
CANADA / JUDGMENT

R. v. Baader

2019 BCSC 1228

COURT

Supreme Court of British Columbia

DECIDED

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2019 BCSC 1228 R. v. Baader

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation:

R. v. Baader,

2019 BCSC 1228

Date: 20190702

Docket: 37239-2

Registry: Port Alberni

Regina

v.

Warren Alfred Baader

Before: The Honourable Mr. Justice Baird

Oral Reasons for Judgment

Counsel for the Crown:

R. Picha

S. Bakken

Counsel for the Accused:

L. Helps

Place and Date of Trial:

Port Alberni, B.C.

April 1-5, 8-12 & 16, 2019

Place and Date of Judgment:

Port Alberni, B.C.

July 2, 2019

INTRODUCTION

- [1] The accused, Warren Baader, is charged with the manslaughter of his two-month-old daughter, Molly Baader, on October 28, 2016. The Crown alleges either that the accused assaulted Molly and thereby inflicted a blunt-force traumatic head injury that caused her death or, if the injury was accidental, that the accused failed in his duty to provide Molly with the necessities of life, first of all by failing to summon medical assistance immediately, and secondly by omitting to give emergency medical personnel an accurate history of what had happened to Molly, the combined effect being the postponement of vital acute care that was a significant contributory cause of her death.
- [2] The Crown called 19 witnesses, including Molly's mother, Kaitlin McMaster, her grandparents, ambulance attendants, medical doctors, and investigating police officers. The defence called two expert medical witnesses in reply. It turned out that the fundamentals of the prosecution were not much disputed. The accused admitted that he caused Molly's fatal injuries and that these were the result of a severe blunt-force traumatic head injury manifested by a skull fracture, subdural and subarachnoid hemorrhages, cerebral edema, and bilateral retinal hemorrhages. The accused does not question the secondary pathology of post-traumatic cardiac arrest and related hypoxic ischemic encephalopathy.
- [3] Instead, the principal focus of this inquiry was the existence or not of an actus reus. The Crown submits that Molly's injuries were so numerous, profound, and severe that they had to be intentionally inflicted, while the accused has presented what he submits is a reasonable and plausible accidental explanation for what happened to Molly. The accused did not testify. His version of events came into the record by means of a warned police statement given on October 30, 2016. In that statement, he claimed to have accidentally dropped Molly from chest height with the result that she landed forcefully head first on a hardwood floor. The defence expert medical witnesses testified that this version of events could account for all of Molly's injuries.

BACKGROUND

- [4] Molly Baader was born on September 2, 2016, and died on November 3, 2016. She was conceived when neither of her parents had yet reached the age of 20. The accused and Ms. McMaster had not been living together long. In the words of Molly's grandfather, the two of them had a lot of growing up to do. Their relationship had been fractious and difficult. Molly was the first child for both of them. Her birth was not planned.

- [5] During Molly's short life, she enjoyed good health. She had no history of significant illness or pre-existing injury. Before the incident that caused her death, however it might have occurred, Molly was well loved and cared for by both of her parents. There was no evidence here, as there often is in the depressingly voluminous body of infant homicide cases in Canada and elsewhere, of a history or pattern of abusive conduct toward Molly. I find as a fact that whatever happened to Molly Baader on October 28, 2016, was entirely unheralded; it had no precursor.
- [6] I was shown a video taken of Molly by her mother, Kaitlin McMaster, in the mid-morning of October 28, 2016, only a number of hours before she sustained the fatal injuries that I have described. In the footage, Molly looks healthy, alert, active, and expressive. She is immaculately groomed and outfitted. Only Ms. McMaster was present at the time of filming. The accused, she told me, was out of the house participating in relationship counselling. Both parents were working toward a more successful and harmonious relationship. They had recently decided to resume living together after a separation.
- [7] Ms. McMaster told me that when the accused returned home from his counselling session, he appeared to be happy, calm, and positive. His session with his therapist had been productive. He was pleased with his progress. In the late afternoon of the same day, the accused took Molly for an outing in her stroller. It was the first time he had done this by himself. He introduced the baby to some close friends who lived nearby. One of the friends, Dillon Chenier, testified that the accused was "in a great mood" and was obviously very proud to be showing off his daughter.
- [8] After the accused left, Ms. McMaster telephoned Mr. Chenier. Mr. Chenier testified that she was angry with the accused and wanted to speak with him. He told her that the accused was on his way home and would be there shortly. Ms. McMaster testified that she remembered speaking with Mr. Chenier but denied being angry. She maintained that there was no discord between her and the accused at any time during Molly's last day of good health.
- [9] Ms. McMaster planned to dye and wash her hair while the accused and Molly were out. She thought that she would have plenty of time to do this, but the accused and the baby came back earlier than expected. The accused knocked on the bathroom door and told Ms. McMaster that he and Molly had returned. Ms. McMaster testified that there was no indication of anything wrong. The accused seemed happy and composed. The baby was fussing and making the sort of hungry noises with which Ms. McMaster was well familiar. The accused said that he would feed the baby a bottle and closed the bathroom door. Ms. McMaster carried on dyeing her hair.
- [10] A short time later, the accused once again knocked on the bathroom door. He said that the baby was still fussing and asked Ms. McMaster how long she would be. She told him that she would be done shortly. The accused remained calm, she said. She had no inkling that anything was amiss. The accused showed no hint of exasperation, upset, or ill temper. He said, "Don't worry, take your time, Daddy's got it. I can't wait to see your hair." There was no

evidence, I should specify, to indicate that the accused had been using or was impaired by alcohol or narcotics.

