IN THE MATTER OF THE *COMMUNITY CARE FACILITY ACT, R.S.B.C. 1996, C. 60, AND THE ADULT CARE REGULATIONS B.C. REG 536/80, AS AMENDED*

And

IN THE MATTER OF THE CAPITAL HEALTH REGION,
COMMUNITY CARE FACILITIES LICENSING AND
MONTREUX SPECIALIZED RESIDENTIAL FACILITY FOR EATING DISORDERS

Before

DR. RICHARD S. STANWICK

MEDICAL HEALTH OFFICER, CAPITAL HEALTH REGION

VICTORIA, B.C.

DECEMBER 1, 1999

DECISION

For Montreux Specialized Residential Facility for Eating Disorder
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INTRODUCTION

This Hearing was held pursuant to Section 6 of the *Community Care Facility Act* which states:

6. If the Director determines following a Hearing that a Licensee or permit holder has contravened an enactment of British Columbia or of Canada or a term or condition of the Licence or Interim Permit, the Director may attach terms or conditions to, suspend or cancel the Licence or Interim Permit.

The purpose of this Hearing was to determine whether there have been contraventions of the *Community Care Facility Act* (the *Act*) and the Adult Care Regulations (the Regulations) as outlined in Licensing s Investigation Report of September, 1998 (Exhibit 2) and the Update Report of April, 1999. (Exhibit 22)

The Licensee for the 1560 Rockland Avenue site in Victoria is the incorporated company, Montreux Counselling Centre Limited.

For those unfamiliar with the British Columbia legislation governing community care facilities, let me make clear the facets of care which are covered by the licensing scheme. The *Act* and its Regulations set forth a minimum standard which all licenced facilities are required to meet. These standards have been developed to ensure a base level of protection of the health and safety, and of the individual rights and dignity, of all patients in licenced care facilities throughout the Province.

If, as a result of the Hearing, I determine that the *Act* and/or Regulations have been contravened, then I, as Hearing Officer, am also to determine what consequence or result should be imposed with respect to the Licence that has been issued under the *Act* that permits a facility, in this case Montreux, to operate.

As emphasized by Licensing, Peggy Claude-Pierre is not on trial, nor are Montreux s ideas on the causes of eating disorders. Neither are the over-all qualifications and general competency of the three general practitioners who provided care to Montreux residents. This is a Hearing about the health and safety of the patients receiving care at the Montreux Clinic.

This Hearing is not about whether new, developing or alternative modalities of treating eating disorders are better or worse than more mainstream treatments, whether Montreux has achieved the levels of success reported in the media or whether it has conducted an evaluation of its outcomes. Provided that the minimum standards are met, the decision on treatment approaches to be used is strictly between a facility, a patient and/or a patient s family, and the medical practitioners involved. I have endeavoured to follow these principles in writing this decision.

While the opinions of individuals who have received therapy at Montreux and their families will be taken into account, it will be only within the context of the alleged contraventions of the *Act* and the Regulations as they pertain to the health and safety of clients being cared for by Montreux.

It was not disputed at the Hearing that the *Act* and the Regulations are the law in British Columbia, as is the *Mental Health Act*, another key piece of legislation relevant to this Hearing. All licenced facilities must comply with the *Act* and the Regulations, as together, they set the minimum acceptable standards established to ensure the health and safety of persons in care in all licenced facilities.

The onus is on Licensing to show that there have been breaches of the *Act* and/or Regulations, and that Montreux has fallen below those minimum health and safety standards established by the legislature of this Province.

In the Report and in their submissions to me, Licensing submits that the Montreux Clinic should lose its licence to operate as a community care facility. They cite what they allege

are numerous breaches of the *Act* and Regulations, and note that Montreux was already given a second chance to come up to standards after a previous finding of contraventions following complaints and an investigation in 1997.

Montreux, in reply, concedes that some errors were made, but proposes that, rather than it lose its licence, I should place conditions upon the licence which should be sufficient to ensure that the *Act* and its Regulations are obeyed, and that the health, safety and dignity of residents are protected. However, the Clinic, through its lawyer, Mr. Dennis Murray, Q.C., urged me not to make any such conditions that were so stringent that they would either be impossible for Montreux to meet financially or would take away from what the Clinic sees as its unique ambiance for treating eating-disordered patients.

On the basis of the evidence presented at this Hearing, I must determine on a balance of probabilities whether or not contraventions of the *Act* and/or the Regulations have occurred and what penalty, if any, shall be imposed upon the licence for Montreux Counselling Centre Limited.

Although, in its submission Licensing cited more than two dozen breaches of the *Act* and Regulations, their lawyer, Mr. Guy McDannold said at the Hearing that Licensing views some of the allegations as considerably more serious than others. Thus, while Licensing staff identified eight areas of concern, they focused their case on client health and safety issues in the areas of:

- Montreux accepting patients for admission that are beyond their capabilities;
- Client suicide risk;
- Feeding practices employed by Montreux staff;
- Secretly caring for a four-year-old child;
- Engaging in a form of imposed treatment under the illusion of no choice.

These matters constitute the core of my decision. The other alleged contraventions, along with a number of new ones raised at the Hearing, are addressed but are not central to my findings.

One other issue which was raised during the Hearing was that of disclosure of the details of Licensing s case to the Licensee. At the request of the Licensee s lawyer and at my urging, Licensing did agree to provide to the Licensee much of the information asked for, including details of certain questionnaires given to Montreux staff. It was also agreed that if any complainants wished not to have their identities disclosed to Montreux, that factor would be taken into consideration by me when deciding how much weight, if any, I should give that evidence, in cases where it was not subject to cross-examination.

HISTORY AND BACKGROUND

Montreux Clinic was first licenced under the *Community Care Facility Act* on June 14, 1995, a little more than two years after Peggy Claude-Pierre and her husband, David Harris, had established in Victoria, British Columbia, a residential facility for treating patients with eating disorders. The licence, which was approved by then-Acting Medical Health Officer for the Capital Regional District, Dr. Tim Johnstone, authorized Montreux to care for nine residential patients at its site at 1560 Rockland Avenue, Victoria. Montreux was classified as a specialized adult residential care facility, specifically for eating-disordered patients. Under that classification, Montreux was allowed to admit patients under the age of 19 only with special permission, and each underage patient had to be approved individually by the Medical Health Officer. This temporary placement arrangement also required that Montreux apply for an extension of the underage client s stay every six months. (Exhibit 2, P3-5)

At the time the licence was granted, the Licensee was a non-profit society duly established under the B.C. *Society Act* as the Montreux Society for Eating Disorders. The society had been incorporated on January 31, 1994, with Victoria Police Sgt. Bill Naughton as president. The Manager for the facility was David Harris.

In January, 1997, Licensing Officers for the Capital Health Region (formerly of the Capital Regional District), received complaints of problems existing at the licenced facility and began an investigation. The allegations included:

- Incomplete and inaccurate resident records;
- Concern regarding an overdose attempt by a resident and the response by facility staff;
- Medication errors;
- Concern regarding staff qualifications;
- Facility response to a resident s request to leave over an extended period of time;
- Limited telephone access for a resident;

- Inappropriate methods of feeding residents including force feeding;
- A family not being informed of a resident s condition.

While this investigation was still in progress, in May, 1997, an application was made to change the actual holder of the Licence from the non-profit society to a for-profit corporation, incorporated under the B.C. *Company Act,* Montreux Counselling Centre Ltd. Montreux at that time also officially changed the Manager from David Harris to Noah Dobson.

In July, 1997, on the basis of an investigation report from Licensing staff (Exhibit 25) and replies provided by Montreux, (Exhibit 25, Tab 32 and Exhibit 65) I found that a number of infractions of the *Community Care Facility Act* and its Regulations had in fact been committed by Montreux. However, it also appeared that the Clinic was making a serious effort to remedy these deficiencies and on that basis, I elected to take no action against their Licence.

In October, 1997, new allegations were made to Licensing investigators and a second investigation was begun. (Exhibit 2, P1-2) It was this investigation which lead to the public hearing which took place over a period of 26 days in May and July of 1999.

In December, 1998, on the basis on the new investigation report provided to me by Licensing staff, I placed a number of conditions upon the Licence of the Clinic. These conditions were:

1) That there be no new admissions or re-admissions of adult or child patients to the licenced Montreux facility at 1560 Rockland Avenue.
2) That, with all costs borne by Montreux, the physician(s) retained by Montreux will complete a medical examination, consisting of:
    a) a review and updating of the medical history of each patient;
    b) a general physical of each patient;
    c) a determination of each patient s medical fitness to remain at Montreux;

d) an assessment of suicide risk;

e) any such additional requirements as the Medical Health Officer may specify for the protection of the health and safety of the patient.

The results of each medical examination were to be communicated to the Medical Health Officer by January 6, 1999.

3) That, with all costs being the responsibility of Montreux, the physician(s) retained by Montreux Clinic would also provide ongoing medical assessments after January 6, 1999 at intervals to be specified by the Medical Health Officer.

4) That the physician(s) retained by Montreux immediately advise both the Licensee and the Medical Health Officer in the event that a patient becomes medically unstable and requires hospitalization.

The conditions remain in effect up to this time.

At the Hearing, Mr. Paul Pearlman, Q.C., was counsel to myself as Hearing Officer. Mr. Dennis Murray, Q.C., and Ms. Fiona McQueen were legal counsel for the Licensee, and Mr. Guy McDannold represented Licensing.

During the Hearing, I heard from a total of 47 witnesses who provided a wide variety of perspectives on Montreux and its operation.

Witnesses on behalf of Licensing included three members of the investigation team: Chief Licensing Officer for the Capital Health Region, Steven Eng; Chief Residential Care Licensing Officer for the Capital Health Region, Kim Macdonald (also a Nutritionist for Licensing); and psychologist Dr. Gerry Stearns, who had been seconded to the investigation team from the B.C. Ministry of the Attorney-General.

Expert witnesses called by Licensing were: Dr. C. Laird Birmingham, a medical internist and Head of B.C. s Provincial Eating Disorder Unit at St. Paul s Hospital, Vancouver; Jennifer White, Director of the Suicide Prevention Information Resource Centre,

Department of Psychiatry, University of British Columbia; and Dr. Geoffrey Ainsworth, a child psychiatrist from Vancouver.

Licensing also called as witnesses five former staff members of the Montreux Clinic: Heather Hestler, Rachel Spence, Adrian Maisonneuve, Marty D Argis, and Alex Garcia. Of note, the testimony of these individuals mirrored most closely the information contained in the written logs, forms and documents of Montreux Clinic put into evidence before this Hearing.

Licensing did not call as witnesses any current or former patients at Montreux. Nor they did not cross-examine any current Montreux clients called by the Clinic. Mr. McDannold stated in their submissions they were reluctant to engage these persons because of the potential impact on their health.

The Licensee, Montreux, called more than two dozen witnesses on their behalf. These included three general practitioners in good standing in the Victoria community who provided medical care to Montreux residents: Drs. David Clinton-Baker, Charles Medhurst, and Mauro Bertoia.

The Licensee called four of the senior managers at the time of the second investigation: Peggy Claude-Pierre, founder of the Clinic and its Program Director; her husband, David Harris, the former facility Manager; Noah Dobson, the Manager at the time of the second investigation and the Hearing; and Margaret Dobson, Associate Program Director. Because the Dobsons were anticipating leaving British Columbia within the next few months after the Hearing concluded, the Licensee also called the person who was their preferred choice to take over as the new Manager, Robert Enoch. He had been functioning as a consultant for Montreux for the past year. (T19, P14) Also looking forward to a revised administrative structure, another witness on behalf of the Licensee was Brenda Loney, who serves on the Clinic s newly established Monitoring Committee.

Montreux also called several members of what might best be termed its middle management team — persons who are below the level of the senior Montreux managers and directors, but who fulfill specific roles in the Clinic senior to the careworkers. These persons included: Kendra Dempsey, the Medical Liaison Officer; Scott Melynk, the Co-ordinator of the Education Program; and Jane McCluskey, a former high-profile patient who now serves as the Family Liaison Officer. Several current and former staff members of Montreux also testified, including Julia Kruz, Nora Desjardins and Janice Lim.

Expert witnesses called by the Licensee were: Dr. Paul Termansen, a psychiatrist and suicide expert from the Lower Mainland, and Dr. Susan Sherkow, a child psychoanalyst who testified via a long-distance teleconference connection from her home city of New York.

The remainder of the Licensee s witnesses were either patients, current or former, or the parents of patients, either current or former. I recognize that it took considerable courage for these individuals to come forward and testify at this Hearing. It was also evident from their at times passionate testimony that they had experienced considerable frustration in their dealings with the health care system. Whether the issue was cost of care or the deficiencies in the programs that were available to them to treat their child s anorexia, the dissatisfaction of witnesses from the United States, the United Kingdom, Germany and Australia was clear. Moreover, I was impressed by the sincerity of the witnesses and their commitment to and belief in the Montreux Clinic and its approach, as well as the considerable distances many of them traveled to tell their stories and the role Montreux played in their efforts to deal with their children s illness.

Nevertheless, the allegations before me did not specifically involve many of the patients and parents who testified. Since the separation of parent from child is often part of the therapeutic approach used at Montreux, most parents who appeared at the Hearing were encouraged to stay away from the Clinic at the time their child s illness was most acute. Although parents did visit later, they were not given the opportunity to watch the care being given to other patients who, at that point, were in the extremely acute stages of the

disorder. Parents were not given access to, and had no opportunity to review, their child s care records or the log books wherein Montreux documented their struggles with the Negative Mind and what will be discussed later in this decision as Montreux s system of imposed therapy .

In implementing the illusion of no choice, part of the imposed therapy system discussed later, Montreux does not accept as valid a patient s desires to leave the facility and to abstain from eating, for these, they argue, are the voice of the patient s Negative Mind. Part of the repertoire of this therapeutic approach has the client under very close scrutiny and monitoring, including having staff members within hearing distance during phone calls. Under such surveillance, there would be little opportunity for clients to complain, and if they did voice opposition to their treatment, this would be construed as the Negative Mind speaking. Such outbursts would, under the Montreux system, be terminated by staff, meaning that parents would be unlikely to witness this negativity .

The testimony of several witnesses, especially Ms. Claude-Pierre, her book *The Secret Language of Eating Disorders*, and several of the Exhibits filed provide the background on the development of the Montreux Clinic from its beginnings to the place it had reached at the time of the second investigation.

In her testimony, Ms. Claude-Pierre described how she, in 1983, cared for her two daughters, first Kirsten and a few months later, Nicole, in helping them overcome their eating disorders. During the course of her work with Nicole, Ms. Claude-Pierre experienced her epiphany on the negative mind-set associated with eating disorders. (The idea that individuals with anorexia nervosa have profound deficits in self-esteem was first elucidated in 1962 by Hilde Bruch.[1] (Exhibit 3, Tab 9)) Using her personal observations with Nicole, Ms. Claude-Pierre began to develop an approach to dealing with anorexia nervosa. She testified that soon after Nicole s recovery, she began to be called on in the

[1] Bruch, H. Perceptual and conceptual disturbances in anorexia nervosa. *Psychosomatic Medicine*: 24; 187-194, 1962.

community, with people becoming aware of her services by word of mouth. (T19, P100, L6-P101, L10)

In 1988, Ms. Claude-Pierre officially opened Montreux Counselling as an outpatient service, having been providing counselling less formally for at least two years previously. In the course of this work, she helped the 8 _ -year-old niece of a physician who would later serve as one of the medical consultants to the Montreux Clinic, Dr. Clinton-Baker. (T19, P103)

As testified to by both Margaret Dobson and Nora Desjardins, Ms. Claude-Pierre s work first gained recognition in the media in February and March, 1993, when articles appeared in the locally-distributed magazine *Focus on Women*. In the articles, she was referred to as a psychoanalyst, although in Ms. Claude-Pierre s testimony, she stated she is still one course short of her Bachelor s Degree and belongs to no professional associations. (T19, P87) In the February article, reference is made to children in the acute stages of an eating disorder being taken into Ms. Claude-Pierre s own home, and it states that since 1983, more than 400 people had sought her help. Highlighted in the article is the case of a seven-year-old girl who was described as not having eaten solid food for months. In the March issue, she indicated that women of 45 years of age and girls as young as five years of age are all susceptible to anorexia. In these articles, she talked for the first time publicly of her plans to open a residential facility.

In the summer of 1992, Ms. Claude-Pierre was briefly involved in counselling a patient named Jennifer Loney. According to the testimony of Brenda Loney, Jennifer s mother, the family followed the advice of their physicians and broke off contact with Ms. Claude-Pierre. (T11, P69) Jennifer committed suicide in September, 1992. Her twin sister, Alison, who had also been suffering from an eating disorder, grew worse after her sister s death. (T11, P57-58) This time, the family turned to Ms. Claude-Pierre and her approach. (T11, P60)

In April, 1993, Alison disappeared for five days before eventually emerging from a secret attic in the family home. After her re-appearance, she was taken to hospital where she was medically stabilized but continued to refuse to eat. According to Ms. Loney s testimony, Alison was discharged by her doctor, Dr. Jim Kirkpatrick, and the family was advised that the health care system could do no more for her. (T11, P63) At that point, Ms. Claude-Pierre put her 24-hour care approach into place for Alison. (T11, P60)

Alison s disappearance and the huge community search that resulted received major media attention in Victoria, including front-page stories in the *Times Colonist.* It led also to the first province-wide media attention being given to Ms. Claude-Pierre through a series of articles by Wendy McLellan, published in *The Province* newspaper on April 25, 1993. The series included three articles: one on the Loney family, one on Ms. Claude-Pierre and her work, and one on some of Ms. Claude-Pierre s other patients.

In the article about Ms. Claude-Pierre, (Exhibit 3, Tab 16) Ms. Claude-Pierre indicated she had been seeing people for eight years and had been treating children as young as three, nearly dead from eating disorders. Ms. Claude-Pierre is quoted as saying she is the last resort to cure these dying kids, and I m petrified of every one — I have a human life in the balance. She described organizing 24-hour care delivered in the client s homes for those near death, but indicated she plans to open a rented house in the coming week. This, she said, was necessary to better care for her acutely-ill clients, for, as she indicated, I ve got a doorful of dying kids and I have nowhere to put them except my house. I don t want to do that anymore.

Ms. Claude-Pierre said in the article that the rented house was planned to accommodate four women in need of 24-hour care. It is worth noting that this in itself would be a violation of the *Community Care Facility Act*, as the *Act* requires a licence for the care of more than two individuals who are not related to the operator.

The article on the Loney family summarized the family s experiences, Alison s disappearance, and Brenda Loney s skepticism of the medical system: I trusted the

medical model all along — and that s the last thing that works. Ms. Loney went on to indicate that, I won t make that mistake twice. Peggy s treatment works — none of her patients have died. Nowhere in the article was it suggested that Jennifer Loney had ever been counselled by Ms. Claude-Pierre, although Ms. Loney confirmed in her testimony that this had, in fact, occurred. (T11, P69)

In this article, Ms. Claude-Pierre s experience was summed up as: In eight years, she had treated 461 clients with anorexia nervosa, bulimia or both. She claimed a 90 per cent success rate, with no deaths. Among those backing her was Dr. Charles Medhurst, who stated that he monitored some of the clients and said, I have to admit I support her results.

(Dr. Medhurst testified at this Hearing as one of the three doctors involved in providing medical care to Montreux patients.)

The third article featured the struggles of Cheri Verhagen with bulimia and also touched on the battles of former clients Mackenzie Stroh and Shelly Lane. Ms. Lane stated she was near death when she became involved with Ms. Claude-Pierre, swallowing as many as 200 laxatives at a time.

Margaret Dobson confirmed in her testimony that Ms. Claude-Pierre did open the first residential program, known as Safehouse , in early May, 1993. (T15, P87) It was located in a rented home on Cedar Hill Road in Victoria and began with three women receiving 24-hour care. The scope of the enterprise expanded with the acquisition and opening of what became the main residential centre at 1560 Rockland Avenue, in Victoria, in July, 1993. (T17, P168, L3)

In a *Times Colonist* article published on December 13, 1993, a young woman named Alyson Parker described her battles with a cougar at the age of 10 and with anorexia nervosa/bulimia at the age of 19. The article ended with an appeal for donations for the Montreux facility, which was described as having four suites and providing residential

care for as many as eight anorexics, most of whom were aged 17 to 27. In this article, Ms. Claude-Pierre was reported to have counselled more than 60 outpatients ranging in age from five to 64. (Exhibit 3, Tab 4) Of note, the number here was substantially lower than the number reported in *The Province* stories published eight months earlier and the *Focus on Women* article in February, 1993.

In early February, 1994, Montreux attracted a great deal more media attention through the case of Charlene Clark, a Chilliwack resident and top university scholarship winner, who had been admitted to St. Paul s Hospital the previous month with severe anorexia nervosa, and who was described as needing the services of Montreux. However, Montreux treatment was not covered by the B.C. Medical Services Plan, and the provincial government was not prepared to pay the bill, described in news stories as $500 per day or $16,000 per month. Despite this, Ms. Clark came directly from St. Paul s Hospital to the Montreux Clinic; she was described by Ms. Claude-Pierre as still in critical condition and not yet over the danger of heart attack. News stories on Ms. Clark s plight appeared in *The Province*, *The Vancouver Sun*, and the *Times Colonist*. (Ms. Clark, who now works part-time at Montreux on environmental management programs for the Clinic, and her father, Bill, both testified in support of Montreux at the Hearing.)

As a result of the publicity generated by Ms. Clark s case, Ms. Claude-Pierre was invited to participate in the U.S.-based talk show *The Maury Povich Show*; she appeared with Charlene Clark and Brenda Loney on February 22, 1994.

Through the Povich show, Montreux became known to a family in Birmingham, England, in which twin daughters were both critically ill with anorexia. In April, 1993, one of the twins, Michaela Kendall, succumbed in England to her eating disorder and her desperate mother, Suzy, made another plea for her surviving, but gravely ill, daughter, Samantha. The Povich show funded Ms. Claude-Pierre to go to England and assess Samantha. Samantha was admitted to Montreux on May 24, 1994. In articles in *The Province* and *The Vancouver Sun*, Samantha described Montreux as her last chance.

Within weeks, the ABC television show *20/20* made contact with Montreux and as a result, a crew filmed in Victoria during August and September, 1994. This led to a full-hour episode of *20/20*, which aired on December 2, 1994 and later won a Peabody Award. This is the program that is viewed as part of the induction training of new staff at Montreux and is Exhibit 75 in these proceedings.

During the time the crew of ABC was gathering footage and information for its story, another high-profile British patient, Jane McCluskey, arrived from Scotland on August 27, 1994. Ms. McCluskey, who is now Montreux s Family Liaison Officer, testified at the Hearing and indicated that when she arrived, she weighed only 49 pounds and was at 46 per cent of her ideal body weight. (T13, P34) Ms. McCluskey indicated she was not admitted to the 1560 Rockland Avenue site for a period of time, because Montreux was just acquiring the mansion. (T13, P35, L1-3) This, however, contradicts the testimony of Margaret Dobson who said Montreux opened the Rockland Avenue facility in the summer of 1993, a full year earlier.

On the *20/20* video, Ms. McCluskey is shown being carried down the stairs by Ms. Claude-Pierre and is so weak she must be hand-fed. Her weight was said to be 57 pounds at the time of filming. The video also includes file footage of Charlene Clark, in hospital with a naso-gastric tube in place, pushing an IV pole and wearing a hospital gown. She is also shown being carried by Ms. Claude-Pierre down the stairs of the Rockland facility. A third girl who is not identified is shown being fed and supported by staff. Also featured on the program is another British client, Donna Brooks. She was seriously ill and travelled to Victoria for treatment. The video shows her being met at the airport by Montreux staff and the fragility of her condition is apparent. The final acute patient depicted is Shawna Krych, who, according to the video, is possibly only weeks away from dying of anorexia nervosa without a feeding tube. She weighs 59 or 60 pounds and is acutely anorexic. Her physician in Cleveland indicates that Shawna is deemed competent, and the use of a feeding tube against her will, while potentially life saving, is not an option. Shawna is convinced to accept the feeding tube, and in a scene from the

video where David Harris details the waiting list for Montreux Clinic clients, Ms. Claude-Pierre states, Take space for her if she is dying. The program suggests Ms. Claude-Pierre would save her from certain death.

Samantha Kendall is shown after three months of therapy and contrasted to earlier pictures of her and her deceased sister. The other recovering client profiled is Sarah Jorgenson who, it is stated, came from hospital at a weight of 69 pounds to Montreux.

In characterising the problems of the clientele at Montreux, one young woman is described as suicidal. Other behaviours manifested by patients, according to Ms. Claude-Pierre, include individuals who burn themselves in the shower, jump off balconies, and cut themselves.

The *20/20* episode was promoted in an article in the *Times Colonist* on the day it was to be shown for the first time. In that article, it was reported that the maximum caseload was seven but that there were tentative plans for expansion at another location in the city that would double the capacity. One week later, on December 9, 1994, a brief update on the *20/20* program indicated that Montreux had leased another house for the most acutely ill.

Five months later, *20/20* aired a follow-up program on Montreux, which featured progress made by Jane McCluskey, Shawna Krych, and Charlene Clark. Also featured is a new client, an 11-year-old boy who was pulled out of hospital by his parents to take him to Montreux. He is described as being so ill that he lost consciousness at the U.S.-Canada border. The program closes with a comment that Ms. Claude-Pierre must choose between people who are dying. Moreover, it states that Montreux has added a house, doubled the number of patients to 22, and increased the staff complement to 80.

In August, 1995, Samatha Kendall returned to Britain for what was to be a holiday. However, she did not return to Montreux, and soon after indicated that she became tired of being wheeled out like a circus freak to publicize Montreux. (Exhibit 3, Tab 16) She

also disclosed at the time that during her stay she had been sneaking away from the Clinic and taking laxatives to help her again lose weight.

Peggy Claude-Pierre s international media coverage continued. On January 17, 1996, she appeared on *Oprah* with three male anorexic patients — Danny, Ross and Charlie — as well as with three-year-old David Bruce and his family. This video, which was also played at the Hearing, showed Ms. Claude-Pierre discussing her theories of Confirmed Negativity Condition (CNC) and stating that all patients who come to Montreux can be saved if they stay and do not use their rights under the *Mental Health Act* to discontinue treatment.

In a December, 1996 article in *Share Magazine International*, (Exhibit 3, Tab 16) Ms. Claude-Pierre described the plight of Jane McCluskey at the time of her arrival at Montreux, and also referred to caring for a six-year-old girl who had a feeder into her blood stream because she had not fed herself in 2 _ years. Ms. Claude-Pierre went on to say: Even if someone has only three to four days to live, we can turn them around within eight months to a year. She also said: We now have 100 requests a day to help dying children. They and their parents arrive desperate, and we are their last hope.

A second *Oprah* show ran on January 30, 1997, just days after the beginning of the first investigation by Licensing staff into the operation of Montreux. The male anorexics of a year earlier were updated. A new client named Erica was presented. She had been admitted two days prior to the episode being filmed, weighing 66 pounds, and was shown being carried by Ms. Claude-Pierre down the stairs of the Rockland facility. The featured client was Courtney Lange who discovered Ms. Claude-Pierre when Ms. Lange was a studio guest at the previous year s *Oprah* show, and had at that point been a patient at the Rockland site for a few months. Jane McCluskey had by then become Courtney Lange s caregiver and was also interviewed.

Ms. Claude-Pierre s book outlining her theories, *The Secret Language of Eating Disorders*, was published in July, 1997, by Times Books, a division of Random House. It

led to another round of media attention being paid to Ms. Claude-Pierre and her theories. (Exhibit 3, Tab 8)

In October, 1997, Samantha Kendall died in hospital in England from liver failure. She weighed less than 70 pounds. (Exhibit 3, Tab 16)

Shortly thereafter, several new complaints were received by Licensing and the second investigation of Montreux Clinic began.

ADMINISTRATIVE AND PROCEDURAL ISSUES

Staffing

Licensing alleged a number of contraventions of the Adult Care Regulations as they pertain to the requirements of staff at specialized adult residential care facilities. During the Hearing, the Montreux Manager, Noah Dobson, conceded that each of these contraventions had in fact taken place on occasion, although he noted that most were not regular occurrences. These were contraventions of the following sections of the Adult Care Regulations:

4(4) The licensee shall

(e) ensure that there is at all times an employee on duty who is the holder of a valid first aid certificate acceptable to the medical health officer.

6(3) The licensee shall

(a) ensure that every person employed in the facility is required to submit a medical certificate completed within 5 days prior to commencing employment and at such other times as required by the medical health officer certifying that the person is free of any communicable disease and is physically and mentally able to carry out his assigned duties;

(b) require each employee, as a condition of employment, to comply with the immunization program of the ministry and to participate in its tuberculosis control program, and

(c) record each employee s compliance with and participation in the program referred to in paragraph (b) and, on request, make records available to the medical health officer.

7(2) A licensee of a facility with 24 or fewer persons in residence must ensure that the services of a registered dietitian-nutritionist are obtained in response to a resident s needs and on the recommendation of

(a) either the resident s primary health care provider or the medical health officer.

7.10 A licensee must ensure that staff responsible for food services

(a) have the training necessary to ensure that food is safely prepared and handled and meets the nutrition needs of the residents, and

(b) receive on-going education regarding food services, nutrition and, where required, assisted eating techniques. [enacted B.C. Reg. 22/97. s. 2.]

8 A licensee or interim permit holder must do all of the following:

(a) only employ at a community care facility persons of good character who meet the standards of employees specified in the regulation.

Montreux Clinic, at the time of the beginning of the second licensing investigation, did not have a medical certificate on file for 57 of its 112 careworkers. There also were no TB tests in the personnel files for 54 staff members. (Exhibit 2, Page 54) These health and safety provisions of the *Community Care Facility Act* are in place to ensure that people in care are not compromised by staff who would be medically unfit for such important duties. Noah Dobson, Manager of the facility, conceded this to be the case at the time, (T18, P96, L22-25) but indicated that these deficiencies have since been rectified. (T18, P97, L20-25**)**

Mr. Dobson also conceded that 54 per cent of staff did not have current first-aid certificates at the beginning of the second investigation and that there was no scheduling system in place to ensure that the requirement of having a person with proper first aid credentials on duty at all times was met. However, he said this problem (T18, P33) and that of 36 staff having no criminal record review at the time of the second investigation had also been addressed. These matters, though, would likely have been remedied sooner had someone on staff had the appropriate health care training, for they would have recognized the importance of staff possessing these skills and a clean bill of health.

Moreover, Mr. Dobson testified that Montreux is committed to meeting the requirements of the *Act* and has had 48 of the staff take a course on suicide prevention from the Need Crisis Line; many also have taken the Foodsafe course. (T17, P180) Mr. Dobson, as well,

indicated that patients who become careworkers as part of their progression at the Clinic would, in future, also meet the same administrative requirements expected of other employees.

As well, during the second investigation it was determined that Montreux had not retained the services of a registered dietitian/nutritionist as required under the Regulations. However, the Clinic has since retained the services of an individual to fulfill this professional requirement, and this was acknowledged by Licensing at the Hearing.

Medication Administration

Significant attention is paid to the handling and storage of medications during any Licensing review of a community-based operation holding a licence under the *Act*. The intent of such scrutiny, which is mandated by the *Act,* is to avoid the serious medical repercussions which can arise from the improper administration and dispensing of medications. The attendant risks from failing to follow the Regulations and the *Act* are captured on pages 151 and 152 of Exhibit 2, as are the community standards for facilities administering both prescribed and over-the-counter pharmaceuticals.

During the second investigation, Licensing reported the following contraventions:

- Medications were not safely and securely stored to ensure the health and safety of residents, contrary to Section 8(c) of the *Act* and Section 8.2 of the Regulations.
- Montreux records indicate that one resident was self-administering a medication, contrary to Section 8.4(2)(a) of the Regulations.
- Medication that was not packaged by the pharmacist was in the medication storage area, despite Montreux s own policy number 807 which states that all medications must be labeled by the pharmacist. This was contrary to Section 8.4 of the Regulations.
- Medications were not kept in the original labeled containers until immediately prior to administration, contrary to Section 8.4(5) of the Regulations.

