REPORT TO THE MINISTER OF JUSTICE

PUBLIC FATALITY INQUIRY INTO THE DEATH OF ALEXANDRU GABRIEL RADITA

Dated January 5, 2024

Justice Sharon L. Van De Veen

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FATALITY INQUIRIES ACT

[1] Pursuant to the *Fatality Inquiries Act* a public inquiry was held into the death of Alexandru Radita in the Alberta Court of Justice on September 19, 20, 22 and 23, 2022, March 21, 22, 2023, April 18, 19, 2023, and June 26 and 27, 2023. Additional court dates took place for procedural issues and entry of additional exhibits.

[2] The Inquiry found that Alexandru Gabriel Radita died at 22:16 hours on May 7, 2013. The place of his death was his home, located at 104 Citadell Dr. NW Calgary Alberta. The medical cause of death pursuant to section 1(d) of the *Fatality Inquiries Act* was staphylococcus aureus due to complications from neglect and starvation. The medical cause of death pursuant to section 1(h) of the *Fatality Inquiries Act* was homicide.

CIRCUMSTANCES OF THE DEATH OF ALEXANDRU RADITA AND RECOMMENDATIONS TO PREVENT SIMILAR DEATHS

GENERAL OVERVIEW

[3] The purpose of the Fatality Inquiry is to examine the circumstances of the death of Alexandru Radita with the objective of preventing similar deaths in future. The Inquiry proceeded on the basis of the evidence and facts found in the criminal trial and appeal court proceedings which concluded with the Raditas both being found guilty of murder in the death of their son. The other relevant court proceeding included in the Inquiry is the British Columbia Court decision which ordered Alexandru be returned from foster care to the guardianship of his parents in 2005.

[4] The Inquiry also examined the evidence of the state agencies whose responsibility included the protection of Alexandru and whose mandate includes the protection of the health, including educational or cognitive health, and well-being of children generally. These agencies include the British Columbia and Alberta Ministries of Child and Family Services, the Department of Education of Alberta, the South Central Alberta Catholic School Board, the School of Hope, the Alberta College of Pharmacy, and the Calgary Police Service.

[5] The Inquiry examined the significant history of the Radita family with the British Columbia Child Protection Services while the Raditas lived in British

Columbia. In particular, the Inquiry focused on the tragic inadvertent failure on the part of the BC Ministry to notify the Alberta Child Protection Services when Alex's BC physician reported Alex may not be receiving the insulin he needed and that his parents had missed two appointments. Despite the BC Ministry discovering the family had moved to Alberta, and having a likely address for the family, they did not notify the Alberta Ministry of Child and Family Services. This unintended oversight removed Alex from the protection he was receiving in British Columbia from his physician's regular monitoring of the Raditas' compliance with the insulin protocol Alex needed to survive.

[6] The Inquiry Report includes recommendations dealing with the improvement of the screening of reports to Child Protective Services which were insufficient in the case of Alex Radita and raises the possibility of a general alert system relating to high-risk children. The report further recommends changes to existing alerts and notifications to other jurisdictions to ensure the ongoing protection of children who move from one province to another and may be in need of continuing child protection services.

[7] The Inquiry examined the functioning of the educational authorities in Alberta since Alex was not registered to attend school for a number of years prior to his death after the family moved to Alberta. The Inquiry Report makes recommendations to Alberta School Authorities, including local schools, School Boards and the Department of Education, to improve the monitoring of student school registration in Alberta and ensure students leaving one school actually register in another. In addition, the Report recommends school authorities consider and address, as part of their mandate, the potential need for wellness checks or family support from Children Services for children who experience extended absence from school.

[8] The Inquiry also dealt with the pharmaceutical industry. For a number of years prior to his death, Alex was given inadequate insulin by his parents while they resided in Alberta. All of the insulin was provided by pharmacists without prescriptions from a physician or oversight by a physician. It was provided at irregular intervals and in differing amounts. The Inquiry examined the role of the pharmaceutical industry which provided insulin over an extended period of time without assessing the patient or having the benefit of physicians' oversight to assure the timing and amount of insulin was appropriate. A recommendation has been made to address the role the pharmaceutical industry played in the Radita case.

[9] The Fatality Review Board also requested the Inquiry to reference two additional cases in which children died as a result of the failure of their parents to provide them with necessary and available medical treatment. Although the Radita case was significantly different in many respects, both the referenced cases and the Radita case involved a reliance upon natural remedies to treat medical issues which required pharmaceutical drugs for effective treatment. I have made a recommendation to address this issue.

CRIMINAL AND FAMILY COURT PROCEEDINGS

Criminal Trial and Appeal Court Decisions

[10] The parents of Alexandru Radita, Rodica Radita and Emil Marian Radita were charged and convicted of first-degree murder for the death of their 15-year-old son, Alexandru (Alex). Alex was diagnosed with type 1 diabetes as a two-year old child, and he died at home of bacterial sepsis resulting from neglect and starvation. The neglect and starvation were brought about as a direct result of the failure of his parents to provide necessary medical treatment for his type 1 diabetes, that being the well-known insulin protocol necessary to preserve his life. Alex died weighing a mere 37 pounds and his body was emaciated, covered with over 40 bedsores.

[11] On May 7th, 2013 emergency medical services were called to the Radita residence in Calgary and Alex was found dead in a bedroom of his home. As mentioned earlier, he weighed only 37 pounds (17 kilograms), despite being 15 years of age, and measured only 4 foot 3 inches or 131 centimeters. EMS described him as emaciated to the point of appearing "mummified." His face had no visible flesh left and every bone on his face was visible. There were black necrotic sores on his face and his left jaw had open sores so deep his jawbone could be seen. His waistline appeared to be only about 3 inches wide, no flesh being left on his stomach.

[12] Since Alex suffered from type 1 diabetes, he required insulin to survive and his parents had failed to provide insulin for an extended period of time prior to his death. Without insulin, his body was denied proper nutrition, as a result of which Alex suffered from starvation prior to his death. His emaciated appearance was evidence of severe malnutrition, his body having a lack of subcutaneous fat tissue and muscle mass. He also had numerous bedsores.

[13] At the time of his death, Alex was residing with his parents and 7 other siblings, 5 of whom were over the age of 18 years. Alex's mother Rodica was a stay-at-home caregiver and his father Emil Radita worked outside of the home.

[14] On May 7, 2013, several people from the church the Raditas sometimes attended came to the Radita home around 9:00 PM, including the church leader Nicolae Brancu, who testified at trial. He went straight to the bedroom and knew immediately that Alex was dead. He told Mrs. Radita to call an ambulance which Mr. Radita eventually did. Another church member who attended the home May 7th, 2013, Marium Altan, testified he was shocked when he saw Alex. He asked Mrs. Radita "Is it alive?", which is indicative of how non-human Alex appeared at his death. The reason for the question, however, was that someone from the church had called Mr. Altan and told him Alex had died and been resurrected. Mrs. Radita responded to the question on May 7, 2013, that Alex was breathing 1 or 2 hours ago and had a bowel movement. Mrs. Radita also said Alex had blinked his eyes that morning.

[15] Both Mr. Altan and Mr. Brancu testified the church did not endorse a view involving a distrust of medical doctors. In fact, both they and their families saw doctors whenever needed. Accordingly, the distrust of doctors evidenced by the Raditas throughout the trial, was not a result of any teachings from the church they attended.

[16] The trial evidence outlined an extensive history of his parents failing to provide insulin to Alex. Alex was born January 30, 1998 and his diabetic condition became known in December, 2000 when his parents bought him to Surrey Memorial Hospital in British Columbia, where they resided at the time. His condition upon admission was described by Dr. White to include an altered state of consciousness, abdominal pain, vomiting, thirst, fever, dark circles under his eyes, and breath smelling of ketones.

[17] He was very ill and even before confirming lab tests Dr. White diagnosed him with the condition of diabetes. He was stabilized and transferred to the British Columbia Children's Hospital (BCCH) Intensive Care Unit due to the severity of his condition and the training his parents would need to care for him. Alex's mother, Rodica, indicated immediately that the diagnosis was wrong and that she would prove it. The resistance on the part of the parents to accept the diagnosis of diabetes persisted throughout his life at various intervals.

[18] The trial judgment contains detailed evidence of diabetic conditions in children and the considerable management actions Alex's parents were trained to

carry out in order to save his life. Since Alex was diagnosed with type 1 diabetes, his disease necessitated insulin treatment for the rest of his life in order for him to live. Alex required insulin daily and required medical monitoring on a regular basis to ensure the correct dosage of insulin was being provided on a daily basis.

[19] On December 14, 2000, when Alex was transferred to the BCCH, he came under the care of Dr. Metzger, a pediatrician specializing in children with diabetes. Dr. Metzger confirmed the diagnosis of type 1 diabetes and noted that the Raditas were in gross denial of Alex's disease. They were so hostile to medical personnel that Dr. Metzger called in a social worker with BCCH and the Ministry of Children's and Family Services (the Ministry). Attempts were made to impress upon the Raditas that diabetes was a treatable but dangerous life-threatening disease and that Alex would not be released into their care if they continued to refuse to cooperate. Alex was discharged from hospital December 22, 2000 after it appeared the Raditas would properly care for him. A nurse came to the Radita home twice a day for several weeks to provide extra nursing care.

[20] Alex was followed by BCCH after discharge and on February 1, 2000, just over a month after Alex's discharge, Dr. Metzger became suspicious someone at the Radita household was falsifying blood glucose readings taken as part of monitoring the insulin Alex was receiving. Alex was losing weight at that time and the readings contrasted with his condition. Dr. Metzger had the nurse assigned to the Raditas check the blood sugar readings kept by the Raditas and found they could not have been accurate medically speaking. Dr. Metzger believed that the Raditas were not being truthful about the log entries made daily for Alex and that Alex may well be receiving too little insulin. The Raditas denied falsifying Alex's blood sugar readings and claimed the BCCH was persecuting them.

[21] On March 16, 2001 Alex was re-admitted to hospital as a result of the Raditas failing to manage Alex's disease. They received additional training.

[22] Dr. Metzger believed the falsifying of logbook recordings to be serious and he recommended to the Ministry that Alex be apprehended. Instead of Alex being removed from the Raditas' care, he was returned to their care on April 4, 2001 and Dr. White, rather than Dr. Metzger, was assigned to their case. The reason for the change in physicians was partly because the Raditas objected to Dr. Metzger, and also partly due to the fact that Dr. White's clinic was at the Surrey Medical Hospital, a location closer to the Radita home.

[23] Alex was closely monitored from April to September of 2001 during which timeframe Dr. White saw Alex 11 times. At first the clinic appointments were weekly, then reduced in May to every 2 weeks, tapering to every month in June, July, August and September. After the September 18, 2001 visit, Alex was not brought to Dr. White. There was some continued resistance by the Raditas throughout this timeframe but Alex's weight went from 14.7 kilograms on March 16, 2001 to 20 kilograms on September 18, 2001. The Raditas were told not to adjust Alex's insulin doses without medical approval because some logbook readings revealed very high blood sugar readings. The Raditas refused to continue nutritional meetings offered to them through the hospital throughout this time frame, saying the clinic meeting with Dr. White was sufficient.

[24] On October 16, 2003 at approximately 7:00 AM Alex was again brought to the emergency department at Surrey Medical Hospital by ambulance in a state of malnutrition and hypoglycemia. He was in an altered state of consciousness as a result of his extreme condition. Alex was almost 6 years old at this time and Dr. White recommended stabilizing him and transferring him to the BCCH. At this time, Mrs. Radita told Dr. White she had not taken Alex for medical care for 2 years and that she had drastically altered his insulin regime because he had a rash. She said he'd only been unwell for a week, but Alex presented with muscle loss and a distended stomach indicative of his being unwell much longer. Alex was suffering from severe chronic malnutrition and was in a "tenuous cardiac state." Surrey Medical Hospital contacted the RCMP and the Ministry to report Alex's condition.

[25] On August 16, 2003 Alex was transferred to the BCCH Intensive Care Unit. In both December 2000 and October 2003, Dr. Seear, an intensive care physician was present. He confirmed that in 2000 Mrs. Radita had told him Alex did not have diabetes, and in 2003, the Raditas had advised hospital personnel Alex had only been sick for a week. Dr. Seear rejected this and indicated that at a minimum Alex had been sick for 2 months. Dr. Seear testified at trial that Alex was only 1 day away from death when he was re-admitted to hospital in October 2003. He stated he had never seen a patient as starved as Alex.

[26] Dr. Seear provided evidence concerning malnutrition and he explained that when the body is starved of glucose it will use its own fat stores first which may take 1 to 3 months, after which the body burns its protein, starting with the stomach lining, then its own muscles. The patient at this stage is skin and bones.

[27] After Alex was admitted to the BCCH Intensive Care Unit in 2003 he was seen by Dr. Korn, an expert in pediatric emergency medicine who described Alex's state upon admission at paragraph 56 of the trial judgment as follows:

> "Alex had profound malnutrition. He had no subcutaneous tissues, and he had what we call "peripheral edema." His legs were very swollen. He had a big swollen abdomen which had fluid in it called "ascites." He had pleural effusion, which is fluid between the lung wall and lung itself. Fluid shouldn't be there. And he had fluid around his heart. We also knew that they had a – he had a big liver. He had a mass behind his stomach, which I believe was finally diagnosed as a pancreatic pseudo cyst. The blood work was entirely consistent with he concerns in , in that his protein in the blood was very low, and that's what was causing this edema with malnutrition. He also was profoundly anemic, so – and his hemoglobin was 44, which is really really low for a child of this age, and he was very pale. He had mildly enlarged kidneys because when you're profoundly dehydrated you end up with damage to the kidneys."

[28] Hospital records admitted at trial revealed that Alex had pneumonia and bacteremia. He had staphylococcus aureus growing in his blood. He had candida growing on his tongue and in his urine. He had significant dental issues and his teeth were rotted away. The Raditas advised Dr. Korn that Alex had only been sick for a couple of weeks when he got a viral infection and began vomiting. Dr. Korn testified this information did not match the physical state Alex was found in when he was admitted to hospital. He also testified that Mrs. Radita was asked directly whether she understood that Alex had diabetes and she did not respond to the question. Dr. Korn further testified that he had never seen a patient as malnourished as Alex in his career.

[29] The Raditas advised Dr. Korn they were positive Alex had different medical issues, namely an issue with malabsorption, in particular that his body just could not absorb his food properly. Dr. Korn accordingly ran tests to determine if malabsorption was an issue and found no evidence of this. In addition, Alex was thriving in hospital, receiving a daily insulin protocol. Within a month he gained weight, the cyst in his stomach had disappeared and "non-viral hepatitis secondary to starvation" was gone. Dr. Korn testified that Alex was now a healthy-looking boy with "chipmunk cheeks." This change in Alex's health was due to his receiving nutrition and regular injections of insulin. Upon discharge December 31, 2003 Alex weighed 20 kilograms.

[30] Dr. Korn concluded that the Raditas did not accept the diagnosis of diabetes and were unable to manage the disease in the event Alex would be returned to them. He recommended Alex be removed from his parents' care, and Alex was placed in foster care with a foster mother who was also a type 1 diabetic.

[31] Alex remained in foster care throughout 2004 and was again treated by Dr. Metzger who saw Alex's foster mother and his social worker, one Patricia McDonald, on a regular basis. Alex thrived while in foster care and had gained 11 kilograms by his April visit to Dr. Metzger. He was a sweet-natured child who loved going to school. Continuing custody proceedings were initiated by Patricia McDonald which would, if successful, result in the Raditas' parental rights being terminated and would ultimately allow Alex to be adopted by his foster mother.

Proceedings in the Provincial Court of British Columbia

[32] The custody hearing was held on December 6 – 9, 16, 17 and 21, 2004. Judge Cohen rendered an oral decision on December 21, 2004 and produced a written decision on January 18, 2005 which is an exhibit at this Inquiry.

[33] The January 18, 2005 written decision ordered that Alex be returned to his parents. The return to his parents was under the Director's supervision for six months, but Judge Cohen set no conditions with respect to the Director of the Ministry concerning the nature of such supervision. He ordered that as long as he was not *functus*, the parties were at liberty to come back before him to impose any conditions relating to the order of supervision.

[34] Sometime later, an order was made with certain conditions designed to ensure Alex was attending school and monitored by physicians. The order required the parents not to leave British Columbia and to continue providing the appropriate treatment for Alex's diabetes. These conditions expired in 6 months from the date of the order. Judge Cohen's judgment clearly anticipates Alex would be monitored by the family doctor and that he would be in attendance at school, where his condition could be noticed.

[35] Judge Cohen noted that the Radita family was from Romania and had a distrust of authority figures given the present regime they experienced in Romania. He mentioned Dr. Metzger's concerns about Mrs. Radita falsifying Alex's blood glucose readings but felt there was insufficient evidence for him to make a fact finding to this effect. Mrs. Radita had testified she had done some readings for friends which were present in the monitoring device, and not attributed to her son.

[36] Judge Cohen stated that it was regrettable, considering the Romanian parents' distrust of authority, for doctors and social workers to have threatened the Raditas with the loss of their child in both December 2000 and March 2001. Judge Cohen stated he believed the parents had the right to expect the child protection authority to work with them and provide services to support them.

[37] At the hearing the Raditas denied any lack of acceptance of the diabetes diagnosis, even though Judge Cohen notes several written statements by them to the contrary. He held there was no proof the parents continued to deny the diabetic diagnosis or that they would not treat his diabetes, should he be returned home.

[38] In his judgment, Judge Cohen felt the parents' concerns about Alex having other conditions contributing to his condition were not properly explored. He noted that Alex had still not been tested for hepatitis, one of the ailments the parents believed was responsible for Alex's lack of health.

[39] Judge Cohen relied upon a 2001 report relating to the Radita family from the Surrey Family Preservation Program dated June 26, 2001, some 3½ years earlier. The Inquiry heard evidence that this report was prepared as a result of extensive BC Ministry involvement with the Radita family from April 1, 2001 to June 2001. As part of the BC Ministry Family Preservation Program, the Radita family met regularly with social workers and were required to engage in diabetic clinic monitoring by medical personnel. There was 47 hours of work by the BC Ministry with the family, 27 of which included direct contact with them. Most importantly, the Raditas' compliance with the insulin protocol Alex needed to survive was monitored by medical personnel throughout this timeframe on a regular basis.

[40] The report favourably described the supportive, caring and affectionate environment the Radita children lived in, which included Alex and 7 other siblings within the family. The fact the other children were well cared for, well behaved, and respectful was noted in this 2001 report which reached the following conclusion:

> "*In conclusion, it is my impression that Emil and Rodica are very caring and conscientious parents who are both very involved in family life. As stated previously, the children appear healthy, happy and very active. It is also my impression that the Radita family is struggling in terms of their housing needs, to some extent, financially and with other basic needs (dental, clothing, funds for social/recreational activities, etc.) yet this*

> *family appears to be functioning and relating very well in most aspects of their lives.*
>
> *The only recommendation I would make at this time would be for you to provide the family with a letter of support and some explanation regarding their present housing situation that would reflect their urgent need for more suitable housing. This would be a great help.*"

[41] Judge Cohen found that Alex had not seen a doctor from September 2001 until October 2003 and that Alex's mother changed his insulin regime without medical advice. This was explained by the fact that Alex had developed a rash, which was attributed to one of the two types of insulin he used twice daily. It was Dr. White who originally took him off one of the two types for a period of time.

[42] In the summer of 2003 Mrs. Radita again took Alex off that same second type of insulin because Alex developed the same rash. She did this without consulting a doctor. Judge Cohen found this was the reason Alex had insufficient insulin for a period of several months. This caused Alex's body to be unable to absorb nutrition, as a result of which he developed a kwashiorkor disease which was noted when he was brought to hospital in 2003.

