WARNING

The court hearing this matter directs that the following notice should be attached to the file:

This is a case under Part III of the *Child and Family Services Act*, R.S.O. 1990, c. C-11, as amended, and is subject to subsections 48(7), 45(8) and 45(9) of the Act. These subsections and subsection 85(3) of the *Child and Family Services Act*, which deals with the consequences of failure to comply, read as follows:

> **45.**—(7) *Order excluding media representatives or prohibiting publication.*— The court may make an order,
>
> . . .
>
> (*c*) prohibiting the publication of a report of the hearing or a specified part of the hearing,
>
> where the court is of the opinion that . . . the publication of the report, . . ., would cause emotional harm to a child who is a witness at or a participant in the hearing or is the subject of the proceeding.
>
> (8) *Prohibition: identifying child.*— No person shall publish or make public information that has the effect of identifying a child who is a witness at or a participant in a hearing or the subject of a proceeding, or the child's parent or foster parent or a member of the child's family.
>
> (9) *Idem: order re adult.*— The court may make an order prohibiting the publication of information that has the effect of identifying a person charged with an offence under this Part.
>
> . . .
>
> **85.**—(3) *Idem.*— A person who contravenes subsection 45(8) (publication of identifying information) or an order prohibiting publication made under clause 45(7)(*c*) or subsection 45(9), and a director, officer or employee of a corporation who authorizes, permits or concurs in such a contravention by the corporation, is guilty of an offence and on conviction is liable to a fine of not more than $10,000 or to imprisonment for a term of not more than three years, or to both.

Brantford Registry No. C287/14E
DATE: 2014·XI·14
CITATION: *Hamilton Health Sciences Corp. v. D.H.*, 2014 ONCJ 603

ONTARIO COURT OF JUSTICE

B E T W E E N :

HAMILTON HEALTH SCIENCES CORPORATION,
Applicant,

— AND —

D.H., P.L.J., SIX NATIONS OF THE GRAND RIVER CHILD AND FAMILY SERVICES DEPARTMENT and BRANT FAMILY AND CHILDREN'S SERVICES,
Respondents.

Before Justice Gethin B. Edward
Heard on 17, 18, 22 and 25 September 2014; and 2, 3, 8, 16 and 22 October 2014
Reasons for Judgment released on 14 November 2014

STATUTES AND REGULATIONS CITED

Canadian Charter of Rights and Freedoms, being Part 1 of Schedule B to the *Canada Act 1982*, c. 11 (U.K.), section 1.

Child and Family Services Act, R.S.O. 1990, c. C-11 [as amended], subsection 37(2), clause 37(2)(*e*), subsection 40(1), subsection 40(2), subsection 40(4), subsection 40(7) and section 72.

Constitution Act, 1982, being Schedule B to the *Canada Act 1982*, c. 11 (U.K.), section 35 and subsection 35(1).

Health Care Consent Act, 1996, being Schedule A to the *Advocacy, Consent and Substitute Decisions Statute Law Amendment Act, 1996*, S.O. 1996, c. 2 [as amended], subsection 4(1).

CASES CITED

Children's Aid Society of Ottawa v. S.(C.) and S.(J.), 2005 CanLII 44174, 205 O.A.C. 245, [2005] O.J. No. 5060, 2005 CarswellOnt 8193 (Ont. Div. Ct.).

Children's Aid Society of Toronto v. P. (Lois) and P. (Nathan), 2010 ONCJ 320, 192 A.C.W.S. (3d) 176, [2010] O.J. No. 3508, 2010 CarswellOnt 5999 (Ont. C.J.).

Re Tarin Hughes: Children's Aid Society of Metropolitan Toronto v. Hughes and Truckel, unreported decision of Justice Janet M. Wilson (Ont. Gen. Div., 5 January 1996).

R. v. Van der Peet, [1996] 2 S.C.R. 507, 200 N.R. 1, 80 B.C.A.C. 81, 23 B.C.L.R. (3d) 1, 130 W.A.C. 81, [1996] 9 W.W.R. 1, 137 D.L.R. (4th) 289, [1996] 4 C.N.L.R. 177, 109 C.C.C. (3d) 1, 50 C.R. (4th) 1, 1996 CanLII 216, [1996] S.C.J. No. 77, 1996 Carswell-BC 2309.

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Martin-Hill, Dawn: *Traditional Medicine in Contemporary Contexts — Protecting and Respecting Indigenous Knowledge and Medicine* (Ottawa: National Aboriginal Health Organization, 2003).

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Daphne G. Jarvis and Meghan A. Lindo ..... counsel for the applicant hospital
Eliza J. Montour ..... counsel for the respondent Six Nations of the Grand River Child and Family Services Department
Mark Handelman and M. Elizabeth Capitano .... counsel for the respondent children's aid society
No appearance by or on behalf of the respondent mother, D.H., even though served with notice
No appearance by or on behalf of the respondent father, P.L.J., even though served with notice
Sandra J. Harris ..... counsel for the Office of the Children's Lawyer, legal representative for the child J.J.

