FAMILY COURT OF NOVA SCOTIA

Citation: Nova Scotia (Community Services) v. C.L., 2014 NSFC 5

Date: 2014 03 27
Docket: F.LB.CFSA-084643
Registry: Bridgewater

Between:

Minister of Community Services

Applicant

v.

C. L.

Respondent

Restriction on publication: PUBLISHERS OF THIS CASE PLEASE TAKE NOTE THAT s.94(1) OF THE CHILDREN AND FAMILY SERVICES ACT APPLIES AND MAY REQUIRE EDITING OF THIS JUDGMENT OR ITS HEADING BEFORE PUBLICATION.

SECTION 94(1) PROVIDES:

94(1) No person shall publish or make public information that has the effect of identifying a child who is a witness at or a participant in a hearing or the subject of a proceeding pursuant to this Act, or a parent or guardian, a foster parent or a relative of the child.

Editorial Notice: Identifying information has been removed from this electronic version of the judgment.

Judge: The Honourable Judge William J. Dyer

Heard: January 14, 15, 16, 21, 23, 2014, in Bridgewater, Nova Scotia

Counsel: Philip Gruchy, for the Applicant
Timothy Reid, for the Respondent

By the Court:

[1] This decision follows a contested review of disposition hearing under the **Children and Family Services Act** ("**CFSA**") in which the Minister of Community Services ("the agency") presented its case for placement of an almost two-year female child in its permanent care and custody with no provision for access by the mother. The agency's plan is for adoption placement.

[2] L. ("the child" or "L.", as the context requires) has been in the agency's temporary care since late January, 2013. C. L. ("C." or "the mother") seeks return of the child to her care under a supervision order for the maximum available time before the child must either be returned unconditionally or placed permanently by court determination. The statutory deadline is in late June, 2014.

[3] Several individuals share the same surname. To minimize confusion, I will resort to first names where necessary.

The Evidence

Social Workers

Shannon Campbell

[4] Shannon Campbell ("Campbell") is an agency social worker. She was the lead worker when L. was taken into care. Campbell's February 4, 2013 affidavit (in support of the agency's application when the proceedings started) was relied upon at the interim hearing stage. It included extensive hearsay evidence which was admitted at the time under section 39 (11) of the **CFSA** and adopted again by her (without objection) at the present hearing. I have received the hearsay content with some caution - given that Campbell sourced her evidence to several individuals who did not testify for reasons not expressed on the record. That said, much of Campbell's historical account found its way into the Parenting Capacity Assessment (PCA) and was not seriously challenged in that context either. With that in mind, I will only touch on the highlights of Campbell's evidence as it first unfolded.

[5] Campbell confirmed that L. was taken into the agency's care on January 29th, 2013 when L. was approaching her first birthday and the mother was 19 years old. C. and her mother S. were both well known to the agency because C. was in agency care for several years as a result of issues surrounding S.'s drug use and inability to meet her daughter's needs. At the age of 16, C. was returned to her mother's care.

[6] Campbell wrote that the agency started receiving referrals around mid April, 2012 about the condition of C.'s home and the belief by referral sources that it would not be safe for an infant. Campbell's co-worker, Nancy Baker, was tasked to interview S. L. who disclosed that both she and C. were obliged to participate in urinalysis testing through their family physician in order to receive prescriptions for ADHD.

[7] S. L. disclosed a history of casual marijuana use by C. and a problematic mother/daughter relationship. She also disclosed that C. was then subject to a Provincial Court probation order which included various conditions. She had been found guilty of assaulting a former boyfriend. At the time, mother and daughter were sharing different levels of a split level bungalow that had been divided into separate apartments.

[8] In early May, 2012 the agency received a referral from the office of C.'s family physician expressing general concerns about L.'s care and C.'s failure to participate in drug testing as a prerequisite to possibly receiving prescription medications. There were also reported concerns about the type of milk being provided to the infant.

[9] Based on observation reports provided by Nancy Baker, Campbell summarized other concerns about the condition of the residence. These were discussed with C..

[10] In late May, 2012 Campbell was still receiving reports about problematic urinalysis for drug use by C.. Co-worker, Jolene Comeau, (who did not testify) reported in mid July, 2012 that several issues remained outstanding. As a result, by the end of July, the agency had arranged to provide the services of a family support worker and offered counselling services to both C. and S. by Mary

Haylock. And, there was a continuing expectation that C. would attend at her doctor's office for regular drug testing.

[11] Despite the provision of services through September and October, 2012 the state of C.'s home continued to be a big concern. The agency restated its expectations for C.. But, within days, C. was not cooperating with drug testing and was refusing entry to her residence by family support workers.

[12] In early November, 2012 C. made a strange disclosure to her family support worker: she had been struck by a car in a "hit-and-run" incident. However, upon following up the report with police, the agency was unable to substantiate the allegations. For her part, at the present hearing, C. did not deny the disclosure and did not attempt any explanation or elaboration.

[13] By mid November, 2012 C.'s physician was still reporting non-compliance with drug testing.

[14] In late November, 2012 C. recounted a bizarre scenario in which (she said) three individuals showed up at her home - two of whom claimed to be social workers from Halifax, and one who claimed to be a police officer. But, once again, the agency was unable to substantiate or corroborate C.'s version of events.

[15] In mid December, 2012 S. L. launched another referral because of her concerns about C.'s association with a boyfriend, identified as B. M.. S. believed her daughter was living in an abusive and volatile relationship and was thereby putting C. and her baby at risk. The agency immediately brought the concerns to C.'s attention. C. was defensive and minimized S.'s concerns.

[16] Around the same time, Campbell said C. purported to recommit to urinalysis testing. She also agreed to a psycho-educational assessment because she claimed an interest in returning to school and also agreed to individual counselling (with a stated preference for Jan Cressman).

[17] Early in 2013, C. learned that S. had made another call to the police regarding the boyfriend, B. M.. Once again, C. minimized the significance of the events. And, in mid January, 2013, during counselling, S. disclosed to Mary Haylock her view that L. was being neglected, and identified several concerns

about C.'s residence and lifestyle. She again alleged (recent) incidents of domestic violence, police intervention, etcetera. Haylock then informed the agency that S. would no longer be able to help C., that C. appeared to be out of control, and that C. was in an unhealthy, violent relationship, and that the young child was at risk.

[18] Campbell was able to substantiate that the police had gone to C.'s residence and that B. M. had been charged with uttering threats on the life of S. L.. Further reports from the police claimed that C. and her then partner were under the influence of alcohol when these events unfolded.

[19] Campbell substantiated that the family physician had not seen C. for an appointment since June, 2012, although L. had been seen more recently. There were no reported serious concerns about the baby, but there was corroboration of continuing problems with drug testing compliance.

[20] The agency continued its discussions with C. about chronic concerns and referrals. Along the way, C. countered with an allegation that S. had been arrested for distribution of prescription medications. (But, C. was not willing to provide the names of people who alerted her to this.)

[21] In late January, 2013 S. L. made yet another referral about the safety and well-being of L.. She alleged that B. M. had reentered the picture and implied there were further incidents of domestic violence. S. advanced allegations of inadequate supervision, cigarette smoking and drug use within the residence, etcetera. S. also disapproved of other individuals with whom her daughter was then associating. S. acknowledged conflict between herself and her daughter, but said that her principle worry was for the welfare of L..

[22] Campbell met with S.'s brother, S. L., to get his version of recent events. He too had serious concerns about B. M. and other individuals in or about C.'s residence. By the end of January, Campbell was able to substantiate that the police were moving ahead with charges against B. M. who was already well known to them. And, around this time, Campbell learned that C. may have taken up residence with one J.H., a gentleman much older than her. The worker located and confronted C. at H.'s residence. She claimed she was only staying with him for a short time and that they were not in a relationship. (H. did not submit an affidavit or testify.)

[23] On the heels of this development, the child was taken into care.

[24] In early February, 2013 Campbell learned that C. had told family support worker, Melissa Zwicker that she (the mother) had not been fully truthful with the agency because "she finds it hard to trust people". Reportedly, C. acknowledged to Zwicker that she had been using marijuana and admitted to so doing as recently as the night that L. was taken into care.

[25] Following the apprehension, C. returned to her former residence but was apparently not spending much time there in order to avoid conflict with S.. Campbell said it was thought that counselling would resume with Jan Cressman - but it was soon learned that C. had not attended her scheduled sessions and that Cressman had terminated her involvement.

[26] By mid February, Campbell had learned from family support workers that the mother had been drinking a lot of alcohol recently, staying at the homes of various friends, not sleeping well, and continuing to smoke marijuana. She was requesting help finding new accommodations.

[27] By that time, the interim hearing had been completed and arrangements were made for the PCA and a psychological assessment of C..

[28] Campbell said that in late February, the agency temporarily suspended access visits because of C.'s history of missed visits with L. on several occasions, despite the efforts of the foster parents and others to make the arrangements. From the agency's perspective, Campbell said it was clear that C. was not planning for her visits or making the visits a priority. At the same time, S. L. was continuing to allege that C. was spending time with B. M..

[29] On March 1st, 2013 Jan Cressman informed Campbell that C. had already missed five scheduled sessions. Not surprisingly, Campbell directed that the service be placed on hold until there was an opportunity to discuss C.'s commitment with her.

[30] By early April, 2013 Campbell was reporting by affidavit that C. had made "minimal" progress toward addressing the identified protection concerns.

[31] Campbell made renewed efforts to get C. into the office to discuss drug screening, residential circumstances, and counselling. However, Campbell said that C. failed to attend a succession of scheduled appointments.

[32] Campbell cosigned the agency's May 30th 2013 Plan of Care along with her supervisor and the child in care worker, Maggie Stewart. Accompanying the Plan was an affidavit updating the prevailing circumstances. Campbell noted that the protection hearing was completed in early April, 2013. Resumption of counselling with Jan Cressman had been discussed in April, but floundered because of inaction by C..

[33] Campbell had contact with physician, Dr. Beaton in mid May, 2013. C. had disclosed to him in late April that she was worried about her mood and sleeping patterns. He informed Campbell that C. was reporting symptoms of depression and seemed more panicked. Accordingly, he made a referral to Mental Health Services, but refused to put C. back on her ADHD medication (a stimulant) until the referral results were available.

[34] In late May, 2013 Campbell learned from a family support worker that C. had been living with her uncle, S. L., and had also disclosed an incident between herself (C.) and one J.H.(previously mentioned) that "became physical". Apparently, no one was arrested or charged as a result of the incident. Despite the best efforts of the agency, resumed counselling with Jan Cressman continued to be problematic.

[35] Campbell said that C. participated in random drug testing during March and April, and that the results confirmed ongoing use of cannabis which C. had acknowledged in any event. As a result, it was determined that further testing was unnecessary. Instead, Campbell wanted C. to participate in an Addictions Assessment and commit to a plan to cease regular drug use.

[36] Returning to the agency's May 2013 Plan of Care, the agency was seeking an order under section 42 (1) (d) that L. remain in the temporary care and custody of the agency for a period of three months on specified terms and conditions, including access. The Plan presented in capsule form the history and developments set out in more detail in other evidence before the court. The Plan

also offered a road map for the direction in which the agency thought the case might be heading. In particular, it was written that the agency's position, quite simply, was that C. had not demonstrated significant progress and that if she did not do so within the following three months the agency might have to consider an "alternate plan". This was obviously "code" for permanent care and custody and, with the benefit of a lawyer, I find would have been interpreted as such. Concern was expressed about L.'s young age and her need to attach to an appropriate caregiver. At the time, L. was described as a 14 month old, extremely vulnerable child who would require a very high level of supervision, consistent structure, routine and care.

Nancy Baker

[37] Nancy Baker ("Baker") is a veteran agency social worker. In a late November 2013 affidavit, Baker wrote that the agency had received the PCA and the Psychological Assessment in mid September, 2013. She noted that C. had been actively participating in family support services up until late August, 2013.

[38] After C. learned that the agency would be pursuing an order for permanent care and custody, C. informed the agency that she wanted a different family support worker. There was discussion about why she wanted a change and about her expectations. Up to that point, the agency was unaware that C. had any concerns with the service. The upshot was that C. was informed that it would be up to her to contact Melissa Zwicker, and that it was up to C. to set up future meetings and to decide what she wanted to cover during the sessions.

[39] By the end of November, 2013 Baker's understanding was that C. had not followed up with Zwicker, but she knew of Cindy Hall's involvement and the work being done on that front. She was also aware that a referral had been made to psychiatric staff at Mental Health Services for a consultation regarding C.'s ADHD medication.

[40] Baker said that her co-worker, Colleen Myra, (L.'s social worker) had arranged for weekly access visits and family support sessions for C. and L. despite the problematic history of C.'s follow-through with supports and services. To

make access more beneficial, it was decided the visits would include a teaching and mentoring component. Brandi Shaw was then assigned to C.'s case.

[41] In her testimony, Baker said that C. was the subject of a child protection proceeding commenced against her mother, S.. Baker said that the agency was on the brink of pursuing permanent care and custody for C.. However, based on C.'s opposition and S.'s legal position, the agency very reluctantly decided not to pursue that outcome. With hindsight, Baker would have preferred otherwise.