- Careworkers were not immediately charting the administration of medication and in some cases, care workers had signed the medication administration record even though they did not personally give the medication. This practice does not follow Montreux s own policy which instructs staff to sign the MAR sheet immediately after administration and is a contravention of Section 8.4(6)(c)(d) of the Regulations.
- Medication administration records were not maintained for one resident, contrary to Section 8.7(a) of the Regulations.
- Medication that a resident was no longer taking was stored in the medication storage area despite Montreux s own policy 808 which requires the removal of any discontinued or outdated medication. This is a contravention of 8.8(a) of the Regulations.
- Montreux staff did not follow the physician s orders for medication for a resident, contrary to Section 8(c) of the *Act*.

Having been made aware of these deficiencies, Montreux has made significant progress in this important facet of patient care, improving upon its policies, tightening the administration of these products and taking steps to ensure compliance by their staff. Kendra Dempsey, the Medical Liaison Officer, has the skills necessary to maintain, if not secure additional gains in meeting Montreux s obligations in medication administration as required under the *Act* and Regulations. While Licensing remains concerned about Montreux s abilities in this area, Kim Macdonald did testify as to the improvements observed by Licensing.

Maintenance of One-On-One Client/Worker Ratio for Children and Teens in Care

As observed during the second investigation, and as conceded by Noah Dobson at this Hearing, the following contravention did occur:

4(5) The licensee shall not

(a) provide a service

(i) of a type other than that specified on the licence except where, in the opinion of the medical health officer, retention or temporary

placement of a person in the facility is in the best interests of the person.

The Montreux facility at 1560 Rockland is licenced to provide care only to adults. If Montreux desired to admit an individual under the age of 19, the facility had to apply to the Medical Health Officer for approval of a temporary placement of that individual at the Clinic. Montreux has successfully made such applications from time to time. (Exhibit 15, Tab 1) This arrangement was subject to a renewal process every six months for each underage individual in care.

A condition placed on the facility for each underage client approved for admission was that: At least one adult staff member must be providing one-on-one care to the child at all times. Staff members must be awake and continuously monitoring the child. (Exhibit 2, P168)

During the second investigation, six patients files (plus that of the four-year-old child whose case will be discussed later in this Decision) were reviewed in depth by Licensing. Of the six, four were at Montreux under such a temporary placement agreement with Licensing. In the time interval of the review from June, 1997 to the end of December 1997, Licensing found 54 instances of doubling up and of clients under 19 years of age being left on their own or with inadequate supervision. (Exhibit 2, Page 169) Mr. Dobson did not dispute the numbers generated by the record review. (T18, P150, L5-14) Moreover, Mr. Dobson did concede that these events were under Montreux s control and could have been remedied through appropriate scheduling of staff. (T18, P120, L7)

Montreux did not bolster its credibility before this Hearing by arguing that the problematic staffing ratios involved a single careworker who was looking after an individual under 19 years of age and who also happened to have an adult patient in close proximity. Evidence presented by Licensing showed that from time to time, there were careworkers looking after two individuals under 19 years of age. (Exhibit 15, Tab 2 — September 17, 1997, October 30, 1997, November 1, 1997)

From time to time, Montreux Clinic did not comply with the condition imposed upon them for the temporary placement of individuals less than 19 years of age in their adult care facility.

Caring for Patients at the Unlicensed St. Charles Site

Licensing alleges that Montreux contravened the following section of the *Act*:

3. A person must not

(a) operate, advertise or otherwise hold himself or herself out as operating, a community care facility,

(b) provide, or hold himself or herself out as providing, any of the services provided in a community care facility, or

(c) accommodate, or hold himself or herself out as accommodating, any person who, in the opinion of a medical health officer, requires any of the services provided in a community care facility, unless the person holds a valid and subsisting licence or interim permit issued under this Act that authorizes the person to provide those services offered at the facility.

Section 1 of the *Act* defines a Community Care Facility as being any Facility that provides care, supervision, social or educational training, or physical or mental rehabilitative therapy to three or more persons not related by blood or marriage to the operator of the Facility.

Licensing inspected the St. Charles site located at 811 St. Charles Street, Victoria, on February 9 and 23, 1999. Four clients met the definition of care included in the *Act* and this overcount was provided to Montreux at the time of the first investigation. (Exhibit 22, Pages 12-16 and Tab 16)

Montreux has argued that there has been confusion surrounding the status of their St. Charles site operation, the level of care and the number of patients they can manage at that location.

The possibility of their being unclear as to the expectations under the *Act* until the conclusion of the first investigation is conceivable. However, the St. Charles site was found to be in contravention of the requirements of the *Act* in the course of that investigation. After that review of the facility s operations, Montreux seemingly understood their obligations, for they indicated to Licensing that they would reduce the number of clients served at this location to no more than two. I also find that it must have been evident to Montreux that should they wish to exceed that number, they would be obliged to licence that property. Licensing went so far as to provide Montreux with a copy of the application package which they would need to complete to apply for the St. Charles site to be licenced. Licensing made it clear that should a Montreux client require maintenance of care plans, control of medications including the use of medication administration records, and/or one-on-one 24 hour supervision, or ongoing monitoring of the client, such a client would be considered in the calculation of patient numbers on subsequent Licensing inspections at both the Rockland and St. Charles sites.

Montreux did not apply for a facility licence for the St. Charles site.

Montreux Clinic contravened the *Act* by exceeding the number of patients that can be managed at an unlicenced site.

Montreux Operations at Other Locations

In his testimony, Noah Dobson, the Manager of Montreux at the time of the second investigation, testified that the Clinic intended to continue to operate satellite facilities at different locations throughout the city, keeping to no more than two individuals at any one of these sites. (T18, P136) Mr. Dobson stated in his evidence that should the facility retain its licence, it would not apply to increase its current capacity. If the need arose to accommodate more than nine clients who sought care from Montreux, these individuals

would be cared for in groups of two at various sites throughout Victoria. Mr. Dobson did, however, testify that Montreux would consider the option of increasing the licence for the Rockland site to include these peripheral operations but not until the status of their licence was determined by this Hearing. (T18, P137)

Licensing introduced evidence concerning an inspection of a Montreux operation in a multi-unit rental apartment building at 1764 Oak Bay Avenue. This June 14, 1999 inspection determined that at least four patients were receiving care at this satellite location. Montreux s explanation was that they believed that each apartment suite or unit was a separate dwelling and that the building was in fact a grouping of individual residences. Should this interpretation prove to be unacceptable to Licensing, Montreux indicated that they would reduce the number of individuals at any single address to two individuals, even if the structure is a multi-family complex.

Licensing argued that what Montreux offers is in fact a single program of co-ordinated care from the Rockland Avenue address. The structured program of services provided by Montreux utilizes the same administration procedures, management and careworker staff, counsellors, doctors, medical liaison, family liaison and educational co-ordination. The staff at all locations are co-ordinated by the Facility Manager for Montreux. The shift schedules amongst the different facility locations are co-ordinated centrally. The careworkers at all sites complete documentation which is then forwarded to the central office at the Rockland site. Employees and transportation are provided to shuttle patients among different facility sites to the Rockland location for educational programs or physician visits, and to counselling offices on Fort Street. The staff person who is fulfilling the role of the float in any given single shift will move from site to site, working with and relieving various careworkers assigned to patients in care at these various sites. The patients in the care of Montreux may spend the day at one site and nights at a different location. Licensing argued that the Montreux Clinic operation is but one facility under an all-encompassing administration which operates a number of sites which are geographically separate but under centralized control.

Licensing adduced evidence through Kim Macdonald describing other facilities operating in similar fashion to Montreux which are licenced for a capacity that reflects the total number of residential clients to whom they are providing service. (T21, P163-167) Each of these facilities has a single licence that covers operation of all facility residential sites, despite their being separate locations either owned or leased by the operators of the facility.

Licensing argued that it would be unfair for Montreux to be treated differently from these licenced multi-site operations.

In fact, the evidence showed clearly that Montreux is a centrally-run operation, no matter how many two-person satellite units it is operating at any specific time. Montreux managers agreed that many of its therapeutic programs, such as counselling and the education program, are provided from the central Rockland site, and that patients receive exactly the same type of care, delivered by the same providers, no matter at which site they reside. If I find that the operation does pose a risk to the health and safety of the nine residents at the Licensed site, it does not make sense that Montreux should be allowed to put patients at risk, simply because there are no more than two of them at any one location. I concede, however, that Montreux may have been confused by the lack of clarity in the legislation in this area. Therefore, I do not find they have deliberately committed contraventions of the *Act* up to this point by having more than two patients in care at their various unlicensed sites.

I would observe that while the *Community Care Facility Act* does not expressly address whether or not a licensee may operate multiple two-person sites from a central location, the *Mental Health Act* does. While not specifically within the jurisdiction of Licensing, this *Act* was central to the discussion of patients rights and imposed therapy covered elsewhere in this decision and was the subject of substantial testimony during the Hearing. It is also referred to in many of the Exhibits. The principals of the Montreux operation also testified to their familiarity with this *Act*.

In the *Mental Health Act*, under the Section Licensing of Private Mental Health Facilities section 5(2) indicates that a person must not receive a mentally disordered person into or cause or permit a mentally disturbed person to remain in a private house for gain or payment, unless the house is licensed under subsection (1). The only community premises that can receive these patients as specified under section 5(1)(b) of the *Mental Health Act* are any community care facilities licensed under the *Community Care Facility Act*. (Exhibit 16, Tab 12) The condition anorexia nervosa is a recognized mental disorder. It is listed in the American Psychiatric Association s *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (DSM-IV). (Exhibit 6, Tab 58)

Montreux management testified that they realize the need to fulfill the requirements of all the various *Acts* and Regulations governing care provision in this province. To do this, they would be obliged to adopt the approach of other mental-health organizations which use a single administration but provide their services at several sites, and obtain a licence that reflects the totality of their patient population.

If Montreux were to continue to operate a licensed community care facility, I would expect it to govern itself accordingly in the future.

Out of Province Patients

In the Hearing, Licensing brought forward a breach of the following section of the Regulations:

17(2) A licensee or an employee of a community care facility must not do any of the following:

(b) bring, cause to be brought, advertise for or in any way encourage the entry into British Columbia or any adult person to become a resident in a community care facility; and

(c) bring, cause to be brought, advertise for or in any way encourage the entry into British Columbia of any child to become a resident in a community

> care facility without first obtaining the written approval of the director of adoption designated under the *Adoption Act.*

Noah Dobson, as the Manager of Montreux at the time of the second investigation, acknowledged the international nature of the clientele attending Montreux. (T18, P138-139) However, in fairness to the Clinic, Montreux never hid the fact that the vast majority of their clients came from outside of the province and the country. In fact, Montreux, in high-profile media coverage of their Clinic dating back to 1994, (Exhibits 3, 4 and 75) was very open about the many countries from which they drew clients. Moreover, as pointed out by Mr. Dobson, Licensing were specifically informed of the home country of all individuals under 19 in the process of gaining temporary approval for such clients to attend the Montreux program. (T18, P161, L1-14) While Montreux Clinic did contravene this section of the *Act*, Licensing did not draw this section of the *Act* to the attention of Montreux until this Hearing. Consequently, while Montreux will be expected to comply with this section of the *Act* in the future, this contravention will not influence my decision on the status of the licence.

MEDICAL MANAGEMENT OF PATIENTS AT MONTREUX

Among the most serious of allegations raised by Licensing staff was that the Montreux Clinic admitted patients which it could not safely care for, given the facilities available, the training of staff, and the medical backup available.

Licensing alleged a number of contraventions of the *Act* and the Regulations in regard to the acuity of patients admitted to Montreux and the medical services provided to them.

The *Act* states that:

8 A licensee or interim permit holder must do all of the following:

(c) operate the community care facility in a manner that will promote the health and safety of persons in care.

The Regulations state that:

6(4) The licensee shall establish and follow an admission screening procedure acceptable to the medical health officer which will, taking into consideration the available staff and physical facilities, ensure that only persons for whom safe and adequate care can be provided, are admitted.

6(6) Notwithstanding the provisions of subsections (1) to (5), the licensee shall ensure that

(d) responsible staff members are on duty and awake at all times to assure prompt, appropriate action in cases of injury, illness, fire or other emergency.

9.1 A licensee must ensure that a resident is assisted in obtaining health services as required and that an emergency call system for a medical practitioner is in place.

The evidence shows that when first applying for their licence, Montreux management, in the person of David Harris, misrepresented and understated the acuity of the condition of a number of the patients who were to be managed at the licensed site at 1560 Rockland.

In late 1993, Licensing officials contacted Montreux Clinic about its activities, which had been widely covered in recent local media stories. Licensing officers were advised by Mr. Harris and recorded in an internal licensing communication dated January 4, 1994, that the Clinic does not provide any care or services that would fall under Licensing s jurisdiction. The residents are engaged in independent living, cook all their own meals, handle all their own daily requirements, and do not receive medical treatment by facility staff. (Exhibit 67)

In the weeks and months following this description of services, Montreux Clinic took in a number of high profile, extremely ill patients for residential care. These included Charlene Clark and Samantha Kendall.

The senior management of Montreux then applied for a licence to operate a community care facility in Victoria. As part of the approval process, Mr. Harris was asked to reply to a number of questions arising from the Clinic s application. In particular, Montreux was specifically asked by Licensing officials about the need to have as a manager of care staff someone who was an active registrant with a professional association recognized in British Columbia, and who was approved by the Medical Health Officer, should Montreux choose to take clients requiring daily professional supervision. In his reply on September 12, 1994, Mr. Harris indicated: Residents under our supervision do not *(emphasis his)* require daily professional supervision. (Exhibit 4, Tab 1) Dialogue on this issue continued between Montreux and Licensing, and in a February 1, 1995, communication, Mr. Harris stated that the clients would meet medically acceptable limits for electrolytes, hemoglobin or be stabilized in a hospital until such limits were met. (Exhibit 4, Tab 1)

Many of the clients admitted to Montreux Clinic for residential care would not meet the admission criteria that Mr. Harris provided to Licensing for months if not years after their entry to the program. Montreux regularly admitted individuals acutely sick with anorexia nervosa, some of whom were critically ill at the time of their arrival.

In addition to Charlene Clark and Samantha Kendall, examples of medically fragile cases include: Lucy, the six clients reviewed by Dr. Birmingham, many of the patients whose parents testified at the Hearing as to the care their seriously ill children received from Montreux, and the patients and former patients who themselves testified.

The acuity and severity of some of the clients served by Montreux, perhaps, can best be summed up in Ms. Claude-Pierre s own words from a magazine article in December 1996 as their having only three or four days to live. (Exhibit 3, Tab 16)

Consequently, Dr. Clinton-Baker s contention that only in the early days did Montreux accept clients whose medical condition was deemed precarious (T6, P6, L2) is at variance with the evidence before this Hearing. Dr. Clinton-Baker s other observation on illness severity — that the clients accepted at Montreux are of a lower level of acuity than the ones presenting to the St. Paul s program (T6, P55, L8) — also is incorrect. Dr. Clinton-Baker, in his testimony, acknowledged that he has never visited the St. Paul s program. (T6, P50) Furthermore, Charlene Clark was one of the patients featured in the *20/20* video about Montreux and was graphically portrayed in the acute stages of anorexia at the St. Paul s program. She discharged herself from St. Paul s against medical advice, travelled from Vancouver to Victoria, and directly entered the Montreux program. (T4, P59, L16)

Montreux Clinic accepted extremely high-risk clients and regularly exceeded the level of care depicted in Mr. Harris s licensing application. The acuity of some of the patients admitted to Montreux rivaled that of any acute, hospital-based, tertiary-care eating

disorder unit, and, in fact, a number of patients had come directly from such a setting to Montreux.

Moreover, Ms. Claude-Pierre was aware of the serious physiological effects of eating disorders as she makes clear on pages 90 and 91 of her book. She describes acute anorexia as the breakdown of body organs. She goes on to catalogue the problems that can be encountered, including heart attacks from electrolyte imbalance (low potassium levels, while not always indicative of problems, can indicate a patient is in danger of dying); complications such as bradycardia and irregular heart beat; edema due to electrolyte imbalances; kidney and liver failure; osteoporosis; fluctuations in blood pressure; esophageal scarring and dental decay from excessive vomiting in bulimic patients; intestinal rupture from excessive use of laxatives; and insomnia. Ms. Claude-Pierre, in her testimony, frequently told of the textbooks she has read on the subject of anorexia nervosa as well as the many centres she has visited and experts with whom she has discussed the problems. (T19, P104-107; T19, P116, L20; T19, P194; T19, P106-107; T21, P127, L1-10)

Dr. Birmingham provided opinion evidence on the attributes necessary for physicians working with eating disordered patients. (T4, P122, L22 — P124, L20) He indicated that a general practitioner who is merely dealing with unrelated complaints should have a general knowledge of eating disorders. That, he explained, is because of the possibility of a patient who presents at the doctor s office with a seemingly unrelated complaint actually having an eating disorder which has a contributory role in the symptom with which the physician is faced. For example, if an individual with an eating disorder presented with a bowel obstruction, Dr. Birmingham suggested a knowledgeable general practitioner would consider the possibility of a foreign body such as a fork as being the cause. These utensils are often used in purging by people with an eating disorder. Dr. Birmingham indicated this was a general level of knowledge all medical practitioners should have of eating disorders in order to provide good care. This subject matter is now

part of the standard curriculum of the medical school at the University of British Columbia.

Dr. Birmingham went on to describe the next level of expertise, recommended for family doctors who knowingly see patients who have eating disorders and are being followed for their eating disorder by clinics like St. Paul s. These family practitioners provide routine care and follow the patients for long-term health problems which are not related to their eating disorder. Despite not being involved in the primary management of the eating disorder, Dr. Birmingham described these doctors as communicating with St. Paul s or B.C. Children s Hospital eating disorder program, reading about eating disorders and developing some knowledge based on the medical information sent to them by St. Paul s. As well, these physicians gain experience by seeing patients over a time. They can call upon St. Paul s Hospital at any time should they encounter difficulties. Dr. Birmingham emphasized in his testimony that there would be a clear delineation of responsibility in what the role of the doctor was and what the role of St. Paul s Clinic was in providing patient care. (T4, P124, L9-10)

Dr. Birmingham then described family doctors who actually treat a few patients with eating disorders in their practice. He describes these doctors as individuals who attend meetings, keep up with medical journals, consult with the St. Paul s staff, visit the St. Paul s Clinic, and treat patients in conjunction with the St. Paul s eating disorder unit. These doctors would gain experience over time and learn how to manage patients medically from a centre with expertise and resources. Under such an arrangement, they could enhance their abilities to provide proper medical management for someone with an eating disorder. Dr. Birmingham described it as a mentoring situation where there would be opportunities for questioning and a back-and-forth dialogue, so that these individuals could take part in the treatment to a certain degree.

Dr. Birmingham emphasized the importance of embarking upon the treatment of eating disorders only with appropriate medical backup. In fact, Dr. Birmingham indicated that

even specialists are loath to undertake the treatment of eating disorder patients without such a network.

Finally, Dr. Birmingham described under what circumstances a general practitioner would play a role in providing care surrounding the eating disorders of their patients and what attributes such a general practitioner would have. Dr. Birmingham emphasized that there are very few general practitioners in British Columbia who have attained the level of competency and professional support to do this. He described them as people who have spent some time at the St. Paul s Eating Disorder Unit. They come to most of the conferences on eating disorders, keep up with the medical literature, and stay in communication with the St. Paul s program regularly to learn as much as they can. Dr. Birmingham emphasized that this is an ongoing learning process, because of the changing knowledge and understanding of the subject. He also indicated that such an interest requires the practitioner to dedicate sufficient time to see patients with eating disorders, (T4, P125, L14-15) for they take considerably more time than does the average patient. He suggested that family practitioners involved at that level could only handle a few patients in their private practice in order that they could spend adequate time learning, counselling, and dealing with the food-related issues of their patients.

Moreover, many of the family doctors engaged in such a practice either have a degree in nutritional sciences or have extra training in such specialties as internal medicine, psychology or psychiatry. Dr. Birmingham implied that this is a highly select group of individuals who have taken on such a challenging role in their practices.

Furthermore, Dr. Paul Termansen, a respected psychiatrist called by Montreux, indicated that he believes that someone with general practice skills wanting to treat individuals with eating disorders would, firstly, have to have an interest in the subject. The interest needs to be deep enough that they are willing to become more knowledgeable about the area including familiarizing themselves with the literature and current issues in the field. As well as general fundamental knowledge, they would need to know the most

appropriate method of treatment and crucial areas of intervention. Dr. Termansen felt that they would have to work with a psychiatrist over a period of time to reach a position wherein the psychiatrist was comfortable with their judgment in certain situations and that the psychiatrist could trust them to know when a referral was necessary and when not. (T5, P125, L7 — P126, L8)

Both expert medical witnesses emphasized the importance of a family doctor involved with eating disorders having relationships with a clinic or individuals with recognized medical expertise, be it in psychiatry or internal medicine/pediatrics. Moreover, the opportunity to gain the necessary medical knowledge, skills and practical expertise is available in British Columbia.

Three physicians attended to the health needs of patients at Montreux Clinic - Drs. David Clinton-Baker, Mauro Bertoia and Charles Medhurst. They all testified at the Hearing. The three are qualified as general practitioners and gave opinion evidence in the area of general medicine. They are not certified members of the College of Family Practice. None of the physicians possess specialists qualifications, nor do they have any advanced degrees in psychology, nutrition or other health sciences that could be applied to eating disorders. The number of eating-disordered clients they have dealt with in their practice outside of Montreux clients is small and in keeping with what a community general practitioner would expect to see. As acknowledged by Dr. Bertoia, in the event any eating disorder client from their practice needs admission to hospital, these practitioners would be required to relinquish much of the responsibility for the provision of inpatient care of such patients to specialists with greater training and expertise in eating disorders. The general practitioners would play secondary management roles.

The three general practitioners have taken some updating in the form of rounds and seminars. These continuing medical education programs were intended for a general practitioner audience but were not designed to equip attendees with the skills to handle complex, acutely ill anorexics.

While Dr. Medhurst testified that he had no real training or expressed interest in eating disorders, (T8, P62, L10-25) the other practitioners indicated they had done some reading in the area of eating disorders, although neither subscribed to specialty journals in this area. The physicians indicated they were familiar with the standard texts on the subject in Canada. Dr. Clinton-Baker indicated that he had not actually referenced these books. (T6, P44, L8) Moreover, when asked about the Capital Health Region (CHR) guidelines for eating disorders, Dr. Bertoia indicated he was aware of them but was not referencing them in his practice. (T9, P39, L20) Dr. Clinton-Baker, as Chair of the CHR s Quality Improvement Council (T6, P3, L6-7) indicated he was very aware of the CHR guidelines on eating disorders as he had shepherded their progress through development to implementation. He did not, however, have any input into the actual content of the guidelines, as that was left to the experts in the Region. Dr. Clinton-Baker did testify, however, that these were only guidelines rather than a formal standard of medical practice. (T6, P9, L13)

Dr. Clinton-Baker testified that he became involved with Montreux after Peggy Claude-Pierre successfully treated a young relative of his for an eating disorder. Dr. Medhurst became involved because he had been the personal family physician of Ms. Claude-Pierre and one of her daughters. In similar fashion, Dr. Bertoia s involvement began after he had been the personal physician for both Margaret and Noah Dobson.

Some of the clients to whom the three general practitioners provided care at Montreux Clinic were gravely ill with acute anorexic nervosa. As Dr. Birmingham clearly pointed out, such acutely-ill patients require a much higher level of expertise in their physicians than do the sort of patients originally proposed to Licensing by David Harris. The complexity and severity of their eating disorders pose a very high risk of complications that can cause permanent harm or even death. Montreux s physicians did not possess the skills associated with the select group of general practitioners whom Dr. Birmingham described as being able to provide the medical management of eating disorder patients as

clients in their practices. The three physicians at Montreux Clinic, on the basis of their training and skills, would, according to Dr. Birmingham s categorizations, be considered community general practitioners who have some awareness of eating disorders.

Of note, Dr. Clinton-Baker confirmed that he called Dr. Birmingham a number of years ago about his seeing patients at Montreux Clinic. Dr. Birmingham s recollection was that Dr. Clinton-Baker was inquiring as to how to follow the patients and what he should do. Dr. Birmingham advised him at the time, because he was concerned about the patients being at medical risk, that such an activity was inappropriate . (T4, P5, L16) Dr. Clinton-Baker stated he did not remember being given this advice by Dr. Birmingham.

Dr. Clinton-Baker described the approach he takes in caring for clients at Montreux as, the more you do, the more you learn. (T6, P26, L16) This unmentored and experiential approach might be sufficient in an inaccessible and remote region of the world where these three physicians constituted the entire pool of available medical skills and expertise. However, these events took place in Victoria, where world-class training and expertise were available through the Vancouver programs and the University of British Columbia.

Among the tasks undertaken by the three Montreux doctors in an assessment of new clients entering the program, including those who are acutely and gravely ill. When asked to describe the constituents of a full assessment of a new client with a serious eating disorder, Dr. Birmingham described the family history required, the psychological history, the history of the various treatments a client had received, and a complete physical, all of which would take approximately 2 _ hours. In fact, Dr. Birmingham testified most assessments take an entire afternoon. Moreover, a multidisciplinary team then discusses diagnoses and treatment plans. Included on the team are a psychologist or psychiatrist, a family practitioner and an internist or pediatrician with training in this area. (T4, P126, L13) He testified that the physician who has patients coming in to his office from time to time with an eating disorder is not in a position to do an adequate assessment. (T4, P74, L11-17)

All three of Montreux s doctors testified they took a considerably shorter time for assessments than the amount Dr. Birmingham suggested would be required. In addition, Dr. Birmingham did not deem it adequate that the general practitioners relied on Montreux staff to assess the patient and determine who would be seen and when for ongoing medical care. (T4, P72, L2-12)

In conducting assessments, the Montreux doctors were frequently provided with inadequate and/or incomplete background about the clients. They also were often given only inadequate, incomplete and/or out-of-date medical information and lab tests. (T6, P60, L7)

- For Alexia, admitted May 17, 1996, Dr. Clinton-Baker was provided with pre-admission information that was a year old, and had no more recent information or lab results. He did not see the patient until four days after she had been admitted to Montreux. Moreover, this patient had eaten nothing for the four days prior to coming to the Clinic. She was restarted on feeding of 1,410 calories per day, a level well above the refeeding amount of 800 calories found in the CHR guidelines.
- Dr. Clinton-Baker also was the physician for Aviva who was admitted February 28, 1996. This patient was at 51 per cent of ideal body weight; her pre-admission information was at least six months old and provided no historical weight information.
- Anja, admitted July 25, 1997, was Dr. Bertoia s patient and he too did not receive any pre-admission information on her weight, nor was there any pre-admission lab work provided on Anja.
- Dr. Medhurst was the doctor for JJ who was admitted April 2, 1996. Dr. Medhurst had not been asked to review the pre-admission information, the medical history was at least seven months old, there was no pre-admission lab work and no information on food intake prior to admission.

Despite the paucity of current background information made available to the physicians, Dr. Clinton-Baker testified he would not insist on such critical information before making a decision on admission. (T6, P62, L5) Moreover, being faced with this problematic information, Dr. Clinton-Baker responded in his testimony that I did my best, (T6, P7, L10) and Dr. Bertoia indicated I usually work with what I have. (T7, P9, L5)

The very real and significant risks to the health and safety of patients managed under such constraints were discussed by Dr. Birmingham. He testified that the lives of these patients were potentially put at risk by the deficits in both the comprehensiveness and timeliness of the information on these patients provided prior to their arrival at Montreux, and the willingness of the Clinic to undertake treatment despite this dearth of critical clinical information and data. (T4, P19; P73-75; P84-88)

Montreux did not have an appropriate set of policies and procedures surrounding the selection of clients for admission to the Clinic, nor did they have criteria on the pre-requisites for medical stability of such patients prior to their travelling to Victoria to attend the Clinic. The associated risks to health and safety from this dearth of suitability guidelines were captured in the review conducted by Dr. Birmingham of the records of the six patients. In addition to the problems he identified associated with these six coming to Montreux, the circumstances of Becky serve to underscore the deficiencies in this area of operations at Montreux.

While Becky appeared to be a challenging patient, she cannot be held solely responsible for what transpired in her coming to Victoria. The evidence is clear that Montreux knew of her previous medical condition and that she had a TPN line in place. (Exhibit 5, Tab 41) Montreux knew that this device inserted in her subclavian vein was providing life-supporting sustenance for Becky, as she suffered from gastroparesis, a disorder of gastrointestinal motility.

That Becky had the TPN line removed in Florida and then travelled to Victoria only to be refused admission, arose from an apparent breakdown in the apparently informal admission procedures practiced by the Clinic. Dr. Clinton-Baker testified he would not have recommended the admission of a client with a feeding device like this in place, (T6, P89) and he was seemingly unaware that such a client was being considered for admission to Montreux. Yet, a note in the Clinic s file dated October 22, 1997, and attributed to Nicole Claude-Pierre by her mother, (T21, P106, L17-18) purports to record that the issue of this feeding line was in fact raised with and commented upon by Dr. Clinton-Baker. However, Dr. Clinton-Baker testified he had no recollection of any such conversation ever taking place, (T6, P86, L11-24) and Montreux did not call Nicole Claude-Pierre as a witness. Although there was significant confusion about what transpired, I accept Dr. Clinton-Baker s testimony that he would not recommend the admission of a patient with a TPN line. However, this does not lessen the confusion in what was communicated to Becky and her family and the resulting stress that this created for them.

The confusion in roles and responsibility of Montreux staff and physicians in dealing with this high risk client s possible admission establishes the importance of having proper policies and procedures in place for the screening of prospective patients, regardless of the type of facility or services offered.

Dr. Birmingham and the three general practitioners who treated Montreux patients expressed differing opinions on the level of care required for the proper management of acute patients suffering from eating disorders.

Dr. Birmingham s observations, on his review of the six patient files, included the following:

- Alexia would have been a candidate for hospitalization according to Dr. Birmingham but Dr. Clinton-Baker disagreed.

- Aviva experienced palpitations and chest pain, along with her left arm feeling heavy; she had a low serum potassium level. A supplement was ordered but lab results were not done for nine days thereafter. Dr. Clinton-Baker acknowledged the care could have been better.
- Dr. Bertoia s patient, Anja did not have any lab results until five days after refeeding had been initiated.
- Dr. Medhurst did not have lab work back on J.J. until four days after refeeding had been initiated.
- Dr. Bertoia s patient Suzanne had an abnormal serum potassium level prior to her admission on February 19, 1998 but there were no lab results initiated and reported upon until June 3, 1998. Dr. Bertoia conceded tests should have been ordered and it was an error not to repeat them a week into Suzanne s admission.
- Dr. Bertoia s patient Wibby did not have her lab results done until two days after refeeding had been initiated on February 9, 1998, and they were not repeated until April 16, 1998.

Dr. Birmingham testified that a deficiency in potassium is very serious, and can cause heart problems which have the potential to be lethal. (T4, P17-18) The suggested standard of practice is to measure phosphate every three days in the acute phase of refeeding. (Exhibit 4, Tab 24) The physicians, in their testimony conceded that monitoring in this area was not optimal and that improvements could be made.

Dr. Birmingham was asked by Licensing as part of his review the of medical files for the six patients mentioned above — Alexia, Aviva, Anja, JJ, Suzanne and Wibby — to provide an expert opinion on whether the six would be suitable candidates for admission to a facility such as Montreux. In his opinion all six were at risk of suffering refeeding syndrome (a complex, potentially life-threatening complication of anorexia nervosa (T4, P15-20)) or were candidates for hospitalization, or both.

However, despite being provided with expert advice on the high level of acuity of the six patients and the attendant risks associated with their management, all three physicians

testified that they would still admit these clients to Montreux. The Clinic did not call any witnesses who were qualified at the Hearing as experts in the area of the medical management of eating disorders. While Dr. Clinton-Baker did speak to the art part of medicine (T6, P9, L24) none of the physicians referred to or produced any medically expert sources that could be used to contradict Dr. Birmingham s expert assessment and opinion. These general practitioners do not have the expertise in the specialty of internal medicine to dispute Dr. Birmingham s findings. I accept Dr. Birmingham s opinion on the level of acuity of these patients and the standard of medical care required for their treatment, and the degree of risk to which they were exposed.

