Court of Queen's Bench of Alberta

Citation: Chalifoux v Alberta Health Services, 2014 ABQB 624

Date: 20141103
Docket: 1403 10042
Registry: Edmonton

Between:

Roseanne Chalifoux

Applicant

- and -

Alberta Health Services, Stollery Children's Hospital and Dr. Jazer Tyebkhan

Respondents

Reasons for Judgment
of the
Honourable Madam Justice D.A. Yungwirth

Introduction

[1] This decision was delivered orally on August 18, 2014 and may differ slightly from the oral decision.

[2] This is an application by Roseanne Chalifoux, for a 90 day injunction to prevent any medical professional from removing the mechanical ventilation support for her child, Ava Alayla Chalifoux-Campiou, born May 2014, to allow her to obtain an independent medical opinion about the child's condition and prognosis and determine further options regarding the child's care. She asks that the injunction be reviewed after 90 days.

[3] Throughout my decision, I will refer to the child as "Ava", though in some of the medical reports and notes, she is referred to as Alayla.

[4] Ms. Chalifoux's application was filed after she received a letter from Ava's treating physician on July 8, 2014, advising her that on July 10, 2014, Ava would be removed from her mechanical ventilator.

[5] Ms. Chalifoux's application was originally going to be heard on July 9, 2014 but the parties agreed to adjourn it to July 22, 2014. On July 22, 2014, the matter came before Gill, J who adjourned the application to August 14, 2014 to allow for the provision of the results of an independent medical assessment to be obtained by Ms. Chalifoux, or, in the alternative, for directions with respect to the completion of an independent medical assessment.

[6] Ms. Chalifoux's independent medical opinion was provided to her Counsel late on August 13, 2014. When the matter came before the Court on August 14, Ms. Chalifoux had not yet had a chance to review it with her Counsel, nor had she had an opportunity to review a second Affidavit filed by Dr. Aziz on August 11, 2014, which Affidavit contains a detailed clinical plan for palliative care for Ava.

[7] Therefore, though Counsel concluded their submissions for the application on the afternoon of August 14, 2014, the decision was reserved until August 18, 2014 to allow Ms. Chalifoux the opportunity to complete her review with Counsel, of her independent medical opinion and the proposed palliative care plan, and to give Ms. Chalifoux the opportunity to further reflect, perhaps in consultation with Ava's father and members of her family, on what was in Ava's best interests.

[8] Ava's father, Paul Girard Campiou is not a party to the application, though he is a guardian of Ava. It is not indicated on the Order that he was present when the matter came before Gill, J on July 22. He was not present when the matter came before the Court on August 14, 2014, nor did Counsel appear on his behalf. The Court was advised that he was provided with notice of the application through his mother. During the course of the application, it was indicated by Counsel from the Family Law Office, that she had spoken to Mr. Campiou by phone during the application, that he supported Ms. Chalifoux's position and that he was looking into getting a lawyer.

Positions of the Parties

[9] The Respondents take the position that it is in Ava's best interests to discontinue mechanical ventilation support and to provide palliative care and comfort measures for her until she passes away. They are of the view that it is ethically inappropriate to force continued intensive care interventions on Ava, who has a terminal condition with no known cure. They point out that intensive care requires multiple medical and nursing interventions some of which have painful or distressing complications or require repeated painful or uncomfortable procedures or diagnostic tests. They believe that every additional day that Ava is on mechanical ventilation adds to her suffering, places her at risk from potentially uncomfortable and distressing complications of intensive care, and that such mechanical ventilation places her at risk of having to undergo further procedures that would increase her discomfort and distress.

[10] The Respondent doctors, who are Ava's treating physicians, submit that the issue on this application is whether this Court should order Ava's physicians to provide active treatment and mechanical ventilation against their professional and ethical judgment.

[11] Ms. Chalifoux does not want the mechanical ventilation discontinued. Though not in her Affidavit, she indicated during the application that she considers her daughter to be a fighter.

Issues

1. Is it appropriate for an injunction to be granted in this case?
2. If an injunction is not granted, is it appropriate for Ava's physicians to proceed with the removal of mechanical ventilation and the proposed palliative care plan for Ava in the absence of the consent of Ava's guardians?

Analysis

[12] All parties agree that the appropriate test to apply in an application for an injunction in these circumstances, is that of best interests of the patient. This test has been adopted in several Alberta cases, including ***Sweiss v Alberta Health Services***, 2009 ABQB 691, ***May v Alberta Health Services***, 2010 ABQB 213**,** ***IHV Estate (Re)***, 2008 ABQB 250, and most recently in the case of ***Alberta (Child, Youth, and Family Enhancement Act, Director) v DL***, 2012 ABQB 562.