- [11] Ms. McMaster put the finishing touches on her dye job and had a shower. I think it reasonable on the evidence to suppose that she was in the bathroom for a further 20 minutes or so. She emerged wearing a towel or dressing gown and went to one of the apartment's bedrooms where there was an electrical outlet for her hair dryer. The baby was not crying or making other noises that she heard. She passed by the accused, who was sitting on a mattress in the living room with his back towards her. She saw the baby's legs next to him. There was a diaper to one side. Ms. McMaster assumed, probably correctly, that the accused was in the midst of changing Molly. Once again, from Ms. McMaster's perspective, everything seemed normal and under control.
- [12] Ms. McMaster testified that she was about 15 to 20 minutes drying her hair. She was hurrying, she said, because she wanted to help with Molly. Her hair was still wet when she entered the living room. She experienced a "weird feeling" immediately. The accused had the baby in his arms and was walking about the room with her. Ms. McMaster asked if everything was all right and the accused said, "I'm not sure." She saw that the baby was pale, lifeless, and had stopped breathing. She knew instinctively that something was drastically wrong and called 9-1-1 immediately.
- [13] The ambulance dispatch went out at 7:24 p.m. and paramedics were on scene within two minutes. They noted that Molly was waxy and pale. She did not respond to verbal or physical stimuli. She was not breathing and had no pulse. There were no visible external injuries to her. Molly's airway was intubated and a breathing bag was applied. Within minutes she was transported to the nearby local hospital. Both parents appeared to be distraught and panic-stricken. The accused told the paramedics that he had no idea what was wrong with Molly. He said nothing about an accidental fall.
- [14] Over the next couple of days, the accused repeatedly told anyone who asked him that he had no explanation for what happened to Molly. He claimed that he fed her a bottle and put her in her bassinet before playing a video game. He insisted that the baby was fine when he put her down. When he went to look at her sometime later, he said, she was not moving and did not look right. It seems that he became defensive and angry when he sensed that anyone suspected him of harming Molly. Once the baby had been medically evacuated to the B.C. Children's Hospital in Vancouver, however, he told Ms. McMaster over the phone that "Whatever happened, you're going to leave me for it."

THE ACCUSED'S NARRATIVE OF EVIDENCE

- [15] The accused's account of what happened to Molly, which changed as time went by, came to me in the form of statements that he made to other people including paramedics, family members, attending clinicians, and police officers, culminating in the police interview to which I have referred taken on October 30, 2016. Both Crown and defence relied on these statements in arguing their respective cases.
- [16] I repeat that in the early going the accused said that he had no explanation for what happened to Molly. This started with the paramedics at the apartment and continued in his first discussion with Constable Black of the Port Alberni RCMP. But after Molly was hospitalised and the medical specialists realised that she appeared to have sustained a blunt-force traumatic head injury, the search for other explanations began. In the absence of any plausible explanation from either parent, non-accidental causes came to be suspected. The accused became the focus of the inquiry, and the questions came not only from doctors and police officers. The baby's grandfather, David Hunt, also suspected that the accused was hiding something.
- [17] Mr. Hunt testified that as the medical updates came in, it was clear to him that things did not add up. Molly was obviously very badly injured in her own home with only her parents present, and yet neither of them had given a history that could conceivably account for her critical condition. In his mind, it was possible that Ms. McMaster might be implicated as well. He was not suspicious only of the accused. On October 30, 2016, while waiting in the intensive care unit of the Children's Hospital with other family members, Mr. Hunt decided to take the accused to task.
- [18] As it happened, just as Mr. Hunt resolved to engage the accused in a frank discussion, the accused burst into the waiting room, swearing and angry. He said that the medical staff had just accused him of harming his daughter. He appeared to take great exception to this. Mr. Hunt followed up immediately. He said that the doctors were not the only ones to harbour suspicions. He told the accused that something terrible must have happened to Molly, but the truth about it had yet to come out. He told the accused, "If you did something, you've got to own it." Eventually, by degrees that were not particularly well defined in Mr. Hunt's testimony, the accused admitted that there had been a mishap on the front steps of his apartment building when he returned from showing Molly to his friends on the night of the incident.
- [19] The accused described how he lost his grip on the baby's stroller as he lifted it up the front stairs into the building. He explained that the stroller tipped to one side and the baby's head fell backwards. He quickly righted the stroller and there was nothing more to it. The baby did not fall out or hit her head. He denied striking or shaking the baby. He made no reference to an accidental fall within the apartment, although, in fairness, it may be that he was interrupted before he got to it. This is because, while the accused and Mr. Hunt were in the very midst of this conversation, the police arrived and arrested the accused for

aggravated assault.

- [20] I do not know if the accused had finished his explanation to Mr. Hunt. It is possible to suppose that he might have been poised to relate the history of an accidental fall inside the apartment, but was interrupted by the arrival of the police and his swift arrest and detention. Later the same day, he told the police during his interview that he had given Mr. Hunt the whole story, including the narrative of an accidental fall, but I accept Mr. Hunt's evidence that there was no mention of this. The Crown submits that the accused was lying to Mr. Hunt, hoping to mislead him into thinking that the only untoward thing that had happened with Molly was this innocuous incident on the front steps.
- [21] The accused was taken away to the Richmond RCMP detachment where he was questioned by Corporal Lounsbury in an interview lasting, with various interruptions, approximately two hours. Corporal Lounsbury explained that she was investigating what had happened to Molly and made it clear from the outset that she did not believe the baby had been harmed in a "natural way". The accused was extremely emotional from the outset of the interview. There were times when he was sobbing so convulsively that he could not speak intelligibly. Early on, he said that what happened to Molly was an accident. He said that he had not admitted to it because he was scared of losing his relationship with Ms. McMaster, he did not want everyone to hate him, and he did not want to go to prison. He said that he had nothing to hide and was relieved finally to be telling the truth.
- [22] The accused began by repeating what he had been telling David Hunt at the hospital, namely that there had been a tipping of the stroller on the front steps of the apartment building. This time he explained that when he lost his grip, Molly was jostled in the stroller and he thought she was hurt because she started crying. When he took her inside the building, however, Molly calmed down and seemed to be fine. In my view, it is reasonably clear that he was not attempting to pass off this occurrence as playing any role in causing Molly's injuries. He carried on without any prompting to explain what had happened once he and Molly were inside the apartment.
- [23] First of all, the accused confirmed that he spoke with Ms. McMaster, who was in the bathroom dyeing her hair. He said it was precisely 6:32 p.m. when he got home. He remembered looking at the clock. Molly was hungry so he prepared a bottle for her. He put her down on the bed in the living room and turned on the kettle. Somewhere in the midst of this, he returned to the bathroom and asked Ms. McMaster how much longer she was going to be. He returned to the bed and changed Molly's diaper. He said that Ms. McMaster saw him doing this as she walked from the bathroom to the bedroom to dry her hair.

