Court File: 483/23

ONTARIO
SUPERIOR COURT OF JUSTICE
(DIVISIONAL COURT)

B E T W E E N:

ASP and SD

Applicants

- and -

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD, COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO, and NICOLE NITTI

Respondents

FACTUM OF THE INTERVENER
JUSTICE FOR CHILDREN AND YOUTH

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PART I - OVERVIEW

1. The central issue in this judicial review is whether a failure to consider the clear, express, repeated objections of a capable Indigenous girl child patient in assessing a physician's conduct in a genital examination constitutes an error. Any correct and reasonable decision of the Health Professions Appeal and Review Board ("HPARB"), and the Inquiries, Complaints, and Reports Committee ("ICRC") of the College of Physicians and Surgeons of Ontario ("CPSO") (together the "Tribunals") must recognize the physician's failure to obtain consent and failure to respect the right to refuse treatment as required by law. Findings that the physician was well-intentioned, and that the examination was clinically indicated do not render illegal treatment provided without a patient's consent lawful.

2. An analysis of the question of consent must consider the impact of the physician's illegal acts on the dignity of this specific Indigenous girl child, placed in the broader social and historical context, while also upholding and reinforcing the rights of children enshrined in domestic and international law.

3. The mandate of the CPSO, including the ICRC, is to regulate in the public interest: to ensure that professionals, who are in a position of privilege and authority, act in accordance with the law in conducting their practice, thereby protecting members of the public who are in a position of relative vulnerability.[1] Protecting the public interest as it relates to J., the subject child in this matter, requires that the Tribunals evaluate alleged breaches of her rights in accordance with domestic and international law.

[1] *Regulated Health Professions Act*, 1991, S.O. 1991, c. 18, s 2.1, s 3

PART II - THE FACTS

4. The intervener relies on the core facts that are undisputed by all parties to the litigation: 1) the child was presumed capable to consent to treatment; 2) there was no finding that the child was "incapable" or that the presumption of capacity had been rebutted; 3) the child verbally and physically refused consent to a genital examination; 4) the physician conducted a genital examination despite the child's express objections; 5) in response to the child's physical resistance, the physician applied physical force in order to conduct the examination.[2]

5. Additionally, it is undisputed that the information regarding the full purposes of the genital examination, which included checking for signs of sexual abuse, were not provided or disclosed in advance to the child or her parents.[3]

6. Except as otherwise stated, the Intervener adopts the facts and history as articulated by the Applicant. Where the facts are in dispute the intervener take no position.

PART III - ISSUES

7. The issue in this appeal is whether the HPARB, in its review upholding the decision of the ICRC, erred in its analysis of the complaint that the physician conducted a non-consensual genital examination, despite the child's express and clear refusal of treatment. The intervener submits that the failure of the Tribunals to address the legal imperatives of the applicable law, namely the *Health Care Consent Act* ("*HCCA*")[4] renders their decisions inherently unreasonable and incorrect.

8. Children are owed all legal rights and entitlements with no diminution due to childhood.[5] In fact, children are entitled to enhanced protections of their rights and entitlements, and to protective

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[2] Record of Proceedings, vol 1, p 382-383; Record of Proceedings, vol 3, p 1228-1229
[3] Record of Proceedings, vol 1, p 377-380
[4] *Health Care Consent Act*, 1996, SO 1996, c 2, Sched. A ["*HCCA*"]
[5] See for Eg. *Justice for Children and Youth v. J.G.*, 2020 ONSC 4716 (CanLII), at para 52

measures to safeguard rights and ensure their meaningful implementation. Enhanced protection is due to children as an equity seeking group, and as inherently vulnerable members of society. That enhanced protections are owed to children in the application and interpretation of legal rights has been unequivocally recognized by the Supreme Court of Canada,[6] and derives from Canada's obligations as a signatory to the United Nations *Convention on the Rights of the Child* (*"UNCRC"*)[7], and in accordance with the values of the *Canadian Charter of Rights and Freedoms* (the *"Charter"*).[8]

9. In the matter before this Honourable Court, the subject child's rights, her entitlement to enhanced protection, and appropriate consideration and remedies, include overlapping and interconnected elements. She has a right to be free from non-consensual examination or treatment;[9] she has rights under the *UNCRC* including respect for her participation and voice in matters engaging her health and well-being,[10] decision making informed by her best interests[11], ensuring that she is free from discrimination,[12] violence,[13] and indignity,[14] intrusion on her privacy and family;[15] and for her rights to be evaluated in accordance with *Charter* values of equality, and security of the person.[16]

10. JFCY adopts the Applicant's submissions with respect to the applicable standard of review. The Tribunals' failure to meaningfully consider the child's refusal to consent to treatment before performing an intimate and potentially traumatic genital examination falls short of the standards of

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[6] *AB v Bragg Communications Inc.*, 2012 SCC 46, [2012] 2 SCR 567 ["*AB v Bragg*"], at para 17. See also: *Ontario (Children's Lawyer) v. Ontario (Information and Privacy Commissioner)*, 2018 ONCA 559 ["*OCL v ON*"], at para 74

[7] United Nations, *Convention on the Rights of the Child*, Can. T.S. 1992 No. 3. ["*UNCRC*"]

[8] *Canadian Charter of Rights and Freedoms*, Part 1 of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), c 11

[9] *HCCA, supra* note 4, s. 10(1)

[10] *UNCRC*, art 12

[11] *UNCRC*, art 3

[12] *UNCRC*, art 2

[13] *UNCRC*, art 19

[14] *UNCRC*, Preamble

[15] *UNCRC*, arts 5 and 16

[16] *Canadian Charter of Rights and Freedoms, supra* note 8, s 7 and s 15; *Doré v Barreau du Québec*, 2012 SCC 12 (CanLII), at para 23; *Lauzon v Ontario (Justices of the Peace Review Council)*, 2023 ONCA 425 (CanLII), at para 11

either reasonableness or correctness.

