

Lecture Notes No. 2

**II. SUBSTITUTE DECISION-MAKING**

**5. Court-Appointed Guardians and POA Litigation**

**Chu v. Chang**  
**2010 ONSC 294 (Ont. S.C.J.); cb, p.1051**

Read this case for the depth of the factual analysis by which the Court determines whether a guardianship should be terminated and the need for an accounting.

**6. Personal Care**

The *Health Care Consent Act, 1996, S.O. 1996, c. 2*, provides:

**10 (1)** A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,

(a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or

(b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act

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**Principles for giving or refusing consent**

**21 (1)** A person who gives or refuses consent to a treatment on an incapable person's behalf shall do so in accordance with the following principles:

**1.** If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.

**2.** If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests.

**Best interests**

(2) In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,

- (a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;
- (b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and
- (c) the following factors:
  1. Whether the treatment is likely to,
    - i. improve the incapable person's condition or well-being,
    - ii. prevent the incapable person's condition or well-being from deteriorating, or
    - iii. reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.
  2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.
  3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.
  4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.

**Rasouli (Litigation Guardian Of) v. Sunnybrook Health Sciences Centre [2013] 3 SCR 341 (S.C.C.); cb, p.1062**

[The bottom line:

"Withdrawal of treatment" = "treatment" under the HCCA. Para 82: "... where an incapable patient has expressed a prior wish... the intended meaning and scope of the wish must be carefully considered... The question is whether, when the wish was expressed, the patient intended its application in the circumstances that the patient now faces... Changes in the patient's condition, prognosis, and treatment options may all bear on the applicability of a prior wish."]

McLachlin C.J.C.

**G. Resolving Disagreements Over Withdrawal of Life Support**

77 Having rejected the physicians' arguments, it follows that the consent regime imposed by the HCCA applies in this case. I earlier outlined that regime. At this point, it may be useful to discuss in greater depth the role of the substitute decision-maker, health practitioners and the Board in cases like this.

**78 To recap, the HCCA [Health Care Consent Act] is a carefully tailored statute. It deals with patients capable of consent and patients who no longer have the power to consent. It seeks to maintain the value of patient autonomy — the right to decide for oneself — insofar as this is**

possible. This is reflected in the consent-based structure of the Act. If the patient is capable, she has the right to consent or refuse consent to medical treatment: s. 10(1)(a). If the patient is incapable, the HCCA transfers the right of consent to a substitute decision-maker, often next of kin (s. 10(1)(b)), who is required to act in accordance with the patient's declared applicable wishes or failing that, the patient's best interests: s. 21. Finally, it provides that a physician may challenge a substitute decision-maker's consent decision by application to the Board: ss. 35 to 37. The physician may make submissions to the Board regarding the medical condition and interests of the patient. If the Board finds that the substitute decision-maker did not comply with the HCCA, it may overrule the substitute decision-maker and substitute its own opinion in accordance with the statute: s. 37(3). To be clear, this means that, even in life-ending situations, the Board may require that consent to withdrawal of life support be granted.

79 Under the HCCA, the substitute decision-maker does not have *carte blanche* to give or refuse consent. He or she must comply with the requirements of s. 21 of the Act, which contemplates two situations. The first is where the substitute decision-maker knows of a prior expressed wish by the patient which is applicable to the circumstances. The second is where there is no such wish, in which case the substitute decision-maker "shall act in the incapable person's best interests".

#### **(1) Prior Expressed Wishes**

80 If the substitute decision-maker knows of a prior wish regarding treatment that the patient expressed when capable and over 16 years old, and that is applicable in the circumstances, the wish must be followed: s. 21(1). This reflects the patient's autonomy interest, insofar as it is possible.

81 While the HCCA gives primacy to the prior wishes of the patient, such wishes are only binding if they are applicable to the patient's current circumstances. This qualification is no mere technicality. As the Ontario Court of Appeal held in *Conway v. Jacques* (2002), 59 O.R. (3d) 737 (Ont. C.A.), at para. 31:

... prior capable wishes are not to be applied mechanically or literally without regard to relevant changes in circumstances. Even wishes expressed in categorical or absolute terms must be interpreted in light of the circumstances prevailing at the time the wish was expressed.