[43] Judge Cohen stated the social workers believed the Raditas had intentionally deprived Alex of insulin because they continued to refuse to believe he suffered from diabetes. He stated the social workers chose to seek a permanent order terminating parental rights rather than put forward suggestions to support the family. He states in paras 36 and 37 the following:

> "[36] I deem it necessary to emphasize this point as it is important. This child had the right to expect his social worker to help him get back together with his family if that could be done safely. The worker involved in this case failed to make any reasonable effort to live up to his duty and, instead, made every effort to deprive A.R. of his family.
>
> [37] As an example of this, the primary social worker in this case deprived A.R. of access to his Romanian heritage, language and traditions, deprived him of contact with his siblings in an inappropriate manner, and falsely accused the parents of actions they had not taken."

[44] He goes on to recognize the parents were not blameless. In his view, they mismanaged Alex's treatment. He states that if they had stopped giving Alex insulin as alleged he would have died. Judge Cohen held the parents acted inappropriately in changing his insulin regime without medical advice and that therefore Alex was in need of protection under section 40 of the *Family and Community Services Act.*

[45] Judge Cohen dealt with some medical history which contributed to the parents' distrust of authorities. He mentioned a hypoglycemic event which occurred in June 2004, during one of the supervised visits between Alex and his parents. Alex's blood glucose reading dropped below 2, a situation which is extremely serious and can lead to death. This hypo-glycemic event was not caused by the parents, but by the actions of one of Alex's caregivers while in foster care. During the event the access supervisor almost caused further harm, possibly even death. She was inexperienced and had been told not to let the family treat Alex's diabetes, because of the Ministry's belief the parents denied Alex's diabetes and could not be trusted to deal with or manage it.

[46] During the event, the access supervisor did not know how to react and it was the mother who managed to get some sugar into Alex, which was necessary to counteract this major diabetic event, an event which could have been life threatening. Alex was actually hospitalized as a result of the caregivers who supervised the parental meeting.

[47] Judge Cohen described this incident as a "monumental" lack of trust between the social worker and the parents. He stated that an effort should have been made to find a social worker who could work with such an otherwise "obviously capable family."

[48] He concluded that the case represented a misunderstanding of the facts by the social worker who believed this case was a denial of diagnosis and withdrawal of treatment. Instead, he held the case was one where the parents accepted the diagnosis but poorly managed the complex treatment regime which Alex's condition required. Hence, he ruled a permanent custody order was not appropriate and Alex was returned to his parents. Judge Cohen was convinced the parents were capable of managing Alex's condition given sufficient education and monitoring.

Continuation of Criminal Court Proceedings in Alberta

[49] Dr. Metzger continued to care for Alex once he was returned to his parents in January, 2005. Dr. Metzger believed the Raditas were very aware he would report to the Ministry, as he had before, if he had any concerns about their management of Alex's diabetes.

[50] At the April 4, 2005 visit, Alex had gained height and weight. He weighed 33.7 kilograms (74 pounds) and measured 118.4 centimeters (3 feet 11 inches). His A/C reading was 80%, the target for children his age. This is a very important test since it gives a measurement of the average blood sugar content over the preceding three months.

[51] In June 2005 the Raditas wrote to Dr. Metzger stating their insurer had not covered the cost of the medical diabetic supplies since he was in foster care and that their supplies had run out. Mrs. Radita complained about the expense for their supplies. Elsewhere in the trial judgment, the Court stated that insulin and diabetic supplies are covered by provincial health care.

[52] At the August 2005 visit, Alex weighed 34.2 kilograms (75 pounds), measured 121 centimeters (3 feet 9 inches). His A/C test was 7.3%. The family was congratulated on the excellent diabetes control to that point. His next appointment was December 12, 2005 and at that point Alex was doing 4 or 5 finger pokes a day by himself (blood tests needed each day), but Mrs. Radita was still doing most of the diabetic care. Alex had again continued to gain weight and grow and his A/C reading was 7.9%, meaning over the past 3 months his blood glucose levels were within acceptable range.

[53] The next visit in May 2006 found Alex again having gained weight and grown. His A/C test reading was 8.6%. However, Mrs. Radita did not want to increase his insulin, as instructed, given his growth. She feared it would give him cold sores. She was corrected on this point. At the January 27, 2007 visit with Dr. Metzger Alex weighed 41.3 kilograms (91 pounds) and measured 126.7 centimeters (approximately 4 feet 1 inch). His A/C test reading was 87.4%. At the August 2007 clinic meeting the Raditas were again congratulated on their management of Alex's diabetes. His A/C at that time was 7.9%.

[54] On January 16, 2008, Alex was last seen by Dr. Metzger. He was nearly 10 years old at that time and in grade 3. His weight was 41.1 kgs., about the same as January 2007. His height was 4 feet 4 inches or 131.8 centimeters and his A/C reading was 8.8%. Dr. Metzger was concerned Mrs. Radita was resisting

increasing the insulin, again due to her belief it caused cold sores. Dr. Metzger impressed upon her that cold sores were caused by a virus, not insulin. He unequivocally told Mrs. Radita to increase the insulin dosage for Alex given his growth. The next appointment was scheduled for July 14, 2008 and the Raditas failed to attend.

[55] The appointment was re-scheduled another 6 months hence, to January 5, 2009. Unknown to Dr. Metzger, the Raditas had withdrawn Alex from Parkside School in September 2008 and they left British Columbia to reside in Alberta without notifying Dr. Metzger or the BC Ministry of Child and Family Services.

[56] When the Raditas failed to attend the January 5, 2009 clinic meeting with Dr. Metzger he asked Jana Wong, a social worker with the Endocrine Unit of the BCCH to follow up with the Raditas. Mrs. Wong testified at the trial and was well aware of the Raditas case, since she had met them in December 2000 when Alex was first admitted to hospital. She recalled the Raditas' resistance to the diagnosis of diabetes. She was aware of the training they received and she was the person who arranged for the home nursing care for Alex when he was first released from hospital in December 2000. Mrs. Wong tried to reach the Raditas in January 2009 when they failed to keep the January 2009 meeting with Dr. Metzger. She called all clinic phone numbers in their system without success. She then searched the pharmacare system in British Columbia, a system into which all pharmaceutical purchases in the province are entered. It showed the last insulin prescription for Alex was filled in December 2008, for a 3-month supply. Mrs. Wong wrote the Ministry on January 2009 advising them of the situation and tried to follow up with the Ministry in late February 2009. She was unsuccessful.

[57] Ravinder Dhami, a social worker with the Ministry in 2009 testified at trial. She confirmed she spoke with Mrs. Wong in January 2009 and was advised of Alex's missed appointments and diabetic condition. She tried to find contact information for the Raditas in Vancouver and the surrounding area, and it was she who discovered that Alex had been withdrawn from the Parkside School in September 2008. Ravinder Dhami was given a Calgary address for Alex's brother by the school system. Unfortunately, her team leader directed her to close the file due to insufficient information, which she did. Thus, there was information at the Ministry concerning an address for the Raditas in Alberta, but nothing further was done.

[58] Alex was registered to receive medical services in Alberta in 2009 but no medical examinations or services were billed to medical practitioners prior to his death. In the spring of 2009, insulin, syringes and test strips required to

monitor Alex's condition were purchased for a value of $1,603.31. In 2010 diabetes related drugs and equipment were purchased at a value of $3,033.89. In 2011 such purchases totaled $880.59 and in 2012, $109.98. None were purchased in the months leading up to Alex's death. Alex was registered in a home-schooling program with the School of Hope in September 2009 but did not submit any work, as a result of which he was withdrawn, by letter, as a student by the School of Hope. The school conducted a home visit in October 2009 and no other visits took place. There are no details in evidence about whether anyone saw Alex at that time.

[59] Police evidence found glucose monitoring meters in the Radita home, showing 2,573 readings taken between April 2005 and July 20, 2009. For most of this time frame Dr. Metzger was monitoring the Raditas' management of Alex's diabetes, which evidences that for some of this time frame the Raditas were properly managing Alex's diabetes, as Dr. Metzger's evidence indicated. The second glucose monitor showed only 11 readings in 2010, 2 in 2011 and 1 in 2012. This is evidence that Alex's glucose monitoring may barely have taken place in the years 2010 through 2012.

[60] Evidence at the trial included testimony from the leader and a few members of the Romanian Apostolic Church which Mrs. Radita regularly attended and which Mr. Radita also attended on occasion. A Radita family member who could not be named, testified her parents did not believe in doctors, but as mentioned earlier, evidence from church leaders and other members was that this position was not taught, accepted or practiced by the church. Church members and their family members regularly sought medical advise when it was needed. There was evidence at trial from one church member who was told by Mrs. Radita that the doctors in Vancouver made Alex sick by giving him insulin. Mr. Radita also stated he had recorded DVD's of doctors in Vancouver abusing Alex so he and his wife decided not to let doctors treat Alex anymore. The Raditas determined they would treat Alex at home.

[61] A friend of one of Alex's siblings testified she saw Alex in March or April 2013 when he was coming downstairs, having to hold the banister and walking at a snail's pace. He looked sick, young and "really, really small." His skin was yellowish, his face pale, and he had a hole in his neck. She was told by one of Alex's siblings after he died that he had cancer.

[62] Certain key fact findings were made by Madame Justice Horner at trial. These were considered by the Alberta Court of Appeal when the first-degree murder conviction was upheld, and these essential fact findings are as follows:

"1. Alex was a Type 1 diabetic first diagnosed in December 2000, which condition did not change throughout his life.

2. Alex required insulin injections on a daily basis in order to survive.

3. Mr. and Mrs. Radita understood that many doctors and much testing had confirmed this diagnosis. Mr. and Mrs. Radita had been told that testing had been done for other causes of Alex's illness and that nothing else had been found.

4. At the very latest by January 2008, Mr. and Mrs. Radita were fully trained and competent to perform Alex's diabetic treatment. They knew how to administer finger pokes, use the glucose meter and test strips to test blood sugar; that a low blood sugar reading meant Alex was required to ingest a fast acting sugar, that a high blood sugar meant Alex required insulin. They understood the type and amount of insulin Alex required and if they were unsure they knew they could call a diabetic hotline or attend at any hospital emergency room. Mr. and Mrs. Radita understood that the food Alex ate impacted his blood sugar reading.

5. Mr. and Mrs. Radita had been told and understood that Alex was required to attend periodic appointments with medical personnel so that his insulin needs could be monitored and adjusted as he developed.

6. Alex had been to the emergency room of SMH twice before, near death, in 2000 and 2003. On both occasions after proper diabetic treatment he recovered and was able to be discharged. On both occasions Mr. and Mrs. Radita were present throughout and witnessed Alex's recovery.

7. Mr. and Mrs. Radita understood that Alex had been apprehended by the Ministry and placed in foster care because they had failed to administer the proper diabetic treatment for Alex as prescribed by his doctor. They understood that the doctors believed Alex had become extremely ill as a result of their actions.

8. Mr. and Mrs. Radita understood that if they enrolled Alex in a school or took him to a doctor his diabetes control and medical condition would be monitored by others.

9. Alex rarely left the Radita's home in NW Calgary and when he did he was always in the company of one or more members of

his family. Alex had no contact with or social life outside his immediate family members.

10. Mr. and Mrs. Radita intended to and did isolate Alex from anyone who could intervene or monitor his insulin treatment aside from themselves.
11. Sometime after they moved Alex to Alberta Mr. and Mrs. Radita intentionally began a program of providing Alex with just enough insulin so that he did not develop DKA or Kwashiorkor but not a sufficient amount to appropriately treat his diabetes and allow him to maintain healthy growth as a child.
12. Alex died as a result of bacterial sepsis brought on by extreme starvation. His physical condition at death was not a sudden or quick occurrence but rather took place over months and possibly, probably, years.
13. For reasons that are not known Mr. and Mrs. Radita never accepted Alex's diagnosis of diabetes. They did however understand the proper insulin treatment and they understood the consequences to Alex of not following a proper insulin protocol and not providing him with medical care."

[63] It is not the purpose of this Inquiry to review the lengthy deliberations on the law set out in both the trial judgment as well as the Court of Appeal decision, but it is worth mentioning that at trial the Raditas conceded they were guilty of manslaughter, but not murder, much less first-degree murder. The Raditas submitted the evidence was insufficient to prove beyond a reasonable doubt that they intended to kill Alex. The Raditas did not testify in their defence.

[64] Justice Horner dealt extensively with whether the Raditas had murdered their son, and also whether their actions constituted either first or second-degree murder. She concluded the actions of the Raditas constituted first-degree murder and that they had been planned and deliberate. She stated that both accused were well aware of the consequences of an improper insulin protocol with respect to the health of their son and that they embarked upon a restricted insulin regime with no supervision or medical care. She went on to state that even knowing of the consequences to their son, they planned to stop giving Alex any insulin at least by late 2012 when the supply they purchased was either inadequate or non-existent. She stated that although it was not clear exactly when the Raditas formulated the plan to murder Alex, at some point they planned Alex's death. By

2012 they were deliberately withholding insulin from Alex. In addition, no insulin was purchased in 2013 and the last glucose meter reading was in July 2012.

[65] Justice Horner held that they isolated Alex from school authorities and doctors, or even a dentist, since the medical evidence showed that at Alex's death, the majority of his teeth were rotten to the gum line. The Raditas had a calculated and deliberate plan to prevent anyone who could control or monitor Alex's diabetes from seeing him or helping him. The Raditas isolated him and were well aware of the consequences of an improper insulin protocol given their prior hospitalizations with Alex. They knew that without medical attention Alex would die and also knew that if Alex came to the attention of Family Services in Alberta, their prior history in the province of British Columbia would be discovered and they would likely lose custody of Alex again. They were not prepared to risk losing Alex to the authorities again, and were not prepared to continue to provide a proper insulin protocol. Justice Horner held, however, that they were prepared to see Alex die. She stated the following at para 251 of her decision, "I am satisfied beyond a reasonable doubt that Mr. and Mrs. Radita engineered a protracted period of deprivation of insulin and medical care which they knew meant lack of nutrition and eventual starvation and death. This series of omissions, which went on for months and possibly years, supports the strong inference that this conduct was carried out in furtherance of a planned and deliberate scheme of murder." She therefore found them guilty of first-degree planned and deliberate murder as joint principals.

[66] In upholding the trial judge's decision, at par 42, the Alberta Court of Appeal held that triers of fact are entitled and even required to rely on common sense and human experience in assessing evidence. The Supreme Court of Canada explained the common sense inference principle in ***R v Seymour*, [1996] 2 SCR 252** at paragraph 19 as follows:

> "*Common sense dictates that people are usually able to foresee the consequences of their actions. Therefore, if a person acts in a manner which is likely to produce a certain result it generally will be reasonable to infer that the person foresaw the probable consequences of the act. In other words, if a person acted so as to produce certain predictable consequences, it may be inferred that the person intended those consequences.*"

[67] Justice Horner also found that the Raditas, as joint principals murdered Alex while unlawfully confining him, a confinement which did not only arise

from his illness but also as a result of the intentional isolation of Alex to prevent anyone who could intervene on Alex's behalf from doing so.

[68] The isolation of Alex by his parents from the state agencies who could have intervened is of significant relevance to this Inquiry and its purpose to prevent similar deaths from occurring. The involvement of state agencies, including Child and Family Services in both Alberta and British Columbia, along with health and education authorities are a primary focus of the Inquiry. There is also relevance to the involvement of the pharmaceutical industry with respect to its involvement with patients without the support of physicians.

EVIDENCE OF CHILDREN SERVICES AUTHORITIES

British Columbia Child Welfare Authorities

[69] The Deputy Director of Child Welfare, James Norman Wale, testified on behalf of the BC Ministry of Children and Family Development (BC Ministry). He testified the BC Ministry first dealt with the Radita family in November 2000 on two occasions. Both times concern about lack of supervision and neglect regarding the Radita children were raised. There were eight children in the Radita family and the November 2000 reports to the BC Ministry came from the general public about children "roaming in the community" unsupervised. There was also a concern mentioned about a lack of a car seat and children not using seat belts in the Radita car. Neither of the November reports referred specifically to Alex and both were resolved after speaking to the mother.

[70] The next report came in December 2000 when Alex was hospitalized and diagnosed with diabetes. The BC Ministry was notified his parents were unwilling to provide the necessary treatment for diabetes and did not accept this diagnosis. As a result, an ongoing investigation commenced and the involvement of a social worker dealing with the family began.

[71] When Alex was released from hospital in December a nurse from the diabetes clinic met weekly with the family to ensure Alex was getting the diabetes treatment he required. There were also clinic meetings with Dr. White from April to September. A short time later, when Alex was re-hospitalized on March 16, 2001, medical professionals recommended Alex be removed from his parents' care, but this did not take place. The BC Ministry records indicate April 1, 2001 was the date this decision to return Alex to his parents took place.

[72] However, the BC Ministry records refer to a memo dated April 1, 2001 setting out the concerns of doctors to the effect that falsification of blood sugar level readings was taking place. This would mean Alex may not be receiving the amount of insulin he required.

[73] The BC Ministry involvement by the Family Preservation Program was implemented in April, involving weekly meetings with the family by a BC Ministry social worker, in addition to the diabetes clinic monitoring by medical personnel. This arrangement continued from April to June 2001, at which time it appeared Alex's parents had worked well with the BC Ministry and that the outstanding concerns had been addressed. It was this June 2001 report Judge Cohen relied upon in 2005 when he returned Alex to his parents' care from foster care where he had been thriving for a year. This report came about as a result of some 47 hours of work which included 27 hours of direct contact with the family. Throughout Alex's life his parents only followed the necessary insulin protocol when they were closely monitored by the authorities.

[74] The BC Ministry file on the Raditas was not closed at this time, but it is unclear what degree of involvement with the Raditas continued. A long-term file was opened, however, which means the BC Ministry believed Alex needed protection, but not removal from his parents.

[75] Another report from the public was received by the BC Ministry on July 18, 2001, alleging the young children of the Radita family were outside without supervision. There was also a concern about lack of nutrition. Another investigation was undertaken in which the children were interviewed and a home visit was completed. The concerns were not substantiated and the file on that report was closed. The Radita file on Alex remained open until March 2002, and there were no concerns about Alex raised between July 2001 until October, 2003.

[76] On October 16, 2003 the BC Ministry received what Mr. Wale described as "a grave report" a "very concerning report." This was the incident where Alex was re-admitted to hospital, in a condition near death. The BC Ministry summary of its records relied upon by Mr. Wale in his testimony stated as follows:

> "Alex was brought to hospital by ambulance. His physical state described as bloated stomach, rotten teeth, his hair is thin, grey complexion. He is extremely underweight. Caller reports concern Alex is not getting enough insulin or nutrition.

> Also noted the paramedics who attended reported the severity of neglect to the RCMP. Alex was transferred from Surrey Memorial Hospital to BC Children's Hospital, ICU - intensive care unit, due to the severity of his condition. The pediatrician says clinical presentation is compatible with severe medical neglect, and without intervention at this time it is highly likely he would have died within hours."

[77] At that point the BC Ministry removed Alex from his parents' care and another investigation was commenced. The remarks of Dr. Korn are recorded as follows:

> "The evidence presented to me indicates that the family has refused to accept a diagnosis of diabetes. In spite of efforts to educate the family regarding this illness, they have elected to deny ongoing medical treatment for Alexandru.
> The admission on October 16th, 2003, was the second time in less than 3 years that the parents' refusal to seek timely and appropriate medical attention for Alexandru has left him near death."