11. JFCY takes no position on the specific disposition of the matter or the underlying complaint.

PART IV: STATEMENT OF LAW

Equal Application of Prohibition of Non-Consensual Medical Treatment

12. As described by the Applicant, the *HCCA* requires a practitioner obtain informed consent from a capable patient in order to administer treatment. There is no minimum age for capacity to consent to treatment: The *HCCA* presumes that all individuals are capable, unless the presumption is rebutted,[17] without distinction or discrimination based on age, gender, or cultural identity.[18] Administering treatment without voluntary and informed consent to the proposed treatment is prohibited. Consent cannot be obtained through misrepresentation or fraud, or where information about the purpose of the treatment, in whole or in part, is withheld.[19]

13. In this case, the Tribunals' decisions were not reasonable because they failed to consider compliance with the applicable law as a threshold issue before any consideration of the clinical appropriateness of the physician's conduct. The protection of this child's right not to be subject to non-consensual genital examination must be a central focus of the Tribunals' decision.

14. The clinical appropriateness of the conduct can only be considered if voluntary informed consent is first established. Clinically indicated treatment cannot proceed without voluntary informed consent. The *HCCA* defines the scope of circumstances in which the medical treatment can be lawfully provided. Medical practice falling outside of what is legally permitted, including a decision to override a patient's right to refuse treatment, goes to the core function of protection of the public.

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[17] *HCCA*, *supra* note 4, at s. 4(1),(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*.
[18] *Ibid; Ontario Human Rights Code*, s 1; see also *UNCRC*, art 2
[19] *HCCA*, *supra* note 4, at s 10

In this case, the imposition of non-consensual treatment in violation of J.'s fundamental rights to bodily integrity must be understood in the context of the structural power imbalance inherent between an Indigenous girl child patient, and a treating physician.

15. There is no dispute that the child expressly refused treatment. The child repeatedly said no, physically resisted as her pants were forcibly removed, and continued to physically resist when the physician tried to pull her legs apart. The physician justified her actions on her belief that the mother, through her "cooperation in encouraging [J]", provided implied consent.[20] The physician herself has recognized this as an error, acknowledging: "[J] had every right to refuse"[21], and that had J. "been an adult, I would have been more respectful of her wishes and taken a different approach."[22]

16. The decision on review is not reasonable or correct because it fails to meaningfully address the fact that J. as a capable child is entitled to be free from non-consensual examination or treatment just as any other patient, and that a capable child's refusal of treatment must be complied with and respected. The ICRC erroneously advises that the physician conduct "a more thorough discussion with the family, to ensure a full understanding and agreement […]".[23] This misstates the duties of the physician, including the duty to be frank, honest, and provide necessary information and to obtain fully informed agreement regarding treatment as an obligation owed to the family, rather than the right of the child herself as the patient.[24]

17. The fact that J. ultimately "opened her legs"[25] after her pants were pulled down to her ankles and the physician repeatedly attempted to pull her legs apart did not alter the child's express refusal

[20] Record of Proceedings, vol 1, p 166; Record of Proceedings, vol 3, p 968
[21] Record of Proceedings, vol 4, p 1229
[22] Record of Proceedings, vol 4, p 1228-1229
[23] ICRC Decision and Reasons, Record of Proceedings, vol 7, p 2903
[24] *HCCA*, *supra*, note 4; College of Physicians and Surgeons of Ontario, *Consent to Treatment* (February 2001), online: <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Consent-to-Treatment> ["CPSO Policy: Consent to Treatment"] at 6 and 7
[25] Record of Proceedings, vol 1, p 378

of consent to treatment. Acquiescence or "reluctant"[26] participation of an Indigenous girl child patient must not be mischaracterized as informed voluntary consent: it is not legally valid consent. As J. described in her letter, she "gave up" and felt "very uncomfortable and I was about to cry because I was very, very sad and I didn't want to do it."[27] In accordance with law and policy directives, if a physician is "unsure about whether the consent is valid, they must not give the treatment until they are assured that valid consent has been obtained".[28] Voluntary, informed consent that is not coerced or obtained through misrepresentation is a fundamental and necessary element to ensuring security of the person and respect for bodily integrity in the *HCCA*.[29] Safeguarding a capable child's right to refuse consent requires enhanced attention to her rights and "heightened protection by the courts", not diluted and reduced attention and enforcement.[30]

18. A physician is not entitled to rely on the consent of a substitute decision maker without first satisfying themselves that the person is incapable with respect to treatment.[31] It is contrary to the *HCCA* and CPSO policy for a physician to rely on a substitute decision maker's implied consent to begin treatment on a child who has repeatedly stated "no", while simultaneously relying on a child's "reluctant" participation or "willingness" after treatment has already begun.[32] Consent is a precondition for clinically appropriate treatment, not subservient to what the physician believes to be the clinically indicated treatment.