[13] In considering what is in the best interests of the patient, Ouellette, J in the ***Sweiss*** case, specified that several matters should be considered and weighed. He listed the following pertinent considerations:

1. The medical condition of the patient;
2. The recommended medical treatment;
3. The wishes and beliefs of the patient, if they are known; and
4. What is just and equitable in all of the circumstances.

[14] This list is not intended to be exhaustive. It was Ouellette, J's view that no one factor is to be considered paramount and that all considerations ought to receive equal weight. He rejected the approach taken in ***IHV***, that the recommended course of treatment is a consideration which trumps all others.

[15] I note that in the ***Alberta v DL*** case, Ross, J put less weight on the decision of the parents, due to the fact that they were in a conflict of interest and because, due to their incarceration and the restrictions of the criminal justice system, they had not been involved in their child's care on a day to day basis. They were therefore not as informed about her condition or as able to appreciate her best interests as they would have been if the circumstances had been different.

[16] Accordingly, an approach which safeguards the interests of the patient and permits the best use of the Court's discretion appears to be one where the determination of whether or not there are any additional factors and the weight to be given to each factor should depend on the circumstances of each case. This is consistent with an approach that sees no factor as paramount and is in keeping with the Court's obligation to thoroughly consider all applicable factors in coming to a reasoned decision.

[17] I turn now to an analysis of the above considerations in Ava's case.

Ava's Medical Condition

[18] Ava was born with thanatophoric dyplasia, which is a lethal form of skeletal dyplasia, also known as thanatophoric dwarfism. This diagnosis was confirmed with genetic testing shorty

following Ava's birth. Her condition is the result of genetics and is not due to anything done by either of her parents.

[19] The poor growth of bones in her body has prevented and will prevent Ava's chest from being able to grow to accommodate her lungs, and she cannot breathe effectively without mechanical support. Thanatophoric dysplasia is a condition that affects all the bones in the body, including the skull and spine, which may compress the brainstem and spinal cord over time. It essentially prohibits the lungs and brain from developing.

[20] Ava required intensive resuscitation and support for the first few days of her life. Since then she has continued to require respiratory support by intubation and ventilation by a mechanical ventilator.

[21] Ava is currently mechanically ventilated through a breathing tube placed into her windpipe through her mouth. This causes her discomfort and increased secretions in the mouth and windpipe, which are managed by frequent suctioning. The discomfort caused by the tube is also managed by morphine that suppresses Ava's urge to cough, as well as the sensation of breathlessness.

[22] Among other interventions, Ava has been medicated with morphine for the reduction of pain, medication to prevent seizures, acetaminophen for discomfort, and antibiotics for the treatment of fever and suspected infection.

[23] Ava is fed formula via feeding tube inserted through her nose or mouth, but in order to confirm that she is receiving this nutrition and that the feeding tube is properly placed, the contents of her stomach must be regularly aspirated.

[24] Nurse practitioners and registered nurses have provided 24 hour a day care for Ava since her birth and have provided Ava with most of her human contact.

[25] The staff notes from Ava's chart indicate that she is, at times, apparently in pain. They indicate that she is at times unsettled, displays painful face expressions and has a silent cry. The July 19-20, 2014 notes indicate that Ava's morphine dose was increased after she was unsettled and crying for almost two hours continuously.

[26] Ava's condition is lethal. It is a condition from which she cannot recover. She is being kept alive by machines. She must be sedated because of the discomfort of the breathing tube in her throat, and she is subject to ongoing medical and nursing interventions, some of which have painful or distressing complications or require repeated painful or uncomfortable procedures or diagnostic tests. Based on the feedback from the nurses who have been responsible for her care since birth, it is likely that Ava is in pain and is suffering.

[27] One of Ava's treating physicians, Dr. Khalid Aziz, indicates that Ava is unlikely to survive very long without the continuous intensive care intervention.

[28] Dr. Anne Tierney, the consultant neonatologist retained by Ms. Chalifoux also says that it is very unlikely that Ava would be able to support her own ventilation and oxygenation if the endotracheal tube were removed.

[29] If the breathing tube is removed, it is possible that Ava will continue to breathe on her own for some period of time. If she does not, the medical opinion is that it would not be in her best interests to be re-intubated. If she does continue to breathe on her own, it is expected that

one or more of the complications that almost always leads to the death of children born with this condition, would then set in.

