JUDICIAL CENTRE OF EDMONTON
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Clerk of the Court

Court of Queen's Bench of Alberta

Citation: Alberta (Child, Youth, and Family Enhancement Act, Director) v D.L., 2012 ABQB 562

Date:
Docket: FL03 35163
Registry: Edmonton

Between:

Director (Child, Youth, and Family Enhancement Act)

Applicant

- and -

D.L. and M.B.

Respondents

Restriction on Publication

Identification Ban – See the *Child, Youth and Family Enhancement Act*, section 126.2.

No one may publish the name or photograph of a child, or of the child's parent or guardian, in a manner that reveals that the child is receiving, or has received, intervention services.

NOTE: This judgment is intended to comply with the restriction so that it may be published.

Memorandum of Decision
of the
Honourable Madam Justice J.M. Ross

I. Introduction

[1] In this application the Director under the *Child, Youth and Family Enhancement Act*, RSA 2000, c C-12 ("*CYFEA*") asks the Court to apply its *parens patriae* jurisdiction to determine the course of medical treatment for M, a two and a half year old girl who is in a persistent coma. The respondents to the application are M's parents, who are charged with criminal offences in relation to M: aggravated assault, criminal negligence, and failing to provide the necessities of life.

II. M's Medical Status and Treatment

[2] On May 25, 2012, following a 911 call, paramedics arrived at M's residence to find her in cardiac arrest. She was resuscitated, but only after 40 minutes of CPR by paramedics and at the Stollery Children's Hospital Emergency Department. She was then transferred to the Pediatric Intensive Care Unit (PICU) at the hospital for on-going life support. She remains there today, more than three months later.

[3] Dr. A. de Caen, Director of the PICU, and Dr. H. Kolski, pediatric neurologist, provided evidence of M's condition. She suffered a profound and irreversible brain injury as a result of the period of cardiac arrest. She is deeply comatose and completely dependent on technology (a mechanical ventilator and feeding tube) to survive. Her condition is essentially unchanged since her admission to PICU.

[4] M does not meet the criteria for brain death, but she is close to it. She has no upper brain activity or function and no brain stem function other than the ability to take some breaths on her own. However, she cannot breathe sufficiently to sustain herself; without the machine she would die. She has no spontaneous movements. She demonstrates small movements in response to painful stimuli, which are characterized by neurologists as reflexes of the spinal cord or brain stem.

[5] M's state, which has now persisted for more than three months, is believed by all of the physicians treating her at the PICU to be permanent. Even if she were to have some recovery, it would not be significant and would still leave her in a permanent coma on a breathing machine. Dr. de Caen testified that the physical damage to her brain means that she does not have the capacity to regain consciousness.

[6] Dr. Kolski testified that M's condition is in a state between brain death and a persistent coma. This reflects brain damage that is more severe than that associated with a persistent vegetative state. Dr. Kolski had researched for reported cases of persons in a persistent coma regaining consciousness after this period of time, and found no case of a patient whose brain injury was as severe as M's who had regained consciousness. In Dr. Kolski's opinion, it is exceedingly unlikely that M could ever regain any form of consciousness.

[7] If M is to continue to receive treatment at the PICU, more invasive forms of treatment than she is currently receiving will be required. She is breathing through a temporary breathing tube, which presents risks to her when it must be changed, and which is not sufficiently stable for long term use. If she is to remain on the breathing machine, she will have to undergo a tracheostomy. This surgical procedure, which will need to be carried out in the very near future, will entail risks, including the risks of bleeding and infection.

[8] M has already undergone three episodes of pneumonia since her admission to the PICU. It is to be expected that, in her fragile state, she will continue to suffer episodes of pneumonia or blood infections. Treatment of a life-threatening infection may require an escalation in her treatment, in the form of escalated ventilation or cardiovascular medications to support her heart and blood pressure.

[9] Because of M's decreased brain function, it is unlikely that she experiences pain as we think of it. She has no brain wave activity that would coincide with pain reception. However, the PICU provides pain medication in circumstances in which it would be provided to other children, for example, for a surgical procedure.