[42] Baker mentioned that she very recently visited C.'s current residence. She described it as very clean and tidy with lots of appropriate toys, etcetera for L.. Indeed, she said she was quite "impressed" with what she observed. Baker confirmed that C.'s rent is being paid directly by the Department of Community Services to the property owner/landlord. This appears to be connected to concerns about the mother's finances and her management skills.

[43] Baker spoke in support of the agency's current plan for L. based on the totality of the presenting circumstances as captured in the agency's final Plan of Care. Baker said that from the agency's perspective C. has still not meaningfully confronted or dealt with a lengthy and troubling history of trauma which it is believed underlies C.'s tremendous difficulties in making consistent progress. Baker reminded that L. is almost two years of age and posited that C. still has not made significant progress. She underlined that the agency holds out little hope or prospect for success in the foreseeable future, keeping in mind the statutory limits.

Colleen Myra

[44] Colleen Myra ("Myra") is an agency social worker who has direct responsibilities for L.. She described herself as a social worker for children in care. In her relatively brief affidavit (January 13, 2014), Myra confirmed that as of the hearing L. remains in an agency-approved foster home. She confirmed that notice of the current hearing was provided to the foster parent (as required by legislation).

[45] According to Myra, L. has been at the same foster home since coming into care in late January, 2013. She characterized L.'s development as "on par with her age". She characterized L. as very active and playful. L. attends daycare twice

weekly and interacts appropriately with toddlers of the same age. Myra described L.'s eating habits as healthy and said she has no difficulty napping or sleeping. She mentioned that L. had ventilation tubes placed in her ears in October, 2013 to hopefully relieve recurring ear infections. There was nothing extraordinary about the diagnosed need or the outcome, which has been positive. Myra said that L. has been seen by a local pediatrician to ensure the child's health and development are on track. Myra characterized L. as affectionate and outgoing.

[46] It was confirmed that L. continues to have weekly visits with her mother and monthly access visits with the maternal grandmother. L. was able to visit with her maternal great-grandparents over the Christmas holiday season.

[47] Myra said that it is her belief that all children are potentially candidates for adoption - although there may be challenges in some cases. Should a permanent care order be granted, she said it is the responsibility of the agency to try to place children for adoption wherever possible.

[48] Myra elaborated that the rationale for the agency's position is that all children need to have a sense of belonging to a family. She said that all children need a permanent home and that foster care is not meant to be such a permanent placement. She confirmed that foster placement is meant to be temporary until a child can either go home or be adopted. She volunteered that adoption provides children with a sense of security and stability as a member of a family that is not available through a long term foster placement.

[49] Myra confirmed that it is the agency's intention for L. that she remain in her current foster home until it is possible for the child to be placed for adoption.

Tina Peddle

[50] Tina Peddle ("Peddle") is an adoption social worker for the Department of Community Services. Peddle was kept informed by social workers Nancy Baker and Colleen Myra about the proceedings and L.'s circumstances.

[51] One of Peddle's main responsibilities is to locate appropriate adoptive families for the children in the permanent care and custody of the agency. In her

affidavit evidence, she elaborated on the process for identifying and selecting potential adoptive families.

[52] Based on the information available to her, Peddle said that she is aware of L.'s needs and any needs that would potentially impact on adoption placement should L. be placed in the agency's permanent care and custody. Peddle's understanding is that the child has no special medical, emotional or behavioural needs that would hinder her in being successfully matched and placed in an adoptive home. Given the child's age and stage of development, Peddle stated that she would be readily placed for adoption.

[53] As of late November, 2013 Peddle disclosed that there were over 100 approved and waiting adoptive applicants within the Province of which close to 90 families were open to the prospect of adopting a female Caucasian child of L.'s age.

[54] Peddle also briefly touched on Section 78A of the **CFSA** which provides for Openness Agreements. She said that these are agreements for the purpose of facilitating some level of contact between adoptive parents and birth relatives of a child. Her evidence was that Openness Agreements are not legally binding and therefore have no effect on the legal status of an adoption order. She said that Openness in adoption can be seen as a continuum from the sharing of non-identifying information such as letters to direct contact. Peddle said that any plan to enter into an Openness Agreement must be in the best interests of the child and be child focussed, must not present a risk to the child's safety, health or well-being, and only occur if the birth family, adoptive parents and child (where appropriate) are able to support the adoption and the contact plans. She said that these Agreements are common in adoptions but that the Department of Community Services does not maintain statistics on the types of contact in such Agreements.

[55] According to Peddle, based on her experience, the most common form of contact is the provision of non-identifying letters and possibly photographs once or twice a year, facilitated by Department offices. She said that she is aware that some adoptive families have direct contact with birth families, but from her experience these are rare.

Access Facilitators

Susan Budden

[56] Susan Budden ("Budden") is an access facilitator who supervised a limited number of access visits. She supervised four visits in February, 2013, one in March, one in April, and two in October, 2013. Budden's evidence was that the February, March and April visits were ones in which C. was usually "very upbeat" and quite excited in her initial contacts and interactions with L.. She characterized the mother as being physical and affectionate during the early part of each visit.

[57] Budden noted that C. had great difficulty attending visits consistently during March and April, 2013. She said that many visits were cancelled with a variety of reasons given, including illness and difficulties with tooth pain.

[58] From her observations, Budden thought it was a struggle for C. to complete an entire visit. Indeed, she said that C. was often eager to get L. ready early to go home - "certainly well before it was time for the visit to end". She said that on a couple of occasions C. questioned if L. was well enough for a visit when there did not appear to be any reason to question L.'s health. Budden also disclosed that during the early visits that C. often expressed fear that L. would forget her and that the mother became sad during some visits. During some visits, she also said that C. did not seem to know quite what to do once routine tasks were completed.

[59] Referring to an access visit in mid October, 2013 during a parent group at the Parent Resource Centre, Budden said she did not see a lot of interaction between mother and daughter. Although C. was initially affectionate and interactive with L., she said the mother allowed her daughter to go off and interact with other children and adults in the group. She said that C. seemed to be more interested in talking with other parents at the group and did not seem to pay particularly close attention to L..

[60] The last supervised visit that Budden was involved with was at the end of October, 2013. She said that visit was similar to previous visits and that the mother ended the visit early in order to attend another appointment.

[61] In fairness, Budden conceded that if C. intended to leave the child for any reason (eg. to go to the washroom, etcetera), she did ask Budden or another parent to supervise her daughter briefly. Budden added, however, that the mother occasionally left the access visit and did not disclose precisely where it was she was going. She elaborated by saying that on one occasion she thought the mother had gone to the washroom, but when the mother did not return, she searched for her for about 15 minutes until she located her. Even then, the mother did not say where she had been.

Penny Carver

[62] In a mid January, 2014 affidavit, access facilitator Penny Carver ("Carver") said she started to supervise access visits in mid March, 2013. She supervised 14 visits between then and late July, 2013.

[63] Carver wrote that initially C. had three scheduled visits per week, two of which she supervised. She noted that overall the visits were a positive experience for the child. Carver wrote that sometimes C. was not well attuned to her daughter's interests or abilities, but added that C. provided lots of physical affection and was eager to play games and have fun with L..

[64] Carver asserted on one occasion L. was left unattended on an indoor table at the access room and that she cued the mother who responded or reacted appropriately. Additionally, the child was left briefly unattended on an outdoor picnic table but, again, the mother responded appropriately when cued. Carver claimed the mother seemed "somewhat defensive" in reaction to her suggestions and directives. But Carver acknowledged that despite the perception of risk no actual harm came to the child and that the mother generally conducted herself appropriately.

[65] Carver's last visit was on July 24, 2013. C. did not answer her door when the worker arrived but was noticed across the street at a neighbour's home. When C. noticed Carver, Carver said she came across the street and claimed that she had called the agency to cancel the visit due to a plumbing issue. However, C. adamantly refused to let Carver view the apartment. As discussed elsewhere, and as eventually admitted by the mother, she was untruthful with the worker that day.

[66] In testimony, Carver recalled at least one visit when C. seemed preoccupied with various issues in her life as opposed to focussing mainly, if not entirely, on L. during the visits. However, she did not say that any of the visits went poorly or that there were any serious concerns. She also confirmed that there was no suggestion of alcohol or drug use by the mother on any occasion when she supervised access.

Beverly Hubley

[67] Beverly Hubley (Hubley) is an eleven year veteran access facilitator. She started to supervise access visits in mid June, 2013. She said that the visits took place initially two times per week at the access room at [...]. Subsequently, they were moved to C.'s apartment. But, since about the end of July, 2013 the visits have been taking place weekly at a baby group at [...].

[68] As of mid January, 2014 Hubley had supervised approximately 22 visits. She characterized C. as very affectionate with L., but asserted that C. is not especially safety conscious during the visits. Hubley said that C. is unable to consistently keep track of where L. is or what she is doing. She said the mother tends to allow the daughter to roam freely without adequate supervision. She said that C. has also struggled to provide appropriate meals for L. on those occasions when visits took place over the lunch hour.

[69] Hubley said she has observed that C. is unable to interact with L. for a sustained period of time. When there is contact, she said that it is for a brief period - following which C. will withdraw and leave her daughter either on her own or in a high chair to watch a movie. She has observed that C. is often very tired during visits and often complained about not feeling well. As a consequence, she said that C. has often been eager to end her access visits early.

[70] In testimony, Hubley said that she was not present for all of the mother/daughter visits as many were tied to family support workers. Indeed, her own involvement, for example, had a hiatus in October and did not resume until January, 2014. She clarified that her own work was interrupted solely because she was reassigned to other families and confirmed that the reassignment had nothing to do with the quality of the visits up until then. In the same vein, her return to the provision of service in 2014 was solely as a result of administrative decisions.

[71] Regarding the safety issues and age appropriate supervision, Hubley was unable to specify more than a couple of occasions when she personally had to intervene. In fairness, it appears that the mother did respond and react appropriately when cued by Hubley.

[72] Hubley expressed some concern about the quality of the lunches being provided by the mother and reported these to the agency. However, none of these appear to have been terribly serious and tended to emphasize that she would have preferred to have seen something other than grapes, crackers and cheese which she characterized as "snacks".

[73] In testimony, Hubley also noted that on one occasion in mid July, 2013 she was at C.'s apartment when she noticed a very strong smell of bleach. This struck her as unusual and perhaps concerning. She reported her observations to the agency. This seems to explain the shift of subsequent visits away from the apartment.

Narah Comstock

[74] Access facilitator Narah Comstock ("Comstock") supervised five visits, two of which were during the summer of 2013, one at the end of December, 2013 and one in early January, 2014. Comstock generally described the visits as positive for mother and daughter. She disclosed nothing extraordinary.

[75] Most recently, Comstock said that C. requested some additional information, advice and guidance from staff about diaper changing because L. was observed to be quite fussy during change times. However, Comstock said there was nothing unusual about the request or the baby's behaviours.

[76] In her relatively brief testimony, Comstock observed that C. often seemed to interact and to be more engaged with other mothers who were present than with her own daughter.

Tina Dearing

[77] Tina Dearing ("Dearing") is an access facilitator who supervised three visits between mother and daughter in late 2013. The maternal grandmother was present during one session. Dearing disclosed nothing extraordinary about the visits, with the exception of one incident when she thought the child's eating could have been more closely supervised and another occasion when the mother left an access room briefly without making specific arrangements for supervision. However, in neither situation was the child placed in any immediate risk. Dearing allowed that there were staff on site at all material times and were available to help with the supervision of the child (and other children who were present).

Carrie Duffney

[78] Carrie Duffney ("Duffney") is an agency access facilitator who supervised a visit in mid December 2013 at [...]. Duffney confirmed that the access visit went without any significant concerns.

Family Support Workers

Melissa Zwicker

[79] Melissa Zwicker ("Zwicker") is a family support worker employed by the agency. She was assigned to C.'s file in late June, 2012 when L. was just three months old. Zwicker authored an affidavit (January 14, 2014). Her early involvement was recounted as follows:

> 20. When I initially became involved with C. she had just started to live on her own and was only 18 years of age. She was experiencing a lot of conflict with her mother, S. L.. The focus of our work was on basic parenting, including budgeting and household cleanliness. I also assisted C. with filling out the application for child tax benefit. I endeavoured to connect C. to community supports to provide positive supports and role models. As our work progressed issues related to C.'s choice of partners became more of an issue and the focus of our discussions. C. made little progress in incorporating any of the strategies I attempted to teach to her. However, she was always very affectionate with L.. The one area where some improvement was noticed was in C.'s efforts to maintain her home in a clean and appropriate state. This appeared to have been maintained when C. moved from her old residence in [...] to her current residence in [...] in March or early April, 2013. As noted above, many of the weekly sessions I had scheduled with C. were missed for various reasons.

[80] After L. was taken into care, Zwicker said C. acknowledged that she was continuing to use marijuana regularly. In mid July, 2013 she said she asked C. to call Addiction Services because she had been asked several months previous to do this and had procrastinated. As a result of the final call, C. did set up an initial appointment with Cindy Hall.