82 Needless to say, where an incapable patient has expressed a prior wish that life support not be withdrawn, the intended meaning and scope of the wish must be carefully considered: see Fleming, at p. 94. The question is whether, when the wish was expressed, the patient intended its application in the circumstances that the patient now faces: see *Conway*, at para. 33; *Scardoni*, at para. 74. Changes in the patient's condition, prognosis, and treatment options may all bear on the applicability of

a prior wish: Conway, at paras. 37-38. For example, had Mr. Rasouli expressed a prior wish regarding life support, his substitute decision-maker would have to consider whether, when the wish was expressed, Mr. Rasouli intended the wish to apply if he were in a permanent vegetative state, with recovery extremely improbable according to medical evidence, and facing the health complications associated with long-term provision of life support.

83 A prior wish need not identify every possible future development in order to be applicable: Scardoni, at para. 74; S. (K.M.), Re [2007 CarswellOnt 4883 (Ont. Cons. & Capacity Bd.)], 2007 CanLII 29956. However, a wish that is unclear, vague, or lacks precision may be held inapplicable to the circumstances. On this basis, the Board has found there were no prior wishes relating to life support<sup>P</sup> applicable to the existing circumstances in numerous cases: D. (D.), Re [2013 CarswellOnt 4211 (Ont. Cons. & Capacity Bd.)], 2013 CanLII 18799; P. (D.), Re [2010 CarswellOnt 7848 (Ont. Cons. & Capacity Bd.)]; B. (E.), Re [2007 CarswellOnt 745 (Ont. Cons. & Capacity Bd.)], 2006 CanLII 46624; G, Re; E., Re [2009 CarswellOnt 3258 (Ont. Cons. & Capacity Bd.)], 2009 CanLII 28625; J. (H.), Re [2003 CarswellOnt 8244 (Ont. Cons. & Capacity Bd.)], 2003 CanLII 49837. I have been unable to locate any case in which there was a prior expressed wish opposing withdrawal of life support that was held to be applicable and therefore binding in the circumstances.

**84 If it is unclear whether a prior wish is applicable, the substitute decision-maker or physician may seek directions from the Board: s. 35. Alternately, if the substitute decision-maker acts on a prior wish that the physician believes is not applicable, the physician may challenge the consent decision before the Board: s. 37. The physician's submissions on the patient's condition, prognosis, and any adverse effects of maintaining life support will be relevant to the Board's assessment of applicability.**

85 In addition, either the substitute decision-maker or physician may apply to the Board for permission to depart from prior wishes to refuse treatment: s. 36. The Board may grant permission where it is satisfied that the incapable person, if capable, would probably give consent because of improvement in the likely result of the treatment since the wish was expressed: s. 36(3).

86 I note that the HCCA also provides that the substitute decision-maker is not required to comply with an expressed prior wish if "it is impossible to comply with the wish": s. 21(1)2. This is not raised on the facts of this appeal, and I consider it no further.

## **(2) The Best Interests of the Patient**

**87 If the substitute decision-maker is not aware of an expressed prior wish of the patient or if the wish is not applicable to the circumstances, the substitute decision-maker must make her consent decision based on the best interests of the patient, according to the criteria set out in s. 21(2). These criteria include the medical implications of treatment for the patient, the patient's well-being, the patient's values, and any prior expressed wishes that were not binding on the substitute decision-**

maker. This legislative articulation of the best interests of the patient aims at advancing the values that underpin the HCCA: enhancing patient autonomy and ensuring appropriate medical treatment.

**88** The substitute decision-maker is not at liberty to ignore any of the factors within the best interests analysis, or substitute her own view as to what is in the best interests of the patient. She must take an objective view of the matter, having regard to all the factors set out, and decide accordingly. This is clear from the mandatory wording of the opening portion of s. 21(2): the decision-maker “shall take into consideration” the listed factors. The need for an objective inquiry based on the listed factors is reinforced by s. 37, which allows the decision of the substitute decision-maker to be challenged by the attending physician and set aside by the Board, if the decision-maker did not comply with s. 21. The intent of the statute is to obtain a decision that, viewed objectively, is in the best interests of the incapable person.

