Court of Queen's Bench of Alberta

Citation: R v Stephan, 2019 ABQB 715

Date:
Docket: 130163405Q1
Registry: Lethbridge

Between:

Her Majesty the Queen

- and -

David Robert Stephan and Collet Dawn Stephan

Accused

Reasons for Decision
of the
Honourable Mr. Justice T.D. Clackson

I. Introduction

[1] David Stephan and Collet Stephan are charged as follows:

> On or between the 27th day of February, 2012 and the 13th day of March, 2012, at or near Glenwood, in the Province of Alberta, did fail without lawful excuse to provide the necessaries of life to Ezekiel Jasher Stephan, a person under his charge and unable, by reason of age to withdraw himself from such charge, and to provide himself with such necessaries and did thereby endanger the life of Ezekiel Jasher Stephan, contrary to s 215(2)(b) of the *Criminal Code of Canada*.

[2] At their original trial they were convicted of the offence by a jury. On appeal, the verdict was upheld (***R v Stephan***, [2017] ABCA 380). On further appeal, the Supreme Court of Canada directed a new trial, largely for the dissenting reasons of O'Ferrall, JA. On the retrial, which I heard sitting without a jury, Mr. Stephan represented himself and Ms. Stephan was represented by a group of three counsel as they were available.

[3] The evidence plainly establishes that Ezekiel had meningitis. The main issues in dispute are:

- Whether he had bacterial or viral meningitis;
- Whether his death was the result of meningitis, or the result of hypoxic injury;
- Whether the Stephans knew he had meningitis; and
- Whether knowing that, they ought to have sought medical intervention.

[4] I have concluded that Ezekiel did have meningitis. The Stephans did not know the Ezekiel had meningitis but were alert to the possibility and monitoring for symptoms. The meningitis Ezekiel had was viral and he did not die from meningitis but from the lack of oxygen. Therefore, I have concluded that the Stephans are not guilty of the charge.

II. The evidence of Drs. Adeagbo, Sauvageau and Burkholder

A. Dr. Bamidele Adeagbo

[5] Dr. Bamidele Adeagbo was the medical examiner assigned to autopsy Ezekiel Stephan. The Crown sought to have him qualified to offer opinion evidence on what he observed and what caused what he observed.

[6] The procedure adopted in this trial was unusual. The *voir dire* as to qualification and the evidence that would have been given if qualified, were all rolled into one. Therefore, by agreement, I heard the entirety of Dr. Adeagbo's testimony in direct, cross and redirect on the subject of his expertise and the substance of his opinion all as part of the *voir dire*. That procedure was necessary because the Stephans' advised that they would be challenging Dr. Adeagbo's impartiality and his reliability and intended therefore to cross-examine him on his opinion as well as his qualifications.

[7] In ***White Burgess Langille Inman v Abbott and Haliburton Co***, [2015] 2 SCR 182, Justice Cromwell offered this on the requirement of impartiality:

> Imposing this additional threshold requirement is not intended to and should not result in trials becoming longer or more complex. As Prof. Paciocco aptly observed, 'if inquiries about bias or partiality become routine during *Mohan voir dires*, trial testimony will become nothing more than an inefficient reprise of the admissibility hearing': "Unplugging Jukebox Testimony in an Adversarial System: Strategies for Changing the Tune on Partial Experts" (2009), 34 *Queen's L.J.* 565, at p. 597. While I would not go so far as to hold that the expert's independence and impartiality should be presumed absent challenge, my view is that absent such challenge, the expert's attestation or testimony recognizing and accepting the duty will generally be sufficient to establish that this threshold is met.

[8] The blended procedure we adopted avoided the reprise. However, despite that efficiency, the *voir dire* consumed six days over a six week period.

1. The Mohan Analysis

[9] There is really no argument that Dr. Adeagbo's education, training and experience qualify him to offer the relevant opinions. The issue relates to bias, communication and presentation. Those were the subjects of the argument by the Stephans that Dr. Adeagbo should not be permitted to offer the opinions sought.

[10] The Supreme Court of Canada's decisions in ***R v Mohan***, (1994) 2 SCR 9 and ***White Burgess***, supra, establish the criteria for determining whether opinion evidence ought to be admitted.

[11] It is worth noting that every medical examiner in this Province is charged, in each case, with determining the cause of death, the circumstances under which the death occurred and the manner of which the death occurred. It is also worth noting that medical examiners invariably end up in Court, at one time or another, to explain their findings and if permitted, their opinions. Therefore, in a real sense, medical examiners could not become such without being expert in forensic pathology. However, the issue in this proceeding is not whether Dr. Adeagbo is an expert in determining the cause, manner and circumstances of Ezekiel's death, it is whether the Court should receive his opinions on the matter. The inquiry, as the Supreme Court of Canada has instructed is broader than whether he has expertise.

[12] The term "expert opinion" when describing the opinion offered by someone with special knowledge, suggests that the opinion cannot be offered by that person unless he or she is expert in that field. Plainly, that is not the case. Any person who has the special knowledge may, if otherwise qualified, offer opinion in that field. Their renown or lack thereof, is only a factor when determining what weight to ascribe to their opinion.

[13] Therefore, I have proceeded on the basis that Dr. Adeagbo is a forensic pathologist and as a result he has specialized knowledge which is essential to my proper understanding of what condition Ezekiel was in at his death and what caused his death.

[14] Ms. Stephan argued that Dr. Adeagbo's evidence was not relevant to any of the essential elements of the offence. She argued that the Crown had conceded as much when called upon by the Court to advise if, after my findings as to the essential elements of the offence had been pronounced, the Crown proposed to call further evidence. There is no merit to that argument. The cause of Ezekiel's death is obviously relevant as is what Dr. Adeagbo observed and inferred when he conducted the autopsy.

[15] As a result, the Mohan criteria of relevance, necessity, and the absence of an exclusionary rule have been satisfied. The remaining Mohan threshold question to resolve is whether Dr. Adeagbo is "properly qualified" as an expert as that phrase was explained in ***White Burgess***, supra. In that case, the Supreme Court of Canada created an approach to dealing with partiality and bias. Those issues must be addressed when considering the fourth Mohan criteria, "a properly qualified expert" and again when performing a Cost-Benefit Analysis commensurate with the Courts gatekeeping role.

2. A qualified expert

[16] The Supreme Court of Canada provides guidance on the burden borne by the party proffering the expert. Where the purported expert swears or affirms that he or she understands their duty to provide fair, objective and unbiased opinion evidence and confirms that they will do so, that is generally sufficient to meet the burden of the party proffering the expert. That was done here by Dr. Adeagbo. Having done so, the tactical burden shifted to the Stephans to raise a realistic concern that Dr. Adeagbo was unable or unwilling to comply with his duty. Importantly, the Supreme Court said nothing about reliability. That subject is frequently raised at this juncture of the Mohan analysis when dealing with novel science or unusual subjects or experiential experts as opposed to trained and educated experts. That is not the kind of reliability concern raised by the Stephans. They take issue with the reliability of Dr. Adeagbo conclusions. That would normally be the subject of argument before the fact-finder. It is up to the fact-finder to resolved matters of conflict in the evidence and to assign weight to the evidence it accepts. Accordingly, while the reliability of Dr. Adeagbo's conclusions may be considered when assessing the cost and benefit of receiving his evidence, it is not an issue when determining if Dr. Adeagbo is a properly trained expert.

[17] On the inquiry as to bias and partiality at the properly qualified expert stage, the Supreme Court of Canada said this at para 49 in ***White Burgess***:

> This threshold requirement is not particularly onerous and it will likely be quite rare that a proposed expert's evidence would be ruled inadmissible for failing to meet it. . . .

[18] After giving examples of the kind of concerns which might cause an issue, Cromwell J, for the Court, offered this again at para 49:

> . . . I emphasize that exclusion at the threshold stage of the analysis should occur only in very clear cases in which the proposed expert is unable or unwilling to provide the court with fair, objective and non-partisan evidence. Anything less than clear unwillingness or inability to do so should not lead to exclusion, but be taken into account in the overall weighing of costs and benefits of receiving the evidence.

