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IN THE PROVINCIAL COURT OF BRITISH COLUMBIA

IN THE MATTER OF
THE *CHILD FAMILY AND COMMUNITY SERVICE ACT*, SBC 1994 CHAPTER 27
AND THE CHILD:

R[redacted] S.

REASONS FOR JUDGMENT
BEFORE THE
HONOURABLE JUDGE P. D'A. COLLINGS

Counsel for the Director:	Frank Potts, R. Hamilton and Shelley Braun
Counsel for the Mother, B[redacted] S.:	Barry Long and R.D. Bellamy
Place of Hearing:	, B.C.
Hearing dates in Vancouver:	November 18-21, 25-28, December 2-5, 9-12, 16, 1996; January 13, 14, 16, 20 - 23, 27, 29, 30, 1997
Hearing dates in Kamloops:	February 4 - 6, 11, 12, 1997
Hearing dates in Vancouver:	February 17 - 19, March 3 - 5, 1997
Date of Judgment:	March 12, 1997

This is an application under section 40 of the new Child Protection statute to determine whether R[redacted] S., aged 10, needs protection. The application is brought by the Director, that is, the officer of the Ministry of the B.C. Provincial Government designated by the Minister under section 91 of the Act - he is the equivalent of the old Superintendent of Child Welfare. R[redacted] has only one parent, B[redacted] S. her adoptive mother. Ms. S. contests this application.

In plain words what the Director has alleged is that, during a period of about a year when R[redacted] was more or less continuously hospitalized, her adoptive mother, being resident in the hospital with her, caused or contributed to the various illnesses that R[redacted] was suffering from. It has been suggested that I'm restricted in the "need of protection" definitions that I could make findings on to the definition or definitions that the Director has alleged. I don't accept this. This is an enquiry; we have no pleadings; and the safety and well being of the child are my paramount considerations (see S.2). The court has, in my view, the power to make findings on any definition that the evidence may substantiate.

For practical purposes, however, I can state that the allegation appears to fall most neatly under definition (a) of S.13 (i):

> "the child has been, or is likely to be, physically harmed by the child's parent".

If I find that R[redacted] needs protection, I may hear more evidence (s. 40(3)) but eventually have to make an order under S. 41(1), either

(a) return to the parent under supervision.

(b) return to another person under supervision.

(c) temporary custody to the Director for 6 months or less, or

(d) continuing custody (i.e. for an indefinite period) to the Director.

The Director's plan suggests (d), continuing custody.

If I find that R[redacted] does not need protection, I must order the Director (who has interim custody) to return her to her mother.

PROCEDURE

I don't intend to belabour this point but something must be said for the benefit of future litigants, lawyers, and judges. This new Act, although longer and more complex than the old one, exhorts us in many places to have speedy trials and prompt resolutions. The Honourable Judge who heard the S.35 Presentation Hearing took this to heart. She was obliged to order that a S.40 hearing must commence within 45 days (see S.37(2)). She went on to provide that it continue immediately thereafter (on the 46th, 47th, 48th days, etc). The Director appealed that to the Supreme Court and the Court of Appeal unsuccessfully. Both courts held we had the power to order such expedited trials.

In fact, the hearing in this case has been a vivid example of "the more haste the less speed". I have said that this trial concerns what happened when R[redacted] was in hospital for a year. Everyday she was in hospital she generated over twenty sheets of paper work, not counting all the reports, opinions, etc. of the doctors. We have ended up with more than 10,000 pages of paper. We have also heard from 4 pediatricians, I pediatric gastro-enterologist, 2 psychiatrists, and no fewer than 10 registered nurses, not to mention reading psychological and other reports, as well as hearing our usual fare of social workers, fosters parents, parent, and friends. The evidence has been of mind-numbing repetitiveness, and, in my view, if counsel had the chance to prepare properly it could have been cut down to a third of its length or less. The essential parts of this story are not very complicated as I hope to demonstrate. We have in fact heard 36 days of evidence over about 5 months; even so I give this final judgment about 9 months after the case started which is par for the course in a substantial protection hearing. So this prodigal outpouring of court time hasn't speeded resolution up - all it has done is to push the rest of the cases further down the list.

