W A R N I N G

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

This is a case under Part lll of the *Child and Family Services Act* and is subject to one or more of subsections 45(7), 45(8) and 45(9) of the Act. These subsections and subsection 85(3) of the *Child and Family Services Act,* which deals with the consequences of failure to comply, read as follows:

> **45.—**(7) **ORDER EXCLUDING MEDIA REPRESENTATIVES OR PROHIBITING PUBLICATION** — The court may make an order,
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> . . .
>
> (*c*) prohibiting the publication of a report of the hearing or a specified part of the hearing,
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> where the court is of the opinion that . . . publication of the report, . . ., would cause emotional harm to a child who is a witness at or a participant in the hearing or is the subject of the proceeding.
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> (8) **PROHIBITION: IDENTIFYING CHILD** — No person shall publish or make public information that has the effect of identifying a child who is a witness at or a participant in a hearing or the subject of a proceeding, or the child's parent or foster parent or a member of the child's family.
>
> (9) **IDEM: ORDER RE ADULT** — The court may make an order prohibiting the publication of information that has the effect of identifying a person charged with an offence under this Part.
>
> . . .
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> **85.—**(3) **IDEM** — A person who contravenes subsection 45(8) or 76(11) (publication of identifying information) or an order prohibiting publication made under clause 45(7)(*c*) or subsection 45(9), and a director, officer or employee of a corporation who authorizes, permits or concurs in such a contravention by the corporation, is guilty of an offence and on conviction is liable to a fine of not more than $10,000 or to imprisonment for a term of not more than three years, or to both.

CITATION: *Children's Aid Society of Toronto v. S.P.*, 2017 ONCJ 340
DATE: May 30, 2017
COURT FILE NO: C81773/15

In the Ontario Court of Justice

At 47 Sheppard East, Toronto, ON M2N 5N1

In the Matter of the Child and Family Services Act, RSO 1990, Ch.C-11
And in the Matter of an Amended Protection Application related to:
Aah., born […], 2015 (boy)
Aar., born […], 2014 (girl)

Between:

Children's Aid Society of Toronto — Applicant

And

S.P. (mother)

P.S. (father) — Respondents

Finding Hearing: May 15, 16, 23 2017

L. Goldfarb, M. Pilch for the Society

G. Colman, G. Antwi for the Parents

Paulseth, J.

Endorsement of May 30, 2015:

Overview:

1. The parents have two young children, a baby boy, (the baby) born […], 2015, and a toddler girl, (the toddler) born […], 2014. On October 3, 2015, father called an ambulance and the younger child was taken to a local hospital and then transferred to Hospital for Sick Children (HSC) due to a head trauma. The child was described as having: a scratch by the left eye, subdural hemorrhaging, both eyes with retinal hemorrhages, blood in the stomach, and suffering from repeated seizures. Medical opinion at that time was that the injuries were inconsistent with any natural cause or medical explanation but must be the result of an impact or shaking.

2. Toronto Police Service was contacted by the hospital and police made a referral to the Children's Aid Society of Toronto (the Society).

3. On October 5, 2017, the Applicant Society apprehended the baby , who remained in hospital, and filed a Protection Application under the Child and Family Services Act (the Act), dated October 9, 2015, seeking a finding in need of protection under subsections 37 (2) (a) and (b) for the baby and (b) for the toddler

4. The toddler was also assessed by HSC and had no medical issues or delays.

5. The parents each retained counsel by the time of the second appearance in December, 2015.

6. The parents were given two extensions of time to file their pleadings and each filed an Answer/Plan of Care on March 11, 2016.

7. Disclosure was complete by April 18, 2016 and the record indicates at that time that father's counsel had retained another medical expert to refute the HSC expert and was going to obtain a report.

8. On a temporary basis, the baby remained in the hospital and the toddler was placed with the maternal aunt and uncle, T.S. and S.K., under a temporary supervision order.

9. On April 18, 2016, the temporary supervision order for the toddler was changed to place her with the paternal great aunt and uncle, J.C. and C.S..

10. By June 29, 2016, mother had new counsel, who had retained an expert. The society was seeking a psychological assessment on mother and father was considering presenting a separate plan.