[78] The BC Ministry was aware the Raditas had previously lived in Ontario and sought information from Children Services in Waterloo. They learned that in 1999, one of Alex's younger brothers, Claudius was born prematurely and placed by hospital medical personnel on oxygen and antibiotics. He was jaundiced and needed phototherapy, a light treatment for jaundice. Rodica Radita was described as irrational and insisted upon taking Claudius home despite the risks. The Ontario authorities apprehended Claudius to prevent Mrs. Radita from removing him from hospital. Only then did Mrs. Radita cooperate with the authorities and follow the doctor's advice. Claudius was discharged to his parents' care on June 25, 1999 and the Ontario Ministry of Children Services file was closed.

[79] On November 29, 1999, Claudius was re-admitted to hospital after having a seizure. Claudius had had earlier seizures and Mrs. Radita had requested he be removed from seizure medication they had prescribed for him in the past. As a result of the medication being discontinued at that time, presumably by the Raditas, Claudius had a seizure. When he was admitted to hospital on November 29, 1999, Mrs. Radita again wanted to discontinue his seizure medication even

though he had just had another seizure. She gave him Tylenol to treat fever which caused elevated liver function. Mrs. Radita believed the seizure medication was responsible for his seizure and that God was looking after her baby. The Raditas attitude toward Claudius and their refusal to accept necessary medical advice and treatment for him, mirrors their treatment and attitude displayed repeatedly in the case of Alex. Only when closely monitored by the authorities who could remove both Claudius and Alex from their care, did the Raditas provide necessary medical treatment to both children.

[80] The file in Ontario was closed December 6, 1999. At that time the family doctor noted Mrs. Radita was a caring parent who did not entirely trust Western medicine.

[81] In October 2003, the BC Ministry records indicate that Alex may have been just hours from death when he was re-admitted to hospital and Alex was placed into a foster home as a result of the court granting custody of Alex to the Director of the BC Ministry on January 28, 2004.

[82] Under BC law the Director must take the next steps within 6 weeks and if it appears there is a reasonable prospect the child can be returned to the parents, usually the Director would seek only a temporary custody order. In Alex's case, however, the Director applied for continuing custody without taking a temporary custody step. This indicates how serious the BC Director believed Alex's case to be and that the Director believed there was no reasonable prospect that the child could safely be returned to his parents.

[83] The continuing custody application was launched in March 2004, but did not take place until December 2004, given various procedures which routinely take place after the launching of such an application. In order for a continuing custody application at a protection hearing to be successful, the court must be convinced there is no reasonable prospect for the child to be returned to the parents safely. Section 41(2) of the *BC Child, Family and Community Service Act* reads as follows:

> "*The court must not order under subsection (1)(d) that the child be placed in the continuing custody of the Director unless (a) the identity or location of a parent of the child has not been found after a diligent search and is not likely to be found, (b) a parent is unable or unwilling to resume custody of the child, or (c) the nature and extent of the harm the child has suffered or the likelihood that the child will suffer harm is that there is little*

prospect it would be in the child's best interest to be returned to the parent."

[84] Mr. Wale agreed that the BC Ministry concluded there was no significant likelihood that the circumstances leading to Alex's removal would improve if he were to be returned to his parents. I note for the record that paragraphs 83 and 84 of my report have been amended March 20, 2024 to reflect accurate legislative provisions recently provided by Counsel for Children's Services in British Columbia, which differ from evidence given at the Inquiry.

[85] Mr. Wale testified there was an incident in June 2003, prior to the continuing custody application, which occurred during a supervised visit between Alex and his parents. Alex was brought by ambulance to hospital due to low blood sugar and on this occasion no further action was taken by the Ministry. This occurred at a time when Alex was in foster care, when his parents could only see him under the supervision of Ministry personnel. The June 2003 incident was set out in Judge Cohen's judgment and refers to a lack of proper care by Ministry personnel supervising the visit. Judge Cohen states they refused to allow Mrs. Radita to rectify the serious condition Alex was in as a result of low blood sugar. He states it was the mother who knew what to do and was prevented from helping her son, increasing the Radita distrust of medical and other authorities.

[86] The next major event referred to in Mr. Wale's evidence is the decision of Judge Cohen to which I have already referred. Judge Cohen ordered Alex returned to his parents on December 21, 2004, but he was to remain under the supervision of the Director. However, no conditions of supervision was set forth in the December 21 order.

[87] When the Director appealed, a settlement conference was held on February 18, 2005 which resulted in the re-integration of Alex with his parents and contained a 6-month supervision requirement with specific conditions. The Consent Order is dated April 2005 and confirms the order of Judge Cohen pronounced December 22, 2004. The order contained specific provisions attempting to ensure Alex received the necessary medical attention he did at the BC Children's Hospital Diabetes Clinic, that his blood sugar levels were properly monitored on a regular basis, that the parents complied with doctors' directions with regard to the insulin protocol, ensuring that Alex attended school on a regular basis, prohibiting the parents from leaving the lower mainland of Vancouver without prior consultation with the Director and prohibiting the parents from changing their address without notifying the Director 14 days in advance. These

conditions and the order itself dated December 22, 2004 lasted for a period of 6 months, and would have expired in 2005.

[88] The BC Ministry records had no further contact with the Raditas until January 2008, at which time a report from the school Claudius attended stated concerns about hygiene. This included dental hygiene such as cavities and Claudius having a body odor. Because of the family history, another investigation occurred, and no evidence of neglect was found. Ministry records indicate the Parkside school officials reported the children were clean and attending school. There was an acknowledgment the teeth could have been better, but nothing required the BC Minister's involvement. The file was closed in March 2008.

[89] The next involvement of the BC Ministry is of particular concern to this Inquiry. In January 2009, as the murder trial decision of Madam Justice Horner states, the BC Ministry received a call from BC Children's Hospital about Alex having missed both July 2008 and January 5, 2009 medical appointments. In addition, the BC Ministry was told the pharmacare record showed Alex was likely not getting the insulin he needed. Their records showed that 2 – 3 months' supplies of his insulin were ordered 6 months apart, meaning the amount of insulin Alex was getting was insufficient.

[90] The BC Ministry worker who took the call completed the prior contact check and noted 8 prior intakes or reports had been received about the Raditas. She tried to find an address for the Raditas and called school district locations. She found a Calgary address for one of Alex's siblings indicating the Raditas resided in Calgary, Alberta. The evidence at trial was that the case worker who took the hospital call was directed by her supervisor to take no action. As a result, the BC Ministry took no steps in response to Dr. Metzger's concerns and the historical medical needs of Alexandru.

[91] The evidence of Mr. Wale is that the then existing Provincial/Territorial Agreement between provinces and territories entitled the Provincial/Territorial Protocol was sufficient for the BC Ministry to contact the Alberta Ministry of Child and Family Services (the Alberta Ministry), but unfortunately this was not done.

[92] The screening process in Alex's case, did not thoroughly review the Raditas' history nor consider the gravity of the BC Ministry's prior dealings with the Raditas. Had it done so, an alert would have been sent to the Alberta Child and Family Services Ministry. Although some of the 8 reports concerning the Raditas were not serious there was repeated resistance on the part of Alex's

parents to provide him with the insulin he needed to survive and it was only when the Raditas were closely monitored by the authorities that Alex received the insulin he required to survive. As a result of the Raditas' failure to provide Alex with the insulin he needed, Alex was admitted to hospital near death on two prior occasions, according to the BC Ministry records.

[93] The screening process that took place in January 2009, from the evidence before the Inquiry, was inadequate and required more depth into the seriousness and specific details of the BC Ministry's involvement with the Radita family in the past. In particular, the fact the Ministry had sought a continuing custody order in Alex's case should have been a clear indication of the fact that Alex may need protection and that the Alberta Child Services Ministry should be contacted. Continuing custody orders were only sought when the Minister was convinced there was no reasonable prospect for the child to be returned to his parents safely. Had the gravity of the prior investigations been considered, it is likely the case would have been referred to the Alberta Ministry in accordance with the existing Provincial/Territorial Protocol.

[94] The specific provisions of the Provincial/Territorial Protocol which the BC Ministry should have carried out are found in section 7 of the Agreement. Section 7.2.1 provides for child protection alerts to be issued when a child is missing or has moved to another province and may be in need of protection. Such an alert is simply a communication by an originating province to the province or territory where the child is located.

[95] The criteria for issuing child protection alerts are set out in section 7.2.1 which reads as follows:

> An originating PT may issue a child protection alert when a child, youth, adult or family is missing or there is knowledge that a person or family has moved to another PT and a child or youth is or may be in need of protection. Circumstances that may lead to the issuing of a child protection alert include, but are not limited to the following:
>
> a. a family, family member or guardian leaves the PT prior to the conclusion of a child protection investigation;
> b. a family, family member or guardian receiving child protection services leaves the PT prior to closing the case;
> c. a family under court-ordered supervision leaves the PT without approval from the PT or court;
> d. a parent or guardian takes a child or youth in care to another PT without prior approval from the originating PT or court;

e. a child or youth in care is missing from his or her placement and is believed to have left the PT;
f. a high-risk pregnant person has or is suspected to have left the PT; and
g. a child or youth is taken or has fled to another PT for a variety of reasons, including child trafficking, sexual exploitation, so called 'honour based' violence or illegal adoption.

[96] This section appears to emphasize the existence of ongoing proceedings in the originating province. Normally this would include an open file being in existence as opposed the closed file in the Radita case. In addition, there is no specific provision stating that the need for medical attention or treatment is a circumstance which may lead to the issuance of a child protection alert to another province.

[97] Given the volume of calls the BC Ministry receives each year (Mr. Wale testified it was some 50,000) it would seem prudent for the protocol to specifically state that an open file being in existence is not necessary, that the severity of prior Ministry involvement be considered, and that the need for medical attention or treatment justifies the issuance of a child protection alert.

[98] The general reference in section 7.2.1 (g) to a variety of reasons justifying the alert is insufficient to ensure screening case workers focus their attention specifically on the past history of the refusal by parents to provide necessary medical treatment to a child especially if there is no open file on the family. Section 7.2.1 could also be strengthened by providing that a prior lack of willingness by parents to provide ongoing necessary medical treatment to their child is a circumstance justifying the issuance of a child protection alert.

[99] Mr. Wale agreed that even without an open file the screening process in this case should have been more detailed so that the severity of the risk posed by Alex not being taken to a doctor was appreciated.

[100] Mr. Wale also testified there was insufficient guidance given to workers receiving reports at the time Dr. Metzger phoned in 2009. He testified that in 2012 changes were made by the BC Ministry which were designed to ensure more thorough screening. These changes were intended to include a structured decision-making screening assessment to provide greater consistency in the assessment of BC reports along with more in-depth examination of prior history of children who potentially require protection.

[101] He testified the BC Ministry has also currently updated its operational policies so that at the screening stage, if there is any belief a child who has had child welfare involvement in any other province is the subject of a report, those provinces are to be contacted for information. The Ontario information concerning Mrs. Radita's reluctance to allow necessary medical treatment for Claudius was relevant information to be considered at the screening stage of Dr. Metzger's office call in 2009 relating to Alex.

[102] Mr. Wale described Alex's case as "a terrible tragedy" and remarked that if there is anything that can be done to prevent similar deaths, it should be. He testified that policy within the Ministry is evolving so that if a screener receives a report about a child that has left BC for another province, and may need protection, the history of the BC involvement should be examined carefully and thoroughly to determine the gravity of prior involvement with the family by the BC Ministry. This assessment is done to determine whether the child may need protection in the other province, and if there is evidence from the severity of prior involvement that the other province should be contacted to protect the child, it should be done. He testified the BC Ministry is working on this approach and that as a result of this Inquiry the BC Ministry is alive to this screening issue and that they are working on a policy amendment which deals with front end screening and would reach out to every ministry screening worker within the province.

[103] Mr. Wale is also a member of the Provincial/Territorial Directors of Child Welfare Table which meets monthly and in person once per year. He testified this Inquiry's report will be considered by this group with a view to examining any gaps that should be addressed to ensure this type of tragedy does not recur.

[104] When asked about the value and practicality of an alert system to notify and identify education authorities and possible pharmaceutical authorities about vulnerable children in need of protection, he agreed it was a good question. However, there are considerable barriers involved in such a pursuit beginning with the lack of integration of data bases within ministries themselves, and even more so between different ministries and professional organizations.

[105] He mentioned the question of legal authority to disclose such information between ministries and professional organizations as well. He stated that despite the increasing technological capacity to share information, there are questions about the legal authority to both collect and to share such information. He believes the examination of such an alert system would begin with examining

legislation to determine authority or lack of authority to collect and share information.

[106] He mentioned that in BC there is legislation permitting disclosure of information without consent where it is necessary to ensure the safety or well-being of a child, but this is done only on a child-by-child basis, not as part of a general alert system. He thought the idea worth examining, primarily because, from a child welfare perspective, operating within silos, does not serve children well. There is a need to balance privacy rights with safety and wellbeing of children. Siloed information can create problems. I will note at this point, that the BC Ministry's information was indeed part of a silo and the fact Alberta did not know about Alex and his need for protection is a clear example of the lethal result of the siloed effect of managing information in Alex's case.

[107] Mr. Wale testified the BC Ministry believes it is important to learn from this terrible tragedy and remain open to working with colleagues across the country to constantly improve child services. He stated that with centralized screening the BC Ministry would be more likely to detect "that Alex was in need of protection," thus prompting action rather than "no further action" as was done in Alex's case.

[108] Mr. Wale concluded his evidence by stating that by April 2023, BC Ministry policy will be clarified respecting the need to refer matters to other provinces at the screening stage of any reports to the BC Ministry. This Inquiry has prompted the BC Ministry to specifically improve its policies as a result of the Radita case, and in particular their clarity at the screening stage to ensure referral to other provinces where protection of the child is needed or may be needed, and in particular to avoid the tragic death that is at the center of this Inquiry.

[109] Another change the BC Ministry has made is to harmonize its Provincial/Territorial Protocol with the operational policies of the Ministry. This is part of the Family Development Response and investigative policies. Currently the Provincial/Territorial Protocol refers to a child who "may" be in need of protection and authorizes the contact of another jurisdiction. The current BC Ministry operational policy, however, speaks of a child "being in immediate danger," which is a narrower standard. The changes to the BC operational policies are to require Provincial/Territorial referral if a child may be in need of protection, as Alex was, thus removing the difference in standards established by the 2 documents, and implementing the broader standard requiring Provincial/Territorial contact if a child "may" be in need of protection. Under the

2009 operational protocol Alex would have had to be "in immediate danger" for contact with the other province to take place, according to the operational policy of the BC Ministry at that time. However, the Provincial/Territorial Protocol at that time called for an inter-provincial referral if Alex "may" have needed protection. It is intended that the broader language from the Provincial/Territorial Protocol will be introduced into the BC Ministry operational policies in April 2023, along with the screening changes already mentioned.

[110] Counsel for the BC Ministry, Mr. Warburton, stated that during the course of the Inquiry two specific developments have become the subject of consultation within the BC Ministry. The first of these is to clarify that when a child is in need of protection and their whereabouts cannot be ascertained, alerts must be placed on provincial and where necessary, inter-provincial, federal and other information systems.

[111] The second change anticipated is that a verbal contact will be made to another province when a child protection report is received in British Columbia and it becomes clear a child is residing in another province. Mr. Warburton stated these changes are being considered, in part, as a result of the Inquiry.

[112] In addition, Mr. Warburton stated that the Provincial/Territorial group of directors of Child Welfare across the country who meet once a month, have been discussing the matters raised by the Inquiry and have decided to await the outcome of the Inquiry to determine possible necessary changes to the Provincial/Territorial Protocol Agreement.

[113] Mr. Warburton stated that the BC Ministry appreciates the invitation to participate at the Inquiry and would welcome any recommendations designed to improve outcomes for the protection of children.

Alberta Children Services Authorities

[114] Ms. St. Amand is an Associate Statutory Director with Alberta Children Services and her role includes responsibility for Fatality Inquiries and other legal proceedings involving serious injury or death of a child who is receiving or had received children's services. She has spent 20 years with Children Services beginning as a case worker in the community. She then went into a specialized investigation role and carried on into various positions at the Alberta Ministry Headquarters including training staff at Children Services.

[115] She testified that there is a duty to report to Children Services if any person has reasonable and probable grounds to believe a child may be in need of intervention. Section 4(1) of the *Child Youth And Family Enhancement Act* states that the duty to report to Children Services provides the option to report to either Children Services or police. Thus, a school, a professional in the community, or any other person who reasonably believes a child is in need of services has a duty to report to either Children Services or to the police. The seriousness of this duty is underlined by the provisions of sec 4(6) of the *Act* which provides that any person who fails to comply with the duty to report is guilty of an offence and liable to a fine of not more than $10,000 or to imprisonment for 6 months or to both a fine and imprisonment. Section 4(1.2) of the *Act* requires police to report the matter to the Director as soon as practicable.

[116] Ms. St. Amand described the process followed by Children Services once such a report under sec 4(1) is received, both with respect to the time frame in 2009 and currently.

[117] In 2009 a report would be received by the specific office where the family was believed to live. Intake workers would secure as much information as possible about the reasons for the report and then a supervisor would review the information collected. Collateral calls would be made to agencies such as schools or doctors who are involved with the family and determine any relevant history regarding the concerns expressed in the report. Children Services records would be reviewed to determine whether prior services had been provided to the family as well as whether there was a history of Children Services having been provided in another province.

[118] Ms. St. Amand testified that since 2009 the Alberta Children Services have centralized the screening process at the reporting stage. The prior procedure was that the worker receiving the report would check with a supervisor concerning the next step. Centralized screening has incorporated an entire team into the screening process, so that the person taking the call is not working within a silo, and has access to expanded assistance to gather the necessary information in order to determine the next steps. There is much more collaboration than there was in 2009.

[119] With respect to ensuring the public and various service providers are aware of the duty to report, Ms. St. Armand testified there are collaborative consultations and meetings with schools, doctors and hospitals. She stated that when she was a community investigator she met regularly with schools and community police officers to ensure there was a collaborative approach to

children services. She testified that the Children Services Ministry is not the only child serving community. Police services, educational services, and health services are also involved, and it is important for the Children Services Ministry to build relationships with all of these communities. Ms. St. Amand also mentioned that if a family appears to be trying to evade an investigation by Children Services, the use of the alert system found in s 7.1.2.1 of the *Act* is available so that any other province to which the family moves is notified and advised of concerns about the children or child needing protection.

[120] She testified the Alberta Children Services was never contacted in 2009 about the Radita family. It appears that had the School of Hope called Children Services, the British Columbia history would have been discovered and the knowledge that Alex was at risk would have been apparent. In particular, the fact that a doctor's office had recently called the BC Ministry with concern about whether Alex was receiving sufficient insulin would have been made known.

[121] From the evidence at the Inquiry there is reluctance on the part of schools to report issues relating to non-attendance to the Director or to police. Ms. St. Amand was in the courtroom when Joy Malloch from the Department of Education testified her belief that non-attendance at school being reported by a school official to Children Services would only result in them saying it's not part of their mandate. Ms. St. Amand testified she was surprised by this testimony and in fact her office would not take such a position. She testified Children Services would inquire to try and understand the reasons for non-attendance and whether further supports could be provided to the family.

[122] Ms. St. Amand also made reference to sec 2(3) of the *Child Youth and Family Enhancement Act* which defines emotional injury of a child as including deprivation of cognitive stimulation. Cognitive stimulation would include school, so Children Services legislation is broad enough for a school to report the extended absence of the Radita or any other children from school.

[123] Children Services' obligation is to assess calls from schools even if they concern truancy. She agreed a wellness check would be part of the Children Services procedure in such a case. She testified that if Children Services had been contacted by a school saying there are children in elementary school who haven't been seen all year, and that parents are overwhelmed or not cooperating with the school attempts to contact them (factors within the knowledge of the School of Hope in Alberta), someone would have seen the child within days, not weeks or months both now and in 2009 given the urgency of the information.