[19] With those observations in mind, I turn to the specifics of the defence arguments. Those arguments may be summarized as arguments respecting communication, arguments respecting attitude, arguments respecting credibility, and arguments respecting noble cause or confirmation bias.

a. Communication

[20] Dr. Adeagbo's evidence was replete with technical medical jargon. His vocabulary was extensive. His ability to articulate his thoughts in an understandable fashion was severely compromised by: his garbled enunciation; his failure to use appropriate endings for plurals and past tenses; his failure to use the appropriate definite and indefinite articles; his repeated emphasis of the wrong syllables; dropping his Hs; mispronouncing his vowels; and the speed of his responses. In addition, his answers were not always responsive and he would on occasion embark upon a mission to educate the parties and the Court. As a result, there were many instances when it was necessary to have Dr. Adeagbo: repeat his answers; slow down his delivery; focus on the question asked; and accept that despite our ignorance, the question asked

needed to be answered. The Transcripts of his testimony are replete with many examples of the foregoing. All of this was exacerbated by the use of a video link as an accommodation to Dr. Adeagbo. However, even when present in person, as he was the final two days of his testimony, the problems I have identified, continued. Nevertheless, the profound difficulty all participants experienced in comprehending Dr. Adeagbo's evidence, does not form a basis for a realistic concern that he was biased or partial. In my view, all of those problems are best considered in the Cost-Benefit Analysis and, if his testimony is admitted, in the weight to be given to is evidence.

b. Attitude

[21] Dr. Adeagbo demonstrated all of the following behaviours and attitudes over the six days of his testimony. He was calm, rational, reasonable, arrogant, petulant, exasperated, combative, argumentative and angry.

[22] Those attitudes were demonstrated not just verbally but also in Dr. Adeagbo's movements, body language and physical antics. Again, these behaviours were more prevalent during the video-link presentation. Unfortunately, the Transcript does not adequately capture some of the behaviours I have described. Suffice to say that they were not the behaviours usually associated with a rational, impartial professional imparting opinion evidence for the benefit of the Court.

[23] Again, however, while concerning, distracting and unprofessional, none of those attitudes demonstrate a bias or partiality. Rather, all may be attributed to the fact that in Dr. Adeagbo's opinion, Ezekiel so obviously died of bacterial meningitis that it is a complete waste of time to even consider anything else. Accordingly, those attitudes do not raise a realistic concern that Dr. Adeagbo is not an appropriate expert. Those attitudes are however, relevant in the Cost-Benefit Analysis.

c. Confirmation/Noble Cause Bias

[24] In his paper "Unplugging Jukebox Testimony in an Adversarial System: Strategies for Changing the Tune on Partial Experts" (2009) 34 Queen's L J 565, David Paciocco (now Justice Paciocco), described Professional bias as follows (at page 581):

> Experts are jealous of their special skill, ability and knowledge. They cling to their theories and opinions most tenaciously and are loath to admit any merit in opposing theories or opinions.

[25] I accept that insight as a reasonable proposition which can be manifested by an expert in the steps he or she takes to defend or explain the opinion reached. In this case, I prefer to apply the label confirmation bias because the cross-examination of Dr. Adeagbo proceeded on that footing. In the cross-examination of Dr. Adeagbo, it was established that he was sure from the beginning that Ezekiel had died from bacterial meningitis. The testing done, post autopsy, was done to confirm that conclusion. There was no specific testing done to rule out viral or fungal causes for the meningitis. Despite records which could tend to support hypoxic injury and hyponatremia, no specific steps were taken to confirm or refute either possibility. These actions are consistent with Dr. Adeagbo's assertion and attitude, that Ezekiel's death was a crystal clear case of bacterial meningitis. He had no doubt on the subject. In that circumstance, testing for anything other than the bacteria which caused the meningitis was a waste of time. Dr. Adeagbo said, and I accept that his additional efforts to identify the bacterial agent were not done to support his opinion but done because he wanted to identify the infectious agent as he felt it was

his duty to do so in the discharge of his responsibilities to the Stephans and the general public. The duty to keep them safe from a similar fate.

[26] That is not confirmation bias or at least not to the extent that it raises a realistic concern as to bias or partiality.

[27] With respect to noble cause distortion, Paciocco offered this at pages 582 and 583:

> Sadly, there have been cases where expert witnesses have succumbed to what lawyers like to call "noble cause corruption" – the distorting effect that can occur from believing that you are on the side of good. Expert witnesses who think that they are serving the public interest by testifying, particularly by combating reprehensible practices or conduct, can fall victim to this form of partiality. . . .
>
> In truth, "noble cause corruption" may not be the best label for this phenomenon because "corruption" suggests the kind of dishonesty in *583 the extreme cases just described. Most often, the corrupting influence of believing that what you say as an expert witness has high social utility is unconscious; that sense of mission can taint one's perspective and encourages confirmation bias. The term "noble cause distortion" may be more apt to describe the reality that crusading expert witnesses –those who have a sense of mission – may be prone to see what they want to see. . . .

[28] In his report and in the death certificate, Dr. Adeagbo states that Ezekiel was not immunized and it is clear that he believes that had Ezekiel been immunized he would not have succumbed to the infection. The Stephans suggest that Dr. Adeagbo is consumed by the cause of immunization and that coloured his opinion and his refusal to consider alternative explanations for Ezekiel's death. I agree that whether Ezekiel was or was not immunized is at best tangentially related to the circumstances of Ezekiel's death. The reference to it in Dr. Adeagbo's opinion and his report does seem like a pet peeve or noble cause. However, it is certainly in keeping with Dr. Adeagbo's character as I became familiar with him over the course of his testimony. He has an overarching need to educate and make sure he is properly understood. As such, it would be contrary to that trait to pass up an opportunity to educate the public on the inadvisability of failing to immunize one's children. As such, I do not see this as a cause which taints his opinion. Again, Dr. Adeagbo concluded, very early on, that this was a very clear case of bacterial meningitis. Having come to that conclusion, he felt compelled to speak out so as to prevent other such occurrences. That is not noble cause corruption.

d. Credibility

[29] On a number of occasions in his testimony, Dr. Adeagbo said he considered everything in reference to various scenarios presented to him and in reference to the various documents contained in the file maintained in the Office of the Medical Examiner. On a number of occasions, he said he did not rely on the pejorative comments made in some of the documents in that file and relied instead on what he saw in the autopsy. In all cases, he testified that he had no present recollection of what documents he saw, when, but he said he saw them all. Of note, some of the file material is inconsistent with the conclusions he reached. All of those concerns are properly raised in the fact-finding phase of this trial. They are matters going to weight. None of those matters raise a realistic concern as to bias or impartiality.

[30] Therefore, I have concluded that at the fourth stage of the Mohan analysis, otherwise known as the "qualified expert phase" of the analysis, I do not have any realistic concerns with respect to bias, independence or impartiality.

[31] The remaining issue is my role as gatekeeper. Does the cost of admitting Dr. Adeagbo's evidence outweigh its benefits?

3. The Cost/Benefit Analysis

[32] Again, in ***White Burgess***, the Supreme Court of Canada offered this on the subject of the cost/benefit phase of the inquiry into whether opinion evidence from a person with special knowledge should be received (at para 16):

> . . . the important role that judges should play as 'gatekeepers' to screen out proposed evidence whose value does not justify the risk of confusion, time and expense that may result from its admission.

And again at para 24:

> At the second discretionary gatekeeping step, the judge balances the potential risks and benefits of admitting the evidence in order to decide whether the potential benefits justify the risks. The required balancing exercise has been described in various ways. In *Mohan*, Sopinka J. spoke of the 'reliability versus effect factor' (p. 21), while in *J.-L.J.*, Binnie J. spoke about 'relevance, reliability and necessity' being 'measured against the counterweights of consumption of time, prejudice and confusion': para. 47. Doherty J.A. summed it up well in *Abbey*, stating that the 'trial judge must decide whether expert evidence that meets the preconditions to admissibility is sufficiently beneficial to the trial process to warrant its admission despite the potential harm to the trial process that may flow from the admission of the expert evidence': para. 76.

[33] The context for the analysis is the recognition that the fact-finder is not equipped to draw true inferences from the facts stated. A person with special knowledge is needed to provide the correct inference or inferences. However, the decision to accept the inference or its premises must remain the province of the fact-finder. From that, it is reasonable to expect the expert to explain the process leading to the proposed inference so that the fact-finder can understand and critically examine the opinion.

a. Protecting trial by jury

[34] A trial should not devolve into a trial by competing experts. As has been said, fact-finding and inference drawing must remain with the jury.

[35] In this case, the tools to assess the opinions offered by Dr. Adeagbo have been very thoroughly explored.

[36] I know what he did and why and what he did not do and why.

[37] There is no risk that Dr. Adeagbo's evidence will override my responsibility to determine the facts.

b. Communication

[38] I would have real concerns had I been sitting with the jury as to their ability to comprehend what Dr. Adeagbo was saying. As well, as I said in the course of trial, I had real concerns about the Accused's ability to cross-examine and make full answer in defence, when the Doctor's evidence was unintelligible. However, those concerns are less troubling in this particular case because of the repetitive nature of the cross-examination, the many instances where Dr. Adeagbo repeated his answers, the fact that both Crown and defence were familiar with Dr. Adeagbo's communication style and his evidence from the disclosure and his testimony in the previous proceeding. Finally, although not a substitution for understanding at the time the evidence is given, we have a transcript of the Doctor's evidence to assist with our understanding of what he said.