- [24] The accused mixed the baby formula in the bottle. He picked up Molly, who was fussing and crying. He was standing upright. He had the bottle in one hand and was cradling Molly in his other arm. He attempted to transfer the baby from one arm to the other. He lost his grip. Molly's head bobbed backwards and "she was falling". On my interpretation of what the accused was attempting to relate, he instinctively thrust out his right hand, which struck Molly's head as she went down. Then she landed heavily head first onto the hardwood floor.
- [25] This then was the defence. The accused did not assault Molly, but dropped her accidentally from about chest height. The injuries were caused by the severe impact of her head on the hardwood floor. The accused seemed to suggest that he may inadvertently have contributed to her injuries when he struck her head with his hand as she fell. His various retellings of the incident were not always clear. The interview was rather chaotic and sometimes difficult to follow. I thought it possible at first, for example, that the accused was saying that when he lost his grip on Molly, he had stopped her from falling entirely, or at least had partially broken her fall, by reaching out with his hand. On the whole of his statement, however, I am persuaded that what he intended to say was this: that he dropped Molly when he attempted to exchange her from one arm to the other; that he reacted quickly with his right hand and struck her head as she fell; that he was not able to catch her as she dropped; and that she landed forcefully on the back of her head on the hardwood floor.
- [26] The accused said that he scooped Molly up immediately. He could tell that she was in pain and was not breathing. He did not immediately raise the alarm or call an ambulance. He was frightened. He put Molly in her bassinet and turned on some music, then picked her up and cradled her. Ms. McMaster came into the room, took one look at Molly, and immediately called 9-1-1. The accused repeated that he did not tell anyone the truth about what had happened. He thought Ms. McMaster would leave him if she knew that he had hurt Molly, and he was worried that he might be sent to jail for it, even though it was an accident. He insisted that he would never intentionally hurt a child and that he had never in his life become frustrated by a crying baby.
- [27] Corporal Lounsbury pressed the accused on his story. She told him that Molly's injuries were so severe that they could not be explained by the mechanism he described. The accused repeated his history of an accident in similar terms in response to Corporal Lounsbury's pointed suggestions that he must be leaving things out. He said that there was nothing else to tell her. Corporal Lounsbury suggested that he and Ms. McMaster must have argued and that this had left him angry and insulted. He denied this repeatedly. He said that he and Ms. McMaster had been getting along well that day. There had been no unpleasantness between them.
- [28] Eventually a second police officer, Sergeant Seabrook, entered the interview room. This had clearly been prearranged. Sergeant Seabrook had a laptop computer on which he played a video for the accused on "shaken baby syndrome". When it was done, Sergeant Seabrook suggested that the accused must have shaken Molly because, he suggested, her injuries were consistent with such a mechanism and they were inconsistent with having been caused by a

short fall. The accused denied this, saying quite simply, "I dropped her and then I picked her up and cradled her again."

- [29] Later, the accused admitted that he shook Molly after she fell, but only "to see if she would wake up." Sergeant Seabrook told the accused that it had to have been much more forceful shaking than that. He said that it was a "medical fact" that Molly's injuries could not have been the result of a short fall. They had to have been the result of an acceleration/deceleration mechanism caused by violent shaking. In the end, the accused showed the police officers what he had done. I would describe it as a minor jostling of the baby while she was on his lap. He said, "It was like, you know, like really quick, you know, and I was like what am I doing? I just fucking shook her, it's the worse thing I could fucking do."
- [30] The accused went on to confirm that he put Molly in her bassinet and turned on some music for her. At that point, Molly appeared to be having seizures. Approximately seven minutes elapsed. Molly by then was pale and lifeless. He picked her up again, and then he said he called out to Ms. McMaster, telling her to call 9-1-1. By this point in the interview, the accused was sobbing uncontrollably and said repeatedly, "I am going to prison." At the end of the interview, he was left lying on the floor wailing in despair.

MEDICAL EVIDENCE

A. Prosecution Witnesses

Dr. Rhiannon Hughes

- [31] Dr. Rhiannon Hughes attended to Molly at the Port Alberni Hospital. She was called from her home at 7:30 p.m. Dr. Hughes is a pediatrician with specialised training in neonatal resuscitation. She arrived at work and assembled her team. Everything was moving quickly. Molly was brought in on a stretcher. The ambulance crew were performing CPR on her and "breathing for her" with the ventilation bag.
- [32] Dr. Hughes noted that Molly had no pulse. There was electric activity going on in her heart, but it was not pumping or circulating blood. The chest compressions and ventilation continued and Molly was administered a dose of epinephrine to start her heart. Dr. Hughes said that on presentation Molly was pale, bluish, and looked dead. She diagnosed a baby in full cardiac arrest. She testified that a lack of oxygen is usually what brings this on and that oxygen deprivation is usually attributable to another illness or trauma.
- [33] Dr. Hughes succeeded in resuscitating Molly within about 10 minutes. She was still not breathing, however, and in fact she never breathed on her own again. In short order, her heart rate returned to normal and her skin "pinked up". External CPR was stopped by this time, but the evidence suggested that Molly had been in cardiac arrest for a half an hour or more. The protocol followed was straightforward and successful, Dr. Hughes said, and the only unusual thing about it in the circumstances was that it worked. Ordinarily, she said, a baby does not come back from cardiac arrest of that length.

- [34] After things had settled down, Dr. Hughes talked to the accused. He said that he had been looking after Molly and that she had been fussy but not sick. He gave her a bottle and went to use his computer. After a while, he noticed that the baby was pale and unresponsive. He said he called 9-1-1 and asked for an ambulance. Dr. Hughes said that the accused was highly emotional and that it was difficult to get details from him. On the basis of what he reported, she thought perhaps the baby had aspirated milk or had an infection. She tested for both of these things and found nothing. The accused never said anything about an accidental fall or a head injury.
- [35] The baby's hemoglobin levels were very low, while her mean cell volume remained normal, indicating that there had been a significant loss of blood. As there was no sign of external injury or bleeding, Dr. Hughes inferred that the blood loss must be internal. She recorded that the baby's fontanelle looked normal. After about an hour, her heart rate started dropping again as the epinephrine wore off. This indicated that Molly's heart was still not functioning properly and epinephrine was administered again.
- [36] It was obvious from the very beginning that Molly needed a higher level of care than could be made available on site, and she was transported by helicopter to the B.C. Children's Hospital. The baby remained in critical condition and was on life support throughout. In cross-examination, Dr. Hughes said that nothing more could have been done for Molly in Port Alberni. She would have looked for a head injury if she had received information that Molly had sustained one, but she could not have treated such an injury given the limitations of a small regional hospital.

Dr. Arthur Cogswell

- [37] Dr. Arthur Cogswell is a staff physician in the intensive care unit at B.C. Children's Hospital. Molly was admitted into his care just after midnight on October 29, 2016. She remained there until her death several days later. Dr. Cogswell reported that the hospital chart's admission diagnosis was "unexplained cardiorespiratory arrest", but the discharge diagnosis was "non-accidental injury resulting in brain trauma complicated by secondary hypoxic ischemic encephalopathy".
- [38] Dr. Cogswell's initial examination of Molly indicated a stable cardio-respiratory state. There had been an epinephrine infusion and she was being ventilated by an endotracheal tube. She showed no motor responses. Her pupils were small and non-light responsive. The anterior fontanelle was full but not unduly tense. There were no external signs of trauma. Eventually, however, a CT scan revealed a left parietal skull fracture, subdural and subarachnoid hemorrhaging, a possible cerebral laceration, and cerebral edema. Dr. Cogswell referred Molly for an ophthalmological examination by Dr. Jane Gardiner which confirmed extensive bilateral retinal hemorrhages.

