IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: ***B.M. (Guardian ad litem of) v. R.M.,***
2009 BCSC 214

Date: 20090223
Docket: S045078
Registry: Vancouver

Between:

B.M., an infant, by his litigation guardian, O.P.

Plaintiff

And

R.M. and Her Majesty the Queen in Right of the Province of British Columbia

Defendants

Before: **The Honourable Madam Justice Dillon**
Reasons for Judgment

Counsel for the Plaintiff:	R.M. Gibbens, G. Mouzourakis, E. Good
Counsel for the Defendant, HMTQ:	J.E. Gouge Q.C. K. Horsman
No appearance by the Defendant R.M.	
Written Submissions:	June 5, 11, and 13, 2008
Dates and Place of Trial:	March 25, 26, 27, 28, 31, 2008 April 1, 3 and 4, 2008 Vancouver, B.C.

I. INTRODUCTION

[1] The plaintiff, B.M., is 6 years old. On September 16, 2002, when he was 4 months old, B.M. was assaulted by his father, the defendant, R.M., when he was alone with him, causing brain injury. R.M. was a known convicted child abuser. B.M. had been declared a child in need of protection from R.M. Three weeks prior to the assault, the social worker responsible for protection of B.M. removed a requirement that R.M. not have access to B.M. unless he was supervised. The plaintiff claims that the defendant, Her Majesty the Queen in Right of the Province of British Columbia (the "Crown") was negligent in failing to protect B.M.

[2] R.M. was convicted of the assault to B.M. and is presently serving his sentence. He did not appear at trial. This trial is about whether the Crown is liable for removal of the no

access without supervision provision that it had imposed on R.M. The trial proceeded towards a determination of liability only with damage assessment to follow.

II. FACTS

[3] The story of B.M.'s birth and history was told by his maternal grandmother, O.P., a fifty-eight year old woman of Russian descent who resides near Castlegar in the Kootenays of British Columbia. She is B.M.'s litigation guardian. I found O.P. to be an honest, straightforward, and thoughtful witness. Although her memory of exact dates was sometimes inaccurate, her memory was good overall. B.M. and his mother, A.V., live with her. O.P. brought up A.V. and her brother on her own after A.V.'s father left the family when A.V. was an infant.

[4] A.V. was nineteen years old when B.M. was born. She had a difficult childhood. A.V. was born with a bilateral cleft palate that O.P., who had a unilateral cleft palate, described as "very bad". A.V. has had forty-three surgeries throughout her still young life to correct the deformity. The surgeries, usually three or four times a year in Vancouver, took several weeks or months of recovery with facial bandages during the healing periods. Her speech and voice are affected by her condition. As soon as she went to school, A.V. suffered such ridicule that she rarely went to school for a whole week even when she was able and suffered such serious depression that she slashed her hands. She described herself then as very self conscious, insecure and without self esteem. She attended with a psychiatrist and with a counsellor, Cathy Evans ("Evans"), provided through the Ministry of Children and Family Development ("MCFD") who had opened a file regarding the family. By the time that she was thirteen, she found school intolerable, stopped going altogether, and studied by correspondence for awhile. According to O.P., A.V. reached only grade three or four.

[5] In 1999, her family bought her a computer with the plan that she could do her schoolwork online. However, she used the computer mostly to chat and so met R.M. online when she was sixteen. At this time, she had few friends and was home with her mother most of the time.

[6] R.M. and A.V. formed a chat room friendship in January 2000. He told her at first that he was a widower raising a young son on his own. They began to talk on the phone. Soon, he told her that he was not a widower, but was, in fact, charged with the assault of his young son. In early August 2000, R.M. and his family came to visit A.V. for his holidays. Despite O.P.'s displeasure, the couple went camping together. This was A.V.'s first boyfriend. R.M. returned to Winnipeg and the online and phone relationship continued for a few months until R.M. returned to Nelson in September 2000 with the stated plan to start school there. O.P. offered him residence in a motorhome that was parked on her property with the expectation that the stay would be short as he looked for rental accommodation closer to the school in Nelson. When school did not happen, R.M. obtained work in fast food outlets but he usually lasted only a few days. O.P. felt that she lost control over A.V. who spent more and more time with R.M. in the motorhome. O.P. was concerned that R.M. seemed "weird": he did the opposite to what he was told, he was rough with animals, he didn't pay rent or contribute to the household, and he would not let A.V. drive her own car. He told O.P. that he had custody of his son who was being looked after by others back in Winnipeg.

[7] After about six months, the owner removed his motorhome from O.P.'s property and R.M. moved into O.P.'s trailer home with O.P. and A.V. in the spring of 2001. R.M. obtained full time employment as a cook in a fast food restaurant in September 2001. By September 2001, A.V. was pregnant. R.M. went back to Winnipeg several times with A.V. On one

occasion, A.V. insisted upon going against O.P.'s wishes even though she had just been hospitalized with high blood pressure.

[8] Eventually, A.V. told O.P. that R.M. had lied about his past and was not a widower. He did, however, have a son from a brief relationship in early 1999. In December 1999, R.M. assaulted his five-week old son in a changing room at a mall, causing a fracture of his leg. He pleaded not guilty to a charge of aggravated assault. His visits to Winnipeg were to attend court. A.V. supported R.M. during the criminal process. While O.P. knew that R.M. was going back to Winnipeg to attend court, R.M. had told O.P. that he did not do it. He was convicted of aggravated assault in December 2001 and sentenced on May 10, 2002 to six months imprisonment which was made conditional upon R.M. having no contact directly or indirectly with his son or his son's mother unless a court ordered access, upon abiding with a curfew from 9:00 p.m. to 6:00 a.m. except for attending work, upon completing a parenting course and counselling as directed, and upon performing one hundred hours of community service within a year.

[9] A.V.'s baby, B.M., was born on May 16, 2002. On the day that B.M. was born, R.M. visited his probation officer.

[10] Despite the conviction, A.V. continued to believe that R.M. had not assaulted his five-week old son as R.M. insisted that the mother had done it. Although O.P. was not aware that there was a court order restricting R.M.'s contact with his first son, she was very concerned when the new baby came home to live with her, A.V. and R.M. She knew that R.M. was on a form of probation. She feared that R.M. would harm the child and that the child would be taken by the Crown. To her pleasant surprise, R.M. seemed a good father at first. He was working full time and seemed genuinely enthused about the child. A.V. was also excited and took complete care of her child.

[11] About June 5, 2002, the MCFD received information from R.M.'s probation officer about the conviction of R.M. for assault of his first son. The MCFD social worker obtained a copy of the probation order and pre-disposition report and spoke with the probation officer who had prepared the report. She was informed that there had been no assessment of the counselling services needed by R.M. or of his risk to re-offend. An investigation was started by child protection workers in the local office of MCFD in Castlegar which was staffed with four social workers, including a supervisor. The child protection social worker was responsible to assess intake files, interview appropriately, consult with the supervisor, and make determinations and plans for risk reduction with respect to a child. Based upon the probation officer's information, B.M. was recognized as a child potentially at risk and a file was opened. The family unit involved in the investigation included B.M., A.V., R.M. and O.P.

[12] On June 6, 2002, O.P., A.V. and R.M. received an unexpected visit from a social worker with MCFD. R.M. thought that they were going to take B.M. away. Because R.M. had to leave to get to work, arrangements were made to meet the social worker at her office the next day. O.P. testified that from that time onwards, the household became tense and scared.

[13] An immediate safety assessment was performed by a MCFD social worker, followed by a comprehensive risk assessment. The comprehensive risk assessment documented that A.V. and R.M. self-reported that they had never been abused. R.M.'s previous conviction for assault of his infant son indicated the likelihood of serious abuse. The risk posed by R.M.'s access to the child was considered high risk, but this risk was mitigated because the child had never been left alone in R.M.'s care and the family agreed that R.M. would not be left alone with B.M. until it was determined that the child would be safe in his care. MCFD planned to remain involved until the risk factors that presented a high risk of harm to B.M. were reduced. Overall,

the risk was considered medium with the mitigating factor being constant supervision by the mother and grandmother. B.M. was found to be a child in need of protection because there was a likelihood that he could be physically abused by R.M. The immediate risk reduction safety and service plan was that the family would ensure that R.M. was not left alone to care for the child and family support was to begin immediately.