[39] In the end, although his communication was challenging and could be said to have prolonged the time needed to receive his evidence, the need for his evidence outweighs that cost.

c. Attitude

[40] I will not repeat the comments I made when considering this matter in the first phase (Mohan phase) of the analysis. It is sufficient to say that like his communication problems, his attitude served to extend the time necessary to obtain his evidence. In my view, his attitude and difficulty effectively communicating are part of the same cost.

d. Credibility

[41] As I concluded in the Mohan phase of this analysis, the credibility of Dr. Adeagbo is a matter for the fact-finder. The fact that there are issues with credibility is not unusual or even troubling in a case such as this where the issues are very complicated. There is nothing on this record to support the kind of credibility concerns which would warrant preventing a jury from having to hear and be potentially tainted by suspect evidence. Dr. Adeagbo's evidence is not untenable. Of course, determining what credit to give to his evidence is a routine requirement of any trial and my burden here.

4. Conclusion

[42] I concluded that Dr. Adeagbo is a forensic pathologist and entitled to offer opinion evidence in that discipline including the cause of Ezekiel Stephan's death. By agreement, his evidence in the *voir dire* became evidence in the trial proper.

B. Dr. Anny Sauvageau

[43] After *voir dire*, the parties agreed, and I concluded that Dr. Sauvageau was qualified to offer opinion evidence on the following: pathology and forensic pathology; cause of death; diagnosis of illness; prognosis of illness; hypoxic and anoxic injuries (including when brain damage and death is caused by hypoxic and anoxic injuries).

[44] Dr. Sauvageau agreed with Dr. Adeagbo that Ezekiel had meningitis but disagreed with Dr. Adeagbo's conclusion that the meningitis was bacterial. She also disagreed with Dr. Adeagbo that the meningitis caused Ezekiel's death.

[45] As foreshadowed, when I addressed the question of Dr. Adeagbo's qualifications, I was left unimpressed by his evidence.

[46] It is plain to me that when he opened the cranial cavity, he was aware that Ezekiel had not been vaccinated. Once he saw the meningitis he concluded it was bacterial consistent with non-immunization and from that point forward, he did not consider any alternative diagnosis, perform any other tests which might suggest a different diagnosis, and pursued an experimental investigative tool to DNA type what he believed had to be a bacterial infectious agent.

[47] Dr. Adeagbo testified that a sample of the right lung tissue across the empyema noted in the pleural cavity was taken and the Gram stain process disclosed Gram negative bacilli which is consistent with bacterial infection. All of which confirmed his opinion that the meningitis had been caused by bacterial infection. He plainly believed the empyema was part of the same bacterial infection which caused the meningitis.

[48] He ignored the presence of enterovirus in the nasal swab/wash. Supposedly, chalking that up to something common in us all.

[49] The reliance on the DNA testing to establish the presence of a bacterial infectious agent was done in circumstances where contamination of the sample could occur. As described by Dr. Sauvageau, the autopsy process is not a sterile one. There are many opportunities to contaminate samples taken for autopsy purposes and the steps taken to protect against such contamination are not the same steps as would be taken to protect against contamination of samples to be utilized in DNA analysis. Therefore, it is unsafe to rely upon the DNA test as establishing the key question as to whether the meningitis was bacterial.

[50] Dr. Adeagbo also confirmed his diagnosis of bacterial meningitis by the presence of certain types of white blood cells. Again, Dr. Sauvageau came to a different conclusion. Although her evidence in the 2016 trial on this subject appears less certain then she was before me, I accept her conclusion that the relative prominence of lymphocytes excludes bacteria as the agent of infection.

[51] In result, I was left unconvinced that the meningitis was bacterial.

[52] Dr. Sauvageau explanation for why the meningitis was viral is consistent with what was observed on autopsy, the history of Ezekiel's illness, the radiology reports, and was logically compelling. As well, Dr. Adeagbo said hemophilus influenza, which is the bacterial agent he concluded had caused the meningitis, is very rare. That fact, plus the fact that the vast majority of meningitis cases are viral in origin (para 62 infra), further supports Dr. Sauvageau's conclusion.

[53] In result, I am satisfied the meningitis was viral.

C. Dr. Shauna Burkholder

[54] Dr. Burkholder was qualified as an expert pediatric intensivist. In the field of pediatrics, there are pediatricians and with further study and qualification, pediatricians can become pediatric intensivists. Specifically, Dr. Burkholder was qualified to give opinion evidence in the critical care of children and in respect to the condition and treatment of Ezekiel and finally with respect to the diagnosis and prognosis of meningitis. Dr. Burkholder was the consulting doctor in the process of arranging to transport Ezekiel from Cardston to the Alberta Childrens' Hospital in Calgary. Additionally, she was initially responsible for Ezekiel's care once he arrived at the Childrens' Hospital. Dr. Burkholder was an excellent witness who presented a fair and balanced explanation of her opinions. She concluded that Ezekiel had bacterial meningitis after having examined, what she described as a devastating CT scan obtained once Ezekiel had finally arrived at the Childrens' Hospital.

[55] Again, Dr. Sauvageau took issue with Dr. Burkholder's conclusions on that subject. Dr. Burkholder as an emergency physician is called upon to interpret radiological information in providing critical care, but the expert is, of course, the radiologist. In this case, Dr. Burkholder's conclusion that Ezekiel had bacterial meningitis is contrary to the reported findings of the radiologist. Findings which the autopsy ultimately confirmed. Dr. Burkholder's description of how the meningitis caused respiratory and then cardiac arrest depended upon evidence of the brain having suffered a herniation. None was observed on autopsy. Dr. Sauvageau offered these opinions as to the foundation for Dr. Burkholder's conclusion (at pages 53-55 of the August 27, 2019 Transcript):

> I'm just going to hand you some transcript material from Dr. Burkholder, and on page -- the first page of that it has 19 at the top as the page number. This is the from the June 13th testimony of Dr. Burkholder, and I'm just going to read to you lines 11 to 17, but my understanding is just for the context is that she's basically speaking about her interpretation of the CT scan?
>
> A That's my understanding.
>
> Q And so starting at line 11: (as read)
>
> Q Were there any other findings or notations?
>
> A I felt that he had effacement of the basal cisterns, also known as transtentorial herniation. So the superior portion of his brain, his cerebellum, because of the swelling, was being pushed downwards through the tentorium into the lower parts of his brain contributing to effacement of the basal cisterns, which are the fluid-filled spaces surrounding the brain stem. They were becoming compressed.
>
> And I'll just asking for your comments on that evidence.
>
> A Okay. So I comment as a forensic pathologist. So this is an interpretation of a CT scan, and with the autopsy, which is the gold standard, this interpretation of the CT scan is wrong. It doesn't mean -- I'm not assessing the expertise of someone, just to be clear. I'm only assessing what she says about the CT scan, and it's not at autopsy. So this interpretation is not correct. The autopsy do not show transtentorial herniation. I've explained it in detail this morning, so I will not go further at this point.
>
> Q Now I did want to ask, so the CT scan is basically on March 14, but the autopsy is several days later. Is -- if there was tonsilar herniation, would -- you know, let's say on the 14th when the CT scan is done, would that still show up at autopsy?
>
> MR. CHAN: Objection, My Lord. There's nothing wrong with the question, but what she's being asked about transtentorial herniation, and just to be clear, tonsilar herniation is not the same as transtentorial herniation.
>
> THE COURT: I didn't think so.
>
> MR. CHAN: So if she's being asked with reference to this passage, it's not properly reflecting the passage to comment on. It's an entirely separate topic.

THECOURT: Yes. I think that's a fair comment, Mr. Buckley.

Q MR. BUCKLEY: Do you actually want to comment on that objection, Dr. Sauvageau?

A I can comment on the question, and then add what -- it's correct. There's three type of herniation. The only one I have addressed is transtentorial. The other two are sub facen (phonetic), the one that -- sub facen, and the one of the -- herniation of the amygdala of the cerebellum, and the other two are not there either. The other two would also have been seen at autopsy. The other two have not been seen by both Dr. Adeagbo and me, so we all agree -- by "all", I mean Dr. Adeagbo and me. We do agree there's no herniation. So that's the first part. And then I forgot your question as I was commenting on that. Oh, the evolution.

