that the hospital should have established a specific system for charting concerns with respect to the risk of violence:

> [270] [I]n the absence of any evidence that would suggest that a reasonably prudent inpatient psychiatric unit in a hospital such as PRH would have a standalone document relating to behaviours and would therefore require certain chart notes be duplicated, I am unable to conclude that IHA failed to meet its duty of care.

Grounds of Appeal

[36] The appellant contends the trial judge erred in law:

a) by applying the wrong standard of care;

b) by imposing a legal presumption that expert evidence was required to set the standard of care in a workplace safety negligence claim; and

c) by drawing factual conclusions regarding causation without making the prerequisite findings as to the applicable standard of care.

Argument

The Appellant

[37] Mr. Cowper, for the appellant, forcefully argues the trial judge failed to ask whether the IHA discharged its duty to provide a safe workplace at the hospital. He says the reference to the wrong standard of care is apparent in the fact that clinical standards suffuse the judge's analysis of every aspect of the case and is reflected in his conclusion that he was unable to describe the appropriate standard of care without expert evidence.

[38] He contends that while the duty of care is appropriately described at para. 116 of the reasons as "a duty to take reasonable care to ensure that the plaintiff's workplace was as safe as reasonably possible, recognizing that vocations that involve psychiatric patients necessarily include some inherent risks", application of that standard is not reflected in the reasons as a whole. In particular he says at paras. 194, 195, and 271 of the reasons, there are references to medical standards of patient care when the judge should have been considering the duty of care owed to employees and medical staff to ensure the workplace was safe.

[39] He says the application of an inappropriate standard is reflected, in particular, in these passages:

> [194] In this case, the plaintiff called no expert evidence as to appropriate practices and procedures on inpatient psychiatric units, whether generally or as it relates to patients who may present as particularly risky as it relates to the potential for violence such as Mr. Nield. The plaintiff also did not lead any evidence regarding the standard of care pertaining to interview rooms in psychiatric facilities. There is no expert evidence to suggest that the IPU did not meet the standard of care in 2014, or that the measures that were in place did not accord with the standard practice of the day.
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> [195] It may be a relatively straightforward matter, with the benefit of hindsight, to conclude as a matter of "common sense" that certain things could have been done differently. If I were to do so, however, there would be a risk of holding the defendant to a standard of perfection, which is not the law, as opposed to one of reasonableness.

[40] He argues that the baseline standard of care IHA owes to its medical staff is to take those measures for their safety that are dictated by common sense. If IHA is of the view such measures are too exacting or will interfere with good patient care, it ought to be required to lead evidence to that effect. The appellant says the case law supports the conclusion that one should start from the premise that the assessment of whether a workplace is reasonably safe is a common-sense question that does not require expertise. He acknowledges account must be taken of medical and clinical concerns when adopting practices and procedures to protect the staff but those concerns should not overwhelm the safety analysis. The question the judge should have asked was whether the risk of injury to medical staff was recognized and whether appropriate tools were employed to minimize that risk.

[41] At paras. 269–270 and 278, the judge asked whether the effect of a particular safety measure would undermine the IPU treatment model. Finding himself unable to answer that question, the judge could not determine whether the proposed safety measures were appropriate. The appellant says the judge should have required the hospital to undertake every reasonable measure to protect the safety of medical staff unless and until there was evidence that the proposed measure would have an adverse effect upon patient care and that that adverse effect was so significant as to outweigh the safety concern. If the trial judge concluded that a condition in the hospital is unsafe, he ought to have required IHA to show that the condition existed as a result of clinical necessity. The burden ought to have been placed upon the defence to show that it was necessary to run the risk incurred. The trial judge erred in concluding that he could not find the condition to be unsafe without evidence of the clinical consequences of rectifying the condition.

[42] He says, for example, that a policy that precluded the transfer of a high-risk patient to a more secure facility did not adequately protect the medical staff. He acknowledges that clinical judgment should inform decisions about workplace safety but not determine the outcome. In practice, the transfer policy did not let physicians ask for the transfer of a very dangerous patient. The policy in effect placed all responsibility for risk avoidance in the hands of the physicians.

[43] Certain tools to reduce the risk to the medical staff were not available to them. Clinical judgment was exercised in an environment that was unsafe and could have been safer. He says the judgment in *Buck & Ors v. Nottinghamshire Healthcare NHS Trust* [2006] EWCA Civ 1576 is instructive. In that case, as here, a violent and unsettled psychiatric patient suddenly assaulted her caregivers. The victims sued the health authority, arguing that their injuries were a result of a policy that precluded them from confining the patient in her room at night when it was clear that doing so would have reduced the likelihood of an attack. The court in that case (at para. 27) found there to be “powerful evidence before the court to the effect that if [existing protocols] had been complied with by the appellants, there would have been a risk assessment, assessing [the patient] as an exceptionally high risk of posing serious

injury to others and that it would have been unreasonable not to take the view that she should be confined in her room at night".

[44] In *Buck & Ors*, after citing *King v. Sussex Ambulance Trust*, [2002] EWCA Civ 953 [*Sussex Ambulance*] and *Cook v. Bradford Community Health NHS*, [2002] EWCA Civ 1616, Lord Justice Waller held:

> 36. … it does not follow that the duty owed to employees can be tested simply by the question whether what occurred amounted to or did not amount to a breach of duty to the patient … If the appellants can take precautions so as not to expose their employees to needless risks and still not be in breach of their duty to a patient, then it seems to me that they may well be in breach of duty if they fail to take those precautions. The question whether they were in breach of duty will be tested by reference to the principles applicable as between employer and employee, not as between a doctor and his patient.