[10] The PICU has involved a broad range of specialists to assess M and provide recommendations regarding M's treatment, in addition to the pediatric intensive care doctors and pediatric neurologists at the PICU. These include specialists in pediatric pulmonary and palliative care medicine, two clinical ethicists, and members of a Complex Care Committee. The unanimous recommendation of all of the specialists, and of all of the PICU physicians who have been caring for M, is that life-sustaining therapy should be withdrawn.

[11] In describing the basis for the recommendation, Dr. de Caen stated that the specialists who care for M believe she will not re-achieve a condition where she is conscious and could interact in any way with her surroundings and environment. In the absence of this possibility, any goal of keeping M alive on a breathing machine that does all of the work for her and artificially feeding her, will not give M pleasure or increase her awareness.

[12] Dr. de Caen also described the ethical issue faced by the medical team, using a concept called beneficence, which is doing good for the patient. He stated that while the medical team is supporting M and keeping her comfortable, when there is a risk of being forced to escalate care because of legal considerations, beneficence is more and more at risk.

[13] Dr. de Caen described the process of family-centred counselling as it is usually practiced in the PICU, and as it has occurred in relation to M. Typically, parents are present in the PICU on a regular basis and are involved in decisions regarding the type and level of treatment to be provided. It is his experience that, in time, they come to understand and accept the recommendations of the medical team. In this case, M's parents were present in the PICU in the first week or so of her admission, and signed a "do not resuscitate" order, directing that if her heart were to stop, the PICU should not provide CPR or medications to restart her heart.

However, M's parents have not been permitted to visit her since June 8, 2012, and since June 12, 2012, they have been restricted in communication with the medical team and with each other arising from their criminal charges and incarceration at the Edmonton Remand Centre (ERC).

[14] Dr. de Caen described the importance of communication to the best interests of M:

> If, without the legal issues, the opportunity early on to speak with the family repeatedly, my hope would be, based on experience, is that with accurate medical counselling, that we would not be here right now and that we would have stopped life-sustaining therapy if the family understood and if they were comfortable with that.
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> Because of these – because of the barriers put in place by the system, it's been difficult. We haven't been able to achieve that. So the down – the problem right now is that we may be three months into providing treatment that may have discomfort associated with it, suctioning, being on a breathing machine, that is not what is in the best interests of the child and if – with counselling the parents, maybe is not what they would have wanted for their child.
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> . . .
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> Intensive care is not a 9-to-5 job. Children's conditions change very rapidly. Two o'clock in the morning, if [M] was to go into what we call septic shock, a fulminant infection, with her condition as she is right now, if the legal issue surrounding this case didn't exist, what I would be doing with M's brain – with her degree of brain injury, I'd be pulling parents into the hospital, talking with them at 2 o'clock in the morning, that dialogue, is this the right thing for us to do, this is what it's going to mean if we go down this path.

[15] Dr. de Caen and an Arabic-speaking physician from the PICU have visited M's parents at the ERC twice, to communicate with them regarding M's condition and the recommendations of the medical team. They have sought, at a minimum, instructions from M's parents that her care should not be escalated in the event of a life-threatening infection. They have recommended that life-sustaining therapy be withdrawn.

[16] M's parents have not accepted these recommendations. In an affidavit, M's father states his position as follows:

> I have not refused to consent to treatment. I have consented to a do not resuscitate order if [M's] heart fails, however, I cannot consent to the withholding of treatment or as expressed by the Doctor's letter "limiting or

> withdrawing life sustaining medical therapy." My religious beliefs [sic] is that if it is Allah's will that despite all the doctors can do to for [M] that she passes from this life then it is God's will. As a devout Muslim and loving father I find it unthinkable to agree to limit or withdraw medical treatment for [M]. I ask that the Court honour my beliefs that the ultimate course of [M's] life not be made by doctors limiting or withdrawing treatment.

[17] M's mother has adopted that statement.

III. Court Proceedings

[18] An Apprehension Order for M was granted by a Justice of the Peace of June 22, 2012 pursuant to the *CYFEA*, s. 19. An Order for Initial Custody of M was granted on July 12, 2012: *CYFEA*, s. 21.1. The Director has commenced an application for a permanent guardianship order ("PGO"). If granted, a PGO would terminate M's parental rights. The hearing of the PGO application has not yet been scheduled. At the hearing, counsel estimated that it would likely require at least six months for the PGO application to be heard.