If you add on March 14 already a transtentorial herniation, it would not solve in the following days, it would have got worse or stable, so that it's not -- that it's not there at autopsy means that the interpretation on the CT scan is wrong. As I said, I'm not commenting on the quality of the expertise of someone. That is done by their peers. I don't do that. I only assess this evaluation of this CT scan, and it's not right. So the CT scan either showed that because of an error of technique but the radiologist didn't see it, and he's the most expert or because it's a wrong interpretation of the CT scan.

Q Thank you. The next page in the transcript pages that I gave you has a page number 35 on the top. This is from the June 13th testimony of Dr. Burkholder, and I'm going to start reading at line 39 and go to page 36, line 14 and then just basically ask you to comment on the answer. So beginning at line 39 on page 35: (as read)

> Q Then you mentioned that you believe the meningitis -- or bacterial meningitis to be responsible for the cardiorespiratory arrest. Can you explain how that would work mechanically?
>
> A Sure. So bacterial meningitis, because of infection and inflammation and injury to the underlying brain, causes direct neuronal injury or direct brain injury. In addition, it causes a pressure-mediated injury due to both hydrocephalus, which is a complication of meningitis and often not seen in early meningitis, so hydrocephalus, as well as cerebral edema. So the extra CSF in the brain and the extra swelling within the brain tissues causes the increased intracranial pressure, which then compresses vital brain structures.
>
> The most important part of the brain that keeps us alive, as we discussed earlier, are the control centres within the brain stem, so when the brain stem is injured or compressed, those control centres aren't able to do their job to make the heart beat appropriately, to maintain the blood pressure, to keep telling the diaphragm to contract, which allows us to breath in and out. All those control

centres that control our basic functions are impaired due to the meningitis.

A Okay. So what she does here is describe two of the three mechanism I have described this morning. She described what happens with transtentorial herniation and when there's too much pressure with the fluid so that it push down and compress -- push down the uncals and compress the brain system, and she also described the other mechanism of direct inflammation to the surface of the brain. There's also the shot that she does not describe. These two mechanisms she describes, they exist, so she's right in saying that, however, we exclude them by autopsy. So the autopsy would have seen what I've explained this morning, and it's not there, therefore, though the theory is true, in this case, it didn't happen.

[56] In my view, Dr. Burkholder was not correct in diagnosing Ezekiel as suffering from bacterial meningitis. Again, I prefer the opinion of Dr. Sauvageau on that topic.

[57] Dr. Burkholder and Dr. Sauvageau both offered opinions as to the diagnosis, treatment and prognosis of bacterial and viral meningitis.

[58] Dr. Burkholder offered this (at page 37 of the June 13, 2019 Transcript):

Q And in this particular case, you were treating a patient in Ezekiel's case who had had an outside-of-hospital cardiac arrest is that correct?

A That's correct.

Q Okay. And did that raise any specific concerns?

A Oh, yes.

So out-of-hospital cardiac arrest is one of the worst calls we can get. It's one of the most concerning things that we deal with in the ICU. Out-of-hospital cardiac arrests can be due to either ventricular fibulation or pulseless ventricular tachycardia. That's more often seen in adults who have heart rhythm problems related to myocardia ischemia. Sometimes we see that form in cardiac arrest in children who have an electrical problem within their heart. That in (sic) quite rare.

More commonly, we see the other type of out-of-hospital cardiac arrest, which is asystole or pulseless electrical activity. Asystolic out-of-hospital cardiac arrests have a uniformly poor prognosis in that less than 5 percent of children who present with asystolic out-of-hospital cardiac arrest which survive. The prognosis is somewhat better for children who present with the other type of out-of-hospital cardiac arrest, ventricle fibrillation or pulseless ventricular tachycardia.

Q And is there a reason why there is such a poor prognosis for children who arrive in asystole?

A So asytolic cardiac arrest in children are usually related to respiratory arrests and a prolonged period of hypoxemia prior to the arrest. Because of the state that the child was in for a period of time before the actual arrest, before the

heart stopped, there was a lack of oxygen delivery to the brain and the other organs prior to the arrest.

[59] Ezekiel had experienced an asystolic cardiac arrest on the way to Cardston hospital.

[60] In response to questions about expected outcomes for children suffering from meningitis, Dr. Burkholder offered this (at page 38 of the June 13, 2019 Transcript):

> A In a general sense, I can say the overall outcome of bacterial meningitis is -- just let me think for a sec. I think of all patients who present with meningitis, less than 5 percent of them will die from the meningitis, but, again, that's all comers, and that's related to the severity and duration of illness that they have upon presentation. So the outcome of bacterial meningitis, when treated early, can be good from a survival perspective, in that 95 percent of those children will live. Neurological sequelae and morbidity is variable and depends on many factors, such as the type of organism, the duration of illness, the age of the patient. So probably somewhere between 10 to 30 percent of survivors of meningitis will have severe neurologic morbidity.
>
> Q And when you say 10 to 30 percent of survivors, are you referring to meningitis generally or bacterial meningitis specifically?
>
> A Bacterial meningitis.

[61] Finally, Dr. Burkholder told us there is no real treatment for viral meningitis.

[62] Dr. Sauvageau offered these observations in her report:

> . . . When a child presents with symptoms of meningitis, the infectious agent is more likely to be a virus (95%) then a bacteria (5%). In viral meningitis, the agent is an enterovirus in 85% to 95% of cases.
>
> While bacterial meningitis are known to be more aggressive, with death rate between 5% and 10% (reaching 31% where intubation is required), viral meningitis are usually mild and resolve without treatment. However, it can happen that an enterovirus meningitis has a more aggressive course, with seizures and coma. Nevertheless, studies of enterovirus outbreaks have clearly known that the expected outcome is of virtually 100% survival with no sequelae. . . .

[63] Again, while I have said Dr. Burkholder was an impressive witness, I accept Dr. Sauvageau's opinion that Ezekiel's meningitis was viral. Dr. Burkholder was faced with an emergency and a CT scan which she says was devastating. Bacterial or viral, she treated for both, as one would expect.

III. The Statements and Testimony of David Stephan and Collet Stephan

[64] Both David and Collet Stephan testified in this case. In the period between March 13 and March 19, each made a statement to Cpl. Bulford and offered information to a variety of medical personnel.

[65] At issue in this proceeding is whether the Accused knew Ezekiel had meningitis. Knowledge is key to the Crown's position that, having had knowledge, the Stephans should have sought medical assistance.

[66] I begin by saying that both Accused impressed me as honest and forthright. I have no doubt that based upon what I have seen and heard in this trial, they have suffered a loss which is still difficult for them to accept.

[67] They had a sick child, who had waxed and waned but had continued to be sick for about two weeks. All of a sudden, he stopped breathing and what followed was a six day nightmare which ended in their agreement that their child, then on life support, was dead. In that six day period they were on a path of hope, despair, questing for answers, grasping at ill-formed theories, and all the while analyzing their own role, however painful, in the loss of their son.

[68] When finally testifying before me, seven years had passed. They had been charged, tried before a jury in which trial they had testified and had been convicted. They lived through an appeal to the Alberta Court of Appeal and then the Supreme Court of Canada. Once this trial was ordered, they had to re-engage with the legal and health systems and meet with a case manager before they finally arrived before me for their new trial.

[69] That context is relevant to assessing the credibility of their testimony and the reliability of what they said in those fateful six days.

[70] In their trial testimony, both David and Collet Stephan denied knowing that Ezekiel had meningitis. They argue that admissions they made in that six day period of knowing and of observing signs consistent with meningitis are not reliable but rather the product of exhaustion, confusion, hunger, lack of sleep and suggestions by those responsible for trying to save Ezekiel and trying to discover the cause of his illness.

[71] Both argue that false confessions such as those obtained in Mr. Big scenarios and as a result of inappropriate police behaviours are a known phenomenon in our criminal law.

[72] This is a case to which the principles espoused in R v W (D), [1991] SCR 742 are also applicable. One must also be wary of rationalization, the impact of the passage of time on memories and contamination of memory by others memories. However, the real issue is the reliability of what the Stephans said in 2012. Plainly, if their statements to the police and various physicians at the Alberta Children's Hospital are reliable, the credit one can attach to their denials before me is undermined.