11. On August 16, 2016, the parties agreed to an assessment of mother, pursuant to section 54 of the Act.

12. On January 9, 2017, the case management judge noted that the baby had been in care since October of 2015 and still no finding in need of protection had been made. The matter was set down for a Summary Judgment Motion on the finding issue only before me on April 25, 2017 with filing deadlines and permission for questioning of the doctor from HSC to be completed by April 14, 2017. The parties were relying upon various medical reports. This was 3 and a half months to prepare and over 3 months to complete the questioning of the doctor.

13. On March 28, 2017, new counsel for both parents sought an adjournment of the Summary Judgment motion. The case management judge dismissed the request. Counsel for the parents appealed.

14. Despite the Notice of Appeal and in contravention of the earlier timelines fixed for filing materials prior to the Summary Judgment Motion, counsel for the parents filed two lengthy affidavits from the parents and several exhibits with curriculum vitae from various experts.

15. On April 25, 2017, the court, with the agreement of counsel for all parties, converted the Summary Judgment Motion into a focused hearing pursuant to Rule 1 of the Family Law Rules (Rules), to permit further time for counsel for the parents to cross-examine the Society's expert, and to include time for the Society to cross-examine the medical expert for the parents. Counsel for the parents also wanted a brief period of time for his clients to give evidence. This was agreed to by the Society. Several possible dates and times, including very early mornings with the use of video conferencing in order to accommodate the parents' out of town expert were provided by the court. The matter was left with counsel and the trial coordinator's office for specific scheduling arrangements. Finally, as time went by and no dates were fixed by counsel for the parents, the court on May 4, 2017 fixed several dates and times for the hearing and repeated the directions from the endorsement of April 25, 2017, as follows:

a. May 15 at 830 am Dr Shouldice for the Society for cross-examination for 45 minutes;
b. May 16 at 2 pm each parent for 10 minutes in chief with 10 minutes of cross-examination;
c. May 23 at 2 pm by video of Dr Scheller from Baltimore for the parents for cross-examination for 45 minutes; and closing submissions for 30 minutes each;
d. All of these dates are confirmed on the condition that the counsel for the parents file a copy of his Notice of Withdrawal of Appeal within 24 hours.

16. The Hearing proceeded in accordance with the endorsement, except for the s light change to accommodate the doctor from Baltimore who was going to be in Toronto on the Tuesday May 23, 2017, and could give his evidence in person but at an earlier time.

17. The following is a summary of the legal framework, the evidence and my findings.

Legal Framework for a Finding based on Physical Harm or Risk of Physical Harm

18. The society seeks a finding that the child is in need of protection pursuant to subsections 37 (2) (a) and (b) of the Act. These subsections read as follows:

> 37 (2) (a) the child has suffered physical harm, inflicted by the person having charge of the child or caused by or resulting from that person's,
>
> (i) failure to adequately care for, provide for, supervise or protect the child, or
>
> (ii) pattern of neglect in caring for, providing for, supervising or protecting the child;
>
> (b) there is a risk that the child is likely to suffer physical harm inflicted by the person having charge of the child or caused by or resulting from that person's,
>
> (i) failure to adequately care for, provide for, supervise or protect the child, or
>
> (ii) pattern of neglect in caring for, providing for, supervising or protecting the child.

19. The society has the onus, on a balance of probabilities, to establish that the child is at risk of harm.

20. The risk of harm under clause 37 (2) (b) of the Act must be real and likely, not speculative. The harm must be demonstrated by a serious form of one of the listed conditions or behaviours. See: *Children's Aid Society of Rainy River v. B. (C.)*, 2006 ONCJ 458 (CanLII); *Children's Aid Society of Ottawa-Carlton v. T. and T.*, [2000] O.J. No. 2273, (Ont. Fam. Ct.).

21. Harm caused by neglect or error in judgment comes within the finding. See: *Children's Aid Society of the Niagara Region v T.P.* [2003] O.J. No. 412 (Ont. Fam. Ct.).

22. Unexplained injury cases are ones in which the child suffers an injury and the parents either provide no explanation or provide an explanation that is not consistent with the expert evidence as to the cause of injury. Absent an explanation from the parents, courts are reluctant to return children with unexplained injuries to their parents. *Children's Aid Society of Toronto v. P.A*. (2002) O.J. No. 5344 (OCJ) and cases cited within.

23. It is not necessary for the Society to prove which caregiver caused harm if one or the other must have either caused the harm or failed to protect the child from the other caregiver: *Catholic Children's Aid Society of Toronto v. De S. (M.),* 2005 ONCJ 336 (CanLII).