**89** The first consideration under s. 21(2), heavily relied on by Ms. Salasel in this case, concerns the values and beliefs of the incapable person. Section 21(2)(a) provides that the substitute decision-maker must consider the values and beliefs that the incapable person held when capable and that the substitute decision-maker believes that the incapable person would still act on if capable. Here, Ms. Salasel argues that sustaining life as long as possible accords with the religious beliefs of Mr. Rasouli, and that as a result he would not have consented to the removal of life support.

**90** The second consideration relates to known wishes of the incapable person that were not binding on the substitute decision-maker under s. 21(1)1. For example, wishes expressed when a person was under the age of 16 or when incapable do not bind a substitute decision-maker, but must be taken into consideration in this stage of the best interests analysis.

**91** Third, in addition to considering the values and beliefs of the patient and any relevant wishes, s. 21(2)(c) requires that the substitute decision-maker consider four factors that relate to the impact of the treatment on the patient’s condition, well-being, and health. This stage of the best interests analysis focuses on the medical implications of the proposed treatment for the patient. The attending physician’s view of what would medically benefit the patient must be taken into account.

**92** The first factor asks whether receiving the treatment is likely to improve the patient’s condition or well-being, prevent deterioration of the person’s condition or well-being, or reduce the extent or rate of the deterioration of the person’s condition or well-being: s. 21(2)(c)1. In this case, the inquiry must determine whether removing life support would improve, prevent deterioration of, or reduce the extent or rate of deterioration of, Mr. Rasouli’s condition or well-being. The physicians argue that artificially prolonging Mr. Rasouli’s life will lead to health complications such as bedsores, respiratory infections, and organ failure — a scenario that can be avoided if life support is removed. On the other hand, Ms. Salasel argues that

new evidence and evaluation suggest that Mr. Rasouli's condition may improve in the future, militating against removal of life support.

**93** The second factor requires the substitute decision-maker to consider whether, in the absence of the proposed treatment, the incapable person's condition or well-being is likely to improve, remain the same or deteriorate: s. 21(2)(c)2. In this case, the inquiry is into the likely medical outcomes for Mr. Rasouli if life support is not withdrawn. The decision-maker must cast her mind into the future and ask what the patient's condition will be in one year, five years, or ten years.

**94** The third factor requires the substitute decision-maker to consider risks of harm associated with the treatment and weigh whether the benefits from the treatment will outweigh those risks: s. 21(2)(c)3. This factor is particularly important in cases where the substitute decision-maker must decide whether to go ahead with a risky procedure, like high-risk surgery, that while offering some hope, could worsen the patient's situation. In this case, the substitute decision-maker must consider the benefits of removing life support, such as avoidance of protracted physical deterioration from bedsores, infections and organ deterioration ultimately leading to death, against the risks, which quite plainly are the hastening of death and the loss of whatever chance of recovery Mr. Rasouli has according to medical evidence.

**95** The fourth factor requires the substitute decision-maker to consider alternative courses of treatment — whether less intrusive or restrictive treatment would be as beneficial as the treatment proposed: s. 21(2)(c)4. In a case such as this, the question is whether maintaining life support would be less intrusive or restrictive than its withdrawal, and if so, whether maintaining life support would be more beneficial to the patient than withdrawal.

**96** As I see it, this review of s. 21(2) reveals that although a patient's beliefs and prior expressed wishes are mandatory considerations, there is no doubt that the medical implications of a proposed treatment will bear significant weight in the analysis.

**97** Where physicians and substitute decision-makers disagree about whether withdrawal of life support would be in the best interests of the patient, the HCCA provides the procedure for resolving this conflict. Under s. 37, the health care practitioner may apply to the Board to have the decision of the substitute decision-maker set aside on the ground that it is not in the best interests of the incapable person, having regard to the factors set out in s. 21(2) of the Act. This is an important avenue of recourse for physicians who believe that life support can no longer be ethically administered because it is not in the best interests of the patient to do so. The Board must duly consider the physician's professional opinion and submissions on what would be of medical benefit to the patient.