[14] Debbie Martens ("Martens"), a senior social worker with MCFD, was assigned the file as lead child protection worker on June 17, 2002. She found it perplexing that the sentencing judge in R.M.'s assault conviction had not addressed the fact that R.M. was expecting another child and had imposed no restrictions with respect to that child. The fact that R.M. denied fracturing his child's leg raised red flags both for the probation officer and for Martens. The child protection worker was also aware that R.M. was identified as having an anger problem. Both she and her supervisor were not satisfied with the depth of information that had come from Winnipeg concerning R.M. No information had been obtained about R.M.'s family history aside from what was received from R.M.

[15] Martens met with each of A.V., R.M. and O.P. individually. Although O.P. told Martens that things had been going well for the family in the baby's first weeks, Martens explained to O.P. that the visit had been for safety concerns for B.M. because of R.M.'s past history. O.P. had not observed any misbehaviour by R.M. towards B.M. to this point and testified that she would have informed Martens if this had not been the case despite concerns that B.M. could be apprehended. Martens told O.P. that she would have to obey the rules set by the Crown or risk losing her grandchild. R.M. recalled that the possibility of B.M. being taken away was discussed, along with the information that MCFD was going to be conducting an investigation. R.M. was not asked about his past history. He was not asked then or thereafter about the conditions that led to the assault of his first son. The social worker told A.V. that they were aware of R.M.'s history of a criminal conviction for breaking his son's leg. A.V. was told that she must never leave the child alone with R.M. The family was aware that a risk plan was to be devised, support workers were to be made available, and R.M. and A.V. were going to take parenting and anger management courses. Martens' opinion was that B.M. continued to be at risk.

[16] In late June 2002, a risk reduction service plan was documented for the period from June 20 to September 20, 2002. The risks identified in the comprehensive risk assessment were addressed to ensure B.M.'s safety. It included the no contact without supervision requirement upon R.M. The plan was designed to demonstrate that R.M. could interact safely with the child while O.P. and A.V. ensured the child's safety. Review of the situation was to be ongoing. Martens and her supervisor signed the document. Martens attended at O.P.'s home. A.V. described that Martens held papers which she told them to sign. A.V. understood that she and O.P. were not allowed to leave B.M. alone with R.M. O.P. was actually thankful for the restriction as it helped her control the situation while she expected that R.M. would attend parenting and anger courses and start to recognize his problems.

[17] The safety plan anticipated that the parents would complete a parenting programme with a review date of July 25, 2002. Social workers attended at the home within a couple of days of Martens' visit, then every day for two weeks and then once or twice a week thereafter. One of the workers was Evans, who had assisted A.V. in the past. The social workers checked to see how B.M. was doing and taught R.M., A.V. and O.P. how to feed, bathe and clothe babies, but without demonstration. O.P., who had raised two children, found these lessons of little value. While she appreciated that the social workers' attendance was protecting B.M., she did not feel that daily assistance was necessary because R.M. was often not there when the workers visited. She asked for a reduction in the number of visits. A.V.

found the lessons on washing and cooking “useless.” They were also likely of little value to R.M. who was most often at work when the social workers visited. When the workers left, O.P. said that R.M. was “uptight” and tense. A.V. and the public health nurse had an uneasy relationship after A.V. decided not to breastfeed the baby.

[18] O.P. told Martens that, although everything was fine, she was worried about R.M.’s past, that he seemed weird and controlling, and that he picked up the baby roughly. She wanted a psychiatric assessment done on R.M. but was told that it was not possible. Martens said that the purpose of having workers attend two to five times a week was to better understand R.M. and the circumstances of the assault so as to determine whether MCFD was meeting its initial plan. However, when the visits were not conducive towards that end, they were reduced to once a week. Martens acknowledged that the circumstances were now that MCFD could not realistically enforce the strategy employed in the action plan regarding no unsupervised access of R.M. to B.M. Reliance was placed upon the presence of the grandmother in the home as the basic safety net. Nonetheless, MCFD remained involved with the supervision plan in place, uncertain as to whether it was effective or when it could be removed.

[19] O.P. remained steadfast in her commitment to no unsupervised access. She was afraid to leave R.M. alone with the baby and fearful that her grandchild would be taken away from her. She absolutely followed the rule that R.M. was not to be left alone with B.M. but was to be supervised at all times. A.V., too, followed the rule. O.P. testified that social workers threatened her with the rule repeatedly and was told that they “were like fish in a pond waiting to be caught”. Nonetheless, she thought that the rule was a good idea, although hard at times.

[20] Near the end of June whilst going to and from a picnic, B.M. developed red marks on his shoulders from the car seat strap. These marks were observed by the public health nurse who attended at the home. Another intake was opened by MCFD social workers after a call from the public health nurse. An investigation was started immediately given the risk factors identified. The next day, Martens requested that O.P., A.V. and R.M. attend at her office. Martens and her supervisor took pictures of B.M. and then brought him to see a doctor. The doctor confirmed that the marks looked like they had been left by the seatbelt and were not symptoms of abuse. Regardless, the social workers wanted to view B.M. naked subsequently. The social worker reiterated the requirement that the father’s access to the child be supervised as established in the risk reduction plan. Tensions rose. O.P. testified that they were afraid to take B.M. anywhere and examined him nightly for bruises. In the meantime, MCFD documented that the child was considered safe because of ongoing supports and monitoring.

[21] At the request of doctors following this incident, O.P. and A.V. brought B.M. in for blood tests in early July. It was a traumatic event as B.M. cried and A.V. got very upset. R.M. and A.V. started to isolate themselves from B.M. O.P. informed Martens that there was tension because too many people were coming to the house and nothing positive was coming from it. She testified that there should have been proper assistance knowing what the risk was. She told Martens that they needed better help and support from qualified personnel. In mid-July, Martens received information from Winnipeg that R.M.’s assault on his first child involved severe use of applied force in circumstances obvious to the assailant, that the first child’s mother reported that R.M. had become easily agitated when caring for the child, and that R.M. was reported to have a temper and to be easily frustrated. The opinion of the Winnipeg social worker was that R.M.’s parenting capacity had not been assessed, that the full potential for abuse had not been determined, and that recommendations for treatment were indicated. There had been no expert assessment of R.M.’s risk of recidivism. Martens said that she and

her supervisor shared the same concerns as the Winnipeg social worker but did not begin the process to obtain a parental capacity or psychological assessment. Although R.M. was never asked if he would participate in a psychological assessment, it is reasonable to conclude that he would have done so because he was generally cooperative, attending and answering questions as asked throughout. Regardless of this information and O.P.'s concerns, MCFD's support service to the family was limited to once a week with the tentative plan to close the file and end MCFD involvement by mid-September.

[22] B.M. slept with O.P. every night and she assumed more and more of his care. O.P. was upset that R.M. would pick B.M. up upside down and roughly handle him, thinking that this was funny. R.M. also spent many hours watching pornography which caused bickering between him and A.V. The social workers' attendance at the home diminished. By mid-July, A.V. and R.M. still had not undertaken a parenting course but Evans gave them materials to read, including a pamphlet on shaking babies, and a video to watch, even though Evans knew that they could not do so because the VCR was broken. In August, Evans went on holiday, leaving the parenting course, such as it was, unfinished and no other support worker coming to the home. Martens, too, was on holiday in early August. By late August, O.P. had taken over most of B.M.'s care.