[73] The visit by Terri Shaw on March 12, 2012 and her evidence as to what occurred had the ring of truth. It is plain that Ms. Stephan was concerned. That is why she asked Ms. Shaw to come early for Ms. Stephan's pre-natal check-up. She wanted Ms. Shaw to check Ezekiel. It is plain that Ms. Shaw, a trained and experienced nurse, including having emergency room experience, could find nothing wrong with Ezekiel after a thorough examination of him. I accept that when Ms. Shaw mentioned meningitis, it was not a diagnosis, but rather something she had recently thought about. That comment led to Ms. Shaw and Ms. Stephan checking the internet on the subject of meningitis. That is a seminal event. That information resulted in tests which Collet Stephan confirmed in a subsequent message to Ms. Shaw were just what the computer said. I accept that evidence and it puts the prospect of meningitis in Ms. Stephan's mind. That is also consistent with Dr. Sauvageau's implicit conclusion that the viral meningitis present at autopsy had formed at least in part prior to Ezekiel coming into professional care.

[74] On the subject of her knowledge about meningitis and her visit with Terri Shaw (Meynders), Ms. Stephan said this (at pages 74, 75, 77 and 78 of the June 25, 2019 Transcript):

> Q And during your conversation with Ms. Meynders, did she ever stress that meningitis was an urgent thing that you would have to take him to the doctors for immediately?
>
> A I'm trying to recall our conversation of what she had said. I believe with the one that she was in contact with that few weeks ago was the bacterial, and she had expressed that with bacterial, it - well, if I remember right, she expressed that meningitis was hard to diagnose, and that the bacterial is more concerning than the viral. And when I was looking at the symptoms and reading on that page, it had -- it said the same thing that-- that she was implying.
>
> Q And when you were reading about the page and comparing, I take it, you compared what Ezekiel was going through to what you found on the page; is that correct?
>
> A Yes.
>
> Q And how did Ezekiel stack up, if at all?
>
> A So when looking at the symptoms, even on the viral meningitis, he just had that achy slash stiff, so, like, the tension of the flu, but he didn't have any of the other symptoms on the viral. So in my mind, I'm thinking, Well, if it - out of the two, he would -- he would be closer to have a viral meningitis rather than bacterial, but at that time, like, it was uncertain.
>
> Q So why didn't you take him to the doctor at that point?
>
> A Because he didn't really have any symptoms that was listed under the viral and the bacterial meningitis.
>
> Q And when Mr. - sorry, Mr. -- when Ms. Meynders said to you that you'd probably be turned away from the hospital because the lack -- because of the lack of symptoms, did you think that was unusual?
>
> A No. Because I had a personal experience of that happening.
>
> Q What do you mean you had a personal experience of that happening?
>
> A When I was younger, I had a cold that just kind of hung on, and so my mom took us to our family doctor, but our family doctor was on vacation so there was a sub, and she got mad and told us that we were wasting her time because there's nothing she can do for a cold.
>
> Q And was that past experiencing (sic) influencing your choices here with Ezekiel?
>
> A Well, when she said that he would be turned away for not having symptoms, then I didn't want to go to a clinic where there's a bunch of sick people, that if he is immune compromised that he would catch something, or waste the doctor's time or take away from someone who is really sick that would need the doctor's attention.

Q And even at this point, on March 12th, did you think Ezekiel was really sick?

A No.

Q Why not?

A Because he, once again, didn't have an exuberating symptoms.

. . . .

Q So after you did your research, on meningitis, did you have any communications with your husband about your research?

A Yes, that -- I did. I can't remember if I did any of it on the phone or if it was once he got home.

Q Fair enough. And do you recall any details of that conversation with David?

A Not really. Just going through, like, the symptoms of viral versus bacterial.

Q And did you ever have the understanding or form the understanding that viral meningitis was critical or deadly?

A No. I remember something on the website saying that being a virus, it was not treatable with antibiotics, and that there's not really a concern for viral meningitis.

Q And what about bacterial meningitis? Did you read it --

A I--

Q Did you ever form the opinion or -- that bacterial meningitis was deadly?

A Not deadly. I do recall saying -- reading on there that treatment would be antibiotics, and that if those symptoms -- the severe symptoms of the seizures, hearing loss, blindness, that if those symptoms set in, that 24 to 48 hours is, like, the critical state.

. . . .

Q Okay. And going back to the plan with Ezekiel -- the care plan is what I called it -- was there a plan in place to take Ezekiel to the hospital at some point?

A Yes. So after that research and I had spoken with David, we were just going to keep an eye on things, and if his symptoms worsened, whether that be, like, he starts coughing or, like, he just really starts to actually get some kind of symptoms that would concern us, then we would take him in.

Q So when you say his "symptoms worsened", what kind of things were you looking for?

A Well, now that I had looked at the viral and the bacterial meningitis symptoms, those symptoms were now in my head, so if I was to start seeing

vomiting and diarrhea or fevers or anything like that, then we would be taking him in.

Q And as of March the 12th, did he have any of those symptoms?

A Nothing except that achy slash tension, stiff, type look.

Q And did you attribute that to -- or what did - what, if anything, did you attribute that to?

A I just attributed it to the flu.

Q And why did you do that?

A Because he had the flu in the past, and I've had the flu, and I know what that feels like and what that looks like, and so I just attributed to what I knew.

[75] The next event which assists with the issue of the reliability of the various statements made by the Stephans is the contact with the naturopathic clinic.

[76] Ms. Stephan testified on that subject as follows (at pages 12 - 14 of the June 26, 2019 Transcript):

Q and at some point on March the 13th, did you ever go see Dr. Pike, AKA Tannis?

A Yes.

Q and what -- just one second, please. And what or who is Dr. Pike and Ms. Tannis?

A She is a naturopath.

. . .

Q Okay. And what happened, if anything, that day with Dr. Pike?

A So before we left, I called the naturopathic clinic and spoke her receptionist. I don't recall our conversation besides her suggesting a product called Blast, which boosts the immune system.

Q Okay. Carry on.

A And she suggested that, and that's all I really remember about that conversation. And then after we were done signing the papers at the lawyer's office, we drove to her clinic, and I just ran in and told the receptionist that I called earlier about immune booster, and she handed me the - - the liquid in - -

Q And when you say - -

A - - in a bottle.

Q - - "she" again, is this Lexie - -

A Lexie.

Q - - or is this Dr. Pike?

A This is Lexie.

. . .

Q Did you ever tell Lexie or anybody at the naturopathic's clinic that there was a concern about meningitis?

A I don't recall today, but I have read through disclosure that I mentioned viral meningitis to her, but I don't have a memory today of it.

Q Did anybody tell you the Ezekiel needed to be taken to the hospital at that point?

A From that office?

Q From that office, yes. Thank you.

A I don't recall what she said on the phone. But when I went in, no one had said anything.

[77] Lexi Vataman testified that she was called asking for a recommendation for an immune system boost for a child who might have meningitis. Admittedly that was Ms. Stephan. I accept Ms. Vataman's evidence on that subject. It is consistent with what is implicit in what Ms. Stephan said at trial. She did not think he had bacterial meningitis and felt if he had any kind of meningitis it was viral, but he was not demonstrating the signs she had learned to watch for from her research.

[78] In addition to the foregoing, there is the episode with the car seat. In their statements to medical personnel and the police, this episode became an instance of stiffness and an indicator of meningitis. In their testimony it was explained as an appearance of discomfort without associated crying or the type of complaint an 18-month old can signal to his parents.

[79] I accept the evidence of the Stephans on that subject. They were going to be in Lethbridge anyway to see a lawyer and to go to the naturopathic clinic. From there it was a short straight shot to Lethbridge's hospital. There is no basis on this evidence to infer that the Stephans callously ignored an indicator of the possibility of meningitis.

[80] Finally, the fact that both parents felt Ezekiel was improving on March 13 to the point where Mr. Stephan suggested Ms. Stephan take a break and go to her meeting that evening is indicative of the true state of affairs, at the time. The child had been sick, had improved, then regressed and was waxing and waning. They were watching him closely for signs of meningitis, just in case, even though he did not appear to have any of the symptoms.

[81] That is in stark contrast to the various statements they gave to police and medical staff about their observations and actions.

[82] I have concluded that I cannot rely on any of the statements to the medical staff or the police beyond what Mr. Stephan and Ms. Stephan told 911 Dispatch, the paramedics and Dr. Clark. All of those recorded exchanges are consistent with the circumstances I have just described and the Stephans' evidence before me.

[83] I do not have evidence as to why honest people commit themselves to false facts, but the case reports confirm it can occur.

[84] Perhaps, as the defence has argued, the combination of stress, suggestion, confusion, lack of sleep, lack of nourishment and the overpowering urge to help save their child, all contributed

to the content of the statements they made, in those fateful six days. In any event, I am of the view that those statements are not reliable.

[85] In result, I accept the testimony of the Stephans, as buttressed by the facts I have found as to the communication with Ms. Shaw and Ms. Vataman and by the recorded exchanges with 911, the paramedics and Dr. Clark. While Ms. Stephan has been the primary focus of this analysis, Mr. Stephan testified and admitted that his knowledge was the same as his wife's. I also accept that admission as fact. His testimony mostly mirrored that of Ms. Stephan with some minor inconsistencies. Again, both Mr. Stephan and Ms. Stephan impressed me as honest and forthright.