I should like a copy of these remarks sent to the Minister in the hope they may demonstrate that, whatever exhortations to speed you put in the Statute, the basic rules of trial management still apply, and attempts to short-cut them, as for instance by forcing the trial on before the parties have had a chance to assimilate the material, see what might go in by consent, delete superfluous witnesses, etc, will be counterproductive.

HISTORY - RAQUEL

What I state as history I find as fact, unless I indicate to the contrary. I propose to narrate the history from R[redacted]s focus first, then fill in the gaps.

When they wrote in the Bible that the sins of the parents are visited on the children, they must have been thinking of poor R[redacted] She is the offspring of a short-lived union between a young native Indian woman and a Guatemalan sailor. Her birth mother had alcohol and cocaine habits, and there were problems in delivery. She was immediately operated on for a blockage of the duodenum known as duodenal atresia, but in truth that was the least of her problems.

Her main problem was Cerebral Palsy, which means brain damage that reduces control over muscle movements. Associated with this, she has seizures (although fairly mild), mental retardation (this fairly severe - at age 10 she can't talk and has a mental age of about 3) motor deficiency (she walks stiffly and with difficulty, has trouble picking things up, etc.) and major feeding problems (which I shall describe in a minute). R[redacted] is described as a spastic quadriplegic - spastic meaning that the muscles are strung too tight and she can only move jerkily, quadriplegic meaning that all four limbs are affected. Spastic quadriplegia is a subdivision among cerebral palsy victims. To add insult to injury she also has many warts. Her normal growth is inhibited so she is small and underweight. Finally, she has a greatly reduced life expectancy. Dr. Riddell who gave me a crash course in Cerebral Palsy, gives her 10 to 20 years from birth, so actually at 10 she is already ahead of the game.

The biggest single problem with such children is feeding. Why?

(1) they can't get the food to their mouth well with their hands.

(2) they can't chew properly or move the food around in their mouths - control of the tongue is particularly difficult.

(3) the act of swallowing is very difficult; they often regurgitate, gag or choke.

(4) their reflexes in the esophagus that move food to the stomach often don't work properly, causing pain and discomfort when food gets stuck.

(5) there is a sphincter in the stomach that closes off the entry from the esophagus when the food is

being pushed out the exit to the duodenum. This may malfunction and cause reflux of stomach contents back into the esophagus.

(6) muscle power in the gut and the bowel is lacking, and so the waste doesn't get pushed down, often causing constipation. Then if the stalled waste gets infected, you get diarrhoea, it runs out, and you get constipation again. Constipation of course can diminished appetite.

As a result of all these inherent problems, these children always have to be watched to see if they're getting enough food orally. If they're not, and the reason is in the part of the system above the stomach, a G-tube, or its cousin a J-tube, may have to be used. A hole is cut from the outside through the stomach wall and one of these tubes, with a valve on it, is installed more or less permanently in that hole. Liquid food can than be fed directly through the tube. G-tubes lead to the stomach; J-tubes are used when there is also a problem in the stomach, and lead through the stomach into the jejunum at the top end of the gut.

If this doesn't work, the child can be kept alive by an IV line putting fluids directly into the blood stream (known as TPN) but this is a stop-gap. Without food going into the digestive system, the child will eventually die of malnutrition.

To get back to R[redacted] - she was apprehended from her birth mother, made a permanent ward, and adopted by B[redacted] S., who first looked after her in January 1990. Prior to that she was in foster homes and I don't have a record. With B[redacted] S. living in a suburb of Kamloops, she did reasonably well by all accounts, including starting school, until November, 1994 when Ms. Sandy Gallup, her teacher, found:

"There was a big change, she had difficulty swallowing and drinking, she wasn't focused, was irritable and mean with her friends".

I don't know why this happened when it did, but according to Dr. Riddell these children are always susceptible to feeding problems, which this clearly was. There was a little improvement in January and February, 1995 but it didn't last. By June, still according to Ms. Gallup, "she was getting worse, looked terrible, cried a lot, pale tired and irritable, wouldn't eat snacks hardly".