[23] Martens returned from her holiday on August 19, 2002 and prepared a revised risk reduction service plan for B.M. on August 20, 2002. On or about August 23, 2002, about two and a half weeks after Evans went on holiday and shortly after Martens returned from her holiday, Martens came to the house and informed everyone that the supervision restriction was lifted from R.M. They were asked to sign the risk reduction service plan. There had been no indication that this was to happen. No questions had been asked. No information about the plan or its origin was forthcoming. This was a significant change to the parenting plan that had been in place since early June when B.M. was three weeks old. R.M. was surprised. O.P. was also surprised and suggested that it might be better to leave it on. There was no response. When Martens left, R.M. elatedly stated that he could now do as he wanted with his son. Up to this time, R.M. had never been left alone with his son. O.P., concerned for B.M.'s safety, told A.V. and R.M. that if she saw anything, she would report them to MCFD.

[24] There are no documented reasons within MCFD for lifting the supervision requirement. There was no reassessment of risk documented. Martens could not point to anything that showed what review was undertaken, what analysis was done, or what conclusions were reached that led to the decision that lifting the supervision order was appropriate. It is not known how or why Martens made this decision. Neither she nor anyone else from MCFD testified. However, some of Martens' discovery evidence was read in by the plaintiff. There was no assessment of how the decision fit into guiding principles. The red flag that had been raised by R.M.'s denial of injury to his first son had never been lowered. The information from Winnipeg had never been resolved. There was no feedback on R.M.'s particular risk demonstrative of the child's safety while in his care. Martens described that it had been an ongoing struggle to decide whether to make changes to the initial plan because R.M.'s denial meant that the triggers that led to the assault were unknown so that it was difficult to tailor a service plan. This was identified as the biggest factor under appraisal. This factor never changed. It had never been determined that B.M. would be safe in R.M.'s care.

[25] The original comprehensive risk assessment, which concluded that R.M. was likely to cause harm to B.M. such that a supervisory protective condition was required, remained in effect. Although the parents' cooperation, partial completion of a parenting course, and planned ongoing monitoring by MCFD were considered positive indicators, the risk remained as originally assessed and the decision to remove supervision was incompatible with the

original assessment. The risk reduction service plan now proposed that R.M. would be given an opportunity to demonstrate through unsupervised access that he could interact with the child safely while MCFD conducted random home visits. This plan was signed by the social worker, R.M. and A.V. on August 27, 2002. O.P. was not involved and her views do not appear to have been considered. When this plan was developed, A.V., R.M. and B.M. were living with O.P. in her home.

[26] According to O.P., R.M.'s behaviour changed around this time. He became assertive towards B.M. and handled him roughly. O.P. was concerned, but had previously complained of R.M.'s rough play to Martens and had been told that this was not abuse, so she said nothing. A.V. and R.M. were angry with O.P. over an incident with the car and locked themselves and B.M. in their room. O.P. was upset and slid a letter under their door telling them, among other things, that she was upset about what she had seen at home, that B.M. cried most times when he was with R.M., that she thought that they were unfit parents, and that R.M. needed help. She listed R.M.'s behaviour towards B.M. that concerned her including hollering, squeezing his face, picking him up by the arms, shaking him and turning him upside down. These complaints about R.M.'s behaviour towards B.M. were not new to R.M. as O.P. had been complaining for a few weeks to him about how he treated B.M. An argument with R.M. ensued and R.M. accused O.P. and A.V. of being crazy. R.M. said that O.P.'s mood and attention had intensified after the supervision restriction was lifted and the relationship deteriorated. O.P. testified that hurtful things were said. A.V. and R.M. moved out with B.M. within a week of the lifting of the supervision provision.

[27] Before A.V. and R.M. moved out, they brought O.P.'s letter to Martens on August 28, 2002 and attempted to explain its contents and portray O.P. as in the midst of a breakdown. This was probably in expectation that O.P. herself would bring the letter to the attention of MCFD. In the ensuing discussion, Martens told A.V. and R.M. that O.P. had previously contacted her about her concerns. In that interview, A.V. and R.M. confirmed O.P.'s description of R.M. holding B.M. by the wrists as his body dangled as a deadweight, a move that Martens told them was inappropriate and which had been described by O.P. as abusive. A.V. and R.M. also confirmed other behaviours described by O.P. in the letter. The social worker considered these behaviours inappropriate for a three-month old child. A.V. and R.M. were not interviewed separately at that time.

[28] Martens knew that the circumstances of the family unit had significantly changed. O.P.'s letter and the confirmation of described behaviours was a cause of concern to Martens. She visited O.P. with the letter that O.P. had written to R.M. and A.V. in her hand. This was the only time that O.P. and Martens met between the lifting of the supervision provision and September 16, 2002. O.P. testified that Martens asked her why O.P. had a change of heart. O.P. told Martens about R.M.'s family history of an abusive father and about R.M.'s change in attitude once the supervision restriction was removed. She told Martens about behaviours that caused her concern for B.M.'s safety when R.M. was caring for him under supervision. She also described R.M.'s reactionary conduct towards suggestions for improvement. She described a declining relationship between A.V. and R.M. because of R.M.'s interest in pornography. The prospect of an imbalance in the relationship because of A.V.'s dependencies was also raised. O.P. explained that she feared for B.M.'s safety and begged Martens to replace the supervision provision. O.P. testified, and it is accepted, that Martens told O.P. that she would do it that day and that she would hire a supervisor. Martens planned to investigate O.P.'s concerns but did not follow up on any of them immediately. She said that she considered O.P.'s information to be accurate and disturbing.

[29] A.V. and R.M. left with B.M. that night. O.P. did not know where they were but

expected that matters would cool off. A.V. and R.M. lived with a cousin for a few days and obtained an apartment of their own at the beginning of September. The family conflict and increased responsibility for A.V. were readily apparent.

[30] In the meantime, MCFD was aware that A.V., R.M. and B.M. had moved out of O.P.'s home. The stability brought through O.P.'s participation in the family was gone. O.P. as a reliable source of information to MCFD about family occurrences was gone. B.M.'s safety net within the stability of the O.P./A.V. family unit was gone. Even though O.P.'s letter and recent interview had put MCFD on notice about R.M.'s behaviour towards B.M., Martens failed to consider that the change in circumstances could cause R.M. to act out or engage in abusive behaviour towards B.M. She did not consider R.M.'s change in attitude as a result of the lifting of the supervision order as relating to B.M. A social worker visited with A.V. and R.M. and advised that intensive contact with them would be resumed pending investigation of O.P.'s concerns. A third intake file was opened but, unlike in early June, no immediate re-assessment of risk was undertaken.

[31] When Martens visited A.V. and R.M. about September 4, 2002, she noticed a change in attitude from R.M. as he was crude and disrespectful. He opened a beer and talked of his sex life in her presence. A.V. and R.M. were not interviewed separately. Martens considered, but rejected, reinstitution of the no access without supervision order. However, the reasons for this decision were not established. Martens did not contact R.M.'s probation officer. Results of the MCFD investigation brought mixed comments about R.M. with concern expressed by some, including a doctor and relatives who confirmed concerns of the grandmother. It does not appear that the intensive contact through family support worker visits resumed before September 16, 2002. Although Martens considered getting a psychiatric or psychological assessment done of R.M. after further information indicated that R.M. had driven recklessly with B.M. in the car, she did not initiate such an assessment until after events of September 16, 2002. O.P.'s niece had reported destructive behaviour by R.M. such that she would not allow her children to be alone with him.

[32] O.P. waited and then phoned the MCFD on September 6, 2002. She wanted to find out if the supervision restriction had been put back on. O.P. testified that Martens told her that the provision had not yet been replaced but assured her that it would be. O.P. expressed concern for B.M. and told Martens about incidents in the past such as R.M. squeezing B.M.'s nipples so hard that fluid came out of them. She told Martens that she was working on a letter outlining all of her concerns. Unfortunately, O.P. was stressed and suffering from all of the commotion and never did get the letter sent before September 16, 2002. In the meantime, R.M. was working at the fast food outlet and A.V. worked as a janitor about four hours per week. It was clear that R.M. was alone with B.M. at least while A.V. was at work.