[124] She testified that in 2009 and at present, if a school calls Children Services stating a child who is studying remotely is not providing any work to the school, and the parents are expressing they are overwhelmed, her office would gather information about the family and take the report seriously. They would determine the age of the child at the outset and if more than one, all of their ages. If there were four children not receiving work and the family expressed being overwhelmed according to the school contacting Children Services (as was the information in the Radita case), the information that the family had moved from BC would have resulted in BC Children Services being contacted to determine if there was a history with the family.

[125] When Ms. St. Amand worked in the field as an investigator, she often received calls from schools. She acknowledged that some families would be offended if the school called Children Services and that schools want to maintain positive relationships with the families of their students. She acknowledged there is hesitancy to call Children Services and even a stigma associated with reporting to Children Services. Professionals believe that to do so may hinder relationships with the family and their clients, so doctors, teachers and community members are reluctant to call. Referral sources are kept confidential by the department for this reason. People also want to ensure that they are reporting for the right reasons; that is, that what they are seeing amounts to the reasonable and probable grounds that the child may need protection under the law.

[126] She stated the following:

> *"We're about safety networks. We're about supports, but first and foremost we're always about child protection. A child always has to come first to ensure that their safety and well-being is met, but however we can do that and keep a family together to provide the right supports and services and help them connect with supports and networks and resources – that's our goal."*

[127] When asked about current practices respecting schools and school authorities in order to educate them of what Children Services can do, she again mentioned that relationship building with school boards is ongoing as well as with other partners in the communities such as policing services and recreational centers. She agreed better collaboration between stakeholders including police, social services, school boards and the Department of Education is desirable. Ensuring wellness checks being completed would be an improvement. She agreed that with the increased online and home-schooling emphasis, there is a greater need for someone to actually see the children.

[128] When Children Services assess vulnerable children, one of the questions asked immediately is who has seen the child, and in this new era of remote learning it is more important than in the past to ensure someone has actually seen the child or has laid eyes upon the child. She agreed with a need for more of a collaborative protocol between various stakeholders given the fact there is more emphasis on remote learning in recent days.

[129] Since 2001 there has been a Provincial/Territorial Protocol agreement which governs situations where children move from one province to another. Ms. St. Armand testified that even if the file in BC was closed, she would expect that when a doctor expresses concern about a child receiving a life-saving measure such as insulin and prescriptions are not being filled appropriately, Children Services in BC would check to locate the child. If BC discovered the child moved to Alberta and had an address in Calgary, Ms. St. Amand would expect BC to advise Alberta of the doctor's concerns and to provide Alberta Children Services with the address and information. It was her testimony that the BC information concerning Alex was such that the matter would be considered urgent. She emphasized the duty to report that the BC worker receiving a doctor's call would have, notwithstanding BC not having an open file.

[130] Ms. St. Armand mentioned that the directors of Children's Welfare across Canada meet monthly to go over inquiries and to share initiatives to improve Children Services throughout the country. The Provincial/Territorial Protocol is discussed at these meetings and every province in Canada is a signatory. The agreement is reviewed every five years. However, as mentioned by the BC Ministry evidence at this Inquiry is a current subject of discussion and could lead to changes outside of the five-year timeframe.

[131] Had Children Services been contacted about non-attendance they would have investigated to see what was going on in the family to explain the lack of schooling , not only because cognitive stimulation is included as part of emotional injury of a child and is a reason the child may require protection under the legislation, but the lack of school attendance has been identified on multiple occasions by the courts as one of the parenting issues giving rise to Child and Family Services seeking to remove children from their parents' guardianship. Often these cases involve long periods of time where the Ministry has unsuccessfully attempted to work with parents to address such issues. Lack of school attendance can be expected to often be accompanied by other serious parental issues leaving children at risk. For example, in ***R v NM(Re)***, 2019 ABPC 76, lack of school attendance and lack of parents meeting with school officials

and signing the necessary forms permitting their children to receive remedial help from the school, was a major issue as to why the children in that case were apprehended. Not surprisingly there was serious parental neglect on a variety of fronts in that case, which accompanied the lack of school attendance issue, and characterized chaos in the home. Issues concerning the lack of routines for bedtime, meals or school times were accompanied by a lack of limitation on the time children use TV or electronics. There was also domestic violence in the home. In that case a permanent guardianship was granted to the Director. My review disclosed several such cases demonstrating that the lack of attendance at school is a major parenting issue which requires investigation. This case is but one example demonstrating that the lack of attendance at school is a major parenting issue which requires investigation.

[132] Ms. St. Armand repeatedly emphasized the duty to report by any person or professional agency, including any worker who receives a report within Children and Family Services itself. If there are reasonable and probable grounds to believe a child is in need of intervention, there is a statutory duty on every individual to report. Ms. St. Amand commented that it's not the job of the person doing the reporting to assess whether there is maltreatment. It is the job of Children Services to determine this. She testified that the department tries to build relationships so that there is confidence Children Services is about keeping families united and helping them access resources. There is a strong obligation on the Department of Children Services to provide such resources when needed. She stated the focus of Children Services has evolved over the years such that Children Services are now "about family unification."

[133] There are timelines in the Children Services legislation which bear mentioning. When a report is received, there is a 14-day time period within which the initial intake must be completed and other time limits are set out for an assessment. These would require Children Services to see the child within a reasonable time. She thought the urgent nature of the information in the Radita case would likely have been such that someone would have seen Alex within a week.

RECOMMENDATIONS RELATING TO CHILD AND FAMILY SERVICES

1. It is recommended that screening processes within both the Ministry of Child and Family Services in British Columbia as well as Alberta be reviewed and strengthened to ensure that a thorough review of prior dealings between families and Child Services is carried out, specifically including the severity of parenting issues historically dealt with along with the urgency and significance of the person making the child protection report. The ongoing risk to the child evidenced by the history and significance of the person making the report should be carefully considered notwithstanding that the Child Protection Services file has been closed for some time.

   In the Radita case Alex was near death repeatedly when hospitalized as a result of his parents' resistance to provide the necessary insulin he needed to survive, but his file had been closed for some time due only to the fact that Dr. Metzger was monitoring Alex's parents provision of insulin to Alex on an ongoing basis. It is highly likely that without Dr. Metzger's monitoring during the timeframe after the BC Ministry's file was closed, there would have been ongoing involvement by the BC Ministry.

   The report which was insufficiently screened in Alex's case came from a doctor's office, a professional who had treated Alex throughout his life and knew his monitoring of Alex's condition was historically required to ensure his parents provided the insulin he needed. The doctor knew of prior reductions in insulin made by the parents without medical approval and also knew that at the time the report was made to the BC Ministry, Alex was likely receiving insufficient insulin. The fact that a professional expressed concerns should have weighed heavily in favor of an alert being issued to Alberta by the BC Ministry. I have included the Alberta Ministry of Child Services in this recommendation because the issues raised by inadequate screening of historical cases within any Ministry are possible given the volume of reports such Ministries receive, and the recommendations arising from the Radita case would benefit both the Alberta Ministry as well as the BC Ministry.

2. It is further recommended that regular auditing of the screening processes be carried out along with ongoing staff training to ensure the thorough review recommended takes place, in light

of the heavy caseloads of reports received by the BC and Alberta Ministries. It is notable that when Dr. Metzger contacted the BC Ministry in 2009, the report was actually reviewed by a supervisor who determined to take no action.

3. It is recommended that the provisions of the Provincial/Territorial Protocol be amended to address the situation where a child having a history with a Ministry moves to another jurisdiction after the Ministry's file has been closed. It is recommended that specific authorization be included in the Protocol for an originating province to alert a receiving province if a child who is the subject of concluded dealings with the Ministry may nevertheless be in need of protection which may include medical treatment necessary for their health or survival. From the evidence before the Inquiry, it appears the existing provisions of the Provincial/Territorial Protocol emphasize ongoing investigations which are current and have open Ministry files. Ministry files which are closed, like the Radita files, are not given the same emphasis, regardless of how serious the family history has been.

In the case of Alexandru Radita, the file had been closed a few years earlier because of the oversight of Dr. Metzger's office, who saw the family on a regular basis and monitored the parents carrying out the insulin protocol Alex required. The family was well aware that if they failed to meet with Dr. Metzger, he would once again report them to the BC Ministry, which he did when they failed to appear for their regular appointments in 2008 and 2009. The existing Provincial/Territorial Protocol Agreement in force at the time was generally sufficient to authorize the BC Ministry to issue an alert to the Alberta Ministry in the Radita case, since there was a catch-all provision under section 7.2.1(g) of the Protocol authorizing an alert "for a variety of reasons." However, specific authorization to issue an alert when a child may be in need of medical treatment, whether or not an open file exists, may have provided specific guidance to screening staff to issue the alert at the time Dr. Metzger's report was received. Reference to the need of medical treatment may have naturally directed Ministry staff to examine the history of the Radita family despite the file being closed for some time.

4. It is recommended that the current consultations within the BC Ministry dealing with the expansion of the issuance of alerts to other jurisdictions when families have moved and their whereabouts are unknown be pursued in circumstances where a child may be in need of protection. It is further recommended that consideration be given to the issuance of alerts being placed upon provincial and where necessary, inter-provincial, federal and other information systems connected to child welfare. It is recommended that part of this consultation ensure that such alerts are not dependent upon an open investigation within the Ministry and that the severity of prior dealings between the family who have moved and the Ministry itself be thoroughly considered.

5. It is recommended that the Child Welfare authorities in both Alberta and British Columbia as well as other jurisdictions consider the examination of a general alert system whereby a high-risk child who may need protection is noted on available data systems of other stakeholders in child health and well-being including educational and pharmaceutical authorities in order to prevent isolation of such children and ensure availability of state intervention when needed, as often as needed. Consideration of such a general system of alerts in the case of particular children necessarily involves legislative changes authorizing both the collection and dissemination of personal data in view of existing privacy restrictions as well as consideration of existing databases in stakeholder agencies.

I am mindful this is an ambitious idea, but in my view it nevertheless deserves careful examination and collaborative discussion between the agencies dealt with in my report. Such collaborative discussions can only enhance child protection since it is not only Child Protection Services who are involved in the well-being and protection of children. These agencies are all child serving communities in their own right. Collaborative relationships between all stakeholders is needed to prevent the siloed effect of information in the hands of only one stakeholder which contributed to the tragedy of Alexandru Radita's death.

I have also carefully questioned whether the extreme circumstances of the Radita case merit more state oversight or

intervention, not only within child protection agencies, but also within agencies whose mandates are not directly focused on child protection. Educational authorities have the primary mandate of educating children and health authorities have the primary mandate of health services, not all of which involve child protection. I have concluded that the concept of a general alert involving high-risk children is worth examining collaboratively between the agencies I have mentioned, primarily because it may very well have saved Alex's life and prevent similar deaths in future.

The Inquiry provided a clear example of the lethal effect of crucial information being in the hands of only one stakeholder concerning children's protection and that crucial information inadvertently not being shared with other stakeholders. The lengthy suffering and death of Alexandru Radita who was not registered in school for four years prior to his death and who received irregular and insufficient amounts of insulin from pharmaceutical companies throughout that timeframe without physicians' oversight strongly suggests the examination of an alert system relating to high-risk children being available to school and pharmaceutical authorities. Such an alert system could properly only be initiated by Child Protection authorities.

Since the Alberta Child Protection authorities were not notified that the Raditas had moved to Alberta, it was not possible for them to take the necessary steps to protect Alexandru. Had a general alert system initiated by Children Services Ministries been in place, Alberta school authorities and pharmaceutical authorities who dealt with Alex for a number of years prior to his death would have been notified of the potential risk faced by Alex, justifying and prompting a report to Children and Family Services in Alberta, which may have saved Alex's life. From a professional standpoint, in the absence of an alert from Child Protection Services, it may be considered improper for stakeholder professionals to take what may seem the draconian step of involving either police or Child Protection Services since their information about the possibility of a child being at risk would be limited.

6. It is recommended that the BC and Alberta Ministries institute a program to expand existing collaborative relationships with other stakeholders involved in the well-being of children. These stakeholders include local school authorities, health services, police services and pharmaceutical services. From the evidence before the Inquiry local educational authorities specifically local schools, would not generally consider contacting the Alberta Ministry or police requesting a wellness check in circumstances where a child is absent from school for an extended period of time, even though often school absences are accompanied by serious parenting issues placing children at risk.

The development of ongoing collaborative relationships between the Ministries of Children Services and other stakeholders could reduce or remove the resistance of other stakeholders to take actions involving either police or Children's Protective Services and place such stakeholders in a position where there may be more information available to them prompting wellness checks to ensure the children are not at risk. Ongoing collaborative relationships between all stakeholders who form child serving communities is particularly important given the increasing remote learning programs, where seeing children face-to-face will be less likely than in the past.

The Alberta Ministry testified their current purpose is to keep families united and provide support where needed. It is only through collaborative relationships on an ongoing basis, at the local level, that this message can be properly communicated to the agencies dealing with children on a day-to-day basis.

It is recommended that local police services be a part of the collaborative relationships, specifically with respect to their ability to conduct wellness checks in circumstances which may or may not lead to further involvement with the Ministry of Child Services.

EVIDENCE OF CALGARY POLICE SERVICES

[134] Sergeant Warren of the Calgary Police Services gave evidence regarding the use of wellness checks by police in order to check upon children who may need intervention services.

[135] She testified that wellness checks are commonly done by Calgary Police Services when a request by a third-party having concerns about another person, including children, is received by the police. Such requests can vary greatly and it was her evidence that no such call is rejected. It was her evidence that if a school contacted the police concerning non-attendance at school after having tried to contact the family about the problem and having not seen the child for a particular period of time, police would do a door-to-door knock to check on the child or children. However, she also testified the school, if they had concerns about the well-being of the children, should be trying to contact Children Services as well. She said that if a school called police, however, they would not wait for Children Services to be involved before doing a wellness check on the child or children involved.

[136] Sgt. Warren described the process involved in wellness checks. Third parties such as schools, neighbours or other professionals, can call CPS Dispatch who then asks a number of questions before sending the request to their automated computer system called CAD. This automated system would provide officers with information concerning who made the call, its nature, and the concerns expressed. The computer automated system is in a police car itself, so that a specific car would be receiving the request for a wellness check and dispatch would determine which car would be available to carry out this duty.

[137] Police may also call Children Services or Social Services if an adult is involved, but the police response does not depend upon their involvement. However, Social Services may well know more about the situation than the police, such as in circumstances where the family had been dealt with on a prior occasion by their Ministry. Also, the question of safety concerns for officers will be explored by the CPS Dispatch. Sgt. Warren gave as an example the subject of a domestic dispute and how the safety level of the call might change if that were the nature of the case.

[138] Upon conducting a wellness check, Calgary Police Services would contact other services if needed, such as EMS if a medical distress was noted. In the Radita case, depending upon the stage of deterioration of Alex's health, a wellness check may well have resulted in police observing the need for medical evaluation and treatment. It is not clear how badly Alex's health had deteriorated by August 2010, when he was withdrawn from school, but since the records

indicate he had been receiving insufficient insulin when he left BC in 2008, it may be that by the school year 2009-2010 when Alex was not providing any work to the school, a wellness check might have resulted in an intervention. Police are required to contact the Director under sec 4(1.2) of the *Act*. Had the Director been contacted, the fact that Alex had come from British Columbia would've prompted Alberta Children Services to contact British Columbia. Had this occurred, of course, the Radita history of resistance to providing insulin to their son and the life-threatening consequences which had taken place in the past when Alex was taken to hospital in British Columbia, would've undoubtedly caused an investigation and intervention by Alberta Children Services. Alex was isolated from the very agencies which could have prevented his death and a lack of a wellness check or any contact with the Children's Protection Services or police facilitated this isolation.

[139] Entered as an exhibit in the Inquiry is the CPS *Child Youth and Family Enhancement Act* Policy document. It begins with a statement of principles stating CPS is committed to the protection of children and is responsible to work with Children and Family Services to ensure the safety and well-being of children. It defines intervention as "actions taken where a child's survival, security and development are not being adequately provided by the guardian." The policy also deals with emergency apprehensions of children if their life or health is seriously and imminently endangered in circumstances which include the child being physically injured. Depending upon when a wellness check was done on Alex, it may well have been noticed that his health was seriously and imminently endangered. The trial evidence is that Alex received too little insulin for a long time prior to his death and the deterioration in his health was clearly noticeable for a considerable period of time prior to his death in May 2013.

RECOMMENDATIONS RELATING TO CALGARY POLICE SERVICE

1. The Calgary Police Service are to be commended on the policy they have created and its principles committed to the protection of children and its ongoing relationship with Children and Family Services to ensure the safety and well-being of children. It is recommended that the Calgary Police Service continue to recognize its status as a major stakeholder in the protection of children and to participate in any collaborative efforts with other child serving communities which may come about as a result of the recommendations arising from this Inquiry.

EVIDENCE OF EDUCATIONAL AUTHORITIES IN ALBERTA

Evidence of the School of Hope

[140] After the Radita family moved to Alberta, there were four of their children, including Alex, who were enrolled in the School of Hope in 2009. The School of Hope is part of the South-Central Alberta Catholic School Board. Mr. Despins the Vice-Principal of the School of Hope, testified at the Inquiry. He has a Bachelor of Education and a Master's Degree in Education. He testified that the School of Hope offers both home-schooling and online learning to students residing in various parts of the province of Alberta. He testified that online learning students have their lessons recorded daily and regular follow-up with teachers and interaction including workshops and activities weekly. There are different centers of the school throughout the province.

[141] With respect to the Raditas there was a home visit in October of 2009 and 25 phone attempts were made to reach the family, some of which were successful but no work had been received from any of the four students in the Radita family that were enrolled in the School of Hope program. At the end of June 2010 the school simply wrote the Raditas a letter telling them the children were withdrawn from school since no work had been received from them.

[142] Mr. Despins said that today, there would be a five-step pyramid process followed which did not exist in 2009. Teachers would begin by phoning the home in the first week. In the second week step 2 would be further attempts by the teacher to reach the parents as well as a reference to the administration of the school to follow-up. During week 3, the Vice-Principal would attempt to contact the parents by email and telephone, in an effort to get schoolwork completed by the students and also to let the parents know the school was there to help. Step four in the pyramid would be a letter and e-mail from the principal of the school stating how concerned they were and that within a week, if there was no response, the mater would be referred to the Office of School Attendance and Re-engagement at the Department of Education. He says he has made this type of referral three to four times in five years. Normally he said a hearing would be held by the Office of Attendance and Re-engagement and in his view there has been mixed success. Sometimes the matter would then be referred to the Attendance Review Board which has more authority to implement consequences and which could issue direct orders to parents stating the work had to be completed or done within a certain date.

[143] Mr. Despins was unaware that such an alert is in fact in existence, according to the Department of Education witnesses. His lack of awareness raises a concern about the effectiveness or lack of effectiveness of the current alert system. Mr. Despins stated that this whole process takes a few months to organize and that in his experience parents could just move to a different school and the whole process would begin again, so that its effectiveness is not a given. In his view, there should be an alert that children had not registered somewhere else if they withdrew from his school, and he testified he would telephone Social Services if such an alert existed and children leaving the School of Hope had not attended another school. Mr. Despins stated that decentralized registration of student information, being a provincial database, known as PASI, has been developed and could be utilized to include such an alert in the event a child was no longer registered in school.

[144] Of note is that Alex Radita was not registered in school between the time he left the School of Hope in June 2010 and the date of his death in May 2013. No one knew he was not attending school. Including the 2009 to 2010 school year, Alex was not receiving an education for 4 years prior to his death.

