**S.C.C. File No. 31955**

**IN THE SUPREME COURT OF CANADA**
**(On Appeal from the Court of Appeal of Manitoba)**

BETWEEN

**A.C., A.C. and A.C.**

Appellants

-and-

**DIRECTOR OF CHILD AND FAMILY SERVICES**

Respondent

- and -

**ATTORNEY GENERAL OF MANITOBA**
**ATTORNEY GENERAL OF NOVA SCOTIA**
**ATTORNEY GENERAL OF ALBERTA**
**ATTORNEY GENERAL OF BRITISH COLUMBIA**
**JUSTICE FOR CHILDREN AND YOUTH**

Interveners

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# FACTUM OF THE INTERVENER JUSTICE FOR CHILDREN AND YOUTH

**Pursuant to *Rule 42* of the *Rules of the Supreme Court of Canada***

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**TABLE OF CONTENTS**

**Page**

## PART I – STATEMENT OF FACTS

### Overview

**1.** A.C., a 14 year old person assessed as having the capacity to make her own treatment decisions, was forced against her will to undergo medical treatment consisting of a blood transfusion. She was denied the right to make her own decision by virtue of Manitoba's *Child and Family Services Act (CFSA*), ss. 25(8) and 25(9), which were interpreted by the courts below to authorize the court to order such treatment. A.C. argues that the impugned sections of the *CFSA* do not oust her common law right to make her own treatment decisions based upon the finding of her capacity to do so.

**2.** If ss. 25(8) and 25(9) of the *CFSA* permit the court to order treatment in the circumstances of this case, then Justice for Children and Youth (JFCY) agrees with the Appellants that the sections unjustifiably infringe A.C.'s rights under ss. 15(1) and 7 of the *Charter*. Canada's international obligations, as manifest in the United Nations *Convention on the Rights of the Child,* together with the domestic law and the *Charter*, constitute legal recognition of the right of young persons to make medical decisions for themselves once they are capable. This is consistent with the obligation in Article 3 of the *Convention* to make decisions in the best interests of children, as their views and wishes acknowledged in accordance their evolving capacities and the recognition that children are entitled to exercise their rights, are to be considered part of this legal approach.

### Facts Relied Upon by Justice for Children and Youth

**3.** A.C. was born on June 7, 1991 and was 14 years 9 months at the relevant time for this appeal. She suffers from Crohn's Disease, which can lead to bleeding in her intestines. A.C. is a baptized member of the Jehovah's Witnesses and sincerely believes that her faith requires that she not consent to blood transfusions.[1]

**4.** A.C. was admitted to the hospital on April 12, 2006, with bleeding from her bowels, and advised hospital staff that she would not consent to blood transfusions. She requested alternatives to blood transfusions, such as intravenous (I.V.) iron and erythropoietin, drugs that stimulate the body's production of red blood cells.[2]

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[1] Affidavit of A.C. (April 30, 2006), at paras. 3 & 5-6, Appellant's Book of Authorities, Tab 29, pp. 210-211
[2] Affidavit of A.C. (April 30, 2006), at paras. 13-17 Appellant's Record, Tab 29, pp.213-214

**5.** On April 13, 2006, A.C. was assessed at the hospital at the request of her treating paediatrician to determine her capacity to decide her own medical care in respect of blood transfusions. Three hospital psychiatrists together conducted the assessment and concluded that she was capable of deciding her own medical treatment.[3] There is no evidence that A.C. lost capacity prior to the imposition of the blood transfusion on April 16, 2006.[4]

**6.** In the hearing held on April 16, 2006, the Respondent Director of Child and Family Services took the position that A.C.'s position on treatment would only be relevant if she were over 16 years of age.[5] The Court proceeded on the basis that A.C. had capacity and that she objected to the blood transfusion, but also that this was not an issue.[6]

**7.** JFCY accepts and relies upon the facts as presented by the Appellants as to the impact of the proceedings and treatment on A.C.