[45] In the case at bar, the appellant's decision to enter into the interview room with Mr. Nield was made with a view toward providing appropriate care. However, the appellant's counsel says the medical staff should not have been put in that position. He contends there are two dimensions to safety in the workplace. The first is to determine what decisions should be left within the discretion of the workers and the second is to establish working conditions that give the workers appropriate options to care for their own safety.

[46] He argues some risk-assessment decisions should not have been left in the hands of the medical staff. The hospital should have adopted a policy that required physicians to be accompanied when interviewing a dangerous and violent patient unless they expressly chose to override the hospital policy at their own risk. He says it does not impose an unreasonable limit upon medical care to have a rule that psychiatrists must be accompanied when they interview high-risk, violent patients unless the psychiatrist expressly determines that a chaperone is not necessary. Such a rule would require the worker to carefully address their own safety.

[47] Turning to working conditions, he contends there was expert opinion evidence on assessment and management of safety risks in hospitals: the report of Ms. Strauss and the post-assault assessment of the safety of the IPU. The hospital

could have had a policy requiring interviews to be conducted in the daytime or at times when there are more support staff available in the IPU. He submits that common-sense safety measures ought to have been addressed by the trial judge and expert evidence was not necessary to support the conclusion that reasonable care required IHA to take these or similar safety measures.

[48] Further, he says the evidence with respect to the transfer policy was sufficient to ground a claim in negligence. It was clear the transfer of the patient who had not been in the secondary care facility for less than two weeks would not, as a rule, be considered for transfer. There was evidence of tighter security and higher nurse/patient ratios at the tertiary hospital. The living units there are locked; secure rooms within the units can also be locked; there is one nurse for every three to four patients (as compared with one nurse to every five to six patients at secondary care units); 99% of patients are involuntarily admitted and it is difficult to obtain day passes to leave. Common sense suggests that violent, dangerous patients who are involuntarily committed should be transferred to such a facility.

[49] To the extent the judge's conclusion on causation poses an obstacle to the appellant, he says the causation analysis is flawed and that he is entitled to have adjudication of causation in light of the proper duty of care. He argues that a judge cannot say a breach of the standard of care was not causative of injury without defining the standard and identifying the breach. So, for example, he says we should not place any weight upon the judge's view that the evidence did not support a request to transfer Mr. Nield to a tertiary care facility. If we conclude that failure to establish a transfer policy that would more readily permit movement of violent patients was a breach of the hospital's obligation to protect the medical staff, we cannot say the breach was immaterial without describing an appropriate transfer policy. He says the judge did not do so.

[50] Additionally, he says that the trial judge never considered whether a confluence of policies operating together would have prevented the assault. The

adequacy of IHA's policies should not have been assessed in isolation from one another.

The IHA

[51] The IHA says all of the significant allegations of negligence in this case required consideration of the exercise of clinical judgment on the part of the nurses and physicians in the IPU and expertise was necessary to properly address those allegations. As the appellant notes, the judge correctly described the issue before him as whether the hospital discharged its duty to take reasonable care to ensure the workplace was safe for medical staff. That standard requires consideration of IHA's responsibility to provide appropriate care for patients and to design its programs and facilities in a manner conducive to good care.

[52] It says the standard of care for risk assessment in psychiatric units cannot be determined without expert evidence. The assessment and management of the risk posed by a patient suffering mental illness is particularly within the expertise of psychiatrists.

[53] The trial judge was correct to say no one was in a better position to assess the risk posed by Mr. Nield than the appellant and it was correct to say the shortcomings in the IPU risk assessment procedures were irrelevant in this case. Other psychiatrists, Drs. McIntrye, Agbodo (both of whom practiced in the IPU) and Dagg (the medical director for the tertiary mental health program for Interior Health, who practiced at Hillside), testified with respect to how they exercised their judgment when interviewing potentially violent patients. Dr. Dagg testified that at Hillside he would normally meet with patients alone. If he was conveying bad news, such as a decision not to discharge a patient, he might meet with the patient in an open hallway. In deciding when to meet a patient he considers the patient's illness, mood, medication and progress. He weighs the interests of maintaining the patient's privacy with his own protection.

[54] The IHA says concerns with respect to Mr. Nield's violent tendencies were moderated on December 5 by the fact he had been seen by a nurse and was calm

and the nurse was of the view he should be assessed for a day pass. There were no signs of aggression on Mr. Nield's part before he met with the appellant on that day. He politely asked to see the appellant and was in the interview room with the appellant for about 20 minutes before suddenly striking out at him. A panic button was available but the appellant could not reach it after he was injured.

[55] The evidence was that many individuals with mental health issues pose a risk of violence. The nursing manager, Karen Gladish testified that aggression in patients in the IPU is a "very common thing". The health service administrator for tertiary mental health, Sandra Da Silva, testified that when considering a transfer request, the tertiary care unit looks at a patient's behaviour in general. Violence may be one of the behaviors considered but it is not the primary behavior because the primary consideration is whether the patient's illness is refractory. Ms. Da Silva testified at length with respect to the clinical criteria for transfer to a tertiary care unit and expressed the view that Mr. Nield did not meet those criteria. Dr. Dagg also testified with respect to the transfer protocol and was not cross-examined on the criteria. The respondent says the judge correctly concluded that he was not equipped to address the adequacy of the transfer protocol without expert evidence.

[56] The respondent contends the trial judge had no lay or expert evidence to support the appellant's submission that Mr. Nield should have been moved out of the IPU. The appellant had not pleaded that not transferring Mr. Nield to Hillside before the assault was negligent. No one suggested that seclusion was necessary and no one recommended it as a reasonable course of action in this case. The evidence was that when there is a security issue in the IPU the RCMP can be called to assist. There was no suggestion that they were called to deal with Mr. Nield on any occasion other than the December 1 escape from custody.