[145] Mr. Despins recommended that there should be a protocol about what should be done should such an alert system be established in terms of either involving the parents or Social Services. He also recommended that a wellness check or house-check could be done remotely to at least see the student, periodically.

Evidence of the East Central Catholic School Board

[146] Glenn Nowosad is the Superintendent of the East Central Catholic School Board and testified there have been substantial changes with respect to oversight and work submission since 2009. He testified that an audit was done by the Department of Education with respect to the School of Hope to help the school address non-attendance and other oversight issues and that as a result of that audit, in recent years there has been more of a structured oversight of assistance to the school. He also testified that in addition to Wainwright, Vermillion, Sherwood Park and Lethbridge, there are schools in Provost, Castor and Stettler. He also testified that the East Central Catholic School Board has schools in Winglight, Vermillion, Sherwood Park, Lethbridge, Provost, Castor, and Stettler.

[147] Mr. Nowosad agreed with Mr. Despins that an alert system should be in existence if no school is noted to pick-up a child who has withdrawn. Notably, as already mentioned, there is other evidence in the Inquiry that this kind of system currently does exist, but neither Mr. Despins nor Mr. Nowosad were aware of this change. Mr. Nowosad believed that PASI could be used to track attendance much more effectively but is not currently used for this purpose. He testified that the School Board loses access to student information once a child has withdrawn from a particular School Board's school, unless the child enrolls in a new school. He also testified that various school boards have different databases and the consistency in the information provided to the PASI system is lacking. Such consistency would be a desirable improvement. He testified that the Office of School Attendance and Re-Engagement at the Department of Education can make recommendations to the school board, and that the Attendance Board is the more consequential level. In the event time is of the essence, the time it takes for this entire process is not satisfactory.

[148] He testified that it is difficult to get teachers in rural areas so that the remote learning, whether it be home-schooling or online schooling with supervision, are desirable and very useful in a number of these smaller rural areas. The ability for him to send staff to do home visits is a serious problem given the distance involved and the expense. He said currently the Board only receives 800 dollars per student per year and he would have safety concerns for his staff, not only financial ones, since they would be going to rural areas in weather that is sometimes inclement and to homes that they know nothing about.

[149] Of importance is that the evidence of the School of Hope is similar to other evidence concerning the use of the decentralized provincial database of student information. Other evidence in the Inquiry is that the reliability of this system effectively monitoring students to ensure they are enrolled in school is questionable.

Department of Education

Evidence of Christine Bouchard

[150] Christine Bouchard is the Field Services Manager and responds to inquiries about policy and legislation. She has the home education portfolio and has taught for 13 years in Edmonton. She stated that the parents have two options. They can have a supervised program where a school board or private school would monitor and provide programming, which is the most common option chosen by parents. The second option is that parents can sign a formal notification to the

Minister permitting parents to educate their children without any school authority or oversight procedure regarding the programming that the child takes as part of their education. In 2009 there was only supervised programming.

[151] Where home school involves a supervised program, the school authority has certified teachers, support for the family, program planning, two evaluations, and they assess the students' progress on an ongoing basis. The school authority enters this information into the PASI system if the school is responsible for the online learning.

[152] If the parents are responsible in an unsupervised home-schooling model, there is no evaluation or oversight. There is no daily interaction or evaluation of the student's progress or even any established curriculum the parents must follow.

[153] In the unsupervised home-schooling model, there is a Notification document parents must sign before enrolling their child in the unsupervised program. The notification authorizes and requires the parents to take responsibility for the home education of their children and permits them to choose either the Alberta curriculum or schedule learning outcomes in any other way. There are very general established outcomes that are expected in this scenario. At one point Ms. Bouchard stated that the children in the unsupervised category are not allowed to take the Grade Three Assessment, Grade Six Provincial Exam and so on because it is an unsupervised choice of education. The unsupervised program may not get high school graduation credits. It is only if the child goes back into the supervised school system in some way that they can be assessed even as to what grade they belong in. Parents can opt out entirely if they want to and choose an unsupervised way of learning if they sign the Notification.

[154] This unsupervised option of education, had it been available in 2009, would have allowed the Raditas to isolate Alex even more readily than they did. The Notification system came about in 2019 under the *Choice of Education Act*. Parents can choose public, separate, charter, private, private ECE, or home education whether it be supervised or non-supervised. There is no recognition of progress in the non-supervised form of home education. Some higher learning institutions will accept the portfolio of work from the unsupervised options, but there is no oversight at all and the provincial examination process is not available to these students.

[155] Under the PASI home schooling system, there is supervision where the school authority is entered upon registration. Outcomes are expected by parents.

Evidence of evaluation by the school is noted in PASI and parents have access to funding supports. In non-supervised home schooling, there is a team that enters the information parents provide when they sign the Notification and a residence board that determines from the Notification form filed by the parents which school division the child resides in.

[156] The unsupervised Notification for home schooling must be filed every year and cannot be registered somewhere else during the same year, presumably including in the public system or the supervised system. There is a provision in the *Act* for a Director to investigate when he believes a child is not receiving an education, but the witness testified it had never been used effectively or at all.

[157] Alex was registered in a supervised home-schooling program in 2009. As mentioned, he went a full year without any work being done in that program and for the next three years after he was withdrawn from the School of Hope, he was not attending school at all. Today, the Calgary Board of Education (the Board where Alex resided) would receive an automatic alert when Alex withdrew from the School of Hope and failed to register in another school. This alert process is expected to occur as part of the provincial educational data system in place in the province of Alberta, known as PASI. This automatic alert would also take place if a child is registered in two different school programs.

[158] It is intended that once the alert is in place, the prior board will see the alert, which would be the School of Hope in Alex's case, and would be able to follow up with the parents to determine what was happening. In addition, it is intended that the resident board, which would be the Calgary Board of Education in Alex's case, can pull up the list of children with this alert in the PASI system and can follow up as well with the parents to ascertain what is happening to that child. This process did not exist in 2009 and neither did the alert system. It is not clear whether there is consistent monitoring by the resident board of the list of children on the alert list, and from the evidence of the School of Hope it appears that not all school boards are aware of the need to follow up with parents, since awareness of the alert system itself is lacking.

[159] In addition, it appears from the evidence that there is inconsistency between various school boards as to what data is entered into the PASI system, and when such data is entered. In order for the alert system to be effective, the school board from which the child is withdrawn must keep the child registered beyond June of the year of withdrawal. This is done by many boards, but not all. Hence the evidence before the Inquiry is such that a child could still fall between the cracks as Alex did, even today. In the result, the child may not be receiving

an education for an extended period of time. The effectiveness of the existing alert system notifying that a child has withdrawn from school and not registered with another school board, is questionable.

[160] There are constant improvements being made to PASI. There are meetings every three months between the stakeholders and regular communications in efforts to improve the system of data collection and follow up on students' attendance in school.

[161] Standardized tests in Alberta include a student learning assessment in Grade Three, Grade Six Provincial Achievement Test, and Grade Nine Provincial Achievement Test, along with high school diploma exams. Since Alex was not attending school, he would not have had the benefit of the assessment of his learning. These exams are all only available to students that are in supervised programs, such as the program Alex was in at the School of Hope. As mentioned, unsupervised students whose parents have signed the Notification cannot participate in these assessments or testings. Parents cannot administer the assessments in the unsupervised programs because they are not attached to any particular school where these assessments and tests can be run.

[162] Notably Mr. Nowosad, the Superintendent of the Central Alberta Catholic School Board of which the School of Hope is a part, said there were problems for him in even getting space in the resident school areas for his students who need to take these exams.

[163] The Calgary Board of Education relies on the boards themselves to utilize the PASI information. However, under the notification system, the unsupervised home-schooling model, parents can totally take their kids off the grid. There are no tests, no oversight and no recognition of any achievements on the part of the students under the unsupervised home-schooling model. There is currently a dearth of data with respect to both supervised and unsupervised home-schooling programs.

Evidence of Joy Malloch

[164] Ms. Malloch oversees the Office of Student Attendance and Re-engagement (OSAR), which includes the Attendance Board. She has a history with Child Services including disabilities. She testified the Office of Student

Attendance and Re-engagement did not exist in 2009 when Alex came to Alberta, but the Attendance Board did.

[165] In 2015 the government required the review of all boards, commissions and agencies. The Attendance Board was one of these and as a result of that review, the practices were found not to meet the needs. In 2017 after Alex's death, OSAR was created to support school administrations. This office is available to any school or authority requiring the assistance primarily with respect to the issue of student attendance. If issues relating to attendance are not resolved at the OSAR level the local board requiring assistance may refer the matter further and the *Education Act*, in s 49.1, sets out the authority of the Attendance Board, which can carry out a hearing designed to ensure non-attendance at school issues are resolved. It takes 3 weeks to a month to arrange an attendance board hearing. However, if parents cannot be notified or do not attend, the hearing cannot proceed.

[166] There are two routes toward an Attendance Board hearing. The first is through a portal where designated school authority staff can make a direct referral of a case to the Attendance Board. Those direct portal referrals, after daily review, can result in the matter going forward to book an Attendance Board hearing quickly.

[167] The second way is though the Office of Student Engagement and Re-Engagement (OSAR) staff which carries out consultations and has re-engagement specialists to resolve the non-attendance issue without going to the next step of an Attendance Board hearing. The hearing itself can take between 6 – 10 weeks depending upon when the referral for a hearing is completed.

[168] The Department of Education is cognizant of local school autonomy and attendance counselors in large boards like the Calgary Board of Education may be in place or principals may be given the task of monitoring attendance of students. Sometimes these authorities, whether it be the counselor or the principal, reach out to OSAR. There are many reasons for non-attendance rather than just defiance, such as trauma, housing, poverty or health issues.

[169] She testified that the services of OSAR are in the annual Guide to Education provided by Alberta Education to school authorities, which is the primary document utilized by school boards to relate to the Department of Education itself. This document provides guidelines respecting numerous day-to-day issues arising in the operation of schools. Ms. Malloch testified that if a school had reported the Radita situation, she would provide guidance concerning

wellness checks at the same time as getting the matter on the Attendance Board hearing stage.

[170] When Ms. Malloch testified the first time, she stated that if Social Services were contacted by a school authority reporting a non-attendance issue, Social Services would say it's not under their mandate. As mentioned earlier, there was significantly different evidence before the Inquiry from this point from Ms. St. Amand, from the Department of Children Services who disagreed with this assessment.

[171] In her initial testimony, Ms. Malloch did agree, however, that some collaborative protocol with respect to non-attendance between OSAR, school boards and Social Services would be useful.

[172] She testified that it would be outside the role of the Department of Education to consider contacting Social Services, primarily because the school authority is autonomous and has that responsibility, whether it is a private, independent, charter, public or Francophone board. Her department would provide advice if contacted by the local boards or schools on the subject of wellness checks by Social Services or police.

[173] It was her testimony that consultations leading to or involving Attendance Board hearings would include questions about whether a child has actually been seen and would include recommendations from department personnel. However, it is up to the school or school board making the referral to decide whether or not to carry out any recommendations made by the department prior to the Attendance Board hearing.

[174] Ms. Malloch also underlined that the *Child Welfare Act* reporting is the responsibility of the school authority, not the Department of Education staff.

[175] It was also her evidence that she has heard numerous times that when a school authority has contacted Children Services about non-attendance issues, Children Services do not feel there is enough information for them to take action. She does not think it is a typical practice by her department or school authorities to ask Children Services to conduct wellness checks, because lack of attendance at school is not, by itself, considered an indicator that the child may be at risk.

[176] In her view, the school often does not have enough information. She gave the example of a child attending for two days and then not returning. The school doesn't have much information. She testified she encourages them to try

to make a connection and see the child using whatever resources they have, whether they are permitted to go out with a resource officer, principal or social worker and see the child.

[177] The primary rule of OSAR and the Attendance Board are to deal with absenteeism, not emergency situations having to do with a child's welfare. However, if, during the non-attendance referral process her department became aware of the online school situation of the Radita family where four children had not done any work and the school authority had not seen the children for some time, Department of Education staff would be asking several questions including the suggestion of a wellness check if the school had resources to implement this. Once someone had seen the children and they seemed healthy, it would be then that the matter could proceed to the Attendance Board hearing and potentially a King's Bench application.

[178] Ms. Malloch testified her department often does presentations and communications with school authorities in field services.

[179] With respect to the Court of King's Bench application, she testified that typically a matter would have to be in front of the Attendance Board a few times, meaning more than once, which emphasizes her earlier point that non-attendance procedures in the *Education Act* are not primarily designed for emergency situations like that of the Raditas. The Inquiry notes, however, that in the course of such non-attendance issues and consultations with the Department of Education, a wellness check may have incidentally been seen as necessary.

[180] She testified that the department and school boards are all running hard to catch up with the choices of education and technology that has evolved in the last few years. The gaps that are ever increasing are known and efforts are being made to close these gaps between the school boards the department and the resources that are available.

[181] Ms. Malloch agreed that wellness checks after 1 month of attended school absence might not be an unreasonable objective. Sometimes there is an informal arrangement between small boards and even the police who might do the wellness checks. Some principals work directly with the RCMP for these purposes. The witness testified that school boards should have wellness collaboration in place if a child is not attending school.

[182] What the Attendance Board can do to get kids back to school is set out in s 49.1 of the *Education Act*. If they can get a child to the hearing, they could

at least see the child and determine whether a wellness issue is present. So that the purpose of an Attendance Board Hearing, if it only accomplishes seeing the child, is something that may have prevented a similar death to that of Alex Radita.

RECOMMMENDATIONS RELATING TO EDUCATIONAL AUTHORITIES IN THE PROVINCE OF ALBERTA

1. It is recommended that school authorities (including schools, school boards and Department of Education personnel) recognize that extended absence from school is often accompanied by serious parenting issues which may place young children at risk. Accordingly, it is recommended that local school officials consider requesting wellness checks in cases where extended unresolved school absence occurs and if necessary reports to Child Welfare authorities be made to ensure children are not at risk. In particular, if such absence continues for a period of a month, or such shorter period school authorities consider appropriate, it is recommended school authorities consider reporting to either police or Child Protection Services notwithstanding any ongoing school authority efforts to resolve the issue of school absence.

   In the case of Alexandru Radita, the deterioration in his physical health would have been obvious for an extended period of time prior to his death given that he only weighed 37 lbs. at death, had little flesh left on his body and appeared mummified. To some degree it would likely have been obvious in 2010 when he was still registered with the School of Hope, since by then he was receiving insufficient insulin. Had police been asked to conduct a wellness check when he was not providing work during the one school term when he was registered in an online school in Alberta, or during the subsequent years prior to his death, his need for medical attention or intervention by Child Protection Services would likely had come to light and initiated a process which may have saved his life.

   The subject of wellness checks was explored in some depth by the Inquiry. The evidence of school authorities is such that existing procedures dealing with student absence are lengthy and depend upon the cooperation of parents. In the

Radita case the family had fled British Columbia and were resistant to following directions from the authorities including failing to ensure their children participated in online schooling for the 2009-2010 schoolyear. They also failed to respond productively to some 25 school attempts to resolve the non-attendance issues of their children and the school was told Mrs. Radita was overwhelmed. The Raditas failed to register Alex in any other school once he was withdrawn from the School of Hope. Therefore, the cooperation of parents in the Radita case was lacking and any dealings with school authorities may not have been successful at any level offered by the Department of Education.

The evidence of the Calgary Police Service is that they have a well-developed policy concerning wellness checks and they are available on a 24/7 basis to carry them out. If schools contact Calgary Police Service with information about school absences and unsuccessful efforts to contact the family or see the child, the Calgary Police Service will physically check on the child's well-being. However, the Calgary Police Service evidence is that the school itself should also contact Child Protection Services if there are concerns about the well-being of children. The recognition by school authorities that extended absences from school are often accompanied by serious parenting issues which place young children at risk is important and may prevent similar deaths in future.

When considering whether to report to the Child Protection agencies, the provisions of section 2(3) of the *Child Family and Youth Enhancement Act* in Alberta should be noted. This legislation defines emotional injury of a child as including deprivation of cognitive stimulation. Emotional injury itself, under section 2(f) of the *Act* is a factor included in the description of a child in need of intervention. Cognitive stimulation would include and indeed require schooling, so Children Services legislation itself may authorize school authorities to report absence of children for an extended period of time, without the matter being resolved in some other way. The Alberta Children Services legislation currently in existence appears broad enough for any school or school authority to report the extended absence of children from school to Children Services.

Many schools are reluctant to contact Child Protection Services or police believing it would damage their relationship with parents and they also believe they have too little information. There is evidence from Alberta Child Protection Services that they would definitely respond to a school authority reporting concern about a child's extended absence from school, and that it is the Child Protection Services who should determine whether a child is at risk, not the person or agency requesting their assistance. Although the Department of Education testified initially that such a call would be met by the response that school absence was beyond the mandate of Child Protective Services, the Alberta Ministry disagreed with this assessment given their experience that extended school absence itself was often an indicator of serious parental issues which placed children at risk. From this differing evidence, the importance of improving ongoing collaborative relationships between local school authorities, local police, and local child services is demonstrated.

2. It is recommended that school authorities create and improve collaborative relationships with local police and local child protective services to reduce or remove reluctance to involve police or child protection services in cases where there is extended absence from school by children. It is further recommended that availability of resource officers be expanded to include small schools and school boards, as well as the large school boards in larger centers, since ongoing relationships tend to remove the stigma attached to requesting the assistance of either police or child services.

The current extensive expansion of online schooling options makes this collaborative approach even more important. Given the lengthy deterioration of Alex's health prior to his death, it was vital that some authority physically saw him and assessed his need for assistance. Such intervention would likely have saved his life.

3. It is recommended that the procedure relating to the entry of student withdrawal information into the provincial educational

data system known as PASI be reviewed to ensure the manner and content of the entry of such information is consistently and effectively monitored to deal with students who have withdrawn from one school and are not registered into another school.

The evidence at the Inquiry is that the school board where a child resides currently automatically receives an alert if a child withdraws from one school and fails to register in another. This alert should result in two safeguards. Firstly, the school from which the child withdrew would be notified and expected to follow up with parents to find out the reasons for the child not attending another school. Secondly, the resident board itself could follow up the alert as well. Since Alex lived in Calgary, in the Radita situation, this procedure would have resulted in the East Central Catholic School Board being notified about Alex not being registered in another school, as would the Calgary Board of Education, since Alex resided in Calgary at the time.

However, from the evidence at the Inquiry it appears there is inconsistent data entry throughout the province as well as inconsistent monitoring of the list of unregistered children by the resident boards. There is inconsistency in both the timing and content of data entry into PASI by various boards as well as inconsistent monitoring of the list of unregistered students listed in the alerts automatically occurring in the resident boards' systems. According to the evidence of Joy Malloch, the alert system works best if the school from which the child is withdrawing keeps the child registered beyond June of the year of withdrawal. Not all school boards follow this procedure.

In addition, witnesses outside the Department of Education were not aware of the alert system being in place and testified such a system would in fact be desirable. From this it appears not all school authorities who are expected to utilize the alert system are aware of its existence and therefore the effectiveness of the system itself is questionable.

4. It is recommended that the Department of Education consider amending the annual Guide to Education provided by the Alberta Education to school authorities to include provision for such authorities to consider wellness checks, when appropriate,

in cases where young students are absent from school for an extended timeframe, or in cases of remote learning, not providing work required by online programs for an extended time period.

5. It is recommended that there be improved communication by the Department of Education with schools and school boards concerning the need for wellness checks when extended attendance from school is an issue. This communication should be broad enough to include not only a superintendent, but attendance officers charged with monitoring attendance. It is recommended that the Office of Student Attendance and Re-Engagement consider recommendations in writing to the various schools and school boards, large and small, that wellness checks in the event of extended non-attendance be considered. The importance of local school authorities initiating wellness checks arises from the fact that ongoing proceedings involving the Office of Student Attendance and Re-Engagement are lengthy and are not designed to deal with potentially emergent situations, where young children may be at risk.