JUSTICE G.B. EDWARD:—

1: INTRODUCTION

[1] The applicant hospital has brought an application under subsection 40(4) of the *Child and Family Services Act*, R.S.O. 1990, c. C-11, as amended, against the respondent children's aid society. It is an unusual request brought about by a very sad circumstance. The subject child of this application is an 11-year-old girl from The Six Nations of the Grand River, named J.J.

[2] In August of this year, J.J was diagnosed with acute lymphoblastic leukemia (A.L.L.). A.L.L. is a form of cancer in the bone marrow. The applicant hospital's position is that it is treated with chemotherapy delivered in a number of phases. In J.J.'s case, the applicant's initial testing indicated she had a 90 to 95% chance of being cured. The specialists at the applicant hospital are not aware of any survivor of A.L.L. without chemotherapy treatments.

[3] Although J.J. had commenced chemotherapy treatment, it was discontinued in August of this year.

[4] This case brings up a number of issues, including whether this court is the appropriate forum and what effect section 35 of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982*, c. 11 (U.K.), has in this court's deliberations.

2: THE PARTIES

[5] When this matter was first returnable on 17 September last, only the applicant hospital, the respondent society and the Children's Lawyer were before the court. However, this court ordered the child's parents, D.H. and P.L.J., as well as the Six Nations Band to be added to this application. At the time the court added these parties, it was felt there was an obvious need for input from the child's parents and the band.

[6] In fact, the band participated throughout these proceedings; however, the child's mother, D.H. and the child, J.J. left the jurisdiction at or near the time of the first return of the application to purportedly attend an alternative cancer treatment facility in Florida.

3: A TIMELINE OF THE EVENTS

[7] As part of the applicant's "bullet point submissions", applicant's counsel prepared a timeline of events that helps to frame the discussion and which I now summarize for the most part.

[8] On Monday, 11 August 2014, J.J. attended the emergency room where blood tests showed an irregularity resulting in J.J.'s admission to the applicant hospital for further investigation. On Wednesday, 13 August 2014, J.J. was diagnosed with high-risk acute lymphoblastic leukemia, or A.L.L. On Friday, 15 August, J.J. began what's described as the induction phase, or, 32 days of chemotherapy treatment.

[9] Initially, J.J.'s treatment was overseen by Dr. Marjerrison, an oncologist with the applicant hospital. However, on 25 August, Dr. Breakey, another staff oncologist with the applicant hospital, took over J.J.'s case.

[10] On Wednesday, 27 August, the applicant hospital indicates D.H. withdrew consent for the continuation of her daughter's chemotherapy treatment.

[11] On that same day and pursuant to section 72 of the *Child and Family Services Act*, Dr. Breakey calls the respondent society to report that D.H. is not prepared to have her daughter continue with chemotherapy treatment. On Thursday, 28 August, the society's intake worker, Greg Skye, contacts D.H., a Six Nations Band council representative and consults with his manager, Kim Martin.

[12] On Friday, 29 August, Mr. Skye returns Dr. Breakey's call and, later that same day, meets with Dr. Breakey and other hospital staff, and receives an undated letter written by Dr. Breakey, addressed to the respondent society's director, which letter was also faxed to the director. I stop here to quote this letter in its entirety, which was introduced as part of exhibit 1.

To the Director of the Brant Families and Children's Services,

It is with grave concern that I report the medical neglect of [J.J.]. [J.] is an 11 yo girl who has been admitted for medical therapy of acute lymphoblastic leukemia since her diagnosis on August 12, 2014. Her mother, [D.H.], initially agreed to treatment with chemotherapy, but decided on August 27 to discontinue the treatment with the plan to treat [J.] with traditional medicines.

As a medical team, we feel that this decision to terminate chemotherapy puts [J's.] life at risk. Given her clinical diagnosis and the genetic tests to assess her risk stratification, this leukemia has an approximately **90% cure rate with the recommended treatment.** Without chemotherapy, we are not aware of any survivors of paediatric leukemia.

We are concerned that [J's.] mother is making this decision independently and under significant stress. [J.] is 11 years old and we feel she is not able to make an informed consent to withdraw from therapy. She is not feeling well from both the cancer and the treatment. We feel that even though she is unwell now, she will regain strength and improve in the coming weeks on the treatment plan. We feel that [D's.] decision to discontinue the only proven therapy will remove any chance of cure and that [J.] will die of a curable condition.

Given that [J.] can not make her own decision, and that the medical team does not agree with the mother's decision, we ask that the Brant FACS intervene to ensure that [J.] gets the medicine that she needs to give her the best possible chance at survival. In our experience, children who survive this type of childhood leukemia are able to live long and independent lives with little in the way of long-term effects of therapy.

Please contact me for any additional information.

Vicky Breakey, MD, Med, FRCPC
Assistant Professor, McMaster University
Pediatric Hematologist/Oncologist
McMaster Children's Hospital
HSC 3N27a-1280 Main St. W.
Hamilton, Ontario, L8S 4K1

[13] On 2 September, a series of telephone calls occur surrounding the appointment of the Children's Lawyer and the involvement of the Six Nations Band Representative.