98 If the Board agrees that the substitute decision-maker did not act in the best interests of the patient, it may substitute its own opinion for that of the substitute decision-maker: s. 37(3). Alternatively, if the Board concludes that the substitute decision-maker did act in the best interests of the patient, it can affirm the decision of the substitute decision-maker. In making these determinations, the Board must objectively apply the same criteria that substitute decision-makers are required to consider under s. 21. The Board is well placed to make a determination of whether treatment is in the best interests of the patient, in light of the statutory objectives of enhancing patient autonomy and ensuring appropriate medical care. This was observed by the Ontario Court of Appeal in *M. (A.) v. Benes* (1999), 46 O.R. (3d) 271 (Ont. C.A.):

A case will come before the Board only when the health practitioner disagrees with the S.D.M.'s application of the best interests test under s. 21(2). The Board will then have before it two parties who disagree about the application of s. 21: the S.D.M., who may have better knowledge than the health practitioner about the incapable person's values, beliefs and non-binding wishes; and the health practitioner, who is the expert on the likely medical outcomes of the proposed treatment. The disagreement between the S.D.M. and the health practitioner potentially creates tension and the Act recognizes this by providing for a neutral expert board to resolve the disagreement. Indeed, after hearing submissions from all parties, the Board is likely better placed than either the S.D.M. or the health practitioner to decide what is in the incapable person's best interests. [para. 46]

**99 The Board must apply a standard of correctness in reviewing the decision of the substitute decision-maker: *Benes*, at para. 36; *Scardoni*, at para. 36.** The wording of s. 37, which provides for full representation and gives the Board the right to substitute its decision for that of the substitute decision-maker, indicates that the Board must consider the matter *de novo*. The critical nature of the interests at stake support the Board's obligation to review the decision of the substitute decision-maker on a correctness standard.

100 The legislature has given the Board the final responsibility to decide these matters. This is not to say that the courts have no role to play. Board decisions are subject to judicial review. This mechanism for court oversight ensures that the Board acts within its mandate and in accordance with the Constitution.

101 Over the past 17 years, the Board has developed a strong track record in handling precisely the issue raised in this case.

102 In some cases, the Board has upheld the decisions of substitute decision-makers to refuse withdrawal of life support as being in the best interests of the patient: *W. (D.)*, Re [2011 CarswellOnt 2312 (Ont. Cons. & Capacity Bd.)], 2011 CanLII 18217; *S. (S.)*, Re [2011 CarswellOnt 816 (Ont. Cons. & Capacity Bd.)], 2011 CanLII 5000; *P. (D.)*, Re. In others, it has reversed the decision of the substitute decision-maker and required consent to be given for the withdrawal of life support: *K. (A.)*, Re; *G. (E.J.)*, Re; *N.*, Re,

2009 CarswellOnt 4748 (Ont. Cons. & Capacity Bd.). The particular facts of each case determine whether withdrawal of life support is in the best interests of the patient.

103 Bringing its expertise to the issue, the Board's decisions may be expected to bring consistency and certainty to the application of the statute, thereby providing essential guidance to both substitute decision-makers and health care providers in this difficult area of the law.

...

## **I. Summary**

**116 I conclude that the following steps apply under the HCCA in a case such as this, where the substitute decision-maker and the medical health care providers disagree on whether life support should be discontinued.**

**1. The health practitioner determines whether in his view continuance of life support is medically indicated for the patient;**

**2. If the health practitioner determines that continuance of life support is no longer medically indicated for the patient, he advises the patient's substitute decision-maker and seeks her consent to withdraw the treatment;**

**3. The substitute decision-maker gives or refuses consent in accordance with the applicable prior wishes of the incapable person, or in the absence of such wishes on the basis of the best interests of the patient, having regard to the specified factors in s. 21(2) of the HCCA;**

**4. If the substitute decision-maker consents, the health practitioner withdraws life support;**

**5. If the substitute decision-maker refuses consent to withdrawal of life support, the health practitioner may challenge the substitute decision-maker's refusal by applying to the Consent and Capacity Board: s. 37;**

**6. If the Board finds that the refusal to provide consent to the withdrawal of life support was not in accordance with the requirements of the HCCA, it may substitute its own decision for that of the substitute decision-maker, and permit withdrawal of life support.**

## **III. Conclusion**

117 Applying the HCCA in the manner just discussed, we arrive at the following conclusions.

118 The appellant physicians, having determined that in their view Mr. Rasouli should be removed from life support, were obliged to seek Ms. Salasel's consent to the withdrawal. Since Mr. Rasouli had not expressed a wish within the meaning of s. 21(1)1, Ms. Salasel was required to determine



whether removal of life support was in Mr. Rasouli's best interests, having regard to the factors set out in s. 21(2) of the Act.