Evidence at the Hearing showed that problems of medical management occurred from time to time after clients had been admitted to the Clinic. Within a week of admission to Montreux, Dr. Clinton-Baker s patient Erica began experiencing abdominal discomfort to the point where it interfered with her sleep. It became progressively more severe during the day of January 10, 1997. Dr. Clinton-Baker saw the patient in the morning of that day but did not record that he had done an abdominal examination. Adrian Maisonneuve, Erica s careworker, testified that Erica did not describe all her symptoms to Dr. Clinton-Baker when he saw her that morning. (T8, P19, L2-3) The only notation in Dr. Clinton-Baker s chart for that date was that Erica s knee joint had been examined. Dr. Clinton-Baker, while expressing concern about the ensuing delay in treatment expressed the opinion that he didn t think that there was a lot of risk to her safety by the delay. She was in pain, and that would be my main concern. (T8, P21, L1-14)

Dr. Clinton-Baker also testified that he was the person who eventually recommended an enema for the abdominal pain but, like the abdominal exam, did not make a notation of that either. (T8, P22, L6-9) Dr. Clinton-Baker s agreed in testimony that neither the abdominal exam nor his prescribing of the enema by him were documented by him. However, he noted that the enema prescription had definitely occurred despite this lack of documentation; therefore, he suggested, both had likely occurred. (T8, P22) However, there was corroboration in Erica s worker s note that Dr. Clinton-Baker had prescribed the enema, but there was no confirmation anywhere that Dr. Clinton-Baker performed an

abdominal examination on Erica. (T8, P20, L10-19) It was the expert opinion of Dr. Birmingham that the patient should have been assessed and had her abdomen examined before any therapy was administered. Otherwise, she was at real risk for a medical misadventure.

Of note, the physicians generally did not discuss with patients or their families other treatment options or the appropriateness of selecting Montreux as a therapeutic setting. Dr. Medhurst indicated that one doesn t try to talk families out of their intentions to go to Montreux for treatment (T6, P88, L22) and this lack of exploration of options was confirmed by Dr. Clinton-Baker. (T6, P103, L9) According to Dr. Clinton-Baker, such matters are discussed only if the patient specifically asks about them. (T6, P104, L5) In contrast, Dr. Birmingham indicated that he does not defer to parents wishes in deciding on the appropriate therapy for a client and in fact may use such information about preferences to gain insight into underlying problems of patient and family. (T4, P92, L11 - P93, L2)

None of the physicians attending clients at Montreux Clinic were involved in a consent process or saw a consent form for treatment detailing the patient s rights and the Clinic s responsibilities. Dr. Clinton-Baker testified that he was never in the habit of doing this. (T6, P103, L7) In his testimony, Dr. Clinton-Baker indicated that in the case of Erica he did not explain other care options to her or her refusal rights, despite her not wanting to have any part of not just going to Montreux, but even being in Victoria. (T8, P11, L9-25) Erica was a legal adult in her early 20s and was arguing with her parents in the lobby of the Empress Hotel about entering the program. However, Dr. Clinton-Baker remembered only talking to Erica about her not getting treatment from Montreux while she was still at the Empress and I can t recall anything else apart from that. (T8, P12, L1-15)

Moreover, Dr. Clinton-Baker suggested that families were aware that this program will be a different program than other programs. And that at times it might seem as though

choices are being taken away for small periods of time when the overall benefit to be obtained is worthwhile. However, he said he did not believe flagrant denials of basic human rights have occurred or are occurring. (T6, P102, L13-20)

Dr. Clinton-Baker, in his testimony, said that the decision to admit or not to admit a patient is one that Montreux makes themselves. He testified that he makes recommendations, but senior Montreux staff are the ones who make the final decision. (T6, P56, L4) However, Dr. Clinton-Baker did find with Montreux that his advice (is) generally taken. (T6, P10, L16-17) Dr. Clinton-Baker summed up the relationship best with the patients are there, in their Clinic. (T6, P135, L7)

Evidence that Montreux staff were very much in charge of the clients staying at their facility included the staff members who were: calling the physicians after clients had been admitted to the Clinic, sometimes not for days; starting the feeding prior to patients being seen by physicians attached to Montreux Clinic; and not necessarily following the advice given by the physicians. Peggy Claude-Pierre testified that she would never override a medical decision by a doctor, (T20, P131, L18-23) never do anything contrary to doctors orders (T20, P157, L13-19) and never have the audacity to speak to a medical issue. (T20, P143, L11-12) However, evidence shows this was not always the case. By way of example, Dr. Bertoia s advice on caloric intake and on the feeding Anja through the night was not followed from July 25 to July 27, 1996. (T9, P82, L6 and P85, L25)

The general practitioners continued to see patients despite their advice not being followed. In fact, the practitioners appear to have accepted roles narrowly defined by the Clinic. Dr. Medhurst testified that in caring for David Bruce, the preschool aged child admitted to the Clinic, he only looked after the medical needs, not psychotherapy or diet plans. (T8, P42, L17; T8, P69, T8, P107, L19) Dr. Bertoia indicated he had no role in weight, meals, nutritional assessment, behaviour or psychological aspects of care, and Dr. Clinton-Baker indicated he was not involved in food intake. (T6, P98, L2) In keeping

with this partitioning of roles and responsibilities, the physicians did not review the records of their patients at the Clinic. Dr. Medhurst indicated he had visited Montreux only once (T8, P72, L16-23) and had never read the logs on his patients. (T8, P109, L9) Both Drs. Clinton-Baker and Bertoia testified they did not review the Montreux charts, (T6, P99, L20 and T9, P69, L14-24) although they provided copies of their medical charts on patients to the Clinic. As well, the Montreux patients were routinely accompanied to the physicians visits by Montreux management, such as Margaret Dobson and/or Medical Liaison Officer Kendra Dempsey, and careworkers who spoke on behalf of the patients. (T6, P140, L21-24 and T8, P118, L17, P119, L26) While Ms. Dempsey, has worked as a pharmaceutical assistant, (T11, P2, L1-3) this experience would not equip her with any special skills for this role other than a familiarity with the clients medications.

Moreover, Dr. Bertoia indicated that the staff makes most of those decisions surrounding initiation of appointments with the doctor, (T9, P15, L12-23) while Dr. Clinton-Baker indicated that he was in charge of determining visits by his patients, and not staff at the Clinic. (T6, P56, L6-11)

Montreux staff withheld information from physicians from time to time and would not discuss certain facets of the care of clients with the doctors. Dr. Medhurst did not recall a note in the file of David Bruce dated July 10, 1996 wherein Janice Lim was referenced as telling him that she couldn t discuss David s questions about his mother and father with him; she further instructed Dr. Medhurst that he shouldn t be discussing that with David. Dr. Medhurst agreed that there shouldn t be any secrets in doctor-patient relationships. (T8, P120, L7) Moreover, Dr. Medhurst was not aware of the care arrangements with David and Lucy, another Montreux patient, (T8, P106, L20; T8, P108, L17) of the separation of David from his mother for months at a time, (T8, P108, L17; P1089, L4) or of the aggressive feeding techniques used with David. (T8, P112, L3-25)

While Dr. Clinton-Baker testified that he had not had any complaints from patients about staff yelling at them or aggressive feeding techniques, (T6, P28, L20) he also acknowledged that he never asked directly whether such occurrences were taking place, for he expected the patient to bring these issues forward to him. (T6, P141, L22) Given that the staff of the Clinic accompanied the clients, and that Margaret Dobson was also almost always present, (T15, P98, L6-24) there would be little opportunity for this type of disclosure.

The physicians rarely relied on anyone other than their own small group for assistance. The evidence shows that these physicians rarely consulted and used only a very few specialists. Usually a precipitating serious event had to have occurred before bringing the Montreux patient into contact with the health system in the Capital Health Region. For example, the suicide gestures by underage patient Andrea resulted in a psychiatric consult only after the second attempt. Dr. Medhurst s management of David s nutrition consisted only of finding out his minimum caloric requirements and food intake from a GVHS nutritionist. Montreux Clinic did call upon Kim Macdonald from time to time to assist them on a variety of food issues — though she did indicate in her testimony that she neither approved meal plans, nor served as an informal consultant to Montreux.

The clients at Montreux were rarely hospitalized by the attending physicians. Many of the patients and their families did not want to become re-involved with the traditional mainstream health care system, preferring to stay at Montreux and rely upon the Clinic staff and doctors to deal with even their acute medical needs. Ms. Bruce and her husband relayed this sentiment to Dr. Medhurst, (T8, P37) and similar opinions were expressed by some of the parents testifying on behalf of the Clinic, including mothers Jan Cullis and Brenda Loney.

Finally, Dr. Medhurst and Dr. Clinton-Baker testified that the physicians had played at best a minor role in deciding upon the discharge of the patient and discharge planning. (T8, P125 and T6, P110-111)

Drs. Clinton-Baker and Bertoia had entered into an alliance with Montreux under which they provided consultative care but relied upon the staff at the Clinic to provide many of the assessments on the clients and to draw urgent situations to their attention. As well, they relegated to Montreux the final say on admissions and feeding, and primary responsibility for psychiatric, behavioural and nutritional care. Despite their reliance on Clinic staff in such important areas, Drs. Clinton-Baker and Bertoia were unaware of the training or qualifications of Montreux staff. (T6, P54, L12 and T9, P64, L16) Dr. Clinton-Baker conceded he did not even ask about their abilities. (T6, P51, L10)

When Dr. Birmingham was asked about the structure and staffing required to operate an eating disorder unit for gravely ill, acutely anorexic patients, he indicated that St. Paul s inpatient ward is staffed at the same acuity as an Intensive Care Unit because the patients are critically ill and at risk of death. The Unit is located within an acute care hospital, can call upon the facility s emergency responders, and has a cardiac arrest cart on the ward. Moreover, should a client require urgent ongoing support, both the cardiac care unit and the medical intensive care unit are available. There were, at the time of Dr. Birmingham s testimony, four inpatient beds on the Eating Disorder Unit.

The area is staffed by registered nurses and registered psychiatric nurses who do the day-to-day therapy. The program has a full-time dietitian who makes all meal changes and helps with the feeding of the acutely ill patients. The unit has a part-time family doctor to address other health problems, a psychiatrist, a psychologist, a social worker and a part-time occupational therapist. From time to time other health care professionals are called upon as required. In addition, such an acute intervention unit would also have access to other therapeutic services such as the psychiatric ward, if a patient has a personality disorder or major depression which is difficult to treat on the Eating Disorder Unit. As well, there are cardiologists, endocrinologists and gastroenterologists available to assist the multidisciplinary team. (T4, P23, P25-26) Dr. Birmingham also indicated that many of the individuals who work on the unit come with expertise from other backgrounds

which provide valuable additional skill sets that can be applied to this challenging group of patients, such as a nurse trained in cardiac care joining the Unit s team.

Moreover, Montreux was not like the residential program called Vista, (T4, P159) a transitional setting in a house which is attached to the St. Paul s program in Vancouver. The spectrum of patients at Vista does not include acutely anorexic patients who are seriously ill, and, even there, the expert staff are multidisciplinary and have strong links to the personnel and resources of the St. Paul s Unit. (T4, P24-25) Dr. Birmingham stated that in his expert opinion the level of medical intervention was not sufficient to prevent death or morbidity in the patients at Montreux. (T4, P6, L13-15) Dr. Birmingham testified that the use of lay individuals only was not sufficient for this patient population and people have to be trained and qualified. (T4, P71, L1-7)

The only medical expert witness called by Montreux was Dr. Paul Termansen, a psychiatrist with special expertise in the area of suicide prevention and intervention. Dr. Termansen is a published researcher and has made many learned presentations. However, none has been in the area of eating disorders and it is not an area of primary interest for him. (T5, P11, L9-18 and T5, P44) As well, Dr. Termansen acknowledged he was not well versed with the *Community Care Facility Act* and its Regulations. (T5, P48, L2 and P159) He visited Montreux on one occasion for three hours to gather information (T5, P4) and was apparently provided with incomplete information by Montreux on suicide gestures/attempts. (T5, P81, L19)

In contrast to the array of services and backup available at St. Paul s, the 1560 Rockland site — a turn-of-the-century mansion - was deemed a pleasant setting by Dr. Termansen. He felt it was positive to have such a fine building as a non-institutional facility for the patients. (T5, P8, L3)

Dr. Termansen also commented that the individuals working at the Clinic were generally caring, compassionate individuals who were highly motivated and enthusiastic. (T5, P8, L5) He suggested that having the careworkers of a similar age to the patients is a plus

because the patients, consequently, are less likely to feel inferior to the staff. (T5, P20, L18)

However, the testimony of the various senior staff at Montreux revealed that no one on the Clinic staff was qualified in suicide prevention (including Peggy Claude-Pierre). (T20, P164, L14-21) No one was trained in early childhood development, no one had schooling in behavioural management, and only a few careworkers had completed a university degree. Ms. Claude-Pierre testified the staff were well reasoned and terribly capable. (T19, P178, L16-22) One careworker, Heather Hestler, testified that despite being one of the most qualified staff at the Clinic, she felt out of her depth and knew some clients needed far more skilled help than was available to them at Montreux. (T2, P48, L2-21) Ms. Hestler indicated that she had no knowledge of anorexia nervosa and was one of the few people hired with a degree — hers is in fine arts. In her testimony, she confirmed a lot of them were young people out of high school or in their first two or three years of university, sort of studying part-time and working part-time but I was not aware of anyone who was formally trained for this particular work in a medical capacity. (T2, P7, L5-22)

Another careworker, Adrian Maisonneuve, testified to the lack of training and qualifications of Clinic staff in even the most basic of skills such as first aid. He indicated that many of the staff were hired right out of coffee shops and (were) friends or brothers or sisters of people that (already) worked at the Clinic. (T3, P50, L8-17) Most staff were in their early 20s. (T3, P142, L8-15)

According to the testimony from several of the careworkers, individuals with formal education were told to forget everything they had previously learned and that, in fact, such education could be construed as a strike against them when applying to work at Montreux. Mr. Maisonneuve testified that Ms. Claude-Pierre told him his degree in psychology was completely useless and that she had doctorates and masters students from all over the world who wanted to work at the Clinic, and she would not have them,

because they questioned what she did it was a strike against me having a degree in psychology. (T3, P43, L9-25)

Alex Garcia testified that in his initial interview with Margaret Dobson, he asked to be given some books to read about anorexia, but was told that it was a point in my favour that I knew nothing about eating disorders, because all the books that were out there were basically bull. There was nothing of any substance to be gained from any work on eating disorders, they had their own way of dealing with things, and in their opinion theirs was the only successful and effective way. (T3, P138, L1-8)

Margaret Dobson testified, I have learnt everything I know directly from her (Peggy Claude-Pierre), (T15, P88, L3-4) as did everybody else working at Montreux. (T15, P89, L25 - P90, L1) (Mr. and Ms. Dobson had been hired by Ms. Claude-Pierre in 1993 from jobs they had in the retail clothing industry.)

Margaret Dobson and Noah Dobson, like Peggy Claude-Pierre, had no training on how to do a suicide assessment. (T15, P31 and T18, P152) Mr. Dobson testified, If I thought there was a need, I would act on it. (T15, P31, L7-11) Ms. Dobson did take a seminar on the subject from the Need Crisis Line in December, 1998. (T15, P109, L19-22) Margaret Dobson did not have any training in nutrition, was unaware of CHR guidelines (T16, P53, L15-25) and had not read the literature, (T16, P60, L23-25) at least not since 1993. (T16, P61, L1-18)

Bob Enoch is the person Montreux would prefer to succeed Noah Dobson as Manager of the Clinic since the Dobsons testified they were leaving Montreux and moving back to Ontario in the autumn of 1999. Mr. Enoch testified that he would ensure the progress made in areas such as criminal record checks, first aid certificates and other similar administrative issues would continue. However, Mr. Enoch did indicate that he is no expert in the area of eating disorders. (T19, P66, L21-22) His knowledge base consisted

of what he had gleaned from staff at Montreux over the last year, learned from reading Ms. Claude-Pierre s book and acquired from perusing the Internet.

Mr. Enoch, who has a background in administering facilities for the mentally challenged and head injured, did acknowledge that some group homes have 24-hour nursing care, (T19, P47) but he indicated that there would only be a nurse-consultant temporarily attached to Montreux in the future. Mr. Enoch testified that Montreux would not be having around-the-clock nursing coverage should they remain open because we re not a hospital and we don t have an intention of transforming ourselves into one. (T19, P45, L20-21 and T19, P66) Dr. Birmingham testified that even a change in staffing to add around-the-clock nursing personnel would not be enough to manage anorexics of the acuity of those admitted to Montreux from time to time because some clients at the Clinic would require daily medical supervision. (T4, P15-24)

In the spring of 1999, Montreux submitted to Licensing a new admissions policy which management said they planned to implement. The policy covers the need for patients to be medically stable for admission to the Clinic, but then goes on to include a broadly-worded exemption clause which would allow Montreux management and its consultant physicians to override all such criteria and admit anyone they believe would benefit from the program. Mr. Enoch testified that he was the one who had developed the exemption clause (T19, P28, L18-20) after discussions with Noah Dobson and possibly Peggy Claude-Pierre and David Harris. (T18, P114, L18-23) That such a clause would be critical to Montreux Clinic operations was made clear from the fact that Ms. Claude-Pierre testified that she would still admit Alexia, Aviva, Anja, JJ, Suzanne and Wibby today, most definitely. (T20, P132, L20) Former Manager Noah Dobson would do the same thing, (T18, L113, L3-14) despite the recommendations of Dr. Birmingham and his warnings about the risks inherent in their cases.

Mr. Enoch, as the proposed future Manager for Montreux, epitomizes the problems with staff recruitment and training at Montreux. Mr. Enoch s understanding of anorexia nervosa is limited to what he has gleaned from Ms. Claude-Pierre and her staff. He came

to a Clinic whose licence was under review, without any experience in policy development for a facility like Montreux. (T19, P27, L1-6) Mr. Enoch generated a policy the likes of which, no one, including the physicians for the Clinic, had ever seen for a licensed facility. The sole purpose of the exemption clause would appear to be to accommodate Montreux s desire to admit whomever they wanted to.

Both Dr. Birmingham and Montreux have spoken of Montreux staff being over cautious in terms of dealing with patients with eating disorders. There is good reason for behaving in such a fashion, for Dr. Birmingham described the subtle therapeutic nuances associated with caring for someone with anorexia nervosa. Problems range from tracking routine electrolytes, being aware of subtle vitamin deficiencies, anticipating deficits in compounds like zinc, B12, magnesium and iron, understanding the roles of the various nutrients in the malnourished, to dealing with acute deficiencies of phosphate, potassium, and magnesium. As indicated in Ms. Claude-Pierre s book, there are many complications, and her list in only a partial one.

For example, Ms. Claude-Pierre did not reference acute thiamin deficiency, which can cause swelling around the third and fourth ventricles of the brain, mammary bodies and the aqueduct, swelling which becomes irreversible after a few days. This damage can lead to permanent loss of memory or even death. This condition is known as Wernicke s Encephalopathy. (T4, P18, L3-14) Ms. Claude-Pierre also did not touch upon the effects that medications, including over-the-counter preparations, may have on debilitated patients with anorexia, even up to sudden death. (T4, P19, L9-18)

To be aware of the plethora of problems faced by persons with acute anorexia nervosa, Dr. Birmingham indicated that the nurses on the inpatient unit at St. Paul s go through an extensive training and mentoring program. Moreover, they have the medical team assess even minor complaints they detect for, as Dr. Birmingham testified, the challenge is distinguishing minor complaints from significant ones. (T4, P18, L17-21) They are trained as health care professionals and can appreciate and identify conditions that might well be missed by caregivers with lesser skills. For a number of months, these individuals

continue to consult with people with considerable expertise about their patients. (T4, P14 — P20 and P136) Dr. Birmingham described how the nurses who take postings on the unit are often psychiatric nurses. Even such skilled persons still shadow nurses experienced at caring for eating disorder patients on the Unit, and take part in rounds and in assessments. After a week or two of shadowing, they receive a day of in-service. Then they will start attending more specific talks on fluid and electrolyte management, chest pain and other aspects of anorexia nervosa. As well, the orientation includes briefings by psychologists and other multi-disciplinary team members. At all times, these staff have access to specialists who can deal with any crises that should arise. (T4, P136-139)

In contrast, the Montreux orientation involved a few shadow shifts and an induction component, of which the centerpiece is the *20/20* special on Montreux. (Exhibit 75) While some improvements have been made with the recruitment of Scott Melnyk and Kendra Dempsey, the Clinic still shied away from hiring people who would be in a position to question all facets of the Montreux operation. While the staff at Montreux has been described as overcautious and keen to seek help, (T8, P33, L2-10; T6, P36, L19 and T9, P13, L5) the skills, training and experience of careworkers and even the most senior managers are so woefully inadequate (T16, P33, L1-9) that they would not be in a position to recognize many of the subtle but serious health problems and complications associated with gravely ill individuals with acute anorexia nervosa.

While licensing staff were concerned about delays in response to careworkers calls, such concerns are likely misplaced, as the individuals responding to the call are at best, no more knowledgeable than the individuals making the call, and in some cases less so. The staff are not sufficiently skilled to provide meaningful health assessments for the attending physicians at Montreux either. The facility does not have the equipment that would allow either staff or physicians (if they happen to be present), to deal with a cardiac arrest at any higher level than could be done in any public building.

Finally, Montreux Clinic had the opportunity to link with other outside organizations, including getting help developing their program. Ms. Claude-Pierre testified as to the numerous meetings she attended and the many recognized centres she visited. Yet, instead of enlisting the assistance of recognized experts in the field, she recruited three local general practitioners with no special expertise in anorexia nervosa or bulimia. The testimony of Alex Garcia indicated that Montreux actively shunned the hospitals because this created messy situations and such involvements were to be avoided. (T3, P145) Alex Garcia also testified about a co-worker named Colin who was criticized for taking a patient who had cut herself, and needed stitches, to the Emergency Department at the hospital without following protocol and calling senior management (T3, P147) first so that they (Peggy, Noah, Margaret or Karim) could attend at the hospital to deal with hospital authorities and try to minimize the damage of having to bring one of their clients there. (T3, P148, L7-17)

Of the few referrals made, Andrea was sent to a psychiatrist only after her second suicide attempt, and Lucy did not receive a consultation until January, 1998, two years after her problems had manifested themselves. A nutritionist for Montreux was not hired until well after the second investigation had begun.

The evidence is clear that at the time of the second investigation, Montreux was in breach of the Regulations in that it did not have in place a proper admission screening procedure. Montreux attempted to remedy this deficiency in April, 1999, with the creation of the new written admissions policy, created by Bob Enoch, then serving as a consultant. The medical criteria in this document are sound. However, the exemption clause which would allow the admission of any patient who does not meet the medical criteria but whom Montreux feels would benefit from their program, effectively castrates the entire policy. Montreux managers made it clear during their testimony that they have no intention of changing that clause. If they maintain this policy, they would continue to be in non-compliance with the Regulations.

Section 9.1 of the Regulations requires that all residents be assisted in obtaining health services as required. All residents at Montreux become the patients of one of the clinic s three doctors, who are able to refer them on to other specialists if they feel this is needed. While the expert witnesses had some concerns about the frequency of such referrals as well as the admission of patients based on incomplete and inadequate assessments, the fact remains that each patient was regularly seen by a duly-registered and qualified medical practitioner. Each of the three practitioners testified they were satisfied with the specialized and adjunct care received by their patients as well as with the arrangements Montreux made for them to see their patients. They also testified that at least one of them was always on call for emergencies and that the Clinic also could, and often did, use the services of walk-in clinics or local hospital emergency wards. In these circumstances, I cannot find that a breach of this Regulation occurred.

Section 6(6)(d) of the Regulations speaks to the need for responsible staff members to be on duty and awake at all times for emergency response. The evidence was clear that Montreux has a number of staff members on duty 24 hours a day, as this is part of their one-on-one care. Some concerns were raised around occasions in which those staff members did not receive prompt responses from management to their pages in case of a patient s illness. The expert witnesses expressed some reservations around the system of back-up involving untrained senior managers, but the Clinic s doctors found it satisfactory. Again in these circumstances, I cannot find on balance that a contravention of 6(6)(d) occurred.

However, the overriding section of the *Act* remains that which requires a Licensee to operate a facility in such a way as to promote the health and safety of its residents, and in this area, the Montreux Clinic falls significantly short. From time to time, they put the health and safety of some of their patients at serious risk. They accepted patients who could not safely be cared for in such a facility, given the lack of trained staff (up to and including all members of the senior management team) and the lack of medical technology.

Montreux managers testified the Clinic put great faith for the medical management of its clients in the hands of the three physicians. However, testimony from the physicians themselves clearly showed that they were often not involved in many of the key issues which affected the health and safety of patients, such as refeeding of anorexic patients and food-planning. On the issue of their level of involvement, I prefer the evidence of the doctors to that of the managers, in large part because of the consistency of testimony among all three physicians.

Moreover, the three general practitioners on whom they relied could not reasonably be expected to possess the type of advanced knowledge and expertise needed to manage the highly-acute patients who were on occasion admitted to Montreux, although their skills would have been quite satisfactory for the client population originally outlined in Mr. Harris s comments to Licensing. Ms. Claude-Pierre, both in her book and in her testimony, indicated she was well aware of the medical fragility of the acute anorexic patient. Therefore, she should equally have been aware of the need for medical back-up with a higher level of expertise in the specific area of eating disorders than community general practitioners, no matter how good their intentions and over-all medical skills.

The result was a system in which the doctors ended up treating patients even when they were given incomplete and inadequate information; had their scope of practice severely limited by Montreux; routinely saw their patients in the company of at least one Montreux staff member; and relied on those staff people for medical assessment, instead of reading the daily logs or Staff Reports themselves (even though, had they done so, they would in some cases have found that their own doctors orders were being overridden by Clinic staff).

In conclusion, I find that Montreux did breach this section of the *Act* and did put the health and safety of some of its patients at serious risk.

SUICIDE RISKS AT MONTREUX

Dealing with suicide risk is not a matter specifically covered in the *Act* or the Regulations. Rather, it falls under the more general portions of the legislation which state that:

8. A licensee or interim permit holder must
    (b) operate the community care facility in a manner that will maintain the spirit, dignity and individuality of the persons being cared for;
    (c) operate the community care facility in a manner that will promote the health and safety of persons in care.

As well, the Regulations state that a Licensee must develop and implement written policies to guide staff actions in all matters relating to the care of residents, and must ensure that a resident is assisted in obtaining health services as required.

Suicide prevention policies and procedures were an issue in the first investigation in 1997. (Exhibit 25, Page 7; Exhibit 25, Tab 32 and Tab 42) Montreux has made some progress in this area recently, and the new policies and procedures are found in Exhibit 37, Policy 811. However, as confirmed by Montreux s expert witness Dr. Paul Termansen in his testimony, at the time of the second investigation, there was a lack of: policies and procedures, written documentation, sophistication in the assessment of suicide risk and consistency in policies of intervention. (T5, P45, L17; P46, L5) While Dr. Termansen did speak to the importance of balancing care provision with bureaucratic form filling and recording, he also conceded that this latter activity was not only a legal requirement of the *Act,* (T5, P50) but that such documentation was helpful in understanding what had transpired in a patient s care. (T5, P62, L10-13 and T5, P124, L3-24)

Risk of suicide is a serious problem in patients with anorexia nervosa. All parties agreed that the patient population served by Montreux is at high risk of suicide attempts, suicide gestures and/or acts of self-harm that can put a patient s health and safety at risk. Neither Drs. Termansen nor Birmingham disputed a suicide rate in this vulnerable population of about nine per cent. (T5, P83-84) While this frequency of suicide is no greater than found in other patients with psychiatric disorders, it is still 10 times more common than in the general population. (T5, P84, L10-16) Moreover, the evidence suggests that thinking about suicide is prevalent in patients with eating disorders, occurring in about 29 per cent of patients, as are suicide attempts, recorded in about 13 per cent of patients, with one-quarter making multiple attempts. (Dr. Termansen s testimony, T5, P83, L1-16)

Dr. Termansen explained that most gestures of self-harm are a coping mechanism. By acting as a buffer against the person s inner emotional state, self-harming behaviours function as a defense for the person. In the more extreme forms, when the inner turmoil exceeds a certain point, the defensive response to blunt these emotions can be life-threatening and even lead to death. (T5, P105, L9-14; P77, L7 - P79, L2)

Dr. Termansen stated that the best way to reduce these defensive acts of self-harm is to focus on the problems that precipitate the emotional state that makes self-harm necessary, rather than concentrating only on the acts themselves, an approach which he suggested could even make things worse. (T5, P78)

According to Montreux s own patient logs, the behaviour of the patient Lucy ranged from scratching, cutting or piercing her skin, at times almost daily, (Exhibit 81) to carefully planning an escape from Montreux, buying and ingesting a large number of pills and lacerating her arms. (T3, P143) This captures the spectrum of these self-destructive activities in a single patient with an eating disorder.

Dr. Termansen testified that the defensive reaction (and ultimately the bodily harm done) depends upon the severity of the psychopathology at the time, the ego strengths of the individual, their ability to control their behaviours and the coexistence of other

difficulties. (T5, P105, L15-20) Dr. Termansen indicated that under similar circumstances some individuals will commit suicide, others will engage in a self-harming gesture and yet others will do nothing. (T5, P105, L21-25) He advised that suicide assessment is complex and, given the factors that may be operating, can challenge even the best of experts. (T5, P59, L15-25) Consequently, suicide prevention is notoriously difficult because it is so hard to predict if and when an attempt will occur. (T5, P55, L8-17)

According to Dr. Termansen, the situation can be diffused if there is a relationship with a care provider wherein patients will communicate their intentions or ideation verbally or non-verbally. (T5, P107) He stated that one must take these communications seriously and they should be explored, no matter how difficult they may be for the therapist to handle. These messages provide a unique insight into the patient s thinking, even if the patient does not fully disclose her plans to the therapist. In the end you rely on their word as to where they are actually at. (T5, P68, L1-14) Dr. Termansen subsequently testified that he agreed with the importance of asking directly about suicide ideation. (T5, P68, L15-18)

Dr. Termansen also spoke of the patient s willingness to communicate to others when they are troubled to the extent that their own life is in danger from trying to kill themselves. He noted that this openness and desire to get better is contingent on the extent to which they are of their own free will committed to overcoming their difficulties. (T5, P107, L2-14) Dr. Termansen was under the impression all patients were at the Clinic on a more or less voluntary basis, referring to their psychological state as well as their legal status. (T5, P108, L5-6) While legally he was entirely correct, he did not discuss in this context the imposed therapy model used by Montreux in which much of that free will is in fact assumed by the patient s caregivers.

Ms. Claude-Pierre (T20, P164, L19-21) and her staff had received no courses in suicide prevention at the time of the second investigation. Ms. Claude-Pierre does speak to the matter of both suicide and self-harm in her book, the reference text for the Clinic. Ms. Claude-Pierre indicates in the book that the Negative Mind, which she says dominates the

thinking of an acute anorexic, may tell the patient to kill herself, and the acute patient is weary of fighting this struggle. (P104) Ms. Claude-Pierre describes the internal mental horror, the unrelenting pressure of the Negative Mind (P60) and tells of a case where the Negative Mind drove one woman to scald herself with hot tap water and was urging her toward destruction. (P98)

Any suicide gesture by a client is viewed by Montreux staff not as a coping mechanism of the patient (as described by their witness Dr. Termansen) but rather as an act of aggression by that patient s Negative Mind. Moreover, these self-harming activities are not regarded as part of a continuum of coping depending on the patient s circumstances (as advanced by Dr. Termansen), but rather as seemingly independent events. In her book, Ms. Claude-Pierre describes patients who she found to be living under the merciless regime of the Negative Mind wherein marking or cutting was an added form of self-punishment as well as the Negative Mind forcing the victim to attempt suicide. (P98-99)

As observed by Dr. Termansen and reported in his testimony, suicide was a side issue and not a primary one for Montreux. (T5, P60, P16-24) Nevertheless, the primary therapy approach of giving the patient the illusion that they have no choice was operative in the management of patients. These clients of the Clinic would have been perceived by staff as having Negative Minds which were not only not letting them eat, but also in some cases encouraging the patient to act out in a puppet-like fashion a series of self-harming actions. (*The Secret Language of Eating Disorders,* P64A) Since the patient s choices were taken away and she was totally dependent on Montreux staff for eating and protection, the Clinic s personnel were responsible for making sure the patient did not harm herself.

Testimony from several Montreux staffers indicated that to ensure safety, the number of staff assigned to provide 24-hour care to a patient thought to be at high risk of suicide was doubled and the client formally was deemed to be on red alert. In her testimony,

Ms. Claude-Pierre indicated that while the acutely anorexic patient is not necessarily suicidal, they are despairing, (T20, P163, L1-15) and needing this level of supervision.