- [39] Especially in the absence of any contrary historical information, Dr. Cogswell diagnosed a severe non-accidental traumatic brain injury as the cause of Molly's death. He testified that Molly's head injury led sequentially to lost consciousness, diminished respiratory capacity, and cardiac arrest. Due to the delay in resuscitation, Molly sustained further substantial brain injury in the form of hypoxic ischemic encephalopathy due to the lack of circulation and oxygen delivery to the brain. It was the combination of the traumatic brain injury and the secondary hypoxic ischemic brain injury that led to Molly's death.
- [40] The following hypothetical situation was put to Dr. Cogswell in cross-examination and he was asked if injuries akin to Molly's could result from it. A five-foot-11-inch man cradles a baby at torso height. The baby falls, impacting the left side of her head, with a resultant skull fracture. The baby has a seizure, goes into cardiac arrest, and is taken to the hospital where she is resuscitated. Intracranial pressure builds and by the following day there are retinal hemorrhages, more prominent in the eye that is on the side of the injury.
- [41] Dr. Cogswell's answer was that it was plausible to suppose that a skull fracture might occur in such a situation, but otherwise he thought that the hypothetical facts and their posited results exceeded the bounds of credibility. He said that most short falls are not associated with significant intracranial injury, seizure, and cardiac arrest, and the retinal hemorrhaging that would result from raised intracranial pressure alone would not be as severe as that reported by Dr. Gardiner in Molly's case.

Dr. Jane Gardiner

- [42] Dr. Jane Gardiner is a pediatric ophthalmologist. She examined Molly on October 30, 2016, between 2:15 and 3:00 p.m., less than 24 hours after she was injured. Dr. Gardiner's report began with a brief history of Molly's case, including her understanding that a CT scan had revealed subarachnoid hemorrhage, subdural hemorrhage, areas of ischemia, and a skull fracture. She proceeded to examine Molly's eyes for signs of trauma.
- [43] She reported that it was not possible to assess Molly's visual acuity. The pupils were reactive but sluggish. There was no sign of external injury. Multiple retinal hemorrhages were seen in all four quadrants, extending from the posterior pole to the far retinal periphery. On the left side there were also pre-retinal hemorrhages above and below the macula, as well as inferior to the optic nerve. The hemorrhages were more confluent on the left side, where the blood vessels and optic nerve were barely visible because of the volume of hemorrhagic blood. There were too many hemorrhages to count, more in the left eye than the right.
- [44] Dr. Gardiner testified that ocular injuries of this magnitude are only seen in cases of severe trauma, such as high-impact motor vehicle accidents or falls from a significant height. She firmly rejected the suggestion that the retinal hemorrhages observed could have been caused by elevated intracranial pressure. In her career, she has examined any number of children with raised intracranial pressure and she said that the condition hardly ever causes retinal hemorrhaging. She did not accept that such injuries could be caused by dropping a

child onto a hardwood floor. She said that retinal hemorrhages are rarely seen except in cases involving far greater trauma than would be produced in this way.

Dr. Margaret Colbourne

[45] Dr. Margaret Colbourne is the former head of the Child Protection Service Unit at B.C. Children's Hospital, a position she still occupied when Molly arrived at the facility. She has been a physician for over 30 years and is a specialist in pediatric emergency medicine. Dr. Cogswell referred Molly to Dr. Colbourne on October 29, 2016 because of his concerns that the baby's critical presentation was due to physical abuse. Dr. Colbourne has many years of experience in child maltreatment pediatrics and abusive head trauma cases.

[46] Dr. Colbourne met with both of Molly's parents and took a history as follows:

According to the parents, Molly was entirely well until the evening of October 28. Apparently, the father had taken Molly to his "grandmother's" house at approximately five o'clock in the evening, but stayed only about 15 minutes prior to returning home. The baby was apparently well at that time. Upon returning home, Warren felt Molly was unusually "fussy" and at approximately 5:45 p.m., he attempted to feed her. She apparently only took 1 or 2 ounces and subsequently vomited some curdy formula. He stated he tried to settle her down by walking with her around the house and then put her down on her side in the bassinet to sleep. According to the mother, she recalls that she was in the bathroom dyeing her hair, but poked her head out at one point in time and noticed Warren changing Molly's diaper on the change table. She [Molly] seemed to be kicking her legs quite normally. The mother subsequently entered the shower and Warren began playing video games. According to the father, he checked Molly at approximately 6:50 or 7:00 p.m. and noticed that she was extremely pale. He states he picked her up and she seemed limp and lifeless, "like a rag doll". He called the mother who came out from the bathroom and noticed Molly's condition immediately. She called 911. According to the father, he did a few mouth to mouth breaths and a few chest compressions as he had some first aid training.

[47] Dr. Colbourne performed a physical examination of Molly. She noted that the baby's anterior fontanelle was full with splayed sutures, suggesting pressure inside the skull. The ears, nose, and mouth were normal. The chest and cardiovascular examinations were normal. The abdomen was soft and not distended. There were no obvious areas of soft tissue bruising or swelling to the trunk or the extremities. She found no evidence of obvious bruising, swelling, or trauma. Molly was obviously very ill, but the external examination revealed nothing in particular to indicate an underlying intracranial injury.

[48] The CT scan of Molly's head was performed during the morning of October 29, 2016. Dr. Colbourne reviewed the results with the consulting radiologist, a Dr. Sargent. The scan revealed a left parietal skull fracture, extensive bilateral subdural and subarachnoid hemorrhage, a possible left cerebral laceration, and diffuse cerebral edema. Dr. Colbourne also received the results of Dr. Gardiner's ophthalmological examination performed the same day with its findings of extensive bilateral retinal hemorrhages. There was, of course,

nothing at all in the history taken from the parents that could account for these very serious and extensive injuries.

[49] As a result, Dr. Colbourne reported as follows. Under the heading "Impression", she wrote:

This young 2 month old baby presented to hospital after being previously entirely well in a full cardiac arrest. She is found to have severe cranial injuries including:

- 1) Parietal skull fracture;
- 2) Extensive bilateral subdural and subarachnoid hemorrhage;
- 3) Diffuse cerebral edema with possible cerebral laceration;
- 4) Extensive bilateral retinal hemorrhages.