[33] In September, R.M. and A.V. struggled with the new responsibilities of living on their own with a newborn child when both were working and had financial pressures. They were isolated from O.P. and other family after the battles with O.P. According to A.V. and R.M. and as confirmed in MCFD documentation, they received no assistance from MCFD. However, a few days before September 16, 2002, O.P. and A.V. reconciled their differences, and B.M. came to stay with O.P. for the weekend.

[34] On September 16, 2002, R.M. was solely in charge of B.M. and facing interrupted sleep and a noisy baby. He shook B.M. B.M. suffered personal injury as a result of the shaking assault by R.M. B.M. was immediately hospitalized and was later flown to Children's Hospital in Vancouver. B.M. is now blind.

[35] B.M. was removed from parental care under a protection order on September 18, 2002.

An immediate safety assessment had concluded that B.M. was not safe. A psychological assessment was initiated of R.M. After B.M. was released from hospital, O.P. obtained interim custody of B.M. She and A.V. now share permanent custody of B.M. Judging by the grandmother's evidence and B.M.'s continuing presence with them, I conclude that the grandmother and mother have provided good care and protection for B.M. A.V. has come to acknowledge that R.M. injured B.M. and she eventually separated from R.M.

[36] R.M. pleaded not guilty to the assault and denied it at trial. He was convicted of aggravated assault before a jury on March 8, 2005. He is presently in jail, serving a sentence of five years' imprisonment less 9 months for time served. R.M. continues to deny that he ever caused injury to his first son or to B.M.

III. EXPERT EVIDENCE

[37] Annie Simmonds ("Simmonds"), a social worker, staff trainer and supervisor with twenty-five years experience in the MCFD, particularly in child protection, testified for the plaintiff. She retired from MCFD in 2002 and has worked as a trainer, policy consultant and writer in child protection since then. She was qualified to provide an opinion to the court as an expert on practice standards for social workers engaged in protection issues in the province and conformity with them, and on the standard practice of social workers in protection cases in the employment of the Crown. She identified, as MCFD policy, the risk assessment model and practice standards applicable to child protection intakes where there is a report that a child may be in need of protection. She had reviewed the documents prepared in the ordinary course of the work of social workers in this case. Although not all of the documentation that Simmonds would have expected to have been in the file was presented for her review, it was not established that the documents that were absent were ever actually produced by the social workers involved or that any specific information that may have been included would have affected Simmonds' opinion.

[38] Simmonds said that the Practice Standards for Child Protection set out by MCFD (the "Practice Standards") are minimum mandatory expectations of a child protection social worker in conducting an investigation and in making decisions regarding child protection. The paramount considerations are the safety and well-being of the child with any doubt about a child's need for protection or a parent's ability to care for and protect the child to be resolved in favour of protection. There is no discretion to be exercised away from that paramount principle. When a report is taken, the social worker investigates and then prepares an immediate safety assessment. If the child appears in need of protection, a comprehensive risk assessment is undertaken in which all the factors that may place a child at risk are considered and from which a plan is developed to ensure the child's safety. At that point, a decision is made whether to obtain a court order, whether services will be put in place within the family to ensure the child's safety, or whether the file will be closed. This decision can be difficult. A risk reduction service plan identifies the highest risks and the plan for reduction of those risks.

[39] Simmonds stated in her report that the failure to obtain an expert assessment of R.M.'s risk of recidivism meant that the likelihood of harm to B.M. could not be adequately assessed and that without this assessment, the social worker was unable to determine what services or action was required to best protect B.M. This conclusion was supported by the evidence from Martens who said that it was difficult to tailor a service plan when the triggers that led to the assault conviction were unknown. In cross-examination, Simmonds said that, given the information at hand, she would not have relied upon information obtained from prosecutors or probation officers about R.M.'s state of mind or risk of recidivism, but would have immediately had discussions with her supervisor and manager about obtaining a psychological

assessment of R.M. as the required first steps to obtain such an assessment. She said that she could not imagine that a request would have been turned down in the circumstances of this case. It has been found that R.M. would also probably have complied with such a request. Section 13(1)(a) of the ***Child, Family and Community Service Act***, R.S.B.C. 1996, c. 46 [***Act***], establishes that a child is in need of protection if he is likely to be physically harmed by the child's parent. The social worker is required to make a determination of likelihood. Simmonds testified that the failure to obtain a professional assessment of R.M.'s risk to re-offend and the failure to obtain a detailed social history regarding A.V. or R.M. was a critical failure to meet the Practice Standards. This meant that case decisions were made without adequate assessment.

[40] Simmonds said that a comprehensive risk assessment must be completed whenever a child is found to be in need of protection. This contains a list and documented assessment of factors that contribute to or detract from the safety of a child. This standard was not met for the third intake that occurred on August 28, 2002. Such an assessment was required at this stage because the Practice Standards required completion of a comprehensive risk assessment whenever a third child protection report is received about a child within one year. This was the third child protection report. Further, a comprehensive risk assessment was required because there had been significant changes in family circumstances with A.V. and R.M. leaving O.P.'s home concurrently with withdrawal of family support services and removal of the supervision requirement. Also, the risk reduction service plan that removed the supervision requirement on August 23, 2002 was completed without a comprehensive risk assessment having been prepared first as required by the Practice Standards. Simmonds said that the information points to escalating risk at the time that the decision was made to withdraw the supervision requirement. This escalation arose from increased family stress due to family conflict, reports of R.M.'s rough treatment of B.M., upset caused by the investigation of the public health nurse concerns, and the reduction of family support services. These risks increased further when A.V. and R.M. lived on their own such that B.M. was then at serious risk of physical harm.

[41] Simmonds also said that the comprehensive risk assessment that was done on June 10, 2002 was based upon limited or incomplete information.

[42] Margaret Osmond ("Osmond"), a social worker from Ontario with extensive experience with children in residential or foster care, testified for the defendant. She has never practiced in British Columbia and was not familiar with British Columbia policies for social workers when involved in child protection cases. She did not purport to opine upon whether the defendant's social workers conducted themselves according to the applicable standard of care and skill to be expected in the circumstances. Rather, she was offered to provide an opinion to the court as to the factors which a social worker should consider when it is proposed that an order or agreement should be made that a parent not be alone with a child. The defence also described that it tendered her evidence to establish "whether the social worker made a decision with reasonable care or in good faith" and to identify issues that a social worker should address to protect children in balancing the risk of abuse against the risk inherent in out-of-home care.

[43] The facts upon which Osmond based her opinion were not set out in her report but were led in her direct evidence. These were: R.M. had been convicted of assault of his other child by another relationship in 2002; he was not allowed to spend time with the child that he assaulted; MCFD was aware of the conviction and the sentence; an arrangement was in place so R.M. was not to be left alone with B.M.; this arrangement was rescinded at one time; three weeks later, R.M. assaulted B.M. Osmond was asked in direct testimony whether she would "infer negligence" on the part of the social worker based upon those facts. That question, and

the follow up question as to whether she would infer "the standard of care and skill of a reasonably competent social worker", were not allowed because, in part, counsel for the defendant had asserted in Osmond's report that Osmond had not been asked and would not offer an opinion about whether social workers conducted themselves with the standard of care and skill to be expected of a competent and careful social worker. Further, it was stated that she could not offer such opinion without undertaking detailed factual enquiries, which she had not done.