Dr. Termansen did indicate that having 24-hour constant care is a passive form of intervention but is simplistic in its conceptualization. However, the presence of a careworker, whatever his/her education, can make a difference, if only in the physical presence making it more difficult to succeed in a suicide attempt. (T5, P35, L9-17)

Moreover, Ms. Claude-Pierre and her senior staff were of the opinion that speaking about suicide to suggestible clients (Exhibit 17, P129, and T20, P165) could be a self-fulfilling prophecy as the negativity in their minds is profound. (T20, P162, L19-20) Having taken over decision-making for clients as part of the illusion of no choice, Ms. Claude-Pierre testified that asking a Clinic patient about suicide in such circumstances could be misconstrued by the client to mean that Ms. Claude-Pierre felt they had to die. (T20, P166, L13-19) Ms. Claude-Pierre was very concerned about reaction of patients in an imposed treatment situation as practiced by Montreux to discussions of suicide and she stated, I m very careful not to make suggestions. (T20, P166, L17-18) Noah and Margaret Dobson shared Ms. Claude-Pierre s interpretation of suicide risk from discussions of the subject.

Even at the Hearing, Margaret Dobson, Noah Dobson and Peggy Claude-Pierre (T20, P162, L6) were extremely reluctant to accept the concept of directly asking a patient about suicide ideation. This shift in care practices would require a departure from the imposed therapy approach, something none of the senior managers and their consultant, Bob Enoch, was willing to relinquish.

As with the management of clients eating, Montreux staff were not provided with any additional suicide training other than learning the illusion of no choice approach from senior managers. (T3, P139, L5-16) Prior to the second investigation, no training on the prevention of suicide was made available, even after a staff request for such training. (T2, P131, L9-25) Dr. Termansen did testify that some interventions rely on an intuitive

approach, (T5, P63, L1) and that the staff at Montreux are aware that their clients with eating disorders are continually struggling with self-destructive impulses which have various manifestations. (T5, P62, L19-22) In the preferred circumstances described by Dr. Termansen, staff would have access to mentors and managers with skills and expertise who could address issues arising. However, careworkers and counsellors were, on the issue of suicide, to report to and defer to senior staff (Noah Dobson, Margaret Dobson, Peggy Claude-Pierre) who were, at best, no more trained than careworkers were.

Moreover, even under new Policy No. 811, (Exhibit 37) Ms. Claude-Pierre, as Program Director, would have episodes involving suicide gestures or attempts referred to her. It would be her role to assess and manage the situation along with the Manager and the client s doctor. Ms. Claude-Pierre did not attend the one seminar on suicide prevention held at Montreux by the Need Crisis Line team or take any other specific training on this subject. (T20, P164, L14-21) Yet, she remains the person who trains the counsellors, for she is the one who has written the book on the illusion of no choice and described the Negative Mind in anorexic and suicidal patients. Even with a complete Policy and Procedure Manual on site, the blueprint for patient management is to be found in Ms. Claude-Pierre s book.

Of equal concern was Dr. Termansen s observation on the limited scope of the therapy at Montreux. He indicated that in interviewing three clients at Montreux, he found that none had any understanding of how their underlying mixed feelings drove their anxiety, and then their anxiety drove their defenses - an eating disorder and possibly other symptoms. Dr. Termansen found that all three were unaware of what their own level of anxiety was or why it was at that level. They knew only that it was less while they were in the Montreux program, but not why. Moreover, Dr. Termansen did not believe that these clients had any understanding as to what may have been the forces or causes (mixed emotions) behind the anxiety in the first place. (T5, P121, L1-9) Dr. Termansen was of the opinion the reduced anxiety was a result of Montreux therapy and of benefit to the clients. However, the patients would need to gain additional insights about the reason(s) for their anxiety once they were no longer having trouble eating, (T5, P121, L10-15)

something which would appear hard to accomplish within an imposed therapy model as practiced at Montreux. However, as acknowledged by Dr. Termansen, no follow-up has been conducted on whether further progress by Montreux clients has occurred in their resolving their underlying, anxiety-provoking problems. (T5, P114, L1-10)

Jennifer White, an expert witness on suicide prevention called by Licensing, indicated that Montreux has made progress in the area of suicide prevention and assessment. However, they would, at the time of her assessment, still require the following skills:

- the ability to conduct a thorough suicide risk assessment;
- the ability to defuse a client s risk of imminent self-harm through specific crisis intervention skills;
- the ability to develop short term and long term plans for safety;
- the ability to remain vigilant and sensitive to changes in the client s suicide risk status and to make changes to the care plan as necessary;
- the ability to communicate and document decisions pertaining to the client s risk status;
- the ability to seek out consultation and outside opinions as necessary;
- the ability to manage effectively the initial impact of a suicide attempt or suicide death on other residents.

On balance, the practice of Montreux in providing one-on-one, or even two-on-one 24-hour care, to acute patients does reduce, but does not eliminate, the risk of a patient being able to engage in self-harming activities or complete a suicidal act. The reduction of anxiety also provides some benefit to clients, but over-all the system of imposed therapy and the lack of suicide training and policies still posed a substantial risk to the health and safety of the residents.

SUSPENSION OF PATIENT RIGHTS AND IMPOSED THERAPY

Licensing alleged several breaches of the *Act* and Regulations in regard to Montreux s treatment practices. These focus mainly on the Clinic s methods of feeding some of its difficult clients and on its methods of dealing with patients who express a desire to leave the program.

The *Act* states that:

8. A licensee or interim permit holder must
    (c) operate the community care facility in a manner that will maintain the spirit, dignity and individuality of the persons being cared for;
    (d) operate the community care facility in a manner that will promote the health and safety of persons in care.

The Regulations state specifically that:

10 (2) The licensee shall not
    (a) except in an emergency, apply or permit an employee to apply, a physical restraint to a resident without first obtaining the written consent of the resident s medical practitioner;
    (b) physically, verbally or mentally abuse a resident.

As well, Section 6 of the *Act* makes clear that action may be taken against a licence if it is shown that the Licensee has breached any law of B.C. or Canada. This would include the provincial *Mental Health Act* which governs the rights of those suffering from mental illness in B.C.

It is difficult to comprehend that a person who is clearly grossly underweight but who insists on continuing to diet and/or exercise to excess and claims to be overweight can be mentally competent. In Exhibit 16, Tab 13, in the chapter entitled *Addressing Treatment Refusal in Anorexia Nervosa: Clinical, Ethical and Illegal Considerations* (by E.M.

Goldner, C.L. Birmingham, V. Smye in *Handbook of Treatment for Eating Disorders*, Second Edition, Eds. D.M. Garner, P.E. Garfinkel), the authors, in discussing competence, suggest that individuals who have anorexia nervosa do not experience a generalized disturbance in their mental functioning. Rather, they tend to hold false beliefs around their weight and body image, which like delusions, are persistently and tenaciously held despite all the contradictory evidence. Consequently, a general intellectual assessment would be unlikely to identify any incapacity. The question of competence for individuals with anorexia nervosa has to centre on their ability to make rational decisions about their own nutrition, refeeding, and other medical treatments. Therefore, in evaluating the competence of these individuals, one must obtain information about their ability to take rational steps to preserve their health and life. At times, according to the chapter s authors, who include Dr. Birmingham who testified at the Hearing, the condition can disable a person from making a free and rational choice about the condition itself and about treatment. Imposed treatment can be justified when death is imminent, because the behaviour does not result from free choice, and, in fact, is likely to result in an outcome that is contrary to the real desires of the patient.

However, the questions of what should be done in circumstances that are not as precipitous, as well as when to end an imposed treatment, are matters of debate in both scientific and ethical circles. Arguments in favour of imposed treatment begin with the idea that the patient s life and health should be protected, and suffering with a potential risk of death should be prevented. Moreover, anorexia is a mental disorder that impairs judgment about treatment, and imposed treatment has the potential to bring about improvement and the first steps towards recovery.

Opposition to imposed treatment stems from the argument that such therapy often does not lead to improvement and in fact, possibly causes harm. Of importance, those who oppose imposed treatment argue that patients are entitled to personal autonomy (freedom to choose their fate).

In determining therapeutic management for anorexic patients, the risks and benefits need to be individualized for each person before embarking upon any therapy including imposed therapy. One approach described in the chapter is the use of clinical decision analysis , which creates a decision tree. In this context, the probabilities of success and most likely consequences for each of the possible treatment methods (imposed or voluntary therapy) are estimated from experience or the literature, as are the relative worth or utility of the various outcomes. On the basis of this information, a reasoned decision can be made on which is likely the best avenue of therapy to undertake for the patient.

In outlining the approach to managing eating disorders preferred by the St. Paul s Unit, Dr. Birmingham testified as to the benefits of, wherever possible, entering into a voluntary contract of treatment with clients, and not going the route of imposed therapy because it does not provide a normalization of eating. (T4, P28 and P 40-49) The textbook chapter in Exhibit 16, Tab 13 outlined the many considerations that should be explored before embarking on imposed treatment. Finally, Licensing also provided descriptions of a number of well-known eating disorder programs which do not resort to imposed therapy. (Exhibit 3, Tab 12 and 13)

The best explanation of Peggy Claude-Pierre s theory about the causes of eating disorders and the approach the Clinic uses in treating them is found in her book. She talks of the profound lack of self and self-worth of the eating-disordered patient and of the voice of the Negative Mind that constantly tells the patients that they are not worthy of having food. She describes the approach that the Clinic uses to tackle this lack of self worth — one which has the patients relinquish all responsibilities, especially those around eating, to Montreux staff. This transference of accountability is briefly described on page 187 of Ms. Claude-Pierre s book, wherein responsibility for recovery is shifted to the therapist. This submission of will is seemingly complete, for Ms. Claude-Pierre describes the process on page 146 of her book as: The acute stage of treatment is synonymous with infancy. The patient needs to be totally without responsibility either for herself or for anyone else in order to begin growth. The acute stage must allow a patient s total

dependence until she no longer needs or desires it. While Ms. Claude-Pierre described a patient in this stage as having the same rights as any of us has as a human being , one would still be dealing with the equivalent of a totally dependent child or infant. (Page 147)

Ms. Claude-Pierre indicated in her testimony that this responsibility is not taken on lightly. They count on us as persisting to save their lives. They count on us caring enough to sit there for hours saying, come on darling, you can do it . (T20, P184, L19-22) She added that the patients don t feel they have the right of that decision (to eat), so they count on us helping them with it, reassuring them that they re - - allowed one more mouthful. (T20, P185, L16-20)

Thus, having assumed a parent-like role, Montreux staff are engaging in a struggle with the Negative Mind. As Ms. Claude-Pierre asserts in her book on page 203, if a person who has an eating disorder is refusing treatment, you can be assured that the Negative Mind is in control and you must be strong for her. Her life may depend on it. Ms. Claude-Pierre also testified that if the patients communicate they do not want to eat and - - even though they say no, then I would persist. (T20, P186, L3-4)

Ms. Claude-Pierre testified that in the training manual for Montreux (The Montreux Residential Care Policy and Procedures Manual, Appendix K, Nutritional Persuasion Techniques), the illusion of no choice is created to deal with the Negative Mind. (T20, P190, L22-P191, L4) In the manual, workers are instructed to ignore even the physical communication of resistance because it is the condition speaking as opposed to the patient. Ms. Claude-Pierre confirmed this in her testimony. (T20, P189, L1-13) So when in cross-examination, Ms. Claude-Pierre was presented with a hypothetical patient who was saying no, shaking her head to indicate no, or clenching her mouth or her teeth, Ms. Claude-Pierre did not consider it wrong to continue to attempt to feed them, because the activities were not directed against the patient but against the Negative Mind. (T20, P183, L7-17) Moreover, Clinic staff had assumed responsibility for these decisions as part of the patient s first phase of therapy. In fact, evidence of success of this approach, as

testified to by Ms. Claude-Pierre, is that patients would change their mind within minutes (T20, P183, L7-17)

The essence of the approach is captured in a description of a patient code-named Paula in Ms. Claude-Pierre s book who states, I don t have to (eat), Montreux can do it I just have to trust Montreux and let them do it. (P127)

This relief at having others assume the decision-making role is confirmed in the Chapter in Exhibit 16, Tab 13 on *Clinical, Ethical and Legal Considerations Around Treatment Refusal*. According to the authors, even though the therapy is imposed, for some patients, the treatment does come to be accepted and valued. These patients indicate that their feelings of shame or guilt, which may otherwise accompany food intake, are diminished when treatment is imposed by an outside authority; thus, nourishment becomes less difficult to accept. Moreover, this authoritative text indicates that some individuals later identified treatment refusal as an element of the disorder and considered imposed treatment to have been life saving. Dr. Birmingham testified about having to tube feed only three or four deathly ill people against their will in 20 years. (T4, P45, L14-15) He indicated that these people stopped resisting and seemingly readily accepted the tube because the choice was no longer theirs. (T4, P45, L20-25)

In their expert testimony, both Drs. Birmingham and Termansen spoke to the value of imposed therapy in acute situations such as an immediately suicidal patient. (T4, P154, L12-25 and T5, P94-95) Dr. Birmingham emphasized that this is a therapeutic tool and just because we certify them doesn t necessarily mean we re going to keep them certified. (T4, P154, L12-13) Moreover, Dr. Termansen cautioned about the importance of minimizing the length of certification, as it is something that is not without some danger to the well being of the patient. (T5, P95)

The evidence before this Hearing suggest that some Montreux patients such as Lucy, Alexia and Aviva have been in a state of treatment and dependency for a period of years,

during which Montreux staff have struggled with the Negative Mind and made decisions on their behalf.

As pointed out in the textbook chapter on treatment refusal, the spectrum of reaction to imposed treatment by patients can be varied and unpredictable. Although some patients come to accept the treatment, others actively resist. Not only may feeding be a challenge, but force feeding, which may become necessary, can also be difficult. This latter group of patients is described by the chapter authors as refusing all food or supplements, removing feeding tubes or intravenous lines, and actually fighting the efforts of the staff to help them. In settings such as St. Paul s Hospital, chemical and physical restraints can be employed, in conjunction with feeding tubes or intravenous or central-line nutrition, (as described in the expert testimony of child psychiatrists Drs. Sherkow and Ainsworth).

The textbook chapter describes that in these circumstances, the negative emotional consequences of using force or restraint can be profound for both the patient and the staff. The authors describe how imposed treatment in an acute care setting, administered on a 24-hour basis, can come to resemble a battle zone . The individual with anorexia is likely to be in extreme emotional distress, and dissension can develop amongst staff members. The authors go on to describe staff members experiencing burn out and confusion about the ethics of treatment, a conflict leading to job dissatisfaction.

The difficulties with such situations also are referenced in Peggy Claude-Pierre s book. Underscoring the nature of the difficulties dealing with someone with such a strong Negative Mind, she notes, If a patient goads a careworker to frustration, the Negative Mind has won. When that happens, the careworker must then be removed from the case since the trust so critical to the healing process will have been destroyed. (P132)

In her book, Ms. Claude-Pierre defines the nature of caring for such patients: As the Negative Mind proceeds with deceit and deception, so must we find ways to fool it into losing its grasp on its victim. (P133) Noah Dobson indicated that it is Montreux s obligation to persist and he also indicated The choice is not the patient s You take

the responsibility away from them for feeding That s what we try to do. Our patients tell us that s easier for them. (T18, P159, L18-24) He indicated finally that, We do whatever we need to do to try to save the lives of these particular patients. (T18, P58, L1-3) Having assumed the responsibility for these clients, he would not stop trying to feed them if they refused the nutrition, for to do so would seemingly be a capitulation to the Negative Mind, in which case we may as well open a hospice. (T18, P155, L3-13)

When faced with such a set of circumstances, one approach is persistence and Ms. Claude-Pierre describes on page 148 of her book a patient who pretends to resist efforts to feed her — there have been times when it has taken three hours, immense concern and reassurance in order for the victim to brave a small bowl of beans. Ms. Claude-Pierre also testified under cross-examination that the persistence and persuasion continue because clients do want to eat but the Negative Mind is refusing to let them. (T20, P186) Part of the process is being patient, for Ms. Claude-Pierre also testified that if patients clench their teeth, the staff will wait until they re ready to receive food. (T20, P189)

Staff also understood the illusion of no choice , meaning that when a patient is verbally saying no or physically resisting, that communication is seen as the condition speaking rather than the person, and therefore the feeding would continue. (Jane McCluskey s testimony, T13, P36, L19) Moreover, it is clear that this approach is a standard part of the training and that the responsibility for making the decision regarding feeding has been taken away from the patient (Jane McCluskey, T13, P45, L11) and confirmed by Ms. Claude-Pierre in her testimony. (T20, P191, L1-4) Margaret Dobson indicated that in the acute stage of anorexia, patients at the Montreux Clinic are saying no when they really mean yes. David Harris indicated that even David Bruce, whom they believed was suffering from a juvenile form of the disorder, similarly meant yes when he was saying no, even though he was only three years old at the time. (T17, P93, L4-7)

Montreux Clinic staff did not, however, use chemical restraints, intravenous or naso-gastric tubes as would be available in a medically supervised site to deal with the most challenging of patients and the Negative Minds. These options were not available to

them. Given that staff have assumed responsibility for decision-making for their clients around nutrition, the onus on them was to ensure an adequate caloric intake, even in the most severe of anorexics.

Former careworker Adrian Maisonneuve described the experience of staff committed to the illusion of no choice: You found that the help became less and less (from senior management), and you had to do whatever you could to make sure this person got their stuff; you d be told just make sure they get all the nutrition, whatever it takes, how ever long it takes, so, I mean, it kind of escalates. You start out trying to convince them very caringly, and then you offer, you know, to do it for them but there were many people that were completely resistant to being fed at all, and - - not many, but quite a few, and they would be put on shakes, and people would feed them, and there would be several instances where people were, I guess you could call it, force fed. (T3, P60, L10-22)

Peggy Claude-Pierre could not describe in her testimony how to differentiate between when the patient was saying no and when the Negative Mind was speaking. She also indicated that she left the teaching of careworkers on how to recognize the difference between the physical person speaking and the condition speaking to staff members Joel Young and Noah Dobson. (T20, P189, L14-21)

Consequently, staff and management did not elect to, but were likely compelled to, resort to techniques such as the holding of little David s head and hands against his will to get food into him. Every effort was made to cradle him while he was force fed. Alex Garcia, one of David s regular workers, testified about how he and Lucy restrained David under the direction of Ms. Claude-Pierre. (T3, P153, L21 — P154, L24) Later in David s stay, these efforts consumed greater and greater amounts of his day. Similarly, both Rachel Spence (T2, P92, L21-22 and P119) and Adrian Maisonneuve (T3, P68) described how they physically restrained patient Lena in order to feed her. Moreover, Mr. Dobson provided evidence in the first investigation (Exhibit 25, Tab 10) of persisting until the patient became physically exhausted and could then be fed and how that would be viewed as a victory over the Negative Mind. (T18, P155, L3-13) It reflected Montreux s

commitment to make and to follow through with the decisions surrounding feeding of the dependent patient. Finally, given the limited repertoire available to Montreux staff for resistant patients, not only did Montreux staff use a spoon to force open Lena s mouth, as acknowledged in the first investigation, but it is likely that this technique was also employed for time to time on difficult patients such as David Bruce according to the testimony of Alex Garcia (T3, P158, L1 and P159, L5) and other careworkers. Moreover it is also likely that this technique was demonstrated to staff by, or in the presence of, Noah Dobson on at least one occasion. (Rachel Spence, T2, P88, L11 and P89, L5)

It is likely that management not only knew about the use of a spoon to force feed patients, but did discuss the technique and have demonstrations to teach staff this approach. Given the resistance put up by some patients Negative Mind , it is improbable that staff would have stumbled on such a technique independently and at different times.

Scott Melnyk s testimony on this issue was not credible. He had claimed such a method would never be used at the Clinic. Only at the Hearing did he find out that Montreux, in the first investigation, had in fact acknowledged that force feeding with a spoon had occurred. He testified that the question of using a spoon to force-feed had been discussed only in the context of Mr. Dobson s dog Scarlet, but this version of events was not corroborated by Mr. Dobson. Mr. Dobson did, though, deny suggesting or demonstrating how a spoon could be used to force feed a client. (T17, P186, L19-25) On this issue, I prefer the testimony of the careworkers because Montreux s own logs are clear that the use of a spoon did occur from time to time and because it seems most unlikely that the careworkers could have all stumbled upon this same technique coincidentally.

Not only did the illusion of no choice apply to the decisions around feeding, but it also was extended to patients decisions about wanting to leave the Montreux program. If one accepts that any expressed desires to leave would be construed as the Negative Mind speaking and that staff had taken over decision-making from the patient to prevent the Negative Mind from holding such sway, that would explain the paucity of policies around early discharge of patients and the effective prohibition of clients from leaving.

Mr. Dobson and other Montreux managers testified they would accede to patients requests to leave only if they deemed them to be serious. (T18, P15 — 16) Having assumed responsibility for such decisions for individuals deemed totally dependent on the Clinic, even with a policy in place, one can at least recognize, if not accept, Montreux s definition of a serious request. This interpretation would also explain why Mr. Dobson provided only two recent examples of clients wanting to leave. (T18, P16, L14-15) The patients desires to leave would have been equated with those of an infant or totally dependent young child.

The five requests to leave made by Alexia and eight by Aviva were construed by Montreux as arising from their Negative Minds and being invalid even though Alexia was 18 years old at the time and Aviva 28 years old. With these individuals still being in the acute phase of their illness, even though each had been at Montreux for more than a year, they were still regarded as needing to have such choices made by Clinic staff. Mr. Dobson testified that we don t have residents who have been with us two or three months that make a request to go home. Generally the timeline would be within the first four to six weeks of admission They want to be at Montreux. (T18, P177, L9-19)

Finally, the issue of careworkers and even senior staff using harsh words, yelling or shouting at their charges might also be explained by Montreux staff struggling with the Negative Mind. As long as the object of this unacceptable behaviour was the Negative Mind, and not the patient per se, such actions might be regarded by persons who subscribed to Ms. Claude-Pierre s theory of the Negative Mind as an acceptable response, especially towards a particularly strong Negative Mind.

While she testified she did not approve of yelling (T19, P203, L24) and deemed it improper at any place, (T19, P204, L5) Ms. Claude-Pierre said that from time to time even she did have to be very firm and very stern. (T21, P91, L21) However, the testimony of Janice Lim and other careworkers suggested that Ms. Claude-Pierre did have to resort to raising her voice with clients to deal with the Negative Mind, and on one occasion did tell a collection of Negative Minds (three patients who were being

extremely noisy and difficult) to shut the fuck up. (T15, P23, L11-25) Other instances were provided by Nora Desjardins, Heather Hestler and Rachel Spence. Mr. Dobson testified he would not condone yelling at the patient, and was not aware of it occurring at the Clinic. (L18, P54, L2-20)

Scott Melnyk testified as to his role in convincing patients at Montreux that they had not in fact been yelled at by careworkers when they thought they had. He would reassure them that it was the Condition being yelled at and not them. (T12, P22-24) Dr. Birmingham testified such actions are totally unacceptable. (T4, P46, L20-25)

The illusion of no choice likely helped, to at least some degree, a number of patients at Montreux and the testimony of their grateful parents at the Hearing may reflect these gains. Nevertheless, it is a form of imposed treatment. Such an infringement on the rights of the patient, according to evidence in Chapter 16, Tab 13, may be a form of assault unless it is legally sanctioned. Only if a patient is deemed to be incompetent as a result of a mental disorder, may the decision-making authority be legally shifted to others and the patient denied their legal right to refuse treatment.

As Montreux s own witness Dr. Termansen testified, you cannot force feed people against their will unless they have been found to be legally incompetent: The only circumstance under which you can force a patient in our society to do anything is when they are committed. And they have to be committed by two physicians to a facility that has been designated as a facility that receives and treats committed patients. (T5, P96, L6-11) Such certification can only occur under the *Mental Health Act*. (Exhibit 16, Tab 12) Moreover, once an individual has been committed, there are a variety of safeguards in place regarding the admission process, the duration of detention, and the review process for the detention order.

Montreux Clinic is not a facility that can receive committed patients. However, the *Mental Health Act* does have a provision wherein Montreux Clinic could have applied to the Lieutenant Governor in Council for a licence as a private mental health facility. The

only requirement under this Section of the *Act* was that they be a community care facility licensed under the *Community Care Facility Act*. There is no evidence before the Hearing that Montreux had pursued this approach, which, if the requirements of the *Mental Health Act* were met, might have allowed them to legally practice the illusion of no choice in appropriate cases.

Ms. Claude-Pierre testified that she was aware of the *Mental Health Act* and that a patient has a right to refuse treatment and to refuse treatment at any time. (T20, P171, L9-19) Ms. Claude-Pierre also indicated during her appearance on the *Oprah* show in January, 1996, that, because of the *Mental Health Act*, patients are allowed to, as adults, walk out of Montreux at any time. However, Ms. Claude-Pierre qualified her position with if she (the patient) indicates that she s serious about it. (T20, P171, L25) Ms. Claude-Pierre testified that Montreux staff are dealing with a population that vacillates considerably in its opinion on whether they want treatment or not and whether they wish to remain at the Clinic or not. Under further questioning, and when presented with situations surrounding early discharge, Ms. Claude-Pierre re-emphasized that most patients were, in her opinion, not serious about their request to leave. Ms. Claude-Pierre argued in her later testimony that really this is the Negative Mind speaking and this is not a true reflection of the patient s desires: There s more to the language than the words. (T20, P177, L1-11)

In her testimony, Ms. Claude-Pierre implied that, in fact, the process could be construed as a voluntary committal wherein the clients are saying, As one patient had put it to me once, no matter what I say, please persist (T20, P187, L6-12) and if they communicate they do want to eat and - even though they say no, then I would persist. (T20, P188, L3-4) Unfortunately, even this conceptual arrangement is not legal. Moreover, Noah Dobson did testify that at Montreux, staff are not instructed about a patient s right to refuse treatment. Instructions to caregivers do not include the option that if a patient is communicating verbally or physically a refusal to eat that caregivers are to respect that decision and stop feeding the patient. (T18, P156) Mr. Dobson also testified that patients in requesting to leave, they may not want to necessarily leave. (T18, P15, L14-15) Margaret Dobson went even further and testified that she did not believe the certification

requirements under the *Mental Health Act* apply to the Montreux Clinic. She indicated that the general right of a patient to refuse treatment does not apply once they are at the Clinic, although she could give no explanation as to why Montreux should be exempt from the provisions of the law. David Harris testified that David Bruce, in displaying the Negative Mind, really wanted to stay when he was asking to go to his mom. (T17, P93, L4-7)

Montreux Clinic has retained the services of Bob Enoch, whom they would have succeed Mr. Dobson as Manager of Montreux. Mr. Enoch testified that he wants to introduce the law and common sense to one another on the subject of anorexia, because it s clearly a unique situation. (T19, P57, L3-12) Mr. Enoch indicated that he has no expertise in this field beyond what he has learned from Ms. Claude-Pierre s book, other staff at Montreux and the Internet. Mr. Enoch was unable to articulate how anorexia nervosa is different from any other mental health disorder where patient choice and rights cannot be suspended without following the proper legal process. In buttressing the argument to allow the Clinic to engage in the illusion of no choice because of an unquestioned amount of therapeutic success, (T19, P46, L15-16) Mr. Enoch apparently had forgotten his own testimony that there have been no studies of the Montreux program s success rate. (T19, P18, L1-4) In rejecting the application of the *Mental Health Act* to Montreux s treatment of eating disorders, Mr. Enoch testified that he could not see how anyone could disagree with the substitution of affection, love and support for an abstract process of legal reasoning. (T19, P34, L7-9) In fact, Mr. Enoch stated in his testimony that if a patient said no or refused feeding 30 times in one hour, it is no violation of their human rights to continue to feed them despite that communication of resistance. (T19, P33, L12-17)

In order to sidestep the *Mental Health Act*, Mr. Enoch gave himself an exemption to allow the continuation of the illusion of no choice when he indicated that Montreux will do everything possible to meet the needs of Licensing and the public — so long as that does not require us to stop healing people with anorexia. (T19, P36, L22-25) Ms.

Claude-Pierre testified that even to this day the illusion of no choice is an accurate description of their therapy. (T20, P190, L1-4)

Montreux is not above the law and cannot operate outside of the law.

The evidence from Montreux s documents, including patient logs and Staff Report Forms, shows that on occasion, Clinic staff, following Ms. Claude-Pierre s model and approach, did breach the Regulations by physically restraining patients and using physical force and mechanical means to get them to eat, by verbally threatening some patients, and by acting in a mentally abusive way towards them. These actions also put them in contravention of the sections of the *Community Care Facility Act* which require all Licensees to maintain the spirit, dignity and individuality of the residents in their care and promote their health and safety.

Testimony from all five of the previous careworkers who testified on Licensing s behalf also made clear that on occasion, Montreux insisted on continuing their system of imposed therapy, even when patients, none of whom were committed under the *Mental Health Act*, were obviously refusing treatment and/or expressing a desire to leave the therapy program and the facility. Patients mentioned in this regard included Alexia, Aviva and Lena. This would put them in breach of the *Mental Health Act.*

It may be true that Montreux s approach of imposed therapy has helped some patients through their anorexia nervosa, at least temporarily, and that some patients and/or their families have, in fact, given what amounts to a voluntary consent for such an approach to be used. However, these anecdotal testimonials cannot be used as a justification for further contraventions of the *Mental Health Act* and its safeguards, for those patients who either never gave such consent or withdrew it during the course of therapy.

The policy on Nutritional Persuasion Techniques contained in Montreux s new policy and procedures manual also does not rectify the situation since it would continue to allow Montreux to impose therapy against a patient s will and thus contravene the *Mental Health Act.*

THE CASE OF DAVID BRUCE

One of Licensing s key allegations was that Montreux took into care a three-year-old boy named David Bruce in contravention of the terms of their Licence, maintained him as a residential inpatient at the unlicensed St. Charles site for a period of 14 months, and repeatedly misled Licensing about the little boy s status at the Clinic.

The key section of the Regulations reads that:

4 (5) The licensee shall not

(a) provide a service

(i) of a type other than that specified on the licence except where, in the opinion of the medical health officer, retention or temporary placement of a person in the facility is in the best interest of the person.

As a licensed adult-care facility, Montreux was not allowed to take in any patients under the age of 19 without the express approval of the Medical Health Officer. Over the years, such approvals had been given for several patients, all of whom were teenagers, but never for a young child. Montreux management conceded they had never asked for such approval from the Medical Health Officer for David.

The story of David was so complex that it expanded during this Hearing to cover much more than just whether David did actually stay as a patient at the St. Charles site. Significant issues were raised about his diagnosis, his course of treatment at Montreux, (especially his prolonged separations from his parents), the qualifications of his careworkers, and the role of his mother in his treatment.

These are most succinctly summed up in the general section of the *Act* which states that:

8. A licensee or interim permit holder must

(b) operate the community care facility in a manner that will promote the health and safety of persons in care.

In an effort to do justice to the complexities of David s case, I have chosen to include here a summary of his history and his stay at Montreux.

David Bruce was born on October 8, 1992, in New York City, weighing 7lbs., 10ozs. at birth. Relying upon the information found in the growth charts in Exhibit 49, David s height and weight followed the 25th percentile until about nine months of age. Over the next nine months, David s weight fell below the 5th percentile.

In her testimony at the licensing hearing, David s mother, Meg Bruce, described the difficulties she encountered with David in attempting the transition from introductory baby foods, which are smooth and creamy, to junior products with more texture and lumps. While David s failure to thrive was most alarming to Ms. Bruce, she also described other behaviours that were disconcerting to her and her family. These included David s crawling on his knuckles (rather than the palms of his hands), his intense fear of getting dirty, and his unfavourable responses to social events and interactions, such as birthday parties and engaging other children at the playground.