[30] Ava is not in a vegetative state, nor is there any evidence that she is brain dead. There is an indication in the notes that she opened her eyes on July 11 in response to her mother's voice. According to the consultation report dated July 26, 2014 from Dr. Michael Van Manen, Ava responds to sound, light, and touch with facial movements and a conjugate gaze. Dr. Goldsand's letter of July 8, 2014 indicates that Ava is often awake and responsive.

[31] As part of the consultation report of Dr. Michael Van Manen, and referenced in the independent medical report of Dr. Tierney, there is an indication that aggressive medical interventions have led to few reported long-term survivors. Dr. Van Manen indicates the following in the last paragraph of his report:

[32] "Given the high morbidity of medical therapies necessary to try to achieve survival and the severe disability reported in survivors, it would certainly be appropriate to shift the goals of therapy for Alayla to comfort care. In other words, it is reasonable to pursue palliative care. Alternatively, if complex medical therapies are to be considered for Alayla such as long-term ventilation with tracheostomy (which I am not advocating for), such decisions should not be done as the "default" to merely sustain life from a vitalistic perspective. Instead, decision making for Alayla must be guided by consideration for what is in her "best interest" by those who are and who will be caring for her."

The Recommended Medical Treatment

[33] Ava's care has been the subject of much consultation and discussion between several neonatologists, a pediatric genetics specialist, and a clinical ethicist. There have also been registered nurses, nurse practitioners, social workers, and an Aboriginal Cultural Helper involved with Ava's case. Ms. Chalifoux has now obtained her own independent medical opinion from another neonatologist, Dr. Tierney.

[34] Without exception, all doctors, including the ethicist, and including Dr. Tierney, are of the view that it is in Ava's best interests to take her off of the mechanical ventilator. They maintain that the current invasive treatment provides no benefit to Ava.

[35] All physicians, including the physician retained by Ms. Chalifoux, agree that long term ventilator support with no hope of any improvement or recovery is not in Ava's best interests and that the focus should be on changing Ava's care to comfort and palliation. An essential part of this change is to remove the endotracheal tube and ventilator support. This is thought to be the kindest and most appropriate care for a child in Ava's situation.

[36] Dr. Aziz recommends palliative care and comfort measures as the correct treatment for Ava. He maintains that it is ethically inappropriate to force continued intensive care interventions on Ava. He proposes that Ava should be removed from the mechanical ventilation with the understanding that if Ava is unable to breathe on her own, she would not be re-intubated. He says that once Ava is off the mechanical ventilator, and if she is able to breathe on her own, there would be consideration given to providing her oxygen or "non-invasive" ventilation with gas blown into her nose, known as "CPAP" or "high flow". It is not known if or for how long Ava would be able to breathe on her own, but Dr. Aziz says that it is likely that Ava's respiratory status will deteriorate. He says that the increasing respiratory distress could be managed with

medication and comfort care. Ava would continue to be fed by tube, but she is at risk for regurgitation of her feeds and aspiration of stomach contents which would injure her lungs.

[37] Dr. Davies, who specializes in palliative care and was consulted about Ava's care, indicated that in the absence of any benefit and in the absence of a realistic goal for treatment, continued intubation requiring sedation which is precluding Ava's natural death, is harmful to her.

The Wishes and Beliefs of the Patient, if they are known

[38] Ava's wishes and beliefs cannot be determined. As her guardians, Ava's parents are entitled to be informed of and consulted about and to make all significant decisions affecting Ava in the exercise of the powers, responsibilities and entitlements of guardianship: s 21(4)(a) of the *Family Law Act*, RSA 2003, Chapter F-4.5 ("*FLA*"). It is therefore appropriate that their wishes and beliefs be considered. Ms. Chalifoux's wish is that Ava not be removed from the mechanical ventilator. Ava's father, Mr. Campiou, supports this. Ms. Chalifoux has not provided any explanation for why she feels it is in Ava's best interests to be maintained on mechanical ventilation. It is reasonable to assume that she wants Ava to stay alive, but in all of the circumstances, there is no evidence that forcing the interventions required to keep Ava alive is in her best interests. The opposite appears to be true.

[39] In considering the wishes of Ms. Chalifoux, it is important to examine the extent to which she has been involved in Ava's care and in engaging with Ava's medical team. This was an important consideration for Ross, J in the ***Alberta v DL*** case because she felt that if the parents were not informed and involved with the child's care, they would be less able to appreciate the child's best interests.