Discussion

Causation

[57] Because the trial judge concluded that certain allegations of negligence were inconsequential, I will begin by addressing the appellant's submission that the judge erred in assessing causation without defining the standard of care.

[58] The appellant contends that the judge's conclusions on causation do not stand as a bar to his claim because the judge assessed causation without defining the standard of care. The appellant cites the dissenting reasons of Justice van Rensburg in *Armstrong v. Royal Victoria Hospital*, 2019 ONCA 963, rev'd 2021 SCC 1 (aff'g dissent of van Rensburg J.A.), as authority for the proposition that it is an error to address causation before finding a breach of the standard of care (and equally that it is an error to permit causation to play some role in defining the standard of care). There is no doubt that logic dictates that the essential elements of a tort claim should be considered separately and sequentially.

[59] In *Armstrong*, van Rensburg J.A. wrote:

> [138] I agree with my colleague … that typically, it makes sense for the trier of fact to consider causation only after finding a breach of the standard of care: see, for example, *Bafaro v. Dowd*, 2010 ONCA 188, 260 O.A.C. 70, at paras. 35–36. Determining standard of care before causation ensures that the trial judge does not wrongly reason backwards from the fact of the injury to determine that the standard of care has been breached. However, I also agree with my colleague's observation that at times the court will need to determine "what happened" (that is, the factual cause of the plaintiff's injury) in order to resolve whether the standard of care has been breached. Determining factual (and not "but-for") causation is sometimes necessary before a conclusion can be reached on whether there has been a breach of the standard of care.
>
> [139] Indeed, this court has determined that, in some cases, it will be an error for the trial judge to fail to determine "how the injury occurred" before assessing standard of care.

[60] That does not mean, however, that we can or should disregard the trial judge's findings on factual questions with respect to causation. It is not an error for a trial judge to ask whether, assuming the standard of care required a particular step to be taken, the breach of the standard caused or contributed to the damages in

question. In cases where the breach of duty consists of an omission to do an act which ought to be done, that factual inquiry is, by definition, in the realm of hypothesis in any event: *Bolitho v. City and Hackney Health Authority*, [1998] AC 232, [1997] 3 WLR 1151.

[61] I would not accede to the appellant's argument that the trial judge made an extricable error of law by making findings on causation without first establishing the requisite standard of care and determining as a fact whether there was a breach of that standard. We are bound to accept the judge's unchallenged findings of fact. Those findings underpin certain inferences with respect to causation. The finding that specific acts or omissions were not causative of damages is binding upon us. It was open to the trial judge to dismiss certain negligence claims on the basis that, even if he accepted the standard of care propounded by the appellant, the facts could not support a claim. Findings of fact pose an obstacle to the negligence claim founded upon the following allegations.

[62] The trial judge's inability to define all aspects of the standard of care in this case did not preclude him from making findings with respect to factual causation. Doing so did not pose the risk, discussed in *Armstrong,* that the definition of the standard of care would be improperly coloured by premature consideration of questions of causation.

Failure to undertake a violence risk assessment

[63] The trial judge accepted the appellant's assertion that IHA was obliged to conduct a violence risk assessment of the workplace, and had not done so. His conclusion that this was a matter of form and not substance was founded upon his assessment of the extent to which the risk of violence in this case was assessed, documented and communicated. The finding that the appellant was aware of the nature and extent of the risk of violence that Mr. Nield posed and was the person most able to recognize the potential for violence is unassailable. So are the findings that it was a matter of clinical judgment on the part of the appellant as to whether he would interview Mr. Nield and whether he did so without anyone else present, and

that he had done so on more than one occasion even though he knew of Mr. Nield's recent history of violence. These findings led to the conclusion that failure to conduct a risk assessment did not, in fact, contribute to the devastating injuries inflicted upon the appellant. That conclusion with respect to causation was unaffected by the alleged error with respect to whether the statutory obligation equated to the standard of care.

Failure to use the ABAS

[64] Similarly, the judge accepted that the staff in the IPU could be faulted for not employing the ABAS tool prescribed by IHA policy but that was not an effective cause of the assault. The absence of formal methods of assessing risk in an objectively quantifiable manner made no difference because the staff were acutely aware of the history of violence and the particular risk posed by Mr. Nield because of his martial arts expertise. In my opinion, it was not an error for the judge to say (at para. 218) “this case is not about whether Mr. Nield had been identified as a risky patient, because the risks he posed were well known”. I see no reason to disturb the trial judge’s conclusion that the failure to use the ABAS tool made no difference.

Failure to adopt a chaperone policy

[65] The trial judge found the appellant, being fully informed of the risk posed by Mr. Nield, did not ask to be accompanied into the interview room and did not opt to conduct the interview in a public area. The appellant is correct to say the judge did not find, as a fact, that the appellant would have seen the appellant alone in the interview room even if the hospital had a chaperone policy that the appellant had to expressly consider and override. The appellant did not testify that such a policy would have affected his conduct. It would have been difficult to make out that case, given that the judge rejected the appellant’s evidence that he asked a nurse to accompany him. In the absence of some evidence that a presumptive rule requiring chaperones to be present at interviews of violent patients would have made a difference in this case, the failure to establish such a policy could not have been found to contribute to the assault.

Failure to transfer Mr. Nield to a tertiary care facility

[66] The appellant argued that IHA policy should have permitted Mr. Nield to be transferred to the tertiary care facility less than two weeks after his admission to the IPU. However, there was no evidence anyone would have sought to have Mr. Nield transferred if that option had existed. There was no evidence the alleged policy failure made a difference. The onus fell upon the appellant to establish that but for the failure to adopt a policy permitting high-risk patients to be transferred to tertiary care, Mr. Nield would have been moved to Hillside prior to December 5. I see no reason to disturb the judge's finding (at para. 230) that "In the absence of evidence that would suggest … that Mr. Nield would … have been transferred to another facility based upon his presentation while he was at the IPU, I cannot conclude that IHA has failed to meet its duty of care."