## PART II – QUESTIONS IN ISSUE

**8.** The submissions of Justice for Children and Youth are focused on the constitutional questions arising in the appeal. Its position in regard to the questions in issue is as follows:

> **ISSUE ONE**: Do *CFSA* ss. 25(8) and 25(9) supersede the common law right of a capable young person to choose medical treatment without state interference?
>
> The intervener takes no position with respect to this issue, but makes submissions in respect of the Ontario legislative scheme which it submits is a codification of the common law in respect of capacity to make medical decisions.
>
> **ISSUE TWO**: Did *CFSA* ss. 25(8) and 25(9) unjustifiably infringe the rights of A.C. under the *Charter*, ss. 2(a), 7, and 15?
>
> The intervener agrees with the Appellants and takes the position that the impugned sections contravene ss. 7 and 15 of the *Charter* and further that the infringement of the rights under ss. 7 and 15 are not justifiable. The Intervener takes no position on the justification of the infringement of A.C.'s rights under s. 2(a).

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[3] Capacity Assessment Report (April 13, 2006), Appellant's Record, Tab 29, pp.227-229
[4] Reasons for Judgment of Huband, Steel, Hamilton JJ.A. Court of Appeal of Manitoba (February 5, 2007), para.47, Appellant's Record, Tab 7, p.50
[5] Transcript of Proceedings before Kaufman J. (April 16, 2006), Appellant's Record, Tab 28, p. 167, lines 26-29; p. 179, lines 1-2
[6] Transcript of Proceedings before Kaufman J. (April 16, 2006), Appellant's Record, Tab 28, p. 180, lines 9-10p. 199, lines 15-16; p.201, lines 20-31

## PART III – STATEMENT OF ARGUMENT

### Synopsis

**9.** JFCY agrees with the Appellant in stating that the central issue is whether A.C. had the legal right to make autonomous medical treatment decisions. JFCY's submissions are premised on the assumption of A.C.'s capacity, as determined by the medical experts, to make that decision and that at no time did she lose her capacity to do so. JFCY adopts the arguments of the Appellants in respect of the issues as stated above and provides submissions specifically on the impact of the United Nations *Convention on the Rights of the Child*. In addition, JFCY makes specific submissions in respect of the rights of children and youth under ss. 7 and 15 of the *Charter* and outlines the Ontario legislative scheme in support of the Appellant's argument that the impugned sections do not minimally impair her rights pursuant to the test under s. 1.

### United Nations *Convention on the Rights of the Child*

**10.** The UN *Convention on the Rights of the Child (*the "*Convention*"),[7] as part of Canada's international human rights obligations to children, informs the interpretation of the content of the rights guaranteed by the *Charter* as well as the interpretation of the objectives which may justify restrictions upon those rights under s. 1.[8]

**11.** The Respondent and the Courts below have relied upon the *Convention*, in particular Article 3, for the position that the consideration of the best interests of the child permits or even requires the state to override the wishes of a capable young person with respect to medical treatment. This is an oversimplification of the *Convention* which must be read as a whole with regard to the evolving capacities of children and the acknowledgement that children are rights holders as individuals. As this Honourable Court has noted, the principle set out in Article 3 is described as "a primary consideration" rather than "the primary consideration" in decisions affecting children.[9] The Committee on the Rights of the Child has repeatedly commented that the *Convention* should be considered as a whole and has emphasized its interrelationships especially

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[7] United Nations, *Convention on the Rights of the Child*, General Assembly, UN. Res. 44/25, November 20, 1989
[8] *Slaight Communications Inc. v. Davidson*, [1989] 1 S.C.R. 1038 at 1056-1057
[9] *Canadian Foundation for Children, Youth and the Law v. Canada (Attorney General)*, [2004] 1 S.C.R. 76 at para. 10

between articles which set out general principles such as Article 3 (best interests) and Article 12 (respect for the views of the child).[10]