19. Although the child in this case had capacity, even if the child had been incapable, the physician cannot act without the informed consent from the child's substitute decision maker. The adults

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[26] Record of Proceedings, vol 4, p 1229
[27] Record of Proceedings, vol 3, p 1066
[28] *HCCA*, *supra* note 4, s 10(1); CPSO Policy: Consent to Treatment, *supra* note 24, online: <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Consent-to-Treatment>
[29] *HCCA*, *supra* note 4, s11(1)
[30] *OCL v ON*, *supra* note 6, at paras 3, 51, 56, 86-88
[31] *HCCA*, *supra* note 4, ss 4(2), 10(1)(b)
[32] Record of Proceedings, vol 7, p 2940; Record of Proceedings, vol 1, p 377-380 (Dr. Nitti's initial statement)

charged with the care of a child who is incapable of consenting or refusing treatment must act in accordance with the child's best interests, which include a robust consideration of the child's views, wishes, and rights.[33] Any analysis of the actions of the care provider in the decision under review must attend to the statutory requirements of the *HCCA*, understood in line with a child's protected rights under the *UNCRC* and the *Charter*. Any consideration of a policy that is inconsistent with the law or violates the rights of a child patient falls short of the standard of reasonableness.

20. The HPARB's decision upholding the findings of the ICRC, including that the physician's actions were "clinically indicated"[34] and therefore "reasonable"[35] do not meet the standard of reasonableness. The HPARB found that the ICRC analysis regarding consent was sufficient as the ICRC had "turned its mind" to the issue of consent.[36] With respect, cursory attention to the core legal rights at stake, especially where the reference to the issue of consent misstates the law and endorses the provision of medical treatment conducted outside of the scope of authorized practice under the *HCCA*, is not reasonable and cannot stand.

21. The ICRC's central misstatements as to the scope of lawful medical practice and treatment upheld by the HPARB, are underwritten by reasons that fail to consider or analyse the centrality of the issue of the child's capacity. Although ascertaining capacity is a necessary condition for consent to treatment,[37] the word "capacity" does not appear once in any of the ICRC or the HPARB's four collective decisions. The ICRC's allusions to the child's "competence"[38] and the underlying fact that "the Patient was uncomfortable"[39] without expressly finding on the central issues of capacity and

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[33] *AC v Manitoba (Director of Child and Family Services)*, 2009 SCC 30, [2009] 2 S.C.R. 181 ["*AC v Manitoba*"], at para 93
[34] ICRC decision at p 14, Record of Proceedings, vol 7, p 2902
[35] *AD-S v Nitti*, 2023 CanLII 65769 (ON HPARB), at paras 45-46
[36] *AD-S v Nitti*, *supra* note 35, at para 48
[37] *HCCA*, *supra* note 4, at s10(1); College of Physicians and Surgeons of Ontario, *Consent to Treatment* (February 2001), online: <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Consent-to-Treatment>.
[38] ICRC first decision, Record of Proceedings, vol 1, p 451
[39] ICRC second decision, Record of Proceedings, vol 7, p 2899

consent is fundamentally unreasonable. The ICRC further diminishes and disregards the child's refusal of consent to treatment by reducing it to the family's 'feeling' that "the examination was performed without adequate consent".[40]

22. The sublimation of the child's voice into that of her parent removes any prospect that the child can exercise her agency in a matter that goes to the core of her bodily integrity and autonomy. The erasure of a child's voice in furtherance of an abstract view of what is 'clinically indicated' or what is best for the child is contrary to law and policy. By treating a child's exercise of agency as mutually exclusive with clinically appropriate treatment, the child becomes the object of treatment, not the subject of treatment, with appropriate legal protections in place.

The Decision is Contrary to Charter Values and International Law Norms

23. To meet the standard required, the analysis and determinations in this case should have included a thorough discussion of the issue of consent and the child's rights informed by and consistent with *Charter* values, and Canada's international human rights obligations. In evaluating the rights of children under domestic law, including in cases of consent to medical treatment, the Supreme Court has relied on the *UNCRC* to determine the scope and substance of legislative and *Charter* obligations on state actors.[41]

24. An application of the law that touches people, including administrative decisions and actions of officials in the exercise of their mandate, must be consistent with the values and principles of the *Charter*.[42] The Supreme Court of Canada has recognized the central importance of the rights engaged in the health care context, finding the imposition of medical treatment inherently "implicates a child's

[40] ICRC second decision, Record of Proceedings, vol 7, p 2903
[41] See for e.g., *AC v Manitoba*, *supra* note 33; *AB v Bragg*, *supra* note 6, at para 17; *R v Sharpe*, 2001 SCC 2, at para 71; *Baker v Canada (Minister of Citizenship and Immigration)*, [1999] 2 SCR 817, at para 71
[42] *Lauzon v Ontario (Justices of the Peace Review Council)*, *supra* note 16, at para 67, 152; *Doré v Barreau du Québec*, *supra* note 16, at para 24; *Baker v Canada (Minister of Citizenship and Immigration)*, *supra* note 41, at para 56

liberty and security of the person"[43] interests protected under the *Charter*. The Tribunals were required to evaluate the seriousness of the breach of law occasioned by the forced non-consensual examination as engaging her rights, dignity, and security of the person interests. When professional authorities engage in the unauthorized exercise of decision making on behalf of a capable child, such actions may be, as here, understood to be discriminatory and arbitrary, contrary to the *Charter* values of equality and security of the person.[44]