119 If the appellant physicians do not agree that maintaining life support for Mr. Rasouli is in his best interests, their recourse is to apply to the Board for a determination as provided by s. 37(1) of the HCCA.

120 When the application is brought, it will be for the Board to determine whether Ms. Salasel's refusal to provide consent to the withdrawal of life support was in Mr. Rasouli's best interests, within the meaning of s. 21(2) of the HCCA. If the Board is of the opinion it was not, it may substitute its decision for that of Ms. Salasel, and clear the way for removal of Mr. Rasouli's life support.

121 It follows that I would dismiss the appeal. I would also dismiss the motions to adduce fresh evidence on the appeal to this Court, without prejudice to the Board receiving any evidence it deems relevant on the hearing before it.

122 This being a matter of public interest, I would not award costs.

### ***Discussion Questions re religious beliefs and end of life decision-making:***

1. A patient has appointed her daughter as the SDM. The doctors review the patient's situation and conclude she is in extremis, in a lot of pain, and does not have long to live. They suggest a DNR; the daughter refuses "Mum always believed 'where there is life there is hope.' How to resolve the situation?"

2. A patient is on ventilator. The doctors say no chance to recover, and that the patient is brain dead. The doctors advise that the patient is in extreme pain and will be taken off the ventilator. The SDM contends the patient's faith dictates that death must be based on cardiac criteria only – the heart has stopped beating with cessation of circulatory and respiratory function.

## **7. Property Management**

### **Palichuk v. Palichuk 2023 ONCA 116 (Ont. C.A.).**

As set out in Section 32 of the *Substitute Decisions Act*, an Attorney for Property has a *fiduciary duty* to the donor of such a legal instrument who is incapable of making such decisions.

There are a number of fundamental principles to follow in managing an incapable person's property. These include:

- The attorney must keep accurate statements of account in respect of your dealings with the incapable's property and retain all receipts, bank and investment statements, and all other relevant documentation. It may be that the Attorney must

“pass his/her accounts” in court at some point including the ability of the Ontario Public Guardian and Trustee to participate in such proceedings as well as ask questions of you with respect to the management of the incapable’s assets.

- The attorney is entitled to hire professional advisers, as is reasonable, such as lawyers, accountants, and investments advisors to provide specialized services.
- The attorney must manage the incapable’s property in his/her best interests. This means that the Attorney may not use her assets for any other purpose, and certainly not for the attorney’s own benefit.
- The attorney must invest the incapable’s property prudently.
- **The attorney not make, or defeat, the incapable’s Will. This means the attorney must locate and review her existing Will, and preserve specific property that is to pass under her Will unless it is necessary to sell such property to make available cash to be used in the incapable’s best interests.**
- The attorney not change beneficiary designations respecting policies of life insurance owned by the incapable on his/her life, or in relation to his/her RRSPs/RRIFs, or any other such financial product which will pass to a designated beneficiary after her death.
- There is a limited power to make gifts using the incapable’s property.

Trotter J.A.:

**[68] In the case of Duke of Marlborough v. Lord Godolphin (1750), Ves. Sen. 61, 28 E.R. 41 (H.C. of Ch.), Lord Hardwicke L.C. remarked that the testamentary document of a living person is nothing more than a piece of waste paper, at p. 50: “[T]he law says, that a testamentary act is only inchoate during the life of the testator, from whose death only it receives perfection: being till then ambulatory and mutable, vesting nothing, like a piece of waste paper.” This decision has been cited in other cases for the proposition that a will only speaks from the moment of death: see Y.P. v. M.L.S., 2006 MBCA 32, 205 Man R (2d) 20, at para. 19; S.A. (Trustee of) v. M.S., 2005 ABQB 549, 18 E.T.R. (3d) 1 at para. 28.**