[81] Zwicker captured her overall assessment in this fashion:

> 22. Based on the time that I have spent with C. I have observed her to take little or no responsibility for what has happened to her. C. has great difficulty in following through on doing what she is told to do. It certainly appears to me that C. feels she knows how to do everything and does not need the assistance of others. I have also observed C. to have trouble being truthful. She had told me various stories throughout my involvement with her that have later proven difficult to verify. C. has had trouble making it to access visits with L. on time, despite my efforts to work with her on time management. I made efforts during my family support sessions to go over strategies with C. for feeding L. during her visits. However, C. appears to have had difficulty grasping what I taught her about making appropriate meals for L.. I also attempted to work with C. on developing boundaries in her personal life with various people she associates with, but her poor choices in friends continues to persist.
>
> 23. My last family support session with C. took place on August 23, 2013 at her home. I have seen her since that date at court appearances. During these last contacts with C. her social worker, Shannon Campbell, told her that she would need to contact me to set up future family support sessions and she would need to decide what we would cover during our sessions. However, C. had never contacted me to follow up with further sessions.
>
> 24. On many occasions C. has shortened her visits with L. and provided various explanations. Often, on these occasions C. appears to lack the energy required to care for L. for an entire visit.
>
> (My emphasis.)

[82] During testimony, Zwicker said that she was privy to the PCA Recommendations (which the lead social worker had shared with her). In reviewing C.'s attendance record for family support sessions, Zwicker was careful to distinguish between sessions that were cancelled for family support, as opposed

to purely access visits. Insofar as her own work is concerned, Zwicker noted that C. frequently changed telephone numbers and contact was often a challenge.

[83] Zwicker insisted that family support services were not deliberately withdrawn from the mother in August, 2013 - rather a decision was taken to put the responsibility on the mother to decide upon and to communicate what services she needed then and for the future. In the aftermath of that decision, Zwicker said that the mother effectively abandoned the service by not following up or identifying what she wanted. When the mother decided to re-engage, Zwicker was no longer the assigned worker and she (Zwicker) has no direct knowledge of the subsequent work with Brandi Shaw and others.

Brandi Shaw

[84] Brandi Shaw ("Shaw") is a family support worker who was recently assigned to work with C.. As at the hearing, there had been only two sessions. Shaw said she was cognizant that she was supposed to take her cues from C. (based on directions given by the agency).

[85] Shaw said that C. disclosed that she could use some input regarding child development and information surrounding normal childhood "milestones". She reportedly was also open to further information and education regarding enhancing L.'s basic speech and other skills.

[86] Shaw's sessions are provided over and beyond routine access visits which continue to be monitored. She acknowledged that there was some delay in her own retainer because she was on vacation for a period of time and also was away on medical leave.

Other Witnesses

S. L.

[87] S. L. ("S.") is the approximately 38 year old mother of C. L. and L.'s maternal grandmother. She lives locally in a three bedroom apartment. Until recently, her brother, S. L., shared the accommodations. (He has relocated to his own apartment, also in the local area.) She is unemployed and receiving income

assistance. However, she hopes to return to school and complete her GED. S.'s boyfriend is N.M. who was planning to move into her apartment (as at the hearing).

[88] In an affidavit authored in mid January, 2014, S. mentioned that she had been babysitting her brother's twin girls who are about ten years old. Additionally, she volunteers at a local church and has other activities. She owns a motor vehicle.

[89] S. wrote that she had concerns with C.'s previous boyfriend - B. M.. According to her, as at the hearing, he was facing various criminal charges arising out of incidents which occurred at her apartment in January, 2013. She indicated that she is the complainant. S. said that the relationship between C. and B. M. ended in the early spring of 2013.

[90] She wrote that last summer, she was also concerned that C. was spending time with another individual against her wishes but that the relationship ended in early August, 2013. She is aware that C. is currently in a relationship with one T. L.. She perceives him to be a steady individual and supportive of C.. (L. did not testify). According to S., L. and C. do not cohabit. S. said that L. was part of family gatherings during Christmas 2013 and she observed their interactions to be friendly and supportive.

[91] S. conceded her relationship with C. has been strained at times, particularly when she has attempted to intervene when she thought it was appropriate. Despite past conflicts, she said that she is mainly concerned about her daughter's best interests and claimed to be her daughter's "main support at this time". According to S., they now have frequent contact and enjoy a generally positive relationship. When C. secured her apartment last June, S. helped her daughter obtain various household supplies and assisted in readying the apartment for L.. She stated that her daughter's apartment has all the physical amenities which would be needed for L. should she be returned to C..

[92] S. broadly stated that since September, 2013 C. has matured and demonstrated (at least to S.) that she can keep her apartment clean and generally manage her time and responsibilities appropriately. She has observed a big improvement in meal preparation and other responsibilities.

[93] As at the hearing, S. was enjoying visits with L. at her residence and according to her, there had been no reported concerns.

[94] S.'s personal physician is Dr. Blaine Beaton who is also C.'s and L.'s physician. She disclosed she is participating in urinalysis through Dr. Beaton's office and that she is taking prescription medication to deal with Attention Deficit Hyper Activity Disorder, depression, anxiety and back pain. She said that she is on a program to reduce her dependence on medications and claimed that there has been a reduction from seven to five prescriptions. Of those, only one was said to be a narcotic, to alleviate back pain. S. also receives physiotherapy for her back problems.

[95] At C.'s request, S. met briefly with Cindy Hall and said that she would do whatever it takes to assist her daughter as she continues her work with Cindy Hall. S. declared that she is willing to offer support and assistance to C. and her granddaughter.

[96] During testimony, S. admitted that providing guidance and assistance to C. in the past has not been an easy task and that many of her past attempts did not go very well. She acknowledged that C. ran from the family home on several occasions, that they argued frequently, and that police services have been involved. Despite C.'s resistance to her past intervention, S. claims that her daughter now accepts her suggestions and advice. She claimed that they have not had any serious verbal arguments or disagreements for several months.

[97] S. asserted that she has not used "heavy narcotics" for many years, but conceded that she uses marijuana "occasionally" which she described as "social use".

N.M.

[98] N. M. ("M.") submitted an affidavit in which he wrote that he is in a relationship with S. L.. He is employed full time with a trucking company.

[99] Mossman said that he has spent time with C. and provided emotional, financial, and transportation support. He did not elaborate. He also said that he

takes part in family activities and emergency situations but, again, did not elaborate.

[100] M. said that he will do whatever is needed to help C. and her family have a stable and happy life together. He said he is committed to providing assistance and encouragement to C. in being a parent to L..

[101] M. adopted the affidavit material submitted by S. L. (which he said he had read).

S. L.

[102] S. L. (L.) is the 42 year old uncle of C. L.. L. was living with his sister, S., until recently but has secured an apartment for his family which includes twin girls, aged 10, who attend a local school. According to L., his daughters have been in his day to day care since August, 2013 and that before then he parented the children on alternate weeks in a shared parenting arrangement with the mother. L. said that he has a girlfriend who also lives with him at the new apartment.

[103] L. works full time at a local company. He wrote that he has observed C. spend time with his own children and that she has always been kind and attentive with them. L. said that he has helped C. with babysitting previously and that he is prepared to continue to provide help and support to her as need be.

[104] L. said that he has observed positive changes in C.'s relationship with S. since August, 2013. He said that he is pleased that she now has her own apartment and that he has seen a steady improvement in her day to day life skills.

[105] In his testimony, L. said that most of the improvements he has seen in C. started when she learned that the agency was seeking to place L. in its permanent care and custody. He said that C.'s attitude to everybody has changed significantly since then. According to him, she realizes now (and apparently did not before) that the various people around her are there to help and not to hinder.

[106] L. conceded that neither C. nor L. have been to his new residence. He also conceded that he has not been to C.'s apartment since last summer (2013). Since

August, he said he has seen C. frequently at her mother's residence - approximately a dozen times.

[107] L. acknowledged that he was aware of the various issues surrounding C.'s former apartment because it was below his and S.'s then apartment. He was well aware that some of C.'s boyfriends and other associates were problematic and admitted that he had concerns not only for C. but for his own children should they have contact with these individuals.

[108] L. said that he has encouraged C. to help care for his own daughters which she has agreed to do from time to time. However, he emphasized that he has never left C. alone with them and insisted that any care that was provided was always under his supervision. In those circumstances, he only spoke positively about her interaction.

Medical Doctor

Dr. Blaine Beaton

[109] Dr. Blaine Beaton ("Beaton") is C.'s and L.'s physician. He conducts a small family practice which has the benefit of a practical nurse.

[110] Working strictly from memory, Beaton recalled only one occasion when he was contacted by child protection agency officials. There was concern centred on the reported use of canned carnation milk as opposed to baby formula milk when L. was younger. The concern appears to have resolved itself without great difficulty.

[111] L.'s early development was described as normal. She met the usual milestones. There was a mild concern regarding tilting of the baby's head which was resolved by a physiotherapy referral. At the eight to nine month stage, there was mild concern that L.'s sitting and balance might be somewhat delayed. But again, the issue was satisfactorily resolved.

[112] Beaton said that C. sought some guidance from his practical nurse on a variety of issues. However, he testified that there were no "red flags" that prompted any serious concerns for the child's welfare.

[113] Since L. was taken into care, the foster mother has brought L. to routine visits. Recurrent ear infections resulted in a referral to a specialist for tubes.

[114] Beaton said pediatric reports indicate there are no developmental delays at this time and that the child appears to be doing very well. (Copies of those reports were not introduced.)

[115] Beaton last saw C. in April, 2013 when she was reporting symptoms of depression. He started her on a low dose of medication and made a referral to Mental Health Services. He is aware that C. may have missed several appointments. He noted that Mental Health Services had requested no information from him. However, he was contacted by Coleen Shepherd incidental to her PCA. He confirmed the difficulties (discussed elsewhere) surrounding consents to release information and C.'s unwillingness or inability to sign the appropriate documents to facilitate Shepherd's work.

[116] C. had disclosed other pregnancies to other professionals. However, Beaton said he was unaware of any other pregnancies. In the same vein, he was unaware of any serious physical injuries (as disclosed by C. to others).

[117] Regarding ADHD, Beaton's understanding is that a pediatrician made a diagnosis when C. was around nine years old and that treatment was by prescription medication for a few years. However, Beaton said his files and charts reveal no recent care or treatment directed to ADHD.

[118] Beaton's opinion was that C.'s presenting problems have been complex. Therefore, he wanted assessment and input from Mental Health Services. He thought that treatment - other than by prescription medications - was available and might be recommended or directed through Mental Health Services.

[119] Beaton also confirmed that he wanted urine/toxicology screens as part of the overall assessment of C. because of possible interactions of any drugs or medications that might currently be ingested and the possibility that (unbeknown) to him, the patient might be using controlled substances. Although Beaton got what he described as one baseline test result, there were no subsequent screens or follow-ups because they were not actioned by C..

[120] When he observed C. with L. at his office, nothing prompted serious or notable concerns. The doctor was aware that the mother was struggling at times and that she had a lot of questions, but he was satisfied that there were no obvious signs of abuse or neglect.

[121] Returning to the expectation that there would be a series of drug screens, Beaton confirmed that as a result of these not occurring that he did not prescribe any medications to C..

[122] Beaton is familiar with the extended maternal family and confirmed that various family members had been attending appointments with C. and/or the baby. He also confirmed that L. continues to see a pediatrician regularly and that there are no current issues regarding the child's health or development.

Psychologist

David Cox

[123] David Cox ("Cox") is a psychologist whose Report dated July 23, 2013 was admitted into evidence by agreement. He did not testify; and there is no countervailing assessment.

[124] Cox had access to material from the agency case file and court documents. He also had the benefit of an early draft of the Parental Capacity Assessment by Coleen Shepherd. He recapitulated C.'s family and personal history as derived from the foregoing sources. It need not be repeated here. The same may be said for C.'s education history and the history of previous assessments and treatment. It appears that Cox had access to psychological assessment results and reports in late October, 2006 and early January, 2007, and to psychological assessment material related to C.'s mother, S..

[125] On the health front, Cox referred to background information previously provided to Coleen Shepherd - much of which "seemed implausible and sometimes fantastic". The following brief excerpt is illustrative:

> ....She said she had broken or injured her ribs after an altercation, but did not seek treatment because she had no health card, and thought that she would have to pay

for an x-ray. She reported having migraine headaches every couple of days as a result of being hit by a car. She claimed that L. was her fourth pregnancy, and that she had a miscarriage at [...] after she was hit in the belly with a basketball. She also reported having a miscarriage after falling down two flights of stairs. (At the time of this Assessment, she reported one previous pregnancy with twins, which she terminated.) C. also reported that she had been receiving "non-stop counselling twice a week for four years," although this does not appear to be accurate. She also indicated that she was "having an identity crisis" with respect to her sexual orientation. (At the time of this Assessment, she said that she had made this statement to provoke her grandmother.)

[126] Under the heading "Assessment Finding", Cox wrote:

C. was asked about some aspects of her personal history. Her account was often illogical, or of very questionable accuracy. She offered a wide range of explanations and excuses for her behaviour, events in her life, and identified Child Protection issues. The explanations she gave tended to emphasize external circumstances, psychological factors, and possible psychiatric disorders. Similarly, she attributed her previous out-of-control in residential programs to the fact that she was living with people who did not care about her.