There is no history of trauma provided to explain these injuries. The presence of the parietal skull fracture suggests blunt force head trauma and the presence of the diffuse bilateral subdural hemorrhage with the "too numerous to count" bilateral retinal hemorrhages suggest an acceleration-deceleration injury such as violent shaking.

[50] In a follow-up report dated November 10, 2016, Dr. Colbourne noted that Molly's condition had continued to deteriorate until the decision was taken to remove her from life support. "As stated in my previous report", Dr. Colbourne wrote, "no history of trauma had been provided to explain these injuries. Thus, it is my opinion that this young baby sustained severe inflicted head trauma and has unfortunately died as a result."

[51] Dr. Colbourne specified in testimony that Molly had no injuries other than those documented in her report, and in particular that there were no bone fractures other than the one detected in the left parietal area of Molly's skull. She said that skull fractures of this sort sometimes result from short falls such as the accused later described to the police, and these generally heal well and have no long-term implications. Short falls - which Dr. Colbourne defined as five feet or less - are not typically associated with the sort of severe intracranial injuries that Molly suffered.

[52] According to Dr. Colbourne, in fact, accidental trauma resulting in such severe and profound damage as observed in Molly is extremely uncommon. In particular, she would not expect to see the extensive retinal hemorrhages observed by Dr. Gardiner to result from a short fall, nor did she think that these would be caused by increased intracranial pressure alone. She said that it was possible, but extremely unlikely, that an accident of the nature described by the accused in his police statement could explain all of Molly's injuries. Such injuries are usually seen in cases of far greater dynamic force. When asked if an infant could die from a short fall, however, she answered "I can't say never. It does happen, but very, very, very rarely," and in cross-examination, she confirmed that while the constellation of Molly's injuries was unlikely to have been caused by such a mechanism, it was possible.

Dr. Lisa Steele

- [53] Dr. Lisa Steele is an anatomical and clinical pathologist with a speciality in neuropathy and forensic pathology. She performed Molly's autopsy on November 7, 2016, several days post mortem.
- [54] Dr. Steele noted a patterned abrasion at the back of Molly's scalp consisting of two parallel lines. This abrasion corresponded, she said, to a small linear fracture of the underlying right occipital bone of the skull. Dr. Steele testified that she was aware that previous clinicians had detected a skull fracture to the left parietal bone, but she found none. She testified that the linear runnel plainly visible in the left parietal radiological imaging was likely a vascular channel, not a fracture.
- [55] Dr. Steele noted that the underlying injuries to the brain were profound. These included significant subdural hemorrhages involving both left and right convexities and the base of the brain, and extensive subarachnoid hemorrhage, especially in the left parietal occipital lobes, but also over the temporal lobes and the cerebellum. The brain itself was diffusely and markedly swollen and edematous. This led to increased intracranial pressure and lack of oxygenation. While there appeared to be herniation of multiple structures of the brain, these were difficult to evaluate due to deterioration brought on by secondary hypoxic ischemic brain injury. She was not able to confirm the possibility of cerebral laceration. Microscopic evaluation of Molly's eyes showed bilateral retinal and optic nerve hemorrhages, with the left eye more severely affected than the right.
- [56] In Dr. Steele's opinion, furthermore, Molly's craniocervical ligaments were disrupted. Her reference to this finding in her autopsy report was cryptic and unspecific. She explained it in greater detail from the witness box with reference to a number of autopsy photographs in which she pointed out the abnormal appearance of the craniocervical ligaments at the foramen magnum. She confirmed in cross-examination that she did not remove or examine the upper cervical spinal column or the spinal cord to further explore or confirm this finding.
- [57] Dr. Steele concluded that the cause of Molly's death was blunt force head trauma manifested by a right occipital skull fracture, bilateral acute subdural and subarachnoid hemorrhage, severe cerebral edema with herniation, features of profound global anoxic-ischemic encephalopathy with infarction, optic nerve and retinal hemorrhage, and craniocervical disassociation. She had never seen injuries of this severity at autopsy after a reported short fall, but said that such a thing could not be ruled out. She agreed that the pathology was consistent with a single impact trauma.

B. Defence Witnesses

Dr. Christopher Dunham

- [58] Dr. Christopher Dunham is a neuropathologist. He was retained by the defence to perform a review of Molly's case. He did this based primarily on the photos and microscopic slides taken at autopsy.
- [59] Dr. Dunham confirmed the opinion of Molly's treating clinicians that the primary cause of her death was blunt-force head trauma. This was indicated by a left parietal skull fracture, as well as microscopy that suggested an underlying contusion and laceration to the left parietal occipital lobes. These injuries caused bilateral subarachnoid and subdural hemorrhage. A secondary cause of death was hypoxic ischemic injury consistent with a lack of oxygenated blood supply to the brain, likely related to cardiac arrest immediately following the absorption of blunt head trauma. His evaluation confirmed Dr. Steele's opinion concerning a single episode of injury.
- [60] Dr. Dunham agreed that Molly's injuries were very severe in nature, but he concluded that they could all be explained by an accidental short fall such as the accused described in his police statement. He seemed to disagree that this would be a rare or an extraordinary thing, saying instead that such a mechanism could easily and completely explain the left parietal skull fracture, the underlying subdural and subarachnoid hemorrhages, and the rapid deceleration of pulse and cardiac arrest, and the secondary complications related thereto.
- [61] Dr. Dunham testified furthermore that the retinal hemorrhages could just as easily be explained by accidental as intentionally inflicted blunt-force trauma, especially when combined with increased intracranial pressure due to secondary cerebral swelling and edema. He made reference to peer-reviewed literature suggesting that retinal hemorrhages such as exhibited in Molly's case can result from accidental as well as abusive blunt-force head trauma. While it is true that retinal hemorrhages are a regular feature of abusive head trauma, he said, they have other causes including severe accidental head injuries.
- [62] Referring to Dr. Steele's autopsy report, Dr. Dunham noted that Molly's ante mortem clinicians, including a radiologist, had not detected the right occipital fracture identified by Dr. Steele at autopsy. He suggested that Dr. Steele must have missed the left parietal skull fracture, which his examination of the materials suggested was the only one present. He said that the pathology did not support Dr. Steele's finding of a right occipital fracture, and he suggested that what she identified as this fracture was in fact a "artefact" created during the autopsy.
- [63] Dr. Dunham also rejected Dr. Steele's findings about craniocervical disassociation. Neither gross nor microscopic details of this diagnosis were included in Dr. Steele's report, and his review of the autopsy photographs failed to support this pathology. He testified that if Dr. Steele had suspected an abnormality of this sort, she should have removed and dissected the cervical spine. In the absence of this, Dr. Dunham testified that any discussion of craniocervical injury was purely speculative and could not be safely included in a theory of non-accidental harm.