[67] The trial judge concluded there was nothing inherently unusual in the waxing and waning of Mr. Nield's symptoms and there was no evidence his symptoms on December 5 warranted "special attention" (at para. 266). The appellant testified that he thought there was some progress in the patient's treatment in early December and that was one reason he did not initiate a transfer. It was open to the judge to find that the case for a transfer was not made out on the evidence.

Failure to establish better communication between team members

[68] The appellant contended the existing communication protocols in the IPU were inadequate, specifically that information suggesting an elevated risk of violence was not sufficiently documented and communicated.

[69] The judge (at para. 205) found as a fact that the "entire care team", including the appellant, was "well aware that Mr. Nield constituted a significant risk". Although this is a full answer to the complaint about insufficient documentation and communication, the judge was also of the view (at para. 269) that the appellant had not made out a case in support of his submission that "IHA was required to have a policy that certain types of observations would be charted twice, once in the regular

patient chart and again on a standalone document relating to behaviour to address concerns of aggression and violence."

[70] In my view these conclusions are unassailable.

Standard of Care

[71] The appellant says the fact that negligence occurs in a hospital setting does not transform the action into a claim sounding in professional negligence. Workplaces, while they differ, are workplaces. He contends the fact the judge looked at his claim through the wrong lens is manifested in five ways in his reasons:

a) The trial judge found that he was "ill-placed to assess or evaluate the treatment model that was in place at the IPU" and he lamented the alleged choice of having to speculate as to where IHA should have been along the continuum between an open therapeutic model of care and the historical prison-like model of psychiatric care.

b) He consistently applied the assumption that "where a healthcare professional complies with the standard practice no breach of the standard of care will follow absent expert evidence to the contrary".

c) He used the professional negligence standard to dismiss each of the appellant's arguments as to the alleged breaches of the standard of care on the sole basis that Dr. Sheoran failed to adduce expert evidence on the points.

d) He relied on medical malpractice cases to inform his assessment of the standard of care.

e) Finally, he considered the nursing staff's conduct through the lens of a "reasonably careful and prudent nurse". The standard of care of a nurse (none of whom were sued) was not the question before the trial judge. The question was whether IHA's policies provided the appellant with a reasonably safe workplace.

[72] The appellant cites the decision of this Court in *Bergen v. Guliker,* 2015 BCCA 283, for the proposition that the standard of care by which conduct is measured is a question of law. That general rule is qualified in *Bergen* and the cases there referred to. The standard of care applied in *Bergen* was a duty to exercise the care that would be exercised by "a reasonable police officer in similar circumstances". (The standard was similarly described by Justice Lowry in *Burbank v. R.T.B*., 2007 BCCA 215, and Justice Kirkpatrick, as she was, in *Doern v. Phillips Estate*, 1994 CanLII 1869, 2 B.C.L.R. (3d) 349 (S.C.), at para. 68, aff'd 1997 CanLII 2433, 43 B.C.L.R. (3d) 53 (C.A.)). The form that duty takes in particular cases, the nature of the "specific obligations" is a question of fact. As Justice D. Smith, writing for the court in *Bergen*, observed:

> [109] Translating the general standard into particular obligations imposed on a defendant in a given case (i.e., the content of the standard) and the determination of whether the defendant has met those obligations (i.e., whether there is a breach), are questions of fact that can only be interfered with on appeal if found to be based on palpable and overriding error (see: *Housen v. Nikolaisen*, 2002 SCC 33 at para. 10; *ter Neuzen v. Korn*, 1995 CanLII 72 (SCC), [1995] 3 S.C.R. 674 at para. 55; *Krawchuk* at para. 125; and *Meady* at para. 34).
>
> [110] External indicators of reasonable conduct, including professional standards and internal policy, may inform the content of the standard and whether it was breached (*Hill* at para. 70; *Ryan v. Victoria (City*), 1999 CanLII 706 (SCC), [1999] 1 S.C.R. 201 at para. 29; *Burbank* at paras. 91-92; *Krawchuk* at para. 125). However, policies and statutory standards, while instructive, are not definitive of the content of the standard of care (*Hill* at para. 70). …
>
> [Emphasis added.]

[73] One of the cases relied upon in *Bergen—Krawchuk v. Scherbak*, 2011 ONCA 352—drew a similar distinction between the standard of care *writ large* and the specific obligations the defendant was called upon to discharge. In that case, the defendant was a realtor. Justice Epstein, writing for the Court, explained the distinction between the general standard of care exacted of all realtors, versus the particular set of obligations owed by a defendant in a given case. The general standard was described as an obligation to exercise the care that would be expected of a reasonable and prudent agent in the same circumstances. There was no need

to establish that standard of care through expert evidence. The obligations that duty entailed, however, remained to be determined on the facts:

> [125] … This general standard, a question of law, will not vary between cases and there is no need for it to be established through the use of expert evidence … The translation of that standard into a particular set of obligations owed by a defendant in a given case, however, is a question of fact (Wong, [*Wong v. 407527 Ontario Ltd*., 1999 CanLII 3788 (ONCA), [1999] O.J. No. 3373, 179 D.L.R. (4th) 38 (C.A.)] at para. 23; Fellowes, [*Fellowes, McNeil v. Kansa General International Insurance Co.*, 2000 CanLII 22279 (ONCA), [2000] O.J. No. 3309, 138 O.A.C. 28 (C.A.)] at para. 11). External indicators of reasonable conduct, such as custom, industry practice and statutory or regulatory standard, may inform the standard. Where a debate arises as to how a reasonable agent would have conducted himself or herself, recourse should generally be made to expert evidence.