C. appeared to have an investment in presenting herself as suffering from a severe psychiatric disorder, presumably in an effort to explain and limit responsibility for her behaviour. She very questionably quoted her Physician as suggesting that she might have Bipolar Disorder. Schizophrenia. She offered a number of misconceptions to explain why she thought she might have Schizophrenia. There was no reason to suspect either disorder.

C.'s verbal, nonverbal, and overall intellectual abilities were estimated in the Average range. Her reading skills were estimated at the late Grade Eleven level, and her vocabulary at the High School Graduate level.

Results from clinical measures were of doubtful validity, and sometimes invalidated, because of C.'s efforts to present herself as having serious psychological or psychiatric problems. On a comprehensive personality and clinical measure, there was strong evidence that she was over-reporting symptoms of various disorders, to the point that the results could not be meaningfully interpreted. This is a very unusual occurrence, which I cannot recall encountering in the past. Findings from a measure of coping style were also of very questionable validity, apparently because of the same "faking bad" response bias.

> Although findings from a measure of parenting and child-rearing attitudes were unremarkable, that measure tends to lack sensitivity. There was a substantially elevated Abuse Scale score on the Child Abuse Potential Inventory. While an elevated score on this scale is not in itself an indicator of significant child abuse risk, it suggests the possibility of personality characteristics and behaviours which are associated with a known risk of physical child abuse. In C.'s case, the pattern of findings suggested the likelihood that her parenting is significantly affected by a high level of personal distress and adjustment problems, and a poor reaction to perceived stress. To some extent, however, it is also likely that this finding was exaggerated by the same "faking bad" response bias which affected her scores on clinical and parenting measures. Other findings were consistent with C.'s history of interpersonal conflict, and her tendency to perceive her relationships as the cause of personal difficulties or distress.

[127] Cox concluded that the child protection concerns which C. was presenting with were not the product of cognitive limitations or severe psychiatric disturbance. Similarly, he concluded that her reported history of chronic lying and sometimes bizarre statements did not indicate a loss of contact with reality. Rather, he opined that her chronic untruthfulness is a longstanding and a strongly habitual pattern which is unlikely to change.

[128] Cox also wrote that C.'s chronically out-of-control behaviour has its origin in severe family dysfunction, inconsistent and negligent care, and exposure to unstable and antisocial conduct by her mother and other adults. In his opinion, while ADHD may have played some role, its contribution to C.'s behaviours was relatively minor. He went on to write as follows:

> C. remains highly emotionally immature. She continues to project responsibility for her behaviour onto external circumstances, other people, and sometimes supposed psychiatric disorders. She has developed almost no ability or inclination to take responsibility for her behaviour, or for making necessary changes. It is expected that she continue to exercise very little control over what she says or does. Coleen Shepherd has raised concern about the extent to which C. expects L. to meet her emotional needs, rather than the other way around.
>
> C. has failed to go through the motions of participating productively in services. Even when she has participated, her chronic lack of truthfulness has made it difficult or impossible for any progress to occur.

> Medication for ADHD will be of very little benefit unless C. is also participating in services and taking responsibility for the changes she needs to make. She is very unlikely to consistently participate in, or benefit from, counselling or psychotherapy. There is a strong likelihood that her current failure to exercise responsibility and self-control will become an entrenched personality trait which is unlikely to change in a fundamental way.
>
> There is very little reason to believe that, within the time constraints imposed by legislation and L.'s developmental stage and needs, C. will be able and willing make the extensive changes which would be needed in order to provide L. with adequate safety, stability, and care.

[129] Near the conclusion of his report, Cox wrote this:

> It is difficult to identify clinical or other services which have not already been tried, and proven to be unsuccessful. If any services are put in place, this should be done on a time-limited, trial basis and discontinued if C. fails to participate consistently and productively. The history to this point suggests that this is very unlikely to occur.

Counsellors/Therapists

Mary Haylock

[130] Mary Haylock ("Haylock") was retained to provide individual and joint counselling for C. and S.. Much of her work focussed on their episodically conflicted relationship. Haylock did not testify, but her handwritten Progress Reports were entered by agreement. They span the period of July to December, 2012.

[131] Because Haylock's work was referenced by others, I will not summarize it here. Her evidence was considered and weighed as proposed by counsel.

[132] Unfortunately, Haylock ultimately concluded that her work was "counter productive" insofar as benefit to C. was concerned and recommended she seek therapy elsewhere.

Jan Cressman

[133] Jan Cressman ("Cressman") was engaged by the agency in 2013 to provide counselling services to C. L.. Unfortunately, C. attended only two out of nine scheduled appointments.

[134] Cressman reported that during her first session C. was oddly focussed on problems with her teeth. The second session focussed on concerns about her living circumstances and her relationship with her mother. They did not have time to work on anything substantive because C. limited the scope of their work.

[135] As a result of the missed appointments and lack of progress in therapy, the retainer was terminated. Cressman said there was no continuity or commitment to appointments which suggested to her (Cressman) that C. was not ready to engage in therapy to assist her with issues surrounding her daughter's apprehension and possible resumption of parenting.

Cindy Hall

[136] Cindy Hall ("Hall") is a clinical therapist employed by South Shore District Authority, Addiction and Mental Health Services. Her educational background includes a Bachelor of Arts Degree in Psychology (1995), a Level 1 Counselling Skills Certificate from the Maritime School of Social Work (2006), and a Master of Education Degree (Counselling) as recent as 2012. The latter included courses regarding Addictions Counselling. She has taken a number of professional development courses since she started work with the Health Authority in August, 2012.

[137] By agreement, Hall was permitted to give expert opinion evidence in the areas of addiction assessment and, more broadly, therapies incidental to addressing substance use and underlying issues. She has not testified previously in court.

[138] In mid September, 2013 Hall sent a reporting letter to the agency at C.'s request. By then, she had met with the mother on three occasions and was intending to continue services. Hall confirmed the initial referral came from the agency for an assessment regarding C.'s use of alcohol and marijuana. She was immediately aware that the agency was considering placement of L. in its permanent care and custody, and adoption placement. Hall noted that she was

familiar with the Cox Report and Shepherd's PCA. She candidly expressed surprise at the findings and opinions of Cox and Shepherd regarding the prospects for long term improvements and progress by the client.

[139] According to Hall, C. acknowledged that she had not been cooperative regarding the wide spectrum of demands made by the agency. However, C. reportedly declared (to Hall) that she is now prepared to do what is required of her.

[140] C. disclosed to Hall that she began smoking cigarettes at the age of nine and in September 2013 was still reporting daily marijuana use. The mother claimed a "recent and significant decrease in use". And, based on C.'s disclosures regarding alcohol use, Hall wrote that the frequency of use did not appear problematic - but the disclosed amount exceeds the level that Health Canada identifies as "low-risk" alcohol consumption.

[141] At the conclusion of formal testing and assessment, Hall wrote that C. is at "high probability of substance dependence" and that "detoxification may be necessary". However, relying on reports by C. and assuming them to be true, Hall opined that C. likely does not require detoxification services. While not endorsing marijuana use, Hall observed that such use is not life-threatening.

[142] Hall wrote that C. was at a high risk of ongoing legal issues because of her lack of impulse control and she noted that C. scored high on indicators of emotional pain. She attributed the latter as likely related to the mother's difficult history during childhood and adolescence.

[143] Hall and C. developed a list of goals which is repeated here:

- Harm reduction or abstinence from substances
- Explore emotional regulation
- Attend Recovery Group and/or Women's Group regularly
- Attend future ADHD group when it begins (this Fall)
- Explore the qualities of healthy relationships and how to foster them

•Coping Skills in relation to stress and life management

•Consult with her physician regarding ADHD treatment

[144] Hall provided a second written report in mid October, 2013. She confirmed that work with C. began in late August, after Hall returned from vacation. In the October report she characterized C. as polite, cooperative and engaged. During testimony, Hall confirmed that C.'s appointments were initially held weekly, but they are now meeting bi-weekly. Attendance has not been a serious issue.

[145] Hall confirmed that a referral had been made to a psychiatrist for a "dosage consultation" for C.'s ADHD medication. She noted that a support group for adults with ADHD was expected to begin under the auspices of South Shore Health but, as at the hearing, the program was still under development and "not up and running".

[146] Hall had recommended that C. attend a recovery group and/or women's group regularly. However, C. attended only one recovery group session. She disclosed to Hall that she was uncomfortable with some of the other participants whom she knew personally. Hall added that the hoped-for women's group involvement has been problematic because of conflicts with access visits.

[147] Hall confirmed that support and education regarding substance abuse and harm reduction was ongoing, but it is being given less priority based on C.'s disclosure of significantly reduced use. As at the hearing, Hall said that she and C. have done some work regarding healthy relationships, but that such work is ongoing. The largest topic, according to Hall, is helping C. cope with emotions and stress in a healthy manner.

[148] Hall conceded that there has been <u>no</u> substantive work on so-called "past trauma" issues, and that the topic of domestic violence has been broached but not fully addressed. C. also expressed interest in introducing her new partner into "couples's counselling" sessions. There has also been one joint session with S. L. to discuss the ongoing child protection case.

[149] Allowing that C. has limited demands in her personal life (because she is not parenting L. full time), Hall nonetheless maintained that C. is managing her personal and household commitments very well. Notwithstanding the opinions of Cox and Shepherd regarding follow through with services, Hall underlined that C. has been engaged in personal counselling with South Shore Mental Health and is progressing as well as can be expected given the number of sessions so far.

[150] Hall confirmed that she and C. have not started to "unpack" past issues directly related to her personal circumstances and upbringing. Hall believes that C. is ready to start down that path, but conceded that C. has disclosed very little to her - as compared to what was disclosed to Shepherd and to others. In the context of therapy with Hall, Hall said that C. claimed that she could not recall with accuracy a lot of historical detail.

[151] Based on her training and experience, Hall expressed concern about re-traumatizing C. should she probe too deeply and too soon into historical matters. In Hall's words, she does not need a "play-by-play" for therapy to progress. This clearly runs counter to the detailed findings and opinions of Cox and Shepherd, as well as those offered by other therapists/counsellors and other professionals who have been involved with the family for a long time. With respect, I find the expertise of Cox and Shepherd, in particular, deserves much more weight than Hall was prepared to allow when she tailored her services and formulated her reports.

[152] However, putting the best light on her evidence, she was asked how long therapy (with her) might take to fully address the identified and outstanding issues. The answer was that it is difficult to estimate - but, not less than six months.

[153] Before concluding her testimony, Hall said that she has not met C.'s new partner. However, she did confirm that she saw the Agency's Plan of Care for L. dated August 19, 2013.

Parenting Capacity Assessor

Coleen Shepherd

[154] Coleen Shepherd ("Shepherd") was retained by the agency upon court approval to assess C.'s parenting capacity. She was aware that the mother wanted to have L. returned to her care, that supervised visits were taking place, and that a mental health services referral was pending. She gleaned from agency disclosures that there were serious concerns about C.'s parenting skills and the absence of appropriate supports in her life. There were also concerns about her lifestyle, dishonesty with the professionals who had been trying to assist her and the fact that she has not followed through with services as expected.

[155] Shepherd was careful to identify the limitations of her work. She noted C. would not give consent for her to contact the Alternatives program, Probation Services, Public Health Services or the various dentists she had reported consulting. And, C.'s family physician and nurse practitioner - who have known C. for many years and have reported concerns about L. to the agency - would not release information, because C. failed to keep an appointment and endorse the proper consent form. Thus Shepherd did not have the independent medical information about mother and child which would have been helpful and relevant.

[156] Shepherd imported an agency Risk Assessment that she thought best summarized C.'s growing-up years:

> There is a history of chronic abuse and neglect of Ms. L. by her mother S.. When Ms. L. was growing up, S. was heavily involved with drugs and was employed as a dancer. S. lived in several places in New Brunswick including [...]. In 2001, when Ms. L. was 7 years old, she came from Lunenburg County to [...] to visit her grandparents. After staying there, S. indicated to the grandparents that she was unable to care for Ms. L. and wanted her to stay with them. Ms. L. lived with her grandparents from 2001 - 2005. She went to visit her mother in 2005 and ended up staying there to live. While there she was placed in temporary emergency foster care for a weekend after a physical altercation with her mother. Ms. L. also called her grandparents and said she was suicidal while staying with her mother. Ms. L. returned to her grandparents' home in Nova Scotia in 2006. Ms. L.'s behavior was out of control for the grandparents to handle and in 2006 the grandparents relinquished care of her. S. L. indicated she was not able to care for Ms. L. either and therefore Ms. L. came into the Temporary Care and Custody of the Department. Ms. L. was in care for roughly two years and during that time she did not cooperate with services or placements set out by the Department. She was placed in residential care during the vast majority of her time in care.