6. It is recommended that the Department of Education of Alberta collaborate with Child and Family Services and other stakeholders in the examination of the general alert system described in recommendation number 5 of the Recommendations Relating to Child and Family Services found in page 36 and 37 of this report.

7. It is recommended that the government of Alberta review the provisions of the Choice of Education Act relating to the Notification System of Unsupervised Educational Programming. The lack of oversight resulting from this choice has the potential to isolate dependent children from the childcare communities mandated to protect the health, welfare, and cognitive development of children. Alexandru Radita was not registered in school for four years prior to his death which significantly contributed to the isolation preventing his need for protection from coming to the attention of the Child Protection Services in Alberta.

EVIDENCE OF PHARMACEUTICAL INDUSTRY

[183] The Inquiry examined what if any role the pharmaceutical industry could play in order to prevent similar deaths and Mr. Greg Eberhart, Registrar of the Alberta College of Pharmacy gave evidence on this subject.

[184] The Alberta College of Pharmacy is established under the *Health Professions Act* for the purpose of regulating the practice of pharmacists, pharmacy technicians, and the operation of licensed pharmacies. Mr. Eberhart has held his current position for 33 years and was a practicing pharmacist for 10 years prior to his appointment as Registrar.

[185] He testified the Alberta Pharmacist Association also exists as an advocacy body for pharmacy in Alberta. However, it is the Alberta College of Pharmacy which established the standards of practice and a code of ethics for individual pharmacists and pharmacist technicians. With respect to regulations of licensed pharmacies, the College also plays a regulatory role under the *Pharmacy and Drug Act.*

[186] The roles of pharmacists and pharmacy technicians were in evidence. The pharmacist technician completes a diploma program of 12 to 18 months duration, and their role is to support pharmacists with duties such as compounding medications, data entry, and collecting patient information to assist pharmacists in assessing patients and making clinically oriented decisions.

[187] There is a body called the National Association of Pharmacy Regulatory Authorities which sets competency standards for pharmacists. These serve as a foundation to build curriculum for education of pharmacists and auditing pharmacy programs for pharmacists and their technicians. Mr. Eberhart testified that once university training has been completed pharmacists are also required to engage in continuing professional development, which is 15 hours annually. Pharmacists also must demonstrate through documentation that they have implemented at least one hour of that learning into their practices. The Practice Improvement Program is currently evolving and being developed to assist pharmacists in whose practices the College has identified deficiencies.

[188] Mr. Eberhart testified that insulin is a schedule 2 drug under the *Pharmacy and Drug Act* regulations. This means it is available without a prescription. It can be accessed both by prescription in which case the pharmacist

has a role in assessing the patient and dispensing the prescription for him. It can also be provided without a prescription in which case the pharmacist is not considered to be dispensing the drug. In that case pharmacists are not required to upload a record of providing the drug onto Netcare, the provincial data system which records health services provided in Alberta. Mr. Eberhart testified that it is likely more pharmacists are not uploading onto Netcare when insulin is provided without a prescription.

[189] There is important evidence which differs from Mr. Eberhart's testimony on this point. Thomas Shadek, the Acting Director for Strategy and Foresight in the Pharmaceuticals and Health Benefits branch of Alberta Health Services gave conflicting evidence on this point. He testified that it is mandatory for pharmacists to enter into NetCare any insulin they provide. He testified insulin is a Schedule 2 drug which lies within the standards of practice for pharmacies and pharmacists issued by the Alberta College of Pharmacy. He testified pharmacists are required to record each transaction where they provide insulin and that this record is then loaded on to the pharmaceutical information network, known as NetCare.

[190] Mr. Shadek testified that Alberta Health is looking at ways to improve record sharing for health information providers within the province and across different jurisdictions. He said there were national efforts underway as well that are in development so that there exists more readily available and shared health information as Canadians move across jurisdictions. There is ongoing collaborative efforts being made between provinces, territories and the federal governments in this regard. Of interest is that Mr. Radita has stated to the Inquiry that there was some insulin purchase in 2016 although pharmacy records indicate otherwise. This may be significant, since Mr. Radita has been saying there was some insulin purchased in 2013 although pharmacy records indicate otherwise.

[191] Mr. Eberhart testified the reason insulin is likely a schedule 2 drug is that it is so critical even without prescription for a patient who needs it that if they forgot their prescription, a pharmacist would assess the patient and if appropriate provide them with the insulin they need.

[192] He also testified that the College's standards are under review and one of the recommendations going forward is that all pharmacists will be required to not only maintain records of providing drugs without a prescription but also to upload their records on to Netcare so that it can be accessed by other healthcare providers. Current regulations require all pharmacists to upload any dispensed drugs, which means those drugs provided pursuant to a prescription. In addition,

current regulations require all licensed pharmacies to have pharmacy information systems in place through connection to the Internet which allows information to be uploaded on to Netcare and also allows information to be retrieved by pharmacists from Netcare. Hence all pharmacists can both record information on Netcare and review it from other pharmacies who dispensed the drug.

[193] According to Mr. Radita, his family could never get a family doctor in Alberta when he came here and when he got insulin for Alex it was with the pharmacist at Safeway, Superstore or Costco. The evidence of long-term provision of insulin by pharmacists was put to Mr. Eberhart and it was his evidence that pharmacists providing medication such as insulin should be doing it collaboratively and there should be communication with a physician. The 3-year time frame when pharmacists themselves appeared to have provided the prescriptions to the Radita family, and then provided the drug, doesn't make sense to him. He testified pharmacists have a responsibility in terms of long-term care not to take on the care of an individual over a long period of time. Their standards are such that long term care is beyond the pharmacist's scope. He testified pharmacists would have an obligation to ask to assess Alex, to see him or get some blood work done. Standards of practice would expect this assessment but if that request was denied, the pharmacist would likely still evaluate the implications of not providing insulin with the result it likely would be provided. The question then arises, as to whether the pharmacist should consider contacting Social Services in the event the pharmacist's request to see the patient is denied.

[194] Mr. Eberhart testified that there is a system of alerts in some cases when a child is at risk. In those cases, there is a specific pharmacy assigned, but this is set up between doctors and care providers, not the pharmacy association.

[195] The Inquiry also heard evidence from Vishal Sharma who graduated from pharmacy in 2003 and from 2005 to 2017 he owned his own pharmacy in Northwest Alberta. He is currently a researcher at the University of Alberta finishing up a PhD in Public Health but he still maintains his pharmacy license. Mr. Sharma testified he has been a diabetes educator for about 7 years and that most of his experience has been with adults with diabetes.

[196] Mr. Sharma confirmed that it was his understanding that the provision of insulin is recorded into NetCare and he used the term "dispenses insulin," when he stated the transaction would be uploaded into NetCare by the pharmacist. It was his evidence that today insulin is tracked on NetCare with or without a prescription.

[197] It was his testimony that the role of the pharmacist in dealing with the person requesting insulin is to follow the framework from the standards of practice laid out by the Alberta College of Pharmacy. This would typically involve doing an assessment and documenting that assessment within the pharmacy system. It was his evidence the standard of practice is quite rigid and the College of Pharmacy monitors and enforces those standards practiced.

[198] The evidence before the Inquiry is that there was no such assessment done or requested in Alex's case, notwithstanding an irregular pattern of insulin provided by pharmacists (both with respect to timing and dosage) without oversight of a physician for an extended period of time.

[199] Mr. Sharma testified it was a reasonable notion for there to be some sort of alert with regard to high-risk patients available to pharmacists, but he acknowledged there would be data sharing difficulties within the province. Mr. Shadek mentioned that NetCare is maintained by Alberta Health as a repository for health professionals to access information about patients to assist with their treatment. It is not accessed by government officials to look at individuals' health records. Mr. Sharma agreed that alerts relating to high-risk patients being incorporated into NetCare would definitely help in their treatment, given the high loads of primary care workers of all kinds, which would include pharmacists and other primary caregivers. He also mentioned it might even have to be limited to NetCare. Alberta Health could set up a different platform of its own. However, he acknowledged the legislative barriers and the need to balance privacy issues with the risk to patients. He mentioned one agency within Alberta maintains a registry of this kind but primarily for research purposes not public health surveillance.

[200] Mr. Sharma testified that there is no training or current protocols from the College of Pharmacists identifying instances where a child might be the subject of medical neglect or is not receiving proper care. He stated he has received no training recognizing vulnerable patients in distress and that most pharmacists don't have that kid of training, with the exception of some specialized pharmacies which may exist. He testified that a recommendation concerning an education piece to provide training and resources to pharmacists to identify patients in distress might be worthwhile.

[201] Mr. Sharma did not think it would be unreasonable for the Inquiry to recommend that pharmacists be required to not only check to see whether insulin is appropriate for the patient by checking NetCare, but also to check the pattern of insulin prescription and if the pattern is irregular, take whatever steps they deem

necessary including calling Social Services if they are unable to complete a detailed assessment and to record the same. He implied that the Alberta College of Pharmacy could be notified and that they are trained to do those investigations and follow up with those matters. He also confirmed that if there was an issue with regard to standards of practice not being followed, the Alberta College of Pharmacy jurisdiction exists to oversee the situation and that the college takes that role very seriously.

[202] It is his view that the Alberta College of Pharmacy does a good job with their standards of practice form comprehensive assessments in all scenarios including insulin. However, the evidence at the Inquiry is that there was no assessment done with regard to Alexandru Radita, that there was an erratic pattern of insulin provided by various pharmacists, and there was long-term provision of insulin without the oversight of a physician.

[203] From the whole of the evidence of witnesses concerned with the pharmaceutical industry, the concept of pharmacists reporting a child at risk to Social Services is not under consideration and has never been done.

[204] With respect to the NetCare system the Inquiry heard evidence that it falls under the Ministry of Health and is 20 years old. There is an initiative underway which recognizes the need for improvements. Originally Netcare was used only by pharmacists and physicians. It was called Wellnet when it began in late 1990's or 2000's and the only information it included was dispensed drug information. Now it also includes laboratory results and some diagnostic imaging information. Other healthcare providers now have access to the information but do not have the capacity to contribute information into Netcare. Mr. Eberhart believes we have a long way to go to realize the potential of the Netcare system.

[205] Mr. Eberhart believes that it would be useful to identify children at risk with an alert determined perhaps by Social Services. In addition he thinks pharmacists and other healthcare professionals, through their professional standards, should have the ability to assess situations and refer people to Alberta Social Services. However, the issue of privacy legislation must be addressed for these ideas to be implemented. Professionals must know such reporting has no implications for possible recourse against them. They must have confidence they do not expose themselves to legal consequences by making a report to Social Services about a child at risk.

[206] He expressed concern such a change in responsibility to assess and report is properly structured and such questions as when, to who, and how to

effectively carry out this change in responsibility are crucial. He remarked that social workers are part of a team which includes educators who are not social workers, but are part of a care team. (This team involves educators, physicians, pharmacists and social workers.)

RECOMMENDATIONS RELATING TO PHARMACEUTICAL INDUSTRY

1. It is recommended that the College of Pharmacy address the evidence at the Inquiry concerning the role the pharmaceutical industry played in the tragic case of Alexandru Radita. The Inquiry is concerned the same practices by pharmacies may exist today and that there may be a need for the college to oversee regulatory safeguards relating to the provision of insulin without prescription by busy pharmacists at the request of caregivers of child patients.

   Alexandru received extended pharmaceutical care for several years prior to his death without the oversight of a physician. As a child patient he was never seen or assessed by any of the pharmacists who provided insulin to his parents for his use. The insulin was prescribed by pharmacists as part of an irregular pattern, in varying amounts, and by a few different pharmacies. The trial evidence is that in 2009 insulin and related diabetic equipment were purchased for a value of $1603.31. In 2010 such purchases totaled $3033.89, in 2011 such purchases totaled $880.59 and in 2012 such purchases totaled $199. No such purchases took place in 2013 according to the trial evidence.

   From the evidence at the Inquiry it seems that insulin is such a necessary drug that pharmacists would not want to deny a customer requesting it. Mr. Radita went to various busy pharmacies, primarily to Superstore, Costco and Safeway in the latter years of Alex's life and there is no evidence any tests or assessments were done or requested for the patient, Alex, even though there was a lack of prescriptions issued by physicians for a number of years prior to his death. There is no evidence any of the pharmacies had procedures in place to ensure a safe and appropriate amount of insulin was being given to Alex, a

child patient, who was not personally seen by the pharmacists and who ultimately endured lengthy suffering and death as a result of insufficient insulin being provided by his parents with whom the pharmacists dealt. There is no evidence before the Inquiry that busy pharmacists took the time to check NetCare records or even their own prior records to verify the insulin they were providing in the Radita case was appropriate or was being monitored by a physician, given his age.

2. It is recommended that pharmacists be required to not only maintain records of providing drugs including insulin, without a prescription from a physician, but also be required to upload their records on to NetCare so that these transactions can be accessed by other NetCare providers, including other pharmacists. There is doubt that there was an ongoing record on NetCare concerning the irregular pattern and amounts of insulin provided by pharmacists in the Radita case over an extended period of time.

3. The existing Alberta College of Pharmacists Code of Ethics, principal 1(7) states that pharmacists and pharmacy technicians use their knowledge, skills and resources to "safeguard the well-being of each patient and in particular any patient who is vulnerable." It is recommended that the College consider standards specifically requiring pharmacists to carry out an assessment of patients who rely upon them in a long-term situation for drugs that can be provided by pharmacists without a prescription, such as insulin, especially if a caregiver repeatedly fills the prescription for a child who has never been seen by the pharmacist.

4. It is further recommended that if a caregiver fails to produce the patient for the assessment requested by a pharmacist that the pharmacist consider reporting the matter to Social Services in accordance with the provisions of section 4 (1) of the *Child, Youth and Family Enhancement Act*. This section requires any person who has reasonable and probable grounds to believe that a child is in need of intervention shall forthwith report the matter to a director or a police officer.

5. It is recommended that the College of Pharmacy collaborate with Alberta Child and Family Services and other stakeholders in the examination of the general alert system described in recommendation number 5 of the Recommendations Relating to Child and Family Services found at page 36 and 37 of this report.

EVIDENCE OF EMIL RADITA

[207] Under s 49(1) of the *Fatality Inquiry Act of Alberta* the next of kin of the deceased are entitled to appear at the Inquiry. The father of the deceased, Emil Radita participated from prison via video link. Rodica Radita was offered the opportunity to do so, but declined to participate.

[208] Much of the evidence Mr. Radita provided, both written exhibits and *viva voce* evidence, is related to issues which were properly before the criminal courts and have been determined. As such this evidence is not relevant to the Inquiry whose mandate and jurisdiction do not include a review of the conclusions reached in the criminal proceedings.

[209] The Inquiry has been made aware that the Raditas' convictions have been accepted for review by Innocence Canada, and the transcripts and written evidence provided by Mr. Radita to the Inquiry may have relevance to their work. I note the Raditas' evidence provided to the Inquiry was not before the criminal courts since the Raditas did not testify at their trial.

[210] There are, however, two salient points made by Mr. Radita's evidence which have relevance to this Inquiry because they to some extent mirror the two issues raised by the two cases referenced by the Inquiry Review Board and dealt with as a part of my report. The first point is that the Radita family had a distrust of traditional medical authorities and treatments in general, and were resistant to accepting or following traditional medical advice. The second is that at times Mr. Radita relied upon natural homeopathic remedies without proper assessments being carried out on his son by a professional, and without proper monitoring of the effectiveness of such natural remedies.

[211] In both of the two cases referenced to this Inquiry by the Fatality Review Board, parents also distrusted traditional medical advice and treatments, turning instead to natural remedies recommended to them by their own Internet

research. In both referenced cases, parents failed to consult physicians and secure the necessary antibiotics which would have saved their children's lives. The misconception that natural remedies could substitute for pharmaceutical drugs in the treatment of infections (in the referenced cases), or diabetes (in the Radita case) resulted in the tragic death of their children.

[212] I note, however, that there are major distinctions between the Radita case and the two referenced cases which bear mentioning. The referenced cases relied upon natural remedies for a short time which were ineffective to prevent the tragic death of their children. In the referenced cases, the parents did not disregard a clear diagnosis and treatment protocol prescribed by medical doctors, as was the case in the Radita matter. In addition, the Raditas' failure to provide the necessary insulin to their son took place over an extended period of time and it was only when monitored by state intervention that they complied with the insulin protocol prescribed by the medical authorities which Alex needed to survive. The parents in the referenced cases were negligent for a short but crucial timeframe during which their failure to provide the necessary antibiotic treatment to their children caused their death.

SIMILAR DEATHS CROSS-REFERENCED BY THE FATALITY REVIEW BOARD

Directions and General Remarks

[213] When the fatality review board directed the Court to conduct the Fatality Inquiry into the death of Alexandru Gabriel Radita, it also stated the purpose of this Inquiry, in addition to preventing similar deaths, was to cross-reference two other cases, namely, ***R v Lovett*, 2017 ABQB 46** and ***R v C*, (2019) ABQB 414.**

[214] The commonality between the Radita case, the ***R v Lovett*** case and the case of ***R v C*** is that parents in each case failed to provide reliable, available medical treatment to their children, causing their deaths. In the Radita case the parents were convicted of murder. In each of the cross-referenced cases the parents were convicted of criminal negligence causing death. All convictions carried prison terms. These three cases along with a number noted in the decisions referred to in this Inquiry are evidence of the willingness of Courts to hold parents accountable to provide reliable, available medical assistance to their children

rather than relying on their own beliefs or Internet research of natural remedies which were ineffective in all of these cases.

[215] The Inquiry dealt in a limited way with the issue of distrust of traditional medicine and a misunderstanding that natural remedies can substitute for, rather than complement, the use of pharmaceutical drugs in cases involving the specific medical conditions dealt with by the Inquiry, namely, infection and diabetes. Especially in the case of young children, conditions such as infection can cause rapid deterioration within a very short timeframe if lifesaving drugs are not administered quickly.

[216] The Inquiry called two witnesses to bring this issue to the attention of Alberta Health Services, one being a medical doctor and the other a naturopathic doctor. The issues raised by these cases warrant an in-depth examination which is beyond the scope of the Inquiry. Specifically, there appears to be a need for Alberta Health Services to initiate a dialogue between traditional medical profession and the natural medical profession with a view to educating the public concerning the effectiveness and limitations of each.

[217] I have relied upon court decisions in both cross-referenced cases to determine the circumstances leading to the death of the children who died as a result of the failure of their parents to provide accessible medical care which would have saved their child's life.

Criminal Proceedings in the Case of *R v Lovett*

[218] The case of *R v Lovett* was a case where 7-year-old Ryan Lovett died March 2, 2013 after having been ill with an ear infection for over a month. His mother cared for him throughout this period but failed to obtain proper medical care when the illness worsened significantly. The autopsy concluded that Ryan died as a result of "overwhelming sepsis due to group A streptococcus and parainfluenza virus infection." Puss was found in the left middle ear and a photograph of the cross-section of Ryan's ear shows a large area of infection just behind the ear drum. All of his major organs showed signs of an infection of the blood and as a result of this infection, the organs that normally produce the immune response of the body appeared exhausted. The liver showed signs of being inflamed and of necrosis (liver cells dying). Blood vessels were all packed with an infection within the blood which had reached every organ of the body including kidneys, windpipe, lungs, heart and brain.