Dr. Slater, the Kamloops paediatrician, noted that she was growing in height but not in weight. She was getting thinner. After various assessments from other specialists, a G-tube was put in by a surgeon named Dr. Olson at Royal Inland Hospital in Kamloops on August 24th, 1995. However, far from things getting better, they got worse. She developed a secretory diarrhoea (that is, involving secretion of body fluids) and the first of a long series of infections. Another sign of things to come was a disagreement between B[redacted] S. and the doctors, particularly Dr. Olson who, according to her, had a "student" do the actual G-tube insertion for him. I shall deal with this whole subject later.

Because of the diarrhoea and infections R[redacted] was hospitalized in Kamloops, and on October 15th, 1995, Kamloops having had no success, she was transferred to B.C. Children's Hospital in Vancouver. B[redacted] S. was with her in both hospitals and in fact took care of R[redacted]'s basic needs (washing, diaper changing, and general care) throughout. Indeed sometimes she seems, with the nurses' approval, to have done some of the nursing care relating to medication and the IV lines as well. In Vancouver she stayed in the same room. On October 16th the G-tube was revised and replaced, and on October 22nd an attempt was made to restart feeding through it which resulted in vomiting, diarrhoea and abdominal cramping. Also at this time, she had further surgery on her left leg because of pain caused by the tight musculature, and that set her back. Another attempt to refeed was started on November 2nd, and persisted in through further vomiting and diarrhoea, but a further infection developed, this time of blood as well as the G-tube site. On November 10th the feeding was stopped and she went on TPN, that is fluids via an IV line.

A J-tube was inserted to see if it would work better than the G-tube had and refeeding on this was started November 14th. But this caused severe pain and diarrhoea and was stopped November 17th. By this time they were, in Dr. Riddell's words "going downhill", she wouldn't take even the blandest most basic food and they had to be content with replacement of fluids through the IV. It was December 9th before they started trying to refeed her through the J-tube. It didn't go well and on December 11th they found out why - the J-tube had become dislodged and was lying curled up in R[redacted]'s stomach. It had been normal at least up to November 15th. More infections developed around the site and were treated.

At the turn of the year, R[redacted]'s problems still were not accounted for, let alone cured, but there was pressure to return her home on T.P.N., and the catheters for that purpose (B[redacted] S. having been instructed in how to use them) were inserted on January 8th, 1996. She was held over a few days because of a brown discharge from the G-tube site. B[redacted] S. left for Kamloops on the afternoon of January 14th and R[redacted] followed on January 16th. Actually, she went direct to the Royal Inland Hospital rather than home, as the septic condition was again in evidence on arrival. On March 4th, 1996 she went home but on March 22nd she had to be hospitalized again because of infection of the IV catheter. Shortly thereafter the replacement devices for that catheter also became infected, it became too much for Kamloops to handle, and she was sent back to Children's Hospital in Vancouver on April 18th together of course with B[redacted] S.

She arrived back in Vancouver feverish and badly infected. One initial attempt to feed her by the G-tube failed and the team

decided to keep her going on the IV line until they could find out why R[redacted] couldn't digest, why did she vomit all the time, and why did she have these continual infections. Between August 24th, 1995 and April 18th, 1996 she had by my count 8 infections (Mr. Hamilton's count is 14, but after a while it became uncertain what was a separate infection) of which at least 2 were infections of the blood stream, very serious stuff. This is a highly unusual number. It's hard to attribute all these to chance or human error in a supposedly sterile environment. Furthermore a whole battery of tests has failed to find a cause for the failure to digest and the infections to wit:

Barium swallow studies

Endoscopies upper and lower

Bowel biopsy

Ultrasound scan

C/T Scan head

C/T Scan abdomen (for hidden abscess or source of infection)

Neurological check

Lumbar puncture

Nothing daunted, the medical team now joined by Dr. Israels their paediatric gastroenterologist, checked their records and began to search for other causes. The search was urgent. By the end of April she was vomiting enough blood that it had to be replaced by 3 blood transfusions. More barium studies endoscopies and biopsies still couldn't locate any likely cause for this reflux. But it was happening.