[86] In result, I have concluded that the Stephans knew what meningitis was, knew that bacterial meningitis could be very serious, knew what symptoms to look for in relation to bacterial meningitis, knew that viral meningitis was much less serious and saw no symptoms of either. They thought their son had some sort of croup or flu like viral infection, as Ms. Stephan said (para 74 supra). They were concerned and monitoring Ezekiel for any signs that something more serious was causing Ezekiel's sickness.

IV. Analysis

[87] In the midst of the Crown's case, while Dr. Adeagbo was being examined, the parties asked me to determine the elements of the offence. I heard argument on the subject and rendered an oral decision, the transcript of which is attached as Appendix 1. For ease of reference, I reproduce my conclusion from that decision.

> As a result, the Crown must establish the following beyond a reasonable doubt to be successful in this prosecution in relation to each of the Stephans: One, that Ezekiel was the son of the Stephans; two, that he was under 16; three, that he was in his parents' charge; four, that he was unable by reason of his age to withdraw from his parents' charge; five, that Ezekiel was unable to get himself a doctor's assistance; six, that had the Stephans obtained a doctor's assistance in the 48-hour period before 10 PM, March 13th, 2012, Ezekiel's life would have been saved; seven, that a reasonably prudent parent would have obtained a doctor's assistance in that 48-hour period; eight, that the failure to obtain a doctor's assistance in the 48-hour period created a risk to Ezekiel's life; nine, that the failure to obtain a doctor's assistance was a marked departure from the conduct of a reasonably prudent parent in the circumstances.

1. Elements 1 – 5

[88] There is plainly no doubt that elements 1 through 5 have been established.

2. Element 6

[89] Again, the Crown's case is that once Ms. Shaw (Meynders) had examined Ezekiel on March 12, 2012, the Stephans' should have taken Ezekiel to the hospital and should have done so before 10 PM on March 13.

[90] Element 6 requires proof beyond a reasonable doubt that had the Stephans sought a doctor's assistance in that period, Ezekiel's life would have been saved.

[91] Again, Dr. Sauvageau offers a compelling opinion on the subject.

[92] As I have said, the physical evidence does not support Dr. Burkholder's opinion that the meningitis caused the respiratory arrest. Dr. Adeagbo offered no opinion as to how the meningitis he discovered caused death.

[93] The physical evidence supports Dr. Sauvageau's conclusion that Ezekiel died because he was deprived of oxygen. That occurred because he stopped breathing and the resulting oxygen deprivation lasted long enough to lead to his death.

[94] Dr. Sauvageau offered these opinions in her report on this subject.

> Why did the child initially stop breathing (i.e. the underlying cause of the breathing arrest – which may or may not be the same as the underlying cause of death)?
>
> There are two possibilities that need to be assessed in this case as potential causes of the child breathing arrest:
>
> a) The child was most likely suffering from laryngotracheobronchitis by enterovirus, a condition that is known as a potential cause of respiratory arrest.
>
> b) The child was most likely suffering from a viral meningitis by enterovirus, a condition that is known as a potential cause of respiratory arrest.
>
> Considering the way Ezekiel is heard breathing on the first 911 call of March 13, the underlying cause of the breathing arrest is most likely from an airway obstruction, and therefore it is most likely that the viral laryngotracheobronchitis is the cause of the breathing arrest than the viral meningitis.
>
> Was this breathing arrest, considering its underlying cause, a foreseeable consequence of the underlying cause?
>
> As explained above, the two possible underlying causes for the breathing arrest in this case are viral laryngotracheobronchitis and viral meningitis.
>
> Since both these conditions are viral, early antibiotics would not have changed the outcome in this case. Furthermore, both conditions are usually of mild severity and are expected to resolve without sequelae ("without sequelae": i.e. a complete recovery where the person is free of any disease or injury resulting from the prior disease or injury). Said differently, prior to the breathing arrest, Ezekiel was not at any realistic risk of death by suffering from viral meningitis and viral laryngotracheobronchitis. Considering the two possible underlying causes of breathing arrest in this case, it is my opinion that a breathing arrest was not a foreseeable consequence and that the death was unexpected.

[95] Further on that subject, Dr. Sauvageau offered this in direct examination (at pages 40-42 of the August 27, 2019 Transcript):

> So that brings me to the three question (sic) that will be very important for this case on page 8. The first question why did this child stop breathing? Because he did have hypoxic brain injury, but why? First he stopped breathing. Is it because he stopped breathing that then he had damages to his brain? We have to look first why he stopped breathing.

. . .

So going back to where I was we know -- well, in my opinion he does have laryngotracheobronchitis by enterovirus and that is a known cause to stop breathing. That's why clinician and people in the street call it croup. It's not the most like - if you look at the probability that you will stop breathing with that, actually most cases are very benign and most cases will resolve by-- by minimal treatment like exposing to -- to air that is humid or things like that. So usually it goes well. In 1 to 8 percent they will need hospitalisation. In only less than 3 percent they will need intubation. So it is possible, but it's rare that they will need -- they will stop breathing, but it's possible, but even if they stop breathing, even if you are in that 3 percent, they usually don't die. It's close to zero percent death with a laryngotracheobronchitis. So but it is -- it's possible that he stopped breathing because of that.

The second possibility is the viral meningitis. There's three ways - and in that discussion, bacterial versus viral would not make a difference. They use the same mechanism to stop the breathing. So whatever is the conclusion, the same mechanism would have applied. There's three ways a meningitis can make you stop breathing. The first is because of the swelling of the brain we described and these unculs going down where they shouldn't have compressing the brain stem. If it happened, we see at autopsy the herniation, the transtentorial herniation, and we see the Purkinje. It's not there at autopsy. This mechanism can be safely excluded. It's not there.

Second mechanism, you can have a direct inflammation of the brain but that is seen at autopsy when it happens, so you can see this irritation below where the pia starts, so you have the pus in the space above the pia matter. If the inflammation go below, you can have irritation of the brain and because of that, you could have a different mechanism of stopping breathing. At autopsy it's not there. So we can safely ignore this also second mechanism of stopping breathing.

And the third and last mechanism is a septic shock. It's harder to explain, but I will try my best to explain it simply. When you have your blood going around, the majority of the blood is in the big vessels. The -- the small vessel in your -- in your skin, in your organs, they only have a little bit of blood. When you are at the stage of having a very severe infection about of any kind, you're - the chemical particle in your blood might contain too much inflammatory molecules that will cause a disbalance [sic] that all these small vessels that should contain just a little blood will open up and they will suddenly have too much blood.

Having all your blood pooling, that's the word we often use to describe that, it's like having a big pool of blood in the wrong places, that means there's not as much blood now in the main circulatory system to go put oxygen to the rest of your organs, and by that you can have a direct influence on your lung, and you can stop breathing, and you can die because of this problem of not having enough blood going around because it's all pooled in the wrong place. When it's present, we see that at autopsy. We see multi-organ failure by organs. There's a lot of description of what we can see. We can see things in the lungs, things in the adrenal glands, things in the liver. I will -- things in the kidneys. Unless someone has a question, I will not go organ by organ, but you don't have that point at autopsy. Dr. Adeagbo did not see it, and I agree with him. It is not there.

> So though it's a possibility in theory that meningitis caused an arrest of the breathing, in this case there's no evidence to support it. The three mechanisms can be safely excluded and therefore it's more logical that it's the laryngotracheobronchitis.

[96] In cross-examination on this subject, Dr. Sauvageau said the meningitis existed but did not contribute directly or indirectly to Ezekiel's death.

[97] As I have said, I accept Dr. Sauvageau's opinion. Ezekiel stopped breathing because of laryngotracheobronchitis complications.

[98] For a variety of reasons, from that point forward, he was without oxygen or without sufficient oxygen until ultimately the lack of oxygen caused his death. There is no argument that the Stephans acted in any way inappropriately once faced with the emergency created when Ezekiel stopped breathing. They did everything they could to get Ezekiel to the hospital and preserve his life.

[99] The theory of the Crown's case is that Ezekiel died of meningitis. That premise is the foundation for the Crown's subsequent arguments respecting the knowledge of the Stephans, the actions of a prudent parent and risk. As I have concluded that Ezekiel did not die of meningitis, it follows that the Crown has failed to prove its case.