[219] The external examination found Ryan to be tall but somewhat light for his age (129 centimeters and 46 pounds). His ribs could be seen and he had yellow discoloration to his skin and to the whites of his eyes suggesting jaundice. His left upper arm was swollen compared to his right. Medical evidence at trial was that once the bacterial infection started to take hold, Ryan's body would have developed an immune response which would include fever, feeling unwell and possibly some vomiting and diarrhea. The cold and cough-like symptoms (runny nose and sore throat) would have progressed such that Ryan became more unwell and had a temperature. Court heard that Ryan had been slurring his words and convulsing shortly before he died. Medical evidence was that this terminal event indicated multiple organs shutting down and dying.

[220] Ryan was under the care of his mother, Ms. Lovett, and did not have a medical health care card. Ms. Lovett attempted natural remedies when her son became ill. Internet searches by her mother for natural remedies continued even after the child's ear was so infected that puss was falling out of it. This occurred by Friday February 22, 2013. By Thursday, February 28, the child required constant 24/7 care, was hot with fever and having trouble standing because of pain in his groin and lymph nodes. The child died March 2, 2013. The morning of March 2, 2013, Ryan was slurring his words and when Ms. Lovett started to dress him and the child began convulsing and throwing up, she called 911 immediately. That call was placed at 5:08 in the morning. EMS arrived at 5:15 AM, found Ryan on the floor outside of the bathroom, and the trial decision states that by all accounts he was likely dead by the time EMS arrived. He was not breathing, his extremities were cold to the touch and there was vomit around him in various stages of drying. Life saving medical interventions were tried without success.

[221] The Court found that Ms. Lovett waited too long to seek medical assistance and that he was on his last breath when she finally called for medical help. The Court found that simple penicillin given earlier would've saved his life and held that Ms. Lovett failed to provide the necessaries of life that endangered Ryan's life. Her failure to do so constituted a marked departure from the conduct of a reasonable parent.

[222] The circumstances of Ms. Lovett were considered by the Court. She was living in poverty. She had been an educated woman and worked in administrative positions in the 1990's, but in the late 90's she suffered from depression and was unhappy with the medical care she received for her mental health issues. She turned to a "natural lifestyle" and "alternative medical" remedies.

[223] Ryan was born October 11, 2005 with the use of a midwife and had only been seen by a chiropractor a few times shortly after his birth. He did not see any physicians throughout his lifetime because Ms. Lovett believed he didn't need to. Ms. Lovett felt she could deal with any cold and flu symptoms on her own through natural remedies like immune boosting teas, vitamin and minerals. Ryan did not have a birth certificate or an Alberta Health Care card. Ms. Lovett believed that he could decide at 18 years of age if he wanted the government to know about him.

[224] On one occasion Ryan had an infected tooth and was given antibiotics by a dentist. On another occasion, friends intervened and ensured Ryan went to a dentist with an infected tooth when he was in a lot of pain. Ms. Lovett refused to provide the care recommended by the dentist believing his baby teeth would fall out eventually anyway. Friends called Social Services with the hope that they would intervene to get Ryan's teeth fixed but the evidence was unclear whether that happened. In the weeks before his death, Ryan was complaining of a "loose tooth" but the court found it was unclear whether it was the same dental requirement involved in the prior dentist's recommendation.

[225] Ryan had gone to school for a short time before his death, starting in kindergarten in January 2011. He completed kindergarten and grade 1 and did well scholastically. Ms. Lovett decided to home-school Ryan during the fall of 2012 and he was enrolled in a charter school in January 2013. He was involved in art classes, scouts and a choir. Ms. Lovett was a loving and caring, perhaps over-protective mother.

[226] The first evidence of his illness began in early February 2013 where Ms. Lovett was Internet searching "swollen groin lymph nodes" on her computer. Ryan was sick at home all week with a bad cough at that time (being February 6 -7). During the first two weeks of February, Ms. Lovett testified that Ryan had a "normal cold." He wasn't energetic and had a cough that seemed to drag on. She treated his immune system with oil of oregano and various vitamins and minerals. On the weekend of February 15, Ryan had a sleep-over with a friend who testified he had not been quite himself. He seemed to be exhausted, slept a lot and was quite lethargic. She didn't seek out any medical assistance and on the evening of February 18th, Ryan had gone bowling and had appeared to enjoy that outing.

[227] The next day, Tuesday, February 19th, he was kept home from school because he was tired and the evidence at trial was that he was dealing with a chest cold as the reason she kept him home from school.

[228] By Wednesday, February 20, the evidence was that Ryan was "sick" with a sore ear, sore throat and a bloody nose. By Thursday February 21, Ryan was sick with an ear and throat infection and throwing up. Ms. Lovett cancelled a cleaning employment appointment and testified she was with Ryan all night. He had an ear ache, loose tooth and bleeding nose. She did some research on the Internet about ear aches and ear infections as well as "children's swollen groin lymph nodes." Ms. Lovett testified she treated Ryan with heat compresses and garlic mixed with olive oil that she dabbed next to the ear.

[229] Under cross-examination Ms. Lovett admitted that she was aware Ryan had an ear infection when she was researching those terms on the Internet and that later on she felt Ryan's balance was potentially affected from the ear infection. She gave Rayan some Advil around this time for a fever and when he had extreme pain.

[230] By Friday February 22, Ryan's condition was the same and he was again kept home from school but she brought him out to a cleaning job that day. She did further Internet researches on "ear aches," "ear ache mucus" and "ear ache oil of oregano," "ear aches and hydrogen peroxide," "vinegar and water for ear infections," "ear ache drainage," along with Internet researches about pain and discomfort and how to rapidly relieve an ear ache using supplies from the home. "Ear infections, facts and treatments," "reiki healing," "reiki healing throat music" were also Internet searches done by Ms. Lovett on February 22.

[231] On February 23 Ms. Lovett texted her friend that they were on day 3 of an ear infection and Ryan stayed in bed that day with a fever. Ms. Lovett herself was only sleeping 2 hours at a time because Ryan was so sick. She testified that she thought the drainage from Ryan's ear was just water from a bath a few nights before when he had his head under water. She said the fluid was clear. The Court found she knew that the drainage was more than bath water and in fact an indication of an ear infection given the evidence before the Court. On cross-examination she admitted this was the case as well.

[232] In direct examination Ms. Lovett suggested that Ryan then started to recover and thought he could go back to school on Monday the 25th of February. However, text messaging from Ms. Lovett confirmed that Ryan was still very ill February 25th and she remarked that he had never been that sick.

[233] On February 25 and 26 she complained to her friends that it was like having a newborn again since he had been sick for so long (over a week) and she was getting "no sleep." On Tuesday the 26 she texted that Ryan had been on a

downward spiral for the past few days, but she also said she thought they were through the worst and that she was still treating him with oil of oregano, fluids and Advil. On Wednesday the 27th he was too sick for school again and she cancelled school for the week. He was too sick to go to his art class and he was suffering. He was complaining of pain in his legs and that he had a fever. She started to notice dark urine which she attributed to the Advil he had taken and all the toxins that were coming out of his body since he had been so sick. She researched "dark golden urine kids sick" she made some "potato poultices" for him as a result of her Internet research and again checked "groin lymph pain." She told a friend she did a lymph massage and placed a hot pack on his lymph nodes. She acknowledged Ryan was complaining about pain in the lymph nodes but she felt that the lymph nodes would swell when he was sick and although they were painful they would go away. On February 28 Ryan required constant care. She texted "he was down with everything." He had a fever, had trouble standing because of the pain in his groin and lymph nodes. He was weak and had fallen over in the bathroom because of his problem standing. She thought this was a symptom from his ear infection. However, his arm was also puffing up and creating pain for him. Ms. Lovett performed further Internet searches for mumps which she said she ruled out. She did further Internet searches for swollen lymph nodes and treatment. She put Ryan to bed when he couldn't stand properly, and it did not occur to her that a doctor was in order. She stated in cross-examination that she believed she was just dealing with a sick child and that she was dealing with it to the best of her ability.

[234] On Friday March 1st Ms. Lovett noticed Ryan's eyes had gone yellow. She thought this was caused by jaundice and agreed that it was a significant escalation of his symptoms. She knew there was a children's hospital in the city and that there was an emergency ward in the Sheldon Chumir Centre that dealt with children, which was only blocks away from where she lived. She thought about bringing Ryan to the hospital at that time but decided against it. Even though he didn't have an Alberta Health Care number she expected he would be treated if she brought him in.

[235] She researched jaundice, swollen joints jaundice, natural cure for children's diseases, dandelion and decided the better route for Ryan was dandelion tea. She said that Ryan had been jaundiced as a baby and she had drunk dandelion tea as she was nursing and this seemed to work. She felt this natural detoxifier would help support his immune system and also be a natural laxative since Ryan was constipated. She felt he needed some vitamin D so she carried him outside and put him in the sun for a bit.

[236] Other people who saw Ryan on March 1 did not believe he appeared to be near death. He was playing with a cat, and for a time was all wrapped up and looked pale. He appeared to have a cold. Other neighbors who testified felt Ryan had the flu, that he had an ear ache and that his leg and arm were sore. These neighbors saw Ryan and spent some time with him.

[237] One of the neighbors who saw Ryan, however, testified that he was gravely ill and that she was shocked at how sick he was. Ryan told her that he had been in bed and that his legs hurt. She pulled the covers down and noted that Ryan was completely emaciated. He had lost weight, his eyes were sunken in and his cheeks were hollow. He was in a state of supreme suffering according to this neighbor and was almost unrecognizable. She could see his ribs and his stomach was sunken in. Ryan told this neighbor, one Ms. Lovetta Pointe that he wanted to go home with her. She promised to come and get him the next day. His eyes rolled back into his head and she thought he wanted to die. With a tremendous feeling of guilt and remorse she testified that it looked like Ryan was going to die.

[238] Ms. Lovett arrived home when she was there and appeared upset, agitated and was not in a state to be reasoned with. Ms. Lovetta Pointe had wanted to get Ryan some gummy bears and coconut milk that she had brought him to eat but Ms. Lovett interrupted and said he had to drink some tea that she had brought him. Ms. Lovett slammed the fridge door and Ms. Lovetta Pointe was afraid to deal with this situation. She didn't want to get into a fight. Ms. Lovett refused to take Ryan to a doctor, despite Ms. Lovetta Pointe telling her Ryan was so sick and something was wrong. Ms. Lovett appeared to be over the top not making sense. Ms. Lovetta Pointe wanted to take Ryan to the doctor since he was in so much pain and in hindsight she wishes she had done so or at least called 911, but she didn't feel strong enough to counter Ms. Lovett's refusal in this regard.

[239] Ms. Lovett testified that she only considered getting medical help when Ryan started slurring his words the morning of March 2. She said she was not aware that a doctor could have helped her and she testified she believed there were lots of cases where children were sent home from emergency with misdiagnosis and end up dying.

[240] The medical evidence was such that Ms. Lovett had failed to recognize how sick her child was and did not provide him with adequate care. Dr. Jadavji testified that she called for help when his organ system had completely shut down and it was irreversible. The medical evidence was clear at her trial that had Ryan been seen earlier, before toxic shock set in, his death could have been prevented. For instance, if he had been brought in when puss was coming out of his ears, any

physician would have treated this child with antibiotics. The bacterial infection Ryan had was there for some time before toxic shock occurred.

[241] This is a case where the Court dealt with a child's illness during the last month of his life. He was sick in early February 2013 with a cough and cold which kept him home from school for a week. He returned to school for the week before the Family Day long weekend February 15 to 18 but then never returned again before he passed on March 2, 2013. He appeared to have recovered somewhat from his cold symptoms before the period of the Family Day long weekend, other than his extreme fatigue but more cold symptoms resurfaced on Tuesday the 19th of February which kept him home from school. More serious symptoms came back with a vengeance on Wednesday the 20th when ear and throat pain problems surfaced. By that Friday the 22nd Ryan's ear was so infected that puss was flowing out of it, indicating that the tympanic membrane (ear drums) had burst.

[242] The Court found that by Friday the 22nd of February Ms. Lovett knew Ryan had an ear infection. She did research to find out what it meant to have drainage and puss come out of the ear and the Court held the Crown had proven that a reasonable parent, in her circumstances, would have sought medical assistance at that point and that her failure is a marked departure from the standard that a reasonable parent would provide.

[243] The Court found that a reasonable parent who uses natural remedies would not rely solely on those in the face of serious and painful ear infection. As well, the natural remedies were not working and instead of getting better Ryan continued to get worse.

[244] Ms. Lovett was found guilty of failing to provide the necessities of life to her son Ryan and criminal negligence causing his death.

[245] In finding her guilty the Court stated the following at paras 137, 138 and 139:

> "[137] In summary, I do not believe that Ms. Lovett was unaware that Ryan was suffering from a very serious and worsening infective process. Nor do I accept that she was unaware that her efforts of treatment with her so called "natural" remedies were not working. She knew he was getting worse yet continued along the same course until it was too late. In my view, the evidence led by the Crown does not leave me

> with any reasonable doubt on this point. Her conduct amounted to a wanton and reckless disregard for the life and safety of her son Ryan.
>
> [138] In my view, although there are parents that choose alternative methods to raise their children, and treat them when they are ill, society is not going to intervene. But there are minimum standards that must be met – and in this case they were the provision of medical aid that would have saved Ryan's life once his illness got to a stage that he was suffering from severe multi-level infection in his body which was obviously apparent.
>
> [139] I find that the Crown has proven beyond a reasonable doubt that Ms. Lovett's actions were a marked and significant departure from those of a reasonable parent in her circumstances and that she ran an obvious and serious risk to Ryan's life that she sadly did not succeed in. Accordingly, she is guilty of criminal negligence causing death contrary to section 220 (b) of the ***Criminal Code***."

[246] In addition to the findings of guilt, the Court applied the *R v Kineapple* Principle, so that a conviction was only entered on the most serious charge of criminal negligence causing death, since both offences arose out of the same facts and elements. Accordingly, a conviction on section 215 of the *Criminal Code of Canada,* that being failure to provide the necessities of life, was conditionally stayed and a conviction on section 220(b) of the *Criminal Code of Canada*, that being criminal negligence causing death, was entered. Ms. Lovett was sentenced to 3 years incarceration in this case.

Criminal Proceedings in the Case of *R v C*

[247] Neither the child victim nor the parental offenders are named except by initial since the identities of siblings were protected in this way. In the decision of *R v C*, the offending parents were each convicted by a jury of one count of criminal negligence causing death contrary to section 220(b) of the *Criminal Code* as well as being guilty of failing to provide the necessities of life contrary to section 215 of the *Criminal Code*. As with the Lovett case, convictions were only entered on the most serious offence of criminal negligence causing death, since

the same facts gave rise to both convictions. They were each sentenced to 32 months incarceration.

[248] The child victim Jo was born on September 21, 2012 and was approximately 14 months old when he died on November 29, 2013. He was raised without outside medical assistance. Accordingly, medical history for the child comes primarily from information provided by the child's mother who willingly described Jo's development and symptoms on November 28, 2013 when the child was brought to the Alberta Children's Hospital.

[249] At 14-months old he was able to sit up but not yet walking or even crawling. He was jumping in his jolly jumper, playing with toys and was socially engaging with his family. He was still breastfeeding and did not eat meat. He obtained protein from yogurt and beans but otherwise had a varied diet. He was not starved, abused or poisoned.

[250] Jo displayed a skin rash for most of his life which his parents believed was eczema. Doctors who initially saw Jo also described the rash as eczema. The offenders said the rash would flare up when Jo was teething and that they treated it with creams without any beneficial effect. At presentation at the hospital the rash covered 70% of the child's body.

[251] In the month leading up to his hospital admission, he had been less interested in eating and in the last few days before admission to hospital he'd been more tired and cool, so that he was "bundled up" to keep warm.

[252] The offenders said they first noticed discoloration in Jo's toes which were turning black during a bath to warm him on the morning of November 28, 2013. This prompted them to take him to the Foothills Medical Centre which they did later that day, again "bundled up" for the journey since he was cold.

[253] They arrived at hospital at 3:30 PM November 28, 2013. Jo was hypothermic, had a low heart rate (78 beats per minute) and two toes on each foot were black or purple in color. Elsewhere his skin was pervasively abnormal, flaky, red and dry. He had numerous open and weeping lesions. He was crying and his pulse, though low, was regular. His hair was sparse and eyelashes were "an orange yellow color."

[254] Doctors considered him a priority and he was diagnosed as being in the 3rd and final stage of septic shock. He was taken by emergency to Alberta Children's Hospital, arriving at 3:50 PM where an emergency doctor had been

waiting because Jo's life was in danger. Jo's condition significantly deteriorated and he suffered a seizure at 4:20 PM and was taken to Intensive Care at 4:48 PM. He suffered a cardiac arrest at 6:08 PM. He was chemically paralyzed to facilitate treatment which included fluid resuscitation through an intra-osseous line and an intravenous line. His body was warmed to approximately 36 degrees Centigrade using fluids and a Bair hugger. He was treated with 3 antibiotics and received medication for his seizures to support his blood pressure and blood profusion to his organs. He was also placed on a ventilator. He experienced another cardiac arrest on November 29, 2013 and resuscitation measures were unsuccessful. He was declared dead at 12:47 PM November 29, 2013. He was between the 3rd and 15th percentile per weight at the time of his death and was below the .1 percentile in height for children of his age and gender.

[255] The offenders were initially calm upon their arrival at the Foothills Medical Centre and were surprised at how quickly events unfolded thereafter. At the Alberta Children's Hospital they were shocked, devastated and very upset. They were appropriately upset and concerned for their child's well-being.

[256] During the months prior to Jo's arrival at the Foothills Medical Centre the offenders' computer showed they had conducted Internet searches in June, October and November. The Internet searches in June had to do with diet and curing eczema. In October the internet search had to do with asthma-allergies-eczema. On November 13, 2013 an Internet search was done for poor circulation in feet and in infants. On the evening of November 7, 2013 an Internet search was done on the subject of whether cabbage leaves could cure gangrene and on November 28, 2013 a further Internet search was done on whether cayenne could cure gangrene.

[257] From these Internet searches, the Court concluded the symptoms discussed in the Internet searches were readily apparent to both offenders at those times. Poor circulation in Jo's feet was known to both offenders by at least as early as November 13.

[258] The Court held that both parents failed to seek proper and timely medical assistance for Jo. While they did not by design starve, beat or otherwise deliberately set out to harm him and always attempted to pursue healthy outcomes, their degree of disregard for Jo's increasing illness revealed they were misguided and tragically misinformed, such that their conduct constituted a marked and substantial departure from the standard of a reasonably prudent parent. The Court found this disregard was reckless, but not wanton. Despite the obvious risk and danger to the life and safety of their child, they failed to seek medical attention.

[259] The duration of the offending conduct was held to be from October 20, 2013, when they were aware Jo's condition was gravely worsening. By November 13 their deprivation of the necessities of life, being necessary medical care, escalated to the standard of criminal negligence. By that time the symptoms displayed further signs of distress including the poor circulation in his feet noted in the Internet search conducted that day.

[260] The Chief Medical Examiner concluded that Jo died from an overwhelming staphylococcal septicemia due to deficiency dermatitis due to malnutrition. This means he contracted an infection that entered his blood stream as a result of his skin condition which was not eczema but a necrolytic migratory erythema. This is a very rare skin condition and it was the result of the nutritional deficiency. In his condition his infection was fatal.

[261] The Court found that the offending conduct of the parents in failing to provide the necessary medical attention was not the sole cause of Jo's death but rather a substantial contributing cause. The rare skin condition should have been treated earlier and the failure to do so caused his death.

[262] Both parents were immensely sad and filled with grief at the death of their son. His mother impressed upon the Court the closeness and love she felt for her son and the tremendous emptiness that she felt because of his death. His father similarly expressed immense grief at his loss along with the loss of his identity as a father, being now also separated from his two other sons WC and LC. He despaired of the fact that he would never see Jo grow up.