- [64] Dr. Dunham emphasised, as well, that Dr. Steele's cause of death opinion was blunt force head trauma without reference to a shaking mechanism of which craniocervical injury is considered to be highly indicative. Dr. Steele considered that while such a mechanism was possible in Molly's case, it was not "necessary" to her opinion about the cause of death. The autopsy did not confirm a shaking theory, in other words, but rather supported the view that Molly's injuries and her death were caused by a single-impact blow to the head, which could just as plausibly have been accidentally sustained as intentionally inflicted.
- [65] Dr. Dunham insisted repeatedly that all of Molly's injuries could be explained by an accidental short fall injury. In his opinion, such a mechanism could comfortably and completely account for the rapid deceleration of pulse leading to cardiac arrest and the resulting hypoxic ischemic injury. It explained the left parietal skull fracture and the underlying hemorrhaging. The retinal hemorrhages might well have been caused by the combination of the primary trauma and secondary intracranial pressure related to the cerebral swelling and edema.

Dr. Matthew Orde

- [66] Dr. Matthew Orde is the senior pathologist at the Vancouver General Hospital. He oversees delivery of all forensic pathology and autopsy services at that facility. He has performed and supervised thousands of autopsies.
- [67] Dr. Orde described in some detail the proper steps to take before an autopsy. First, of course, is to ensure that the procedure is legally authorised. Then comes the process of information gathering: researching all available medical charts and records, discussing the case with the coroner and the police if foul play is suspected, and in a complex case, such as Molly's, to consult with and consider the etiological views of previous clinicians. This would include a radiological consult if imaging had been completed. In an appropriate case, moreover, he would undertake his own X-ray examination of the deceased.
- [68] Dr. Orde was quite critical of Dr. Steele's procedure and methodology in performing the autopsy in the present case. He noted her failure to do a proper history. Dr. Steele herself testified that such a history would be optimal, but she said that it is not always done. I found it somewhat surprising, I have to say, that Dr. Steele should have undertaken an autopsy in a case of suspicious infant death with only the coroner's Form B summary of information to guide her. I agree with Dr. Orde that additional preparatory research and workup should likely have been done.
- [69] For example, a consultation with the radiologist, Dr. Sargent, might have been instructive on the question of the existence or not of a left parietal fracture. Dr. Orde is not a radiologist, but as I have said he is the veteran of thousands of autopsies, and these, according to his manner of conducting them, are interactive and multidisciplinary exercises. In his role as a pathologist he routinely reviews medical imaging with radiologists. While his expertise in interpreting such imaging does not rival a radiologist's, nevertheless he has a great deal of

practical experience in this area.

- [70] Dr. Colbourne, I should add, also has this extensive working experience with medical imaging and she agreed with Dr. Sargent's opinion that there was a left parietal fracture. Dr. Orde observed strong evidence of this, with the additional observation of proximal overlying swelling indicating the left parietal as the site of injury. His interpretation of the radiological imaging was confirmed by Dr. Julie Mack, a radiologist from the United States whose evidence went into the trial record by admission.
- [71] I should emphasise that the summary information Dr. Steele received from the coroner did not include a left parietal fracture. It referred only to a skull fracture, and Dr. Steele's autopsy report does not refer to her receipt of this information from anterior clinicians or indicate that she specifically looked for a left parietal fracture. She stood alone amongst the clinicians involved in the case in identifying, instead, a right occipital fracture, and Dr. Orde agreed with Dr. Dunham in supposing that this was an "artefact" produced during the autopsy itself.
- [72] Reference was also made to Dr. Steele's admitted misidentification of the fracture site in sworn testimony given at the preliminary inquiry in this case. Dr. Orde suggested, furthermore, that the linear pattern abrasions identified by Dr. Steele in the scalp over the right occipital were in fact lividity marks, a possibility which Dr. Steele did not vigorously dispute. In any event, Dr. Orde saw no evidence of injury to the undersurface of the skull at the location of these marks. This was in line with Dr. Dunham's conclusion that, if these marks were assumed to be abrasions, that they were not proximal to the right occipital injury identified by Dr. Steele.
- [73] Dr. Orde also criticised Dr. Steele's theory of craniocervical ligamentous disruption, which he testified in reasonably strong language should not be advanced in the absence of specific investigatory work that Dr. Steele left undone. The best practice in cases of suspected craniocervical injury would be to remove the base of the skull, with the top end of the spinal column attached to it, and to X-ray and CT scan that specimen separately. Craniocervical ligamentous injury, Dr. Orde testified, can only be identified positively by taking these steps, and without them such a finding would be speculative and possibly incorrect.
- [74] Dr. Orde examined the same photographs to which Dr. Steele had earlier referred in her testimony, pointing out what she maintained was an absence of posterior craniocervical ligaments at the foramen magnum. But Dr. Orde testified that he could see nothing anatomically abnormal in these photographs. He said that the foramen magnum had a typical appearance after the dura is stripped away from it. He saw nothing in the photos to indicate ligamentous injury or any other abnormality. Everything seemed to be in its right place. There was nothing to suggest disruption, slippage, or displacement of any of the anatomical structures at this site, nor was there any discernible evidence of bleeding or swelling. In short, there was no positive evidence whatsoever to suggest any injury to this part of Molly's anatomy, which appeared to Dr. Orde, to the contrary, to be intact and

entirely normal.