**12.** Article 1 defines a child as "every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier." Despite the specific definition, the importance of the evolving capacities of children is echoed throughout the *Convention*, in particular, in Article 5 which provides a framework for the relationship between the child, her parents and the state in a "manner consistent with the evolving capacities of the child", in Article 12 where due weight is to be given to the views of the child "in accordance with the age and maturity of the child" and in Article 14 where the parents' (and legal guardians') rights and duties to provide direction to the child in respect of her freedom of thought, conscience and religion are to be exercised in the same manner.[11]

**13.** As noted by Cook and Dickens, the *Convention* recognizes that children exercise their own rights in a manner consistent with their evolving capacities as individuals.[12] Lansdown, in a report prepared for the Canadian International Development Agency, describes the *Convention*'s approach to the concept as recognizing the child's "'emancipatory' rights: that as competencies develop, so too must the child's entitlement to take increasing responsibility for the exercise of their own rights."[13] While the U.N. Committee on the Rights of the Child talks about minimum age requirements in its General Comment No.4 on adolescent health, it states that "if the adolescent is of sufficient maturity, informed consent shall be obtained from the adolescent her/himself."[14] This approach was also enunciated by the Committee in respect of its interpretation of Article 5 in the context of its General Comment No. 7 on the implementation of child rights in early childhood:

> Evolving capacities should be seen as a positive and enabling process, not an excuse for authoritarian practices that restrict children's autonomy and self-expression and which

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[10] Hodgkin, Rachel and Newell, Peter for UNICEF (2007) *Implementation Handbook for the Convention on the Rights of the Child* (3rd ed.) United Nations Children's Fund: Geneva, at pp.7, 37-38, 77, 153,189
[11] *Ibid*.
[12] Cook, R. & Dickens, B.M., "Recognizing Adolescents' 'Evolving Capacities' to Exercise Choice in Reproductive Healthcare" (2000) 70 Int'l J. of Gynecology & Obstetrics 13 at p.15, Appellants' Authorities Tab 59.
[13] Lansdown, Gerison. *Evolving Capacities and Participation*, 2004, Prepared for The Canadian International Development Agency (CIDA), International Institute for Child Rights and Development at p. 3 <http://www.acdi-cida.gc.ca>
[14] Committee on the Rights of the Child, General Comment No. 4, 2003, CRC/GC/2003/4 at paras. 9, 32 & 33

> have traditionally been justified by pointing to children's relative immaturity and their need for socialization.[15]

**14.** Canada's Senate Committee on Human Rights, in a comprehensive report on Canada's obligations with respect to the rights of children, *Children: The Silenced Citizens*, emphasized the importance of the rights-based approach embedded in the *Convention*, which requires that children not be seen "as merely objects of concern to be protected but are [to be] also recognized as persons in their own right."[16]

**Human Dignity**

**15.** This court has stated that the *Charter* and the rights it guarantees are inextricably linked to the concept of human dignity.[17] Inherent in this concept are a person's privacy rights and the right to make choices.[18] The importance of the dignity of the child in respect of Canada's obligation in international law was acknowledged by the Senate Human Rights Committee:

> Ultimately, ensuring the promotion of and respect for children's rights strengthens recognition of children as individuals – full human beings capable of making meaningful choices with the right guidance. By enhancing the dignity of a child, we also enhance their acceptance of their role as a citizen with both rights and responsibilities.[19]

**16.** The human dignity of the child is a critical consideration in both the s. 7 and s. 15 analyses. Further, the argument, that the provisions denying A.C. the right to choose her own medical treatment are arbitrary, is inextricably linked to the breach of her equality rights. As this Court stated in *Law*, human dignity is harmed by unfair treatment premised upon personal traits not related to *capacities* or where the individual is *ignored*.[20]