[74] While it has long been settled that the general standard of care does not hinge on expert evidence (see the judgment of Chief Justice Duff in *Regal Oil & Refining Co. v. Campbell*, [1936] S.C.R. 309, [1936] S.C.J. No. 23), the definition of the specific obligations owed to the plaintiff is a question for the trial judge to address on the facts of the case. That task is described by van Rensburg J.A. in *Armstrong* as determining "what is reasonably required to be done (or avoided) by the defendant in order to meet the standard of care": at para. 87.

[75] The manner in which the analysis should move from the definition of the legal standard of care to the identification of particular obligations is reflected in Lady Justice Hale's judgment in *Sussex Ambulance*, upon which the appellant relies. Describing the standard of care her ladyship wrote:

> 21. The starting point is that an Ambulance Service owes the same duty of care towards its employees as does any other employer. There is no special rule in English law qualifying the obligations of others towards fire fighters, or presumably police officers, ambulance technicians and others whose occupations in the public service are inherently dangerous: see *Ogwu v. Taylor* [1988] 1 AC 431. Such public servants accept the risks which are inherent in their work, but not the risks which the exercise of reasonable care on the part of those who owe them a duty of care could avoid. An employer owes his employees a duty to take reasonable care to provide safe equipment and a safe system of work, which includes assessing the tasks to be undertaken, training in how to perform those tasks as safely as possible, and supervision in performing them.
>
> 22. What then is reasonable care in this context? The classic statement of the standard by which an employer is to be judged is that of Swanwick J. in

> *Stokes v. Guest, Keen Nettlefold (Nuts and Bolts) Ltd* [1968] 1 WLR 1776, at p 1783C-F :
>
> > " . . . the overall test is still the conduct of the reasonable and prudent employer, taking positive thought for the safety of his workers in the light of what he knows or ought to know; . . . where there is developing knowledge, he must keep reasonably abreast of it and not be slow to apply it; . . . He must weigh up the risk in terms of the likelihood of injury occurring and the potential consequences if it does; and he must balance against this the probable effectiveness of the precautions which can be taken to meet it and the expense and inconvenience they involve."
>
> However, there is a further dimension which is particularly applicable to the statutory services. As Denning LJ put it in *Watt v. Hertfordshire County Council* [1954] 1 WLR 835 at p 838:
>
> > "It is well settled that in measuring due care you must balance the risk against the measures necessary to eliminate the risk. To that proposition there ought to be added this: you must balance the risk against the end to be achieved. If this accident had occurred in a commercial enterprise without any emergency there could be no doubt that the servant would succeed. But the commercial end to make profit is very different from the human end to save life or limb. The saving of life or limb justifies taking considerable risk, ... I quite agree that fire engines, ambulances and doctors' cars should not shoot past the traffic lights when they show a red light. That is because the risk is too great to warrant the incurring of the danger. It is always a question of balancing the risk against the end."

[76] Similar considerations, regarding balancing the risk of harm to employees against the value of the task the employees are engaged in, were discussed in *Kendal v. St. Paul's Roman Catholic Separate School Division No. 20*, 2003 SKQB 214, aff'd 2004 SKCA 86. Justice Wimmer addressed a claim brought by a teacher injured by a "special needs" student who violently struck her. He described the standard of care as follows:

> [19] … [T]he duty of care owed by an employer to employees generally. … is nothing more than a duty to take reasonable care to provide and maintain as safe a workplace as is reasonably possible in all the circumstances of the particular case. … In other words, it is a duty to guard against exposing employees to unreasonable risk of harm, though not every possible risk.
>
> [20] The following passage from Linden, *Canadian Tort Law*, 7th ed. (2001) at p. 120 is apropos:
>
> > Conduct is negligent if it creates an unreasonable risk of harm. This does not mean that *all* risky conduct attracts liability, for virtually everything that anybody does creates some hazard to somebody. If *every* act involving danger to someone entailed liability, many

> worthwhile activities of our society might be too costly to conduct. The law of negligence seeks to prevent only those acts which produce an unreasonable risk of harm. In measuring whether the hazard is an unreasonable one, the court balances the danger created by the defendant's conduct, on one hand, and the utility of that conduct, on the other hand. If the hazard outweighs the social value of the activity, liability is imposed; if it does not, the defendant is exonerated.
>
> [Emphasis added.]

[77] The passage from Linden cited in *Kendal* is particularly apt in this case, where the conduct in question, rendering care to a patient suffering mental illness, has great social value.

[78] The trial judge in this case was bound, as the appellant suggests, to determine whether IHA discharged its duty to take reasonable care to ensure the appellant's workplace was as safe as reasonably possible, recognizing the inherent risks in caring for psychiatric patients. However, the law also required him to engage in the balancing process described in *Kendal* and *Sussex Ambulance*.

[79] The description of the obligations owed by the defendant to the plaintiff in the context of the case turns on the facts. For that reason, as this Court noted in *Burbank*, the judge's findings with respect to what the duty entails is case specific and subject to a deferential review. Justice Lowry wrote:

> [63] … [It] is for the trier of fact in each instance to assess the conduct and the consequences in question in the context of the risk of harm measured against the utility of the activity to determine the standard of care and whether it has been met. In cases like this, it is generally more a matter of process based on the evidence of the conduct involved than it is one of evidence as to what constitutes the applicable standard.

[80] That is the balancing process referred to in para. 193 of the reasons as a balancing that required the benefit of expert evidence.