24. Justice Harvey Brownstone provides a good summary of the law with respect to unexplained injuries in JFCS *v. Y. B.,* [2011] O.J. No. 5892 (OCJ):

> **16** In some "unexplained injury" cases where the cause of the injuries is determined to be non-accidental, the issue of identifying the perpetrator(s) is a necessary component of determining whether the child is in need of protection. However, this is not always the case. As a general rule, where the person(s) who had exclusive opportunity to inflict the injury have not provided a satisfactory explanation for the injury, this has almost always justified a protection finding and a refusal to return the child to such person(s): *Children's Aid Society of London and Middlesex v. K.W.*, 1995 CanLII 9824, 60 A.C.W.S. (3d) 314, [1996] W.D.F.L. 512, 9 O.F.L.R. 162, [1995] O.J. No. 4104, 1995 CarswellOnt 634 (Ont. Fam. Ct.); *Children's Aid Society of the Region of Peel v. J.L.*, 2001 CanLII 37562, 109 A.C.W.S. (3d) 742, [2001] O.J. No. 4422, 2001 CarswellOnt 3967 (Ont. C.J.); *Children's Aid Society of the Districts of Sudbury and Manitoulin v. C.C.*, 2001 CanLII 37561, 115 A.C.W.S. (3d) 807, [2001] O.J. No. 5802, 2001 CarswellOnt 5125 (Ont. C.J.); *Children's Aid Society of Toronto v. P.A.*, 2002 CanLII 61173, 121 A.C.W.S. (3d) 1082, [2002] O.J. No. 5344, 2002 CarswellOnt 4935 (Ont. C.J.); *Catholic Children's Aid Society of Toronto v. M.D.S.*, 2005 ONCJ 336, 140 A.C.W.S. (3d) 669, [2005] O.J. No. 2914, 2005 CarswellOnt 2932 (Ont. C.J.); *Director of Child Welfare for Prince Edward Island v. J.C.D.*, 2009 PECA 19, 71 R.F.L. (6th) 26, 289 Nfld. & P.E.I.R. 45, 890 A.P.R. 45, [2009] P.E.I.J. No. 39, 2009 CarswellPEI 43 (P.E.I.C.A.).
>
> **17** In child protection cases, the onus is always on the applicant Children's Aid Society to prove that the child is in need of protection. However, in "unexplained injury" cases, the tactical onus to provide a satisfactory explanation for the injury shifts to the parent if two necessary preconditions exist: (1) that the evidence is sufficient to establish on a balance of probabilities that the child's injury may have been caused by that parent; and (2) that the evidence is not sufficient to establish on a balance of probabilities that the injury was caused by someone else: *Children's Aid Society of the Districts of Sudbury and Manitoulin v. L.N., V.M. and D.M.*, 2011 CarswellOnt 12356 (Ont. S.C.).
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> **18** In this case the above preconditions have been met because: I am satisfied on a balance of probabilities that the father may have been the perpetrator; and there is insufficient evidence to establish on a balance of

probabilities that Ya.B.'s injuries were caused by Ms. A.So. or Ms. M.D.[4]. Accordingly, the "unexplained injury" principle applies. As none of Ya.B.'s caregivers have provided a plausible and credible explanation for Ya.B.'s injuries, Ya.B. should on that basis alone be found to be in need of protection pursuant to s.37(2)(a)(i) and (b)(i) of the Act. Similarly, because S.B. was in the care of the same caregivers as Ya.B., she is also found to be in need of protection pursuant to s.37(2)(b)(i) of the Act.

The Expert Evidence:

For Society:

25. Dr M. Shouldice gave evidence based on her reports of November 2, 2016 and May 13, 2017. Her credentials include:

- 4 post-secondary degrees in science-related areas including her MD in 1994
- 5 years of post-graduate specialization in paediatrics, obtaining her specialist FRCP with the Royal College in 1998, a re-certification in 2009, certification with the American Board of Pediatrics, and a sub-specialty with American Board of Pediatrics in Child Abuse 2009- 2021
- Associate professor at University of Toronto Faculty of Medicine 2011 to present
- Division Head Paediatric Medicine HSC, 2014 to present
- Her curriculum vitae is replete with appointments to related positions, Honours and awards in her field, professional affiliations, peer review grants and research awards, current research projects, peer reviewed publications, and other publications, guest speaker engagements

26. The court ruled that Dr Shouldice was permitted to give evidence as an expert in paediatric medicine, child maltreatment, injury interpretation and evaluation in children.