[44] Osmond's report was put into evidence. It dealt with the "complex process" to place a child in out-of-home care as a trade off against the risk of harm within the home. Risk assessment factors to predict whether a child may come to harm within the home were identified and described without reference to the factors involved in MCFD's comprehensive risk assessment. The factors generally described by Osmond include: social history, social support factors, individual child factors, mental health and substance abuse factors, background of harm to the child, and protective factors. Forensic evidence of harm was said to provide a rare example of clear indication of imminent risk with the necessary implication that such fact makes the decision to impose protective measures easier. Stability of relationships over time was also an important indicator. The balance of the report focused upon the potential consequences of admitting a child to out-of-home care, outcomes for children in permanent out-of-home care, reunification issues, and balancing the scale in making decisions about out-of-home care. Although Osmond did say that child protection workers must constantly assess and re-assess parental risk factors against the possibility of unintended repercussions of admissions to care, one can extrapolate that this process also applies to decisions to obtain and maintain agreements with the family that are undertaken in the child's interest to provide protection, such as a supervision requirement upon an abusive parent.

[45] Little weight can be given to the Osmond opinion evidence. Osmond did not offer an opinion on the applicable standard of care for social workers involved with child protection issues and was not in a position to do so given her unfamiliarity both with the Practice Standards in British Columbia and with the facts of this case. Her report focused upon the process to place a child in out-of-home care, a situation that was not considered as an alternative in this case. Her experience with foster care in Ontario rather than child protection in British Columbia is such that the opinion offered by Simmonds is generally to be preferred in any area of opinion that touched upon issues relating to the actual decisions that were made about B.M. In cross-examination, Osmond effectively supported several of Simmonds' opinions including: that an adequate parental social history should include accessing other sources than the parent and that a social worker should not take the word of the at-risk parent that he was not abused himself as a child; that working at minimum wage and paying rent are financial stressors; and that infant children are the most vulnerable and most likely to be at risk. Osmond also said that it is generally preferable to do individual interviews of parents.

IV. SUMMARY OF ARGUMENT

[46] The plaintiff submits that claims of assault and negligence against R.M. had been established by his assault on B.M. while the child was under his care. R.M. denied these facts in the statement of defence but did not appear at trial.

[47] The plaintiff argues that the law on negligence against the defendant Crown is guided by the principles established in ***Just v. British Columbia***, [1989] 2 S.C.R. 1228, 41 B.C.L.R. (2d) 350, 64 D.L.R. (4th) 689, [1990] 1 W.W.R. 385, 1 C.C.L.T. (2d) 1, 103 N.R. 1 [***Just***]; ***Brown v. British Columbia (Minister of Transportation and Highways)***, [1994] 1 S.C.R.

420, 112 D.L.R. (4th) 1, [1994] 4 W.W.R. 194, 19 C.C.L.T. (2d) 268, 42 B.C.A.C. 1, 89 B.C.L.R. (2d) 1, 164 N.R. 161 [***Brown***]; ***Hill v. Hamilton-Wentworth Regional Police Services Board***, 2007 SCC 41, [2007] 3 S.C.R. 129, 285 D.L.R. (4th) 620, 230 O.A.C. 253, 368 N.R. 1, 50 C.C.L.T. (3d) 1, 50 C.R. (6th) 279 [***Hill***]; and ***D.H. (Guardian ad litem of) v. British Columbia***, 2008 BCCA 222, 81 B.C.L.R. (4th) 288, [2008] 9 W.W.R. 82, 255 B.C.A.C. 293, 57 C.C.L.T. (3d) 36, 430 W.A.C. 293 [***D.H.***], so that an operational decision such as occurred in this case is bound by a duty of care in negligence and not by a duty of good faith. The standard of care owed in the circumstances of this case is that of a reasonable social worker in like circumstances. The Crown acted in breach of the standard of care when social workers failed to follow mandatory policy and practice standards and failed to remediate that failure when opportunity arose. If the court finds that the standard of care was to act in good faith, the plaintiff argues that the Crown acted in bad faith when it agreed with O.P. to reinstitute the supervision requirement and then did not do so and when it failed to comply with its own policy by removing the supervision requirement. Both parties agree that there must be a causal connection between the breach of the duty of care and the injury complained of on the basis of the "but for" test set out in ***Resurfice Corp. v. Hanke***, 2007 SCC 7, [2007] 1 S.C.R. 333, 278 D.L.R. (4th) 643, [2007] 4 W.W.R. 1, 404 A.R. 333, 69 Alta. L.R. (4th) 1, 394 W.A.C. 333 [***Resurfice***]. The plaintiff says that the failure to maintain the supervision requirement increased the risk to B.M. that he would be harmed by R.M., and that the assault would not have occurred if it had remained in place. The plaintiff also says that the Province was in breach of the fiduciary duty that it owed to the vulnerable plaintiff and acted in disloyal breach of that duty when Martens told O.P. that she would replace the supervision requirement and then did not do so.

[48] Although the Crown does not argue that there was no duty of care owed, she says that "…the scope of the duty of care owed by social workers employed by MCFD was to act in good faith and to consider relevant factors in making protection decisions about B.M.'s care…" based upon ***Dorset Yacht Co. Ltd. v. Home Office***, [1970] A.C. 1004, [1970] 2 All E.R. 294, [1970] 1 Lloyd's Rep. 453, [1970] 2 W.L.R. 1140 (H.L.) [***Dorset Yacht***], and ***L.C. v. British Columbia (Ministry of Children and Families)***, 2005 BCSC 1668, 49 B.C.L.R. (4th) 164 [***L.C.***]. The Crown says that there is no evidence to establish that the social workers failed to act in good faith and that the most that can be said is that they failed to comply with practice standards. Further, the Crown argues that there was no breach of a standard of care that could be causally linked to the injury to B.M. Although in the opening by defence counsel and in argument, it was conceded that an inference of a causal connection between the lifting of the supervision requirement and the subsequent injury to B.M. could be drawn, the defence says that there is no evidence that a reasonably prudent social worker would not have lifted the supervision term or that the result would have been any different if the term had remained. Further, breach of policy indicative of breach of the standard of care is not actionable in itself. With respect to breach of fiduciary duty, the defendant Crown argues that there was no fiduciary relationship here and no evidence of breach of fiduciary obligation that requires proof of dishonest or intentional disloyalty.

[49] The Crown does not rely on the statutory immunity provided by section 101 of the ***Act***. She also acknowledges that if the social workers are found to have been negligent, the Crown would be vicariously liable.

V. ANALYSIS

(A) Assault

[50] The evidence established that R.M. intentionally assaulted B.M. on September 16,

2002. This assault caused damages that are to be determined.

(B) Negligence

[51] In order for the plaintiff's action in negligence to succeed, he must establish three things: that the defendant owed the plaintiff a duty of care, that the defendant breached that duty of care, and that damages resulted from that breach (***Odhavji Estate v. Woodhouse***, 2003 SCC 69 at para. 44, [2003] 3 S.C.R. 263, 233 D.L.R. (4th) 193, 180 O.A.C. 201, 312 N.R. 305, 19 C.C.L.T. (3d) 163).

1. Negligence by R.M.

[52] R.M. was in a parental relationship with B.M. and B.M. was under his sole care when he intentionally assaulted the child by shaking him. B.M. was in a particularly vulnerable position and R.M. was in the first three weeks of exercising unsupervised access. R.M. acted in breach of his duty to take reasonable care of B.M. in the circumstances and his breach caused injury, the extent to be determined.

2. Negligence by the Crown

(a) Duty of Care

[53] The test for determining whether a public authority owes a duty of care, as recently confirmed by the Supreme Court of Canada in ***Hill*** at para. 20 and by the British Columbia Court of Appeal in ***D.H.*** at para. 33, involves two questions. As noted in ***Hill*** at para 20, these questions derive from ***Anns v. Merton London Borough Council*** (1977), [1978] A.C. 728, [1977] 2 All E.R. 492 (H.L.) [***Anns***], as developed and explained in ***Cooper v. Hobart***, [2001] 3 S.C.R. 537, 2001 SCC 79, 206 D.L.R. (4th) 193, 96 B.C.L.R. (3d) 36, [2002] 1 W.W.R. 221, 160 B.C.A.C. 268, 261 W.A.C. 268, 8 C.C.L.T. (3d) 26, 277 N.R. 113 [***Cooper***], and ***Brown***. These are: first, does the relationship between the plaintiff and the defendant disclose sufficient foreseeability and proximity to establish a *prima facie* duty of care; and, second, if so, are there any residual policy considerations which ought to negate or limit that duty of care?