- [75] On Dr. Orde's review of the case, there was no positive pathological evidence to support the theory, advanced by ante mortem clinicians in the absence of any other plausible explanation for Molly's critical presentation at hospital, that part of the mechanism of injury was violent shaking. Shaking may have been involved, he said, but there was nothing positive in the evidence to confirm it as a factor. Instead, he said, the evidence strongly suggested a severe blunt traumatic head injury as the cause of death, with the only remaining question being whether an accidental cause was possible or whether, to the contrary, the injury had to have been intentionally inflicted.
- [76] In Dr. Orde's opinion, a short fall onto a hard surface such as described by the accused in his police statement provides "a complete, thorough, plausible, and sufficient explanation for the entirety of Molly's injuries." On the subject of retinal hemorrhages in particular, Dr. Orde referred to deeply divided medical opinion, with a significant demographic of expert professionals on one side supporting the supposition that these are necessarily indicative of violent shaking, or acceleration/deceleration abusive head trauma, and on the other side a second demographic which accepts that there may be other explanations, such as severe accidental head trauma.
- [77] Dr. Orde clearly falls into the second demographic. In his report filed in evidence, he wrote:
- The diagnostic use of retinal and optic nerve sheath haemorrhages . . . as a base for the diagnosis of shaking and/or abusive head trauma -- has at its core old and outdated dogma, that is now recognized to be based in significant part on circular reasoning, and which is not supported by the current published evidence base. In short, there are now ample published data to support the contention that retinal and optic nerve sheath haemorrhages can develop simply as a consequence of head injury, likely mediated . . . by way of an elevation of pressure inside the head and resultant compression of the optic nerves and blood vessels contained within. Cases of infantile retinal haemorrhage have even been described following accidental falls.
- [78] Dr. Orde made reference to a "sizeable and expanding body of published data" indicating that the physical forces typically generated by short falls are thought to exceed those created by forcible shaking, and therefore he said it is entirely possible that retinal hemorrhages could be produced by such a mechanism, even as he conceded that this will likely be rare.
- [79] In short, Dr. Orde's opinion was that all of the clinical and pathological observations made in Molly's case could be accounted for by a single-impact blunt-force traumatic head injury caused by a short fall onto a hard surface, such as described by the accused in his police interview. Fatalities in such cases are rare, he said, but they are possible.

LAW

- [80] As I have said already, the accused elected not to testify. All that I know concerning his version of events comes from his October 30, 2016, police interview led into evidence by the Crown. The contents of this interview, once admitted, became evidence both for and against the accused: *R. v. Higgins* (1829), 3 Car. & P. 603 at 604; *R. v. Hughes*, [1942] S.C.R. 517 at 521; *R. v. Knox*, [1968] 2 C.C.C. 348 at 360 (B.C.C.A.). It is for me to decide what weight to attach to his statements. I may accept all, part, or none of what he said.
- [81] Furthermore, the approach set out in *R. v. W.(D.)*, [1991] 1 S.C.R. 742 at para. 28, and *R. v. C.W.H.* (1991), 68 C.C.C. (3d) 146 at 155 (B.C.C.A.), is not limited to situations where the accused gives sworn evidence at trial. It is also applicable to situations where an accused's statement is tendered as part of the Crown's case: *R. v. B.D.*, 2011 ONCA 51 at paras. 105 and 114; *R. v. Grant*, 2013 MBCA 95 at paras. 31-33; *R. v. McDonald*, 2014 BCSC 477 at para. 58.
- [82] The burden of proof is on the Crown to establish the accused's guilt beyond a reasonable doubt. The accused is never required to prove his innocence or disprove the Crown's case. If I believe the accused's police statement denying guilt and alleging instead that Molly's death was an accident, or if I am not confident that I can accept the Crown's contrary version or theory of events, I must enter an acquittal.
- [83] A criminal trial, furthermore, is not a credibility contest. My role is not to choose which of the conflicting versions offered by the prosecution and defence in this case is true or more plausible, but to ask myself whether the prosecution, on all of the evidence, has proved its case beyond a reasonable doubt. If, after a careful consideration of the evidence in its totality, including the accused's version of events given in his police statement, I am unable to decide whom to believe or which of the available competing theories is true, I must enter an acquittal.
- [84] Finally, a mere rejection of the accused's exculpatory police statements cannot be taken as proof of his guilt. Even if I reject the accused's version of the manner in which Molly sustained the fatal injuries described in evidence, I am not simply to assume that the Crown's theory about how they were caused must therefore be true. Rather, I must carefully assess the evidence that I do believe and decide whether the evidence persuades me beyond a reasonable doubt that the accused is guilty.
- [85] The accused is presumed innocent. This presumption is only defeated if and when the prosecution satisfies me that the accused is guilty by proving every essential element of the offence of manslaughter including the existence of an actus reus beyond a reasonable doubt. A reasonable doubt is not an imaginary, farfetched, or frivolous doubt. It is not doubt based on sympathy for or prejudice against anyone involved in this trial. It is a doubt based on reason and common sense. It is a doubt that logically arises from the evidence or the lack of evidence.

- [86] Proof beyond a reasonable doubt will be achieved if, after considering all the evidence, I am sure that the accused caused Molly's death by means of an unlawful act. It is not a standard of absolute or mathematical certainty, but it is much closer to that standard than proof on a balance of probabilities. If the evidence goes only as far as to persuade me that it is probable or likely that the accused is guilty, an acquittal must be the result as a matter of fundamental criminal law.

LIABILITY

- [87] I will address the Crown theories of criminal liability in reverse order. I have concluded that Molly Baader was uninjured when Ms. McMaster came out of the bathroom after taking her shower. I would refer with emphasis to the narrative given by Ms. McMaster to Dr. Colbourne, where she saw Molly's legs kicking quite normally as she passed from the bathroom on to the bedroom to dry her hair. The evidence strongly suggests that whatever calamity befell Molly occurred in the brief interval while Ms. McMaster was in the bedroom drying her hair. The accused said that seven or so minutes elapsed between when Molly was injured and when 9-1-1 was called. The ambulance personnel arrived with astonishing promptness and Molly was removed to hospital within minutes.
- [88] Dr. Hughes was clear that she did everything that she could for Molly at the Port Alberni hospital. It is true that she was provided no history explaining why the baby presented at hospital in cardiac arrest, but she would have done nothing different to resuscitate Molly if she had received such an explanation. It was clear from the beginning that Molly would require a higher level of care than could be offered at a small regional hospital, and she was evacuated by helicopter to B.C. Children's Hospital as soon as possible.
- [89] On all of the evidence, I have concluded that Molly's injuries were fatal as soon as they were sustained. Her death would have resulted from them even if she had been removed from the apartment several minutes earlier. While it appears that Molly was in full cardiac arrest, likely in seizure, and not breathing for a number of minutes before the paramedics were summoned and arrived, nevertheless she was transported to hospital and revived with remarkable rapidity, all things considered.
- [90] Thereafter, medically speaking, everything possible was done to keep Molly alive. The sad truth, however, is that this unfortunate little person never breathed independently again, and she only survived until November 3, 2016, because she was on life support. When it was agreed that such support should be discontinued, Molly passed away within minutes. In my view, it has not been established that the brief delay in summoning help or the accused's failure to give attending clinicians an accurate history of what occurred was a significant contributing factor in her death.
- [91] I am satisfied beyond a reasonable doubt that Molly's death was caused by a single impact blunt-force traumatic head injury. This view was uniformly expressed across the breadth of medical opinion evidence that I received, and importantly it was the specific cause of death

identified by Dr. Steele at autopsy. I note the conflict of evidence concerning the site of Molly's skull fracture. The radiological evidence, with which Drs. Colbourne, Orde, and Mack concurred, suggested that Molly suffered a left parietal fracture without any indication of a right occipital fracture. Dr. Steele, by contrast, identified no left parietal fracture, but found a right occipital fracture that no clinician before her had observed. To this extent, the evidence about the site of the fracture is inconclusive, even if, in my assessment of all of the evidence, the posited left parietal injury is likelier.