Then one barium study revealed an apparently loose caecum (a dangling part of the bowel) thus raising the possibility of a malrotation in which the caecum would be twisted around the artery which serves the bowel, cutting off the blood supply. After a fierce discussion among the team, a highly invasive procedure was decided on to check this out. On May 14, 1996, R[redacted] underwent a laparotomy - an operation in which her body cavity was opened right down the front as if she were a gutted rabbit - and the whole bowel was inspected. To no result. The caecum was a little mobile and there were some adhesions from prior surgery, but there were no malrotations, no obstructions, and nothing to explain her problems.

During the operation, a biopsy (or slice) of the bowel was taken and sent for lab inspection. This lab reported an unusual number of eosinophils in the blood vessels in the bowel wall, thus raising the possibility of eosinophilic vasculitis, a rare condition in which these eosinophils attack blood vessels. I shan't delve into these arcane matters beyond saying that both Dr. Riddell and Dr. Israels thought this was a red herring and events seem to have proved them right. R[redacted] had no treatment for this and yet has got better.

The part B[redacted] S. played in R[redacted]'s problems had been discussed by the team throughout this period. Dr. Israels had thought that she should be excluded even before the laparotomy - that was one of the fierce arguments - but he lost, largely because there was no direct evidence of her harming the child and no one liked to believe it. Dr. Israels took no account of personal considerations - in fact, he sounded, in evidence, as if he had a chess problem in front of him. The mother was the only non-medical staff person present and so the most obvious source of possible intrusion. Also it was a non-invasive procedure as far as R[redacted] was concerned.

I should mention that infections were not only continuing but getting worse. On June 2nd, 1996, she was septic again with no less than 3 separate organisms, and quite ill, getting near the danger level and running a fever till June 29th.

B[redacted] S. had consistently opposed refeeding on the grounds that R[redacted] had suffered so much during the refeeding last fall. When it was suggested that she be excluded from the hospital while R[redacted] would be refed, naturally she opposed that too. There is some evidence that she changed her mind when she realised that the medical team was determined to do this anyway, but the doctors weren't going to rely on her at this stage - mutual trust had broken down as I shall discuss later. On July 8, 1996 an ex parte order excluding her was made under S.29(3) of the Act, and on August 1st R[redacted] was apprehended, giving rise to these proceedings.

Following July 9th when B[redacted] S. left Children's Hospital R[redacted] enjoyed what I can only call a miraculous recovery from the medical point of view. They had one recurrence of an infection on July 14th which cleared up within 24 hours - I should add that Dr. Riddell said that the progress from entry of a bacteria to symptoms of infection isn't an instantaneous thing but may be delayed for days, so the timing of this infection when B[redacted] S. has an alibi for it, so to speak, isn't conclusive that she didn't cause it. We aren't lucky enough to have such solid pieces of evidence to work with. But there have been no further reported infections.

They started feeding R[redacted] through another J-Tube, on the theory of working up from the most easily digested means. They were able to increase the feed till by early August they were able to take her off the IV and even feed her a bit by mouth. On August 26th they took out the J-tube and fed directly into her stomach with a G-tube. All this went without significant retching and vomiting and no diarrhoea at all. On October 2nd she was well enough to leave hospital for a foster home. In early November she stopped feeding by the G-tube and fed totally by mouth. She's taking enough food to even gain weight. She is now back at school - in fact back where she was in the summer of 1994 before her feeding troubles started. The speed and completeness of this recovery are truly striking.

HISTORY - B[redacted] S.

Ms. S. is 38 years of age, from the Kamloops area, once married for a short while and divorced. She has been interested in handicapped children since she was a teen and baby-sat one. After the divorce she adopted R[redacted]. In fact she didn't stop there. By the spring of 1995 she was also fostering a 4 year old Downs' Syndrome child and a 21 year old Angelman's Syndrome child. She also applied to adopt another child at one stage. When R[redacted] got really sick and B[redacted] moved to the hospital, she gave up the 4 year old and the 21 year old. All the psychiatrists and psychologists tell me that her life revolves around the care of the handicapped, and that she isn't psychologically abnormal.