[100] It is perhaps helpful to explain this result somewhat differently. Ezekiel was sick. Section 215 of the *Criminal Code* does not impose a duty to seek medical attention for every sick child. For that duty to arise there must be a risk to the child. In this case, the risk is particularized as a risk to Ezekiel's life. The cause of that risk is further particularized as resulting from meningitis.

[101] The evidence before me does not establish that the viral meningitis Ezekiel had constituted a risk to his life. Therefore, the duty to seek medical attention did not arise.

[102] Did the duty to seek medical attention arise because Ezekiel had meningitis and his parents were aware that it was possible he had some type of meningitis and aware that some meningitis can be life threatening?

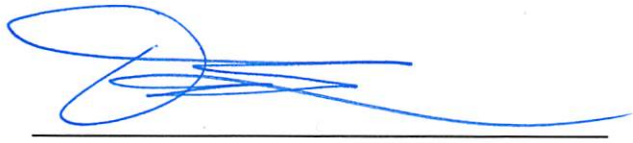
[103] One suspects that many parents when faced with the scenario which presented itself to the Stephans on March 12 would have been perfectly justified in feeling their child needed medical attention.

[104] However, as I said when addressing what the Crown must prove in Element 6, this is not a civil action. The objective analysis of what prudent parents in the circumstances would have done are captured in the other elements of this offence. The duty to act only arises on this charge, as framed, if medical intervention would have saved Ezekiel's life. That it could have saved his life was not, in my view, sufficient.

[105] In this case, we know there is no specific treatment that is effective for viral meningitis. It follows that the Crown did not prove medical attention would have saved his life or that if he had viral meningitis and it was life threatening (which is not established in the evidence), medical attention even could have saved his life.

[106] As a result, as I have said, the Crown has failed to establish that the Stephans owed Ezekiel a duty to such medical assistance beyond what they actually did. Having failed to prove this essential element, the charge against the Stephans must be dismissed.

Heard on the 3 to 7; 10 to 14; 17 to 21; 24 to 28 days of June; 9 to 12; 25, 26, 29 and 30 days of July; 6 and 7; and 26 to 30 days of August, 2019.
Dated at the City of Edmonton, Alberta this 19th day of September, 2019.



T.D. Clackson
J.C.Q.B.A.

Appearances:

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for the Crown

David Robert Stephan
Self-Represented

Jason Demers, Ingrid Hess and Shawn Buckley
for the Accused Collet Stephan

Action No.: 130163405Q1
E-File No.: RCQ19STEPHAND
Appeal No.: _____

IN THE COURT OF QUEEN'S BENCH OF ALBERTA
JUDICIAL CENTRE OF LETHBRIDGE

HER MAJESTY THE QUEEN

v.

DAVID ROBERT STEPHAN
COLLET DAWN STEPHAN

Accused

T R I A L
(Excerpt)

Lethbridge, Alberta
June 19, 2019

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TABLE OF CONTENTS

Proceedings taken in the Court of Queen's Bench of Alberta, Courthouse, Lethbridge, Alberta

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June 19, 2019	Afternoon Session
The Honourable Mr. Justice Clackson	Court of Queen's Bench of Alberta
B. Kristensen	For the Crown
J. Chan	
(No Counsel)	For the Accused D.R. Stephan
I. Hess	For the Accused C.D. Stephan
K. Kunz	Court Clerk
A. Porco, CSR(A)	Official Court Reporter

THE COURT: Thank you. Good afternoon. Please be seated.

MR. CHAN: Good afternoon, My Lord.

THE COURT: All right. My plan is to give you my decision on the essential elements of the offence and then to give you a few minutes to digest what I've said, and then we'll get back together and deal with the scheduling issues that remain, and then if that's what the decision is, we'll deal with the next witness.

Okay. So my decision.

Ruling

THE COURT: As a result of Justice O'Ferrall's decision in an earlier iteration of this case, the *R. v. Stephan*, 2017 ABCA 380 and 2018 SCC 21, one can safely say that there are four essential elements in this indictment under Section 215(2)(b) of the *Criminal Code*. They are -- ignoring issues of identity, jurisdiction, and relationship -- as follows: (a) that the accused were under a legal duty to provide the necessaries of life to their son at the time of the alleged offence; (b) that objectively, employing the judgment of the reasonably prudent parent, the accused failed to perform that duty; (c) that objectively, employing the judgment of a reasonable person in the particular factual circumstances of the case, the accused's failure to perform the duty endangered the life of their son, or, put another way, it was objectively foreseeable that the failure would lead to a risk to their son's life; and (d) the accused's conduct represented a marked departure from the conduct of a reasonably prudent parent in the same circumstances.

However, in order to gain a conviction on this indictment, there are additional facts which must be proved beyond a reasonable doubt. Here, the Crown has alleged that in the 48 hours before Ezekiel was surrendered to the emergency medical personnel in the ambulance which met the Stephans south of Cardston, the Stephans committed the alleged offence. That particularization requires the Crown to prove that the actions or omissions of the Stephans endangered Ezekiel's life in the time period specified.

Additionally, it is plainly the Crown's case, as presented to me, that the Stephans' failure to seek a doctor's assistance in that time period is the essential underpinning of this prosecution. I say "doctor's assistance" because Ms. Stephan spoke to Ms. Shaw, then a registered nurse, concerning Ezekiel on March 12th, and Ms. Shaw told us she had examined the child, touched the child, and used her stethoscope in the examination. She said she found nothing remarkable, but she told us that she told Ms. Stephan that if Ms. Stephan was still worried, to take Ezekiel to the doctor.

The defence has argued that in addition to the common essential elements which must be proved and the onus of proving beyond a reasonable doubt that the omission occurred between March 11th and March 13th, there are additional elements specific to this case which the Crown must prove beyond a reasonable doubt in order to secure convictions. I am asked to resolve these issues in advance of the close of the Crown's case in order to assist the parties in determining how to present their cases.

The defence argues that where the Crown alleges a failure to obtain a doctor's assistance, the Crown must prove beyond a reasonable doubt that the assistance would have made a difference. The argument is that unless the assistance would make a difference, it cannot be considered a necessary of life. A necessary must be defined by the circumstances. Here, a necessary is whatever is needed so as to avoid putting Ezekiel's life in danger. Here, the Crown defined that necessary as a doctor's assistance; therefore, it is the failure to seek that assistance which is alleged to have endangered Ezekiel's life.

Does that mean that the Crown must prove seeking assistance would have made a difference? That is the defence argument. In support of that position, I was directed to the following cases: *R. v. Peterson*, 2005 O.J. No. 4450 (ON CA); *R. v. Naglik*, [1993] 3 S.C.R. 122; *R. v. Stephan* as previously described; *R. v. Palombi*, 2007 ONCA 486; *R. v. Incognito-Juachon*, 2008 CarswellOnt 5463; *R. v. Tom*, 2007 BCSC 1407; *R. v. Turley*, 2002 BCSC 397; *R. v. A.M.*, [2013] O.J. No. 5379; *R. v. Kos-Rabcewicz-Zubkowski*, 2019 ONCA 234; *R. v S.N.A.*, 2018 ABQB 1052; *R. v. S.J.*, 2015 ONCA 97; *R. v. Pertab*, 2004 CanLII 47791; and the *R. v. German,* 2010 ONSC 3739.

None of the foregoing, with the exception of *R. v. Turley* and *R. v. S.J.,* make any such

statement. What those cases represent are examples of a Court concluding either that the evidence established or did not establish the endangerment or objectively foreseeable risk to the victim's life that was in issue in those cases. In *Turley*, the defence conceded that had the child been taken to the hospital in a timely way, her life would have been saved. In *S.J.*, although the accused were acquitted of the offence under Section 215(2)(a)(ii), and that was not appealed, the Court offered this: (as read)

> The first issue turns on whether a failure to provide medical attention is captured by Section 215(2)(a)(i) of the *Code*.
>
> As mentioned, the appellants concede that medical attention is a necessary of life within the meaning of Section 215(1) of the *Code*. However, they submit that failure to provide medical attention does not amount to necessitous circumstances and, therefore, does not fall within Section 215(2)(a)(i) of the *Code*. They state that necessitous circumstances encompass natural needs such as food, shelter, and clothing, not medical attention. Failure to provide medical attention may only constitute an offence if the conduct falls within Section 215(2)(a)(ii) of the *Code*. That is, the failure to provide medical attention must endanger the life of the person to whom the duty is owed or causes or is likely to cause the health of that person to be endangered permanently.
>
> The appellants submit that having already concluded that the requirements of Section 215(2)(a)(ii) of the *Code* had not been met, thus forming the basis of the appellants' acquittal on the other charges, the trial judge erred in finding that Section 215(2)(a)(i) of the *Code* had any application.
>
> In contrast, the Crown submits that a parental failure to provide medical attention or treatment for a child may attract liability under either Section 215(2)(a)(i) or Section 215(2)(a)(ii) of the *Code*. Put differently, liability ensues if medical attention was not provided and H. was in destitute or necessitous circumstances within the meaning of Subsection (i) or if the appellants' failure to provide medical attention endangered H.'s life or caused or was

likely to cause his health to be endangered permanently within the meaning of Section (ii).