[14] On 4 September, a further telephone discussion occurs between Mr. Skye and hospital staff to discuss J.J.'s impending discharge from the applicant hospital. On that same day, the Children's Lawyer, Sandra Harris, meets with J.J. and her family.

[15] On 8 September, the applicant hospital says it first became aware of the plan to take J.J. to Florida to undergo the alternative treatment plan.

[16] On that same day, Mr. Skye advises Dr. Breakey that the society is aware of the travel plans and that the society has no plans to intervene.

[17] On that same day, Dr. Breakey meets with D.H. to discuss the need to complete intravenous antibiotics for J.J.

[18] Dr. Breakey then faxes another letter to the society dated 8 September 2014, and also introduced as part of exhibit 1, which re-states the family's refusal of chemotherapy for J.J. and further expressing concerns about the need for J.J. to complete the course of treatment for the intravenous infection prior to the family travelling to Florida.

[19] On 8 September, D.H. agrees to postpone the trip to Florida for one week and J.J. is discharged from hospital with follow-up visits planned for 11 and 15 September. In fact, J.J. missed the 11 September appointment but attended the next day for the follow-up.

[20] On 12 September, the society manager spoke to Dr. Breakey about the applicant's undated letter delivered to the society on 29 August. Specifically, the conversation focused on J.J.'s incapacity.

[21] On 15 September, J.J. attended the applicant hospital for her second follow-up.

[22] On Tuesday, 16 September, the society's executive director, Andrew Koster, and the society's director of Native Services Branch, Sally Rivers, met with the applicant's senior hospital administrators to explain the society's decision not to intervene.

[23] At 4:40 p.m., applicant's counsel faxes a letter to society counsel and OCL regarding its intention to bring an application under subsection 40(4) of the CFSA returnable on 17 September.

[24] On 17 September, Dr. Breakey writes and faxes a letter to the society but dated 16 September which addresses the issue of J.J.'s capacity from the perspective of the applicant hospital. On this issue, I quote the following from Dr. Breakey's letter, which has been introduced as exhibit 2.

> On Thursday September 11, 2014 I received a phone call from Ms. Kim Martin, Supervisor at Brant FACS. She voiced her concern that in my previous letter, I suggested that (J.) is not capable of making her own medical decisions. She suggested that I was incorrect to state:
>
> > We are concerned that [J's.] mother is making this decision independently and under significant stress. [J.] is 11 years old and we feel she is not able to make an informed consent to withdraw from therapy.
>
> I wish to be clear that based on my assessments and interactions with [J.], as well as with input from other members of our treatment team, I have found that [J.] is not capable of making an informed decision. During her time in hospital, [J's.] diagnosis was explained to her in very simple terms. She did not ask questions and deferred all discussions to her mother. She lacks the maturity even of typical children her age and did not have the capacity to understand the details of her complex therapy. She was therefore not included in the initial disclosure meeting when the diagnosis and therapy plan was discussed in more detail with her mother, who is her substitute-decision-maker. In the days that followed, she was not able to describe her symptoms and did not address questions directly asked by the medical team, but looked to mom for her responses. I have found that she lacks the ability to understand her diagnosis and its therapy, nor could she possibly fully appreciate the consequences of the decision to stop chemotherapy. During her hospitalization, [J.] did not exert any independence and looked to her mom for every answer

> and decision. In my experience, this is not unusual for an eleven year old child. Most of my patients at this age are scared and would do anything to feel better and leave the hospital. I feel that [J.] would not be able to give informed consent for therapy or its discontinuation. [J's.] mom was clear that this was her decision and that she felt it was "best for [J.]" to discontinue chemotherapy.

[25] As I indicated earlier, on 17 September, the applicant and respondent and the Children's Lawyer made their first appearance before me. At that time, I made an order that J.J. not be removed from the Province of Ontario without further order of the court. Despite best efforts by Sally Rivers of the society, D.H. and J.J. were already on their way to Florida and declined to return.

4: THE CAPACITY ISSUE

[26] In its argument, the respondent society has stated that J.J. is not a child in need of protection but rather a child in need of a diagnosis.

[27] As such, the society argues this case should more properly be adjudicated before the Consent and Capacity Board as provided under the *Health Care Consent Act, 1996*, being Schedule A to the *Advocacy, Consent and Substitute Decisions Statute Law Amendment Act, 1996*, S.O. 1996, c. 2. Moreover the respondent society argues that J.J.'s capacity or lack thereof as argued by the applicant hospital was never properly assessed, nor was the finding of incapacity ever properly articulated to J.J. or D.H., the substitute decision-maker.

[28] To this argument, the applicant hospital responds that they have determined that J.J. is not capable of making an informed decision, that they have concluded D.H. is J.J.'s substitute decision-maker and that, by deciding to discontinue J.J.'s chemotherapy, that decision has placed J.J. at medical risk and thus a child in need of protection.

[29] To properly assess these competing arguments, we need to consider the evidence raised at the hearing. The hearing of evidence on the application took place on 17, 18, 22 and 25 September and 2, 3 and 8 October, and the argument was heard on 16 and 24 October.