She is a member of a Kamloops Group called SNAP - Special Needs Adoptive Parents, - the Queen Bee of whom is a lady named Cheryl Lenchewski. I have this note of Ms. Lenchewski's evidence, "I told B[redacted] to find out what they were doing and why down at Children's Hospital. I found those doctors to be too high and mighty. B[redacted] is too naive and trusting. I was getting her to be demanding of Doctors. She had to understand everything". Ms S. certainly took this advice to heart; she was demanding and critical of them throughout. The catch-word was "advocate" - she must be an "advocate" for her child. The SNAP approach to doctors and hospitals reminds me of kicking your TV to get it to work better - you might get lucky once or twice but in the long run it will be counterproductive.

So it proved for Ms. S. anyway. She had, in her evidence before me, no good word to say for any doctor (until I pointed it out). I have already mentioned her criticisms of Dr. Olson who did the first G-tube placement. Her relations with the profession deteriorated from there into a power struggle. In Kamloops she cancelled a Doctor's feeding programme for R[redacted]. At Children's Hospital she cancelled a barium study Dr. Riddell had ordered. I sympathize with her often expressed feeling that if R[redacted] were going to die she shouldn't have to go through those painful refeedings trials but should be allowed to go home to die in peace. Anyone would feel that way. But because of her distrust of the doctors, she was too willing to write R[redacted] off - indeed the doctors proved that in the end. Her ideas were based on insufficient knowledge and often on her own limited experience, viz: her frequent remarks that she thought R[redacted] had cancer of the bowel because her own father and brother had died of it.

At times one gets the impression that Ms. S. had inflated expectations of her position at Children's Hospital. Here is a quote from a Parent's Data Base she filled in (Notes volume 6A-p.2121):

> "Very frustrated re communication and lack of acknowledgement of my concerns and expertise in dealings with my own child who is chronically ill."

I add one thing about Ms. S.. She isn't a reliable witness. She got some quite large payments (totalling $69,000) from a health insurance policy for [redacted]'s hospitalization. I can't accept that as a motive for harming R[redacted], first because that money didn't even make her break even financially, and secondly because the passion with which this whole trial and sequence of events has unfolded has to be about the child, not about money. But nevertheless many of her communications with the company, both at the beginning in the policy application and at the end in the claims forms seemed to me deceptive. The last letter she wrote in which she claimed for the period after R[redacted] had been apprehended and was no longer in her care, was really grossly misleading. I take the opportunity to apologise to Mr. Hamilton for initially criticising him for leading this evidence. When Ms. S.'s evidence contradicts that of other witnesses I shall tend to accept theirs.

EXPERT EVIDENCE

Because the history of this case unfolded in hospitals, we have had many expert witnesses. For the same reason, most of the evidence that they gave was narrative, interspersed with opinion as needed. Furthermore very little of that evidence was contradicted. The history from R[redacted]'s point of view, as I described it, is not really contentious. I must however comment on three things.

> 1. Dr. Slater no doubt for the best motives showed himself to be such an advocate for Ms. S. that I cannot accept his opinions as objective.
>
> 2. In so far as any expert purported to opine that Ms. S. either did or didn't harm her child, I do not accept that as a proper matter for expert evidence. Weighing evidence is a matter for the court.
>
> 3. Munchausen's Syndrome by Proxy alias Factitious Illness, has turned out to be a red herring as far

as I am concerned. The issue is whether or not Ms. S. harmed her child. Evidence that Ms. S. suffered from a psychological condition that caused her or predisposed her to harm her child would of course have been relevant. But all the experts who testified on Munchausen's denied that it was such a psychological condition. The words were only used to describe "a particular form of child abuse, where illness in a child is fabricated simulated or induced, usually by a caregiver" (definition given by Dr. Hlady, but generally approved by everyone else who dealt with it). What I draw from this is that I have to make the conclusion that B[redacted] S. induced illness in R[redacted] BEFORE I can call it a case of Munchausen's which is the wrong way round as far as I am concerned.