27. Her report was based on the child's past health records and her direct assessment of the child on October 3, 2015, along with the information provided by the mother and a police officer.

<u>Before the Events of Oct 2, 2015</u>

28. The baby was born 6 and ½ weeks premature. His Apgar scores (a medical term that summarizes the overall health of a newborn child) were very good though- 9 and 8 at one and 5 minutes after birth. He was given some pressurized air for about 15 minutes which is normal. He had some haziness in his lungs, which is normal for newborns. He was placed in the Neonatal Intensive Care Unit with antibiotics and feeding support- all normal for premature births and without any real illness whatsoever. He was noted to have a faint heart murmur (followed up by a cardiologist and became normal) and a "click" in his left hip which was treated through a hip brace and was resolved by August 24, 2015. He was seen by his paediatrician 5 times from June through September, 2015. He was noted to be a "spitter" but ultra sound of the stomach was normal.

29. On July 13, 2015, the baby was brought to Emergency at HSC for noisy breathing but examination proved normal.

30. From 2 to 4 months of age, the baby's head circumference went from the 50th per centile to the 97th per centile.

Oct 2-22, 2015

31. The baby was reported to be well during the day of October 2, 2017with normal feeding and behaviour. Mother fed the baby about 15:45 and placed him in bassinet. She left the house about 16:00. About 45 minutes later, the child began to cry inconsolably for about 15 to 20 minutes. Father tried to settle the baby by burping and tapping his cheek. Suddenly the baby's eyes began to flicker and his head turned to the side. Father brought the baby downstairs to grandmother and called 911 at 17:21. There are some inconsistencies between the father and paramedic reports as to whether father did full cardiopulmonary resuscitation (CPR) on the baby or one or both of chest compressions (using just fingers for the baby) and mouth to mouth resuscitation.

32. The ambulance arrived at 17:26 – the child was unresponsive and bluish in colour. Baby improved with bag mask ventilation and began to move his limbs. They arrived at Scarborough Centenary Hospital Emergency at 17:48. The baby required a breathing tube and received intravenous fluids, antibiotics, and antiepileptic medication, although there was no documentation of seizure activity. He was transferred to HSC.

33. On examination at HSC, the following were noted:

- By CT scan, multiple areas of subdural hemorrhage; his head circumference was greater than the 97th percentile.
- Tenderness when his abdomen was pressed, with blood draining from his stomach thru a tube in nose.
- Tiny abrasion to top of left ear.
- Retinal hemorrhages, more on the left than the right, chiefly intraretinal and some preretinal.
- Started to have decreased movement on the right side of his body.

34. From October 5 to 10, he had clinical seizures, requiring multiple medications to control.

35. On October 11, the breathing tube was removed and he was transferred to the regular pediatric inpatient unit.

36. Dr Shouldice reviewed all of the laboratory and radiology testing, which included:

- CT scans of head and neck on October 2, abdomen and pelvis on October 3, and of head on October 5;
- MRI of brain and spine on October 3, of the brain on October 9 and 19
- Skeletal survey on October 4 and 16
- Ultrasound on October 5

37. There has also been extensive follow up of the baby at both HSC and Bloorview Hospital, a rehabilitation centre.

38. Dr Shouldice describes each of her findings and discusses possible causes:

1. Subdural hemorrhages:
Most commonly caused by trauma, including birth trauma, accidental injuries, and inflicted head trauma. Rarely could be caused by a medical disorder, such as a bleeding disorder or an inherited disorder of metabolism. For this baby there is no indication of any of these other possibilities.

Birth trauma unlikely here because child was born by C section and the hemorrhage was documented at 4 months of age. May still be possible if there was an unusually prolonged course of ongoing or re-bleeding.

A focal impact to the head, such as a fall or blow to the head may cause this. It is an area of ongoing medical discussion. There are no physical findings or radiology that support this in this case.

An indirect trauma which results in significant deceleration/acceleration, such as whiplash or a fall, may cause this. Forceful shaking of an infant may lead to intracranial bleeding but there is a debate about whether shaking alone could cause this. She discusses the controversy and concludes, from her review of the research and literature, that there is evidence to indicate that the application of force during shaking of an infant and/or blunt trauma can result in subdural hemorrhages- this opinion is shared by the major paediatric societies in North America- both American and Canadian.