[30] The scheduling was piecemeal, owing to the urgency of the matter. Counsel were most accommodating in making sacrifices to make themselves available. It is fair to say that this issue of urgency was recognized by counsel who were, for the most part, very focused on their questioning. One worries whether this urgency affects the fulsomeness of evidence that witnesses were able to provide.

[31] The court heard from Dr. Stacey Marjerrison who was the first doctor to diagnose and treat J.J. Dr. Marjerrison is a duly qualified paediatric oncologist who holds a blood cancer specialty. She was qualified as an expert to give opinion evidence on the nature of A.L.L., the expected outcomes of A.L.L. with and without chemotherapy treatment and the side effects of treating A.L.L. with chemotherapy.

[32] We learned that what triggered J.J.'s admission to the applicant hospital on 11 August was her low blood cell count and that further testing confirmed J.J.'s diagnosis of A.L.L.

on 13 August. We heard from Dr. Marjerrison that, when discussions occurred regarding the treatment procedure, J.J. would look to her mom. And when the side effects were described; that she would feel unwell and that her hair would fall out, again J.J. would look to her mom.

[33] When discussing whose decision it was to stop chemotherapy, Dr. Marjerrison's evidence was unequivocal. It was absolutely mom's decision. In quoting D.H., Dr. Marjerrison testified, "I [being D.H.] have decided this with [J.]".

[34] In cross-examination by the society counsel, Dr. Marjerrison acknowledged no one explained the role of the substitute-decision-maker to D.H. Nor did Dr. Marjerrison ever note in the hospital chart whether she felt J.J. was capable or incapable. Nor did Dr. Marjerrison ever tell J. about her lack of capacity to give consent.

[35] Nor, however, did Dr. Marjerrison resign from her firm belief that it was abundantly clear J.J. was not able to make her own decision on this life-or-death issue of whether to continue with her chemotherapy treatment. When specifically asked why she felt J.J. was not capable, Dr. Marjerrison replied, "she did not believe J.J. understood the details". And in response to the Children's Lawyer's questioning, Dr. Marjerrison indicated she never had a discussion with J.J. without D.H. in the room, saying, "it didn't seem appropriate" and that J.J. was not interested in a discussion without her mom being present.

[36] In re-examination, Dr. Marjerrison reminded the court she was treating an 11-year-old child with a disease, which, if left untreated, would cause her death. Dr. Marjerrison also reminded the court there was never any question from J.J. or her family surrounding the issue of capacity. And finally, at no time did J.J. ever disagree with the involvement of her mother in this decision-making.

[37] Dr. Breakey was the second paediatric oncologist called by the applicant hospital. She took over the care of J.J. on 25 August. She observed J.J. to be somewhat introverted and that D.H. was the active participant in medical discussions. She, like Dr. Marjerrison, concluded that D.H. was making the medical decisions for J.J. Again in cross-examination by society counsel, Dr. Breakey also acknowledged she made no notes regarding J.J.'s lack of capacity. Yet, Dr. Breakey firmly maintained that J.J. lacked the capacity to make life-and-death decisions. Dr. Breakey's view also appeared to be a belief shared with D.H. when Dr. Breakey described their relationship as follows: "You talk to me, I'll talk to [J.]".

[38] In assessing the evidence of the two doctors on the issue of J.J.'s lack of capacity, I simply cannot conclude Dr. Breakey's conclusion as set out in exhibit 2 is anything but accurate. Some of Dr. Breakey's letter bears repeating:

> In the days that followed, she was not able to describe her symptoms and did not address questions directly asked by the medical team, but looked to mom for her responses. I have found that she lacks the ability to understand her diagnosis and its therapy, nor could she possibly fully appreciate the consequences of the decision to stop chemotherapy.

[39] I find that the applicant's treatment team was correct in concluding J.J. lacked capacity to make such a life-and-death decision as to the discontinuation of chemotherapy.

Within the foregoing quote, Dr. Breakey reminds herself of the test to determine capacity as codified within subsection 4(1) of the *Health Care Consent Act, 1996*, and at common law. Certainly, the doctors may be criticized for not making chart entries on the issue of lack of capacity, but this letter certainly makes clear their findings of incapacity.

[40] Even having concluded that J.J. lacks capacity, counsel for the society would still urge the court to dismiss the applicant's claim and send the matter to the Consent and Capacity Board for it to determine whether D.H.'s decision to discontinue chemotherapy treatment is an appropriate course of treatment for a substitute decision-maker to make.

[41] Conversely, the applicant argues that D.H's decision to discontinue chemotherapy treatment is a child protection issue and its proper adjudication is before this court under the *Child and Family Services Act*.

[42] I would agree with the applicant hospital for these reasons. In 1996 in the case of *T.H. v. Children's Aid Society of Metropolitan Toronto et al.*, a case on appeal to Madame Justice Janet M. Wilson from both the Ontario Court (Provincial Division) as this court was previously called, and the Consent and Capacity Review Board, as the Consent and Capacity Board was previously called, Justice Wilson wrote, at page 33 of her decision:

> This case persuasively exhibits the need for one forum to determine whether a child is in need of protection for the purposes of medical treatment. Often these cases are emergencies. As in this case, it may well be a matter of life and death, with very short time frames. One forum should be determining all of the issues relevant to the inquiry with the benefit of the entire context and hearing all of the evidence. That forum is the Ontario Court (Provincial Division). Apart from the costly, and confusing procedures for the parties if a bifurcated proceeding was adopted, there are significant adverse cost consequences for the health system, the justice system, the Board and the child involved.