- [92] In the end, this factor may not be all that material. So profound and diffuse was the underlying damage to Molly's brain that I doubt much could be deduced from it to confirm either a left parietal or a right occipital fracture as the site of the impact. The evidence suggested, in any event, that the site of a skull fracture is not always indicative of where blunt-force head trauma has been sustained. I will merely say that the evidence has led me to conclude that Molly probably sustained a left parietal skull fracture, or possibly a right occipital fracture, but not both. It is also perfectly clear to me, on all of the evidence, that such injuries as these, along with retinal hemorrhages too numerous to count, are severe in nature and could only have resulted from the application or absorption of a significant amount of force.
- [93] I do not accept Dr. Dunham's testimony, advanced in part by his surprising and disconcerting decision to selectively edit a passage quoted in his report from a medical journal, that Molly's injuries are easily and readily accounted for by an accidental cause such as described by the accused in his police statement. I find that bilateral retinal hemorrhaging, in particular, would typically not result from such a mechanism, and elevated intracranial pressure alone would not account for this. The evidence is clear, in my view, that retinal hemorrhages are far more closely associated with abusive head trauma or much more dynamic accidental head trauma. I accept the prevailing medical opinion evidence that I have received, including from Dr. Colbourne and Dr. Orde, that injuries of the scope and severity involved in this case would only rarely be produced by a short fall.
- [94] I have decided, furthermore, that shaking as part of the mechanism of Molly's injuries, while possible, has not been conclusively established. For one thing, I did not find the accused's statements on this subject or the manner in which they were elicited during the police interview to be particularly revelatory, persuasive, or reliable. Of far greater significance, however, Dr. Steele did not include shaking in her opinion concerning a cause of death, saying for some reason that it was not necessary. I am also left in substantial doubt about the involvement of a shaking mechanism by Dr. Orde's evidence rebutting the possible existence of craniocervical ligamentous disruption. Proof positive of such an anatomical irregularity might have been a powerful indicator of a shaking mechanism, but such proof is lacking here.

- [95] The remaining question, of course, is whether the single impact blunt-force traumatic head injury established in evidence was intentionally inflicted rather than accidentally sustained. In order to find the accused guilty of manslaughter, as previously stated, I must be satisfied beyond a reasonable doubt on all the evidence that the accused assaulted Molly thereby causing her death.
- [96] In this connection, I would note the absence of injury to any part of Molly's anatomy other than those observed by the clinicians at B.C. Children's Hospital. There was no indication of a pattern or a history of abuse. Importantly, in my view, there is no evidence suggesting that the accused bore a hostile animus towards Molly on the day in question or at any other time. There is no intimation of any particular deficit in parenting skills or any inadequate coping abilities in the accused. The evidence suggests that the accused and Ms. McMaster were getting along well throughout the day on which Molly was injured. There is no basis for supposing that anger or upset between them might have been taken out on Molly.
- [97] I accept the undisputed contrary evidence that the accused was happy and feeling positive that day. There is no evidence whatsoever to suggest that the accused was frustrated or overwhelmed looking after Molly. Ms. McMaster, in particular, noticed nothing at all amiss in the accused's behaviour or attitude, and even after Molly was injured, it did not occur to her for a second that the accused might have been responsible for it.
- [98] Naturally, I find it suspicious that the accused said nothing about an accident until two days later when he was interrogated by police, and that, to the contrary, he became defensive and angry when the spotlight of suspicion was trained on him. It may be correct to suggest that if a child has been harmed by accident, most parents would say so at the first available opportunity. However, I take into account that the accused was only 20 years old at the time, and in my impression, at any rate, his police interview belies a certain lack of sophistication.
- [99] I also accept that he was very frightened about what had happened and was unsure about what he should do. He could not bring himself to tell Ms. McMaster for fear that she would hate him and leave him for it. He was afraid that he might be sent to jail. I accept that these may have been his motivations for keeping quiet at first. I am unable to conclude, in other words, that his initial incomplete or untrue statements about what happened necessarily indicate consciousness of guilt for the commission of a crime. Instead, I accept that the accused might have concealed the truth out of panic and fear, just as he repeatedly told Corporal Lounsbury during his police interview. It is notable, in my view, that as soon as he was arrested, the accused insisted on talking to Corporal Lounsbury even though his lawyer had advised him not to, and his statement about an accidental cause came out more or less immediately and without much prompting.

- [100] I conclude from the totality of the medical evidence in this case, including the peer-reviewed articles referred to me, that injuries of the scope and severity sustained by Molly Baader will only rarely be produced by a short fall such as that described by the accused in his police statement. However, it is also clear that the minimum amount of force required to produce such injuries is unknown, and I accept the possibility that, although atypical, the force created by a short fall may be sufficient.
- [101] I do not say that I believe the accused's version of events given to Corporal Lounsbury. I say merely that his account might be true. It raises a reasonable doubt in my mind about his guilt, because it comprises an innocent, accidental explanation for what happened to Molly which, while perhaps unlikely, cannot be ruled out.
- [102] An important determining factor in the accused's favour, furthermore, is the complete absence of any evidence to suggest that he was ever in the least bit angry, upset, frustrated, or unable to cope with Molly at the material time or otherwise. As I have considered this case over the past weeks and gone over the evidence again and again, I have not been able to reach the stage where I might confidently conclude that within a few minutes, without any buildup, warning, or identifiable cause, the accused should have lost his temper and violently attacked Molly in the manner suggested by the Crown.
- [103] Only you, Mr. Baader, know what really happened to Molly. You caused her death and you bear sole responsibility for it. In criminal legal terms, however, the Crown has failed to prove beyond a reasonable doubt that you committed an unlawful act that caused Molly's death. On all of the evidence I am unable to attach criminal liability to you for it. It follows that you are entitled to an acquittal, and an acquittal is hereby entered.
- [104] I would like to express my gratitude to counsel for their measured, sensitive, and professional handling of a difficult and disheartening case. That is all.
- "Baird J."

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