[19] On August 1, 2012 the Director applied to Judge Dalton in Provincial Court asking the Court to exercise its discretion under the *CYFEA* regarding M's medical condition. M's parents took the position that the *CYFEA* did not give the Provincial Court legislative authority to order the withdrawal or limiting of treatment, nor did the court have *parens patriae* jurisdiction. Judge Dalton directed that the Director seek a remedy in the Court of Queen's Bench.

[20] That application was brought and on August 17, 2012 I heard *viva voce* evidence. Counsel for M's parents advised that they had received a large number of pages of medical records only the day before. With agreement of all parties, Dr. de Caen gave his direct evidence only, and the application was adjourned until September 7, 2012 for cross-examination and further evidence.

[21] In Dr. de Caen's testimony on August 17, 2012, he described the shortcomings in the process of consulting with M's parents because of their present circumstances.

[22] I directed that during the period of the adjournment, counsel for the Director and M's parents should contact counsel involved in the criminal proceedings and make efforts to provide for further consultation between the medical team and M's parents, including, if possible, an opportunity for the parents to see M and to speak to each other. I offered my assistance in meeting by telephone with counsel to discuss any issues, if they were unable to agree.

[23] On September 7, 2012 the application with *viva voce* evidence continued. No meeting with counsel had been scheduled in the interim, and I was advised that no steps had been taken to

facilitate further consultations. This was due, at least in part, to unavailability of counsel who had been retained by M's parents in relation to the criminal proceedings.

IV. Positions of the Parties

[24] The Director took the position that he does not have authority under the *CYFEA* to consent to a withdrawal or limiting of M's treatment, and requested that the Court exercise its *parens patriae* jurisdiction and determine the appropriate course of treatment. Counsel for M, speaking in the role of advocate for M's best interests, also requested the Court to exercise its discretion and to find that escalation of treatment is not in M's best interests. Counsel for M made no recommendation regarding withdrawal of life-sustaining treatment, stating that she would leave that to the Court's discretion. However, she observed that any delay in the decision regarding M's treatment will mean that she will be subjected to a tracheostomy, an invasive procedure which will negatively impact her dignity and bodily integrity.

[25] Counsel for M's father argues the *parens patriae* power may be invoked in the absence of applicable legislation and in the best interests of the child, and that neither of these circumstances exists in the case.

[26] The *CYFEA* provides in s. 22.1(2) for treatment of a child who has been apprehended:

> (2) If the guardian of a child who has been apprehended refuses to consent to essential medical, surgical, dental or other remedial treatment for the child that is recommended by a physician or dentist, the director must apply to the Court for an order authorizing the treatment.

[27] It is the position of all counsel that the limitation or withdrawal of treatment does not come within the definition of essential treatment, which has been interpreted as referring to life-preserving treatment. Judge Dalton was apparently inclined to agree with this interpretation, and so directed the application be brought to this court.

[28] M's father submits that the legislation does not leave a "gap" requiring the exercise of *parens patriae* jurisdiction, as it provides for life-preserving treatment.

[29] Alternatively, M's father argues that the Court should not exercise its *parens patriae* jurisdiction to protect M by making a treatment decision that will limit or end her life. There is no legislation to give the Court direction to determine when treatment should be withdrawn. Decisions about treatment should be made by M's parents, working together with her medical team. In making their decision, they should be entitled to take into account their views and beliefs. Counsel for both of M's parents indicated that, at a bail review scheduled to be heard by the Court of Queen's Bench on September 21, 2012, they would seek to have the restriction on communication between the parents lifted so that they would be able to consult about M's treatment.

[30] Counsel for M's mother supported this position, and further argued that the role of the Court in making determinations in the best interests of a child is restricted to situations in which the parents or responsible family members do not agree on a course of treatment. There is no disagreement between the parents in this case. *Parens patriae* jurisdiction does not include the jurisdiction on making determinations that end life, as this is an issue that should be left to elected officials through legislation. Further, if the Court does have jurisdiction, it would be premature to exercise it before the issue of consultation between the parents is addressed at their bail review.