[43] In 2010, my colleague Justice Heather L. Katarynych in the case of *Children's Aid Society of Toronto v. Lois P. and Nathan P.*, 2010 ONCJ 320, 192 A.C.W.S. (3d) 176, [2010] O.J. No. 3508, 2010 CarswellOnt 5999 (Ont. C.J.), succinctly summed up the debate as follows, at paragraph [123]:

> This court's duty is to find coherence between the two statues. It would be frank mischief to interpret the *Health Care Consent Act, 1996* as an "over-ride" or "nullification" of the scheme of the *Child and Family Services Act* for management of a parent's refusal or inability to provide consent to medical treatment of a child.

[44] These two cases need further elaboration. Both cases saw medical evidence being led to the effect that the subject child in each case needed blood transfusions to survive and in both instances consent from the parents was not forthcoming because, as Jehovah Witnesses, authorizing blood and blood product treatment for their child would be breaking an important tenet of their faith. Both judge were provided with detailed argument on why their respective cases ought to be placed before the Consent and Capacity Board and both juges, as noted above, declined to do so. These decisions find support with other cases such as *Children's Aid Society of Ottawa v. C.S. and J.S.*, 2005 CanLII 44174, 205 O.A.C. 245, [2005] O.J. No. 5060, 2005 CarswellOnt 8193, a decision of the Ontario Divisional Court

where, at paragraph [14], the court stated:

> The parents also argued that there is reason to doubt the correctness of the decision in that the motions judge failed to consider a remedy under the *Health Care Consent Act, 1996* ("HCCA") as being the least intrusive alternative. Section 27 of that Act permits a doctor to administer emergency treatment to an incapable person despite the refusal of that person's substitute decision-maker, if the refusal was not made in the best interests of the incapable person. It is clear from the transcript that the application of that Act was considered by the motions judge. We agree with the society, however, that the Act is ultimately irrelevant to an application under the CFSA.

[45] Based on the precedents, I conclude this court is the appropriate forum to decide this case.

5: THE SOCIETY QUANDRY

[46] This is not to say the court is unsympathetic with the situation Mr. Koster, the executive director for the respondent society, found himself in at the end of August of this year.

[47] To its credit, the respondent society spent time investigating the situation. Its investigation revealed D.H. to be a devoted mother and concerned only with what was best for her daughter. This was a view even shared by the applicant hospital's doctors. Dr. Breakey testified she felt D.H. was an excellent mother and felt she was doing the best for J.J.

[48] Aside from the medical decision, the society's investigation concluded there was no protection concern as it related to D.H.'s care of J.J. As such, the society decided not to apprehend J.J. under the provisions of subsection 40(7) of the CFSA which reads:

> (7) *Apprehension without warrant.*— A child protection worker who believes on reasonable and probable grounds that,
>
> (*a*) a child is in need of protection; and
>
> (*b*) there would be a substantial risk to the child's health and safety during the time necessary to bring the matter on for a hearing under subsection 47(1) or obtain a warrant under subsection (2),
>
> may without a warrant bring the child to a place of safety.

It is acknowledged that the applicant hospital is considered a place of safety within the meaning of this section.

[49] At the risk of over-simplifying Mr. Koster's dilemma, if his reason for not apprehending J.J. was his doubt as to the appropriate course of medical treatment, was he not able to do what any prudent parent would do in a similar circumstance and travel 60 miles to the west of Brantford to get a second opinion from Western University's paediatric oncology department?

[50] The situation that now presents itself is untenable. J.J. has been discharged from the applicant hospital, we have heard of the fractured doctor-patient relationship and, if the court makes an order under subsection 40(4), one order that can be made is that one of the

respondent society's workers would have to bring the child to a place of safety. As revealed in the Band's cross-examination of the respondent society's intake manager, Kim Martin, that will have its challenges, given the support the Six Nations community has shown this family.

6: THE SUBSECTION 40(4) APPLICATION

[51] Subsection 40(4) of the *Child and Family Services Act* reads as follows:

> (4) *Order to produce or apprehend child.*— Where the court is satisfied, on a person's application upon notice to a society, that there are reasonable and probable grounds to believe that,
>
> (*a*) a child is in need of protection, the matter has been reported to the society, the society has not made an application under subsection (1), and no child protection worker has sought a warrant under subsection (2) or apprehended the child under subsection (7); and
>
> (*b*) the child cannot be protected adequately otherwise than by being brought before the court,
>
> the court may order,
>
> (*c*) that the person having charge of the child produce him or her before the court at the time and place named in the order for a hearing under subsection 47(1) to determine whether he or she is in need of protection; or
>
> (*d*) where the court is satisfied that an order under clause (*c*) would not protect the child adequately, that a child protection worker employed by the society bring the child to a place of safety.