[157] Shepherd noted there were times when C. appeared to accept some responsibility for L. being in care, and appeared to have some understanding of what she had to do so that her daughter could be placed back with her. She mentioned an interview the day after a court appearance in April 2013 when C. said she understood the agency's expectations were that she "quit smoking pot", have a stable residence, attend counselling (which she had requested be reinstated), and attend Addiction Services (although resistant to the latter).

[158] Shepherd declared she shared virtually all of the concerns which had been identified by the child protection workers and other professionals. The most serious of these were said to include her upbringing, childhood experiences and issues related to her family of origin:

> A great deal of information regarding C.'s history as a child and adolescent, her family of origin and her relationship with her mother in particularly (sic) has been included in this report. Given C.'s youth in that she is now only nineteen, this history is particularly relevant in that the information clearly illustrates how unstable and dysfunctional her childhood and adolescent years were and the longevity of her troubled behavior and relationship with her mother, S..
>
> .....
>
> What is especially sad is that reading the Child Welfare file regarding S.'s difficulties with parenting and in other aspects of her life is similar in many respects to the description of C.'s difficulties with parenting and in her everyday life both before and after L. was born. Concerns which resulted in the recent Child Welfare involvement include C.'s emotional instability, involvement in negative or abusive relationships, having inappropriate people around L. and in a caregiving role at times, lifestyle issues including substance abuse, a dirty and cluttered home environment, neglect and a lack of stimulation and focussing on own needs rather than those of her baby daughter. These phrases could just as easily describe S.'s difficulties as a young parent.
>
> C. stated: "The past doesn't make me who I am today; I've changed for the better." However, the majority of the time she blames her upbringing for the many difficulties she continues to experience. Although C. has been hurt and her childhood was far from ideal, her continued focus on blaming her mother and the Agency is neither helpful nor productive in terms of her making positive changes in her life. Again, file notes written in 2009 about S. indicating that, despite her participation in services including assessments, therapy and family support, there

was no significant change for the better, could just as easily describe C.'s current situation.

[159] Shepherd wrote extensively about C.'s physical health, emotional instability, personality characteristics and coping ability. I am compelled to say the following passages echoed as I carefully weighed the evidence of many other witnesses. (The **emphasis** is mine, where it appears.)

> As is evident throughout this report, C. has consistently complained about her health, the multiple injuries she has (allegedly) sustained in the past and ongoing pain resulting from these, migraine headaches and tooth decay. She complains about a disturbed sleep pattern that results in her being awake all night and sleeping during the day. She typically presents as being tired, lethargic and lacking the energy one would expect of a nineteen year old. She has cancelled appointments with professionals and visits with L. citing health reasons. Despite all of these complaints, however, as far as the evaluator knows, C. rarely sees her family doctor or consistently follows through with pursuing appropriate treatment. She has recently discontinued medication without consulting with her family doctor and it is difficult to know the status of the dental work she claims she has been receiving from three to four different dentists.
>
> With regard to her intelligence and emotional health and functioning, although testing indicates that C. has normal intellectual abilities, **something is drastically interfering with her capacity to function with more stability than she has to date**. **Moreover, C. seems to be determined to explain or excuse her longstanding out of control behavior by claiming to have a number of psychological disorders which, apart from ODD and ADHD which were diagnosed when she was a child, there is no evidence she has. Moreover, even if ADHD remains a factor, it hardly accounts for her very problematic conduct since she was a young adolescent.** Another concern with regard to possible ADHD is that C. has not followed through as expected by her doctor so that she could receive appropriate treatment. C. has described herself as being chronically depressed since age twelve and as being unable to think straight without medication. However, again, she has not consistently followed through with seeking medical assistance for these conditions.
>
> .....
>
> **C., who has few personal boundaries, also presents as being a very angry, defiant and aggressive young woman. She behaves much like a hurt and confused child in that she vents her anger at anyone and much of her behavior seems to be related to anger.** Indeed, when meeting with Psychologist

David Cox recently, C. described herself as being an angry person saying that she was the one, and not B. M., who became angry and smashed things.

C.'s anger is somewhat understandable given her very dysfunctional upbringing and life experiences to date. However, her very immature, willful and oppositional behaviour have, in large part, contributed to her present difficulties including the loss of her daughter. Moreover, her tendency to lash out, perhaps in an attempt to have some control in situations, often results in more difficulties for her and this is especially so when there is an expectation that she comply with rules or the expectations of others including the professionals who are trying to assist her. Phycologists David Cox has noted that C. exerts little self-control over what she says or does.

.....

One has only to review Agency file notes and the Affidavit sworn to by Social Worker Shannon Campbell to realize that **C. has repeatedly given misinformation, or outrightly lied, about herself and others.** The detailed account she told of the Police attending her home when they hadn't; being the victim of a hit and run accident; a former boyfriend, A.T., being taken into custody, etc. were not true. Indeed, immediately before L. was taken into care in January, the Police commented on C.'s ability to lie well and often. When meeting with Agency personnel, C. gave contradictory accounts about her little daughter's development and schedule. When meeting with the evaluator C. often contradicted herself during the course of an interview.

.....

C. told stories which, although difficult to verify, were dramatic and appeared to be exaggerated and far-fetched.

.....

While, perhaps understandably, C. was far from eager to meet with the evaluator, she has told so many falsehoods throughout the assessment process that it was difficult to believe anything she said. Psychologist David Cox noted that C. had no sense of personal responsibility for her behavior and that much of the information provided by C. "seemed implausible and sometimes fantastic".

Ironically, one of the few things C. was honest about was her dishonesty. She says "Lots of times I don't tell the truth. The only person I'm

> totally honest with is my grandmother. Truth is not the first thing that comes into my head. It's a compulsion."
>
> .....
>
> ...What is certain, however, is that C. has lied for years and her continued tendency to do so makes it very difficult to work with and assist her.
>
> .....
>
> **C. says that she lies because she doesn't trust anyone. Unfortunately, the very fact that she lies so often and with such apparent ease results in other people not trusting her or believing what she says.**
>
> **C.'s lack of insight also makes working with her difficult. She questioned the relevance of her history and functioning being included in the assessments and showed little recognition that these are related to parenting. She sees nothing wrong with her parenting skills and, when asked what would help or have helped her, C. says that having her own place to live is a big improvement and it would have helped if someone had shown her how to keep her apartment clean. While both of these things are important, being a stable person and providing safe and appropriate care for a child involve a lot more than having your own place to live and keeping it clean.** Indeed, C. had her own apartment immediately before L. was taken into care and has done little since that time to demonstrate that her housekeeping skills have improved to any great extent.

[160] Regarding C.'s involvement in unhealthy, and apparently abusive, relationships:, Shepherd said that agency personnel were justifiably concerned about the number of boyfriends C. has had and the nature of her relationships with these men and noted her history of putting herself at risk by spending time with significantly older men when she was a young adolescent. She noted C. did not have a good role model in terms of relationships and that apart from her grandfather, there were no consistent father figures in her life and her mother was involved in several significant and often abusive relationships during C.'s childhood.

[161] Shepherd said C. indicates that she wants to protect L. and knows it is her responsibility to raise her daughter whether or not she is involved in a relationship again. However, she disclosed "she had to take care of herself and teach herself

growing up so she now wants someone to take care of her". She opined that C. seems to crave attention and affection from males. Shepherd predicted that given C.'s high dependency needs, history of poor decision-making and that she has not benefited from counselling regarding healthy relationships, she will continue to make bad choices in this regard and, thereby put herself at risk and L. at risk if she is in her care.

[162] Shepherd was concerned that C. has a very limited support system and wrote:

> Given the nature of their relationship over the years, the personal problems they continue to have and their volatile personalities, it is safe to assume that any truce between C. and her mother will be short-lived and that L. would be used in the struggle and conflict between them. **Unfortunately, it is unrealistic to expect that S. will be a positive source of support and assistance to C. who struggles to accept mother's limitations and says quite emphatically that she "loves her and hates her"**. Therefore, it remains to be seen whether, through time and / or counselling, C. will be able to come to terms with her disappointment in and anger toward her mother; stop blaming her; move on with her life and accept responsibility for the choices that she, as an adult, is making.

[163] In the same vein, Shepherd noted that C. appears to have few friends or at least few who are a positive influence on her and that C. readily offers that she trusts very few people.

[164] Shepherd highlighted C.'s attitude toward, and very limited cooperation with, and capacity to benefit from professional help:

> It has been made abundantly clear throughout this report that, **despite many years of trying, professionals have had very little success helping C. to change her behavior or to learn parenting and other life skills. This is not to say they haven't tried.** Indeed, a number of resources have been provided to C. and her family over the years. Although C. has definitely not attended "non stop counselling twice a week for four years" as she recently reported to David Cox, counselling has been made available to her on many occasions over the years. **C. is very critical of most of the help she has received and of the professionals who have attempted to provide assistance. She finds fault with most and, even when she speaks about very few of them in positive terms, she is dishonest with them and doesn't believe that any intervention has been helpful**.

> **Unlike many clients who are anxious to have their children returned to their care, even though they aren't happy about meeting with evaluator, or social workers in general, they are cooperative with the assessment process. This wasn't the case with C. who is probably one of the most difficult clients the evaluator has encountered during more than twenty-five years in private practice in terms of scheduling and keeping appointments. Moreover, even when C. agreed to meet, it was always on her terms and rarely for the length of time requested. As referred to initially in this report, C. refused to give the evaluator permission to contact most of the professionals with whom she has been involved in recent years and, even when she did so in the case of her family doctor, she failed to keep an appointment with him as requested**.
>
> **As with many issues C. is all over the place in terms of her personal problems and the help she needs and her attitude toward professional help is no exception. During the course of this assessment she has said she wants counselling; is ready to accept counselling; doesn't need counselling; doesn't want to deal with issues related to her past and prefers to deal with things on her own.**

[165] Later Shepherd wrote:

> Over the years professionals have noted C.'s unwillingness to address her problems and, unfortunately, this remains the case today. **C.'s perception is that she is "fighting" for L.. However, she is clearly not doing what she could and should be doing to improve the chances of L.'s being placed back in her care. Sadly, although C. is adamant that she intends to be a better mother to her daughter than S. was to her, her lack of follow through with services is reminiscent of her own mother's behavior over the years**.
>
> **.....**
>
> Obviously, C.'s ongoing dishonesty is a huge stumbling block in terms of being able to work with therapists and other professionals. **C. is adamant that no one is going to tell her what to do and that she'll make her own mistakes. Unfortunately, she continues to do so. Moreover, it is particularly troubling that the professionals who have known C. for some years are very pessimistic about her ability to mature and change to the extent necessary to provide safe and appropriate care for her little daughter.**

[166] Shepherd addressed lifestyle issues by saying her ongoing use of marijuana is a concern - as is her involvement in situations which result in the police being called and added:

> ...Agency personnel have expressed concern about some of C.'s associates. In the past C. allowed people who were highly unsuitable to hang around, drink, stay at her apartment and even to mind L.. It is early days in terms of C.'s having her own residence and it remains to be seen whether she will stick to her position of allowing very few people, and then only a few close friends and family member, to come to her apartment.
>
> The **need for a healthy routine** for herself remains a concern as well in that C. acknowledges that she often sleeps through the day and has difficulty sleeping at night.
>
> **Financial mismanagement** is another area of concern in that, if C. really did receive $3400 in March, by her own reports she did not spend it wisely or handle it well.

[167] Under the Evaluation heading, Shepherd said L., like all children, deserves to have a family situation which will provide her with a satisfactory level of physical care and safety, and with the love, stimulation and nurturing she needs to help her to reach her potential. When evaluating parenting capacity, she said the quality of attachment between parents and their children, the ability of parents to recognize and meet the needs of their children**,** and to transmit acceptable and appropriate values to them, as well as possible rejection, are important factors to consider; and that satisfactory parenting also involves being available to one's children both physically and emotionally, along with being receptive to professional help if indicated:

> The quality of attachment between parents and their children is one of the most significant considerations when evaluating parenting ability because secure attachment is a requirement for optimal emotional development. The attachment relationship is the foundation upon which all other relationships are built. Establishing healthy attachment to significant caregivers is crucial in terms of developing self-confidence, a positive self-concept and, eventually, the independence to function as an emotionally healthy adult. Children who fail to form secure attachments have difficulty trusting others and their inability to communicate their feelings, emotions and needs in an open and healthy manner interferes with their capacity to develop long term intimate relationships in adulthood.
>
> As is evident from the report of the Access Facilitators and others, L. is always happy to see her mother and responds to her warmly. L. typically has a big

smile for and opens her arms to adults she knows such as the Access Facilitators. She goes to her mother readily but seeks affection and attention from other adults who are present during visits as well. However, L. certainly has a bond to her Mom.

Reports from Access Facilitators indicate that L. smiles and holds out arms to C.; whimpered when her mother left her and went to the washroom and smiled when she returned. For the most part L. consistently gravitated toward C. during visits and went the other adult (sic) C. didn't respond to her.

It is difficult to know with any certainty how strong this bond was before L. was taken into care when she was ten months old.

.....