[54] In ***Childs v. Desmormeaux***, [2006] 1 S.C.R. 643 at para.15, 2006 SCC 18, 266 D.L.R. (4th) 257, 80 O.R. (3d) 558 (note), 210 O.A.C. 315, 347 N.R. 328, 39 C.C.L.T. (3d) 163 [***Childs***], the Supreme Court of Canada pointed out that a nuance from the ***Anns*** test as developed in ***Cooper*** is that as case law develops, categories of relationships giving rise to a duty of care may be recognized, generally making it unnecessary to go through the ***Anns*** analysis. The categorical reference acknowledges that if a duty of care has been recognized previously for the same relationship between the parties or an analogous one, the court can infer that proximity is established and that the risk of injury was foreseeable, so to give rise to a duty of care in negligence. The recognized categories listed in ***Cooper*** at para. 36 were summarized by Smith J. in ***McClelland v. Dr. Stewart***, 2003 BCSC 1292 at para. 19, 229 D.L.R. (4th) 342, rev'd on other grounds, 2004 BCCA 458, 245 D.L.R. (4th) 162, 31 B.C.L.R. (4th) 203, 204 B.C.A.C. 150, 333 W.A.C. 150, and by the Ontario Court of Appeal in ***Haskett v. Trans Union of Canada*** (2003), 224 D.L.R. (4th) 419 at para. 22, 63 O.R. (3d) 577, 169 O.A.C. 201, 15 C.C.L.T. (3d) 194 (C.A.). The first category, as developed in ***Childs*** at para. 31, is where the defendant's overt act foreseeably causes physical harm to the plaintiff or the plaintiff's property.

[55] In this case, the defendant agreed that the social workers established a close and direct relationship with B.M. as a child in need of protection such that it was reasonably

foreseeable that their actions would cause harm to B.M. The statutory scheme under which they worked required that B.M. be placed under protection if there existed a likelihood that he would be physically harmed by his parent.

[56] Neither party argued that this case fell within a recognized category. However, I conclude that the defendant conceded that the relationship between social worker and child in a protection case is close and proximate such that a *prima facie* duty should be recognized. Both parties focused on the second part of the ***Anns*** test as determinative of whether the duty of care arose within the general law of negligence. From ***Hill*** at para. 31, it is apparent that uncertainty may arise as to which factors fall to be considered at which stage of the analysis. McLachlin C.J. said:

> In accordance with the usual rules governing proof of a cause of action, the plaintiff has the formal onus of establishing the duty of care: ***Odhavji*** and ***Childs***, at para. 13, should not be read as changing this fundamental rule. Uncertainty may arise as to which factors fall to be considered at this part of the stage one analysis, and which should be reserved to the second stage "policy" portion of the analysis. The principle that animates the first stage of the ***Anns*** test — to determine whether the relationship is in principle sufficiently close or "proximate" to attract legal liability — governs the nature of considerations that arise at this stage. "The proximity analysis involved at the first stage of the ***Anns*** test focuses on factors arising from the relationship between the plaintiff and the defendant", for example expectations, representations, reliance and the nature of the interests engaged by that relationship: ***Cooper***, at paras. 30 (emphasis deleted) and 34. By contrast, the final stage of ***Anns*** is concerned with "residual policy considerations" which "are not concerned with the relationship between the parties, but with the effect of recognizing a duty of care on other legal obligations, the legal system and society more generally": ***Cooper***, at para. 37. In practice, there may be overlap between stage one and stage two considerations. We should not forget that stage one and stage two of the ***Anns*** test are merely a means to facilitate considering what is at stake. The important thing is that in deciding whether a duty of care lies, all relevant concerns should be considered.

[57] The real issue pertains to the second part of the test. Is there a broad policy reason for declining to recognize a duty of care? Are there policy considerations which negate or limit the duty of care (***Anns*** at 752)? What is the nature of the decision at issue here? Do discretionary decisions by professional public officials, in this case, social workers, fall outside

a duty of care in negligence?

[58] As enunciated in ***D.H.*** at para. 45, the second question in the ***Anns*** test asks whether the nature of the decision made here by the social worker constituted exercise of a discretion in respect of policy or quasi-judicial matters, or whether it is in relation to how the action is performed. The answer to this question will determine whether the standard of care to be applied is the general standard arising in the law of negligence or the higher standard required to challenge policy decisions, that is, that the decision was not made in the *bona fide* exercise of discretion.

[59] It is no longer the case that the exercise of a statutory discretion necessarily negates a duty of care in negligence (***D.H.*** at para. 57). The question was stated by Saunders J.A.:

> The question is not whether the role of the public official engages discretion, but the nature of the discretion exercised – is it discretion requiring the exercise of judgment in policy considering broad criteria, or is it more narrow? If it is the former, as in ***Cooper***, the case may not support a duty of care. If the latter, as in ***Hill***, the discretion will not negate a duty of care but will be a factor in determining the applicable standard of care.

[60] The analysis of ***Anns*** in ***D.H.*** at paras. 38-41 is also instructive:

> Generally, the first question has not been conceptually difficult in determining whether a duty of care exists. One cannot say the same of the second question from ***Anns*** - the existence, or not, of a policy consideration negating the *prima facie* duty of care. Before ***Anns***, in ***Dorset Yacht***, the distinction was made between discretionary decisions and other decisions, with the proposition that discretionary decisions were afforded immunity from suit unless the exercise of discretion was unreasonable. That distinction was adopted in ***Anns*** using the added terms "policy function" and "operational function", with policy function equated generally with discretionary decisions. Further, in ***Anns***, liability for discretionary acts was restricted to an exercise of discretion not "within the limits of a discretion *bona fide* exercised" (p. 755).
>
> The broad meaning of the term "discretion", as applied in ***Anns***, had the theoretical effect of greatly limiting the situations in which the exercise of statutory power by a public official was actionable. To some degree this limitation was relaxed in ***Just***. There, the Supreme Court of Canada narrowed the circumstances in which public policy would negate the existence of a duty of care to "pure policy decisions". This approach was also taken in

Brown, with liability arising from a policy decision restricted to one "made in bad faith or in circumstances where it is so patently unreasonable that it exceeds governmental discretion" (p. 435).

The same narrowed approach was taken in ***Cooper***. In considering the existence of a duty of care of a registrar of mortgage brokers sued by members of the investing public for economic losses incurred as a result of the misfeasance of a mortgage broker, the Supreme Court of Canada said:

> [38] It is at this second stage of the analysis that the distinction between government policy and execution of policy falls to be considered. It is established that government actors are not liable in negligence for policy decisions, but only operational decisions. ... On the other hand, a government actor may be liable in negligence for the manner in which it executes or carries out the policy. ... The exclusion does not relate to the relationship between the parties. Apart from the legal characterization of the government duty as a matter of policy, plaintiffs can and do recover. The exclusion of liability is better viewed as an immunity imposed because of considerations outside the relationship for policy reasons - more precisely, because it is inappropriate for courts to second-guess elected legislators on policy matters. Similar considerations may arise where the decision in question is quasi-judicial. (see ***Edwards v. Law Society of Upper Canada***, [2001] 3 S.C.R. 562, 2001 SCC 80).
>
> [Emphasis added.]

On my reading of ***Hill***, the Supreme Court of Canada has affirmed this restricted approach to the second ***Anns*** question, leaving the denial of a duty of care where there is sufficient proximity to establish a *prima facie* duty to cases where there is "a real potential for negative policy consequences" (para. 43). In other words, mere

> exercise of discretion is not sufficient to negate a duty of care; the discretion must engage policy issues that would be negatively affected by finding a duty of care.