**Interests Under s.7 of the *Charter***

**17.** It is not disputed that the order under ss. 25(8) and 25(9) of the *CFSA* that forced A.C. to undergo medical treatment against her will infringed her right to security of her person under s. 7 of the *Charter*. The treatment in question involved the use of physical force and an invasion of her body to which A.C. was clearly not consenting. JFCY agrees with the Appellant that the

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[15] Committee on the Rights of the Child, General Comment No. 7, 2005, CRC/C/GC/7/Rev.1 at para.17
[16] Standing Senate Committee on Human Rights, *Children: Silenced Citizens, Effective Implementation of Canada's International Obligations with Respect to the Rights of Children*, 2007 at p. 24
[17] *Blencoe v. British Columbia (Human Rights Commission)*, [2000] 2 S.C.R. 307 at para.76, Appellant's Authorities, Tab 6
[18] *Ibid.* at para. 86
[19] *Children: The Silenced Citizens* (*supra* note 16) at p. 30
[20] *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497 at para. 53, Appellant's Authorities, Tab 23

provisions are arbitrary and thus the infringements of A.C.' s rights were not in accordance with the principles of fundamental justice.[21]

**18.** In holding that the state's interest in respect of the medical treatment of children is different than that for adults, the Court of Appeal placed great emphasis on the language in an article by Jennifer Rosato describing society's interest in protecting children as the state's expectations for the future potential of children to become productive adults.[22] The Respondent repeats this description of society's interest elevating it to a concept of preserving the "sanctity of children".[23] JFCY disagrees that this is a legitimate concern within the s. 7 analysis, being a broader state interest beyond the protection of children under the *CFSA*. Further, Canada's Senate Human Rights Committee noted that many witnesses before it emphasized "that the government, Parliament, and civil society need to move beyond that cliché [i.e. our children are *our* future] and recognize that children are citizens *today*."[24]By placing too much weight on children as future citizens, the danger is that we ignore the present assaults on their dignity premised on a paternalistic, "it's for your own good," approach.

**19.** The Respondent and Attorney General of Manitoba counter the Appellant's argument that the provisions are arbitrary by reference to the legislative goal or objectives of the *CFSA,* of the importance of ensuring age-appropriate participation in decisions by children who are subject of its proceedings.[25] Chief Justice McLachlin states in *Chaoulli v. Quebec* that in order not to be arbitrary the limit on the claimant's s. 7 rights requires "not only a theoretical connection between the limit and the legislative goal, but a real connection on the facts."[26] Once the views and wishes of a competent child are relegated to the list of factors in the best interests analysis, the risk is that the child's competence will be disregarded. In the context of this case, the fact of A.C.'s own capacity was overlooked as was the impact that the treatment would have on her psychologically. Her attempts to make treatment choices, rather than simply refusing treatment, were also not seriously considered.

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[21] *Chaoulli v. Quebec (Attorney General),* [2005] 1 S.C.R. 791 at para 128, Appellants' Authorities, Tab 9
[22] Reasons for Judgment of Huband, Steel, Hamilton JJ.A. Court of Appeal of Manitoba (February 5, 2007), at para. 73, Appellant's Record, Tab 7, p.62
[23] Respondent's Factum, para.64
[24] *Children: The Silenced Citizens, supra* note16 at p. 24
[25] Factum of the Attorney General of Manitoba, para. 27
[26] *Chaoulli, supra* note 21 at para. 113

**Section 15 (1) of the *Charter***

**20.** The Attorney General of Manitoba acknowledges the vulnerability of children and youth but suggests that there is no pre-existing disadvantage given that the distinction is based upon age (quoting McLachlin C.J.C. in *Gosselin*).[27] The context of *Gosselin* is the alleged discrimination against young adults, a group that was unable to establish the historic disadvantage and vulnerability recognized by this court as being the experience of children.[28] In *Canadian Foundation for Children, Youth and the Law v. Canada (Attorney General)*, this Court with the exception of Arbour J., who did not address the s. 15 arguments, acknowledged the pre-existing disadvantage of children.[29]

