[redacted]

[redacted]

[redacted]

October 30, 2025

[redacted]

[redacted]

ATTN: [redacted]

Dear Counsel

RE: In the matter of the child Bennett James Thomas

Witnesses for the Presentation Hearing

I am following up on our previous correspondence regarding the issue of how many witnesses need to be called for the Presentation Hearing. We have received no response. Please be advised that I will be drafting an Application to seek direction from the Court on this matter, specifically for an order that pursuant to section 68(2)(a) of the *CFCSA* the medical reports written by the medical professionals involved in Bennett's life prior to the Director's removal can be treated as reliable evidence. It is our position that given the number of medical professionals involved in Bennett's life, and given the allegations that the Director is making against our client, admitting this evidence without the need to call them all as witnesses is necessary to ensure efficient use of court time. This is also in light of the fact that the Director was provided with most of these reports prior to removing Bennett from my client's care, and all of them were disclosed again through counsel. I will be setting this application to be heard on November 13, 2025 [redacted]

Disclosure Update

As a follow-up to our previous correspondence, I am inquiring on when I can anticipate receiving the Director's disclosure? I am aware that you intend to send them in batches, but I am seeking clarification on an exact date we will be receiving the first batch. Please be advised that if we do not receive most of the

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disclosure by November 13, 2025 I will include the Disclosure issue along with the application for direction from the court.

G-Tube Complications

My client informs me that she is concerned about the level of medical attention Bennett is actually receiving.

Bennett was scheduled to see his G.I specialist, [redacted], for ongoing management and assessment on Friday October 24, 2025. It is important to note that while Bennett continues to be followed by [redacted] as his gastroenterology (GI) specialist, [redacted] is not a G-Tube specialist. His role is focused on Bennett's overall gastrointestinal health and medication management, not the mechanical or site-specific care of the feeding tube.

A G-Tube specialist is required to evaluate the stoma site, address mechanical or tolerance issues, and update Bennett's feeding protocol in collaboration with a dietician as his medical and nutritional needs evolve. The contact between the Director and [redacted] (Bennett's G-Tube nurse) was explicitly recommended to ensure ongoing safety and proper management of Bennett's G-Tube, which was reinserted during his hospitalization on medical professional advice—a fact documented in the hospital discharge paperwork dated September 5, 2025. The lack of follow-up with the BCCH G-Tube nurse since that reinsertion raises concern about continuity of care and adherence to the discharge recommendations outlined by the medical team. The Director was provided the contact information for this G-Tube nurse on October 8, 2025. The delay in getting Bennett seen by this specialist is unreasonable and negligent, especially in light of the concerns brought up by my client. Those concerns (relating to Bennett's recurring granulation tissue issue) were raised during a meeting between my client, the child's RCY, and the Director on October 8, 2025. To date, the G-Tube nurse has still not been involved and no assessment by a qualified clinician has been done. While the Director did mention to my client recently that a photo of Bennett's G-Tube site was sent to [redacted] responded that she was unable to fully comment because she could not assess the back of the tube from the limited photos provided. [redacted] clearly indicated that she requires a full in-person evaluation or additional images to provide accurate clinical feedback, and yet that has not been done. The failure to involve a qualified clinician to assess site-related complications reflects a serious gap in understanding of Bennett's care requirements.

While Bennett has been reported to be eating well, it cannot be overlooked that Bennett was on a therapeutic dose of his anxiety medication when discharged from hospital, which increases appetite. He was on a gradual titration schedule throughout July and August, reaching his target dose around the time of

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[redacted]

apprehension or shortly thereafter. This is relevant to his increased appetite and eating behaviours, as one of the primary reasons for starting this medication was to address both his anxiety and his ongoing struggles with low appetite and weight gain—issues that have been consistent over the past year and a half to two years and which have been part of the medical disclosures provided to the Director but not reviewed prior to the removal.

The Director has shared that their goal is to remove Bennett's G-Tube. It must be emphasized that Bennett's need for a G-Tube is accurately reflected in medical reports and was not a decision made by my client. My client shares the goal for Bennett to be able to eat and get all of his calories without the use of a G-Tube. That said, if the G-Tube is removed prematurely and Bennett later requires it to be re-inserted, that would necessitate another surgery under general anesthesia. The decision to remove the G-Tube must be made cautiously and in consultation with specialists who are familiar with Bennet's complex medical and feeding history.

Given Bennett's extensive history of medication trials, noted by Dr[redacted] letter disclosed to the Director, many of the previous medications only provided temporary relief of his symptoms. It would, therefore, be unwise and clinically inappropriate to consider removing the G-Tube based solely on an increase in appetite that is likely the result of the intended benefits of his new medication. Bennett's past patterns have shown that these effects may be transient, as documented and disclosed through his medical records. Bennett's G-tube is an essential safeguard to ensure consistent nutrition, hydration, bowel regime and medication administration if his oral intake declines again. As mentioned, my client has always been hopeful the G-Tube can be removed, but that should not take place without at least 6 months of consistent appetite and undisrupted oral caloric intake.

Thank you for your attention to this matter.

[redacted]

[redacted]
Barrister & Solicitor