I add that the "typical motivation" for Munchausen's given by Dr. Mitchell and others is to seek attention from Doctors and the medical community. I suppose there are Doctor groupies, but I don't think that the universality of such motivation will be self-evident to anyone except Doctors. Certainly Ms. S. seems to have disliked and distrusted most doctors.

DISCUSSION

The central fact in this case, which overshadows all others, is the speed and completeness of R[redacted]'s recovery after B[redacted] S. was excluded. The doctors naturally accepted this as cause and effect, i.e. that B[redacted] S. had harmed the child while she was in the hospital with her, that when she was excluded the harm ceased, and that the cessation let to the recovery.

Beyond that circumstantial evidence, we have little besides speculation. What we have, I consider in point form:

1. The medical problems R[redacted] suffered from August, 1995 through July, 1996 were of three general types - vomiting, diarrhoea and infections - which combined to make her unable to digest food. These three problems could all have been caused by sabotage, fairly easily and without much risk of detection. But there is no direct evidence that they were.

2. If they were caused by sabotage, B[redacted] S. is the obvious suspect, having the physical opportunity and the medical knowledge. In fact she was the only constant person in attendance on R[redacted] the doctors and nurses coming and going. But there is no direct evidence linking her to any such sabotage.

3. R[redacted]'s quick and complete recovery was due to her successful refeeding in July, 1996. One must contrast that with the several failed attempts at refeeding between August, 1995 and April, 1996. The B.C. Children's Hospital team were satisfied, as I have said, that they had not only isolated, but also demonstrated, B[redacted] S. as the cause of their earlier failures. In spite of that there could have been other factors in play, for instance:

- refeeding R[redacted] hadn't been tried between April and July, 1996. It could be argued that perhaps it would have succeeded in July, 1996 even if B[redacted] S. had remained.

- the July, 1996 refeeding used an operative J-tube. The last time R[redacted] had been fed through an operative J-tube was prior to November 15, 1995. Perhaps feeding through an operative J-tube would have succeeded in July, 1996 even if B[redacted] S. had remained.

- perhaps, after all, the eosinophils had an unexpected effect.

- Maybe R[redacted] infected her own G-tube and IV sites, in spite of her lack of fine movement coordination.

- the Hospital Team's conclusion that B[redacted] S. was sabotaging their efforts depended on a process of elimination, which is a notoriously uncertain process. Both Dr. Hlady and Dr. Riddell admitted that it was not practical to cover all possible alternatives particularly with a fragile child like this where her ability to withstand tests was a wasting asset.

But here again, we're dealing in speculations and possibilities, not direct evidence.

4. Presence or absence of motive on B[redacted] S.'s part is endlessly arguable. I was impressed by her declared love for the child and find it hard to believe that she would deliberately have caused R[redacted] all this suffering. I find the idea that she would have done it for insurance benefits, or to impress doctors as per the Muchausen theory, doubly hard to believe. However she did get into the power struggle with the doctors, and I never underestimate the temptation to prove oneself right in such struggles. Also, she

> stated several times that if R[redacted] was going to die anyway (and one must never forget R[redacted]'s short life expectancy) she should be allowed to go home and die in peace. Perhaps a surreptitious act to hasten this desirable day isn't too hard to understand. But if we postulate intentional infection for the purpose of getting R[redacted] home, why did she keep getting infected in the Spring of '96 when she was home? We can theorise but it is hard to construct a theory which fits all the facts. Here again we are in the realm of speculation.