**21.** In the *Canadian Foundation* case the Court held that the reasonableness standard required a different approach depending upon the age of the child and his or her capacity to learn from correction. Justice Binnie, in his dissenting judgment cautioned how difficult it was to generalize about the "capacities and circumstances" of such a disparate group of people (i.e., children) noting the enormously different capacities of a 2-year-old and a 12-year-old.[30] The distinction in this case means that no assessment of a child under 16 needs to take place, while this is a matter of routine for all medical procedures for those over 16.[31]

**22.** JFCY agrees with the Appellant in asserting that the Manitoba Court of Appeal erred in looking at the needs, capacities and circumstances of children generally rather than those of the claimant. The impugned provisions establish an arbitrary age that clearly is not linked to the capacity of the claimant in this case. In this regard, it was the position of the Respondent at the emergency hearing that A.C.'s capacity to consent was not relevant to the court's determination.[32]

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[27] Factum of A.G. of Manitoba, para. 40
[28] *Gosselin v. Québec (A.G.)*, [2002] 4 S.C.R. 429, Appellant's Authorities, Tab 16
[29] *Canadian Foundation for Children, Youth and the Law, supra* note 9 at para. 56, 92 and 225
[30] *Ibid.,* at para. 103. See also para. 97-98 respecting Binnie J.'s caution regarding the dangers of considering societal values in the s.15 analysis.
[31] Manitoba, Report of *the Mental Health Act* Review Committee (January 1997), at p. 23, Appellant's Authorities, Tab 72; Picard, Ellen I. & Robertson, Gerald B. *Legal Liability of Doctors and Hospitals in Canada*, 4th ed. (Scarborough: Carswell, 2007) at pp. 49, 79, Appellant's Authorities, Tab 75; Rozovsky, Lorne E., *The Canadian Law of Consent to Treatment*, 3d ed. (Markham, ON: LexisNexis Butterworths, 2003) at p. 11, Appellant's Authorities, Tab 76
[32] Transcript of Proceedings before Kaufman J. (April 16, 2006), Appellant's Record, Tab 28, p. 167, lines 26-29; p. 179, lines 1-2

**Section 1 Minimal Impairment: An Overview of the Ontario Legislative Regime**

**23.** In Ontario, the comprehensive legislative scheme in respect to health care consent is a clear demonstration of an approach that respects the rights of children, yet provides for their health and well-being when caregivers fail to act in their best interests. It was enacted by the legislature following a thorough examination of the legal issues in the Enquiry on Mental Competency.[33] The Weisstub Enquiry concluded that the common law position for consent to treatment for children was the same as for adults.[34] The Ontario legislature enacted the *Consent to Treatment Act* which codified the common law on this point and set no presumptive age.[35] This legislation was followed by the *Health Care Consent Act* (the "*HCCA*") which made no change to this fundamental principle in Ontario law.

**24.** The Ontario *HCCA* generally prohibits a health care practitioner from administering a treatment to a capable person unless they have provided consent.[36] Consent must be informed, voluntary, relate to the treatment, not obtained through fraud or misrepresentation and must be provided by a person who is capable.[37] There is no minimum age for capacity under the *HCCA* - a person is capable when they are able to "understand the information that is relevant to making the decision about the treatment" and "to appreciate the reasonably foreseeable consequences of a decision or lack of decision."[38] The Act presumes that all individuals are capable but this presumption is rebuttable.[39] Despite the Respondent's assertions that capacity is not "readily ascertained"[40], the Ontario consent cases cited along with the professional guidelines of health practitioners demonstrate the ability of professionals and the Court within the Ontario context to make such determinations, including all the elements of a valid consent, even on an urgent basis.[41]