Other possible causes were ruled out because:

- Rebleeding would not typically result in a sudden onset of severe neurological symptoms; usually it is slow and steady. The studies at the time did not show enough pressure to cause the neurological symptoms. In this baby there was ongoing accumulation long after the events of Oct 2/3, up to December of 2015.
- Sometime infants with larger spaces around the brain will stretch blood vessels leading to easier breaking and bleeding. That was not documented with this baby preceding the October event; he did not have head imaging prior to October events.
- A brain or blood malformation can cause a predisposition to easier bleeding but no such malformations were noted here.
- Sometimes reduced oxygen due to choking can cause subdural hemorrhaging; but without other contributing factors such as birth abnormal bleeding- this explanation remains tenuous.

In summary, Dr Shouldice concludes that it is most likely that it was caused by a traumatic injury from a focal impact or inertial force.

The symptoms associated with subdural hemorrhaging/head trauma include: enlarged head size, irritability, lethargy, fatigue, restlessness, crying, vomiting, decreased appetite, breathing disturbance, respiratory arrest, seizures, unconsciousness, and death. More severe injuries generally have more rapid onset of symptoms, which was the case here.

When the baby had projectile vomiting at 2 months, Dr Shouldice thought it could have been due to a common infant reflux or due to pressure on his brain resulting from an injury event at that time. Another possible physical cause in the stomach was ruled out. All of the baby's symptoms on October 2, were in her opinion, typical signs of a recent head injury.

2. Retinal Hemorrhages
Ophthalmologic examinations on October 3 and 4, 2015 and retinal photos taken on October 6 and 13 document a few retinal hemorrhages in the left eye and multiple ones in the right eye. They were confined to the posterior pole in both eyes. This is bleeding within the lining of the back of the eyeball.

Possible causes, according to Dr Shouldice, include:

- a medical disorder- such as a bleeding disorder, metabolic disorder, or leukemia- none of which the baby had. It is possibly seen with abnormal connective disorders- this baby did not have any of these.
- a number of other possible disorders but the doctor states that this baby had none of these.
- a trauma- frequently from the trauma of vaginal birth- but not in this case as the birth was by c-section.
- a direct eye trauma, such as blunt force. There is a current medical controversy about the amount of impact or inertial force necessary to cause this. In this case, there was no history of any direct eye or head trauma and the baby was immobile so he could not generate substantial force on his own. It is unlikely that there was an accident not witnessed by a caregiver. There is only one case in all the literature of similar aged infant falling from a propped standing position with these injuries. Otherwise there is extensive literature about inflicted head trauma resulting from acceleration/deceleration forces with or without impact and sudden severe deceleration. Current controversies include the mechanism of injury, the amount of force needed and the specificity of the findings, but not whether there was force.

Could the injury be from the CPR performed by father? Dr Shouldice indicates that, in a small number of reported cases in literature reported in a journal in 1990, there was some damage caused by CPR but the majority were children with disorders and with few retinal hemorrhages.

Dr Shouldice did not know that the father did two or three finger chest compressions - but it is still an unlikely cause, based on the literature. These types of CPR related injuries may resolve within days; most of these resolve within 3 to 4 weeks and at the very most in 8 weeks.

To conclude, Dr Shouldice indicates that based on the number, extent, and the layers involved, the most likely cause is a traumatic injury.

3. Brain Injury

The baby sustained significant damage to the brain tissue. The baby's symptoms were a sudden onset of progressively worsening seizures and restriction on his brain followed by evidence of permanent brain damage. Dr Shouldice indicates that this is typical of a significant traumatic brain injury. The early symptoms relate to the effects of the recent injury and the subsequent development of the symptoms relate to secondary physiological responses to tissue injury and reduced oxygen and blood flow.

A severe episode of choking could have caused the baby's brain damage, but no there was no indication that he didn't feed normally and no evidence of any obstruction in the early x-rays.

4. Liver Abnormality
This showed on the blood tests and the CT scan noted it as well. A possible explanation is a traumatic injury to the abdomen and damage due to inadequate blood or oxygen flow.