25. Canada's international human rights commitments provide a helpful framework for the interpretation of the legal requirements that medical treatment be performed only with valid consent, and in the evaluation of a physician's conduct under these provisions. As held by the Supreme Court in *Mason*, a decision that fails to consider "the legal constraints imposed by international law"[45] is "unreasonable and should be quashed".[46] The Tribunal's analysis and determination must interpret the child's legal rights as an Indigenous girl child receiving health care in accordance with the protections provided for and described by international law instruments, including the *UNCRC*, the General Comments of the UN Committee on the Rights of the Child, the *Convention on the Elimination of All Forms of Discrimination Against Wome*n,[47] and as guaranteed under Canada's *United Nations Declaration of the Rights of Indigenous Peoples Act*.[48]

26. The denial of a child's legal right to exercise agency in matters of her own bodily integrity go to the core principles of the *UNCRC*: a child's right to have their best interests made central, to be heard, to be free from discrimination, and to life, survival and development.[49] These rights operate

[43] *AC v Manitoba*, *supra* note 33, at para 100
[44] *Ibid*, at para 116
[45] *Mason v Canada (Citizenship and Immigration)*, 2023 SCC 21 ["Mason"], at para 121
[46] *Ibid* at para 122
[47] United Nations, *Convention on the Elimination of All forms of Discrimination against Women New York*, 18 December 1979, Preamble, art. 14
[48] *United Nations Declaration on the Rights of Indigenous Peoples Act*, SC 2021, c 14, Schedule A arts 21, 23-24
[49] *UNCRC*, arts 2, 3, 6, and 12

interdependently: a child's right to consent or refuse consent to treatment in healthcare cannot be meaningful without a child's right to be heard and participate, to be free from violence, and to be free from discrimination. Appropriate decision-making requires that a child's legal rights be meaningfully accessible, enforced, and respected in an integrated way in accordance with a child's best interests.[50] The *HCCA*, and, in particular, the absence of aged-based distinctions therein demonstrates a legislative intention to ensure respect for a child's agency and autonomy consistent with the *UNCRC*'s articulation of the human rights of children, and respect for their evolving capacities.[51]

27. As a signatory to the *UNCRC*, Canada has undertaken to ensure that "[i]n 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."[52] A child's best interests is a procedural guarantee, as well as a substantive right and a fundamental interpretive legal principle.[53] A child's right to have her voice heard, independent from her parents, is central not only to the physician's treatment of the child, but to the adjudicative process. The failure to consider the child's voice and perspective on the underlying events as expressed in her letter and afford her perspective due weight is contrary to the child's right to be heard.[54] The fact that the child's parents have standing as parties before the Court does not eschew the need for a child's unique perspective to be represented in the decision before the Court.

28. The professional regulators mandate to protect the public interest demands that a child's dignity, bodily integrity and autonomy, and human rights be fostered by, not subordinated to, healthcare institutions and practices charged with safeguarding the child's physical health and well-

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[50] GC No.14, *supra* note 49, at paras 17, 46-48, 82
[51] *UNCRC*, art 12
[52] *UNCRC*, art 3; See also, United Nations Committee on the Rights of the Child, General Comment No. 14, (2013) on the right of the child to have his or her best interests taken as a primary consideration, CRC/C/GC/14, 29 May 2013 ["GC No. 14"]
[53] GC No.14, *supra* note 49, at para 6
[54] *Ibid*

being. As recognized by the United Nations Committee on the Rights of the Child, "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 have traditionally been justified by pointing to children's relative immaturity and their need for socialization".[55] The vulnerability of a child does not empower those with authority over the child to override their agency. Rather, enhanced protections are required to ensure that rights are safeguarded.[56] The protection of the right of any person - including a child - to give or refuse consent in accordance with their capacity is central to safeguarding the public interest and trust in the medical profession.

29. The analysis and decision in this case required the Tribunals to actively consider whether the physician's conduct and their own determinations addressed and met the standard of acting with the best interests of the child as a primary consideration, including domestic and international rights and *Charter* values.

Harmful effects of the physician's actions

30. Although it was not so in the case at bar, in the face of legitimate concerns regarding possible harm or abuse to the child, the analysis of a physician's conduct must address both the unique standard of care owed to children who have experienced alleged maltreatment, and the experience of the child receiving care. This includes the heightened vulnerability and unique threats to the dignity and human rights of children receiving care from people in positions of trust and authority.