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[33] Weisstub, David N. *Enquiry on Mental Competency: Final Report* (Toronto: Queen's Printer, 1990) at p. 131, Appellant's Authorities, Tab 82 [It recommended a rebuttable presumption at age 14 which was not followed.]
[34] *Ibid.* at p. 152
[35] *Consent to Treatment Act, 1992*, S.O. 1992, c.31, (repealed), s. 6
[36] *Health Care Consent Act, 1996,* S.O. 1996, c. 2, Sch. A, s. 10(1), ("*HCCA*")
[37] *HCCA*, s. 10. It should be noted that many of the concerns raised by the Respondents as to the elements of capacity are addressed in both the definition of capacity and the requirements of consent.
[38] *HCCA*, s. 4(1).
[39] *HCCA*, s. 4(2) & (3). If the person is not capable, a substitute decision-maker can consent to the treatment decision under s. 10(2) of the *HCCA*.
[40] Respondent's Factum, para. 34
[41] *Re E.J.G.*, 2007 CanLII 44704 (Ont. C.C.B.), Appellant's Authorities, Tab 35; *Re H.W.*, 2005 CanLII 57736 (Ont. C.C.B.), Appellant's Authorities, Tab 36; College of Physicians & Surgeons of Ontario, *Policy Statement 4-05 – Consent to Medical Treatment*, (College of Physicians and Surgeons of Ontario, 2006),

**25.** In an emergency, treatment may be administered without the consent of a capable person only in exceptional circumstances.[42] This does not apply if the individual is capable and able to communicate their consent or refusal to consent during the emergency.[43] This exception also does not apply if the individual is unable to communicate their consent or refusal but the health care practitioner has reasonable grounds to believe that the person expressed an applicable wish while they were capable and 16 years of age or over.[44] This provision deprives children under 16 from making advance health care directives.[45] Contrary to the assertion by the Attorney General of Manitoba, it does not, however, allow treatment of capable children who are able to communicate their consent or refusal to consent during an emergency.[46] Rather, it respect the developing capacities and views of the young person.

**26.** In addition to the HCCA, there is no provision in the *Child and Family Services Act* (the " Ontario *CFSA*") that allows a capable child to be apprehended and administered a treatment against their will.[47] The Ontario *CFSA* does, however, provide protection where the child is under 16 and not capable and their parent or guardian substitute decision-maker refuses to consent to a necessary treatment.[48] The legislation contained a transition provision which stated

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pp. 3 & 7, Appellant's Authorities, Tab 58; College of Nurses of Ontario, "Practice Guideline: Consent" (College of Nurses of Ontario, 2005), pp. 6-7, 10, Appellant's Authorities, Tab 57

[42] Section 25(1) defines an "emergency" as being where the person is "apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm." The case cited by the A. G. of Man. in respect of the inapplicability of this section to a child involved a very young infant who clearly did not have capacity and whose parent was refusing treatment contrary to her best interests. Factum of A. G. of Manitoba, para. 18.

[43] Section 25(3) allows emergency treatment without consent of a capable person if there is: (i) an emergency (ii) a communication barrier (language or disability) that prevents the person from consenting or refusing to consent (iii) no means of enabling the communication that have been found, despite reasonable steps in the circumstances (iv) a delay required to enable communication to take place that would prolong suffering or put the person at risk of sustaining serious bodily harm and (v) no reason to believe that the person does not want the treatment.

[44] *HCCA*, s. 26

[45] As there was no time at which A.C. was considered to be incapable in the context of this case, the issue of the enforceability of an advance directive or the constitutionality of the denial of this option for a young person under 16 are not relevant issues to this appeal.

[46] Factum of A. G. of Man., para. 56. This would not meet the requirements of s. 25(3). *Lewis et al. v. Children's Aid Society of Metropolitan Toronto et al.* (2000) unreported endorsement of Justice Macdonald dated December 8, 2000 (Ont. S.C.J.). See also practice guidelines, *supra* note 41.