Reports from the Workers who observed C. with L. more than a year ago indicate a somewhat mixed picture in that, at times, she was affectionate toward L., who responded accordingly, and was able to comfort and soothe her baby daughter. However, it was also in June of last year that concerns about the lack of attachment between C. and her three month old daughter were noted including a lack of engagement between mother and child and the fact that C. was not spending face-to-face time with L. who presented as being under-stimulated.

.....

In terms of attachment, L. never shows any distress when she has to leave her mother at the conclusion of their visits as one would expect her to do if the attachment was strong and healthy. Moreover, L. has been in care for several months now so it is safe to assume that, although she loves her mother, she also loves her foster mother who she depends on to meet her day to day needs.

.....

Along with positive and secure attachment, satisfactory parenting involves the ability of parents to recognize and meet the physical, emotional, social and educational needs of their children. Obviously, children need to be fed and clothed properly and to be provided with clean and appropriate shelter. The physical needs of children also include living in a safe environment and receiving medical care as indicated.

.....

L. was in C.'s care for the first ten months of her life. Unfortunately, during this time, C. was unable to provide a safe and clean home for her infant daughter. Concerns regarding physical neglect, Unfit Living Conditions and Risk of Physical Harm were substantiated.

.....

The physical needs of children include proper supervision and living in a safe environment. Safety concerns in the past included the volatile atmosphere in the home given the relationship between C. and her mother and also between C. and B. M.. C. also had a lot of people in and out of her apartment, some of whom should not have been around L. or in a caregiving role with her. C. admitted to falling asleep on the couch with L. who was an infant at the time. She also admitted to leaving L. alone while she went outside to smoke. She allowed a young woman who has a history of violent and aggressive behavior to live in her home.

Before L. was taken into care, Workers were concerned that C. allowed people with known histories of violence, mental health and substance abuse problems into the home and permitted them to be in a caregiving role with L.. File notes written on the day L. was taken into care state: "She (C.) continues to make decisions that indicate L.'s safety and her own safety are not a priority".

Thus, as is evident from previous documented history, L., at ten months of age, was far from living in a safe environment when she was removed from C.'s care and there have been ongoing concerns which continue to date about how carefully she supervises L. during the relatively brief supervised visits.

.....

What about C.'s ability to meet the medical needs of her little daughter? C. failed to keep appointments with the family physician and nurse practitioner as expected in the past. Moreover, she refused to become involved with services offered by Public Health which would have been beneficial for L.. Indeed, when L. was taken into care at ten months of age, C. indicated that she didn't even have a health card for her. Moreover, C. has not looked after her own health as indicated. Therefore, one cannot help but be concerned as to whether she would seek appropriate medical care and attention for L..

The emotional health and well-being of children are dependent on them having parents or caregivers who consistently recognize and respond to their need for love, physical affection, comfort and empathy. L. should be able to rely on her parent(s) or caregiver(s) to provide consistency of care, affection, acceptance,

sensible child care routines and appropriate child management practices, all of which help to make children feel safe, cared for and emotionally secure.

Children need to have a sense of belonging to a family and a community. It is also important for parents to be available to their children emotionally as well as physically and to teach them sound values and model appropriate behavior for them. Parents typically demonstrate their caring and concern for their children by spending quality time with them and showing a sincere interest in their day to day lives and activities. The emotional health of young children is also directly related to that of their parents or significant caregivers.

There is little question that C. loves L. and wants what is best for her. She is affectionate with L. and appears to be proud of her accomplishments. Unfortunately, however, C. often fails to recognize L.'s cues and to correctly interpret what she wants or needs at a particular time. L. is definitely not a fussy baby and seldom cries unless she isn't feeling well or is distressed for other reasons. On those rare occasions C. has been at a loss as to what to do and how to comfort and reassure L.. Usually C. has ended up in tears herself. While, given her youth and immaturity, it isn't surprising that C. lacks confidence as a parent, and looks to others to assist her when situations with L. occur, the situations have been typical for a baby / toddler and do not require extraordinary parenting skills. Therefore, one cannot help but question how C. would manage on her own and provide the care, empathy and comfort young children routinely require on a daily basis.

.....

Children benefit from having as much consistency and routine as possible in terms of expectations, child care routines, child management practices and management of their behavior. Satisfactory parenting involves teaching, guiding and supervising children, having reasonable expectations of them and providing guidelines, boundaries and the discipline necessary to teach them appropriate behavior. Parents also have to be able to handle any negative behavior in a sensitive, fair consistent and appropriate manner.

.....

Again, C. says some of the right things in terms of wanting to learn and follow the routines for L. which have been established in the foster home. C. readily admits, however, that she needs to establish a much healthier routine for herself in that she is often awake at night and sleeps during the daytime. She doesn't appear to prepare proper meals for herself or to have a daily routine which

would be conducive to parenting a young child. In fact, it appears that C. can hardly take care of herself at times.

In terms of being able to recognize and meet the emotional needs of her daughter, it is very concerning that C. expects L. to fulfill her emotional needs rather than vice versa. She has repeatedly made comments such as "I need L.. She makes me happy. She takes away the dreariness and hopelessness. I need her ten to thirty times more that she needs me. Why would I get up every day if not for L.? Why go through all these hoops for Social Services if not for L.? I have a purpose now - to fight for L.. I have a reason." "L. makes everything better. I'm not sad when I'm with her". "I"m L.'s favorite person." "L. is the most important person to me. No matter how many boyfriends I have, L. will be there to love me unconditionally."

It goes without saying that children cannot be expected to meet the needs of adults and that expecting them to do so is a recipe for disaster. In C.'s case, her little daughter cannot fill the emotional gap in her life or make up for the neglect she experienced in the past. Rather, C. needs to feel emotionally healthy herself if she is going to be able to respond appropriately to L.'s emotional needs. Moreover, the emotional well-being of young children is directly related to that of their parent(s) or caregiver(s). given C.'s emotional instability, L. would be at risk emotionally in this regard as well

The evaluator cannot help but feel badly for C. who often says the right things and clearly wants her daughter to feel loved, cherished and to have a positive self-image. C. repeatedly said that she wants L. to grow up to believe that she's "special, beautiful and amazing" and wants her to feel "loved, happy, safe, wanted and respected". She wants L. to be able to confide in her and "for her to have a relationship with me like I have with my grandparents". C. anticipates the special times she and L. will share and shows little recognition that these will only happen if she is receptive to changing her life, accepting the help she needs, being honest and doing the work she needs to do to provide a home for her daughter.

It remains to be seen whether C. will be able to manage L.'s behavior appropriately. Again, she says that she does not believe in physical punishment but, depending on L.'s age, would give her a period of time out or take away something she enjoys. C. realizes that L. is too young to reason with now but believes that she is learning that "no means no." **Again, C. says the right things but, given her temper, unresolved anger, lack of self-control, low frustration tolerance and poor impulse control, her ability to handle L.'s negative**

behavior sensitively and consistently, with appropriate firmness, is extremely doubtful.

.....

C.'s choices and experiences in relationships have been discussed as a source of significant concern in previous sections of this report as has the very troubled and conflictual relationship between her and her mother, S.**. Given both of these realities, it is safe to assume that L. would be exposed to serious conflict, if not violence, in C.'s care. Moreover, C.'s interactions with other people often involve verbal, and sometimes even physical, conflict and L.'s exposure to this would be detrimental as well.**

In terms of healthy emotional development, children benefit from having a sense of belonging to a family and community. Given C.'s history of transience, it is very unlikely that she will stay in one residence or community long enough to establish a stable home life for her daughter. Moreover, family relationships will have to improve significantly to be beneficial for L..

Parents should also teach their children values and model appropriate and socially acceptable behavior for them. C. repeatedly said that she wants her daughter to have the love, stability and security she never experienced as a child and is very critical of her mother in this regard. It is certainly true that S. L. was not a positive role mode. Sadly, it is also true that C. has copied much of her mother's behavior. Moreover, C. has shown little capacity to handle or resolve conflict appropriately. She talks about "smashing people in the face" and resorts to handling conflict in very inappropriate ways. When she was only seventeen, she was charged with Assault. She appears to be proud when exaggerating the number of charges which were allegedly laid against her when she was an adolescent. The Police have been called to C.'s home on several occasions. Obviously, C.'s pattern of lying more often than she tells the truth is hardly good role-modelling for L.. Unfortunately, C. has little motivation to change her maladaptive patterns of functioning or learn more positive ways of relating to other people.

Last but far from least in terms of healthy child rearing practices and meeting the emotional needs of children, parents have to be consistently available to their children both physically and emotionally and to be involved with and interested in their day to day lives. In this regard the evaluator is very concerned that C. has not been available to her little daughter emotionally, or even physically, at times and, even now, her focus is on herself and her own needs

.....

... However, the evaluator has some concern about C.'s ability to communicate with day care and school personnel in an appropriate and positive manner to ensure that L.'s educational needs are met.

..... Appropriate parenting also involves acknowledging the need for, seeking and following through with professional help for oneself and one's children as indicated. Thus, the ability of parents to work with professionals, and to be guided by and benefit from their advice, is an important consideration when assessing parenting capacity and one which has been discussed at some length in a previous section of this report. In summary, the evaluator has considerable concern about C.'s cooperation with and ability to benefit from professional help as well as about her lack of honesty with those who are trying to assist her so that L. could be placed back in her care.

When assessing parenting capacity, it is important to determine whether there <u>are risk factors</u> or "red flags", regarding the child(ren), the parent(s) or caregiver(s) and in the overall situation or environment.

.....

Concerns or "red flags", regarding C. as an individual and a parent have been discussed at some length in previous sections of this report. In summary, C. has many complaints about her physical and emotional health. Many of her longstanding personality traits are contraindications to positive parenting as is her behavior which has largely been out of control since she was very young. C.'s choice of partners has placed herself and her little daughter at risk and she fails to recognize how harmful this was. C. has difficulty coping with everyday life and even taking care of her own very basic needs. By her own admission she has difficulty controlling her anger. Concerns about C.'s lifestyle and ongoing use of marijuana have been referred to previously as well. Moreover, despite her youth, C. has a long history of resisting the help which has been made available and remains determined to do as she pleases despite the consequences for herself and, recently, for L.. Thus, her dishonesty with professionals and failure to follow through with the help she needs is an additional risk factor.

The family situation or overall environment is the third factor to consider when attempting to predict safe and appropriate parenting. Risk factors in this area include C.'s limited education and employment opportunities as a result. She appears to have little motivation to improve her situation in this regard. Moreover, C. needs help with budgeting and financial management. She needs help to keep a clean home and prepare adequate meals. She has a very limited informal support system which represents a risk for L. as does the animosity and

feuding between C. and her mother. Even though C.'s grandparents are a positive influence in her life, her grandmother has recently suggested that the onus is on the Agency to provide the help C. needs. C.'s "friends" and associates have certainly been of concern in the recent past. Unfortunately, apart from her very recent participation in a play group with L., C. has not developed healthy connections in the community or participated in programs which might have assisted her.

There are some positives in this situation as well in that, even when C. was presenting such challenging behavior as a young adolescent, professionals and others described her as being a bright and curious young girl who had a good sense of humour; could be kind and tried to help others and was loyal to her family

.....

Indeed, many of the professionals who have known and worked with C. have noted her positive traits. C. certainly loves L. and is wants (sic) her to have a much better childhood than she had.

Obviously, the severing of parental rights should be the last step in a Child Welfare proceeding and one which is only taken when services have been refused by the parent(s), attempted but failed or would be inadequate to protect their children and ensure their ongoing safety and well-being.

Sadly, despite being encouraged to do so, C. hasn't used the several months since L. was taken into care to address personal issues and improve her ability to take care of her little daughter. Despite the expectations of the Agency, the only goal C. has really achieved is getting her own apartment a month ago. Securing an apartment doesn't mean suddenly developing the maturity necessary to parent and, unfortunately, none of the other concerns identified in the Plan of Care dated May 30, 2013 have been addressed. C. has yet to participate in counselling to develop healthy relationship skills, learn to manage her anger appropriately, address domestic violence and abuse in relationships, substance use/abuse and other personal issues. Nor has she increased her understanding of child development and demonstrated progress in learning appropriate parenting practices. Unfortunately, given this lack of progress, C.'s dishonesty and her failure to cooperate with professional help, it is difficult to identify additional services which would ensure L.'s safety and well-being if she was returned to her mother' s care. Moreover, given the very careful monitoring and supervision which would be required, it is unlikely that an Order for Supervision would be adequate to protect L..

> C. is young and some her behavior (sic) reflects this. However, the bottom line is that, although C. loves her little daughter, she is not mature, capable, responsible or emotionally stable enough to be a parent. Moreover, she fails to recognize, and has made little effort to address, these shortcomings. Rather, she continues to point the finger at others and assumes little responsibility for her own behavior.
>
> As is abundantly clear from C.'s history, being in care doesn't necessarily result in a stable childhood. However, unlike C., L. is very young (sic) could enjoy a secure, healthy and safe upbringing and home life.

[168] Ultimately, Shepherd recommended permanent care and custody, and placement for adoption. She added a *caveat* that if the agency was reluctant to consider such a plan (at the stage when her Report was submitted) C. could be given a period of <u>not more than three months</u> to clearly demonstrate her willingness and ability to change and to cooperate by doing what is expected of her. Shepherd cautioned she was reluctant to make that suggestion "because, even though she is young, C.'s behavior difficulties are longstanding, her personality traits deeply ingrained and the prognosis for change and improvement extremely guarded".