[40] After discharging herself from the hospital on May 22, 2014, Ms. Chalifoux visited Ava on 5 days in May, 8 days in June, 11 days in July (to July 22) and usually for only one hour at a time. Ms. Chalifoux was incarcerated between June 30 and July 8, and she is currently in custody, but it is unclear when she went back into custody. There is also some indication that she has been permitted to visit with Ava notwithstanding that she is in custody – a recent visit having occurred on August 8, 2014.

[41] As of July 22, 2014, Mr. Campiou had visited Ava once on May 25 and once on June 12 – each time for less than one hour.

[42] The evidence is that there were meetings by medical staff with Ms. Chalifoux on June 5, and on June 9, and on June 11. There was a meeting with both parents on June 12. In all of these meetings, Ava's condition was explained along with the recommendations of Ava's doctors that it is in Ava's best interests for the mechanical ventilator to be removed and for palliative care to be provided. On June 12, after Mr. Campiou requested time to allow his family to attend and for a traditional blessing to occur, plans were made to remove Ava's breathing tube on June 16, 2014. Unfortunately, no family visit or traditional blessing occurred and on June 16, neither parent attended. A message was left by Ms. Chalifoux requesting that nothing should be done until she was there. On June 17, Mr. Campiou advised hospital staff by phone that "no one was going to do anything to the baby without our permission". From that point forward, ongoing efforts to communicate with and engage Ava's parents were unsuccessful. Finally, on June 27, 2014, a letter was prepared advising both parents that Ava would be removed from the

mechanical ventilator on July 3, 2014. This letter, with the date for extubation having been changed to July 4, 2014, was given to Ms. Chalifoux on July 1, 2014. Efforts were made to find Mr. Campiou and eventually it was determined that his mother was in contact with him. On July 7, 2014 the letter was revised to indicate that the ventilator would be removed on July 10, 2014. Arrangements were made to give the letter to Mr. Campiou through his mother. Ms. Chalifoux received the letter with the revised July 10 date, on July 8, 2014. She retained Counsel on July 9 and on July 10, 900 pages of hospital NICU records of treatment were provided to her Counsel and have since been updated weekly.

[43] There was a meeting between Dr. Aziz and Ms. Chalifoux on July 21, 2014. The notes from July 21, 2014, indicate that Ms. Chalifoux told Dr. Aziz that she could not bring herself to decide to stop intensive (ventilator) care and that she was hoping for a miracle. She also indicated that she did not want to become attached to Ava.

[44] According to Dr. Aziz, discussing care for Ava with her parents has been a challenge for her physicians and the health care team as the parents often were not in attendance, or could not be found.

[45] According to Dr. Van Manen, one of the consulting physicians, he attempted to contact the parents multiple times using the available contact information, with no success.

[46] Dr. Goldsand, the ethicist, indicated in his June 23, 2014 report that Ms. Chalifoux and Mr. Campiou have only rarely been at the baby's beside in the month that she has been alive, which is preventing normal lines of communication from operating. He points out that these lines of communication are particularly important in a critical care setting that strives towards shared decision making for patients – shared among parents and family, staff and physicians, based on wishes of parents and best interests of children. He says that if parents are absent and unreachable, it becomes impossible to make proper decisions in a timely fashion, as the baby's condition evolves.

[47] Dr. Goldsand was of the view on June 23, 2014, that in order to respect the baby's personhood, she needs to have someone who can represent her wishes and interests in the health care setting. If the parents are unable to engage the team in care planning, he suggested that steps should be taken to formally remove them from decision making, so that a palliative care plan could be implemented.

[48] In his July 8, 2014 report, Dr. Goldsand notes the following:

> "It is generally accepted, in clinical practice, that patients with terminal conditions are best cared for when a reasonable balance is struck between enabling decent quality of life over one's final hours, days, and weeks, while not prolonging suffering with life sustaining treatments that detract from quality of life, and thus become harmful."

[49] In the same report, Dr. Goldsand says that as time passes, it becomes more and more likely that the NICU interventions are actually prolonging suffering rather than helping Ava. He says that at this point (July 8), each passing week increases the sense that this is unreasonable prolongation, rather that respectful treatment.