[52] It is common ground that certain of the conditions in subsection (4) have been met. "On a person's application" is obviously the applicant hospital. No issue was raised as to whether a hospital is equated to a person and, in any event, Dr. Breakey initially commenced the application.

[53] Nor is it contested that the society was served, or that the matter had been reported to the society, as evidenced by the correspondence previously referred to and introduced as exhibit 1. Nor is it disputed that the society has not made an application under subsection 40(1), nor has a child protection worker sought a warrant under subsection 40(2) or apprehended the child under subsection 40(7).

[54] The real issue in this application is whether the court is satisfied there are reasonable and probable grounds to believe J.J. is a child in need of protection.

[55] It is not contested that the only applicable paragraph under the subsection 37(2) definition section of child in need of protection is clause (*e*), which reads as follows:

> (*e*) the child requires medical treatment to cure, prevent or alleviate physical harm or suffering and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable or unable to consent to, the treatment;

[56] Again to be clear, no one including the applicant hospital is suggesting D.H. is an-

yone but a caring loving parent.

[57] The applicant hospital's contention is simply that D.H.'s decision, as the substitute decision-maker, to discontinue chemotherapy for J.J. has made her a child in need of protection.

[58] The evidence is also clear that, at the 27 August meeting with the hospital staff, and as testified to by Dr. Marjerrison, D.H. had expressed her strong faith in her native culture and was discontinuing her daughter's chemotherapy treatment to pursue traditional medicine which she and her family believed would help to heal J.J.

[59] In referring to the intake manager Kim Martin's evidence, we learn her investigation revealed J.J. is one of a number of children born to D.H. The family are committed traditional longhouse believers who integrate their culture into their day-to-day living. In short, their longhouse adherence is who they are and their belief that traditional medicines work is an integral part of their life.

[60] It is at this juncture that the band argues the court must consider the application of subsection 35(1) of the *Constitution Act, 1982*, which reads as follows:

> 35.—(1) The existing aboriginal and treaty rights of the aboriginal peoples of Canada are hereby reorganized and affirmed.

[61] To understand the implications of this section, it is instructive to consider Professor Peter W. Hogg's *Constitutional Law of Canada*, 5th ed. (Toronto: Carswell, 2007, loose-leaf service), and specifically chapter 28.8 sub-paragraph (b), where the author writes:

> Section 35 is outside the *Charter of Rights* which occupies sections 1 to 34 of the *Constitution Act, 1982*. The location of s. 35 outside the *Charter of Rights* provides certain advantages. The rights referred to in s. 35 are not qualified by s.1 of the Charter, that is, the rights are not subject to "such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society" although, as we shall see, they are subject to reasonable regulation according to principles similar to those applicable to s.1. Nor are the rights subject to legislative override under s. 33 of the Charter. Nor are the rights effective only against governmental action, as stipulated by s. 32 of the Charter. On the other hand, the location of s. 35 outside the Charter carries the disadvantage that the rights are not enforceable under s. 24, a provision that permits enforcement only of Charter rights.

[62] With this overview, we need to start our analysis by determining whether D.H.'s decision, as J.J.'s substitute decision-maker, to pursue traditional medicine is in fact an aboriginal right to be recognized and affirmed. For this, the court looks to the Supreme Court of Canada's decision in *R. v. Van der Peet*, [1996] 2 S.C.R. 507, 200 N.R. 1, 80 B.C.A.C. 81, 23 B.C.L.R. (3d) 1, 130 W.A.C. 81, [1996] 9 W.W.R. 1, 137 D.L.R. (4th) 289, [1996] 4 C.N.L.R. 177, 109 C.C.C. (3d) 1, 50 C.R. (4th) 1, 1996 CanLII 216, [1996] S.C.J. No. 77, 1996 CarswellBC 2309. The majority opinion was delivered by our former Chief Justice Antonio Lamer. A statement of the facts in *R. v. Van der Peet* is set out at page 7 of the decision as follows:

> **II. Statement of Facts**

> **[5]** The appellant Dorothy Van der Peet was charged under s. 61(1) of the *Fisheries Act*, R.S.C. 1970, c. F-14, with the offence of selling fish caught under the authority of an Indian food fish licence, contrary to s. 27(5) of the *British Columbia Fishery (General) Regulations*, SOR/84-248. At the time at which the appellant was charged s. 27(5) read:
>
> > **27.**—(5) No person shall sell, barter or offer to sell or barter any fish caught under the authority of an Indian food fish licence.
>
> **[6]** The charges arose out of the sale by the appellant of 10 salmon on September 11, 1987. The salmon had been caught by Steven and Charles Jimmy under the authority of an Indian food fish licence. Charles Jimmy is the common law spouse of the appellant. The appellant, a member of the Sto:lo, has not contested these facts at any time, instead defending the charges against her on the basis that in selling the fish she was exercising an existing aboriginal right to sell fish. The appellant has based her defence on the position that the restrictions imposed by s. 27(5) of the Regulations infringe her existing aboriginal right to sell fish and are therefore invalid on the basis that they violate s. 35(1) of the *Constitution Act, 1982*.