[61] In ***Hill*** at paras. 51-53, the discretion inherent in police work was taken into account in formulating the standard of care, not whether a duty of care arose. This was because police work is professional in nature, based upon exercise of discretion and judgment according to professional standards and practices, not unlike other professions. British Columbia argued in ***D.H.*** that the decision by a probation officer to permit an offender to reside in a suite in the same house as children contrary to his probation order engaged the officer in broad public law discretions dissimilar to the discretion exercised by professionals. In rejecting this argument, the court said, at paras. 59-60, that the issue of immunity based upon the exercise of discretion depends upon "the function in issue and the role that the official was playing in the circumstances giving rise to the action." In ***D.H.***, the officer's function in monitoring compliance with a probation order did not involve the design of terms or a program so as to bring the function within the high policy level contemplated before immunity from liability at this stage of the analysis could prevail.

[62] While previous cases involving government social workers in comparable circumstances may provide guidance, it is no longer necessary to bring this case within previous situations in which a duty of care was found to exist. The two stage approach of ***Anns***, as interpreted in ***D.H.***, must be followed. In ***A.G. v. Superintendent of Family and Child Service*** (1989), 38 B.C.L.R. (2d) 215, 61 D.L.R. (4th) 136, [1990] 1 W.W.R. 61, 21 R.F.L. (3d) 425 (C.A.) [***A.G.***], the parents of seven children that were apprehended by government social workers because of alleged sexual abuse claimed that the social workers were negligent to a degree amounting to bad faith. Esson J.A. concluded at 225 that the nature and quality of the decision made was in the exercise of a discretion conferred by statute so that the degree of care required in the circumstances was not to be determined by the general law of negligence but by the standard of due care established in ***Dorset Yacht*** for the exercise of statutory discretion. The court did not consider whether the decision in that case was a pure policy decision or an operational decision. It had been conceded that a duty of care to act in good faith arose. This case preceded ***Just***, ***Cooper***, ***Brown***, and ***Hill***.

[63] In ***C.H. v. British Columbia***, 2004 BCCA 385, 31 B.C.L.R. (4th) 26, 242 D.L.R. (4th) 470, 202 B.C.A.C. 25, 331 W.A.C. 25, 26 C.C.L.T. (3d) 51, the Ministry of Social Services was found liable for damages resulting from sexual abuse for failure to arrange supervision of a child in her father's home. The social worker's failure to inform herself of the information necessary to make a decision to place the child in her father's home without supervision amounted to bad faith. The issue on appeal was whether the trial judge had erred in his articulation and application of the good faith standard. There had been no dispute in that case that the Crown was immune from liability where it exercised its statutory discretion with due care. The policy/operational discussion within duty of care did not arise.

[64] In ***L.C.***, parents of a child that had suffered a severe skull fracture brought an action in negligence for economic loss suffered as a result of costs incurred in fighting social workers to retain custody of their child. The parents alleged that social workers failed to conduct a proper investigation into the injury after the child was apprehended. The child was returned to the parents after a court concluded that the child was not in need of protection. An explanation for the injury had evolved mostly through the trial process. The court considered that the decision not to return the child to his parents was especially difficult because all evidence suggested

that the mother had inflicted the injury despite the lack of familial risk factors. The court relied upon the analysis in ***A.G.*** to find that there was so much room for differences of opinion and errors of judgment that the degree of care required could not fall under the general law of negligence but was at the higher standard of lack of good faith.

[65] Both ***L.C.*** and ***A.G.*** denied that there was a duty of care in negligence due to the thankless nature of the tasks undertaken by social workers and the fact that they must make difficult discretionary exercises of judgment. Both decisions preceded ***Hill*** and ***D.H.*** wherein the fact of a difficult discretionary decision alone does not deny the existence of an ordinary duty of care. The role of the social worker must require the exercise of judgment in policy considering broad criteria before a duty of care in negligence will be negated (***D.H.*** at para. 57).

[66] In this case, it cannot be said that the social workers were exercising their discretion at a policy level as contemplated in ***Just*** or ***Cooper***. Rather, the social workers were engaged in an operational function at the servicing and investigation level as described in ***M.B. v. British Columbia***, 2000 BCSC 735 at paras. 167-170 [***M.B.***].

[67] In ***M.B.***, allegations of negligence against the Crown related predominantly to the failure of social workers to adequately supervise and monitor the foster parent home where the plaintiff was sexually abused. The nature and quality of the decisions made with respect to supervision were found to be operational in nature and different from the inherently difficult decision to place or remove a child in care. Levine J. (as she then was) said at para. 170:

> In my view, a social worker's responsibilities to monitor and supervise do not involve the exercise of discretion sufficient to raise the application of the defence of good faith. The nature and quality of the decision of a social worker in deciding whether and how often to visit a foster home, for example, is not to any extent the exercise of a "policy-making" function, but involves only practical considerations, such as geography, time, workload and similar factors. The decisions made in carrying out the duty to monitor and supervise foster children are not discretionary in the sense used in ***G.(A.) v. Supt. of Fam. & Child Service***, ***McAlpine v. H.(T.)*** and ***D.(B.) v. British Columbia***. As in ***Dorset Yacht*** (see p. 301), the issue of good faith does not arise here because no discretion was given to the social workers in respect of their duty to monitor and supervise the plaintiff while she was in foster care.

The cases cited all pertained to the placement or removal of children in care. The decision to place a child in need of protection is analogous to these "larger decisions involving the exercise of discretionary authority" (at para. 168). The conduct giving rise to the allegation of negligence here does not involve the placement or removal of a child from protection.

[68] The decision to place B.M. under protection is not challenged. Rather, as in ***M.B.***, the allegations relate to the failure of social workers to adequately supervise and monitor R.M. The conduct complained of is: dropping the supervision requirement for R.M. contrary to the comprehensive risk assessment, allowing B.M. to have unsupervised contact with R.M. notwithstanding that an assessment had not been done as to the cause of R.M.'s assault upon

his first child and in face of a finding that there was a likelihood that R.M. would cause serious injury to B.M., and failing to reinstate the supervision requirement after circumstances changed significantly. The design of terms of supervision or monitoring does not involve that degree of discretion to bring this function to the level of a broad policy decision as suggested in ***D.H.*** at para. 60. There was no discretion to be exercised when it came to completing a comprehensive risk assessment at significant changes in family circumstance or after the third child protection report in one year or when it came to the overall goal of ensuring child safety at all times. The Practice Standards are mandatory.

[69] There are no policy reasons to negate a finding that there exists a duty of care in negligence in this case.

(b) Standard of Care

[70] The standard of the reasonable social worker in like circumstances is the appropriate standard to apply here. This was the standard applied in the case of an alleged negligent police investigation in ***Hill*** where, at para. 68, this standard was found to provide a "flexible overarching standard that covers all aspects of investigatory police work and appropriately reflects its realities." This standard incorporates "an appropriate degree of judicial discretion, denies liability for minor errors or mistakes and rejects liability by hindsight" (*ibid.*). The standard of good faith, described sometimes as a defence, was rejected in ***M.B.*** at paras. 169-170 as applying to operational decisions of a supervisory nature involving the day-to-day tasks of a social worker.

[71] The reasonableness standard was also applied to a probation officer in ***D.H.*** at para. 67, where Saunders J.A. said:

> In ***Hill***, the Supreme Court of Canada found the appropriate standard to impose in relation to the tort of negligent investigation by a police officer was that of a reasonable police officer in similar circumstances. In this case, I consider that the appropriate standard is that of the reasonable probation officer in similar circumstances. The considerations that supported the standard for a police officer in ***Hill*** support this standard: it is flexible and may be tailored to reflect the realities of the case, it is parallel to the standards applied in other negligence cases and in particular to cases concerning the negligence of professionals, and it fits easily with the common law factors usually considered in determining the content of the standard of care such as the likelihood of harm, the gravity of the potential harm, external indicators of reasonable conduct, statutory standards and the burden incurred to prevent the injury.