V. Law

A. *Parens Patriae* Jurisdiction

[31] *Parens patriae* jurisdiction is vested in the provincial superior courts of Canada. The common law recognizes the power of the state to intervene to protect children, where their lives are in jeopardy, and to promote their well-being. This intervention is based upon the state's *parens patriae* jurisdiction: ***B(R)v Children's Aid Society of Metropolitan Toronto***, [1995] 1 SCR 315, at para 88, 122 DLR (4th) 1.

[32] The history of *parens patriae* jurisdiction, as well as the scope and discretion in applying the jurisdiction, was canvassed by the Supreme Court of Canada in ***E (Mrs) v Eve***, [1986] 2 SCR 388, 31 DLR (4th) 1. The principle underlying the application of *parens patriae* is the child's "best interests," and is founded on the necessity to act for the protection of those who cannot care for themselves. The Court is required to exercise this jurisdiction in the "best interests" of the protected person. Justice La Forest also stated that the categories under which the Court may exercise its *parens patriae* jurisdiction are never closed, the jurisdiction is very broad in nature and can be invoked in matters regarding custody, health problems, religious upbringing. and protection against harmful associations (at 426). Furthermore, the Court noted that the jurisdiction may be exercised "not only on the ground that injury to person or property has occurred, but also on the ground that such injury is apprehended" (at 426).

[33] Noteably, the Court in ***Eve***, stated there was no doubt *parens patriae* jurisdiction may be used to authorize the performance of a surgical operation necessary to the health of a person. However, the Court chose not to address the issue of whether the courts should permit the removal of life-sustaining equipment (at 427).

[34] A central requirement of the proper exercise of *parens patriae* jurisidiction is that the Court must consider only what is necessary for the protection of the person, for whose benefit the jurisdiction is exercised. The Court in ***Eve*** determined the discretion under *parens patriae* is to be exercised for the benefit of that person, not for that of others (at 427).

[35] Generally, in order to exercise *parens patriae* jurisdiction, there must be a legislative gap which requires the Court to exercise it's discretion: ***Beson v Director of Child Welfare***, [1982] 2

SCR 716; ***RR v Alberta (Child Welfare Appeal Panel)***, 2000 ABQB 1018, 267 AR 249. *Parens patriae* cannot override express statutory authority: ***JU v Alberta (Regional Director of Child Welfare)***, 2001 ABCA 125 at para 7, 281 AR 396.

B. Religious Beliefs

[36] In ***B(R) v Children's Aid Society***, the Supreme Court of Canada dealt with a conflict between a child's parents and her medical team. The parents, who were Jehovah's Witnesses, refused to consent to blood transfusions and the child's doctors believed her life was in danger and she might require a blood transfusion. Ontario courts had granted a wardship of the child during the period that she was at risk.

[37] The parents argued that the legislation under which the wardship was granted infringed their right to choose the medical treatment for their child, in accordance with their religion, contrary to ss. 7 and 2(a) of the *Canadian Charter of Rights and Freedoms*.

[38] The majority of the Supreme Court of Canada determined that the *Child Welfare Act*, RSO 1980, c 66 deprived the appellants of their right to decide which medical treatment should be administered to their child, infringing their parental liberty protected in s. 7 of the *Charter* (at para 87). However, this deprivation was made in accordance with the principles of fundamental justice (at para 101).

[39] Writing for the majority, Justice La Forest held that s. 7 of the *Charte*r protects the parental interest in raising a child, including providing medical care and a moral upbringing, as this is an individual liberty interest of fundamental importance to our society (at para 83). Parents are presumed to have the ability to make important decisions which affect their children because parents are more likely to appreciate the best interests of their children and because the state is ill-equipped to make such decisions. The state may interfere only where it considers it necessary to safeguard the child's autonomy or health and where such intervention is justified (at para 85).

[40] With respect to s. 2(a), the majority found the freedom of religion of the parents was at stake in the appeal, not that of the child itself. The right of parents to raise their children according to their religious beliefs, including that of choosing medical and other treatments, is a fundamental aspect of freedom of religion (at para 103, 105). However, freedom of religion is not absolute and religious practices can be limited where they impact on the fundamental rights and freedoms of others (at para 107).