[263] There was ample third-party evidence concerning the admirable character, disposition and conduct of the parents in this case. They were described as gentle, good, upstanding, hardworking, loving, honest and dependable people. The mother was hardworking and dedicated. She was beloved by her students, since here employment was that of a teacher and in fact she was "adored" by them. She was described as quiet, gentle, capable, creative, gracious and a "sweet lady." She loved music and playing the saxophone and would sing with her sons as they went around the house.

[264] The couples' other sons were missing their mother and father terribly which is an understatement according to the Court. Both were highly intelligent, soft-spoken and had a deep faith in God which was not embittered or disillusioned by all they had been through. Many references said that neither of the parents were people in need of rehabilitation or from whom society needed protection. Many indicated they considered the convictions "unfathomable." The Pre-

Sentence Report describes the parents as devoted, loving parents whose children were their priority in life. They created imaginative playtimes and activities with their boys and involved them as they went about household tasks. Their decisions were for their boys' best interests. The two older sons were apprehended by Child and Family Services shortly after Jo's death and both were under the permanent guardianship of their paternal grandparents. The older child was born in 2006 and the second was born in 2010. The parents had been compliant with all of the restrictions in their release recognizance requiring supervised access with their older sons.

[265] As part of the sentencing submissions, the case of ***R v MacDonald, (2013) SKCA 38*** was referred to, being a case where a young mother pled guilty to criminal negligence causing death following the death of her young daughter who died as a result of a skin infection. In that case a doctor had visited the MacDonald home two weeks prior to the child's death and recommended Ms. MacDonald take her daughter to the Emergency Department. Ms. MacDonald failed to do so, out of concern that some bruising on her daughter's body would cause her child to be apprehended and taken from her. By the time she did call emergency, her daughter had stopped breathing and had been dead for some time. She was sentenced to 3 years imprisonment, but the court would have imposed a longer sentence if the Crown had sought the same.

[266] In determining the appropriate sentence, in R v C the Court considered the fact that this was not a case of deliberate or malicious abuse and that the parents were concerned, loving and dedicated parents whose beliefs were misguided. The tremendous loss suffered by the parents as a result of their child's death and their grief were also considered.

[267] The Court stated that a period of incarceration was necessary to deter other parents who may similarly recklessly forgo proper and timely medical care for their children. Such choices are "unacceptable, reprehensible and criminal." The Court stated the following with respect to sentencing:

> "The gravity of the risk accorded by C's failure necessitates a term of imprisonment. They were dealing with a baby, and briefly a very young infant, who by definition was totally and entirely dependent upon them, who could not communicate his fiscal state beyond his cries. Deceased had ready access 24/7 to all manner of modern medical expertise here in Calgary, free of charge. They had the time and the means of getting Jo there. They suffer no deficiency of intellect. They have demonstrated

> an immense capacity for selfless compassion toward others, yet they preferred to forgo all that was readily available for Jo medically, until it was too late. It is one thing for an adult to take that risk with their own life and health, to decline timely medical attention and then enjoy or suffer the consequences, but it is quite another to do so with the life of someone else, especially when that other person is so entirely vulnerable and entirely trusting. The jury found the C's criminally negligent because of their failure to secure proper and timely medical care. They were not convicted of choosing a vegan diet. They were not convicted of making a poor choice of the kind of medical practitioner they sought out, for example choosing a practitioner of holistic medicine, not Western medicine. The C's were convicted of failing to take Jo for any proper and timely medical attention."
>
> "And so, this failure must be denounced in no uncertain terms, by a period of incarceration, and its recurrence by others deterred."

[268] The Court felt that a short, sharp period of incarceration recommended by the defence was not appropriate to the gravity of harm and the degree of moral culpability. Nor would it reflect the vulnerability of Jo or the other aggravating circumstances and it would fail to adequately denounce or deter others.

[269] The Court pointed out that the degree of harm to Jo risked by the offenders was Jo's very life. However, the foreseeability of the risk by the offenders placed them lower on the range of moral culpability than the 4 to 5 years incarcerative sentence the Crown urged upon the Court. The Court found that the Crown was correct in observing that while the offenders were criminally negligent for two weeks, the longer period of depriving Jo of the necessities of life represents a longer period of offending behaviour and therefore greater moral blameworthiness.

[270] The Court dealt with the case of *R v Lovett* and considered the moral culpability of the offenders was less than in *Lovett*. The duration of criminal conduct by the offenders was longer than the 2 weeks for which they were found to be criminally negligent, but the findings in the *Lovett* case describe the parent still declining to deliver the child for medical attention despite the urging of another adult. The Court found the offenders did actually take Jo for medical attention whereas in the *Lovett* decision the offender did not do so despite far more

glaringly obvious symptoms than with Jo. The Court also noted that in *Lovett* the offender was held to be the sole cause of the child's death. However, Jo was a much younger child and therefore more totally dependent than the 7-year-old child in *Lovett.* In both cases the children's dependence on their parents and vulnerability to their parents result in a moral culpability which is not so substantially different. The Crown recommended a term of incarceration of between 4–5 years sentence. The Court consider a fit sentence to be less than the 3 years imposed in the *Lovett* decision after factoring in the difference in the degrees of moral blameworthiness and recognizing the collateral consequence already suffered by the offenders' separation from their other sons which they will continue to suffer for at least as long as they are in prison. The Court sentenced the offenders each to 32 months in custody for the criminal charge of criminal negligence causing death.

[271] With respect to the *Lovett* matter a Fatality Inquiry was not held, given that no state agencies were involved in the direct care of the Lovett child. However, in the case of *R v C*, the Fatality Inquiry Board has recommended a Fatality Inquiry be held in future.

Evidence of Dr. Ann Crabtree

[272] Dr. Crabtree sat on the governing council of the College of Physicians and Surgeons for 6 years, specifically the Competence Committee of the College of Physicians and Surgeons. She was qualified as an expert in the area of medical care and use of pharmacological remedies.

[273] She testified that with respect to someone on insulin, particularly a younger person, there would be a need to closely follow blood sugar content assessments and monitoring. It was her evidence that there is no medically accepted evidence that natural health products are effective to treat either infection or diabetes. Only prescription medications are reliable for these conditions. She further testified that the information on the Internet is notoriously inaccurate since it comes from many sources that have no qualifications.

[274] She stated that it is not uncommon for people to come in with information that they've accessed the Internet to obtain information which may be correct or incorrect. When it is correct, however, it may not apply to the particular situation the individual is facing and individual patients don't always completely understand the medical situation they are facing. She reiterated that

there are no natural health products that are medically recognized to appropriately treat either infection or diabetes. It was her evidence that regardless of the type of infection, the same principle would apply.

[275] Dr. Crabtree testified there are supportive measures for infection that are possible and helpful such as nourishment, sleep and reduced emotional stress in life along with getting fresh air, being warm, and having access to clean water and clean food.

[276] It is particularly important in cases of acute infection to seek qualified physician assistance as early as possible. The reason for this is that the course of the illness, particularly in young people or elderly, can be different than the course of the illness in midlife. She stated a child can appear quite well, even though the infection is progressing. In fact, they can appear relatively normal and then get sick very, very quickly.

[277] It was her evidence that the progression of illness in adults tend to deteriorate slowly and in a more recognizable form. Therefore, when a child is ill, it is essential to seek the advice of a qualified physician who can understand the fact that the health of a child can fall off very quickly. Qualified physicians are educated and experienced to recognize some of the very subtle signs and symptoms in the child that the parents may not recognize. Parents may assume that the child is completely well, while a qualified physician would recognize certain subtle significant changes in their vital signs, their behaviour or their appearance that indicate the presence of infections and that the infection is progressing aggressively.

[278] With respect to the cause of death in the case of C, who contracted an infection that entered his blood stream as a result of a skin condition called necrolytic migratory erythema, Dr. Crabtree testified this was a rash that was killing cells locally and that it would be observable by a qualified physician. The fact that it was migrating meant that it was spreading. She testified that a qualified physician would recognize the significance of the rash and refer the patient on to a dermatologist, who could have described the course of the natural history of that type of rare skin disease and advise the parents of what is likely to happen. Such advice would include if it was likely to get infected, and what kind of treatments were required. A long-term prognosis for the child with that disease could have been recognized by a qualified physician.

[279] She also spoke that especially given the age of C when this rash was noted, parents should not be diagnosing the rash on their own. In fact Dr. Crabtree

went so far as to say that anything one is observing in a newborn should be taken to a doctor. Anything that is abnormal requires parents to seek medical advice from a qualified physician who could help them understand whether it was something serious or not, how to look after it in the moment, and also what things to look out for going forward.

[280] Dr. Crabtree testified that she has encountered a lot of distrust of the pharmaceutical industry, especially since the medical profession prescribed drugs like Oxycontin which has resulted in significant addiction. She did however state that she believed it inappropriate for parents to make their own decisions based on their own knowledge or that found on the Internet in the care of a child. Failing to seek medical advice is not reasonable in such circumstances.

[281] Dr. Crabtree testified that scientific literature is always looking for additional information to treat infection and there is some scientific research around oil of oregano. However, this research has not been tested on human beings and has been limited either to a Petrie dish or the treatment of third degree burns on mice. There was also some research with respect to battlefield wounds where oil of oregano may limit the progression of infection. She stated the advice on the Internet to take oil of oregano for infections is not reliable.

[282] She pointed out that physicians have access to lab tests of blood which provide significant information that would be unavailable to ordinary individuals. For instance, whether bacterial organisms that are indicative of infection are present can be determined by lab tests and the various kinds of infection can be ascertained. In addition to determining the presence and type of infection, the monitoring of prescription pharmaceutical drugs is an equally important aspect of treatment to ensure that the drug is having the desired results. Appropriate monitoring, whether its an antibiotic or insulin is extremely important. Dr. Crabtree was asked by Mr. Radita what steps would be taken in a hospital setting. She gave a very lengthy answer. She indicated that in addition to examining the patient and their vital signs, other signs and symptoms would be noticed. Such symptoms such as nausea, vomiting or whether the patient was dehydrated would be evaluated by a physician. In addition to the examination blood work would be done which would include a complete blood count from which it could be ascertained whether there is a response by the body to an infection is occurring. If an infection is present, additional tests would likely be done, such as looking for the presence of bacteria in a wound or taking a sample of a wound and determining which prescription antibiotic would be appropriate. She testified that

prescription antibiotics are known to kill bacteria and in particular specific antibiotics are known to kill specific bacteria.

[283] She testified that if a wound is present, physicians could even grow the bacteria organism as well from a culture of blood. From that there could be testing to see which antibiotic would respond to the particular bacteria.

[284] Treatment in a hospital setting would consist of the prescription antibiotic and ongoing monitoring. In addition to that, there would be support of treatment if the body were fighting an infection. For instance, if a person was dehydrated he would be given fluids or other medication to reduce fever, for example. There would be assurances that the person would be well nourished and kept warm and comfortable and could sleep. In addition, there has to be ongoing monitoring to see if the interventions are effective.

Evidence of Dr. Trevor Hoffman

[285] Dr. Hoffman has been a naturopathic doctor for 26 years. His university training consisted of three years of pre-medicine and four years of naturophatic medical training at the Sonoma University in Arizona. He graduated in 1997 and has been a Board Member of the College of Naturopathic Doctors of Alberta (CNDA). He was also Chairman of the Competence Committee of the CNDA which designates the training needed for naturophatic doctors to perform certain higher risk procedures which include IV nutrition, chellation, injection therapies like acupuncture, ozone therapy, and hyperbaric oxygen therapy. For such higher risk procedures, naturophatic doctors must maintain continuing education and must also maintain emergency procedure training.

[286] Dr. Hoffman has been an expert witness in several court cases involving death or injury and he carries out his practice in private clinics.

[287] Dr. Hoffman testified that naturophatic medicine or the term naturophaty comes from understanding the nature of disease. Although naturophatic doctors utilize natural remedies they also incorporate pharmaceuticals in their practice as needed. Therefore, they often work in collaboration with medical doctors.

[288] Naturophatic physicians do not have authority to write prescriptions for pharmaceuticals in Alberta, although in Arizona they do have such authority.

In Alberta, when pharmaceutical prescription medicines are needed for certain patients, Dr. Hoffman testified naturophatic doctors refer patients to medical doctors for this purpose. He said this type of referral is built into his practice.

[289] Dr. Hoffman testified that naturophatic doctors are trained in both pharmaceuticals as well as nutritional supplementation. The naturophatic oath is not too different from the Hippocratic Oath. He testified there are five tenets naturophatic doctors follow. They are:

1. do no harm;
2. understanding and use the healing power of nature;
3. doctor as teacher;
4. treat the whole person; and
5. Prevention is the best medicine.

[290] Lifestyle modifications, nutritional and herbal supplementation, and such things as acupuncture or homeopathy fall within the scope of naturophatic practice.

[291] The relationship of naturophatic medicine to traditional medicine is such that naturophatic medical treatment can sometimes minimize the use of pharmaceuticals, but naturophatic medicines are not substitutes for pharmaceuticals. Naturophatic medicine is evidence based and Dr. Hoffman testified that many patients come to him looking for substitutes to pharmaceuticals and it is not an unusual part of his practice for him to have to explain to such patients that naturophatic remedies and treatments do not replace pharmaceuticals in certain scenarios. For example, he recently personally went through surgery himself which required antibiotics. He stated that he also took probiotics to restore gut bacteria compromised by antibiotics, but the probiotics, while enhancing the immune system, did not replace his need for antibiotics.

[292] As a naturophatic doctor, Dr. Hoffman can order blood tests, but not radiological exams such as MRI's, CT scans, or X-rays. He relies on medical doctors to order radiological tests, but he is trained to read the results. Although naturophatic physicians do not have direct access to Netcare, they obtain access through patients' permission or through the general practitioners of their patients.

[293] Dr. Hoffman generally described examples of naturophatic treatments as including nutritional IV's, or oral supplementation, lifestyle counselling, meditation, and therapies like chelation and ozone therapy.

[294] He testified he used ozone therapy in conjunction with antibiotics to increase the effectiveness of the antibiotics when treating a bone infection he himself had experienced. He stated there is no suggestion that ozone therapy on its own would have been successful in treating the bone infection he experienced.

[295] In summary, naturophatic medicines are used in conjunction with antibiotics at times, but not instead of.

[296] With respect to patients who require insulin, he testified that natural remedies do not replace the need for insulin, that such things as diet and certain supplements may minimize its need. He was not questioned with respect to people having Type 1 Diabetes, however, and on the whole of his evidence, it is doubtful he would have suggested that naturophatic remedies could reduce the amount of insulin doctors prescribe for patients having Type 1 Diabetes. In fact, on the whole of his evidence, naturophatic doctors would not interfere with the amount of any pharmaceutical prescribed by a medical doctor. The role of a naturophatic doctor would be to add natural remedies to increase the effectiveness of the pharmaceuticals prescribed by medical doctors.

[297] Dr. Hoffman underlined the need for naturophatic treatments to be monitored with respect to ensuring their effectiveness and understanding whether the patient's health is progressing as a result of their use. He stated Internet searches do not offer the needed monitoring of a person's condition, which is critical to the effective use of naturophatic remedies. He has had to educate some patients who think naturophatic treatments can substitute for pharmaceuticals and sometimes patients are adamant that they don't want to go the traditional medicine route.

[298] It was the evidence of Dr. Hoffman that he has to convince some patients that traditional medicine isn't all that bad and that sometimes they need pharmaceuticals. He stated he has documented this advice he has given to patients, including when he has told patients they need to go to a hospital and get emergency care.

[299] With respect to diabetes itself, Dr. Hoffman testified that natural remedies may minimize the risk of certain health issues caused by the diabetes itself. For instance, the risk of retinal issues (retinopathies), nerve problems (neuropathies), and heart issues (cardiomyopathies) can be the subject of natural remedies used in conjunction with insulin prescribed by a medical practitioner. Dietary changes can also reduce, but not eliminate the need for insulin. Patients

who utilize natural remedies in conjunction with insulin are monitored to evaluate their progress.

[300] Specifically with respect to children, Dr. Hoffman stated that children tend to spiral quickly and so he instructs his patients to call him day or night if something starts to deteriorate with respect to a child's health. Often the parents are directed to take the child to hospital immediately. In his opinion, children must be watched more closely than adults. On the subject of infection, children have much less leeway than adults to deal with infections. He stated that if a child patient appeared to have an infection, he would order blood tests and consider other medical referrals to physicians who could assess the patient in terms of the use of antibiotics. Dr. Hoffman testified that antibiotics are needed for bacterial infections, and as stated earlier, naturophatic doctors are not authorized to prescribe pharmaceutical medications.

[301] The fact that blood tests in Calgary can take a month at the present time was raised in Dr. Hoffman's evidence. He expressed concern that since children can spiral downward very quickly, it is a problem that blood tests cannot be obtained within a reasonable time. Notably, both the Lovett and the C cases involve children whose medical conditions spiraled downward within a very short time.

RECOMMENDATIONS ARISING FROM CROSS-RFERENCED CASES

1. It is recommended that Alberta Health Services initiate professional dialogue between traditional medical practitioners and natural medical practitioners in an attempt to create more reliable public health information and eliminate misinformation which undermines public health.

   The Inquiry heard evidence that there is a degree of public distrust of the use of pharmaceutical drugs which both professional groups agree are necessary to treat certain medical conditions, including infections and diabetes. In particular, naturopathic practitioners find the public unaware and resistant to the fact that natural remedies can supplement and complement, but not substitute, for pharmaceutical drugs in the treatment of certain medical conditions which include infections and diabetes.

There is a lack of awareness on the part of the public that the use of natural remedies must be accompanied by an assessment by a qualified natural medicine professional along with essential monitoring of the natural remedy to evaluate its effectiveness in dealing with the health issue concerned. Assessment and monitoring are just as essential with respect to the use of natural medication as they are in the use of traditional medicine. The fact that children can spiral downward very quickly makes the need for professional assessment and monitoring more urgent with respect to young children who are ill.

In addition, there is a lack of awareness that Internet research is not reliable since it fails to provide the necessary assessment of the patient by a professional, along with the necessary monitoring of the effectiveness of the natural remedy utilized. The children in both referenced cases were treated with natural remedies chosen from unreliable Internet research in the absence of the assessment and monitoring by reputable professional natural practitioners. In the Radita case, there was a similar lack of assessment with respect to the use of homeopathic remedies and the necessary monitoring of their effectiveness also did not take place. The deaths of all three children mentioned in this Inquiry were preventable.

FINAL REMARKS

[302] The Fatality Inquiry was delayed for a number of years due to a number of factors including lengthy trial and appeal proceedings in the cases dealt with, as well as COVID 19 restrictions which created a lack of availability of witnesses and participants. Innocence Canada also accepted the Radita conviction for its review, which caused further delay since Fatality Inquiries are only held at the conclusion of all court proceedings and it was not clear whether additional proceedings would be forthcoming. However, it became apparent that the review by Innocence Canada had an indefinite timeframe, and the Inquiry was held without waiting for the review to take place.

[303] Notwithstanding the delay, however, the evidence called at the Inquiry relates to current practices and procedures of the agencies who participated in the

Inquiry. The recommendations made are based upon improvements to current procedures in order to prevent similar deaths in future.

[304] The Inquiry dealt with the deaths of three innocent young children. In each case, the child's death was entirely preventable by well-known, tried and true medical remedies which were readily available to save their lives had their parents accessed them. It is hoped the recommendations contained in this report assist in the prevention of similar heartbreaking and unnecessary deaths of innocent, totally dependent young children.

DATED January 5 ,2024

At Calgary, Alberta.

and AMENDED March 20, 2024

Original Signed

Justice Sharon Van de Veen
A Justice of the
Alberta Court of Justice