[81] The utility and occasional necessity of expert evidence in giving substance to the standard of care is reflected in *Bolitho v. City and Hackney Health Authority*

[1997] UKHL 46; [1998] AC 232; [1997] 4 All ER 771; [1997] 3 WLR 1151, where Justice Browne-Wilkinson wrote:

> … [I]t will very seldom be right for a judge to reach the conclusion that views genuinely held by a competent medical expert are unreasonable. The assessment of medical risks and benefits is a matter of clinical judgment which a judge would not normally be able to make without expert evidence. … [I]t would be wrong to allow such assessment to deteriorate into seeking to persuade the judge to prefer one of two views both of which are capable of being logically supported. It is only where a judge can be satisfied that the body of expert opinion cannot be logically supported at all that such opinion will not provide the bench mark by reference to which the defendant's conduct falls to be assessed.

[82] In my view, the trial judge did not err in describing the standard of care. The standard is a question of law but its content is always contextual. The duty one owes to one's neighbour is not absolute; it is framed in terms of *reasonable care in the circumstances*. While the jurisprudence to which the judge referred when formulating the standard of care was not particularly apt, because some of the cases referred to addressed the duty of care a physician or hospital owes *to a patient*, he clearly stated that he was seeking to establish the duty the IHA owed to protect the health and safety of its medical staff. The cases he relied upon were examples of the nature of the duty of care a hospital owes to anyone who may be injured on the premises.

[83] The judge accepted that the standard should be "informed by the *Worker's Compensation Act* and the related *OHS Regulations*, IHA's own internal policies, and by the actions taken by other health authorities". He accepted that the IHA was required to conduct a violence risk assessment for the IPU in compliance with the *OHS Regulations* and held that the statutory requirement was "subsumed within the law of negligence" (at para. 198). He held:

> [201] … [T]he requirement for IHA to have conducted a violence risk assessment at the IPU was a statutory obligation and was not a duty that was owed to the plaintiff. IHA's obligation was to ensure that the IPU was reasonably safe. While a violence risk assessment may lead to the identification of policies, practices, and procedures that render the IPU safer, the standard of care must be considered with regard to what ought to have been in place, as opposed to whether or not a document entitled "violence risk assessment" had ever been prepared.

[84] He accepted that the use of the ABAS had been adopted as a policy by the IHA but had not been employed in psychiatric wards. The allegation of inadequate assessment rising from the failure to use this tool, and inadequate communication or charting did not turn on the standard of care because the judge found the appellant was aware of all material information that bore on his decision to enter the patient interview room with Mr. Nield on December 5. The judge held:

> [217] The ABAS is intended as an objective tool designed to assess a patient's risk for aggression and violence. The IHA does not dispute that the ABAS was policy across IHA, but even though it was policy, it was not actually used on psychiatric wards such as the IPU. Although the ABAS was policy for IHA, there was no evidence that would suggest it was in use elsewhere, although other hospitals and health authorities have other tools in place.
>
> [218] However, this case is not about whether Mr. Nield had been identified as a risky patient, because the risks he posed were well known. The ABAS form requires that it be completed by a registered nurse, licensed practical nurse, or registered psychiatric nurse. However, as Dr. Agbodo said, the ABAS does not override the clinical judgment of a psychiatrist.

[85] The trial judge clearly regarded evidence with respect to the manner in which psychiatric patients should be treated as essential to the translation of the standard of care into a particular set of obligations owed by a defendant when addressing the most significant allegations of fault:

a) that IHA should not have permitted physicians to interview high-risk patients alone in the closed interview room (or as suggested in argument on appeal, in the alternative, should have required physicians to justify the decision to conduct such interviews on medical grounds); or

b) that IHA should have had plans or procedures in place that would permit high-risk patients to be transferred out of the IPU to a tertiary care unit, with a higher level of security and higher nurse to patient ratio within 14 days of their admission.

[86] When addressing these two allegations, the trial judge could not describe IHA's duty to ensure workplace safety without informing himself with respect to how

the safety standard proposed by the plaintiff could be met while, at the same time, permitting the staff to care for their patients appropriately.

[87] Where the work itself entails some risk of injury, determining what measures should reasonably be taken to reduce that risk requires appreciation of the costs and benefits of the measures. Physicians and nurses who treat patients with infectious diseases run some risk of infection. A layperson may be ill-equipped to determine what measures will be effective to reduce or eliminate that risk and which, if any, will interfere with optimal patient care. In the case at bar, there was evidence of psychiatrists to the effect that there is some medical value in meeting with a patient alone and barriers to direct communication can interfere with the establishment of a physician/patient relationship. The appellant described the importance of assessing patients in private because confidentiality is "central to medicine". Another psychiatrist, Dr. Dagg, testified to the fact that he interviews patients alone, where possible, because doing so "respects the need to develop a therapeutic relationship". To fail to take account of professional standards of care in this context is to address safety in the workplace while ignoring the nature of the work.

[88] The trial judge addressed the workplace safety question by asking "what a reasonably prudent inpatient psychiatric unit would have done" to protect the medical staff. He noted (at para. 128) that determining what constitutes reasonable care in any case will depend on a number of factors, including those described in *Ryan* at para. 28 as follows:

> [28] . . . The measure of what is reasonable depends on the facts of each case, including the likelihood of a known or foreseeable harm, the gravity of the harm, and the burden or cost which would be incurred to prevent the injury. In addition, one may look to external indicators of reasonable conduct, such as custom, industry practice, and statutory or regulatory standards.

[89] In the context of this case, assessing the burden or cost which would be incurred to prevent the risk of injury was a societal cost: the effect of proposed preventative measures on the quality of medical care. As the judge noted,

"[i]npatient psychiatric units such as the one at PRH serve a societal purpose" (at para. 186).