31. Age-appropriate care for a child does not consist of concealing concerns regarding the prospects of abuse or the reasons for an examination: Instead, the obligations owed to children place a greater weight on transparency and a child's right to exercise agency over their own bodily integrity

[55] United Nations Committee on the Rights of the Child, General Comment No. 7 (2005) Implementing child rights in early childhood, CRC/C/GC/7/Rev. 1, 20 September 2006 ["GC No. 7"], at para 17
[56] *OCL v ON*, *supra* note 6, at para 56

in cases of suspected harm. Before conducting any examination of an intimate nature, including of sex organs, a physician must at minimum "explain to patients in advance, the scope and rationale of any examination [...] and if asking questions regarding sexual matters why they are being asked".[57] The failure to disclose the purpose of the examination to "assess for other causes of dysuria *and to exclude sexual trauma*"[58] deprived the child of the ability to make an informed decision about the most intimate aspects of her own body. Without meaningful information about the purpose of an examination, neither the child, nor a substitute decision maker acting on the child's behalf, is able to provide legally valid consent.

32. The rights and interests of a child exist independently, not as an accessory of their parents. In genuine circumstances of abuse, a child may have strongly divergent interests from those of his or her parents. The suggestion that a physician who suspects a child is at risk of harm could, without first discussing the concerns privately with the child, rely on a parent's implied consent is not only unlawful, but potentially dangerous.[59]

33. A child's right to have their voice heard is central both for the protection against non-consensual treatment under the *HCCA*, and to trauma informed practice and duties of care owed to children in cases of suspected harm. A child's statement and voice is central to any case in which a physician suspects harm. In both urgent and non-urgent cases, an interview should be conducted with a *child* before any medical examination is done.[60] Looking to physical signs of assault over a child's own expression of her experience relies on dangerous, false stereotypes of child abuse: As recognized

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[57] College of Physicians and Surgeons of Ontario, Boundary Violations (September 2008), online: <https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Boundary-Violations> at 3c)

[58] ICRC first decision, *supra* note 38

[59] Canadian Paediatric Society, "*Ethical Approach to Genital Examination in Children"*, Record of Proceedings, vol 4, p 1613

[60] Canadian Paediatric Society, "*The medical evaluation of pre-pubertal children with suspected sexual abuse*", online: *Canadian Paediatric Society* <https://cps.ca/en/documents/position/the-medical-evaluation-of-pre-pubertal-children-with-suspected-sexual-abuse>

by the CPSO, genital exams do not provide useful diagnostic information; in the overwhelming majority - over 90% - of *confirmed* sexual abuse cases, genital examination results were normal.[61] The suggestion that a genital examination is a reasonable or exhaustive response to a concern regarding a child's well-being is unreasonable and is inconsistent with what would be expected from a physician who is "educated to have a high level of suspicion for child abuse".[62]

34. Literature and evidence recognize the potentially traumatic psychological impact on children and adolescents of medical examinations in cases of suspected sexual abuse.[63] The application of physical force to view the most intimate parts of a girl child's body by a physician, a person in a position of trust, structural authority, and informational imbalance, is an inherently violative experience. The violation is exacerbated when it occurs without consent. Force, coercion, and restraint of any degree are inappropriate in the context of an examination to investigate suspected sexual abuse.[64] If a child is reluctant or distressed about the proposed examination, the appropriate course is to defer the examination.[65]

35. The physician, through her conduct, unreasonably relied on the child's exercise of her right to refuse treatment as a justification for the non-consensual application of that treatment. In her remedial agreement, the Physician acknowledges that J's hesitancy "increased my suspicion that there was in fact something for me to see, it was not right for me to dismiss [J]'s hesitancy."[66]

36. Where a capable child refuses an examination, or where there is a question as to a child's capacity to consent to the examination, the appropriate course of conduct is to simply defer the examination, thus doing no harm, not insist upon it. Indeed, the subject physician in this case

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[61] Record of Proceedings, vol 7, p 3353
[62] ICRC, first decision, *supra* note 38
[63] Dafna Tener et al, *"Laughing Through The Pain: Medical Clowning During Examination of Sexually Abused Children: An Innovative Approach,"* (2010) 19(2) J Child Sexual Abuse 128, p 129
[64] The medical evaluation of pre-pubertal children with suspected sexual abuse, *supra* note 60
[65] *Ibid*, p 2; Record of Proceedings, vol 4, p 1612-1613
[66] Record of Proceedings, vol 4, p 1228

acknowledged just that.[67] Policy, guidance and best practice dictate that where there is a refusal of consent or a concern regarding capacity the physician should carry on without that examination to provide treatment that is consensual.[68]

Intersectional Identity and Discrimination in Refusing to Recognize Agency

37. Any analysis of the statutory obligations must give careful attention to the experience of the child considering the child's intersectional identity, in this case, as an Indigenous girl child. Children who are particularly vulnerable to discrimination are often less able to exercise autonomy in health care decision making,[69] including children whose identity is at the intersection of historically marginalized groups. Protection of these rights must be understood and applied against the backdrop of historic discrimination against Indigenous children, who are particularly vulnerable to violations of their basic human rights.[70] Indigenous girl children, including children living in rural areas, may face compounding facets of discrimination that demand particular attention to ensure that the child's rights are meaningful and realizable.[71]

38. In Ontario, Indigenous children continue to face a "very high risk" of negative experiences within the health care system, including racism, that would "without doubt fit the criteria for an adverse childhood experience".[72] A lack of privacy, misunderstanding of health care professionals,

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[67] Record of Proceedings, vol 3, p 1229- "anyone can refuse an exam, diagnostic investigation or treatment and the job of the physician is to carry on without it [the exam, diagnostic investigation, or treatment]. [J] had every right to refuse and I could have documented this in the chart ... My concerns of abuse, if still present, could have been reported to CAS or her family doctor."