Ms. Bruce indicated she was limited in the care options available for David: I had to see people, of course, that were on my health insurance plan. (T7, P119, L10-11) In her pursuit of answers, Ms. Bruce did express disdain for some of the doctors she went to, saying there were occasions when there was one visit and (I) never went back again because of their nasty remarks and patronizing tone. (T7, P33, L12-14)

Ms. Bruce described how David, who she said was extremely articulate at a very young age, spoke about a man under his hair , who was telling him he was not allowed to eat. (T7, P33, L5-7) She indicated that shortly after this disclosure, she was channel-surfing and came across the December 2, 1994 hour-long *20/20* show on the Montreux Clinic. During that program, patients with anorexia nervosa attending the Clinic were talking about voices in their head. (T7, P38, L14)

Ms. Bruce testified her response was: I thought to myself, oh my God, I am not looking any further. This is where David has to go . (T7, P38, L19-20) Ms. Bruce stated she obtained a number for the Clinic from the offices of the *20/20* program and faxed a letter to Montreux. She received a call back four days later from Peggy Claude-Pierre. Ms. Claude-Pierre testified that this was also her recollection of events. (T20, P38, L14-28)

Ms. Bruce testified that she and her husband battled with David over food in New York and at times resorted to holding David down to feed him. (T7, P42, L22-P43, L2)

Ms. Bruce met Ms. Claude-Pierre when Ms. Claude-Pierre was on business in New York City. (T7, P43, L14) During this meeting, Ms. Claude-Pierre told Ms. Bruce and her sister, a teacher who accompanied Ms. Bruce to the meeting, that what was happening with David was no one s fault. Ms. Bruce testified she felt great after the meeting. (T7, P45, L7-11) It was after this meeting that she decided to go to Montreux with David. Ms. Claude-Pierre indicated that she told Ms. Bruce that she would help her, and try to help monitor her, and advise what assistance was available. (T19, P154, L6-8)

Child psychiatrist Dr. Geoffrey Ainsworth, called by Licensing, was asked about the appropriateness of Ms. Claude-Pierre s decision to initially not take David on as a client, but to support the mother by telephone, based on the post-*20/20* contact and a single meeting. The opinion evidence which he offered was: That was dangerous to be honest. (T22, P26, L9-10) Dr. Ainsworth explained that for a psychiatrist to offer advice is risky unless they are sure that the child is physically safe and his physical health is being properly monitored.

The same question was put to Dr. Ainsworth, asking him to make the assumption that David was receiving medical help through pediatric sources in New York and Ms. Claude-Pierre s support was being offered as an adjunct to that help. Dr. Ainsworth reiterated that more would still be needed if, in fact, the situation were so desperate that the mother was forced to seek help thousands of miles away. He suggested that if that were the case, anybody with any knowledge of psychiatry, and child psychiatry in

particular, would say, if it s that scattered that she can t get the help she needs closer to home, then I have got to work like crazy to make sure that there is a team available of skilled professionals closer to her that she can phone on the weekend or go to visit the next day, so that, if some emergency happens, they know who to contact It s difficult enough to do that from an office, but to do that from thousands of miles away is plain, downright impossible. (T22, P27, L1-16)

Dr. Ainsworth added: I think Mrs. Bruce was getting the wrong advice; she was doing what she thought was responsible as a mother. He testified he believes it was irresponsible on the part of Montreux to first, suggest that they could somehow do something helpful long-distance, and then, to recommend coming to Victoria from New York when there had been no proper attempt, as far as I am concerned, to get the right kind of treatment locally. (T22, P28, L9-19)

A similar conclusion was reached by Dr. Charles Medhurst, the doctor who monitored David s medical care while he was at the Montreux Clinic. In his testimony, Dr. Medhurst eventually conceded that: I think she (Ms. Bruce) was trying to do everything that she could do right. But I m not sure, especially in retrospect, that her insights were correct. (T8, P132, L17-20)

In preparation for going to the Montreux Clinic, Ms. Bruce obtained two letters from pediatricians who had seen David, along with his recent blood work. (T7, P46, L22-25) Dr. Ainsworth s opinion is unequivocal about the two doctors letters provided in evidence, supporting Ms. Bruce going to Montreux. He testified: There is nothing in either of those letters that is sufficient, in my view, to base any kind of opinion on, so I can t really comment on that. I don t know why they would say this is a severe case of anorexia nervosa that has to be treated in Canada. There is nothing to base that on. (TT22, P28, L25-P29, L5)

Referring to one letter written by one of the pediatricians to Montreux, Dr. Ainsworth testified: At first blush, seeing a letter like that for a child as complicated as this, it

sounds like somebody has rushed into the office and said, look, I just need a quick letter rushed to the Montreux Clinic to say this kid needs to be sent over there. It doesn t really sound like a reasoned opinion at all to be honest. I m quite shocked that anybody who is a pediatric specialist would write such a short letter on such a complicated issue. Dr. Ainsworth equated the letter with one which would be provided for a child who is away from school for a day or two because of illness. He went on to testify, The politest interpretation would be that he had been asked to send a short note to justify a decision that the family had already made, which was to take him to a clinic in another city. (T22, P21, L16-P22, L11)

In contrast, Dr. Ainsworth outlined what he would expect from a proper referral from a medical doctor in similar circumstances. It would be expected they do a summary of the history and all its aspects, including a family history and background, and other illnesses that may have been there, and then a detailed physical examination of the child also a record of what had happened with the previous specialist and what their opinions had been. At the minimum, that s what I would expect. (T22, P47, L12-23) He noted the letter did include one key piece of history, which was the historical data of David s growth.

According to Peggy Claude-Pierre s testimony, David came to Victoria because Meg Bruce became more fearful of his diminishing ability to eat food. (T19, P154, L25-P155, L1) He arrived at the Clinic shortly after his third birthday in October, 1995. At that time, his weight was 26.5 pounds. Despite his mother s fears, on the basis of the weights reported in Exhibit 49, David had shown significant improvement in his weight from a year earlier. He had gained 3.5lbs. and had moved from well below the 5th percentile at age two years, up to the 5th percentile for weight at three years.

In her testimony, Ms. Claude-Pierre indicated that in her opinion David looked as if he was underweight, (T19, P156, L6-7) undernourished and had been compromised for a long time. (T20, P34, L7-8) She also repeated in her interview with Licensing in September, 1998, and again in her testimony, the story as she understood it of David prior

to his coming to Montreux, receiving sustenance in the order of eight Cheerios™ a day or something akin to that, and very little other nourishment. (T19, P158, L19-21 and Exhibit 17, P66) Margaret Dobson also described David on arrival as a pretty sick little kid when we got him. (Exhibit 20, P147)

However, careworkers Heather Hestler and Alex Garcia, in their testimony, both questioned whether David was ever sick physically in the first place. (T2, P39-40 and T3, P171, L11-13) The growth parameters in Exhibit 49 indicate that at the time of his arrival at the Clinic, David s height and weight were both at the 5th percentile. While he was smaller than 95 per cent of children his age, his presentation would have been that of a child whose weight was appropriate for his height. He would have looked younger than his chronological age because of his small size. He would not, however, have had the physical characteristics of individuals with anorexia nervosa whose body weight is significantly reduced compared to their stature.

Dr. Charles Medhurst, who took over medical monitoring of David when he arrived at Montreux, apparently concurred with this view. In testimony, he described David as under weight for his age, under height for his age. He was not a thriving little boy. (T8, P35, L22-23) Dr. Medhurst indicated that David was not medically compromised. (T8, P36, L22-24)

Dr. Medhurst did not prescreen David s medical file prior to his coming to Victoria to determine David s suitability for the Clinic program. (T8, P29, L9-10) Dr. Medhurst saw David for the first time shortly after his arrival in Victoria. At this juncture, Dr. Medhurst had been provided with the referral letters from New York, and information on David s blood work which had been done recently, and in which the only abnormality was that his triglycerides were slightly elevated. (Exhibit 48)

Dr. Medhurst testified he relied on the opinion of Dr. Dilello, one of the two New York pediatricians who provided information about David Bruce. (T8, P38, L1-3) He stated he did not initiate any additional contact beyond the referral letters with the New York

pediatricians to obtain any more information about David. (T8, P96, L23) Despite having no experience in his own practice in dealing with a child of this age with an eating disorder of this severity, (T8, P96, L24-P97, L7 and P98, L7) Dr. Medhurst agreed to do the medical monitoring of David while David attended Montreux for treatment of anorexia nervosa. Dr. Medhurst was adamant that he was involved in neither providing psychotherapy to David, nor in determining his diet plan. (T8, P42, L17) Moreover, Dr. Medhurst repeatedly testified he believed David had anorexia (any condition characterized by a loss of appetite for a variety of reasons), but not anorexia nervosa, the classic eating disorder marked by an unrealistic fear of gaining weight. (T8, P35, L17-21; P95, L16-19; P99, L16-21)

Dr. Medhurst also testified that, on initial assessment, he had formed the impression that David was unable to get the medical help he needed in New York, that the family had met with failure in their estimation in terms of helping him deal with his eating disorder. (T8, P35, L13-15) However, later in his testimony, after reflecting on Dr. Ainsworth s expert report, Dr. Medhurst indicated that the most prudent course would have been a thorough assessment of David, something he agreed could have been done in New York. (T8, P105, L21-P106, L1)

The only outside advice Dr. Medhurst sought in providing care for David was that of a nutritionist from the Greater Victoria Hospital Society (as it was then), who provided information on daily caloric and fluid intake requirements for a boy of David s age, on the assumption that his height and weight were corrected to the 25th percentile. (T8, P45, L16-P46, L8) Dr. Medhurst made no other local referrals to health care specialists to assist him in caring for David. (T8, P97, L4-16) When asked why, when confronted with a failure-to-thrive child, he did not get such a referral for David, Dr. Medhurst testified it was because of the parents apparent dissatisfaction with medical practitioners and their decision to adopt the Montreux approach. (T8, P37, L22-P28, L3)

In her testimony, Peggy Claude-Pierre left the impression that Meg Bruce was responsible for all facets of David s involvement with the Montreux Clinic. Ms. Claude-

Pierre testified that the decision that David be admitted to Montreux was one she merely concurred with. His mother made the decision and I agreed with her. (T20, P4, L2-3) Ms. Bruce was apparently able to make the decision to place her child in a for-profit facility even though, according to both her testimony and that of Ms. Claude-Pierre, the family never paid for his care. (T20, P11, L9-10)

Ms. Claude-Pierre reinforced the contention that Ms. Bruce orchestrated David s course at Montreux when she testified that Ms. Bruce had called her one hour prior to her testimony at this Hearing, saying: Peggy, remember that I had directed this with my son, and everything we did — you did — you did under my direction. (T20, P4, L15-19) When asked specifically if she was in charge of David s care, Ms. Claude-Pierre answered, I monitored his care. (T20, P4, L24-25) She said the question of a psychiatric referral and any medical decisions would have been made by Ms. Bruce and David s doctor while he was at Montreux — Dr. Medhurst. (T20, P26, L20-P27, L4) Even David s separation from his mother and the guideline under which Ms. Bruce was not allowed to visit or talk to David were decisions made by Ms. Bruce, according to Ms. Claude-Pierre. (T20, P29-30) Ms. Claude-Pierre testified that even David s food intake at Montreux was purportedly under Ms. Bruce s control, with all food planning issues discussed with her. (T19, P156, L7-10) She concluded with the opinion that Ms. Bruce could override anything I would have to say. (T19, P166, L22)

Moreover, Ms. Claude-Pierre felt that this was a satisfactory arrangement. She testified she had no qualms about working with David s mother, noting that had there been a moment of alarm, I would have done something more definite. (T20, P32, L18-23)

Ms. Bruce also testified in support of this arrangement, saying she was party to decisions made involving the care of David. It was, she said, her decision to move David from outpatient to inpatient care, and she also agreed to cooperate with the request not to see David in unplanned meetings during their trial separation. (T7, P90, L4-11) She made it clear she was not going to give up on her decision to come to Montreux and return to New York if David was still having problems. (T7, P70, L13-20) Ms. Bruce

acknowledged on a number of occasions in her testimony the kindness shown her and her family by Montreux, and how the family s needs were attended to by Peggy Claude-Pierre, her husband David Harris, and the Clinic staff.

Ms. Claude-Pierre s testimony suggests she played only a peripheral role in David s care and course while at Montreux. Yet, Ms. Claude-Pierre was the Program Director throughout David s stay at the Clinic, and when guidelines were drawn up for David s care on August 25, 1996, Ms. Claude-Pierre is listed as both David s Counsellor and his Team Leader. (Exhibit 11) Ms. Claude-Pierre did confirm this latter role in her testimony. (T20, P5, L1-2) Furthermore, Staff Report Form Number 4s and Patient Logs, including David s, were forwarded to Ms. Claude-Pierre for review. (T20, P5, L12-P6, L11) The testimony of both current and former staff confirms Ms. Claude-Pierre s key role in overseeing David s care. It was Ms. Claude-Pierre who was regularly paged when issues or problems arose with David.

Moreover, had Ms. Bruce been directing David s care, orchestrating his food plan, and overseeing the trial separation, her response to being presented with the August 25, 1996, guidelines during her testimony should not have been first time I ve ever laid eyes on the guidelines , making it clear she had not previously seen them, let alone been involved in their development. (T7, P109, L1) Moreover, these guidelines list only Peggy, Marg, Janice, Lucy (all Montreux managers or staff persons) as persons to call about David s food plan. (Exhibit 11)

Again five and a half months later, when David s food plan is described in a Weekly Progress Report dated February 11, 1997, Ms. Bruce is still not listed under the section Food Plan — Who to call for Questions . The name listed is Brenda Morton, another Montreux staff person. (Exhibit 11)

As well, of the 46 changes in David s diet made without following a formal approval process, all were made by Montreux staff; none were initiated by Ms. Bruce. (Exhibit 2, P122; Exhibit 9, Tab 8) In addition, for any inquiries concerning outings or questions

about the guidelines, staff were to call either Ms. Claude-Pierre or Ms. Dobson. (T16, P16, L3)

The limited extent of Ms. Bruce s actual involvement was also reflected in the fact that she was unaware of Ms. Claude-Pierre referring to David s suicidal ideation in a Progress Report dated November 7, 1995. Moreover, if Ms. Bruce were directing a trial separation from her son, why then in her letter to Ms. Claude-Pierre, dated December, 1996, (Exhibit 14, Tab 4) would she say: I need to be somewhat part of my son s life, and if you can, try to have someone call me regarding my son. As well, the director of any such trial would not be requesting to here (sic) Peggy Claude-Pierre s suggestions and volunteering, I know I have a few. (Exhibit 14, Tab 4)

In high-profile media coverage of the Clinic, Ms. Claude-Pierre is consistently presented as the person in charge of the care of patients. When David appeared on the *Oprah* show, on January 17, 1996 and was described on the edge of death , Ms. Bruce was introduced as his mother, not as the primary therapist. Ms. Claude-Pierre played that role.

Meg Bruce subscribed to the Montreux approach, believed in Peggy Claude-Pierre and willingly went along with whatever intervention Montreux proposed. She was not, however, the person most responsible for David Bruce s care. That was Peggy Claude-Pierre.

A key question in examining the treatment David received at Montreux was whether he was in fact suffering from anorexia nervosa, like the other Clinic patients, all of whom were at the time at least ten years older than he was.

In her testimony, Ms. Claude-Pierre said that when she initially talked to Ms. Bruce, she did not accept that he was suffering from anorexia nervosa, although she accepted that Ms. Bruce believed he was. However, she said that after her first lengthy conversation with David, she concluded he was in fact suffering from anorexia nervosa. The things he said were consistent with what I understood of the patients I had He was manifesting a

behaviour and he was speaking the same language. (T20, P38, L8-9) She formally recorded the diagnosis on November 7, 1995, a week after David s arrival in Victoria. (Exhibit 11)

Ms. Claude-Pierre, in her book, states that she has come to believe that failure to thrive in infants and toddlers can in fact be an early manifestation of the Negative Mind The seeds of anorexia may have been planted at a much earlier age than the one at which individuals become body-conscious. (P67) Ms. Claude-Pierre reiterated this opinion on the *Oprah* show which featured the Bruce family, saying that Confirmed Negative Condition — which she believes is the underpinning of anorexia nervosa — can be present at birth or shortly thereafter. On the show, David was described as suffering from anorexia nervosa, and Ms. Claude-Pierre did not dispute or correct this impression.

In her interviews with Licensing, in her testimony, and in several media interviews, Ms. Claude-Pierre has reiterated that she has, in her outpatient practice, dealt with patients as young as two, three, four or five years old, all of whom she believed were suffering from anorexia nervosa. That David was viewed as having anorexia nervosa with Confirmed Negativity Condition and its accompanying Negative Mind is underscored by Ms. Claude-Pierre s including David s story in her book. She describes his coming to Montreux on pages 97 and 98 under the subtitle The Psychology of the Acute Patient, in Chapter 4, which is entitled, *The Acute Patient: Held Hostage by the Forever Intruder.*

Other witnesses also testified that Ms. Claude-Pierre had discussed David s suffering from anorexia nervosa with them. Ms. Bruce testified that Ms. Claude-Pierre told me that she hasn t really worked with a child this young. (T7, P47, L21-22) However, according to Ms. Bruce because she hadn t met him yet, she didn t realize how intelligent he was, and how, although he was three, he exhibited the same symptoms as an older child did. (T7, P47, L24-P48, L1) Ms. Bruce testified that later in David s stay at Montreux, Ms. Claude-Pierre came to her and said, He showed all the signs, just like

any of her patients there, there was no difference from his age and theirs. (T7, P70, L7-9)

Margaret Dobson, in her testimony, added that: In my opinion, and I m not an expert, there s no difference in the way David thought to the way an older person would think. (T16, P83, L5-7) Janice Lim, who was one of David s primary care providers, testified that Ms. Claude-Pierre told her that David had anorexia nervosa. (T15, P40, L21-24)

In her testimony, Ms. Claude-Pierre was asked about supporting evidence from the medical literature regarding infantile anorexia nervosa and whether it existed in children of David s age. She mentioned work done on anorexia by a psychiatrist in California and a doctor in Norway, (T20, P37, L18-P38, L8) and no scientific papers or documents were entered as exhibits to support her contention of the existence of this condition at such an early age. Scott Melnyk confirmed in his testimony that he had conducted a literature review on the topic for Ms. Claude-Pierre in 1997. (T12, P72, L12-P73, L2) In her answer, Ms. Claude-Pierre did not specifically differentiate between anorexia and anorexia nervosa, although she testified she did know the difference between them. (T20, P83, L23)

The two child psychiatrists who testified as expert witnesses at the Hearing both stated that it is virtually unknown for a child as young as David Bruce to suffer from anorexia nervosa. Dr. Geoffrey Ainsworth and Dr. Susan Sherkow both testified that a key element of anorexia nervosa is being distraught over body image. That, they said, cannot occur until a child has developed greater powers of abstract reasoning, something which is not present so early in life. This subject will be addressed in greater detail when the psychiatrists views are presented later in this section.

Ms. Dobson testified that while David did receive some special consideration because of his age, in terms of the treatment of the anorexic condition, his therapy was the same as that received by other Montreux patients. (T16, P80, L5-25) Ms. Claude-Pierre did not contradict this opinion, but indicated only: I will say that he was loved, as all our

patients (are) loved. (T20, P44, L2-3) Ms. Claude-Pierre did note that unlike other patients, David did not have a formal counsellor assigned to him, but rather a more informal counselling process was used for him. (T20, P45, L20-P46, L3) Moreover, no formal reports were kept of these sessions.

Several witnesses testified that a frequent intervention in treating anorexic patients at Montreux is to separate the clients, normally adolescents or adults, from their families for a period of time. Careworker Alex Garcia confirmed that for patients from the age of 12 and up, it was sometimes considered best for them not to have any direct contact with them (family members) for a period of time. (T3, P177, L20) This treatment modality was also confirmed by Margaret Dobson.

Mr. Garcia noted, however, that, I d never thought that they would take a protocol that seemingly applied to older, more mature people and apply it to a child of three years old. (T3, P178, L1-7)

However, Ms. Dobson made it clear that the same logic was applied in David s case. She testified she saw no important difference between separating a three or four-year old child from his or her parents for a lengthy period of time and doing the same thing to a teenager or adult. She said she, Ms. Claude-Pierre and Montreux all thought the separation of David from his mother was a good treatment technique, adding she still believes that, because, in her opinion, it worked, and David is now well. (T16, P99, L11-16)

In her testimony, Ms. Claude-Pierre also spoke to the success of the technique of separating parent and patient for David: The presentation of these children doesn t allow them to eat in front of their parents sometimes because they feel guilty And this was so in little David s case. He felt much more relaxed eating initially without his mother there. (T20, P83, L7-13)

As an individual deemed to display Confirmed Negativity Condition and have anorexia nervosa, David was managed using the techniques described on page 131 of Ms. Claude-Pierre s book: We answer every negative thought with a positive one. It is essential to respond to every self-defeating outburst with unconditional gentleness and kindness. However, Montreux s repertoire beyond this approach, in the evidence before me, was rather limited. Separation is one of the few additional options available to focus on the individual and their situation.

The Patient Logs for David Bruce, found in Exhibit 10, indicate he was an outpatient at the Montreux Clinic from the beginning of November, 1995, until March 26, 1996.

In her testimony, Ms. Dobson confirmed that in a Daily Report Form documenting David s care on November 15, 1995 she wrote: David is becoming less shy each day he is happy and bright and interacts easily with staff and patients his body language shows a happier little boy. (T16, P88, L9-17) Ms. Dobson also acknowledged that on a Progress Report Form dated March, 1996, under Behaviour and Sociability, she described David as a usually happy, occasionally preoccupied child. When the condition is prevalent, he responds well to staff. On the same form, under Concerns, she wrote: We have no real concern about David s recovery because his behaviour and progress are predictable David adapting well to this program. (T16, P89, L19-P90, L15)

David, who had gained only three and a half pounds between October, 1994 and October, 1995, gained two pounds in the three and half months between November, 1995 and February, 1996, while he was an outpatient. He moved from the 5th percentile to the 10th percentile for weight. Despite being referred to as on the edge of death on the *Oprah* television show on January 17, 1996, David was gaining weight and experiencing some catch-up in his growth parameters. On the video of the *Oprah* show, David looks younger than his chronological age, but presents as a chubby-cheeked little boy on his parent s lap. When his father is asked by Oprah Winfrey, Eating was bad? Mr. Bruce replied:

Other than that, he is a very happy, energetic, well-behaved child. We never had a problem with him — only when you put him down in front of food.

According to Ms. Claude-Pierre, her initial management of David consisted of her visiting the Bruce household, often on her way home from work, and talking to David s mother about how things were going. Gradually they begin to discuss whether it would be a good idea for Ms. Bruce to be away from him, just to try it out and see if he could feel better about eating. (T19, P160, L1-2) It was, she said, a slow progression from her seeing David at his home to David spending increasingly greater amounts of time during the day at the Clinic facility. She expected that if David spent more of his waking hours at Montreux, staff would be able to distract him so he could eat more easily, and he would also learn to become more sociable. (T19, P159, L3-8)

Ms. Bruce indicated that although she understood the Montreux philosophy and the approach being taken to David s eating disorder, he still seemed to lose ground when he came home to her in the evenings. I understood her whole theory, and I understood the whole methods, she testified. But I couldn t do (it) with him, just like the doctor cannot operate on their own child, just like the doctor cannot even examine their own child. It was the same way with me. The emotions were too close, and I knew it. David knew it. (T7, P62, L17-24) Ms. Bruce agreed with the idea of David staying for greater lengths of time at the Clinic. (T7, P63, L13-14)

Despite David s weight gain and the favourable description of his progress in his Montreux chart, David moved in as an inpatient at the St. Charles site on March 26, 1996. A variety of explanations are offered for this change in approach. One explanation Ms. Claude-Pierre suggested was that Ms. Bruce was probably exhausted as well from having lived with this for several months or years. (T19, P161, L9-11) Ms. Claude-Pierre also indicated that Ms. Bruce was wanting something more to happen than was happening, (T19, P165, L20-21) and noted that David was having nightmares as well sometimes with her, and I think that she thought the man under his head or his hat or his hair was louder at night and she wasn t sure that she was able to reassure him we

would keep him as needed at that point to try to make a difference to his sleeping. (T19, P165, L23-P166, L8)

Ms. Bruce also testified that David was having bad dreams while staying with her. She testified that one of her considerations in making the move was that David was experiencing weight loss in the outpatient setting, (T7, P123, L22-P124, L2) despite the evidence that he was not, in fact, losing weight but actually experiencing catch-up gain in weight.

Ms. Dobson seemingly shared Ms. Bruce s apprehension about David s life being in the balance and taking the appropriate actions. She testified she sympathized with Ms. Bruce s conflict at having to be separated from her son, but I know that if it was my child, I would have done the same thing to save her life. (T15, P128, L8-15)

Mr. Garcia testified that Ms. Bruce felt she needed to go along with whatever interventions Montreux proposed, including the inpatient move and separation, because she believed that was the only chance for David to become healthy. He recalled that Ms. Bruce said that she had been told that her child was going to die, and Peggy had told her that she was the only one that could save her child. He recalled Ms. Bruce feeling very guilty over agreeing to the separation and the conditions imposed by the Clinic, but she felt she had to do it because this was her only hope to have her son survive, and that if she questioned too much or wanted to change the program, that it would harm the child. Mr. Garcia said Ms. Bruce also wanted to appear cooperative because she believed that would give her a better chance of being able to visit with David. My view was that she saw no other choice, and she had to accept this, because, as any mother would do in that situation, they would want to follow what (a) supposed expert told them to do. (T3, P179, L1-25)

Moreover, the motivation and commitment of Ms. Bruce to Ms. Claude-Pierre s technique is reflected in the testimony of another careworker, Adrian Maisonneuve, who testified about a conversation he had with Ms. Bruce. He said Ms. Bruce had asked him

to tell her if David was nearby because he was not allowed to see her. I said, What are you talking about? and she said, Oh, well, Peggy says it s not good for me to be seeing him right now. I can t even be seen by him, so if he comes, tell me, and I ll hide around the corner. And that s actually what she did, he said. (T3, P66, L9-16)

Ms. Claude-Pierre did not seek an opinion on the arrangements for David s stay at the St. Charles site from Dr. Medhurst who was his physician. (T8, P108, L3-16) Dr. Medhurst indicated he did not keep track of where David was living, and was not part of daily decisions about David s care. (T8, P107, L19) Dr. Medhurst also indicated in his testimony that he had visited the Clinic only once, (T8, P72, L16-23) and had never reviewed patient logs or Staff Report Form Number 4s for David. (T8, P11, L2-5) Dr. Medhurst was also unaware that Montreux was licensed as an adult facility only. (T8, P93, L21-23) Neither did the Clinic get the opinion of a psychiatrist or a psychologist before making the move. (T16, P97, L23)

Having David take up full-time residence at the St. Charles site on March 26, 1996, reduced but did not entirely eliminate contact between David and his mother. His initial stay as an inpatient was not associated with significant issues around intake. His behaviour was described in the Progress Report Form filled out by Margaret Dobson in May of 1996 and confirmed in her testimony as, David seems to be more sociable every day, interacts well with everyone he meets and is comfortable with every situation. (T16, P92, L11-15) The form ended with an observation by Ms. Dobson that while David has a way to go, we are confident he will fully recover. (T16, P92, L21-25)

Mr. Garcia concurred that David s early stay as an inpatient was relatively problem-free, noting there was not much difficulty in getting him to eat and drink, and that they had time for games and play. But after the first four to eight weeks, he said, it started becoming increasingly difficult because he was going into panic and terror at every feeding. (T3, P155, L21-P156, L2)

Ms. Dobson acknowledged in her testimony that David was separated from his mother for a month in June and July of 1996. (Exhibit 14, Tab 1 and T16, P94, L3-7) The next separation commenced on July 16, 1996 and the indication from the Montreux documents at that point was that David did not see his mother or father at all except for prearranged visits, and there are none planned in the near future. This was confirmed by Ms. Dobson in her testimony. (T16, P97, L4-12) This separation, according to the testimony of Mr. Maisonneuve, lasted until October 8, 1996, David s fourth birthday. Mr. Maisonneuve testified that after that, the next visit that David s parents had with him was at Christmas. (T3, P66, L17-23) The Patient Logs for David support this testimony. (Exhibits 10 and 11)

It is uncertain how many visits the Bruces had with David between Christmas Day, 1996 and his discharge on May 29, 1997, if any. The Patient Logs for November through May for David, while definitely generated by staff, and confirmed by Ms. Dobson as existing (T16, P141, L13-16) were not entered as evidence. Despite numerous requests, the Montreux Clinic did not produce this documentation. No evidence was produced to suggest that there were any visits between David and his parents from Christmas until discharge, as suggested by Mr. Maisonneuve s testimony. Ms. Claude-Pierre, in her testimony, acknowledged that David had been physically separated during the summer of 1996. (T20, P25, L5-7) She did not dispute the care records showing David being separated from his parents from July 6, 1996 to at least August 13, 1996. (T20, P68-69) It was never made clear by her testimony how long that separation, or any future ones, actually lasted.

During the first separation of David from his mother, in June and early July, 1996, Montreux documentation shows increasing difficulty in feeding David. Moreover, he experienced significant problems shortly after the commencement of the second separation which likely lasted until his birthday in October 1996. When presented with that documentation, Ms. Dobson admitted it appeared David s problems were worsening, but added, I don t think it had anything to do with the separation. (T16, P114, L11-16) Despite the patient log notations, Ms. Dobson would not agree that David appeared to be

a happy, bright and sociable child at the beginning, and that he got worse as the treatment, the feeding and the separation from his mother went on. (T16, P84, L8-19)

Mr. Garcia made it clear in his testimony that David s problems appeared to be worsening during the time of separation. He said David was more difficult to distract and keep calm while eating, that there were no signs of improvement in his ability to take food, and that caring for him became increasingly difficult up to the time Mr. Garcia left the Clinic s employ in August, 1996. (T3, P170, L7-P171, L25)

Despite the daily logs not being available from November, 1996 to May, 1997, an overview of David s latter course can be derived from the counselling reports and staff summaries which are available.

A reflection of the increasing difficulties that staff were having in feeding David is seen in the diminishing amounts of time available for David to play, as documented in his Montreux chart. Ms. Claude-Pierre s testimony indicated that in reports which said a meal took an hour, an hour doesn t mean for an hour of feeding. An hour means holding the child, telling them stories, putting the food away for a moment with a cover on until he is distracted. (T20, P90, L2-6) Staff reports from earlier in David s stay as an inpatient would support this version of how feeding would take place. However, towards the end of David s stay as an inpatient, it does appear that staff were requiring greater amounts of time to be focused on feeding and less on other distractions. On March 17, 1997, David s careworker commented: David was not happy because he didn t have any playtime, so he started kicking objects and screaming NO a lot. (Exhibit 11, Staff Report Form Number 4, Renee S., March 17, 1997)

Shortly after this, Meg Bruce went back to New York and remained there from April 10, to May 16, 1997. Immediately after her departure, on April 11, 1997, David s careworker recorded, Changes in food intake big changes for David today. (Exhibit 11, Staff Report Form Number 4, Julia K., April 11, 1997) The difficulties which ensued during

this separation can be seen through a summary of Staff Report Form Number 4s for the next month and included in Exhibit 11:

- April 15, 1997 — Written by Brenda Morton — David gets frustrated with his lack of playtime; he knows this is because he doesn t swallow and the snacks run together.
- April 17, 1997 — Written by Nicki — The Bad Man was giving David a very rough time today He spent 5 _ hours attempting/doing feeding — which didn t improve David s head space.
- April 17, 1997 — Written by Julia K. — On the next shift, David spent four hours (4-8 p.m.) having his intake (with one 15-minute bike ride break).
- April 18, 1997 — Written by Brenda Morton — Play-time is cut really short because of the storing issue. (David would not swallow but would hold the food in his mouth.)
- April 20, 1997 — Written by EJD — Spent the majority of the shift (6 _ hours) doing intake.
- April 21, 1997 — Written by Genevieve — Terrible Would not swallow at all. Under General Comments in letters one inch high, AACK!
- April 27, 1997 — Written by EJD — Tough time today for David with solid food. (Snack #1 and #3). No swallowing and major storing. Mood and space very good otherwise.
- April 28, 1997 — Written by EJD — A good day with David — except for not swallowing In a pretty good mood all day — even with cheeks stuffed like a chipmunk.
- May 6, 1997 — Written by Alison D. — A three-minute time-out due to kicking me, pulling my hair, and not swallowing Pudding took forever (1 _ hr.).
- May 11, 1997 — Written by EJD — Intake very hard for him, especially the swallowing part As a result spent 4 _-5 hrs. on intake and very little time for play. It is also noted that David vomited once on this day.