In examining all of the details of the case, Dr Shouldice is of the opinion that the baby suffered a traumatic head injury which occurred soon before he presented for assessment on October 2, and for which an explanation has not been provided - Further there was at least one previous episode which raises concern for another injury event.

The injuries were life threatening and the baby will have ongoing and significant neurologic problems and developmental delays.

Expert for the Parents

Evidence of Dr J. Scheller

39. Dr. Scheller is a pediatrician and child neurologist, working in private practice since 2014, with privileges at Sinai Hospital in Baltimore, Maryland. He has 30 years' experience as a child neurologist. His longest standing appointment was to a staff neurologist position at the Children's National Medical

Centre from 1997 to 2012 and, during that same period, as an Assistant Professor of Pediatrics at George Washington University. In addition, he is

- Certified as a paediatrician since 1988 with the American Board of Paediatrics
- Certified as a child neurologist with the American Board of Psychiatry and Neurology since 1989
- He has written on childhood seizures, epilepsy, cognitive deficits in children, and , in 2014, an abstract on subarachnoid and retinal hemorrhages.

40. The court ruled that he was an expert in pediatrics, child neurology, and neuro-imaging. The last speciality was obtained by him so as to avoid the use of the middle- doctor, the radiologist.

41. He reviewed all of the medial records, reports and various CT and MRI scans. His opinion in a report dated April 3, 2017, is that:

1. The baby had a chronic medical condition that caused him to accumulate fluid between his brain and inner skull- subdural hygroma- paediatric neurologists and neurosurgeons encounter this often in practice when infants are referred for larger than expected head circumference- most are not related to accidental or abusive trauma- they develop at birth or for no known reason
2. These subdural hygromas are usually benign but can occasionally cause small subdural and subarachnoid hemorrhages- either because the vessels are stretched and can tear and leak blood or the body builds a membrane which is apparent in this baby's ct scan and the membrane can leak blood as well.
3. Subdural hemorrhages are not usually life threatening but subarachnoid ones can be because they irritate the surface of the brain and cause seizures.
4. The chronology went like this: chronic fluid build-up around August 2015, membrane forms a wall, blood leaks into subdural and subarachnoid spaces on October 2, seizure, decreased blood flow causes brain compromise.
5. Baby continued to have a propensity to rebleed from chronic fluid collecting. October 19 and December 1 showed new subdural bleeding, but both times it remained in the subdural area.
6. Retinal hemorrhages can be caused by increased pressure within the head and whenever there is subarachnoid hemorrhage.
7. In his opinion the SCAN team should have considered the possibility of the rebleed causing the seizures.
8. Typical findings of abusive head trauma were not present; such as external injuries like rib, limb, skull fractures and neck injuries. The baby had none of these injuries.

Dr Shouldice responded to Dr Scheller's Opinion:

42. Firstly she reviewed the opinion with a paediatric neurosurgeon, a pediatric Ophthalmologist and a pediatric neuroradiologist from the HSC team who were involved in the case.

43. She remains firm in her opinion and provides references in the literature to support her opinion. She describes their areas of differing opinions as follows:

1. Rebleeding causing the symptoms per Dr Scheller

Collective clinical experience and her understanding of the literature is that bleeding into increased extraaxial collections does occur but it does not lead to sudden onset of significant symptoms like in this baby. She then provides 4 references to medical studies that have addressed this issue, from 2006 to 2013.

2. Retinal Hemorrhages

Dr Scheller attributes this to either increased pressure around the brain or to subarachnoid hemorrhages. Dr Shouldice describes the first diagnosis at length and concludes by saying that the neurosurgeons did not recommend a lumbar puncture to diagnose for this symptom, which is the only definitive way to reach that diagnosis.

Secondly, Dr Shouldice describes why it is unlikely that this pressure around the brain was sufficient to result in retinal hemorrhages, as there would also usually be optic nerve swelling in that case and there wasn't here. She notes a 2013 study and a more recent one in 2017, both of which dispute Dr Scheller's theory.

Thirdly, with respect to the subarachnoid hemorrhage connection, she says it has been found in children with a ruptured aneurism or blood vessel abnormality. This baby did not have a significant subarachnoid hemorrhage nor any abnormality. Further a review with the ophthalmologist ruled out Terson syndrome based on the pattern and appearance of the retinal hemorrhages. She references an article discussing these items from 2012.