[41] In constitutional analysis, balancing competing rights should be analyzed within the framework of s. 1 (at para 110). The majority found that the *Act* was not arbitrary in allowing the state to assume parental rights, when a judge determines a child requires treatment that the parents refuse consent to. Therefore, the *Act's* restrictions on parental rights were justified under s. 1 (at para 113).

[42] ***Sweiss v Alberta Health Services***, 2009 ABQB 691, 483 AR 340 dealt with religious beliefs in relation to an adult patient. Mr. Sweiss had significant health problems, and knowing this, signed a declaration stating he practiced Islamic faith and that, should anything happen to him, he wished Islamic law be followed. Mr. Sweiss suffered a subsequent cardiac arrest and was placed on mechanical ventilator support. The treating physician's opinion was that he suffered severe irreversible brain damage and it was in Mr. Sweiss' best interest that the mechanical ventilation support be discontinued, and the doctors not be compelled to perform CPR. The doctors stated that any medical treatment, other than palliative care and comfort measures, would be medically futile and ethically inappropriate.

[43] The family sought an injunction on an emergency basis to discontinue a "do not resuscitate" order (DNR) and to prevent the removal of the mechanical ventilation machine, on the grounds that the proposed treatment was contrary to Mr. Sweiss' religious beliefs.

[44] Justice Ouellette found the patient's direction regarding treatment is a factor which must be considered by the Court, whether or not those wishes are grounded in religious belief. However, religious beliefs can not trump all other opinions or principles in determining what is in the patients' best interests. Therefore, religious beliefs should be given considerable weight, but subject to the patient's best interests (at para 44).

[45] The appropriate test to apply for injunctions where the situation is urgent and life-threatening is what is in the patient's best interest. Justice Ouellette, at para 63, outlined several considerations including:

(1) The medical condition of the patient;

(2) The recommended medical treatment, which includes doing something, nothing, or very little;

(3) The wishes and beliefs of the patient, if they are known; and

(4) What is just and equitable in all of the circumstances of the case.

[46] The Court found as a general premise, that courts and patients should not require doctors to provide a course of treatment which is not in the patient's best interest. The Court would not order the removal of the DNR because it would be in Mr. Sweiss' best interest that there be no attempts at resuscitation, based on the doctor's evidence that active intervention would create substantial harm and no benefit. However, the Court issued an interim injunction to prevent the removal of the mechanical ventilator in order to obtain an independent assessment regarding Mr. Sweiss' condition (at paras 66-70).

C. Limiting or Terminating Treatment and the Best Interests of the Patient

[47] ***Child and Family Services of Manitoba v Lavallee*** (1997), 154 DLR (4th) 409, 123 Man R (2d) 135 (MBCA) concerned a three month old child who had been savagely attacked. When the child was admitted to hospital, it was apprehended by Child and Family Services. The child existed in a vegetative state and the medical opinion was that the child could die at any time. The doctors recommended a DNR. The doctors' opinion was that the child would eventually become seriously ill, requiring "intrusive heroic measures" that would only bring the child back to a persistent vegetative state. Child and Family Services agreed the DNR order was appropriate, however the parents refused to consent.

[48] The Manitoba Court of Appeal held that there is no legal obligation on a medical doctor to take heroic measures to maintain the life of a patient in an irreversible vegetative state (at para 14). While there are philosophical arguments about whether or not the best interests of the child includes making an "order permitting it to die," it is in no one's best interest to artificially maintain the life of a patient in an irreversible vegetative state, "unless those responsible for the patient being in that state have an interest in prolonging life to avoid criminal responsibility for the death" (at 411-12).

[49] ***Children's Aid Society of Ottawa-Carleton v MC*** (2008), 301 DLR (4th) 194 (ON Sup Ct) dealt with a child who had been apprehended at birth by the Children's Aid Society (CAS). The Court labelled the child a "crack baby" who weighed 1.8 pounds at birth, had a major brain hemorrhage, and a serious heart abnormality. The doctors recommended termination of treatment, rather than surgery. The mother of the child was aware of the condition, but did not return to the hospital. The Court authorized CAS to consent to the termination of treatment. The Court determined that the best interests of a child, where appropriate, can require "refraining from invasive treatment or withdrawing medical treatment other than palliative care" (at para 25).