[63] At page 11 of his decision, Chief Justice Lamer succinctly gets out the questions that "lies at the heart of this appeal: how should the aboriginal rights recognized and affirmed by subsection 35(1) of the *Constitution Act, 1982* be defined?"

[64] But before delving into defining what an aboriginal right is, Chief Justice Lamer made what I consider to be an incredibly important statement as to why aboriginal rights exist at all. At paragraph [30], he reminds us all of the following:

> In my view, the doctrine of aboriginal rights exists, and is recognized and affirmed by s. 35(1), because of one simple fact: when Europeans arrived in North America, aboriginal peoples **were already here**, living in communities on the land, and participating in distinctive cultures, as they had done for centuries. It is this fact, and this fact above all others, which separates aboriginal peoples from all other minority groups in Canadian society and which mandates their special legal, and now constitutional, status.

[65] So how did Chief Justice Lamer propose an aboriginal right was to be defined? At paragraph [46] of his decision he writes:

> In light of the suggestion of *Sparrow*, *supra*, and the purposes underlying s. 35(1), the following test should be used to identify whether an applicant has established an aboriginal right protected by s. 35(1): in order to be an aboriginal right, an activity must be an element of a practice, custom or tradition integral to the distinctive culture of the aboriginal group claiming the right.

[66] In the discussion preceding the recital of this test, Chief Justice Lamer emphasized the importance of the activity being integral to the culture of the aboriginal group claiming the right. He reiterated the importance of this factor at paragraph 55 of his decision:

> To satisfy the integral to a distinctive culture test, the aboriginal claimant must do more than demonstrate that a practice, custom or tradition was an aspect of, or took place in, the aboriginal society of which he or she is a part. The claimant must demonstrate that the practice, custom or tradition was a central and significant part of the society's distinctive culture. He or she must demonstrate, in other words,

> that the practice, custom or tradition was one of the things which made the culture of the society distinctive — that it was one of the things that truly made the society what it was.

[67] And further at paragraph [59], the Chief Justice writes:

> A practical way of thinking about this problem is to ask whether, without this practice, custom or tradition, the culture in question would be fundamentally altered or other than what it is. One must ask, to put the question affirmatively, whether or not a practice, custom or tradition is a defining feature of the culture in question.

[68] Another important consideration for Chief Justice Lamer in determining whether an aboriginal right existed was the time when the practice started. As he writes at paragraph [60]:

> The time period that a court should consider in identifying whether the right claimed meets the standard of being integral to the aboriginal community claiming the right is the period prior to contact between aboriginal and European societies. Because it is the fact that distinctive aboriginal societies lived on the land prior to the arrival of Europeans that underlies the aboriginal rights protected by s. 35(1), it is to that pre-contact period that the courts must look in identifying aboriginal rights.

[69] By way of a summary, the Chief Justice sets out the following at paragraph [63]:

> . . . Where an aboriginal community can demonstrate that a particular practice, custom or tradition is integral to its distinctive culture today, and that this practice, custom or tradition has continuity with the practices, customs and traditions of pre-contact times, that community will have demonstrated that the practice, custom or tradition is an aboriginal right for the purposes of s. 35(1).

[70] The issue of the practice having its roots in pre-contact times led the Chief Justice to suggest the rules of evidence to establish such facts would have to be relaxed. To this end, he writes at paragraph [68]:

> In determining whether an aboriginal claimant has produced evidence sufficient to demonstrate that her activity is an aspect of a practice, custom or tradition integral to a distinctive aboriginal culture, a court should approach the rules of evidence, and interpret the evidence that exists, with a consciousness of the special nature of aboriginal claims, and of the evidentiary difficulties in proving a right which originates in times where there were no written records of the practices, customs and traditions engaged in. The courts must not undervalue the evidence presented by aboriginal claimants simply because that evidence does not conform precisely with the evidentiary standards that would be applied in, for example, a private law torts case.

[71] Before leaving the case of *R. v. Van der Peet*, *supra*, it is instructive to note Chief Justice Lamer upheld Ms. Van der Peet's conviction by concluding she could not demonstrate that the exchange of fish for money or other goods was an integral part of the distinctive Sto:lo society prior to European contact.

[72] Can this court conclude, to paraphrase Chief Justice Lamer's summary, that the Six Nations' practice of traditional medicine is integral to its distinctive culture today, and that

this practice arose during pre-contact times, so that the community will have demonstrated that the practice is an aboriginal right for the purposes of subsection 35(1)?

[73] To begin with, did the practice of using traditional medicine for the Six Nations exist in pre-contact times?

[74] Professor Dawn Martin-Hill, currently holds the McPherson Indigenous Studies Research Chair in the Anthropology Department at McMaster University. At the hearing of this application, Professor Martin-Hill was found by this court to be an expert in the area of First Nations' traditional medicine and was therefore qualified to provide opinion evidence on the history of traditional medicines, the procurement of traditional medicines and the use of traditional medicines to treat First Nations communities.