[50] In the last paragraph of his July 8, 2014 report, Dr. Goldsand states the following:

> "We respect Ava's autonomy by providing her with decision-makers who are able to make reasonable decisions for her. They need to be able to understand and address the

> question of whether her goals are curative or palliative, and then to understand the details of what each of those paths would mean. Assuming they are able to understand, it follows equally that Ava's surrogates then need to engage with the clinical team in order to discuss options, and inform themselves, so they can participate in a shared decision making process. If her parent-surrogates are unavailable to engage, repeatedly and consistently, we need to find a way to assign someone else to fulfill this role (without delay). Respecting Ava's autonomy requires us to have a proper decision making team in place. The NICU physicians and staff have been trying hard to establish this for her, for weeks."

[51] In considering the wishes of Ms. Chalifoux, It is also appropriate to consider her personal circumstances to see if there are any other factors that might impede her ability to make a decision about what is in Ava's best interests.

[52] Ms. Chalifoux and Mr. Campiou are separated at this time. They have other children together. Four of these children are being cared for by Mr. Campiou's mother. According to Counsel, Ms. Chalifoux had a stillbirth in 2013 and a baby who died from Sudden Infant Death Syndrome in 2012. These events have no doubt had a significant impact on Ms. Chalifoux. Mr. Campiou also suffered the death of another daughter since Ava was born.

[53] According to Dr. Goldsand as of June 10, 2014, Ms. Chalifoux "does not want or plan to be the central decision maker, and she clearly accepted the news and opinions given to her." Dr. Goldsand described Ms. Chalifoux as "fragile and grief-stricken".

[54] During the application, Counsel for Ms. Chalifoux indicated that she was in the Remand Centre and that there was an expectation that her matters would be dealt with in court on August 27, 2014. It was also the expectation that Ms. Chalifoux would be out of custody on that day.

[55] It was indicated by Counsel for Ms. Chalifoux that Ms. Chalifoux acknowledged that she would need help caring for Ava and that there are eight family members from the Driftpile First Nation who are willing to visit with Ava and provide Ms. Chalifoux with support in this regard. I note that to date, no such support has been provided.

[56] In a further Affidavit sworn by Dr. Aziz on August 17, 2014, he deposed that if Ava's extended family can now be involved in her care, the treating physicians will consider the fact of her family's involvement and her family's ability and willingness to be present when Ava's mechanical ventilation is withdrawn, to be important factors in deciding when it would be in Ava's best interests for the withdrawal of ventilation to occur.

[57] Although the wishes of Ms. Chalifoux and Mr. Campiou must be considered, I conclude that their ability to make decisions that are in Ava's best interests has been compromised for several reasons. The primary reason for Mr. Campiou is his absence most of the time. For Ms. Chalifoux, her absence and refusal at times to engage with the physicians treating Ava, especially since June 12, 2014 are significant factors. In addition, she is also dealing with the loss of two infant children in the past two years. She has struggled with the idea of attachment to Ava and she has resisted having to make the difficult decisions related to Ava's care. Mr. Campiou has also had to deal with the death of a child very recently.

What is Just and Equitable in all of the Circumstances

[58] In addition to the above, I note that the Affidavit of Christine Westerlund, Director, Critical Care and Operative Services at the Stollery Children's Hospital, indicates that where treating physicians consider that mechanical ventilation is of no benefit to the patient and is clinically inappropriate, it puts all of the non-physician members of the NICU care team under great strain and creates great moral distress. The effect on the nursing staff, of the delays in coming to a decision about what is best for Ava, should also be considered when looking at all of the circumstances of this matter.

[59] I am also taking into account, the fact that the medical team made reasonable efforts to engage Ms. Chalifoux and Mr. Campiou in the process of determining what is in Ava's best interests and that despite those efforts, a shared decision about what is best for Ava has not been possible. The ongoing efforts to achieve this result in the face of parental absence and unwillingness or inability to engage in the process have led to ongoing delays that have unnecessarily prolonged Ava's suffering. Ava's best interests require that this matter no longer be delayed.

[60] I have also considered the view of Germain, J in the ***IHV*** case, that it is inappropriate for the courts to injunctively prescribe a course of treatment for a patient that is contrary to the unanimous view of the physicians responsible for that patient's care.

[61] I am also taking into account that an injunction would have the effect of putting Ava's treating physicians in the position of either acting in a manner that is contrary to their ethical and professional judgment, or being in contempt of a court order.

[62] After considering all of the above matters, I find that it is in Ava's best interests to refuse to grant Ms. Chalifoux's application for an injunction. I therefore dismiss Ms. Chalifoux's application for an injuction.