[72] In considering this standard of care, the degree of discretion is important. As stated in ***Hill*** at para. 73:

> I conclude that the appropriate standard of care is the overarching standard of a reasonable police

> officer in similar circumstances. This standard should be applied in a manner that gives due recognition to the discretion inherent in police investigation. Like other professionals, police officers are entitled to exercise their discretion as they see fit, provided that they stay within the bounds of reasonableness. The standard of care is not breached because a police officer exercises his or her discretion in a manner other than that deemed optimal by the reviewing court. A number of choices may be open to a police officer investigating a crime, all of which may fall within the range of reasonableness. So long as discretion is exercised within this range, the standard of care is not breached. The standard is not perfection, or even the optimum, judged from the vantage of hindsight. It is that of a reasonable officer, judged in the circumstances prevailing at the time the decision was made - circumstances that may include urgency and deficiencies of information. The law of negligence does not require perfection of professionals; nor does it guarantee desired results (Klar, at p. 359). Rather, it accepts that police officers, like other professionals, may make minor errors or errors in judgment which cause unfortunate results, without breaching the standard of care. The law distinguishes between unreasonable mistakes breaching the standard of care and mere "errors in judgment" which any reasonable professional might have made and therefore, which do not breach the standard of care (see *Lapointe v. Hôpital Le Gardeur*, [1992] 1 S.C.R. 351; *Folland v. Reardon* (2005), 74 O.R. (3d) 688 (C.A.V.); Klar, at p. 359.)

Other factors to consider include “the likelihood of known or foreseeable harm, the gravity of harm, [and] the burden or cost which would be incurred to prevent the injury” (***Hill*** at para. 70).

[73] There was an obvious likelihood of harm in this case. A finding had been made under section 13 of the ***Act*** that B.M. was a child in need of protection because he was likely to be physically harmed by his parent. Given his infancy, he was extremely vulnerable and the family circumstances were such that social workers determined that there was a likelihood of serious abuse. The previous recent conviction of R.M. for assault of his young child in Manitoba made this an easy case for determination. The high risk that R.M. posed was reduced only because O.P. and A.V. were required to supervise R.M. with the child at all times.

[74] The appropriate standard of care should also examine external indicators of reasonable conduct, including professional standards and internal policy (***Hill*** at para. 70; ***Burbank v. R.T.B.***, 2007 BCCA 215 at paras. 91-92, 65 B.C.L.R. (4th) 290, 279 D.L.R. (4th) 573, 239 B.C.A.C. 252, 396 W.A.C. 252, 47 C.C.L.T. (3d) 25, leave to appeal ref’d, [2007] S.C.C.A. No. 316). Compliance with policy may be an important factor to consider in determining whether

the standard of care has been met (***Doern v. Philips Estate*** (1994), 2 B.C.L.R. (3d) 349 at para. 68, [1995] 4 W.W.R. 1, 23 C.C.L.T. (2d) 283). However, failure to follow policy does not automatically compel the conclusion that the standard of care was breached (***D.H.*** at para. 83).

[75] The social workers failed to meet the applicable standard of care in this case when it was decided to remove the supervision provision and when that decision was not reconsidered after significant changes in family circumstances and when a third child protection report was made within a year. At the time that the supervision requirement was removed for R.M., B.M. was a child in need of protection due to the fact that he could be physically harmed by R.M. The criminal conviction provided clear indication of imminent risk in a profession where such clarity is rare. There had been no request to remove the provision. There was no urgency. There was no basis to remove the requirement founded upon protection to B.M. or elimination of risk, the mandatory priority concern. It is not known why the social worker removed the requirement or how the decision was made. The elimination of the supervision requirement was incompatible with the comprehensive risk assessment and no new risk assessment was done. A reasonable social worker would not have lifted the supervision requirement without performing another risk assessment and without having determined that there was no real risk to B.M. from unsupervised contact with his father. It was not reasonable to fail to complete a new comprehensive risk assessment which was mandatory under the Practice Standards in this circumstance.

[76] The risk to B.M. then increased as A.V. and R.M. left O.P.'s home, when it was clear that R.M. would have sole care of B.M. when A.V. was at work, and when R.M.'s attitude changed. Any doubt about what led R.M. to assault his first son had to be resolved in favour of protection to B.M. A new risk assessment should have been done at this time. On the basis of the existing risk assessment, there was no basis to lift the supervision provision. There was ample opportunity and a stated intention by Martens to re-instate the provision but this was not done. Any danger or risk to B.M. was required by policy to be resolved in favour of protection. Given the previous history, unresolved recidivism of R.M., and risk factors, the plan to leave A.V. and R.M. with only sporadic home visits was unreasonable.

[77] A reasonable social worker in the same circumstance would not have removed the supervision provision. The primary operative principle was protection of B.M. High risk factors had not decreased. There was a failure to follow policy to assess risk. This situation only worsened when A.V. and R.M. left O.P.'s home. It matters not that such a provision could not have remained indefinitely. Priority had to be given to B.M.'s safety and this was still in the short term. The decision to remove the supervision requirement cannot be considered a mere error in judgment in light of the existing comprehensive risk assessment. Further, removal in the circumstance of increased, unresolved risk was unreasonable. The social worker did not act as would be expected of a reasonable social worker in the same circumstance. Failure to do so was in breach of the required standard of care.

(c) Causation

[78] The plaintiff and Crown agreed that the failure to exercise reasonable care on the part of the defendant must have caused the injury complained of based upon the "but for" test of causation as asserted in ***Resurfice*** at paras. 21-23. The plaintiff must show that the injury would not have occurred but for the negligence of the defendant. Causation does not have to be proven with scientific precision as it is a practical question requiring application of common sense (***Athey v. Leonati***, [1996] 3 S.C.R. 458 at para. 16, 140 D.L.R. (4th) 235, [1997] 1 W.W.R. 97, 81 B.C.A.C. 243, 203 N.R. 36, 132 W.A.C. 243, 31 C.C.L.T. (2d) 113).

[79] The Crown has conceded that it is open to this court to draw an inference of a causal connection between the lifting of the supervision term and the injury to the plaintiff. However, the Crown says that there is no evidence that a second comprehensive risk assessment would have resulted in a different decision.

[80] In this case, the family was following the supervision requirement faithfully and there had been no incidents during the time that the supervision requirement was in place from June 20, 2002 to August 23, 2002. There is no evidence that A.V. or O.P. would have allowed R.M. to have unsupervised care of B.M. until the Ministry had determined that B.M. was no longer in need of protection from R.M. B.M. had never been left alone with R.M. while the defendant had imposed the supervision requirement. B.M. was safe. There is a substantial connection between removal of the supervision requirement and R.M.'s assault of B.M. when B.M. was solely in his care shortly thereafter. The decision was inherently risky without resolution of the recidivism issue and without a re-assessment of risk in the changed family circumstances and after the third child protection report. The decision created a dangerous situation whereby R.M. was permitted to have unsupervised access to B.M. despite the fact that the risk factors were high, unresolved, and increasing. Removal of the supervision requirement gave R.M. the opportunity to assault B.M., which was not available to him while the supervision requirement was in place. The assault upon B.M. by R.M. would not have occurred if the supervision requirement had remained in place.

(C) Breach of Fiduciary Duty

[81] Because I have found the Crown liable in negligence for the injury caused to B.M., it is not necessary to decide whether the Crown is also liable for breach of fiduciary duty. The arguments of all parties focused on negligence with very little reference to breach of fiduciary duty. In this circumstance, I decline to embark upon an analysis for breach of fiduciary duty.

VI. CONCLUSION

[82] The defendant, R.M., is liable to the plaintiff for assault and negligence. The defendant Crown is liable in negligence. The parties may now proceed to assess damages and to seek a determination as to costs.

"Dillon J."

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The Honourable Madam Justice Dillon