[50] ***May v Alberta Health Services***, 2010 ABQB 213, 498 AR 167 related to a child who suffered severe neonatal encephalopathy during his birth. As a result, he was put in neonatal intensive care and placed on a ventilator. The doctors wished to discontinue mechanical ventilation support and the parents disagreed. The parents sought a 90-day injunction so that they could obtain independent medical opinions about their child's condition and prognosis.

[51] The child died before the Court had an opportunity to issue its decision. However, at the request of the parties, Justice Crighton issued an advisory decision dealing with procedural matters and applicable principles of law. With respect to granting injunctions in the context of end-of-life or urgent life-threatening applications, Justice Crighton found that the appropriate test is the "best interests of the patient" (at para 22). She determined that medical opinions are one of several factors to be considered when determining what is in the patient's best interests.

[52] ***IHV (Re)***, 2008 ABQB 250, 449 AR 211 addressed the best interests of an adult patient who, as a result of her illness, was no longer capable of making her own health care decisions. IHV was diagnosed with terminal cancer. She suffered from failing kidneys and reduced circulation. The doctors recommended that active treatment be discontinued and IHV be given

palliative care. SC, a daughter of the patient, requested positive and aggressive medical steps be taken to prolong her mother's life. Another daughter, DF, asked the Court to accept the medical advice and allow her mother to die with dignity and peace.

[53] Justice Germain appointed a guardian for IHV and ordered disclosure of health care records to counsel for the guardian, so that they might obtain an independent medical opinion (at para 22). He held that it would be inappropriate for the Court to mandate by injunction medical treatment that may be contrary to the unanimous view of health care practitioners, as they are the ones with the expertise, experience, and the compassion (at para 27). He refused the application for injunctive relief because there was nothing in the medical records to indicate the doctors were not acting in the best interests of IHV (at para 28).

[54] ***Re LIC (Dependent Adult)***, 2006 ABQB 130, 398 AR 229 concerned a dependent adult who suffered from a long-standing brain injury and was under the guardianship of the Public Guardian. She suffered a cardiac arrest as a result of which her condition declined, and she lapsed into a vegetative state. The doctors determined that there was no reasonable likelihood she would recover to pre-cardiac arrest neurological status. She would remain in a permanent vegetative state and ultimately would die because of an infectious complication.

[55] The doctors recommended that the endotracheal tube be removed, and if the patient went into cardiac arrest, no further life-sustaining treatment would be undertaken. The doctors felt that any continuing medical care should only focus on comfort and supportive measures (at para 7). The family did not dispute this and entrusted the decision to the Public Guardian, who sought direction from the Court.

[56] In considering what was in the best interests of the dependent adult, Justice Acton relied on the reasoning of Lord Goff in ***Airedale NHS Trust v Bland***, [1993] 1 All ER 821 (HL) who stated "the question is not whether it is in the best interests of the patient that he should die. The question is whether it is in the best interests of the patient that his life should be prolonged by the continuance of this form of medical treatment or care" (at para 33).

VI. Analysis

[57] I conclude that I do have *parens patriae* jurisdiction to make an order in the best interests of M in the circumstances of this case.

[58] M as an apprehended child is in the care of the Director. All parties to this proceeding take the position that the governing legislation does not give the Director authority to make end of life decisions about apprehended children. Judge Dalton effectively agreed with this position by referring the matter to this court. Her direction has not been appealed. For purposes of this application, I accept that there is a legislative gap at least in relation to apprehended children.

[59] There is some dispute between the parties as to whether the same gap would apply following the issuance of a Temporary Guardianship Order (TGO). I do not need to determine that issue as there is no TGO regarding M, nor has one been applied for. The Director is seeking a PGO which would terminate M's parents rights, but no decision on that application can be expected for some time. So, at least for the time being, there is a legislative gap that supports the existence of *parens patriae* jurisdiction. The impact of timing issues should be considered in the context of a consideration of M's best interests, in determining whether and how that jurisdiction should be exercised.