At the time of the last entry on May 11, 1997, David s intake consisted of yogurt, Alphagetti,™ and pudding. This is not markedly different but actually includes less

variety than his diet a year earlier. The Program Report found in Exhibit 10 and dated May, 1996, and completed by Ms. Dobson, listed his intake at that time, shortly after his admission as an inpatient, as: Two servings turkey or chicken and the vegetables, one serving sweet potato and one serving green beans, two servings yogurt, and fresh fruit, cereal, animal crackers, chocolate, 16 oz. Juice (usually mango), 24 ounces light cream.

A little more than two weeks later, on May 29, 1997, David was discharged to his mother s care.

On the basis of the weights found in Exhibit 49, David gained about six pounds during the 14 months he spent as an inpatient at the Montreux Clinic. His rate of gain as an inpatient did not improve on the gains documented during his days as an outpatient.

In her interview with Licensing, in September, 1998, Ms. Dobson said that at the time of discharge, His height and his weight and everything improved, (Exhibit 20, P149) compared to his time as an outpatient. However, the evidence suggests this is not accurate. David s height and weight were not available for the time when he returned to New York in the autumn of 1997, after a stay of almost two years in the Montreux Clinic program. No evidence was provided to show what David s current weight and height are since leaving the Clinic, and whether gains have been maintained. Although Meg Bruce insists David s eating is no longer a problem, Dr. Susan Sherkow, who assessed David in New York in the autumn of 1998, never saw David eat, and the video of David (Exhibit 41) taken the week of May 25, 1999, does not show David eating.

A critical phase in David s management was his nutrition and caloric intake. Ms. Dobson testified that she had no nutritional training. (T15, P156, L8) David s diet was usually determined by Ms. Claude-Pierre with some input from time to time by Ms. Dobson. (T15, P149, L3-5) Ms. Dobson confirmed that there was no nutritionist s referral in the management of David s case other than determining his minimum caloric and fluid intake. Furthermore, Ms. Dobson stated that Ms. Claude-Pierre was in charge of David s meal plan and nutritional requirements. (T16, P133, L14-25) She said David s progress

was tracked by having him weighed daily, with discussions around his progress apparently hinging on these daily weights. Given that David was a child suffering from failure to thrive, additional measurements should have been secured and, at a minimum, his course plotted on the appropriate pediatric growth charts.

Ms. Claude-Pierre, the person in charge of David s nutrition, was questioned about the methods she used to put a plan together. She stated she had been developing plans in her outpatient practice, had read numerous books on nutrition, and now uses a combination of common sense, experience and those texts to develop meal plans. (T19, P194, L5-12) However, Ms. Claude-Pierre could not remember how she converted the information contained in the nutritional advice on minimum caloric and fluid intake obtained by Dr. Medhurst for her into a nutritional plan for David. (T20, P120, L2-9) Neither could she explain the presence in David s meal plan of adult products, such as Boost™ puddings, Gatorade™ and light cream, although, she did note they might be used if David was enthusiastic about eating them when he was refusing most other foods. (T20, P123, L8-15) Ms. Claude-Pierre testified she remembered asking Dr. Medhurst about Pediasure™ versus Boost™ with David, and I m not sure what the answer was, but whatever it was, we proceeded with, I am sure. (T19, P164, L16) She said Dr. Medhurst had also suggested speaking to a dietitian, and again, my memory doesn t serve me well, but I know that that happened. However, she could provide no details, beyond a belief that both Dr. Medhurst and Ms. Dobson had available a pool of dietitians who could be called upon. (T19, P164-P165)

The difficulties Montreux experienced in feeding David and ensuring he obtained sufficient calories are captured in Ms. Dobson s testimony. She indicated that normally careworkers do not change meal plans for patients and agreed that careworkers had no special skills or training in caring for a preschooler. However, she confirmed that she would tell David s careworkers just to try things to see if they would work. (T16, P135, L20-P136, L20) As a consequence of adopting this approach, there were at least 46 changes in David s meals which are documented in Exhibit 9 and confirmed by Ms. Dobson in her testimony. (T16, P135, L6-11) Ms. Claude-Pierre testified that she was

aware of changes in David s meals and could fill in the blanks at any given moment. She said staff were made aware of options available in meal plans, and changes were not made randomly. (T20, P121, L14-17)

Ms. Claude-Pierre had devised a meal plan in which adult products were fed to David, and substitutions made from time to time which were equally inappropriate although seemingly not out of place in the day-to-day nutrition of David, as it was practiced at Montreux.

Finally, even just prior to David s leaving in May, 1997, he continued to receive a large component of his caloric intake by means of ingesting five cans of Pediasure™, a liquid nutritional supplement. Ms. Claude-Pierre s rationale for reliance on such a product so late in David s course at Montreux was that it was guaranteed to be something that would be medically approved because it had all the supplements necessary for growth. (T20, P125, L1-11)

Both Ms. Dobson and Ms. Claude-Pierre confirmed that David would routinely be refed after vomiting. (T16, P139, L15-22 and T20, P118, L4-14) This approach was taken without obtaining medical advice about its advisability or the risks that might be associated with it. (T16, P139, L23-P140, L14 and T20, P118, L24-P119, L4) Ms. Claude-Pierre indicated this was critical in dealing with the patient s negative mindset because failure to take in calories would strengthen their resistance to feeding. Her decision arose from her understanding of this mindset. (T20, P118-P119)

Documentation in Exhibit 11 and the testimony of several careworkers showed that not only did staff frequently verbally threaten David in an attempt to get him to eat, but that on numerous occasions staff also had to hold David s hands and head in order to complete feedings. Mr. Garcia, in his testimony, provided the careworker s perspective on how staff persisted with David to the point of force feeding: I was told that if we didn t get the food in him, that he was going to lose weight and that he would die so that it was imperative to get the food in whatever you had to do to have him eat, you did,

because it wasn t about how it appeared; it was because his life was in danger. (T3, P157, L8-21)

Careworker Janice Lim acknowledged that the documentation in Exhibit 11 was correct and that David did have to be restrained to be fed when he was resisting food, moving his head away from the spoon or bottle and shaking his hands. She confirmed that from time to time, workers would have to be called to hold David s hands down, and the workers would also hold his head still so they could get food into him. However, in defense of this approach, Ms. Lim indicated that so long as you re not hurting them it was always done with gentleness at the end of the day, he didn t come away with bruises. (T15, P34) However, Ms. Lim disputed the portrayal of David as dying and said it was not her understanding that food had to be gotten into him in anyway possible. (T15, P41, L11-12)

Ms. Claude-Pierre, in her testimony, originally indicated that David was not held down he was cradled, noting that to hold him down would have been counterproductive and that if this had occurred, it had been done without her knowledge or consent. (T20, P100-P101) When presented with examples from Exhibit 11, she testified that she interprets the entries differently, suggesting that it may be a matter of translation or the careworkers wording rather than reality. (T20, P107, L6)

Mr. Garcia indicated that in addition to physically restraining David, staff on occasion resorted to using a spoon to pry David s teeth open to get food into his mouth. Mr. Garcia testified that from time to time he himself had had to resort to this method. (T3, P158, L1-18) Of note, Mr. Garcia indicated that he had reported that he was concerned about the effect the use of a spoon was having on David s dentition and oral health. (T3, P159, L6-17)

Mr. Garcia s testimony contradicts Ms. Claude-Pierre s testimony that she would neither approve of nor condone force-feeding. He recounted a situation at which, near the end of an extremely difficult day with David, he paged Ms. Claude-Pierre and told her he would

need help if there was going to be any chance of getting the day s nutritional intake into David because David was so terrified. Mr. Garcia then took David to Ms. Claude-Pierre s office at the St. Charles site. Once they were at the office, he testified, Peggy scooped him (David) up and was talking to him, calling him her Superman, he had to be strong, and asking if the Bad Man was in his head again, and that they were there to keep him safe from the Bad Man in his head. Mr. Garcia and patient/careworker Lucy then told Ms. Claude-Pierre there was still about three-quarters of a feeding of yogurt to go. At this point Ms. Claude-Pierre suggested they go into the kitchenette off of the office where there was a chair. She told us to sit him down there, for me to hold his head steady and keep his arms from interfering, and for Lucy to spoon the yogurt into him. They followed these instructions according to Mr. Garcia s testimony. When Ms. Claude-Pierre had to leave a short while later, she told them to go up to the suite where David and Lucy lived and finish feeding David there. (T3, P153, L21-P154, L24) Mr. Garcia then described how he kept David s head straight and held down his arms, on Ms. Claude-Pierre s instructions, while Lucy fed him.

Dr. Medhurst testified that he was not involved in the psychological or behavioural aspects of David s care, only the medical monitoring. (T8, P42, L17) Dr. Medhurst did not do developmental testing such as a Bailey Developmental Assessment or monitor even the most basic of developmental milestones for children. (T8, P127, L8) Dr. Medhurst relinquished his responsibility in this area to Montreux.

Moreover, as indicated in Noah Dobson s deposition in September of 1998, none of the caregivers received any training on how to deal with preschool children. (Exhibit 19, P161) Margaret Dobson acknowledged that she had no early childhood education training, apart from developing my own children (T15, P156, L7) Ms. Claude-Pierre, when asked about milestones in her deposition also given in September of 1998, initially described the pathologic behaviours being displayed by David, ranging from what she saw as his overwhelming sense of responsibility to his not being able to accept or receive things offered to him because he did not deserve them. When the question was rephrased to ask specifically what a child at different ages would be expected to achieve, she

replied: I am not sure there were milestones as such it just evolved over time. We could see the change in his happiness. She also noted that David had never displayed the signs of the terrible twos, and said she had books on child development that she would refer to and also make available to staff members. However, careworker Janice Lim noted in a log trying to explain David s deteriorating behaviour on October, 20, 1996 that: He hit his terrible 2 s at 3 _ and started to push all boundaries. (Exhibit 11) Ms. Claude-Pierre did not share this view, and she believed David was acting like an adult. (Exhibit 17, P70-71) In her assessment, Ms. Claude-Pierre indicated that when he went home as a five-year old, he was reading, and she saw him as a very advanced five-year old. (Exhibit 17, P72) In fact, Ms. Bruce testified that David was reading before the age of two and would spend vast amounts of time reading the New York Yellow Pages."

David s developmental milestones were at best assessed in the most cursory fashion. Montreux failed to mention that David was still in diapers at the time of his fourth birthday, a time at which most children have gained mastery over their bodily functions. Despite their paucity of skills in child development, Montreux staff testified that they did not seek assistance from qualified individuals such as pediatricians, psychologists or educators to assist in tracking David s progress in evaluating the success of the program on these standardized pediatric benchmarks.

In her testimony, Margaret Dobson confirmed she had no training in behaviour management. (T15, P156, L10-11) Neither did Ms. Claude-Pierre. Despite this lack of expertise, Ms. Dobson describes David s relationship with Lucy, one of his primary caregivers as beneficial to both of them. (T15, P123, L20-21) Ms. Claude-Pierre says Lucy was very good for him. (T20, P66, L2-10) The evidence of how their relationship affected Lucy, who was an acute-care inpatient for most of the time she was working with David, will be documented later in this decision.

Moreover, it is of note that some careworkers documented concerns about this relationship, including one expressed by Lucy herself. On November 28, 1995, while

David was still an outpatient, Lucy s careworker reported: Very excited about visits with David, although she is concerned that he may pick up on her fears during meal times (specifically she is worried he will pick up on the meal time routine of needing reassurance before each bite of food/sip of juice or shake). (Exhibit 81, Associate Care Worker Report Form Number 4, Toni Ellis)

While this ritual was apparently not passed on to David, another careworker did document concerns about developments in David s behaviour which had similarities to Lucy s. On July 31, 1996, Ms. Lim recorded: Concerns: Yesterday David kept hitting the wall, hard enough to hurt his hand. Today he punched his leg hard several times. Both incidents occurred during meals, and I could see he KNEW he had inflicted pain on himself. Is Lucy s behaviour affecting David? (Exhibit 10, Staff Report Form Number 4, and T20, P64, L13-25) (Lucy was known to have a history of self-harm.) Two days later, Ms. Lim wrote: This is the first day that I noticed the hitting of himself and him talking about the Bad Man hitting him, and then hitting his head with his arm/hand. He s got a mark on his head that Marg (Dobson) noticed (under his hair) and I saw a bruise? on his nose tip. (Exhibit 11, Staff Report Form Number 4) Six days later, Lucy wrote in a Weekly Progress Report: Banging his head with his hands, the walls or the floor, and he is being very whiney (sic) and teary. (Exhibit 11, Weekly Progress Report, August 8, 1996)

In her testimony, Ms. Claude-Pierre did not concur with the caregivers concerns, saying that the writings were Ms. Lim s perception of the situation, but not hers. (T20, P66, L2-10)

David subsequently seemingly channeled his aggression to the surrounding environment and careworkers. On August 12, 1996, Ms. Lim described David as very playful but almost too aggressive, probably venting his frustrations with being told to take proper everything! (Exhibit 11) Six weeks later, another careworker, Juliette, observed that At Cadboro Bay Park he was pretty aggressive with the other little kids. (Exhibit 11, September 28, 1996)

David also acquired the habit of biting his nails at Montreux, and this is documented in numerous careworker reports. (Exhibit 11, October 24, 1996; December 4, 1996; December 17, 1996; and January 4, 1997)

I leave the expert opinion on David s unresolved aggression to Dr. Sherkow, the child psychiatrist called by Montreux Clinic. However, on the recent video of David at home, (Exhibit 41) David is shown relating in a fairly rough fashion towards his father and his dog, Ranger. Moreover, the family cat jumped off the bed at the mere sight of David and it immediately fled the area.

During his inpatient stay at the St. Charles site, David, when experiencing a troubled sleep, called out for Worker, Worker rather than his mother. As well, evidence was presented that David, during the separations from his mother, was developing an increasing attachment to his careworkers to which Ms. Claude-Pierre responded, One would only hope so. (T20, P47, L6) Ms. Claude-Pierre acknowledged that she was aware that David was calling some of his workers Mother. (T20, P75, L5-11) The careworkers indicated that they did advise David that they were not his mother, but rather his careworker and friend. (Exhibit 11, Janice Lim, August 20, 1996) Ms. Claude-Pierre did not consult with Dr. Medhurst or ask for a referral to a pediatric specialist or a psychiatrist but did talk to David about this issue herself. On the basis of this discussion with David, Ms. Claude-Pierre testified she did not share Ms. Lim s concerns about David being confused about who his mother was. (T20, P77-78)

Ms. Claude-Pierre went on to describe how patients establish trust in their careworkers and consequently feel safe with them, allowing them to eat no matter what the negative thoughts in their head. She stated that, The attachment is an interim healthy thing, describing that David now is a very happy boy without any attachments. (T20, P79) When it was pointed out to her that in David s case, the interim period covered months and the careworkers were concerned about the problems of having to wean David away from them, she said this was only the caregivers impressions and that any person is weaned off any therapist as they grow and have confidence. (T20, P79, L13-21)

The disruption of David s bond to his family is possibly reflected in his calling workers mom and crying out for worker rather than his mother. Of concern is Peggy Claude-Pierre s concept of what constitutes interim . As will be covered later, both Dr. Ainsworth and Sherkow speak to the benefit of a temporary respite. While the psychiatrists did not agree on whether a therapeutic separation should be a few days in length or a few weeks, neither supported one that ran months at a time over a 14-month period. In fact, the benefits of such a separation were reflected in the early progress observed in David s weight gain. However, as the separation became more prolonged and David s contact with his parents restricted to his birthday and Christmas, his problems around feeding got worse, based on the evidence. It is clear he was still having serious feeding problems just two weeks before he was discharged back to the care of his mother.

In her 1998 interview with Licensing, Peggy Claude-Pierre stated that by the time David returned to New York, he was a happy little boy interacting beautifully in kindergarten his social skills were very good. They were easily up to the norm Had he been my child, I wouldn t have been worried about him anymore at the time he left. (Exhibit 17, P72-73)

Margaret Dobson expressed a similar view, noting his reading abilities, but also that he became more sociable he became very outgoing and was anxious to accept what we would give him. (Exhibit 20, P149-150) Ms. Dobson said she still talks to David on the phone from New York and writes to him, and in her opinion, he is well now. (T16, P99, L15-25) Julia Kruz, one of David s careworkers testified David was now a happy, healthy, getting-on-with-life little boy. (T9, P135, L12-15)

However, another careworker, Heather Hestler, testified she observed no change in David, and that he was basically in the same condition at the end of his stay at the Clinic as he was when he first arrived at Montreux. (T2, P39, L9-15)

Psychiatric Opinion

The complexities of David s case were such that both Licensing and Montreux called expert witnesses to testify about his diagnosis, treatment and outcome. Montreux called Dr. Susan Sherkow, a child psychoanalyst from New York City, where the Bruce family resides. She testified via a long-distance teleconference connection from New York. Licensing called a rebuttal witness, Dr. Geoffrey Ainsworth, a child psychiatrist from Vancouver.

Dr. Sherkow, in providing her expert opinion evidence, had the benefit of three sessions with David, by himself, between September 18 and October 21, 1998.

Meg Bruce provided a history of David s difficulties to Dr. Sherkow. However, Ms. Bruce was not in a position to describe fully the outpatient care David received between the beginning of November 1995 and March 25, 1996. She was even less able to describe the circumstances of David s inpatient treatment by Montreux Clinic from March 26, 1996 to May, 1997 aside from a few visits and observations from a distance from time to time. The evidence also shows that Ms. Bruce did not access David s records and was unaware of what was being documented about her son. Dr. Sherkow was left with the impression by Ms. Bruce that David was severely malnourished when he was admitted to the Montreux program. (T21, P75, L21 and P76, L1) Dr. Sherkow did not have the benefit of the evidence in Exhibit 69 which showed that David was not malnourished but was a child of small stature whose weight was appropriate for height.

Moreover, the Montreux Clinic did not advise Dr. Sherkow that the staff at the Clinic lacked qualifications and experience in both child care and child development. (T21, P52, L23 and P53, L5) Although Dr. Sherkow was retained to assess David on behalf of the Montreux Clinic, the Clinic did not provide Dr. Sherkow with David s inpatient medical files and caregiver logs. Dr. Sherkow was also unaware that David s careworker, Lucy, during the first nine months of his inpatient stay, was also on one-on-one 24-hour care herself. Dr. Sherkow would not recommend this arrangement nor would she recommend David sharing a bed with a careworker who had recently divulged that she had been

sexually abused as a child and who regularly engaged in self-mutilating behaviours. Montreux documents showed Lucy had allowed David, on occasion, to sleep in her bed, although Lucy was still struggling to cope with these problems of her own. (T21, P56, L2 — P58, L21)

Drs. Ainsworth and Sherkow agreed that the care arrangements that had Lucy allowing David into her bed were a concern. (T21, P56, L13 and P58, L14-25 and T22, P15, L16)

Dr. Sherkow was not appraised of the difficulties experienced by Montreux staff from time to time in feeding David, their needing to feed David for long periods of time, sometimes late into the night, and their having to physically restrain him to get nourishment into him. (T21, P58, L25 and P62, L11) Dr. Sherkow was not aware that David had nightmares at Montreux, that they contributed to David moving to inpatient care at the Clinic, and that they persist even now. (T21, P76, L2-11) In the home video of the Bruce family, (Exhibit 41) David tells his father that he is helped in coping with the bad dreams by having his dog sleep at the foot of his bed, and he also has a magic wand for the nightmares. Dr. Sherkow was unaware that Dr. Medhurst, David s physician, had not been told of the separation and she believed he should have been informed. (T21, P64, L5) Dr. Sherkow also thought it odd that Dr. Medhurst had no involvement with the behavioural, social or psychological component of David s care and that he only took care of David s physical requirements. (T21, P77, L5-11)

When Dr. Sherkow was queried about her experience with working with general practitioners in their being alert to unusual problems like David s, and making the appropriate referrals she replied, Well, we hope they do. They don t always but - - because they can be pretty dense about failure to thrive syndrome, but it would be a good idea. (T21, P85, L13-15)

In her testimony, Ms. Claude-Pierre testified that Dr. Sherkow may not have received full information from Montreux, indicating, There is more information to give, perhaps, if I

were to sit down and speak with Dr. Sherkow on his behalf (T20, P84, L24 — P85, L7) and I just thought I had added information to give her. (T20, P87, L2-3)

Dr. Ainsworth, who was retained by Licensing, had access to information about David prior to David s coming to Montreux. (Exhibits 42 and 45) He had Meg Bruce s testimony, (T7) the video of David at home on May 25, 1999 (Exhibit 41) and medical information with respect to David. (T22, P4, L3-4) Dr. Ainsworth did not, however, have the opportunity to personally examine David or to interview his family.

The two expert witnesses had different information upon which to draw and base their professional opinion. Nevertheless, both psychiatrists did draw a number of similar conclusions. Dr. Sherkow indicated David was too young to be preoccupied with how much he would weigh in relation to his mental image. He would have to be able to have some idea about being thin. (T21, P29) David had anorexia which means he was starving himself. Anorexia nervosa usually is used as a diagnosis when you have evidence that a child or an adult or a teenager is preoccupied with how much they weigh in relation to their mental image. In other words, they want to slim themselves down That s not something you would see in a one-year-old or two-year-old in my experience with very ill children an abstract idea in their mind about thin That doesn t usually come into play until they re four or five, and even then it is often an imitation of their mother who is preoccupied with being slim. (T21, P29, L13 and P30, L3)

Dr. Ainsworth also challenged the idea of a three-year-old having a disturbance of body image, noting it s very hard to imagine a child that age having any kind of idea or perception of their body image separate from themselves. (T22, P4, L20-23)

Both pediatric psychiatrists agreed that David Bruce did not suffer from anorexia nervosa. (T21, P44, L15 and T22, P5, L9)

Drs. Sherkow and Ainsworth on more than one occasion in their testimony indicated David s problems should have been assessed by someone possessing qualifications like

theirs. (T21, P45, L9; T21, P51, L11; T22, P7, L19 and T22, P30, L22) Both psychiatrists concurred that the approach to helping David with his problems should have engaged the entire family. (T21, P79, L8; T22, P12, L7-8) Dr. Ainsworth indicated he would have to perform a family assessment to establish more definitely what he suspected was David s problem and to arrive at a diagnosis. (T22, P18, L9-12) The two experts in psychiatry discussed the regularity with which children with severe eating disorders are hospitalized at facilities with the equipment and expert staff to meet such a pediatric challenge. Examples of such centres included Tufts Medical School and the B.C. Children s Hospital. The unique attributes of children s wards were cited by both pediatric psychiatrists. The expert opinion of both doctors was that had David been starving, this is the type of setting he should have attended. There, he could have been stabilized in a week to ten days before going on to other therapy. (T21, P81, L3 and T22, P43, L1-8) Both Drs. Ainsworth and Sherkow reference the use of a naso-gastric tube and an intravenous as adjunct therapies in severe cases, procedures which can only be ordered by doctors in appropriate health care settings. (T22, P43, L20 and T21, P23, L9-23)

Both experts were of the opinion that David s issues could have been dealt with in New York. (T21, P51, L12 and T22, P22, L22) These opinions contradict Ms. Bruce s contention to Dr. Medhurst that the family had exhausted the options in New York. (T8, P37, L20) Furthermore, Dr. Ainsworth suggested that the Bruces may have been doctor shopping in New York. (T22, P20, L7) That may explain Ms. Bruce s testimony that I would make that initial visit and then, you know, I was out the door. (T7, P118, L25 — P119, L2)

While not reaching agreement on what constituted the reason for David s failure to thrive, both psychiatrists drew attention to the obsessive/compulsive component of David s problems, a phenomenon that Dr. Sherkow had been told about having its onset in David s infancy. (T21, P17, L25 — P18, L2) Dr. Sherkow describes how David in her time with him made sets of rules with all kinds of prohibitions that were a combination of obsessive/compulsive symptomatology and aggressive anxiety. He put up lists around the room: no hitting , no crying , no eating , no slapping , no making giant

messes , reflecting his anxiety about doing things that would be bad. (T21, P27, L16-23) However, Dr. Sherkow did comment there didn t seem to be as severe obsessive symptoms as there were early on, so that part seems to be resolved somewhat. (T21, L28, L20-22) Dr. Ainsworth, in describing the unusual behaviours David Bruce manifested at a very young age, stated this suggests certainly, some compulsive and almost certainly associated with some obsessive thinking. (T22, P5, L16-18) In later testimony, he stated: We certainly know that obsessive/compulsive behaviours can start in very young children...it often does start very young. These symptoms can be very distressing and extreme, and of course, can involve food or other things just because that happens to be their obsession. (T22, P5, L19 — P6, L2) Dr. Ainsworth did indicate the obsessive-compulsive disorder is a difficult diagnosis to make without seeing someone, particularly well after the symptoms were displayed. However he did indicate that as a possibility. (T22, P6, L3-6)

Like Dr. Sherkow, Dr. Ainsworth was unaware of the care arrangements which minimized Dr. Medhurst s involvement in the day-to-day decision-making. Dr. Ainsworth found this of concern, noting that if he wasn t being presented with the proper facts, there is no way he could provide proper medical care. (T22, P16, L10-15)

Drs. Sherkow and Ainsworth offered expert opinion evidence that a separation of David and his mother could be part of the therapy for David s eating disorder. (T21, P21, L24; P22, L25 and T22, P12, L17, L25) There was a difference of professional opinion on how long this separation should be. Dr. Ainsworth advocated that it should be as short as possible - up to a few days, (T22, P14, L9-19) while Dr. Sherkow suggested as long as three to six months. However, both psychiatrists concurred that such a decision could only be made by trained professionals such as pediatricians or psychiatrists. (T21, P49, L7-13; P50, L2-3 and P51, L11) Dr. Sherkow testified Ms. Bruce viewed the staff and management at Montreux as being trained professionals. (T21, P50, L24-25)

The two pediatric psychiatrists did not agree on the cause for David Bruce to fail to thrive, and the etiology of his unusual behaviours, with Dr. Sherkow believing David had

Asperger s Syndrome, (T21, P14, L14-22) and Dr. Ainsworth suggesting David had an obsessive-compulsive disorder and/or attachment disorder. (T22, P6, L24) In order to resolve this difference in diagnosis, an extensive evaluation, as recommended by both psychiatrists, would have to be performed and include the entire family in New York.

Regardless of the diagnosis, David Bruce also needs to have an on-going relationship with an expert in child psychiatry. According to Dr. Ainsworth, if David has Asperger's Syndrome, he will need to be followed for a ten-year period because of social interaction issues. (T22, P35, L5-16) If David has an attachment disorder, and it is not properly treated, there can be pronounced effects when that child goes through later separations as a teenager and profound effects when they go through changes in adult life. Even if they escape all that, it can sometimes have profound effects when the child is then grown up, getting married and having their own children and difficult forming attachments to their own children. (T22, P18, L25 and P19, L8) Dr. Ainsworth indicated that it is impossible to say after three years that this child has overcome all of those problems. (T22, P19, L8-9)

Of note, David, when selecting a story to read on his video to the Victoria audience, (Exhibit 41) chose to read a book entitled *Are You My Mother?* (by Philip D. Eastman ©1968), the story of a baby bird trying to find out who and where his real mother was.

Dr. Sherkow, who had the benefit of seeing David, described him as being of short stature and small for his age. She testified it was clear in his play and his drawings that he was concerned about his short stature; that he wouldn t measure up to the bigger boys, to his father, to be able to do sports. (T21, P20, L4-9) Dr. Sherkow s description of David was not accompanied by actual growth parameters so it is difficult to judge objectively how well he is maintaining any gains realized at Montreux. Ms. Bruce alluded to her son s growth issues in her testimony indicating that David still had all his primary dentition at the age of 6 _ and in her opinion his growth is stunted. (T7, P127, L4-7)

Of note, Dr. Sherkow did not see David eat either by himself or with his family; she relied upon what David and his parents told her. (T21, P67, L21 and P68, L2) Dr. Sherkow was also not aware that David regularly spoke of wanting hamburgers and french fries at McDonald s™ during his inpatient stay at Montreux, (T21, P68, L3-18) although Mr. Garcia testified David would never eat them if they were actually presented to him. In the family video, David is not shown eating and the taping is discontinued when the family is about to go for dinner. (Exhibit 41)

Nevertheless, when asked to comment on the success of the intervention provided to David by Montreux, Dr. Sherkow states whether that (the oral hypersensitivity) got dealt with therapeutically or went away on its own or is just taking a different shape is something I can t speak to. (T21, P28, L13-15)

Dr. Ainsworth s comments on the impact of Montreux on David Bruce were more definitive. He said: I think the thing that is terribly worrying here is that you would expect a three year-old to improve with inpatient treatment, but you would expect him, in all the evidence I have ever had with children like that, if you get the cooperation of the family and have them in an adequate facility, they re going to improve in perhaps three weeks to a month. I think what Montreux did was not improve the child, but in fact, prolong the treatment for so incredibly long that it just boggles the mind to be honest. (T22, P49, L9-19)

Dr. Ainsworth indicated one did not need the help of a child psychiatrist, just common sense, to know that Montreux s separating a mother from her child for an extended period, sometimes for months on end was not acceptable, and is just is the opposite to everything we (psychiatrists) have been working towards for the last fifty years. (T22, P33, L8-14)

Both Drs. Sherkow and Ainsworth felt David should have had a psychiatric assessment, something that Montreux did not do. Peggy Claude-Pierre gave evidence of calling a Dr. Vogt but never followed up when she could not reach Dr. Vogt by phone, but Ms.

Claude-Pierre also testified there was no moment of alarm necessitating such action. (T21, P31, L11 — P32, L23)

Dr. Medhurst also recognized in his testimony the need for David to undergo continuing psychological monitoring and therapy. (T8, P134, L10-13)

Summary Findings

Despite the testimony of Meg Bruce, Peggy Claude-Pierre and Margaret Dobson of what they saw as David s success in the Montreux program, it is impossible to conclude other than that Ms. Claude-Pierre and Montreux embarked on an overwhelmingly risky venture with this preschool aged child.

Evidence from numerous Montreux witnesses and documents confirmed that the Clinic spent close to two years treating David for anorexia nervosa. While Ms. Claude-Pierre believes anorexia nervosa can be present at birth or shortly thereafter, both child psychiatrists testified this was a condition from which David never suffered in the first place. Moreover, they stated David s young age at the time he came to Montreux made him incapable of engaging in the abstract thinking required for developing such a disorder.

Ms. Claude-Pierre began work with the family through providing telephone support from 3,000 miles away, a process described as dangerous , especially as no thorough evaluation of the child and family had apparently ever been completed. Moreover, had David been as ill as senior management at the Clinic claimed him to be, both psychiatrists indicated he should have then received inpatient treatment and assessment in a pediatric facility, and this was available in New York.

The Clinic s lack of expertise around, and experience with, young children showed more pronouncedly after David came to Victoria and was then admitted as a residential patient to Montreux s unlicenced St. Charles site. For part of his inpatient stay he was in the care of a Montreux patient who was herself on full care and who had serious problems of her

own. Both expert witnesses disagreed with this arrangement. Moreover, Montreux staff never developed a proper nutritional plan for a child of his age, and throughout used adult products and arbitrary substitutions in an effort to provide him with adequate nutrition. Convinced he was dying , although no objective evidence backed up this contention, Clinic staff resorted to aggressive feeding methods, which sometimes involved verbal threats and/or physically overpowering him to hold his hands and head still and even forcing his mouth open with a spoon.

With no trained staff in early childhood education, they provided no suitable daily program for a child of his age, instead treating him much like any of their older adolescent or adult patients. The normal developmental milestones of childhood were not monitored or recorded. Montreux did not involve the entire family in a treatment plan, something which both child psychiatrists said was essential. The psychiatrists agreed some separation of David from his mother could have been a valuable part of treatment. However, Montreux, without the benefit of any professional advice and monitoring, deliberately separated David from his mother for weeks and months on end — separations which the Clinic records show were associated with marked deterioration in his eating and other behaviours. Separation such as this, in the opinion of the two child psychiatrists, should be done only under the direction of a qualified professional and in David s case, it was not.

Although Margaret Dobson and Peggy Claude-Pierre testified about what they perceived as David s steady progress while an inpatient, Montreux s own records and Staff Report Form Number 4s show overwhelming evidence to the contrary. Rather, those documents paint a distressing picture of a young boy whose difficulties around feeding and swallowing remained extreme in April and May of 1997, after more than 13 months of residential care and only two weeks before he was returned to the care of his mother.

Moreover, it is still unclear what the long-term results of his Montreux stay will be on David s future physical and psychological development. Both child psychiatrists warn of potential problems as David reaches adolescence and/or adulthood caused either by the

underlying conditions that sparked his feeding problems in the first place, or by the lengthy treatment process itself, particularly his separation from his mother and family.