[169] With the passage of time, the agency concluded it should move ahead with the primary recommendation. As of her Report date, Shepherd reminded:

> As discussed in the previous section of this report, many services have already been provided with very little progress being made by C. who has little insight into her difficulties or motivation to change. It is significant that, although her little daughter's future with her is at stake, C. has not taken advantage of counselling and other services. If additional services are provided, it is strongly advised that this be done on a time limited basis and continue only if C. shows a commitment to them. Obviously, the success of any intervention is fully dependent on C.'s being completely honest with professionals and others.
>
> It is recommended that the services of the Family Support Worker continue for this three month period and especially if L. is having longer visits with her mother. The expectations of C. in terms of demonstrating parenting and household management skills, including budgeting and establishing a healthy daily routine, and how she meets these, should be carefully documented.
>
> Given the ongoing concerns about L.'s overall health, it is recommended that there be immediate follow-up with medical personnel to determine whether L.

> has been referred to a Pediatrician and, if not, it is suggested that this be done immediately.

[170] I note that there is no countervailing expert opinion evidence regarding the mother's parenting capacity. She did not ask for an updated evaluation by Shepherd before the hearing started. And, apparently she did not seek a "second opinion" or critique by another service provider. Therefore, Shepherd's work went largely unchallenged (except through minor inroads made during cross-examination).

[171] Shepherd's assessment was not binding on the agency. Nor is it binding on the court. It must be considered along with all the other evidence before the court. (*Children's Aid Society of Pictou County v, A.J. G.*, 2009 NSFC 26.)

C. L.

[172] C. L. ("C.") did not formally respond to the agency's mounting case against her until she submitted an affidavit in late November, 2013. Even then, she did not confront and address the bulk of the factual assertions advanced by various agency representatives. Rather, she started by saying that when L. was apprehended she stopped all contact with her then former boyfriend, B. M., who was a "problem" for her. She reported she was enjoying a healthy relationship with a new (then unnamed) boyfriend who was said to be about 24 years old and employed.

[173] She mentioned she had secured her own apartment in June, 2013 which she furnished and baby-proofed. She admitted that there were "problems" with her landlord in July which were later resolved. She confirmed in July, 2013 access visits were approved to take place at her residence. She acknowledged that she had not been preparing full lunches for her daughter, but explained she did not have enough money that month to do so. She conceded she could have sought help from the local food bank but did not. By comparison, she said that she currently is unafraid to ask for help and that she can and will stock her residence with adequate food.

[174] C. wrote that she had dental problems for about six months preceding her affidavit which caused her pain and resulted in cancellation of some of her access

visits. She described the situation as temporary. She did not provide any reports from her dentist(s).

[175] C. wrote that on one occasion in July, 2013 she did not permit a worker to check inside her apartment; and that there were some cancelled visits that month. She wrote that she knew her mother disapproved of her relationship with B. M. and that her mother wanted her to attend a family meeting to discuss a variety of issues. But, she chose not to attend. C. later elaborated on why she "pushed her family away in August, 2013". She said it was because she thought that they really were not going to help her. She said she believed her situation was not her fault and she thought that "stuff would go away". In other words, C. seemed to be saying she believed her family was at fault and added "they are the reason I am who I am". Subsequently, she claimed she changed her mind.

[176] C. initiated contact with Addiction Services in July but cited systemic delays in arranging for services. (This is not in dispute.)

[177] Regarding counsellor Mary Haylock, C. acknowledged that it was her mother S. who first requested Haylock's services to help with their relationship. She also confirmed that it was Haylock who referred C. to Jan Cressman at C.'s behest. Subsequently, C. reneged on services through Cressman and justified it by simply saying that "it was not a good fit for me".

[178] In her subsequent (November) affidavit, C. also asserted that "not having the proper medication has made it difficult for me to keep appointments and stay focussed". And, she admitted she was slow to connect with resources and to reach out for additional help, but claimed she has made the changes necessary to remain on task. Specifically, C. wrote that she has "re-set" her goals and that she would be seeking additional time to develop her parenting skills and to demonstrate that she can parent on a full time basis.

[179] By November, 2013 C. said she was keeping her apartment clean and tidy and that agency workers were welcome to view and visit at any time.

[180] She said she has obtained a library card and has borrowed and read parenting books on her own initiative. Additionally, she said she is taking advantage of all resources that the Family Resource Centre has, including its "baby group". Other supports C. identified included her mother S., her mother's

boyfriend, N. M., and her uncle, S. L.. In her second affidavit, C. also requested more frequent access visits and provided some elaboration.

[181] In a later affidavit (filed in late January, 2014) C. wrote that she had an appointment with a psychiatrist to determine "appropriate treatment for ADHD". No psychiatric report accompanied her affidavit. When pressed, she was vague and unclear about the assessment and recommendations. She thought he had recommended continuing counselling. She confirmed that he prescribed no medications. She asserted that her memory of what was discussed with the psychiatrist was "foggy", but did not elaborate.

[182] C. discussed her counselling with Cindy Hall and that she intended to continue with services, including possible expansion of sessions to include a new boyfriend whom she identified as T.L.. C. confirmed that he has not yet met her daughter and that she believes she needs to know him better and longer before making any decisions about introducing the child to him. L. did not submit an affidavit or testify.

[183] C. wrote that she had regularly attended all of her access visits, including baby group sessions at the Family Support Centre. She stated she has been improving her skills in housekeeping, cooking and cleaning. She claimed to have learned a lot from her boyfriend who spends time with her showing her the methods that he uses for cleaning, cooking, preparing healthy meals, etcetera. She reported keeping a regular routine at her residence with her day starting at 9:00 in the morning and ending before midnight.

[184] C. included in her January, 2014 affidavit a list of books and other materials which she has either purchased or borrowed, read and reviewed. On the face of it, the list includes material dealing with needs of toddlers, child development, preparing healthy meals, etcetera.

[185] In this final affidavit, C. wrote of her belief that she has the right supports in place and that she is ready to have extended access visits at her residence. She wrote "My mom is my main support and our relationship is very positive. She calls me daily and we meet for coffee at least twice a week".

[186] C. conceded that she did not follow up with Melissa Zwicker on an offer of family support sessions after August 23, 2013. She justified this by writing that

she "became determined to show that I could make significant progress without their help". However, she had to admit she was pleased that Brandi Shaw became available to work with her starting in November, 2013.

[187] C. wrote that she has a strong attachment to her daughter and wants her daughter returned to her care. She reiterated that she is not afraid to ask for help from the local food bank or Feed Nova Scotia under the auspices of the Better Beginnings Program.

[188] As at the hearing, C. was receiving public assistance benefits and (through no choice of hers) her rent is being paid directly to the landlord by the Department of Community Services. She is unemployed at this time and not pursuing any educational opportunities pending the outcome of this case.

[189] C. reiterated that she had many dental problems and lots of dental work done, including removal of several teeth. However, she was nonspecific and, as already mentioned, she did not tender any written reports.

[190] As already noted, C. admitted that as of July, 2013 she had very few supports at home or in the community and that she had "pushed her mother and grandparents away" because she did not think that they could assist her. She frankly admitted that at the time she did not want those family members in her life.

[191] C. conceded that after L.'s birth when she set up her own residence that she was not fully meeting L.'s needs. She acknowledged that Melissa Zwicker was engaged to better help her but the service floundered. In testimony, C. largely faulted Zwicker for this. She said that Zwicker was supportive "in title only". She broadly described her as being unhelpful and inconsistent in delivery of advice and services. She freely admitted that there was a personality conflict between her and the worker who made her feel "on the spot". She had uncomplimentary things to say about Zwicker's personality. The upshot was that she admitted she missed a lot of sessions and decided to ask for a different worker. However, as discussed elsewhere, another worker (Brandi Shaw) was assigned, but not until November.

[192] During cross-examination, C. was challenged on many of her assertions. But she insisted that she felt bullied by Zwicker and that she could never do enough to satisfy the worker. She claimed that Zwicker firmly believed that she (as the mother) would never be able to do anything right and that the worker drew these

conclusions after many months of working with her. However, when pressed, C. admitted that Zwicker never said anything hurtful or negative - rather that she picked these things up from her tone and by her demeanor. In testimony, she conceded that all this was a matter of her perception.

[193] Referring to Exhibit 7, paragraph 11, she described her relationship with the unnamed individual - now believed to an older man, J.H. - as "more of a friendship" than anything else. Aware that her family was concerned about him, she admitted that she did not want or appreciate their interest. That relationship ended, she said, at the end of July or in early August, 2013.

[194] C. spoke positively of her professional relationship with Cindy Hall. She perceives Hall as a worker she can trust, and she believes Hall is "trying to help her move things out of her way". C. claimed that her past memories (about her upbringing and family of origin) are "fuzzy" and "all mixed up". She struggled to explain why this is so. She was vague and uncertain about the relevance or importance of her past experiences and upbringing for counselling or therapeutic purposes. She does not understand why (in counselling) she has been repeatedly called upon to discuss a past she cannot fully recall and believes those forays are unnecessary for current therapy to be successful. In almost the same breath, however, C. claimed she is now prepared to address past issues and to engage in more in-depth counselling with Cindy Hall. (She said they had started those discussions but have not gone into any depth.)

[195] Oddly, she stated that S. would remember more about her history and know more about her past than she. If this is so, it lends credence to S.'s disclosures made to various professionals during the course of this proceeding.

[196] C. said that her relationship with S. changed in August, 2013 when she finally told her mother that she desperately needed her help. Currently, she claims that her relationship with S. is "awesome". C. also spoke positively about the Baby Group which she has been attending regularly and she said that she has learned a lot from the other mothers and children who are there. She appears to be comfortable in that setting and, as discussed elsewhere generally doing well.

[197] C. said that Nancy Baker visited her apartment shortly before the case began. She said that no one else had been to visit her since August, 2013. As far as she knows, Baker was satisfied with the condition of her residence.

[198] During testimony, C. also broadly referred to support from her father's extended family - an apparently recent development. However, she did not name the individuals and none of them testified on her behalf or submitted affidavits.

[199] C. freely admitted that she still uses marijuana - but claims that she does not need it. She admitted to significant past use - but claims she can now handle the substance socially. In cross-examination, C. admitted to smoking marijuana as recently as the Sunday before the hearing started. She reaffirmed that reduced use of marijuana has not been easy for her because she resorted to it as a crutch in the past. She volunteered that use of marijuana tends to reduce bad memories and that she is able to find some clarity of thought through consumption of marijuana. Again, somewhat oddly, she claims to have replaced or substituted marijuana use with caffeine consumption.

[200] Regarding alcohol consumption C. said that she consumes "no more alcohol than any other 20 year old" and suggested that she drinks socially maybe once monthly. She claimed that there are no alcoholic beverages kept at her residence and that she has tried to reduce her consumption outside the home, even on social occasions.

[201] In testimony, C. strongly asserted that she wants L. at home with her because of the progress she has made. She admitted that she "can't do it tomorrow and that it will take some time". She admitted that she wants help and will accept help voluntarily - not "just because the agency is going against me". Asked about her general attitude towards supports and services, C. replied "Bring it on!" She freely admitted that she cannot parent alone, full-time as at the hearing - but she wants an opportunity to prove herself capable within the available statutory time lines.

[202] C. was carefully cross-examined on the voluminous evidence (from others) regarding her personal history. Because she did not seriously dispute most of the detail, there is no need to repeat it here.

[203] Although she acknowledged that L. has since birth needed stability, someone to count on, love and affection, etcetera, she (as the mother) was not meeting those needs for a very long time.

[204] C. claimed to have "made a 180 degree" in August, 2013. She denied that this had anything to do with the PCA and the agency's decision to seek permanent care and custody. In her words, these were "not a game changer". Rather, she claimed the about face was attributable to L. saying directly to her, "I love you" for the first time. She claimed that this simple declaration was, in and of itself, a turning point in her attitude and sparked the changes she says have been made since then. In terms of her present relationship with S., she said that both she and her mother have forgiven each other and both have accepted some responsibility for past events and the consequences.

[205] C. also listed a number of professionals associated with the agency to whom she told she wanted more frequent and longer access visits. However, she also admitted that the agency was looking to her for follow-through and commitment to supports and services as a prerequisite. Given that she floundered on so many fronts, she admitted that the agency's reluctance to enhance access was understandable.

[206] During testimony, C. also rounded out her disclosures about various men in her life by identifying one R.B. as another person with whom she had a relationship, after the relationship with B. M. ended. She agreed he visited her apartment but claimed he did not cohabit with her. Apparently, there was a dispute with the landlord over B.'s presence in the building which resulted in her terminating the relationship. She claimed that B. kept returning to the residence, even after she ended the relationship. She learned from others that B. apparently had a criminal record. She acknowledged that S. was one of those who knew about the man's background and confronted her about it. That said, she claimed that she has never intentionally put herself or her child deliberately in harm's way and, more recently, in the last six months that she has been coping very well with Cindy Hall's assistance.