[60] The argument that *parens patriae* jurisdiction should apply only to medical decisions regarding life-preserving treatments, ignores the fact that medical decisions must also be made about whether and by what means life in a permanent coma should be prolonged, about what treatments should be pursued and whether and when to limit or withdraw treatment. The cases that I have referred to provide examples of concerned individuals bringing these issues to court. It is a clear theme in the case law that the standards of our society require that these decisions on behalf of children, or others who cannot make the decisions for themselves, be made in the best interests of the patient. Recourse to the court's *parens patriae* jurisdiction ensures that the best interests of the patient will be the governing consideration.

[61] The argument that *parens patriae* jurisdiction does not include the decisions at issue here because these matters should be left to legislation confuses the decisions being urged by M's medical team and decisions that could give rise to criminal liability. While the issue of limitations on the application of criminal laws regarding end of life treatment has been characterized by the Supreme Court of Canada as a matter that should be left to legislators (***Rodriguez v British Columbia (Attorney General)***, [1993] 3 SCR 519, 107 DLR (4th) 342), that concern does not apply to the decisions that are made by parents and family members in relation to what type of treatment, if any, should be provided to their loved ones. These decisions are made in hospitals across this country every day, in the way described by Dr. de Caen, with the decision-makers receiving information and recommendations from medical professionals, and considering their own and their loved one's wishes and beliefs. There is no need and there may not even be any possibility for legislative standards to govern these decisions, which must be made in the best interests of each individual patient in the circumstances applying to that patient.

[62] The argument that there is no need for the Court to exercise its *parens patriae* jurisdiction because M's parents agree on appropriate treatment for her ignores some of the most difficult circumstances that are presented by this case. M's parents are, as the Director described it, in an inherent conflict of interest. It is agreed that if M does not survive, they may be charged with other or additional offences. Further, there **is** a dispute about M's best interests among those entrusted with her care. The Director is charged under the *CYFEA* with exercising his authority and making decisions about M that are in her best interests. The Director is not supporting M's parents' views, but has sought to have the Court consider all of the evidence and determine what treatment decision is in M's best interests. Finally, M's medical team, who are charged with

providing her care and treatment on a day-to-day basis, have come to a different assessment of M's best interests.

[63] What then is in M's best interests?

[64] M's parents believe that an order that leads to her death cannot be in M's best interests. They want the doctors to continue to make all efforts to preserve her life, short of resuscitation if her heart fails. Their evidence is that their wishes are based on their religious beliefs and on their love for M.

[65] It is my view that the court cases which have considered treatment decisions of this type, and the evidence of medical teams given in those cases, reflect a general societal understanding that a life without awareness and totally supported by machines is not in accord with the best interests of any patient, including a child. This is particularly clear where sustaining such a life requires invasive medical treatment that interferes with bodily integrity and human dignity. It is not an answer to concerns about invasive treatment that the patient does not suffer pain or is unaware of the intrusions. Our respect for the patient requires that we impose these intrusions only where there is at least a potential benefit to the patient.

[66] From the perspective of that general societal understanding, the evidence in this case that it is in M's best interests that life-sustaining treatment be stopped is clear and uncontradicted. A large number of specialists have been involved in her care, and it is their unanimous recommendation that treatment be stopped. M has no awareness of her surroundings and is completely dependent on mechanical supports to live. The unchallenged evidence of the doctors is that she will never regain consciousness and be interactive. The evidence is also that she will require invasive treatment, imminently, in the form of a tracheostomy, simply to be maintained on the ventilator, and that she will continue to contract pneumonia or other infections, and may require further invasive treatments in response. There is no potential benefit to her from these treatments, as they will not improve her current condition.

[67] Not all people agree with the general social understanding that I have described. Some may disagree due to religious convictions, some for other personal reasons. M's parents disagree. It is important in a democratic society that these different views be accommodated to the extent that they reasonably can be.

[68] Parents are normally presumed to appreciate what is in the best interests of their children and to have the ability to make important decisions that reflect those interests. However, in this case there are circumstances which cause me to put less weight on the decision made by M's parents. One factor which cannot be ignored is that they are, inherently, in a conflict of interest. M's parents were not cross-examined about their reasons for wishing to continue M's treatment, but they are already facing criminal charges in relation to their alleged treatment of M and it is an admitted fact that they may incur additional or other charges if M dies. Even assuming that M's

parents think that their decision is motivated by religious beliefs and love for M, I am left with a concern that their decision may in fact be affected by self-interest.