It is impossible to come to any conclusion other than that Montreux, not only did keep this preschool age child as an inpatient in breach of the Regulations and their Licence, but also put the health and safety of David at serious risk through their treatment of him as a residential patient.

Lucy and David

Inescapably tied to the case of David Bruce is that of Lucy, who was admitted as a residential patient to Montreux on April 1, 1995 and whose records are found in Exhibit 81. When looking at Lucy s case, the key section of the *Act* involved is again that which requires all Licensees to act in such a manner as to promote the health and safety of persons in their care.

Lucy had been a patient at the Clinic on 24-hour care for approximately 18 months when David came to Montreux as an outpatient. Testimony was given by Nora Desjardins describing how individuals can make the transition from patient to careworker. In the case of Lucy, the records, filed by Montreux during the hearing, show that she was not moved from full care to partial care until October 27, 1996. (Staff Report Form Number 4, Jane McCluskey, October 27, 1996) While the exact amount of time Lucy spent with David as his caregiver is not documented initially, a note on June 21, 1996 by Terry Almeida, Lucy s counsellor, recorded in the patient log maintained by Montreux, indicates that Lucy is taking care of David B. evenings plus two days a week. There were times when these hours were exceeded and Lucy made reference to the fact that she had worked 14-hour days with David back-to-back for three days. (Staff Report Form Number 4, Mary Lynn S., July 20, 1996) In a note by Terry Almeida on November 22, 1996, Lucy was noted still to be with David evenings . It appears that a reduction in her responsibility for David was initiated by Peggy Claude-Pierre on or about October 19, 1996 (see note by team leader Marilyn on October 25, 1996 in the Weekly Progress Report). On November 23, 1996, Ms. Claude-Pierre reduced Lucy s responsibilities for

David to four nights a week. (Staff Report Form Number 4, Kate Devlin, November 23, 1996) On December 3, 1996 a reference was made by Terry Almeida to the fact that Lucy was relieved about not being responsible for David anymore . (Exhibit 11)

According to Ms. Claude-Pierre s testimony she (Lucy) was dealing with little David because she wanted to and she expressed a wish to. (T20, P66, L17-19) Ms. Claude-Pierre repeatedly referred to their relationship as positive and therapeutic for both Lucy and David, and that she watched it very cautiously. (T19, P162, L6-9; T20, P47, L11-12)

Lucy cared very deeply about David and was committed to his well being. Lucy remained concerned about the care David received even after relinquishing the careworker responsibility and spoke of looking forward to engaging him in fun times outside the domain of their previous caregiver-patient relationship. (Counselling Report Form Number 2, D. Yost, December 5, 1996 and Terry Almeida, January 24, 1997) Initially, David was likely the joy of her life at that point. (T20, P62, L9) In her early encounters with David, when he was still an outpatient, staff observed a beautiful side of Lucy emerges when little David comes around and joyous rapture. (Staff Report Form Number 4, Debbie Buvyer, November 23, 1995)

Nevertheless, Lucy was still an acutely ill individual with anorexia nervosa for most of the time she participated in David Bruce s care. As described by expert witness psychiatrist Dr. Paul Termansen, individuals with eating disorders like Lucy can display behaviours that are probably part of an obsessive, compulsive, defensive structure. (T5, P106, L4-5) Moreover, the likelihood of patients with eating disorders engaging in activities such as self-harm has to do with the level of psychopathology at the time, the ego strengths of the individual, their ability to control their impulses to restrain them, the coexistence of other difficulties at the same time. (T5, P105, L16-20)

David was not the only complexity that Lucy encountered in 1996. Stresses that she experienced included news that her parents were stopping payment for her care at Montreux (according to a careworker, Lucy was upset that her parents would rather

spend their money on something else rather than on her. (Staff Report Form Number 4, Sarah Burns, May 22, 1996) Lucy disclosed in June and again in July, 1996 that she had experienced sexual abuse by her mother and grandmother. A counsellor commented that Lucy perceived it was perfectly normal as her mother and grandmother presented it. (Counselling Report Form Number 2, Terry Almeida, June 21, 1996 and July 26, 1996) In addition, Lucy was challenged by progressing to solid food as part of the course of treatment of her eating disorder, a significant and stressful hurdle. In August, 1996, Lucy also commenced the Educational Program from 1 p.m. to 5 p.m. daily with one of her workers observing she does not have enough time for everything. (Staff Report Form Number 4, Bev Donald, August 25, 1996)

Lucy s coping mechanisms included obsessive compulsive behaviours and rituals. She required a routine of repeated reassurances before each bite of food or sip of juice or shake at meal time. (Staff Report Form Number 4, Toni Ellis, November 28, 1995) Lucy also did a lot of dishwashing/handwashing including other people s dishes; as one counsellor described, she did the counsilor s (sic) dishes the minute we arrived. (Staff Report Form Number 5, Johanna H., May 16, 1996) For a period, Lucy also was preoccupied with her water intake and engaged in excessive water consumption, possibly bordering on psychogenic polydipsia. On one occasion she consumed 40 ounces of water and 16 ounces of grape juice in eight hours. (Staff Report Form Number 4, Juliette K., July 2, 1996) Similar aberrant consumption patterns were observed in the July and August of 1996 care records of Lucy. This pattern of drinking large amounts of water was stopped by Ms. Claude-Pierre on September 1, 1996. (Weekly Progress Report, Marilyn McKee, September 1, 1996) Lucy was then restricted to a maximum of 40 ounces of water per day. Of note, the dizzy spells, manifested by Lucy in the preceding months, seemingly resolved. Lucy may have had a self-induced fluid imbalance resulting in dizziness and other symptoms, which had been dismissed by workers as a show and not valid. (Staff Report Form Number 4, Bev Donald, August 25, 1996 and Weekly Progress Report, Marilyn McKee, September 1, 1996) Lucy began eating unpopped popcorn in October and November of 1996 (examples included October 18, October 27, November 23, and November 26, 1996), (Staff Report Form Number 4, Kate Devlin,

October 18, 1996; Staff Report Form Number 4, Jane, October 27, 1996; Staff Report Form Number 4, Kate, November 23, 1996; Staff Report Form Number 4, Jane, November 26, 1996)

Lucy also self-mutilated as a coping mechanism to protect herself against her inner emotional state (as described by Dr. Termansen, T5, P105, L13-14). She scratched, cut or lacerated herself with a variety of objects including scissors, a razor and a nail. These events occurred on March 15, May 10, June 20 and July 25, 1996. (Staff Report Form Number 4, Eddie Spak, March 15, 1996; Counselling Report Form Number 2, Terry Almeida, — May 10, 1996; Counselling Report Form Number 2, D. Yost , June 20, 1996; Counselling Report Form Number 2, Terry Almeida, July 26, 1996)

Lucy also had eczema which seemingly was aggravated by her excessive handwashing and doing of other people s dishes. However on two occasions, staff also indicated that stress contributed to the condition. (Staff Report Form Number 4, Johanna H, May 16, 1996; and Weekly Progress Report, Marilyn, October 19, 1996)

The change in David s conduct and his care requirements during his stay had a direct bearing on the course of events for Lucy. Margaret Dobson confirmed in her testimony that in the time David was an outpatient and during his first days as an inpatient, she described him as: becoming less shy each day happy and bright and interacts with staff and patients. (T16, P88, L9-23) However, in his testimony, careworker Alex Garcia indicated that David became more difficult as his stay at the St. Charles site lengthened in that he was getting more and more difficult to distract and keep calm. In my experience, it was going from bad to worse. (T3, P170, L9-14)

Early in David s stay at the St. Charles site, Lucy s concern about David s well being resulted in her taking David into her bed to make him feel safe . (Staff Report Form Number 4, Casey, April 14, 1996) Both Margaret Dobson and Peggy Claude-Pierre were aware of this arrangement and approved, (T16, P100, L9-19; T20, P125, L16-17) and Ms. Claude-Pierre referred to it as a positive thing. (T20, P125, L12-20) A careworker,

however, directly observing the scene, expressed the opinion: I am concerned about her getting any sleep tonite (sic) as they both move a lot. (Staff Report Form Number 4, Casey, April 14, 1996)

Lucy spent more time with David than other careworkers did and was consistently there for him. By mid-May, 1996 careworkers started expressing concern about Lucy s stress level and the toll on Lucy s well-being that taking care of David was having. There were signs in the Staff Reports that Lucy might be experiencing both sleep deprivation and stress. (Staff Report Form Number 4, Johanna H., May 16, 1996 and Staff Report Form Number 4, Sarah Ion, May 25, 1996)

Early in the course of David s first separation from his mother in June, 1996, a careworker commented on Lucy having a hard time feeding him at night the last couple of days. (Staff Report Form Number 4, Sarah Burns, June 23, 1996) These late feedings were difficult for both Lucy and David.

A careworker described Lucy s sleep on the night of July 2, 1996 as a very tormented sleep and while partially awake Lucy reportedly was saying NO, NO, NO HONEY. (Staff Report Form Number 4, Juliette K., July 2, 1996) Lucy was described the next day as tired and frustrated (with David). (Staff Report Form Number 4, Sara A., July 3, 1996) Just over a week later, on July 11, 1996, a careworker again observed, I think she s quite tired from her ordeal with him last night. (Staff Report Form Number 4, Heather J., July 11, 1996)

A week into the second separation of David from his mother, which may not have ended until his birthday on October 8, 1996, Lucy described July 17 as the worst day she ever had with David . She went on to say, I was 1 _ hours late — STARTING TO STRESS!!! . Lucy s careworker described her as being very tired, frustrated with David. (Staff Report Form Number 4, Sara A., July 17, 1996) On July 20, 1996 Lucy commented on the 14-hour days with him can be a bit much, esp. back to back for three days. (Staff Report Form Number 4, Mary-Lynn, July 20, 1996) However despite her

being tired from her shift, Lucy described David being in a far better mood today than last time I was with him (couldn t be worse).

Caring for David Bruce seemingly became more complex, as he was described on August 8, 1996 by a careworker as not eating or drinking and would not stop crying . However, the careworker noted that Lucy worked miracles with David Bruce but had little time for herself. (Staff Report Form Number 4, Bev Donald, August 8, 1996) On August 19, 1996 Lucy was described by a careworker as being very stressed out over David and the Educational Program because she had to balance caring for David with additional challenges of homework and other responsibilities. In the caregiver summary for the day, under the section entitled ACTIVITIES the only activity listed was feeding David. (Staff Report Form Number 4, Alex G., August 19, 1996) The next day Terry Almeida under the same category of ACTIVITIES listed the Educational Program from 1 to 5 p.m., and her other comment on Lucy s routine was: is with David Bruce most of the other times. (Counselling Report Number 2, Terry Almeida, August 20, 1996) The difficulties of providing care for David were also alluded to by this same counsellor in a note that said, David B. has been having a very hard time with his meals the past few weeks; Lucy feels like she is at the end of her rope and doesn t know what else to do .

An additional complication to providing care was described by Lucy on August 29 when the careworker indicated she (Lucy) said she couldn t handle him screaming one more night before we picked him up . She admitted to being very tired. The careworker also commented about David being a sense of frustration for her (Lucy). (Staff Report Form Number 4, Juliette K., August 24, 1996) The next day a careworker described the situation as: Lucy is exhausted and I told her how important proper sleep is. (Staff Report Form Number 4, Bev Donald, August 25, 1996)

Lucy described her experience with David in late August, 1996 as follows: Oh joy! What a day so far and only 1 p.m.! I ve really had enough of the tears and screwing around, especially as I can t yell at him as I have a cold! I put him to bed and what a state he was in! plus I told him if he threw up he wouldn t live here so he didn t

Anyway, the evening, I guess got a bit better — couldn t have been worse than this morning.

Lucy also provided instructions to other workers: If David is upset and crying tell him firmly to stop — this often makes throwing up easier and warn him very firmly NOT to throw up. David s ability to projectile vomit, which was mentioned in testimony of other witnesses, was yet another burden for Lucy and other careworkers looking after David.

On September 1, 1996, Lucy recorded: I was really, really strict with S.P. (a snack) and he screamed, cried and spit out the shake everywhere for the first couple of times. Later she wrote: I wanted to make sure he went to bed knowing he was loved still, because everyone had yelled at him who possibly could have done (and probably more!). (Exhibit 11)

On October 1, 1996, Lucy observed: He was wearing what probably took 20-30 minutes to go down. Little beep! (Exhibit 11) A careworker had an experience with David on October 1, 1996 in which David had a bit of a fit on my lap when I was holding on to him. He started kicking his legs and screaming and crying. I calmed him down pretty quickly but he was freaking out so much that the veins on his neck were showing. I though it was interesting because this fit just came out of the blue since before that he was laughing at the movie. (Juliette, October 1, 1996, Exhibit 11)

The next day Lucy stated, I just laid down the law about if he doesn t help us get rid of the bad man, he ll be at Peggy s house with a tube stuck up his nose. (Lucy, October 1, 1996, Exhibit 11) A careworker commented that David s struggles during the past few days were really taking toll on Lucy and her patience. (Staff Report Form Number 4, Lisa Bradley, October 3, 1996)

David s behaviour did not improve. On October 9, 1996, the day after his birthday and David s first visit with his mother for almost four months, a careworker indicated: Marg (Dobson) said that we are in for a bad period over the next few days with the party and

seeing his mother yesterday. (Juliette K., October 9, 1996, Exhibit 11) In keeping with the prediction, on October 10, 1996 David bit the lid off of a bottle while in a careworker s jeep (Karim) and spilt 1/3 all over him and the driver s seat. Disaster! (Janice, October 10, 1996, Exhibit 11)

On October 16, 1996 Lucy s frustration with the situation seemingly boiled over. She wrote: How long do you get for aggravated murder (and believe me it s VERY aggravated murder). How long is life? Do they mean life? Or is it just 25 years. Well, I could be off for good behaviour in — what do you think? 18 years?

She went on to say: I think I could be hysterical right now. David had a heyday with my NOT being able to run after him. David had THE BIGGEST FIT FOR AN HOUR. SCREAMING, CRYING, DRINKING 2 oz in 45 mins. — PATHETIC Then out of the blue David decided a sip had gone down the wrong way yeah, whatever!! so he chucked up about _ can. I cleaned up the floor, etc. with Jane and sent David to undress himself in the bathroom. He didn t want to because he d get itchy on his hands so he stayed in the bathroom and with Jane and with me and with Barb and combinations yes — get this 2 HRS. Who? Why? How? — I couldn t?!! The kid finally decided to undress himself.

Lucy then described how she had had it and went to a movie. In the meantime, as recorded by Lucy, David went down to Alexia s and Kornelia s suite (two other acute patients) for the second night in a row and promptly threw up, and Lucy believed that they would think it was her fault.

Lucy closed with anyway, yes, seriously preparing myself for many years of bars - I thought the mansion days felt like prison — I ll soon be experiencing the real thing! Lucy then had an additional observation: P.S. 12:15 a.m.: One of us is on death row — I m either as the executioner or as the executee — who knows!! David has thrown up TWICE since he s been asleep. 10:50 p.m., and midnight. WHAT IS THIS! He doesn t know how close I came to inventing my own tube to shove up his nose and God was he

SCREAMING?! He slept, talked, sat up, looked asleep still, threw up. I told him to stop and he started screaming. Second time Eric was taking David to the bathroom (I can t carry him right now) and 2 seconds later he was chucking again. UNBELIEVABLE!

David s resistance to feeding was not unique to Lucy. The next day a careworker described David as being very aggressive, kicking and screaming and hitting the bottle away with his hands. Hitting everything in front of him including me. (Staff Report Form Number 4, Juliette K., October 17, 1996, Exhibit 11)

A careworker observed over the ensuing two days that Lucy really needs some time away from David just now as it s stressing her out to much just now and she really needed to concentrate on herself. The careworker also advised that Lucy really needs to get a good night s sleep. (Staff Report Form Number 4, Jane McCluskey, October 17 and 18, 1996) A second careworker on October 18 described Lucy as very worried and distressed about David and concerned that Peggy Claude-Pierre was angry with her because David needed a lot of reassurance tonight. (Staff Report Form Number 4, Kate Devlin, October 18, 1996)

On October 20, 1996, Lucy wrote about Peggy Claude-Pierre s role with David: She (Peggy) thinks she will have to take David, but can t possibly until the end of the month as her book s deadline is then. So I guess we just keep him going till then. (Exhibit 11)

Two days later, in describing a vomiting episode by David, Lucy wrote: there is nothing genuine about the throwing up — little b! (Exhibit 11) A few days later another careworker commented that Lucy was losing patience with David — seems stressed. (Counselling Report Form Number 2, D. Yost, October 24, 1996)

On October 25, 1996, Ms. Claude-Pierre changed staffing and the careworker wrote approved four new people to work with David. Hurrah! Hurrah! Hurrah!!! (Staff Report Form Number 4, Janice, October 25, 1996, Exhibit 11) Ms. Claude-Peggy likely reduced Lucy s involvement to nights only, based upon the description of Lucy s

responsibilities by Terry Almeida on November 22, 1996. (Weekly Progress Report, Marilyn, October 19, 1996 and Counselling Report Form Number 2, Terry Almeida, November 22, 1996)

There was a significant improvement in Lucy s spirits and attitude on October 27, 1996 which was described as a great day as she moved on to partial care. (Staff Report Form Number 4, Jane McCluskey, October 27, 1996)

In November, Lucy went to a movie with her careworker after Montreux retained a sitter for David. Later that week, despite the apparent personal progress, Lucy was described by her careworker as being disappointed in herself for not being able to make a difference with David having a hard time not seeing it as a failure. (Counselling Report Form Number 2, Terry Almeida, November 22, 1996) The next day Lucy was described by the careworker as, got very frustrated and ended up leaving because she couldn t deal with him anymore. She feels she is useless with him and her patients (sic) is very low. (Staff Report Form Number 4, Kate Devlin, November 23, 1996)

At this point Peggy Claude-Pierre reduced the number of nights Lucy was to spend with David to four a week. The next day Lucy was still described as really frustrated with David . As well she was experiencing pain below the rib cage for about the previous two weeks. (Staff Report Form Number 4, Jane McCluskey, November 24, 1996) On November 27, 1996 Lucy went to the emergency room with severe cramping, spending 1:00 a.m. to 4:30 a.m. at the hospital. No diagnosis was made. However the worker did state: Lucy seems to need a break from David right now.

David s careworker observed that same day: David was being very abusive physically when playing with things — more hitting of toys with other toys — and sometimes hitting me. He would stop when asked. (Staff Report Form Number 4, EJD, November 27, 1996, Exhibit 11) There did not seem to be any let up with the difficulties with David as he was described as going through a tough time at the moment. (Staff Report Form Number 4, Genevieve, November 27, 1996)

Two days later the source of Lucy s abdominal pain was determined to be an ulcer.

By December 3, 1996, Lucy was no longer involved in caring for David and her worker described Lucy as relieved about not being responsible for David any more. (Counselling Report Form Number 2, Terry Almeida, December 3, 1996) On December 5, 1996, a counsellor described the situation with Lucy as that she misses being with David but knows it is best for both — planning on spending fun time with him. (Counselling Report Form Number 2, D. Yost)

According to Peggy Claude-Pierre, Lucy has continued her dedication and devotion to children and has enrolled in a Montessori teacher-training program. (T19, P162, L4)

Lucy was available to testify but was not called by Montreux. Ms. Claude-Pierre indicated in her testimony that I would love the opportunity for you to talk to Lucy about it. (T20, P105, L16-17) Lucy did however, see fit to hold an impromptu news conference during the Hearing. It took place in the parking lot just outside of the hearing room at the Oak Bay Beach Hotel immediately prior to her departure for a brief trip to England. (T21, L119, L11-16)

Ms. Claude-Pierre disputed the observations of staff on the adverse effects that providing care for David was having on Lucy. (T20, P66, L9-10) She indicated in her testimony that: When I thought there was a problem with Lucy, she moved from the situation. (T20, P66, L12-13) Ms. Claude-Pierre indicated David s feeding problems and behaviour were not a factor in Lucy relinquishing care responsibilities for David, (T20, P51, L4-7) although earlier in her testimony, she had indicated, I m not unaware (sic) that Lucy - - that David was the cause of Lucy s stress. I am aware that Lucy had a rough time. (T20, P49, L4-6) Moreover, Ms. Claude-Pierre implied that in fact the careworkers were taking care of the situation and were caring well for both David and Lucy. (T20, P48, L19-21)

However, when it was pointed out Lucy s relinquishing her role in caring for David only occurred after Lucy developed an ulcer, Ms. Claude-Pierre placed the responsibility for the adverse event on Lucy, a patient, for displaying faulty judgment: If it didn t happen

until then that was because of her choice, and not mine. (T20, P66, L22-23) Ms. Claude-Pierre s testimony about Lucy s role in the care of David, and about the impact of her role, upon both David and Lucy, is inconsistent with much of what it is recorded in Montreux s own patient logs.

Ms. Dobson and Ms. Claude-Pierre both continued to insist that the arrangement by which Lucy served as one of David s primary caregivers while still a patient on full-care herself was of therapeutic benefit to her as well as to David. Again, Montreux s own files demonstrate clearly that this was not the case. Lucy s records document a pattern of increasing, sometimes nearly intolerable stress, as her frustration in not being able to help David more grows, to the point it appeared to be affecting her physical as well as emotional health.

While Lucy may have derived some small benefit in being associated with David Bruce in her original role as playmate and big sister, the next step of having Lucy take on the much more demanding role of being his primary caregiver for more than six months had a significant negative impact on her physical and emotional health, as documented in Montreux s own records introduced in evidence at this Hearing. This is a further contravention of Section 8 of the *Community Care Facility Act.*

Misrepresentation by Montreux

As much as any issue discussed during this Hearing, the story of David raises the question of whether Montreux management deliberately misled Licensing officials, either during the 1997 investigation, during their interviews with Licensing investigators in 1998, or indeed at this 1999 Hearing before me.

On the basis of complaints received by Licensing, an investigation into the operations of Montreux Clinic was started in January, 1997. One of the allegations made to Licensing at that time was that an unauthorized four-year-old child was receiving residential care at the St. Charles site. Licensing officials investigated this allegation during the spring of 1997.

On May 29, 1997, the then-acting managers for Montreux, Justin Williams and Nicole Claude-Pierre, were asked about this child. They told Licensing staff that David Bruce stays with his mother. Brought to the facility for counselling. He has not lived at the facility. Records on David, according to staff, were unavailable. (Exhibit 25, Tab 25)

There was a follow-up meeting between Licensing and Montreux staff on June 10, 1997. Present at that meeting were Peggy Claude-Pierre, Noah Dobson, Margaret Dobson and David Harris. (Exhibit 25, Tab 32) At that meeting, Montreux advised Licensing staff that Child Number 1 (who was in fact David) did not receive residential care at the Rockland site; but that he did stay overnight on occasion and for a month at the St. Charles site.

Minutes of the meeting were sent to Montreux for review. No corrections were forthcoming from Montreux to rectify any misperceptions on the care arrangements for David Bruce at Montreux. (Exhibit 25, Tab 39)

When presented with my decision on the first investigation, dated July 2, 1997, the Montreux response by David Harris and Noah Dobson on July 15, 1997 clarified some of the issues in the decision, but no attempt was made to address the misinformation surrounding David receiving inpatient care at Montreux. (Exhibit 65 and T17, P69, L2 and P71, L4)

The records of David Bruce, which Montreux had said were unavailable, were discovered by Chief Licensing Officer Steven Eng during the course of the second investigation. These records led Licensing to pursue again the question of David s status during his time at Montreux.

The logs and staff reports established that David had been an inpatient at Montreux (Exhibits 9, 10, 11, 12, 14 and 81) and that he had resided at the St. Charles site between March 26, 1996 and May 29, 1997.

During the second investigation, interviews were conducted by Licensing officers with senior Montreux staff. During those interviews, conducted in September, 1998, Montreux personnel were represented by legal counsel. Ms. Claude-Pierre gave her responses with her husband David Harris present. (T19, P175, L5-7, and L17-18)

When asked about David being a residential client, Ms. Claude-Pierre responded he was an outpatient he was allowed to stay to have confidence but that wasn t on an ongoing basis we said that we couldn t take him as a resident. He was underage (Exhibit 17, Page 66)

Mr. Harris, after hearing Ms. Claude-Pierre s responses to these questions, did not comment upon or contradict his wife s version of events when given the opportunity to do so. (Exhibit 18, Page 32)

Margaret Dobson testified in her interview in September,1998 that we couldn t accept him as an inpatient because of his age. He had to be an outpatient He had to be with his mother and then come to the clinic in the day. Ms. Dobson went on to describe the St. Charles arrangement as, occasionally he would stay overnight. If he was having a particularly rough day we would allow that to happen. Not on a regular basis. When again asked about the records suggesting David lived at St. Charles for a year, Ms. Dobson replied: During that year, on and off but not consistently for a year No, not at all. (Exhibit 20, Pages 147 and 148)

Noah Dobson, Facility Manager at the time of the second investigation, also denied in his September, 1998 interview that David was placed at the St. Charles site as an inpatient. David would stay there when he was having a difficult time, but his day program actually worked out of 1560 Rockland. Mr. Dobson suggested that he only stayed at the St. Charles site with his mother when there were problems. When asked about a prolonged stay by David, he replied I couldn t tell you if it was a day or a year. (Exhibit 19, page 159 and 160)

Mr. Dobson was the personnel director for Montreux during all but the last month of David s stay at the St. Charles site — at which time he was promoted to the Manager s job. (T18, P112, L19-21) As the person who oversaw scheduling co-ordination for the entire organization, he had to know of the workers assigned to David, along with every other client at Montreux. For Mr. Dobson to perform this duty he also had to be aware of the level of care of every patient. (T18, P86, L2-18) As Manager, he should have been aware of David s care guidelines, and, as well, he would have known the circumstances of David s management, including the length of his inpatient attendance at the St. Charles site. Included in this stay was a time when Margaret and Noah Dobson were David s legal guardians during a one-month absence of Meg Bruce. The date of the guardianship was from April 10 to May 16, 1997. (T17, P76, L16-18) Ms. Bruce testified that she gave a one-week oral extension of the arrangement.

During the 1999 Licensing Hearing, Margaret Dobson was again asked about David staying at the St. Charles site for a prolonged period of time. She replied: To my knowledge, I did tell the truth (in the 1998 interview), (T15, P144, L12) and I don t think I was under oath. I am under an oath now, however. (T15, P144, L14-15) However, she did concede that it was incorrect that David stayed overnight only over rough times and not on a regular basis. (T15, P150, L22-25) When asked if he had stayed for over a year, she agreed this was true.

Noah Dobson confirmed only that David was at the St. Charles site during the guardianship arrangement with Ms. Bruce. (T18, P90, L22-P91, L2)

Ms. Claude-Pierre testified that David was staying at the St. Charles site overnight and that he ended up staying consistently for a period of time. (T19, P161, L15-20, P166, L11; P168, L5-6) Ms. Claude-Pierre also said that she thought David was a residential client only if he stayed at the Rockland site. (T20, P20, L15-22)

Alex Garcia testified that in conversations with Margaret Dobson about where David was staying, why he was there, and what they were doing with him: I remember being told to

stay quiet about it, because that as a facility they weren t actually licenced to hold somebody of that age. (T3, P152, L6-12)

Meg Bruce was interviewed by Licensing staff on the afternoon of May 29, 1997 and indicated that David spends nights with me. Spends the day at Montreux except if there is a problem. Then stays at a suite if having a tough time Pick up at 9 a.m. — Montreux drops off usually by bed time (8:30 — 9:00) Overnight stays — the most two nights in a row. Frequently in the beginning. Last overnight stay six months ago. (Exhibit 25, Tab 25)

The records now show that David had in fact been returned to his mother s care only hours before this interview took place. Ms. Bruce also said that she left David in the care of the Dobsons from April 10 to May 16, 1997 while she was in New York. For that time, she said, she assumed he stayed at the Clinic during day, then stayed with Margaret and Noah overnight.

At the 1999 Hearing, Ms. Bruce testified she could not remember the call from Licensing on the afternoon on May 29, 1997 to discuss David s care arrangements. (T7, P95, L16 and P96, L10) Even seeing her answers in Exhibit 25, Tab 25 did not help her recall the telephone call. (T7, P94, L24) Ms. Bruce, in her testimony, did concede that David had not only been at the Montreux Clinic in the six months leading up to May 29, 1997, but had been staying 24 hours a day, seven days a week for those months. (T7, P95, L21 - P96, L7)

The careworkers Janice Lim, (T15, P51, L22-25 and P53, L1-2) Alex Garcia, (T3, P175, L10-15) Adrian Maisonneuve, (T3, P66, L16-23) Heather Hestler (T2, P38-39) and Rachel Spence, (T2, P91, L18; P92, L5) all spoke to the imposed separation between David and his mother and the lengths caregivers had gone to avoid contact between David and his mother. In a letter dated December 96 , Ms. Bruce wrote to Ms. Claude-Pierre commenting on not seeing him for a long periods of time and not getting information about her son for months.

However Ms. Bruce, in her testimony, claimed the longest period she went without actually having a visit with David was when I went back to New York for those couple of weeks. (T7, P111, L2-3) The actual stay in New York at that time was for a period of five weeks. Ms. Bruce reiterated in her later testimony that there was only one separation (T7, P114, L4) although this does not match with the evidence of the Clinic s own guidelines and documents.

When the issue of a separation was raised in the September, 1998 interview with Margaret Dobson, she indicated that David occasionally would stay overnight if he was having a particularly rough day So it was quite - - it was mostly her (Ms. Bruce s) decision, actually, to try and keep a little distance. To let him have some space. As with any other patient really. Again, when asked whether he had lived with Lucy for a year at St. Charles, Ms. Dobson replied during that year, on and off, but not consistently for a year. (Exhibit 20, Page 147 and 148) In her testimony at the Hearing however, Ms. Dobson confirmed that David had been separated from his mother and that this was a component of the standard therapy at Montreux.

When Ms. Claude-Pierre was asked in her 1998 interview with Licensing whether David had been isolated from his parents for a period of time she responded: I m not aware of that. His mother took the time - - a small time to go back to New York to visit. A very small time but there was not an idea of isolation or separation in my mind. (Exhibit 17, page 67)

Ms. Claude-Pierre in her testimony did acknowledge a separation between David and his mother from July 16 to August 13, 1996. (T20, P68, L19; P69, L25) However, Ms. Claude-Pierre indicated David was only physically separated from his parents but not truly isolated from them because, We keep David and his mother aware of each other. We kept David very aware of his mother and what she was doing. She was always in the conversation. (T20, P24, L19 — P25, L7) Ms. Claude-Pierre also testified that the

separation of David from his mother, in her opinion didn t feel like it was a licensing issue. (T20, P24, L17-18)

In his testimony, David Harris conceded that David Bruce had stayed continuously for months on end. (T17, P84, L14-19) Mr. Harris explained the situation as one in which Montreux had really wanted his mother to be with him all that time, so I was stating our policy more than the fact of the situation. He went on and stated that because it was impossible for David to be with his mother because of his eating disorder, this was not a lie. This was the situation as we saw it It s an extension of the reality. Occasionally it became perpetually. (T17, P85, L12-25) Mr. Harris also testified that David could come and go as he pleased, (T17, P43, L10) although he later acknowledged, I guess that is a bit of a stretch. (T17, P95, L12)

In his testimony at the Hearing, Noah Dobson admitted he knew David had been an inpatient, but had not been aware that the period of time had stretched on for more than a year. (T18, P80, L18-21 and P86, L1-2) Although he was serving as the Facility Manager, Mr. Dobson claimed that he only learned of the details around David s stay as a result of his attendance at this Hearing. (T18, P88, L12-14) Mr. Dobson also admitted that David s records could have been handed over to Licensing when they were requested in 1997, if there was more thought put into it. (T18, P84, L3-18) Although he also suggested that I believe we gave them as much information as we could at that particular time, (T18, P90) he insisted that neither in 1997 nor in his September, 1998 interview was his intent to lie or mislead Licensing. (T18, P91, L6-13)

Meg Bruce responded to the first question under direct examination by Ms. Fiona McQueen for 80 minutes without a pause when asked to describe the symptoms associated with David s eating disorder, how old he was and what sort of things she noticed. (T7, P2-P53) However, she could not recall a telephone conversation with Licensing, even after being presented with notes of the interview. Ms. Bruce also underestimated the length of time she went without having seen her son and contradicted the recollection of a number of careworkers.