[68] *Ibid*

[69] *Ibid*, at para 21; United Nations Committee on the Rights of the Child, General Comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health (2013), CRC/C/GC/15 17 April 2013 ["GC No. 15"], at paras 8-9, 21

[70] United Nations Expert Mechanism on the Rights of Indigenous Peoples. (2016). *Study on the Right to Health and Indigenous Peoples, with a Focus on Children and Youth.* Geneva, Office of the High Commissioner for Human Rights at page 8., Online: <https://documents.un.org/doc/undoc/gen/g16/177/09/pdf/g1617709.pdf?token=A0ixdEbwm1B9mnvaTF&fe=true>

[71] United Nations Committee on the Rights of the Child, General Comment No. 11 (2009) Indigenous children and their rights under the convention, 12 February 2009, at paras 5, 29

[72] Conference proceeding from the annual meeting of the Canadian Association of Pediatric Surgeons, pg 795, Record of Proceedings, p 725

discrimination, and feelings of being denigrated permeate the interactions of Indigenous peoples with Ontario's health care system, as manifest in this case.[73]

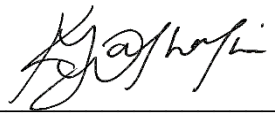
39. The existence of systemic marginalization and victimization of Indigenous girls - 25-30% of Indigenous women identify having experienced sexual assault as a child[74] - must not be used as a tool to justify the violation of a child's right to bodily integrity and right to be free from non-consensual medical treatment. Instead, the application of domestic law in the regulation of health practice must recognize an Indigenous girl child's exercise of agency to consent or refuse treatment based on all available information, provided in an accessible manner.

40. In addition to age-based discrimination stemming from the historic conceptualization of children as property, Indigenous children are frequently denied their fundamental rights to family and identity.[75] Rights-based guidance on consent for children and caregivers, and ensuring the child has meaningful access to a trusted adult or supportive person, not to replace, but to foster, a child's exercise of agency.[76]

PART IV - ORDER SOUGHT

41. JFCY takes no position on the determination of the matter. JFCY seeks no costs and asks that no costs be awarded against the intervenor.

ALL OF WHICH IS RESPECTFULLY SUBMITTED this 31st day of May, 2024.



Mary Birdsell, Allison Williams and Katherine Long, counsel for the intervener
JUSTICE FOR CHILDREN AND YOUTH
55 University Avenue, Suite 1500, Toronto, ON M5J 2H7

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73 Brenda Cameron et al, "Understanding Inequalities in Access to Health Services for Aboriginal People: A Call for Nursing Action" (2014) 37(3) Advances in Nursing Science 1, p 13
74 The medical evaluation of pre-pubertal children with suspected sexual abuse, *supra* note 60
75 United Nations Expert Mechanism on the Rights of Indigenous Peoples. (2016). *Study on the Right to Health and Indigenous Peoples, with a Focus on Children and Youth, supra* note 70
76 See GC No. 15, supra note 67, at para 21; The medical evaluation of pre-pubertal children with suspected sexual abuse, *supra* note 60, p 2

SCHEDULE A

LIST OF AUTHORITIES

Cases

1. *Justice for Children and Youth v J.G.*, 2020 ONSC 4716
2. *AB v Bragg Communications Inc.*, 2012 SCC 46, [2012] 2 SCR 567
3. *Ontario (Children's Lawyer) v Ontario (Information and Privacy Commissioner)*, 2018 ONCA 559
4. *Doré v Barreau du Québec*, 2012 SCC 12
5. *Lauzon v Ontario (Justices of the Peace Review Council)*, 2023 ONCA 425
6. *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30, [2009] 2 S.C.R.181
7. *AD-S v Nitti*, 2023 CanLII 65769 (ON HPARB)
8. *R v Sharpe*, 2001 SCC 2
9. *Baker v Canada (Minister of Citizenship and Immigration)*, [1999] 2 SCR 817
10. *Mason v Canada (Citizenship and Immigration)*, 2023 SCC 21

Secondary Sources

1. Woods, S, *"Ethical Approach to Genital Examination in Children."* (1999) 4(1) Paediatr Child Health 71

2. Tener, Dafna, Lev-Wiesel Rachel, Franco Nessia &, Ofir, Shoshi, *"Laughing Through The Pain: Medical Clowning During Examination of Sexually Abused Children: An Innovative Approach,"* (2010) 19(2) J Child Sexual Abuse 128.

3. Smith, Tanya, Chauvin-Kimoff Laurel, Baird Burke, & Ornstein, Amy, *"The Medical Evaluation of Pre-Pubertal Children with Suspected Sexual Abuse,"* (2020) 25(3) Paediatr Child Health 180.

4. Cameron, Brenda, Carmargo Plazas, Maria, Salas Anna, Bearskin, Lisa & Hungler, Krista, *"Understanding Inequalities in Access to Health Care Services for Aboriginal People a Call for Nursing Action"* (2014) 37(3) Advances in Nursing Science 1.

SCHEDULE B

RELEVANT PROVISIONS OF STATUTES, REGULATIONS, AND BY-LAWS

REGULATED HEALTH PROFESSIONS ACT, 1991, S.O. 1991, c. 18

Duty of College
2.1 It is the duty of the College to work in consultation with the Minister to ensure, as a matter of public interest, that the people of Ontario have access to adequate numbers of qualified, skilled and competent regulated health professionals. 2008, c. 18, s. 1.