[90] There was evidence that beds at the tertiary care facility are limited; admission to that facility is regulated by committee and not always afforded to those for whom transfer is requested. The transfer decision is a medical one, not solely or primarily dictated by security concerns. It was right for the judge to be hesitant to decide when the transfer of a psychiatric patient to a tertiary care facility is warranted without expert evidence.

[91] The appellant is correct to say that the jurisprudence referred to by the judge in relation to the standard of care primarily dealt with the duty owed by a physician or a hospital to their patients, notably *Braun v. Vaughan*, [2000] 3 W.W.R. 465, 2000 CanLII 17227 (M.B.C.A.), (failure to promptly inform a patient of a lab result); *Martin v. Listowel Memorial Hospital*, [1998] O.J. No. 3126, 81 A.C.W.S. (3d) 548 (Gen. Div.), rev'd in part [2000] O.J. No. 4015, [2001] 2 W.W.R. 384 (C.A.), (failure to establish protocols to ensure oxygen supplies in ambulances); *Lachambre v. Nair*, [1989] 2 W.W.R. 749, 1989 CanLII 4529, [1989] 2 W.W.R. 749 (S.K.K.B.), (communication of test results); and *Paur v. Providence Health Care*, 2015 BCSC 1695, aff'd 2017 BCCA 161, (monitoring potentially suicidal patients). In my view, while none of these cases are directly on point, each is an example of how to consider the factors enumerated in *Ryan.* For example, in *Braun*, the court canvassed the duty of care owed by hospitals to patients generally and (at para. 45) cited *Wellesley Hospital v. Lawson*, [1978] 1 S.C.R. 893, 1977 CanLII 29, as authority for the proposition that hospitals may be liable for failure to take proper measures to prevent a disturbed person from injuring other patients.

[92] Reading the judgment as a whole, it is evident that the judge did not simply adopt as applicable the standard of care the IHA owed to patients. In a passage that clearly reflects his attention to the issue of the safety of patients and others in the hospital, the trial judge referred to the "inherent tension between making a psychiatric ward *safe for patients and others* on the one hand, and providing therapy

to patients with the goal of medical improvement on the other" (at para. 192). That tension does not arise in describing the medical standard of care owed to patients. It arises where the court is addressing the duty to make premises (particularly psychiatric wards) safe as a workplace, while also ensuring effective therapy. It is not an error of law to place some weight upon the value of therapy and the cost of measures that make therapy less effective or more difficult.

[93] The judge properly found support for that proposition in the judgment of this Court in *Paur,* where Justice Newbury writing for the Court, held:

> [62] There can be no doubt that medical professionals in the psychiatric field are aware of the desirability, from a therapeutic point of view, of permitting patients to have as much privacy and personal dignity as possible. Such professionals must also operate in the real world, where there simply may not be personnel or resources available to enable a hospital always to meet "best practices" or to provide one-to-one supervision to every patient in the psychiatric ward. Such patients cannot generally be turned away — thus if Mr. Paur had arrived at the hospital at a time when all beds in the Comox Unit were occupied, he would likely have been placed in a much less secure environment. In any event, a "balancing" must clearly take place between *complete* safety (which would effectively mean subjecting patients to a prison-like environment), and complete freedom and privacy. [Emphasis original.]

[94] While the complete safety referred to in that case was the safety of the patient, the reasoning in the passage is equally applicable where the litigation arises out of an injury to another patient or a staff member. Setting the standard of care requires a balancing between complete safety of the staff and complete freedom and privacy. That balance requires evidence with respect to therapeutic care.

[95] In *Buck & Ors*, the court had evidence with respect to therapeutic care. The medical experts who testified were all of the view that had recommendations arising from a risk assessment been adopted and had the staff had the option to lock the patient in her room at night, it would have been reasonable to take that measure. Waller L.J. wrote:

> 27. Thus it was that there was powerful evidence before the court to the effect that if the Tilt directions had been complied with by the appellants, there would have been a risk assessment, assessing Miss Agar as an exceptionally high risk of posing serious injury to others and <u>that it would</u>

> have been unreasonable not to take the view that she should be confined in her room at night.
>
> [Emphasis added.]

[96] The trial judge in the case at bar wrote:

> [194] In this case, the plaintiff called no expert evidence as to appropriate practices and procedures on inpatient psychiatric units, whether generally or as it relates to patients who may present as particularly risky as it relates to the potential for violence such as Mr. Nield. The plaintiff also did not lead any evidence regarding the standard of care pertaining to interview rooms in psychiatric facilities. There is no expert evidence to suggest that the IPU did not meet the standard of care in 2014, or that the measures that were in place did not accord with the standard practice of the day.
>
> [195] It may be a relatively straightforward matter, with the benefit of hindsight, to conclude as a matter of "common sense" that certain things could have been done differently. If I were to do so, however, there would be a risk of holding the defendant to a standard of perfection, which is not the law, as opposed to one of reasonableness.

[97] In my opinion these passages do not reflect the application of an inappropriate standard of care. Nor can the appellant, in my view, make out an error of law in the judge's findings of fact in relation to causation.

Conclusion

[98] Because I am of the view the trial judge did not err in his analysis of the negligence claim, I find it unnecessary to address the IHA's contractual defence.

[99] It is unfortunate that Dr. Sheoran is unable to seek redress from his assailant. He has sustained life-altering injuries while engaged in a most laudable and important task. However, being unable to find any legal error in the judgment

dismissing his claim against IHA, I am compelled to conclude that I would dismiss the appeal.

"The Honourable Mr. Justice Willcock"

I agree:

"The Honourable Madam Justice DeWitt-Van Oosten"

Reasons for Judgment of the Honourable Madam Justice Fisher:

[100] I have read the reasons of my colleague, Justice Willcock. I agree with his analysis of the standard of care and would dismiss the appeal on that basis alone.