Analysis on Issue 2

[63] Having refused to grant the injunction, I must decide the second issue, that is, whether or not it is appropriate for Ava's physicians to proceed with the removal of mechanical ventilation and the proposed palliative care plan for Ava in the absence of the consent of Ava's guardians. I say this because I am not prepared to go as far as to confirm the position taken by the Respondents, that the responsible physicians do not require the consent of the family or the approval of a Court to withdraw or withhold treatment or to make the decision to issue a non-resuscitation direction.

[64] In this regard, the Respondents rely on the Manitoba Court of Appeal decision in the 1997 case of ***Child & Family Services of Central Manitoba v L(R)***, 1997 CarswellMan 671. In that case, the Court of Appeal concluded that neither consent nor a court order in lieu is required for a medical doctor to issue a non-resuscitation direction where, in his or her judgment, the patient is in an irreversible vegetative state. It appears that no court in Alberta has gone as far as endorsing the position taken by the Respondents in this regard.

[65] This leaves the Respondent doctors in the position of either proceeding on the basis that they believe they have the legal authority to do so, or of having to address the issue of

proceeding in the absence of the consent of Ava's guardians, which may cause further conflict, litigation and delay.

[66] As indicated above, pursuant to s 21(4) of the *Family Law Act*, Ava's guardians have the right to be informed of and consulted about and to make all significant decisions affecting Ava in the exercise of the powers, responsibilities and entitlements of guardianship.

[67] Section 21(1) of the *Family Law Act* provides that:

> "A guardian shall exercise the powers, responsibilities and entitlements of guardianship in the best interests of the child."

[68] Section 30 of the *Family Law Act* gives the Court the authority, on its own motion, to review a significant decision of a guardian. A significant decision is defined in s 30(1) as a decision that:

> (a) involves a serious risk to the health or safety of a child, or
>
> (b) is likely to have serious long-term consequences for the child.

[69] The decision of the parents to continue with the current treatment regime for Ava is likely to have serious long-term consequences for her, and as such, it is my view that it is a significant decision as defined by the legislation. The Court therefore has the authority to review it pursuant to s 30 of the *Family Law Act*.

[70] Pursuant to s 30(2), on reviewing a significant decision, whether or not it has been implemented, the court may;

> (a) confirm, reverse or vary that decision, and
>
> (b) provide advice and directions in respect of that decision.

[71] The evidence in this case, that it is in Ava's best interests that the mechanical ventilator be removed and palliative care treatment be implemented, is clear and uncontradicted. It is the unanimous recommendation of all of the doctors involved in Ava's care and of the consultants, and Ms. Chalifoux's independent medical expert, Dr. Tierney, that long term ventilator support with no hope of any improvement or recovery is not in Ava's best interests and that the focus should be on changing Ava's care to comfort and palliation. An essential part of this change is to remove the endotracheal tube and ventilator support. This is thought to be the kindest and most appropriate care for a child in Ava's situation.

[72] I accept the unanimous opinion of all of the neonatologists that it is in Ava's best interests for the mechanical ventilation to be removed and for a palliative treatment plan to be implemented. Accordingly, the decision by Ava's guardians that the mechanical ventilator should not be removed and that further efforts should be made to prolong her life, is not in Ava's best interests.

[73] I therefore reverse the guardians' decision to keep Ava on the mechanical ventilator and I authorize Ava's doctors to proceed in the manner that they have determined is in Ava's best interests. This would include removal of the mechanical ventilation and implementation of a comfort and palliative care treatment plan for Ava.

[74] If I am wrong in relying on the authority of s 30 of the *Family Law Act* in this manner, then this would mean that there is "legislative gap", which is required to allow the Court to

exercise *parens patriae* jurisdiction: ***Alberta (Child, Youth and Family Enhancement Act, Director) v DL***, 2012 ABQB 562, para. 35. As Justice Ross did in that case, I conclude that if there is a legislative gap, I do have the *parens patriae* jurisdiction to make an order that is in the best interests of the child in the circumstances of this case. The result is the same. I would conclude and direct that the recommendation of Ava's medical team that mechanical ventilation be removed and a palliative treatment plan be implemented, should be followed. Appropriate arrangements should be made to have Ava's parents and other family members who wish to attend, with Ava when the endotracheal tube and ventilation support are removed.

Heard on the 14th day of August, 2014.
Delivered Orally on the 18th day of August, 2014.
Dated at the City of Edmonton, Alberta this 3rd day of November, 2014.

D.A. Yungwirth
J.C.Q.B.A.

Appearances:

Lydia Bubel and Heather Malaryk
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