...

Duty of Minister
3 It is the duty of the Minister to ensure that the health professions are regulated and co-ordinated in the public interest, that appropriate standards of practice are developed and maintained and that individuals have access to services provided by the health professions of their choice and that they are treated with sensitivity and respect in their dealings with health professionals, the Colleges and the Board. 1991, c. 18, s. 3.

HEALTH CARE CONSENT ACT, 1996, SO 1996, c 2, Sched. A

Capacity
4 (1) A person is capable with respect to a treatment, admission to or confining in 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, confining or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision. 2017, c. 25, Sched. 5, s. 56.

Presumption of capacity
(2) A person is presumed to be capable with respect to treatment, admission to or confining in a care facility and personal assistance services. 2017, c. 25, Sched. 5, s. 56.

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, the confining or the personal assistance service, as the case may be. 2017, c. 25, Sched. 5, s. 56.

...

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.

UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD, Can. T.S. 1992 No. 3.

Preamble

Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Bearing in mind that the peoples of the United Nations have, in the Charter, reaffirmed their faith in fundamental human rights and in the dignity and worth of the human person, and have determined to promote social progress and better standards of life in larger freedom,

Recognizing that the United Nations has, in the Universal Declaration of Human Rights and in the International Covenants on Human Rights, proclaimed and agreed that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status

...

Article 2

1. States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.
2. States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members.

...

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 6
1. States Parties recognize that every child has the inherent right to life.
2. States Parties shall ensure to the maximum extent possible the survival and development of the child.

...

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 16
1. No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation.
2. The child has the right to the protection of the law against such interference or attacks.

...

Article 19
1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.
2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement

CANADIAN CHARTER OF RIGHTS AND FREEDOMS, Part 1 of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), c 11

Life, liberty and security of person
7 Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

...

Equality before and under law and equal protection and benefit of law
15 (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

ONTARIO HUMAN RIGHTS CODE, R.S.O. 1990, c. H.19

Services

1 Every person has a right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability. R.S.O. 1990, c. H.19, s. 1; 1999, c. 6, s. 28 (1); 2001, c. 32, s. 27 (1); 2005, c. 5, s. 32 (1); 2012, c. 7, s. 1.

CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN, GA RES 34/180, 18 December 1979

Preamble

Recalling that discrimination against women violates the principles of equality of rights and respect for human dignity, is an obstacle to the participation of women, on equal terms with men, in the political, social, economic and cultural life of their countries, hampers the growth of the prosperity of society and the family and makes more difficult the full development of the potentialities of women in the service of their countries and of humanity,

...

Article 14

1. States Parties shall take into account the particular problems faced by rural women and the significant roles which rural women play in the economic survival of their families, including their work in the non-monetized sectors of the economy, and shall take all appropriate measures to ensure the application of the provisions of the present Convention to women in rural areas.

2. States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right:

(a) To participate in the elaboration and implementation of development planning at all levels;
(b) To have access to adequate health care facilities, including information, counselling and services in family planning;

(c) To benefit directly from social security programmes;

(d) To obtain all types of training and education, formal and non-formal, including that relating to functional literacy, as well as, inter alia, the benefit of all community and extension services, in order to increase their technical proficiency;

(e) To organize self-help groups and co-operatives in order to obtain equal access to economic opportunities through employment or self employment;

(f) To participate in all community activities;

(g) To have access to agricultural credit and loans, marketing facilities, appropriate technology and equal treatment in land and agrarian reform as well as in land resettlement schemes;

(h) To enjoy adequate living conditions, particularly in relation to housing, sanitation, electricity and water supply, transport and communications.

UNITED NATIONS DECLARATION ON THE RIGHTS OF INDIGENOUS PEOPLES,
A/61/L.67, 13 September 2007

Article 21

1. Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security. 2. States shall take effective measures and, where appropriate, special measures to ensure continuing improvement of their economic and social conditions. Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities.

...

Article 23

Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

...

Article 24

Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services. 2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

GENERAL COMMENT NO.14 ON THE RIGHTS OF THE CHILD TO HAVE HIS OR HER BEST INTERESTS TAKEN AS A PRIMARY CONSIDERATION, CRC/C/GC/14, 29 May 2013

17. Article 3, paragraph 1 seeks to ensure that the right is guaranteed in all decisions and actions concerning children. This means that every action relating to a child or children has to take into account their best interests as a primary consideration. The word "action" does not only include decisions, but also all acts, conduct, proposals, services, procedures and other measures.

...

46. As stated earlier, the "best interests of the child" is a right, a principle and a rule of procedure based on an assessment of all elements of a child's or children's interests in a specific situation. When assessing and determining the best interests of the child in order to make a decision on a specific measure, the following steps should be followed: (a) First, within the specific factual context of the case, find out what are the relevant elements in a best-interests assessment, give them concrete content, and assign a weight to each in relation to one another; (b) Secondly, to do so, follow a procedure that ensures legal guarantees and proper application of the right.