Section 215(2)(a) creates two offences, both of which are predicated on a failure to perform the legal duties imposed by Section 215(1)(a) or (b). This case involves Section 215(1)(a) and specifically the duty owed by parents to a child. Section 215(2)(a)(i) addresses the situation in which parents' failure to perform their duties under Section 215(1)(a) puts the child to whom a duty is owed at risk of harm because of the child's dire circumstances. Section 215(2)(a)(ii) addresses the situation in which the parents' failure to perform their duties under Section 215(1)(a) puts the child at risk by virtue of the consequence of the failure to perform the duty, that is, endangers the life or causes or is likely to cause health to be endangered permanently. A failure to provide medical attention could well generate the risk of harm prescribed by either offence.

The purpose of Section 215 of the *Code* is aimed at the protection of others. The subsections of Section 215 have a common object: The imposition of a defined legal duty of care on an individual in charge of another. Children under the age of 16 who are the subject matter of Section 215(1)(a) of the *Code* and owed such a duty exemplify this protective objective.

As mentioned in oral argument, the appellants conceded that medical attention is a necessary of life within the meaning of Section 215(1) of the *Code*. It follows that failure to provide necessaries of life -- in this case, medical attention -- may amount to necessitous circumstances.

Neither the purpose of Section 215 of the *Code* read as a whole nor its language compels the interpretation advanced by the appellants. There is nothing that would suggest that the liability for a failure to provide medical attention should be restricted to and bound by the requirements of Section 215(2)(a)(ii) of the *Code*. Failure to provide medical treatment can lead to criminal liability

> under either Section 215(2)(a)(i) or Section 215(2)(a)(ii); the one does not preclude the other.
>
> The appellants complain that including medical attention in the ambit of Section 215(2)(a)(i) of the *Code* results in criminalizing a failure to obtain treatment of no consequence. They argue that criminal liability for failure to provide necessaries of life follows only where the failure has resulted in permanent danger to the health or life of that person. They submit that there must be a causal connection between the appellants' failure to provide necessaries of life and the child's necessitous circumstances, and here, there was none.

And here is the portion to which defence made reference in the course of argument before me: (as read)

> I disagree. Inclusion of medical attention in the ambit of Section 215(2)(a)(i) of the *Code* does not compel criminality for any failure to provide medical attention. In order for there to be criminal liability, the child must be in necessitous circumstances, and the conduct must amount to a marked departure from what a reasonably prudent parent would have done in the circumstances. This requirement imposes a limitation on actionable criminality. There was no need for the Crown to establish that the appellants' failure to obtain medical treatment would have made any difference. That is a requirement of Section 215(2)(a)(ii) of the *Code*.

In my view, the comment about making a difference is in that judgment obiter. It is true the appellants in that case had argued that making a difference was part of both Section 215(2)(a)(i) and Section 215(2)(a)(ii). It is true that in deciding that making a difference "did not apply to Section 215(2)(a)(i)", the Court in *S.J.* made a distinction between that offence and Section 215(2)(a)(ii) as follows: (as read)

> Section 215(2)(a)(i) addresses the situation in which parents' failure to perform their duties under Section 215(1)(a) puts the child to whom the duty is owed at risk of harm because of the child's dire circumstances.

Section 215(2)(a)(ii) addresses the situation in which the parents' failure to perform their duties under Section 215(1)(a) puts the child at risk by virtue of the consequence of the failure to perform the duty; however -- and it is important to remember, in my view -- Section 215(2)(a)(ii) was not in issue, except in juxtaposition to Section 215(2)(a)(i) in the *S.J.* case.

Nevertheless, there is merit in this argument. Essential Elements 2 and 3 are objective measures. The first essential element is not. It is fact-based and susceptible to determination not just by consideration of the knowledge available to the participants at the time, but all of the circumstances then known and since discovered. The circumstances of the case must determine what was or was not a necessary.

I think that is what Justice O'Ferrall meant when he said that the Stephans' failure could be "one of simply not taking him to a hospital soon enough". I agree with the defence that those words imply that the need was to save Ezekiel's life. One had to get to hospital soon enough for that to happen, and, by corollary, if in the 48-hour period in issue Ezekiel's life would not or could not have been saved, getting him to the hospital was not necessary. Therefore, a doctor's assistance was not a necessary unless the Crown proves beyond a reasonable doubt that it was. That cannot be done without having regard to the circumstance that the assistance would have accomplished.

It is important to remember that in Elements 2 and 3, the accused's behaviour is being judged against an objective standard founded on the assumption that their failure was a departure and that departure created risk of death. In that, it was assumed that the necessary which was not performed would or could have prevented that risk if it had been performed. The defence argues that "would" and not "could" is the applicable standard. I agree. "Could" in this context suggests that a mere possibility would be sufficient. That is a civil negligence standard. This is a criminal prosecution. There is no reason to reduce the Crown's burden on this essential element.

The Supreme Court of Canada in *Naglik* having determined that the offence was one which measured the accused's behaviour "against an objective societal standard" and having found that the section sets a floor for the provision of necessaries at the level indicated by the circumstances the subsections of Section 215 describe offered this opinion on the essential elements of a Section 215 offence at paragraph 46: (as read)

> What parts of the offence must be objectively foreseeable? I would hold that Section 215(2)(a)(i) punishes a marked departure from the conduct of a reasonably prudent parent in circumstances where it was objectively foreseeable that the failure to provide the necessaries of life would lead to

a risk of danger to life.

Notably, determining what was necessary is not part of the formulation the Supreme Court of Canada offered in *Naglik*. Therefore, the burden of proof in regard to the first essential element must not be a "part of the offence which must be objectively foreseeable".

Of course, "objectively foreseeable" is consistent with possibilities and probabilities and the word "could". Furthermore, if this essential element can be established on the mere possibility that a doctor's assistance may have saved Ezekiel's life, then one can foresee parents facing the dilemma of running to the medical system for every bump and scrape and minor illness which could become more serious or run the risk of being charged with an offence under one of the subsections of Section 215.

Finally, while it may seem odd that a parent who does nothing with a terminally ill child may not be culpable, it must be remembered that this case is about endangering life, not necessitous circumstances or endangering health or any of the other offences which such callous behaviour might substantiate.

Does the formulation of the first element as requiring proof beyond a reasonable doubt that a doctor would have made a difference conflict with the formulation of the remaining elements? In my view, it does not. If a doctor's assistance would have saved Ezekiel's life, then the question of whether a reasonably prudent parent would have taken Ezekiel to a doctor in the circumstances remains a real question. Similarly, whether in having failed to take Ezekiel to a doctor, the Stephans created an objectively foreseeable risk of death is also a live question.

As for the defence's other arguments respecting the proper analysis of risk endangerment versus death and the phraseology to be employed in considering the essential elements that I have identified, I am not persuaded that there is substance to those arguments. As a result, I have concluded that the Crown must establish the following beyond a reasonable doubt to be successful in this prosecution in relation to each of the Stephans: One, that Ezekiel was the son of the Stephans; two, that he was under 16; three, that he was in his parents' charge; four, that he was unable by reason of his age to withdraw from his parents' charge; five, that Ezekiel was unable to get himself a doctor's assistance; six, that had the Stephans obtained a doctor's assistance in the 48-hour period before 10 PM, March 13th, 2012, Ezekiel's life would have been saved; seven, that a reasonably prudent parent would have obtained a doctor's assistance in that 48-hour period; eight, that the failure to obtain a doctor's assistance in the 48-hour period created a risk to Ezekiel's life; nine, that the failure to obtain a doctor's assistance was a marked departure from the conduct of a reasonably prudent parent in the circumstances.

And that's my decision.

Okay. As I indicated, I want to give the parties an opportunity to reflect on what it is that I've said, and we'll reconvene in 15 minutes.

(PORTION OF PROCEEDINGS OMITTED BY REQUEST)

PROCEEDINGS ADJOURNED

Certificate of Transcript

I, Angela Porco, certify that the foregoing pages are a complete and accurate transcript of the proceedings taken down by me in shorthand and recorded by a sound-recording machine and transcribed from my shorthand notes to the best of my skill and ability.

Angela Porco, Court Reporter
Order Number: AL-JO-1003-4199
Dated: June 19, 2019