[69] There are a couple of Superior Court of Justice decisions that involve a review of the validity of a trust or will during the grantor or testator’s lifetime. See, e.g. Brandon v. Brandon, [2001] O.J. No. 2986, which was upheld by this court in brief reasons, see Brandon v. Brandon, [2003] O.J. No. 4593, and Rubner v. Bistricher, 2018 ONSC 1934, 36 E.T.R. (4th) 79. Neither case involved a direct challenge to the trust or to the will. Instead, the question of the validity of these instruments was incidental to another dispute. The Brandon case was primarily an action to enforce a mortgage, with a counterclaim to discharge the mortgage and declare an inter vivos trust invalid due to undue influence. In Rubner, the validity of a

will was directly relevant to the current management of property by joint attorneys for property for the incapable person.

**[70] Another Superior Court of Justice decision, Dempster v. Dempster, 2008 CanLII 2747 (Ont. S.C), cites Brandon in suggesting at para. 9. that the law in Ontario “may well be moving towards” permitting claims of undue influence where a testator remains alive. Given the incidental nature of the validity issue in Brandon, I disagree with this portent. I also disagree with the suggestion that Cullity J.’s comment at para. 28 of Stern v. Stern, (2003) 49 E.T.R. (2d) 129 (Ont. S.C), is intended to open the door to will challenges during the testator’s life:**

**The court should not, I think, close its eyes to the fact that litigation among expectant heirs is no longer deferred as a matter of course until the death of an incapable person. While, in law, the beneficiaries under a will, or an intestacy, of an elderly incapable person obtain no interest in that person’s property until his, or her, death, the reality is that very often their expectant interests can only be defeated by the disappearance, or dissipation, of such property before the death.**

**I read this quote consistently with the two cases discussed above: litigation among expectant heirs may occur before death when a present dispute comes before the court. Practically, there will be some cases in which the validity of a will, trust or transfer incidentally comes into play. This does not mean that it is either necessary or desirable for the law to permit direct challenges to these instruments during the grantor or testator’s life.**

[71] To the contrary, there are strong public policy reasons not to permit a challenge to a will prior to the death of a testator. A testator may change their will as often as they like. It is entirely unknown how much, if any, money or property there will be left to dispute until the testator dies. It cannot be known if any of the beneficiaries will have predeceased the testator. Thus, the common law insists upon the death of the testator before litigation. Otherwise, the courts would be inundated with litigation that is hypothetical during the lifetime of the testator, with the potential for re-litigation after their death.

[72] The application judge was aware of the problems associated with considering the validity of the will and the property transfer in the circumstances. As he said at para. 126 of his reasons:

It is less obvious that I need to assess Nina’s testamentary capacity or her capacity to transfer the Acton property to Susan, when Nina is alive and these instruments are executory. However, if Nina did not have the requisite capacity, and if she was not expected to regain capacity, it might be open to Linda to challenge the validity of the Will at this time. In that case, the issue of the validity of the Will and property transfer might not be premature or hypothetical.

Nonetheless, although the application judge refused to consider undue influence in relation to these instruments, he did determine Nina's capacity.

[73] The application judge should not have provided his "opinion, advice or direction" on either basis because there is every possibility that Nina may decide to reorganize her affairs. As Dr. Shulman reported in his assessment report, Nina said that her will was not "written in stone". Nina said she might change it if Linda treats her better.

[74] As for the transfer of the Acton property, Susan has no beneficial interest in the property. She simply holds it in trust for Nina. Even absent the trust agreement, since the transfer was gratuitous, the law presumes that Susan holds the property in trust for Nina. In *Foley v. McIntyre*, 2015 ONCA 382, 125 O.R. (3d) 721, Juriansz J.A. said, at para. 26: "Equity presumes bargains, not gifts. Thus, when a parent gratuitously transfers property to an adult child, the law presumes that the child holds the property in a resulting trust for the parent: *Pecore v. Pecore*, 2007 SCC 17, [2007] 1 S.C.R. 795, at para. 36".

[75] For all these reasons, the application judge should not have provided his "opinion, advice, and direction" on the validity of the transfer and settlement of the trust as part of Nina's estate planning. As the application judge said, at para. 161: "...the transfer of the Acton property might properly be treated as testamentary. Because