47. Assessment and determination of the child's best interests are two steps to be followed when required to make a decision. The "best-interests assessment" consists in evaluating and balancing all the elements necessary to make a decision in a specific situation for a specific individual child or group of children. It is carried out by the decision-maker and his or her staff – if possible a multidisciplinary team –, and requires the participation of the child. The "best-interests determination" describes the formal process with strict procedural safeguards designed to determine the child's best interests on the basis of the best-interests assessment.

48. Assessing the child's best interests is a unique activity that should be undertaken in each individual case, in the light of the specific circumstances of each child or group of children or children in general. These circumstances relate to the individual characteristics of the child or children concerned, such as, inter alia, age, sex, level of maturity, experience, belonging to a minority group, having a physical, sensory or intellectual disability, as well as the social and cultural context in which the child or children find themselves, such as the presence or absence of parents, whether the child lives with them, quality of the relationships between the child and his or her family or caregivers, the environment in relation to safety, the existence of quality alternative means available to the family, extended family or caregivers, etc.

...

82. In weighing the various elements, one needs to bear in mind that the purpose of assessing and determining the best interests of the child is to ensure the full and effective enjoyment of the rights recognized in the Convention and its Optional Protocols, and the holistic development of the child.

UNITED NATIONS COMMITTEE ON THE RIGHTS OF THE CHILD, GENERAL COMMENT NO.7 (2005) IMPLEMENTING CHILD RIGHTS IN EARLY CHILDHOOD,
CRC/C/GC/7/Rev. 1, 20 September 2006

17. Evolving capacities as an enabling principle.

Article 5 draws on the concept of "evolving capacities" to refer to processes of maturation and learning whereby children progressively acquire knowledge, competencies and understanding, including acquiring understanding about their rights and about how they can best be realized. Respecting young children's evolving capacities is crucial for the realization of their rights, and especially significant during early childhood, because of the rapid transformations in children's physical, cognitive, social and emotional functioning, from earliest infancy to the beginnings of schooling. Article 5 contains the principle that parents (and others) have the responsibility to continually adjust the levels of support and guidance they offer to a child. These adjustments take account of a child's interests and wishes as well as the child's capacities for autonomous decision-making and comprehension of his or her best interests. While a young child generally requires more guidance than an older child, it is important to take account of individual variations in the capacities of children of the same age and of their ways of reacting to situations. 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 have traditionally been justified by pointing to children's relative immaturity and their need for socialization. Parents (and others) should be encouraged to offer "direction and guidance" in a child-centred way, through dialogue and example, in ways that enhance young children's capacities to exercise their rights, including their right to participation (art. 12) and their right to freedom of thought, conscience and religion (art. 14).

GENERAL COMMENT NO.15 (2013) ON THE RIGHT OF THE CHILD TO THE ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF HEALTH,
CRC/C/GC/15, 17 April 2013

8. In order to fully realize the right to health for all children, States parties have an obligation to ensure that children's health is not undermined as a result of discrimination, which is a significant factor contributing to vulnerability. A number of grounds on which discrimination is proscribed are outlined in article 2 of the Convention, including the child's, parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status. These also include sexual orientation, gender identity and health status, for example HIV status and mental health.5 Attention should also be given to any other forms of discrimination that might undermine children's health, and the implications of multiple forms of discrimination should also be addressed.

...

9. Gender-based discrimination is particularly pervasive, affecting a wide range of outcomes, from female infanticide/foeticide to discriminatory infant and young child feeding practices, gender stereotyping and access to services. Attention should be given to the differing needs of girls and boys, and the impact of gender-related social norms and values on the health and development of boys and girls. Attention also needs to be given to harmful gender-based practices and norms of behaviour that are ingrained in traditions and customs and undermine the right to health of girls and boys.

...

21. The Committee recognizes that children's evolving capacities have a bearing on their independent decision-making on their health issues. It also notes that there are often serious discrepancies regarding such autonomous decision-making, with children who are particularly vulnerable to discrimination often less able to exercise this autonomy. It is therefore essential that supportive policies are in place and that children, parents and health workers have adequate rights-based guidance on consent, assent and confidentiality.

UNITED NATIONS COMMITTEE ON THE RIGHTS OF THE CHILD, GENERAL COMMENT NO.11 (2009) INDIGENOUS CHILDREN AND THEIR RIGHTS UNDER THE CONVENTION, 12 February 2009

5. The specific references to indigenous children in the Convention are indicative of the recognition that they require special measures in order to fully enjoy their rights. The Committee on the Rights of the Child has consistently taken into account the situation of indigenous children in its reviews of periodic reports of States parties to the Convention. The Committee has observed that indigenous children face significant challenges in exercising their rights and has issued specific recommendations to this effect in its concluding observations. Indigenous children continue to experience serious discrimination contrary to article 2 of the Convention in a range of areas, including in their access to health care and education, which has prompted the need to adopt this general comment

...

29. In the design of special measures, States parties should consider the needs of indigenous children who may face multiple facets of discrimination and also take into account the different situation of indigenous children in rural and urban situations. Particular attention should be given to girls in order to ensure that they enjoy their rights on an equal basis as boys. States parties should furthermore ensure that special measures address the rights of indigenous children with disabilities

Court File Number: 483/23

ASP and SD Applicant	and	**HPARB, CPSO, and NICOLE NITTI** Respondent

ONTARIO
SUPERIOR COURT OF JUSTICE
(Divisional Court)

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