In summary, I can say that the case thus approximates to a fact pattern, familiar in allegations of physical abuse to a child. We see what is apparently the result of intentional injury to the child and the parent is the obvious suspect. But the parent denies causing the injury and we have no direct evidence how the injury was caused. Mr. Bellamy argues, for the mother, that the case doesn't really fit that fact pattern because R[redacted]s various illnesses aren't apparently the result of intentional injury. I agree that in most such cases the relationship of the result to the injury is more clear cut - e.g. bruises, broken bones, etc, that are obviously the result of traumatic injury. I agree that the nature and complication of R[redacted]'s illnesses make it more difficult to deduce the cause as injury. But I'm convinced by the evidence of Drs. Hlady, Riddell and Israels that interference with medical procedures, probably intentional, is the most likely cause of R[redacted]'s illness, and that brings it within the fact pattern.

I'm not just relying on the doctor's opinions here. As I have said, this is essentially a matter of cause and effect, of the weighing of evidence; I regard it as falling within the Court's sphere to rule on the facts that the doctors have related and explained to me, and I have so ruled. Particularly convincing to me were the long series of serious infections in a supposedly antiseptic environment, which ceased almost immediately after B[redacted] S.'s exclusion.

THE LAW

The fact pattern which I have outlined has caused frequent problems under Child Protection legislation.

Under both our old statute (***The Family and Child Service Act SBC 1980 Chapter 11***) and our new statute (***The Child, Family and Community Service Act SBC 1994 Chapter 27***) the basic plan of Court Proceedings is similar:

> 1. A child is apprehended on the grounds he is "in need of protection". This is a term of art defined in S.1 of the old Act and S.13 of the new.
>
> 2. There will be heard, or at least begun, within a specified time limit, a hearing to determine whether he was or was not in need of protection. (S.13(1) of the old Act - S.40(1) of the new).
>
> 3. Only if the child is found to be in need of protection can the Court proceed to make one of the disposition orders provided (S.13(1) of the old Act - S.41(1) of the New). The finding of "in need of protection" is a threshold that the Superintendent (or now Director) must surmount.
>
> 4. The issue whether a child is "in need of protection" is, of its nature, an issue of fact. The burden of proof lies on the Superintendent (or now Director) and the standard of proof was traditionally quite high. It wasn't proof beyond a reasonable doubt, but the Judge had to be "reasonably satisfied" bearing in mind the "nature and consequences of the fact or facts to be proved", which were of course usually of a serious nature.
>
> > See WARNOCK vs GARRIGAN (1978) 8BCLR 26 (BCCA) and cases cited therein
> >
> > SMITH vs SMITH (1952) 2SCR 312 (SCR)
> >
> > BRIGINSHAW vs BRIGINSHAW (1938) 60 CLR 336 (Australia)

Under this procedure and these standards, the evidence vacuum commonly made these physical abuse cases hard to litigate.

I turn to the case of *Superintendent vs. G.* (1989) 22RFL 3rd pl. (B.C.C.A.), which fitted the fact pattern I had outlined above point by point. There were twin 5 month old babies who both had extensive rib fractures and other damage, apparently the result of intentional injuries; the injuries must have happened when they were in the care of the parents and while there was lots of speculation about how the injuries could have been caused, there was no real proof. The parents denied hurting the children, and they were impressive witnesses. None of the usual indicators in the parents' personalities with respect to physical abuse was present. There was a potential alternative cause for the injuries in the person of a jealous older sister. The trial judge (myself) approached the case in the traditional statutory manner by concentrating on whether the twins were in need of protection and holding, in effect, that there was simply not enough evidence to made a finding - the injuries might point to abuse by the parents but all the other evidence pointed to some other explanation, probably the sister.

The Court of Appeal reversed this judgment and held the twins to have been in need of protection. There were two judgments which arrived at that conclusion in two separate ways.

Locke J.A., at p.9, got there by lowering the standard of proof. He adopted an obiter statement of Proudfoot J. in *Superintendent vs. M.* (1982) 28 RFL 2nd p. 278 (BCSC) at p. 287:

> "while I say the test to be applied is, on the balance of probabilities, as to what is in the best interests of the Child, no such test exists when we deal with the element of risk of injury. I am satisfied that a much lower test would be applicable when we are dealing with that aspect".