[69] While M's parents' religious beliefs are entitled to be considered, they are not the determining factor of what is in M's best interests, especially since M herself is too young to have ever made her own individual religious commitment. The beliefs are those of M's parents, not her own. The religious practices of M's parents are properly limited where they are contrary to M's best interests in a fundamental way: ***BR v Children's Aid Society***.

[70] Another reason to place less weight on the decision of M's parents is that as a result of their incarceration and the restrictions of the criminal justice system, they have not been involved in her care on a day-to-day basis, and so are not as informed about her condition or as able to appreciate her best interests as they would be if the circumstances were different. This may seem like blaming M's parents for something that is beyond their control, but the issue before me is not whether to blame or how to help M's parents, the only issue that I must decide is what is in M's best interests. And, because of their lack of information and involvement, I place less weight on M's parents' views regarding her best interests.

[71] This last point relates to the alternative submission by M's parents, that any decision by this Court should be delayed until they can seek judicial interim release, or at least an exemption from the Provincial Court order that prohibits them from communicating, so that they can participate in a meaningful way in family-centred counselling with the PICU medical team and work with the team to make decisions in M's best interests.

[72] In considering this submission, I keep in mind that my role is to consider only the best interests of M, not those of her parents or any other person: ***E (Mrs) v Eve*** at 427. While family-centred counselling might provide M's parents with psychological support at a difficult time, that is not relevant to the issue that I must determine. I am concerned only with whether the participation by M's parents in the counselling process would advance M's best interests.

[73] I conclude that it would not for two reasons. One is that the process will inherently involve delay. The issue of M's treatment has been in court - before the Provincial Court and this court - for over six weeks now and no progress has been made in terms of improving the counselling process. M's parents point to a bail hearing on September 21st as a time at which such progress may be made, but the outcome of that proceeding is uncertain. I am told that the Crown Prosecutor does not consent to the request that will be made by M's parents. In the meantime, M has been in a coma and dependent on mechanical life-supports for three months. If there is a delay, even until September 21st, and if she is to stay on the ventilator for that period of time, she will have to undergo a tracheostomy. Further, every day that M remains in her current circumstances, she faces the risk of contracting a life-threatening infection and requiring invasive treatment in response. There is no 'status quo' for M while she awaits the resolution of her parents' legal difficulties. There are further medical challenges, and further invasive treatments aimed only at continuing a life that holds no benefits for her.

[74] The second reason that I reject a delay for the purpose of family counselling, is that it seems very unlikely that it will be successful in resolving the impasse between M's parents and the medical team. Dr. de Caen did meet with M's parents on two occasions before this legal proceeding, and during his testimony in this proceeding on two separate days he spoke at length and clearly and compassionately about M's condition and the reasons for the recommendations of the medical team. His testimony and that of Dr. Kolski was translated for M's parents. Both doctors were cross-examined by counsel for M's parents. There is no indication that this has led to any modification in the position of M's parents. They have not indicated a readiness to consider even limiting an escalation of M's treatment. On the contrary, their position as stated indicates that their decision will not and cannot change: they state that as devout Muslims and loving parents, they find it "unthinkable to agree to limit or withdraw medical treatment" and they ask that the Court "honour [their] beliefs." The Court cannot do so, where their beliefs come into a fundamental conflict with M's best interests. I am satisfied that there is such a fundamental conflict in this case.

[75] For these reasons, I conclude and direct that the recommendation of M's medical team that she be withdrawn from life-sustaining treatment and provided with palliative care is in M's best interests and that this course of treatment should be followed.

Heard on the 17th day of August, 2012 and on the 7th day of September, 2012.
Dated at the City of Edmonton, Alberta this 14th day of September, 2012.

J.M. Ross
J.C.Q.B.A.

Appearances:

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Ms. April C. Kellett
for the Respondent (M.B.)

Ms. JoAnn T. Quinn
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