3. Regarding Dr Scheller's view that the clinical and radiological features in this case are not typical for abusive head trauma, she reviews the recent literature and points to the associated features noted there- 11 features were found in this baby- out of a possible 13.
4. Finally she reports that "it is well recognized that while external features of abuse may be present in traumatic head injury cases, they are frequently not present."
5. In her opinion, it is likely that there was an injury event.

The Parents' Evidence:

44. Father described the events of the afternoon of October 2 and his call to 911, while trying to give CPR. He may not have tried the mouth to mouth, but he did try the fingers' compression and his mother continued those. He is not sure why the paramedics recorded something differently.

45. Mother admitted that she had not told the Section 54 assessor, who conducted a psychological assessment on her, that she did in fact have a history of emotional distress- in her late teens and in her early twenties- the latter resulting in a hospitalization and a diagnosis from CAMH of borderline personality disorder. She entered treatment for a year. She also pled guilty to a credit card fraud charge to cover for her boyfriend of the time in her late teens. For this conviction, she served 90 days on weekends and a year of probation.

46. For the first time, mother postulated that the baby could have been hit by the toddler and she recalled two incidents of this happening- when the baby was about 2 months and again at 3 months of age. Mother described her baby as very happy and placid, not needing a lot of holding and cuddling, but only crying when he needed to be fed or changed.

Statutory Findings:

47. The identifying information for the children was not in dispute. I make the statutory findings consistent with the Amended Protection Application.

Finding in Need of Protection:

48. The onus is on the Society to prove on a balance of probabilities, pursuant to section 47(1) Act, that these two children are in need of protection under one or more of the subsections defining "child in need of protection" in section 37 of the Act. In this case the Society in its Protection Application is relying on subsection 37(2) (a) and (b) for the baby and (b) for the toddler.

49. The underlying facts to support the finding are in dispute and amount to two medical views on the interpretation of the very serious and life threatening physical events that impaired this baby in October of 2015, almost 20 months ago.

50. After the Summary Judgment Motion was set, the parents retained new counsel and Dr Scheller. Normally, the court might question whether one counsel could represent both parents in an unexplained injury case, but the delays have been such that the forced adjournment of the Summary Judgment Motion required a timely hearing for cross-examination of these two doctors.

51. I have reviewed the evidence of the doctors in some detail above.

52. For the following reasons, I accept the views of Dr Shouldice over Dr Scheller:

1. More experience in the specific child maltreatment field
2. Higher positions in terms of medical appointment positions- head of paediatrics as opposed to staff physician
3. Higher University appointment- associate professor rather than an assistant
4. More publications dealing directly with these issues
5. Greater expertise in suspected child abuse area
6. Greater recognition as expert in this area from medical speaking engagements and papers

7. Broader team approach- with other professionals and also double checked with other professionals.
8. Very thorough report with options discussed in detail
9. Very thorough and respectful response to Dr Scheller's opinion with detailed references
10. Very balanced approach in her evidence, recognizing the controversies within each field and the limitations of medical research
11. Dr Scheller provided a very short and somewhat simplistic approach to a very complicated set of medical issues.

53. I find that the baby suffered a traumatic head injury soon before his presentation at hospital on October 2, 2015, for which the parents who had charge of him have failed to provide an explanation. Mother's most recent description of the toddler wielding the remote or the blocks' sorter, was not credible due to its very late timing combined with her two admissions of lack of honesty about her mental health past and her criminal past.

54. I find that it is more probable than not that one or both of the parents caused the injury or failed to take reasonable steps to prevent the injury.

55. The baby's injuries were so significant as to be life threatening and leaving him with permanent brain damage. These injuries are consistent with a finding under subsection 37(2)(a) and also raise the risk of concern as described in (b)

56. The events of October 2, 2015 which necessitated the baby's hospitalization also raise significant concerns for the safety of the toddler, and I have no hesitation in making a 37(2)(b) finding with respect to her as well.

57. I am grateful for the concise and focused manner in which counsel conducted this hearing, and share the concern of the case management judge regarding the delays in this case.

58. The matter is adjourned to the case management judge on June 20, 2017 at 9:30 am for a timetable for an agreed upon disposition or a timetable to be fixed by the court. I would ask counsel to discuss the timetable in advance and if no agreement is reached to serve and file their respective proposals in advance of the return date.

Dated at Toronto

May 30, 2017

Debra Paulseth,

Ontario Court of Justice