Applying that lower test, as "the proper standard of proof", he allowed the appeal. It is fair to say that this approach, raising as it does the difficult question of what is a "much lower test" than the balance of probabilities, hasn't been widely followed.

Hinkson, J.A., at p.7, used s.2, the "paramountcy section", to make end run around the need for a finding of "in need of protection" and proceed directly to the making of a disposition order.

S.2 of the old Act provides:

> "In the administration and interpretation of this Act the safety and well-being of a child shall be the paramount considerations".

I pause to say that S.2 of the new Act includes the same provision. Hinkson J.A. said:

> "The starting point for a judge hearing an application pursuant to s. 13 of the Act is to consider the safety and wellbeing of the children. In the present case the evidence disclosed serious injuries to each of the twins while they were in the custody of the parents. The cause of those injuries was unexplained. In those circumstances it was for the hearing judge to consider at the outset whether in those circumstances, having regard to the safety and wellbeing of these children, they should be placed in the custody of the superintendent for a period of six months.
>
> That is the focus that is required when the hearing judge is called upon to made a decision on such an application."

It is this rather daring approach that has, in my experience, been generally followed, no doubt because it sends such a clear and powerful message that the safety and well-being of children must override all else. My colleague Judge Stansfield, in the unreported case of *Superintendent vs. H.L.* (1995) Provincial Court, Kelowna Registry No. 24861, has usefully synopsised this decision as follows at paragraph 25:

> "I understand the ratio of Mr. Justice Hinkson's decision to be that if a child has suffered harm while in the care of her parents, in the absence of proof of a cause unrelated to the parents' care, the hearing judge must protect against the reasonable apprehension that the parents may have been the cause of the injury. The child must in that circumstance be understood to be in need of protection, and the hearing judge must move to the second stage of the inquiry under section 13(1)."

Mr. Bellamy has argued that the authority of this case has been shaken by a recent Supreme Court of Canada decision:

> *B.R. vs Children's Aid etc.* (1995) 9.R.F.L. 4th p. 157. (S.C.C.)

It is true that certain remarks of La Forest J. indicate an attachment to due process and what I have called "an approach in the traditional statutory manner"; also a distaste for weakening the standard of proof, as for instance at p. 211 where he says that the "Children's Aid Society must present a strong case." It may be that La Forest J. would disapprove of both the lowering of the standard of proof by Locke J.A. and the short-circuiting of the threshold finding, by Hinkson J.A. But these matters weren't before him and one must always remember that Child Protection is a statutory field in which each Province has passed quite different statutes. For instance, *B.R. vs. Children's Aid* is an Ontario case, and the relevant Ontario statute has no paramountcy section that counsel or I could find, so it is hard to see how such a decision could affect Hinkson J.A.'s decision in the *G.* case.

I conclude that the B.C. Court of Appeal's decision in the *G.* case is still good law, and that authority governs the decision I must make in this case.

DECISION

I turn to Judge Stansfield's clear restatement of Hinkson J.A.'s decision in the *G.* Case, and I rule:

1) R[redacted] was still in the care of her mother while in the hospital.

2) She suffered harm while in that care.

3) There is no proof of a cause unrelated to her mother's care.

4) There is a reasonable apprehension that her mother may have been the cause of R[redacted]'s illnesses or some of them.

5) I therefore find R[redacted] to have been in need of protection on ground (a) of S.13. I conceive that taking Hinkson J.A. literally, I may not need to, but I don't want to leave a loose end.

6) Alternatively, under the lowered standard of proof laid down by Locke J.A. I find R[redacted] to have been in need of protection on the same grounds. I deliberately refrain from stating what my decision would have been had I had to decide on a balance of probabilities, or any higher standard. That would have placed me back in the dilemma from which the *G.* case delivered me.

Having made this finding I turn to disposition order under S.41, and should like to state for guidance of counsel, that I lean in favour of a 6 month temporary order under S.41(1)(c). This raises the question of terms of access. I invite further submissions, and if desired further evidence under S.40(3)(b).

The Honourable Judge P. D'A. Collings

Provincial Court Judge

March 12, 1997