[47] *Child and Family Services Act,* R.S.O. 1990, c.11. S.62 provides that a children's aid society derives no greater powers to consent to treatment than what a parent would have legally, ensuring that the *HCCA* regime in respect of capacity governs.

[48] Ontario *CFSA*, s. 72(5); *Children's Aid Society of Ottawa v. C.S.*, 2005 CarswellOnt 8193 (S.C.J.) at para. 14, A.G. of Manitoba's Authorities, Tab 7

that the Ontario *CFSA* would prevail for a period of one year after which it was repealed.[49] The Ontario Superior Court of Justice has held that the two pieces of legislation operate together harmoniously.[50]

**27.** The Ontario legislative scheme represents an approach to the medical consent of children that accords with their rights under the *Charter of Rights and Freedoms* and the UN *Convention on the Rights of the Child*. Children are recognized as having the right to make treatment decisions in accordance with their evolving capacities. Where children are found to be incapable with respect to treatment, treatment decisions must be made in their best interests. Where parents fail to do so, child protection authorities must step in to make the decision that a parent would make in accordance with the best interests principle. It is a clear demonstration that the government of Manitoba has available to it an approach that minimally impairs the equality and security rights of children under 16 by ensuring the child protection legislation follows the common law respecting all person's capacity to consent to treatment.

## PART IV – SUBMISSIONS RELATING TO COSTS

**28.** JFCY makes no submissions in relation to costs in this matter.

## PART V – ORDER REQUESTED

**29.** JFCY respectfully requests permission to present oral argument.

**30.** JFCY joins the Appellant in requesting that this Court grant the appeal and answer the constitutional questions as set out in paragraph 116 of her factum.

All of which is respectfully submitted this 2nd day of May, 2008.

_____ _____

Cheryl Milne Mary Birdsell
Counsel for the intervener, Justice for Children and Youth

[49] Exempting the CFSA from the consent legislation was considered by the legislative committee at the time, but concerns about its unfairness and constitutionality were raised. Howard, Paul. "Consent and Minors" (1992) Legal opinion presented to the Standing Committee on Administration of Justice on October 5, 1992, at pp. 25, 27, 28. Both the *Consent to Treatment Act* and *HCCA* provided for a short transition during which the Ontario *CFSA* was to prevail in the event of a conflict.
[50] *Lewis v.CASMT, supra* note 46

## PART VI—TABLE OF AUTHORITIES

**Cases** **Paragraph**



**Other Authorities**

## PART VII – STATUTORY PROVISIONS

**Title** **Page**

## *The Child and Family Services Act,* S.M. 1985-86, c.8 C80

**Court order authorizing examination or treatment**

25(8) Subject to subsection (9), upon completion of a hearing, the court may authorize a medical examination or any medical or dental treatment that the court considers to be in the best interests of the child.

**Child's consent to order required if 16 or older**

25(9) The court shall not make an order under subsection (8) with respect to a child who is 16 years of age or older without the child's consent unless the court is satisfied that the child is unable

(a) to understand the information that is relevant to making a decision to consent or not consent to the medical examination or the medical or dental treatment; or

(b) to appreciate the reasonably foreseeable consequences of making a decision to consent or not consent to the medical examination or the medical or dental treatment.

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## *Health Care Consent Act, 1996* S.O. 1996, ch. 2

**Capacity**

**4.** (1) A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. 1996, c. 2, Sched. A, s. 4 (1).

**Presumption of capacity**

(2) A person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services. 1996, c. 2, Sched. A, s. 4 (2).

**Exception**

(3) A person is entitled to rely on the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment, the admission or the personal assistance service, as the case may be. 1996, c. 2, Sched. A, s. 4 (3).

**No treatment without consent**

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

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

(b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act. 1996, c. 2, Sched. A, s. 10 (1).