[101] Although the trial judge made some findings that related to questions of causation, I do not see this as a case where the judge set out to conduct a causation analysis. If he did, I agree with the appellant that such an analysis would be an error of law, as causation is to be assessed only after finding a breach of the standard of care. As Justice van Rensburg stated in *Armstrong v. Royal Victoria Hospital*, 2019 ONCA 963, rev'd 2021 SCC 1 (aff'g dissent of van Rensburg J.A.), "[d]etermining standard of care before causation ensures that the trial judge does not wrongly reason backwards from the fact of the injury to determine that the standard of care has been breached": at para. 138. I do not consider this case to fall within the exception to this principle identified in *Armstrong*, where the court needs to determine the factual cause of a plaintiff's injury in order to resolve whether the standard of care has been breached. The factual cause of the appellant's injury is undisputed, and therefore, this was not an appropriate case to assess causation before identifying the standard of care.

[102] I depart from my colleague's reasons with respect to the basis on which the trial judge addressed causation. I do not agree that the judge made no error in asking whether, "assuming the standard of care required a particular step to be taken, the breach of the standard caused or contributed to the damages in question": at para. 60. This assumes that the judge was assessing the evidence based on the standard of care asserted by the appellant. As I understand the appellant's argument, the standard of care required the respondent to implement various policies that together would mitigate the risk of harm to physicians working in the inpatient psychiatric unit (IPU). The trial judge considered only whether the lack of one measure or another, in isolation, would have prevented the assault. He did not consider how a confluence of policies operating together could have done so. In my view, these findings were not responsive to the more broadly asserted standard of

care. In any event, as I stated at the outset, I do not read the reasons as setting out to make definitive findings on causation.

[103] The trial judge found the evidence insufficient to establish that the respondent was required to have certain policies (such as not meeting with a potentially violent patient alone, treating the risk of violence as an exception to the policy for transferring patients to tertiary care, requiring double charting for certain types of observations). Although he expressed the view that for some of these matters, he was "unable to conclude that [the respondent] failed to meet its duty of care" (at paras. 230, 270) he ultimately dismissed the negligence claim on the basis that the appellant failed to prove the applicable standard of care:

> [278] I find that the plaintiff has failed to prove the applicable standard of care. Without evidence of the required standard, the court is left without any method of determining and assessing the defendant's conduct, whether with regards to psychiatric care generally, the organization and management of the IPU at PRH, or the management of a patient with the characteristics of Mr. Nield.
>
> [279] While there may be cases where a breach of the standard of care might be inferred from all the surrounding facts and circumstances or alternatively is so obvious that expert evidence is not required, this is not such a case.

[104] Given the pleadings and arguments made before him, I see no error in the judge's conclusion that the evidence was insufficient to establish what the respondent was required to do to ensure the IPU was a reasonably safe work environment.

[105] There is no question that the respondent's failure to conduct a violence risk assessment, as required under regulation, as well as its failure to implement its own Aggressive Behaviour Assessment Scale, raise serious concerns as to whether the respondent, through inaction, created a risky environment in the IPU—one that placed the burden of managing the risk of harm entirely on the individual physician. Although psychiatrists play a major role in assessing risk, they do so within the confines of the environment in which they are working. The respondent has a responsibility to mitigate the risk of harm in that environment by providing reasonably

safe facilities and establishing and implementing policies that allow for clear communication among the staff.

[106] While there is no dispute that the respondent owed the appellant a duty of care to provide a reasonably safe workplace in the IPU, the standard of care cannot be established without showing which measures should have been taken. The question of the specific obligations of this respondent to provide a reasonably safe workplace must be determined in the context of an IPU where the interplay between safety and therapeutic intervention is important. There may be issues of workplace safety that do not impact patient care and can be determined as a matter of common sense. In this appeal, however, the appellant did not focus his argument on common-sense measures such as installing cameras in the interview room; rather, he argued, for example, that the standard of care required a policy that prescribed how and when dangerous patients may be transferred to a tertiary care facility. That policy is one which affects patient care and thus requires specialized knowledge. I see no error in the trial judge's conclusion that he could not determine if the respondent's transfer policy and practice met the standard of care in the absence of expert evidence. The same can be said for a policy requiring a two-person team approach or a particular method of recording and communicating patient information.

[107] I appreciate some of the appellant's concerns that the trial judge conflated workplace safety with professional negligence, as he referred, for example, to "the conduct of health professionals" (at para. 271) and "what a reasonably prudent nurse would have done" (at para. 266). I attribute some of this confusion to the way in which the claim was pleaded, as the Notice of Civil Claim asserted that the respondent was "vicariously liable for the negligence of the nursing and security staff". However, I agree with Willcock J.A. that reading the judgment as a whole, the judge was cognizant that the standard of care related to the safety of the psychiatric ward and his role was to balance workplace safety with an appropriate therapeutic environment. In this respect, the judge was rightly concerned that the issues raised by the appellant were beyond the knowledge of an ordinary person.

[108] In this appeal, we are also constrained by the trial judge's findings that the system of communication in place at the IPU was adequate (or at least had not been proven to be inadequate) (at para. 244) and the appellant "had all the available and necessary information to make a clinical decision as to whether to meet with Mr. Nield alone". Because the IPU was operating in this fashion, and in the absence of expert evidence as to what policies and protocols would be appropriate in this specialized context, the judge was not satisfied that the omissions of the respondent were sufficient in themselves to establish the standard of care.

[109] I echo my colleague's closing comments about this unfortunate case but I too, see no basis on which this Court can interfere with the judgment below.

"The Honourable Madam Justice Fisher"