[75] As part of her testimony, exhibit 27 was introduced on consent of all parties. This exhibit consists of two papers; the first being the *Haudenosaunee Code of Behaviour for Traditional Medicine Healers*, published by the National Aboriginal Health Organization, headquartered in Ottawa, and the second being a paper written for that organization by Professor Martin-Hill entitled *Traditional Medicine in Contemporary Contexts*. The reliance of the court on these materials recognizes Chief Justice Lamer's decision in *R. v. Van der Peet* to relax our application of the rules of evidence in understanding the history supporting First Nations' claims.

[76] As part of its introduction, the first paper describes one of the Haudenosaunee's stories of creation. I stop here to indicate that what is often referred to as the Iroquoian Confederacy is more properly called the Haudenosaunee, meaning people of the longhouse, with whom the Six Nations is a part.

[77] At page 4 of the first paper, the following is recited as part of the Haudenosaunee story of creation:

> Soon after this new world had begun its transformation, the Sky Woman gave birth to a baby girl. The baby girl was special for she was destined to give birth to twins. The Sky Woman was heartbroken when her daughter died while giving birth to her twin boys.
>
> The Sky Woman buried her daughter in the ground and planted in her grave the plants and leaves she clutched upon descending from the sky world. Not long after, over her daughter's head grew corn, bean, and squash. These were later known as the Three Sisters. From her heart grew the sacred tobacco, which is now used as an offering to send greetings to the Creator. At her feet grew the strawberry plants, along with other plants now used as medicines to cure illnesses. The earth itself was referred to as Our Mother by the Creator of Life, because their mother had become one with the earth.
>
> There is much more to our oral traditions, but the crux of this story explains how the Haudenosaunee received their knowledge of traditional medicines — medicines that are used by the traditional healers in ceremonies and healings to this day. Traditional medicine, as practiced by Haudenosaunee people, is key to the health and survival of Haudenosaunee as a nation.

[78] Certainly, this creation story supports the conclusion the use of traditional medi-

cines by Six Nations was practiced prior to European contact. Second, as to the **integral** nature of the practice, Professor Martin-Hill in her paper quotes from Christopher Jock's article "Spirituality for Sale: Sacred Knowledge in the Consumer Age":

> Traditional ceremonies and spiritual practices . . . are precious gifts given to Indian people by the Creator. These sacred ways have enabled us as Indian people to survive – miraculously — the onslaught of five centuries of continuous effort by non-Indians and their government to exterminate us by extinguishing all traces of our traditional ways of life. Today, these precious sacred traditions continue to afford American Indian people of all [nations] the strength and vitality we need in the struggle we face everyday; they also offer us our best hope for a stable and vibrant future. These sacred traditions are an enduring and indispensable "life raft" without which we would be quickly overwhelmed by the adversities that still threaten our survival. Because our sacred traditions are so precious to us, we cannot allow them to be desecrated and abused (CSPIRIT, 1993 IN Jock, 2001:66).

[79] Although it may be argued this is a general statement as to the integral role traditional ceremonies and spiritual practices play for First Nations communities, it is important to note that Dr. Karen Hill testified during the hearing. Dr. Hill is from Six Nations and is a duly qualified medical doctor, practicing family medicine on Six Nations. But despite being schooled in "western medicine", she operates a medical practice on Six Nations with Alba Jamieson, who practices traditional medicine. The point is traditional medicine continues to be practised on Six Nations as it was prior to European contact and, in this court's view, there is no question it forms an integral part of who the Six Nations are.

[80] One of the issues raised by the court during the hearing was the issue of integrity. To this end, I would reiterate how the evidence points to D.H. as being deeply committed to her longhouse beliefs and her belief that traditional medicines work. She has grown up with this belief. This is not an eleventh-hour epiphany employed to take her daughter out of the rigors of chemotherapy. Rather it is a decision made by a mother, on behalf of a daughter she truly loves, steeped in a practice that has been rooted in their culture from its beginnings.

[81] It is this court's conclusion, therefore, that D.H.'s decision to pursue traditional medicine for her daughter J.J. is her aboriginal right. Further, such a right cannot be qualified as a right only if it is proven to work by employing the western medical paradigm. To do so would be to leave open the opportunity to perpetually erode aboriginal rights.

[82] Further, as Professor Hogg reminds us, section 1 of the *Canadian Charter of Rights and Freedoms*, being Part 1 of Schedule B to the *Canada Act 1982*, c. 11 (U.K.), does not apply to a section 35 analysis. Nor am I satisfied that there has been an extinguishment of D.H.'s right to practise traditional medicine apart from the dark history of our country's prosecution of those who practised traditional medicine as described by Professor Martin-Hill.

7: CONCLUSION

[83] In applying the foregoing reasons to the applicant's subsection 40(4) application, I cannot find that J.J. is a child in need of protection when her substitute decision-maker has

chosen to exercise her constitutionally protected right to pursue their traditional medicine over the applicant's stated course of treatment of chemotherapy.

[84] The Application is dismissed. This is not an appropriate case to consider costs.

[85] I wish to thank all counsel for their efforts in this very difficult case.

Dated at Brantford, Ontario
This 14th day of November 2014

The Honourable Justice Gethin B. Edward