**Elements of consent**

**11.** (1) The following are the elements required for consent to treatment:

1. The consent must relate to the treatment.

2. The consent must be informed.

3. The consent must be given voluntarily.

4. The consent must not be obtained through misrepresentation or fraud. 1996, c. 2, Sched. A, s. 11 (1).

**Emergency treatment**

**Meaning of "emergency"**

**25.** (1) For the purpose of this section and section 27, there is an emergency if the person for whom the treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm. 1996, c. 2, Sched. A, s. 25 (1).

**Emergency treatment without consent: capable person**

(3) Despite section 10, a treatment may be administered without consent to a person who is apparently capable with respect to the treatment, if, in the opinion of the health practitioner proposing the treatment,

(a) there is an emergency;

(b) the communication required in order for the person to give or refuse consent to the treatment cannot take place because of a language barrier or because the person has a disability that prevents the communication from taking place;

(c) steps that are reasonable in the circumstances have been taken to find a practical means of enabling the communication to take place, but no such means has been found;

(d) the delay required to find a practical means of enabling the communication to take place will prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm; and

(e) there is no reason to believe that the person does not want the treatment. 1996, c. 2, Sched. A, s. 25 (3).

**No treatment contrary to wishes**

**26.** A health practitioner shall not administer a treatment under section 25 if the health practitioner has reasonable grounds to believe that the person, while capable and after attaining 16 years of age, expressed a wish applicable to the circumstances to refuse consent to the treatment. 1996, c. 2, Sched. A, s. 26.

**Conflict with *Child and Family Services Act***

**84.** (1) If a provision of this Act conflicts with a provision of the *Child and Family Services Act*, the provision of the *Child and Family Services Act* prevails.

**Repeal**

**(2) Subsection (1) is repealed on the first anniversary of the day this Act comes into force.**

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## *Consent to Treatment Act, 1992* S.O. 1992 ch. 31 [repealed]

**Capacity with respect to treatment**

**6.** (1) A person is capable with respect to a treatment if the person is able to understand the information that is relevant to making a decision concerning the treatment and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

**Conflict with *Child and Family Services Act***

**49.** (1) If a provision of this Act conflicts with a provision of the *Child and Family Services Act*, the provision of the *Child and Family Services Act* prevails.

**Repeal**

*(2) Subsection (1) is repealed on the third anniversary of the day this Act receives Royal Assent. 1992, c.31, s.49.

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## *Child and Family Services Act,* R.S.O. 1990 c. 11

**Society ward: consent to medical treatment**

**62.**(1)Where a child is made a society ward under paragraph 2 of subsection 57 (1), the society may consent to and authorize medical treatment for the child where a parent's consent would otherwise be required, unless the court orders that the parent shall retain any right that he or she may have to give or refuse consent to medical treatment for the child.

**Idem**

(2)The court shall not make an order under subsection (1) where failure to consent to necessary medical treatment was a ground for finding that the child was in need of protection.

**Court order**

(3)Where a parent referred to in an order made under subsection (1) refuses or is unavailable or unable to consent to medical treatment for the child and the court is satisfied that the treatment would be in the child's best interests, the court may authorize the society to consent to the treatment.

**Duty to report child in need of protection**

**72.** (1) Despite the provisions of any other Act, if a person, including a person who performs professional or official duties with respect to children, has reasonable grounds to suspect one of the following, the person shall forthwith report the suspicion and the information on which it is based to a society:

5. 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.

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## *Convention on the Rights of the Child,* General Assembly, U.N. Res. 44/24, November 20, 1989

***Article 1***

For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.

***Article 3***

1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

2. States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.

3. States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.

***Article 5***

States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention.

***Article 12***

1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

***Article 14***

1. States Parties shall respect the right of the child to freedom of thought, conscience and religion.

2. States Parties shall respect the rights and duties of the parents and, when applicable, legal guardians, to provide direction to the child in the exercise of his or her right in a manner consistent with the evolving capacities of the child.

3. Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health or morals, or the fundamental rights and freedoms of others.