Ms. Bruce also claimed to have attended all of David s doctor visits, which would have been in keeping with her having regular and frequent contact with her son. In her testimony, she repeated this assertion: Even when he was there full-time I did attend his doctor s appointments, yes, with the worker I mean I attended the majority of them. (T7, P114, L9-16) Ms. Bruce modified her testimony shortly thereafter to, I knew of them, (T7, P114, L22) and still later conceded that it was Lucy who most often attended with David at Dr. Medhurst s office. (T7, P115, L3)

Ms. Bruce had similar problems recalling situations in which she had been critical or questioning of Montreux staff or procedures. In filling out a form on Pro s and Con s (of her separation from David), she testified, I can remember as though it were yesterday, (T7, P63, L24) claiming but one Con against separating from David. However the evidence at the end of Exhibit 11 showed her documenting six Con s , something that she ultimately acknowledged when presented with the evidence. (T7, P110, L4-17)

In reference to the letter that Ms. Bruce sent to Ms. Claude-Pierre in December 96 , Ms. Bruce testified December 96, it s in the early part of when he was staying at the Clinic. (T7, P88, L22) The evidence shows David had been in full time residence for more than eight months, and at least two separations of more than a month had already occurred.

I find that Montreux management provided false information to Licensing regarding the care of David Bruce, and that they must have known that information to be false. I also find Meg Bruce s recollection of her involvement in David s care, and of the extent of her separation from David to be unreliable, particularly where it is contradicted by the documentary evidence described above.

Discharge of David Bruce to Outpatient Care

Montreux records show David Bruce moved from inpatient to outpatient status on May 29, 1997.

Dr. Medhurst testified he was not involved in David s discharge. (T8, P122, L10)

Margaret Dobson described David s departure in her interview with Licensing staff in 1998 as, I sort of got her (Meg Bruce) involved in being with him when he was eating and just a gradual progression to her taking him home to New York. (Exhibit 20, Page 150) In her testimony Margaret Dobson said she saw no evidence of problems when David was reunited with his mother and went back to living with her. Ms. Dobson indicated she was involved in this reintegration of David and his mother to an off-site setting. (T16, P183, L11-14)

Ms. Claude-Pierre, in her interview with licensing staff, indicated that David left Victoria just before he was five. His mother chose to stay much longer with him in the city that I would have felt was necessary. I might have sent him home six months earlier. But she said she would rather just stay, so she felt totally comfortable that he was well, completely well. (Exhibit 17, Page 72)

When Ms. Claude-Pierre was asked at the Hearing about the end of David s inpatient stay at the St. Charles site, she replied: It wasn t anything that was premeditated, it was something that just seemed to happen and develop with the child, and we went with it, whatever it was, and it began to get better slowly in that there were many obvious behaviour changes So it is my recollection that when we came back from Europe, I said to her, Well, you know, it s time now and he can come back to you. She did note that, I could be wrong in the spaces of time. (T19, P168, L17 — P 170, L4)

The evidence suggests quite a different course of events. The care logs show David leaving the St. Charles site on the day of an unannounced Licensing inspection on May 29, 1997. In her testimony, Heather Hestler stated that, as the float worker, she had to

fill in for the first hour for Treena Cook, the regular worker for an inpatient. Ms. Cook was late for an unknown reason. Ms. Hestler testified that when Ms. Cook did arrive, at about 10:30 or quarter to 11:00, she explained, I ve been helping Bill, the maintenance man move some stuff. When asked by the patient whose belongings were being moved, Ms. Cook said she had been involved with Bill in moving little David s stuff he s going to his mother s apartment. Ms. Hestler also testified Ms. Cook said the move was being made because we are not licensed to have children that young. (T2, P24, L1 — P25, L4) Treena Cook in her testimony confirmed that I came in at 8:00 but I didn t go on shift with the patient. I was helping to move David that morning. (T14, P32, L4-10)

Ms. Cook did not recall that there was a Licensing inspection on that date. However, evidence found in Exhibit 25, Tab 24 indicated that an unannounced inspection of Montreux by licensing staff commenced at 10:00 a.m., May 29, 1997. The notation in Exhibit 25, Tab 25 indicates that Licensing staff arrived at and inspected the Rockland site first.

The acting managers, Justin Williams and Nicole Claude-Pierre, were not truthful about David living at the St. Charles site, nor did they produce his records as requested. Moreover, Justin Williams, Karim Nasser (another middle manager), and Nicole Claude-Pierre told licensing officials that they did not have a phone number for Family Member number four. (Meg Bruce) (Exhibit 25, Tab 25) Ms. Bruce was a Team Leader at the Richmond site and had been a staff member at Montreux, albeit an unpaid one, for almost a year. Yet, they were unable to produce her telephone number.

However, the number for Ms. Bruce was provided to licensing in the afternoon of May 29, 1997, (Exhibit 25, Tab 25) apparently after David had been moved out of the St. Charles site.

When asked about the arrangements for David s care at Montreux that afternoon, Ms. Bruce lied about whether David had stayed at St. Charles, both in the frequency with which he had stayed there and the time when he had last stayed overnight at the site.

Moreover, the documentary evidence shows that the version of David s discharge testified to by Ms. Claude-Pierre and Margaret Dobson could not have occurred. Ms. Bruce was away from Victoria from April 10, 1997 to May 16, 1997. (Exhibit 25, Tab 25, Question 11) She did not return until after the Dobsons had departed for Europe as documented in Exhibit 66. Noah Dobson had transferred responsibility for managing Montreux to Nicole Claude-Pierre and Justin Williams from May 14, 1997 to June 2, 1997. As well, Karim Nasser makes reference to Ms. Claude-Pierre leaving town on the same day. (Exhibit 25, Tab 26) Moreover, Ms. Claude-Pierre would have known about the move, had she been in town, for her office is located in the St. Charles building. (T20, P5, L11)

On the basis of the evidence, Meg Bruce, Peggy Claude-Pierre and Margaret Dobson had not been in the same city for a period of seven weeks prior to David s discharge. Moreover, the precipitous reunion of David with his mother occurred on a date when both Ms. Dobson and Ms. Claude-Pierre were still absent from Victoria.

I can only conclude that Peggy Claude-Pierre, Noah Dobson and Margaret Dobson lied, under oath, in giving evidence at this Hearing regarding the discharge of David Bruce. Moreover, Ms. Bruce only reluctantly acknowledged her part in the deceit surrounding David s leaving the St. Charles site as an inpatient and becoming an outpatient. The principals in this Hearing had the opportunity to correct a misrepresentation of events. Instead, they continued to be untruthful, and did so under oath.

In considering the testimony and the actions of Peggy Claude-Pierre, David Harris, Noah Dobson, Margaret Dobson and Meg Bruce, I find they have undermined their credibility before this Hearing through their lack of candour and their withholding of the truth.

CONCLUSIONS

In conclusion, Montreux conceded that in the past they had not complied with some sections of the *Act* and the Regulations. These included Section 8(a) of the *Community Care Facility Act* and Sections 4(1), 8.3, 8.4(1), 8.4(2)(a), 8.4(4), 8.4(5), 8.4(6)(c), 8.4(6)(d), 8.7(a), 8.8(a), 4(4)(e), 6(3)(a), 6(3)(b), 6(3)(c), 7(2)(a), 7.10(a), 7.10(b) of the Adult Care Regulations. However, Montreux also noted it had, since the beginning of the second investigation, made considerable progress in its efforts to bring these issues into compliance.

On the basis of the evidence put before me at this Hearing, I have also concluded that Montreux contravened other sections of the *Act* and Regulations. These included Sections 8(b), 8(c), 3(a), 3(b), 3(c) of the *Community Care Facility Act* and Sections 4(5)(a)(i), 10(2)(a), 10(2)(b), 6(4), 17(2)(b), 17(2)(c) of the Adult Care Regulations. I have found several separate practices which contravened key sections of the *Act* which require all Licensees to promote the health and safety of all persons in their care, and also maintain the spirit, dignity and individuality of each person. In some cases the risks to patients health and safety were severe.

I have also concluded that Montreux repeatedly breached provisions of B.C. s *Mental Health Act*. Under Section 6 of the *Community Care Facility Act,* this is also cause for the finding of a contravention against their Licence.

However, I have concluded as well that on the basis of all the evidence and the legislation, the Licensee did not breach the following sections of the Adult Care Regulations: 6(6)(d) and 9.1.

Having found the Licensee to be in non-compliance with the *Act* and Regulations, the question that remains to be decided is what consequence should be imposed. In making this determination, I have considered the following factors: severity of the

contraventions; attitude of the principals as demonstrated during the course of the Hearing; credibility of Clinic staff and management; and expressed willingness of the management to change.

On the basis of the evidence before this Hearing, I have found that senior management at Montreux withheld information from Licensing and from others involved with the Clinic; have lied about their conduct in operating the Clinic; and/or were singularly confused about their responsibilities for the management and operation of a licenced facility. Examples of this include:

- Former Manager David Harris described a level of care to be provided at the licenced facility that was in sharp contrast to the dire condition of patients already being treated by his wife Peggy Claude-Pierre.
- Montreux did not provide their expert witness on suicide, Dr. Termansen, with either an accurate number of the suicide gestures at the Clinic or the true severity of some of the attempts. Moreover, Dr. Termansen was not made aware of the details of Montreux s system of treating anorexic and suicidal patients.
- Dr. Susan Sherkow, the child psychoanalyst called by Montreux, was not provided with a full picture of the care provided to David Bruce by the Clinic, nor with a summary of David s logs and patient records from his time at Montreux.
- Montreux s senior management collectively misrepresented and withheld information from Licensing concerning David Bruce s treatment and care at Montreux and whether he was separated from his parents for months at a time. Montreux staff withheld files on this boy despite being asked to produce them by Licensing. To this date, they have also failed to produce the missing logs for this boy from November, 1996 to May, 1997 despite repeated requests.
- Senior Montreux staff were not under oath for their depositions in 1998, and a number of misrepresentations from these interviews about the care provided David were corrected at the Hearing. Nevertheless, Peggy Claude-Pierre, Noah Dobson and Margaret Dobson were under oath when they provided a version of David Bruce s leaving the inpatient care setting which was contradicted by the evidence before this Hearing.

- Montreux also denied having to resort to the use of verbal threats and of physical restraint in order to feed David and certain other patients, including the use of a spoon from time to time, although cases of these management methods were contained in their own files, and were supported by the testimony of former caregivers. I reiterate that I prefer the testimony of those careworkers to that of Montreux managers on the grounds that the patient logs confirm the use of the methods and that it appears inherently improbable that the individual workers would all have stumbled upon the same feeding techniques at about the same time by sheer coincidence and without some direction from Montreux management.
- Montreux misrepresented a number of consultative relationships with the Clinic. Ms. Claude-Pierre in her testimony acknowledged that Dr. Elliott Goldner, a consulting psychiatrist with expertise in eating disorders, was not connected with Montreux but only was aware of their operation. Bob Enoch conceded in his testimony that Dr. Steve Kent, a Victoria pediatrician with an interest in childhood eating disorders, had reviewed only the clinical elements of their proposed new admission policy and had not endorsed the entire document, specifically the exemption clause.
- Montreux misrepresented the role played by the three general practitioners in the provision of care to clients at the Clinic. While Montreux managers testified they relied on the doctors for all key medical decisions, the doctors evidence showed they were often not involved in key decisions affecting medical care, for instance, around nutritional plans and food intake. I prefer the doctors evidence over that of the Montreux managers because it more closely matches the documents before this hearing and the testimony of several of the former careworkers who testified.
- Montreux contended they were confused about the number and acuity of patients they could maintain at the unlicensed St. Charles site, even though the issue had apparently been well clarified with them following the 1997 investigation.
- Montreux also was seemingly confused about the role of Kim Macdonald, Licensing s Nutritionist, and whether she could act as an informal consultant to the Clinic on nutritional issues.

Peggy Claude-Pierre, despite being the program director and co-principal of the corporate Licensee, testified she was little involved in the administration of the Clinic s operations.

Ms. Claude-Pierre testified that she was unaware that the former Manager of Montreux, her husband, David Harris, claimed in the initial licencing application that Montreux was going to take only residents that would not require daily professional supervision. (T20, P128, L16-25)

She testified that she was unaware of any overcounts at St. Charles (T20, P16, L25) despite having her office located in this building. (T3, P153)

She testified she didn t deal with licensing issues and left those matters to Noah as the Manager . (T20, P9) According to her testimony, this went so far as not reading either the first (T19, P191, L24-25) nor the second (T21, P134, L16-19) investigation reports of alleged contraventions occurring in her facility. Moreover, Ms. Claude-Pierre said she expected staff to correct any errors in the minutes of meetings with Licensing as this was their responsibility. (T20, P15, L25)

Ms. Claude-Pierre also testified that both the new admissions policy, (T20, P133, L1-2) early discharge forms, (T20, P179, L6) and new policy and procedure manual were not her responsibility but that of Joel and Noah. She was also apparently unaware of the manual s contents or that she had been listed as the person responsible for these policies. (T20, P160, L21 — P161, L13)

Ms. Claude-Pierre s non-participation was not restricted to administrative matters only. She testified that despite the complexities of the concepts around the illusion of no choice as explained in her book, she left the teaching of this basic tenet of Montreux to Noah and Joel. (T20, P190, L14-25)

Ms. Claude-Pierre testified she was under the impression that the three doctors who cared for patients staying at Montreux were much more involved in the Clinic s provision of

care than the doctors themselves believed they were. The evidence before me confirms that the doctors testimony as to their roles as consultants, deferring to Montreux on many aspects of patient care and limiting the scope of their involvement, is accurate. I accept the evidence of the physicians on this point, where it contradicts that of Ms. Claude-Pierre.

Finally, Ms. Claude-Pierre also testified that many of the decisions around patient care were left to the patients and their parents. The logs and patient records clearly identified Ms. Claude-Pierre as the Program Director and she was identified by herself and by numerous Montreux witnesses as the troubleshooter when issues arose with any of the clients. Moreover, many witnesses called on behalf of Montreux, including fellow members of the management team, Margaret and Noah Dobson and Bob Enoch, testified that they considered Ms. Claude-Pierre to be the person with the expertise in eating disorders at the Clinic. She is the individual whose theories all staff members have learned to use in dealing with anorexia nervosa, for she is the one who has literally written the book on the subject.

Ms. Claude-Pierre is the driving force behind the Clinic and, as a Director of the for-profit corporation holding the licence, is also responsible for all aspects of its operation. Ms. Claude-Pierre must accept responsibility for what has occurred at Montreux, whether she was personally responsible or had delegated the functions to other individuals. She was the person who retained those individuals services, decided on the pre-employment qualifications and trained them.

The co-principal and corporate licensee, David Harris, showed no more willingness to take responsibility for the shortcomings found in the operation of the Clinic. In his testimony, Mr. Harris indicated he believed Montreux s difficulties — including the licensing investigation that led to this Hearing as well as some media coverage he saw as less than favourable — were the result of some type of conspiracy. (T17, P47, L1-2) Although he could not provide any details of just who might be involved in this covert enterprise, Montreux management apparently took their concerns about this possible

conspiracy seriously enough that they hired a private detective to try to determine the details of it.

As a result, and as I heard during the Hearing, another private detective, apparently working under a sub-contract to the agent hired by Montreux, directly approached one of the complainants in this investigation in what might well be construed as an attempt to harass a witness. Although Montreux management denied this was their intent when they engaged the first detective, and Mr. Harris apologized to the complainant in question, this unfortunate incident appears to be another example of the Clinic attempting to deflect responsibility and avoid being held accountable.

Critical to my decision is the question of whether Peggy Claude-Pierre and David Harris fully and deliberately intended from the beginning to run the facility with high risk clients for whom death from anorexia and/or suicide were very real possibilities.

Although Dr. Birmingham looked at the admission records of only six Montreux patients, the evidence shows this was not an aberrant sample. Evidence presented involving David Bruce and his caregiver, Lucy; Jane McCluskey, Sophie Feller, Bronte Cullis, and Nora Desjardins revealed issues of equal significance or acuity. The *20/20* video showed several other patients who, on admission, also were obviously considerably more acutely ill than the patient-group suggested in Mr. Harris s letter.

If Ms. Claude-Pierre s descriptions of her own credentials are to be believed, she ought to have been aware of the extremely risky enterprise that she was embarking on with a cadre of staff who were ill-equipped and ill-prepared to deal with a population that, according to expert witness Dr Birmingham, would be a challenge to the most professional and well-qualified staff.

I therefore accept the submission of the Licensing staff that the Montreux Clinic has misled the authorities from their initial application and has been fully aware of the risks being posed to the health and safety of individuals taken into their care.

Despite this awareness, they proceeded to hire individuals as caregivers, who by virtue of their minimal qualifications, would not be in a position to appreciate fully the risks to the health and safety of these very acute patients.

They also recruited to care for these patients various needs, general practitioners who did not have the specialized training or experience required to fully appreciate the gravity of the clients situation.

On the basis of the evidence before me, I conclude that Peggy Claude-Pierre and David Harris knowingly misrepresented to Licensing the type and nature of the residential facility they intended to operate.

If Montreux had focused on patients needing the level of support described in Mr. Harris s letter of Sept. 12, 1994, it would not be disconcerting that none of the members of Montreux s board of directors — Peggy Claude-Pierre, David Harris, Noah Dobson, Margaret Dobson and Nicole Claude-Pierre — were members of any professional health-care association, nor that none had had any previous experience of operating, managing or working in a care facility. Neither would it be a concern that none of them undertook any additional training themselves to equip themselves to cope better with such a high-risk group of patients.

At the conclusion of the 1997 investigation, I agreed to take no action against Montreux s licence on the basis that I was convinced the Clinic s management was making a serious and sincere effort to change and bring itself into compliance with all aspects of the *Act* and Regulations. The evidence presented to me at the current Hearing, however, leads me to conclude that neither then nor now was Montreux management prepared to change the fundamental aspects of its program that lead them into serious non-compliance with both licensing standards and the *Mental Health Act.*

To be fair to the Licensee, it is clear from the evidence that they have tightened up policies in order to comply with the Regulations in various administrative and procedural areas. Examples include staff TB tests and medical records, first aid training, and

FoodSafe courses. I believe that were Mr. Enoch to take over as Clinic Manager, he would maintain, and improve upon, these gains.

However, none of these changes deal with the substantive issues which I find put patients health and safety at risk and/or undermined their dignity or spirit. And in these areas, Montreux managers, including their proposed new Manager Mr. Enoch, made it clear they were not willing to make the major changes necessary.

Among the concerns in this area is the insistence by virtually all the Montreux managers that they would continue to persist in feeding and treating patients against their will, even though those patients would not be legally committed for treatment under the *Mental Health Act.* To do otherwise, they said, would make it impossible for them to function as a treatment centre for anorexics who have failed at numerous other treatment programs.

Of equal concern is the testimony by Peggy Claude-Pierre and other managers that they would still take as residential clients all six of the patients whose medical records were reviewed by Dr. Birmingham and who were found to be at significant risk if admitted to a facility like Montreux. The Clinic s argument that no one has yet died on the premises is not an acceptable defense. Were the actual death of a patient the sole criterion for a licensing hearing, none would ever occur except in the wake of a coroner s inquest. The critical issue is the risk to which patients are put, not whether that risk has yet led to an actual fatality.

It is noteworthy that Mr. Enoch, the Clinic s proposed choice as the new Manager, not only agreed with these views but was actually the author of exclusion clauses in new Clinic policies, which would in fact ensure that Montreux would continue to contravene the *Act* and Regulations.

In rendering my final decision, I am not unmindful of the testimony of patients and parents who remain convinced that Montreux was, and is, the only place that could have saved themselves or their child from death. I am aware also that in the majority of cases,

treatment was effected through loving and caring kindness, not through actions which would jeopardize a patient s health, safety or dignity. However, these anecdotal stories and the over-all kindly atmosphere prevailing are not sufficient to offset the objective evidence of serious risks to health and safety which occurred from time to time with some of Montreux s patients as presented in the evidence before me.

Given the serious breaches of the *Community Care Facility Act* and the Adult Care Regulations which have been demonstrated before me, as well as Montreux management s lack of honesty in dealing with the Licensing process, including this Hearing, their unwillingness to accept responsibility for the Clinic s shortcomings, and their unwillingness to change key aspects of their operation to bring them into compliance with B.C. legislation, I conclude that their Licence to operate a community care facility must be cancelled.

I hereby order that the licence for 1560 Rockland Avenue, in the name of Montreux Counselling Centre Ltd., be cancelled, effective January 31, 2000. I am giving Montreux Counselling Centre Ltd. two months to conclude their operations. In the interim, the conditions imposed upon the licence by myself December 1, 1998 remain in place.

Respectfully Submitted

Richard S. Stanwick, M.D., M.Sc., FRCPC, F.A.A.P.
Regional Medical Health Officer and Director of Research

APPENDICES

EXHIBIT LIST

Exhibit 1	Letter December 1, 1998 — Dr. Stanwick to Ms. P. Claude-Pierre (Montreux)
Exhibit 2	Second Investigation Report — September 1998
Exhibit 3	Appendices for Introduction
Exhibit 4	Appendix — A — Part 1 of 3
Exhibit 5	Appendix — A — Part 2 of 3
Exhibit 6	Appendix — A — Part 3 of 3
Exhibit 7	Appendix — B
Exhibit 8	Appendix — C
Exhibit 9	Appendix — D — Part 1 of 4
Exhibit 10	Appendix — D — Part 2 of 4
Exhibit 11	Appendix — D — Part 3 of 4
Exhibit 12	Appendix — D — Part 4 of 4
Exhibit 13	Appendix — E
Exhibit 14	Appendix — F
Exhibit 15	Appendix — G
Exhibit 16	Appendix — H
Exhibit 17	Transcript of Interview #1 — Peggy Claude-Pierre
Exhibit 18	Transcript of Interview #2 — David Harris
Exhibit 19	Transcript of Interview #3 — Noah Dobson
Exhibit 20	Transcript of Interview #4 — Margaret Dobson
Exhibit 21	Montreux Response

Exhibit 22	Update Report April 8, 1999
Exhibit 23	Licence dated April 23, 1997
Exhibit 24	Licence dated December 1, 1998
Exhibit 25	First Investigation Report dated June 16, 1997
Exhibit 26	CV for Dr. G. M. Stearns
Exhibit 27	Policy Manual of Montreux — April 1999 — 811 Suicide
Exhibit 28	Letter April 30, 1999 — Dr. Termansen to Ms. McQueen & Mr. Murray
Exhibit 29	Introduction — Training Manual for Montreux — April 1999
Exhibit 30	Training Quiz — Rachel Spence
Exhibit 31	Training Quiz — Adrian Maisonneuve
Exhibit 32	Training Quiz — Alex Garcia
Exhibit 33	Admissions Policy and Procedure Manual - April 30, 1999
Exhibit 34	CV for Dr. L. Birmingham
Exhibit 35	Nutrition Care Plan — 806
Exhibit 36	Letter from Dr. Birmingham dated January 20, 1994
Exhibit 37	Training Manual — April 29, 1999 — Emergency Procedures
Exhibit 38	CV for Dr. Paul Termansen
Exhibit 39	Letters — Margaret Bruce — August and September 1998
Exhibit 40	Pages from Montreux Log Books — January 9, 1997
Exhibit 41	Video of David Bruce (taken the week of May 25, 1999)
Exhibit 42	Letters from US Doctors suggesting Suzanne come to Montreux
Exhibit 43	Report of Geoffrey Ainsworth dated June 23, 1999
Exhibit 44	CHR documents regarding June 14, 1999 — Facility Inspection Report

Exhibit 45	Tape recording of telephone message left by Mr. Lee for Alex Garcia
Exhibit 46	Alex Garcia s note dated July 2, 1999 and attached business card
Exhibit 47	Clinical records regarding patient Erica
Exhibit 48	Dr. Medhurst s clinical notes regarding David Bruce
Exhibit 49	Binder of medical records regarding Montreux patients
Exhibit 50	David s food plan — November 1995 to May 1997
Exhibit 51	Draft Medical Criteria for Admission to Montreux
Exhibit 52	Montreux food plan for Anja D llman, July 26 — 30/97
Exhibit 53	Cover The Secret Language of Eating Disorders
Exhibit 54	Contract for services between Cullis and Montreux dated May 1, 1996
Exhibit 55	First aid manual
Exhibit 56	Daily log entry — July 5, 1997 — Jane McCluskey
Exhibit 57	Extract from letter from Treena Cook to Peggy Claude-Pierre
Exhibit 58	Treena Cook s log entry — August 19, 1997
Exhibit 59	Treena Cook s Montreux staff review dated January 10, 1995
Exhibit 60	Interview notes — Janice Lim, March 10, 1998
Exhibit 61	Staff report dated July 30, 1996
Exhibit 62	Undated letter from Noah Dobson To Whom It May Concern
Exhibit 63	Dr. Clinton-Baker s log book (extract only)
Exhibit 64	Report by Susan P. Sherkow, M.D., dated May 26, 1999
Exhibit 65	Correspondence between Dr. Stanwick and Montreux re 1999 Investigation Report
Exhibit 66	Letter from Noah Dobson to CHR dated May 12, 1999
Exhibit 67	Memorandum dated January 4, 1994 prepared by Alan Kerr

Exhibit 68	Various Montreux patient lists November 1997, January 23, 1999
Exhibit 69	Letter dated June 30, 1999 from Mr. McDannold to Mr. Murray
Exhibit 70	Insurer s bulletin
Exhibit 71	Financial summary of patient care
Exhibit 72	Annual reports and July 12, 1999 corporate search re Montreux Society for Eating Disorders
Exhibit 73	Declaration dated April 18, 1997
Exhibit 74	Temporary guardianship agreement re David Bruce
Exhibit 75	Montreux 20/20 video
Exhibit 76	Montreux website printout
Exhibit 77	Montreux notes re Lucy
Exhibit 78	Dr. Sherkow s addendum — July 19, 1999
Exhibit 79	Readings on eating disorders
Exhibit 80	Black s Medical Dictionary extract
Exhibit 81	Lucy s medical records
Exhibit 82	CRD Residential Care pamphlet
Exhibit 83	CRD assessment of nutrition and food service
Exhibit 84	Disclosure binder

WITNESS LIST

WITNESS	TESTIFIED
Steven Eng, Chief Licensing Officer Capital Health Region	May 25, 1999
Kim Macdonald, Chief Residential Care Licensing Officer Capital Health Region	May 19, 1999 May 26, 1999 July 22, 1999
Dr. Gerry Stearns, Registered Psychologist Expert in Clinical Ethics (CV Ex. 26)	May 4, 1999 May 5, 1999
Heather Hestler Former Careworker	May 17, 1999
Rachel Ann Spence Former Careworker	May 17, 1999
Marty D Argis Former Careworker	May 17, 1999
Adrian Maisonneuve Former Careworker	May 18, 1999
Alex Garcia Former Careworker	May 18, 1999 July 5, 1999
Dr. C. Laird Birmingham Expert Witness in Eating Disorders Medical Director of St. Paul s Eating Disorders Clinic Program (CV Ex. 34)	May 20, 1999
Jennifer White Expert Witness, Director of Suicide Prevention Information Resource Centre, Dept. of Psychiatry at the University of British Columbia (CV Ex. 7, Tab 14)	May 5, 1999
Dr. Geoffrey Ainsworth Child Psychiatrist (CV Ex. 43)	July 24, 1999

Dr. Paul E. Termansen Psychiatrist Founder of SAFER Program (CV Ex. 38)	May 25, 1999
Dr. David Clinton-Baker	May 27, 1999
General Practice	July 5, 1999
Dr. Charles Medhurst General Practice	July 5, 1999
Dr. Mauro Bertoia General Practice	July 8, 1999
Dr. Susan Sherkow Child Psychiatrist (CV Ex. 64)	July 23, 1999
Kendra Dempsey Medical Liaison for Montreux	July 9, 1999
Julia Kruz Careworker	July 9, 1999
Treena Cook Careworker	July 14, 1999
Janice Lim Former Careworker	July 15, 1999
Jane McCluskey Family Liaison and Patient of the Montreux Program	July 14, 1999
Scott Melnyk Education Program Co-Ordinator	July 14, 1999
Nora Desjardins Careworker and Patient of the Montreux Program	July 15, 1999
Charlene Clark Environmental Programs for Montreux (part-time) Patient of the Montreux Program	May 31, 1999
Margaret Dobson	July 15, 1999
Montreux Associate Program Director	July 16, 1999

Noah Dobson Montreux Manager and Former Personnel Director	July 19, 1999 July 20, 1999 July 21, 1999 July 22, 1999
David Harris Co-Director of Private For-Profit Corporation holding the licence for Montreux and Former Manager	July 19, 1999
Robert Enoch Consultant to Montreux and preferred candidate for Manager	July 21, 1999
Peggy Claude-Pierre Co-Director for Private For-Profit Corporation holding the licence for Montreux and Program Director	July 21, 1999 July 22, 1999 July 23, 1999
Meg Bruce Parent of Montreux Patient	May 28, 1999
Dr. Dan Smith Parent of Montreux Patient	May 25, 1999
Dr. Ed Feller Parent of Montreux Patient	July 9, 1999
Irwin Carasso Parent of Montreux Patient	May 27, 1999
Garry Love Parent of Montreux Patient	May 28, 1999
Nancy Houssels Parent of Montreux Patient	May 28, 1999
Pat Demus Parent of Montreux Patient	May 31, 1999
John Broadbent Parent of Montreux Patient	May 31, 1999
Bill Clark Parent of Montreux Patient	May 31, 1999
Jan Cullis Parent of Montruex Patient	July 9, 1999

Brenda Loney Parent of Montreux Patient	July 9, 1999
Christina Pabst Parent of Montreux Patient	July 15, 1999
Diana van Maaseyk Patient of the Montreux	May 31, 1999
Sophie Feller Patient of the Montreux	May 31, 1999
Anya D llman Patient of the Montreux	July 14, 1999
Bronte Cullis Patient of the Montreux	July 21, 1999
Celeste Steindt Patient of the Montreux	July 19, 1999
Alexia Zographos Patient of the Montreux	July 14, 1999

TRANSCRIPT KEY

Transcript Number	Witness	Date of Testimony
1	Jennifer White	May 5, 1999
2	Heather Hestler (P4-78)	May 17, 1999
	Rachel Spence (P79-126)	May 17, 1999
	Marty D Argis (P127-145)	May 17, 1999
3	Marty D Argis (p2-37)	May 18, 1999
	Adrian Maisonneuve (p38-134)	May 18, 1999
	Alex Garcia (p135-209)	May 18, 1999
4	Dr. C. Laird Birmingham	May 20, 1999
5	Dr. Paul Termansen	May 25, 1999
6	Dr. David Clinton-Baker	May 27, 1999
7	Meg Bruce	May 28, 1999
8	Dr. David Clinton-Baker (p1-25)	July 5, 1999
	Dr. Charles Medhurst (p25-135)	July 5, 1999
9	Dr. Mauro Bertoia (p1-115)	July 8, 1999
	Julia Krux (p116-161)	July 8, 1999
10	Dr. Edward Feller	July 9, 1999
11	Kendra Dempsey (p1-40)	July 9, 1999
	Brenda Loney (p41-91)	July 9, 1999
12	Scott Melnyk	July 14, 1999
13	Jane McCluskey	July 14, 1999
14	Treena Cook	July 14, 1999
15	Janice Lim (p1-80)	July 15, 1999
	Margaret Dobson (82-163)	July 15, 1999
16	Margaret Dobson	July 16, 1999
17	David Harris (p1-164)	July 19, 1999
	Noah Dobson (p165-191)	July 19, 1999
18	Noah Dobson	July 20, 1999
19	Noah Dobson (p1-10)	July 21, 1999
	Robert Enoch (p11-75)	July 21, 1999
	Bronte Cullis (p76-95)	July 21, 1999
	Peggy Claude-Pierre (p96-212)	July 21, 1999
20	Peggy Claude-Pierre (p2-109)	July 22, 1999
	Noah Dobson (p111-115)	July 22, 1999
	Peggy Claude-Pierre (p116-191)	July 22, 1999
21	Dr. Susan Sherkow (p1-87)	July 23, 1999
	Peggy Claude-Pierre (p88-142)	July 23, 1999
	Kim Macdonald (p146-167)	July 23, 1999
22	Dr. Geoffrey Ainsworth	July 24, 1999