[207] C. also admitted that she continues to associate with and to drink alcohol with her friends who should not be around her daughter. However, she limits her associations to those occasions when she is away from her residence. When asked directly why she does not completely sever her relationship with those individuals, C. struggled to explain and finally resorted to describing her friendships as being "important to her" - even if contact by the friends with her daughter may be inappropriate. When Mr. Gruchy suggested she <u>should</u> cut off all inappropriate

contacts, C. responded “I don’t have very many friends”. The clear implication was that severance of those friendships is not going to happen.

[208] With respect, C.’s courtroom testimony was disjointed and, at times, difficult to follow. Outwardly, she presented as a sincere witness; but her evidence was simplistic and often appeared rehearsed or practised. This is not inconsistent with the observations of some of the professional witnesses.

Discussion/Decision

The Statute

[209] All of the pertinent **CFSA** sections will not be reproduced. And, because the relevant case law is not in dispute, I incorporate the following excerpts from my decision in **Nova Scotia (Community Services) v. M.A.B.**, 2013 NSFC 11, starting at paragraph 54:

> “ ... the preamble sets out a number of basic principles, several of which are intersecting and sometimes seem to be competing.
>
> I am mindful that children are entitled to protection from abuse and neglect; and that the basic rights and fundamental freedoms of children and their families include a right to the least invasion of privacy and interference with freedom that is compatible with their own interests and of society’s interest in protecting children from abuse and neglect. Also, parents have responsibility for the care and supervision of their children; and children should only be removed from that supervision, either partly or entirely, when all other measures are inappropriate.
>
> ... children, are presumed to have a sense of time that is different from that of adults, and services provided under the **CFSA** must respect the child’s sense of time.
>
> Also, as a matter of principle, when it is necessary to remove children from the care and supervision of their parents they should be provided for, as nearly as possible, as if they were under the care and protection of wise and conscientious parents...
>
> I have also directed myself that the purpose of the **CFSA** is to protect children from harm, promote the integrity of the family and assure the best

interests of children. In this proceeding, the paramount consideration is the best interests of the children.

Under section 3 (2) of the **CFSA**, when making orders and determinations in the best interests of a child, I must consider a host of relevant circumstances as set out in subsection (a) through (n)...

A broad statement of agency functions will be found in section 9. And section 13 elaborates on potential services promoting integrity of the family. The agency must take reasonable measures to provide services to families and children that promote the integrity of the family. The range of services intended to promote family integrity include, but are not limited to those services provided directly by the agency or provided by others with the agency's help for the purposes set out in subsections (a) through (k), inclusive.

Section 22 (2) sets forth when a child is in need of protective services. Where there is reference to "substantial risk", that means a real chance of danger that is apparent on the evidence.

Under section 41, one will find directions regarding disposition hearings. The court must also consider a plan for the child's care and the minimum content standard is set out in section 41(3) sub-subparagraphs (a) through (e).

The court's so-called options at the conclusion of a disposition hearing are set out in section 42 (1).

The court must not make an order removing a child from the care of a parent unless satisfied that less intrusive alternatives , including services to promote the integrity of the family pursuant to section 13 have been attempted and have failed, have been refused by the parent or guardian, or would be inadequate to protect the child.

Under paragraph 42 (3), where the court determines that it is necessary to remove a child from the care of a parent, the court must before making a permanent care and custody order ... consider whether it is possible to place the child with a relative, neighbour or other member of the child's community or extended family, with the consent of the relative or other person...

There is also an overreaching directive that the court shall not make an order for permanent care and custody of a child unless the court is satisfied that the circumstances justifying the order are unlikely to change within a reasonably foreseeable time not exceeding the maximum time limits, based on the age of the

child, set out in section 45 (1), so that the child can be returned to the parent. Section 46 deals with review hearings. The key portions follow:

(3) Where an application is made pursuant to this Section, the child shall, prior to the hearing, remain in the care and custody of the person or agency having care and custody of the child, unless the court is satisfied, upon application, that the child's best interests require a change in the child's care and custody.

(4) Before making an order pursuant to subsection (5), the court shall consider

(a) whether the circumstances have changed since the previous disposition order was made;

(b) whether the plan for the child's care that the court applied in its decision is being carried out;

(c) what is the least intrusive alternative that is in the child's best interests; and

(d) whether the requirements of subsection (6) have been met.

(5) On the hearing of an application for review, the court may, in the child's best interests,

(a) vary or terminate the disposition order made pursuant to subsection (1) of Section 42, including any term or condition that is part of that order;

(b) order that the disposition order terminate on a specified future date; or

(c) make a further or another order pursuant to subsection (1) of Section 42, subject to the time limits specified in Section 43 for supervision orders and in Section 45 for orders for temporary care and custody.

(6) Where the court reviews an order for temporary care and custody, the court may make a further order for temporary care and custody unless the court is satisfied that the circumstances justifying the earlier order for temporary care and custody are unlikely to change within a reasonably foreseeable time not exceeding the remainder of the applicable maximum time period pursuant to subsection (1) of Section 45, so that the child can be returned to the parent or guardian.

Section 47, among other things, sets out the consequences of a permanent care and custody order, addresses the subject of access, and related issues. I am aware that

section 48, among other things, addresses the question of variation and termination of permanent care and custody orders.

Minister of Community Services v. C.B., 2012 NSSC 358 is a decision which dealt with an application by the Minister of Community Services for a permanent care and custody order, with no provision for access between a mother and her children. The case presented itself as a review of disposition hearing.

In her decision, Justice Elizabeth Jollimore directed herself that a disposition order is one that requires the court to consider the best interests of the child or children. After mentioning the various disposition options, she emphasized that each possible disposition must be considered. She cited **Children's Aid Society of Halifax v. B.(T.), 2001 NSCA 99** at paragraph 19.

[27] I'm to consider each of these possible dispositions, according to Justice Saunders in *Children's Aid Society of Halifax v. B.(t.),* 2001 NSCA 99, at paragraph 19.

[28] Ms. B has been clear that she is not asking for more time, either to address the application with regard to C (which would need to be concluded in just five weeks, in any event) or to consider another possible disposition for J. By virtue of J's age, a final disposition isn't required until May 21, 2013.

[29] Ms. B has had more than one year to address the Minister's concerns. The concerns were identified at the outset of the proceeding. The Agency has been alerted about concerns relating to the children frequently since M was born and those referrals have been annual since 2007. Ms. B has been provided with services to assist her in remedying the deficiencies and problematic circumstances.

She also noted that the court is not required to defer or delay a permanent care decision until the maximum time limit prescribed by statute has expired. To this end she cited the decision of **Nova Scotia Minister of Community Services v. L.L.P.**:

[30] According to the Court of Appeal's decision in *Nova Scotia (Minister of Community Services) v. L.L.P.,* 2003 NSCA 1, at paragraph 31, I am not required to defer a permanent care decision until the maximum time limit has expired.

Justice Jollimore was facing a situation in which the legal options had been reduced to returning the children to their mother or placing them in the Minster's permanent care and custody...

As mentioned, the court must also consider section 42 (2) and 42 (4) of the **CFSA**. The first mandates that the court not make an order that removes children from their parent unless the court is satisfied that less intrusive alternatives have been tried and have failed, have been refused, or would be inadequate to protect the children. The latter section instructs the court that it must not make a permanent care and custody order unless the court is also satisfied that the circumstances which justify the order are unlikely to change within the reasonably foreseeable time, not exceeding the maximum time limits prescribed by the statute.

On the issue of access following a potential permanent care and custody order, Justice Jollimore similarly faced a request by the Minister of Community Services that there be no order for access between the mother and her children. It was noted that a decision with regard to access following a permanent care order is <u>not</u> one which requires the court to consider the children's best interests. Rather, under section 47 (2), the court may not make an order for access unless satisfied that one of the identified circumstances in the subsection exists. Access may be available where an adoption is not planned or where some other special circumstances justifies an access order. In the circumstances she faced, Justice Jollimore had evidence that adoptions were planned for the children involved and there was evidence that an ongoing access order could impair the prospect of the adoptions.

Mi'Kmaw Family and Children's Services v. KDo, 2012 NSSC 379 is a decision of Justice Theresa Forgeron who, at a review hearing, was asked to decide whether three children should be placed in the agency's permanent care and custody - despite the fact that the legislative timelines had not been exhausted. The issue to be decided was whether the circumstances giving rise to a previous temporary care and custody order were likely or unlikely to change within a reasonably foreseeable time.

In addressing the issue, Justice Forgeron wrote as follows:

[18] In this case, the agency is assigned the burden of proof. It is the civil burden of the proof. The agency must prove its case on a balance of probabilities by providing the court with "clear, convincing, and cogent evidence"**: C.(R.) v. McDougall**, 2008 SCC 53. The agency must prove why it is in the best interests of the children to be placed in the permanent care and custody of the agency, according to the legislative requirements, at this time.

[19] In making my decision, I must be mindful of the legislative purpose. The threefold purpose is to promote the integrity of the family, protect children from harm, and ensure the best interests of children. The overriding consideration is, however, the best interests of children as stated in sec. 2 (2) of the *Act*.

[20] The *Act* must be interpreted according to a child centred approach, in keeping with the best interests principle as defined in sec. 3(2). This definition is multifaceted. It directs the court to consider various factors unique to each child, including those associated with the child's emotional, physical, cultural, and social development needs, and those associated with risk of harm.

[21] In addition, sec. 42 (2) of the *Act* states that the court is not to remove children from the care of their parents, unless less intrusive alternatives have been attempted and have failed, or have been refused by the parent, or would be inadequate to protect the children.

[22] When a court conducts a disposition review, the court assumes that the orders previously made were correct, based upon the circumstances existing at the time. At a review hearing, the court must determine whether the circumstances which resulted in the original order, still exist, or whether there have been changes such that the children are no longer children in need of protective services: sec. 46 of the *Act*; and **Catholic Children's Aid Society of Metropolitan Toronto v. M.(C.)** [1994] 2 S.C.R. 165.

[23] Past parenting history is also relevant as it may be used in assessing present circumstances. An examination of past circumstances helps the court determine the probability of the event reoccurring. The court is concerned with probabilities, not possibilities. Therefore, where past history aids in the determination of future probabilities, it is admissible, germane, and relevant: **Nova Scotia (Minister of Community Services) v. Z.S.** 1999 NSCA 155 at para. 13; **Nova Scotia (Minister of Community Services) v. G.R.** 2011 NSSC 88, para. 22, as affirmed at **Nova Scotia (Minister of Community Services) v. G.R.** 2011 NSCA 61.

[24] Section 42(4) of the *Act* provides the court with the authority to make a permanent care order, even when the legislative time lines have not been exhausted, if circumstances are unlikely to change within a reasonably foreseeable time. Section 42(4) states as follows:

> (4) The court shall not make an order for permanent care and custody pursuant to clause (f) of subsection (1), unless the court is satisfied that the circumstances justifying the order are unlikely to

> change within a reasonably foreseeable time not exceeding the maximum time limits, based upon the age of the child, set out in subsection (1) of Section 45, so that the child can be returned to the parent or guardian. 1990, c. 5, s. 42.

[25] Section 46(6) of the *Act*, notes a similar provision. Section 46 (6) states as follows:

> Where the court reviews an order for temporary care and custody, the court may make a further order for temporary care and custody unless the court is satisfied that the circumstances justifying the earlier order for temporary care and custody are unlikely to change within a reasonably foreseeable time not exceeding the remainder of the applicable maximum time period pursuant to subsection (1) of Section 45, so that the child can be returned to the parent or guardian. 1990, c. 5, s. 46.

Justice Forgeron provides helpful guidance on what I conclude is one of the crucial issues or themes in the present case - the likelihood of circumstantial change within the reasonably foreseeable future:

[26] Although discretionary, secs. 42(4) and 46(6) of the *Act* do not provide the court with unlimited jurisdiction. All discretionary authority must be exercised judicially, and in accordance with rules of reason and justice, not arbitrarily and based upon a rational and solid evidentiary foundation: **MacIsaac v. MacIsaac** (1996) 150 NSR (2d) 321 (C.A.). This requirement is heightened when the meaning of "reasonably" and "foreseeable" are examined.

[27] "Reasonably foreseeable" is not defined in the legislation. In *Words & Phrases: Judicially Defined in Canadian Courts and Tribunal* vol, 7. (Toronto: Carswell, 1993) (June 2012 supplement) at p. 7-36, s.v., "reasonably" is defined as follows:

> ...the definition of "reasonably" in Webster's Third International Dictionary [is as follows:]:
>
> 1. in a reasonable manner (acted quite...)
>
> 2. to a fairly sufficient extent (a book that is good).What is "reasonable" is not the subjective view of either the respondent or appellant but the view of an objective observer with a knowledge of all the pertinent facts.

The Shorter Oxford English Dictionary on Historical Principles refers to"reasonably" as an adverb meaning "in a reasonable manner; sufficiently; fairly". (Income Tax)

Bailey v. Minister of National Revenue, [1989] 2 C.T.C 2177 at 2182, 2183, 89 D.T.C. 416 (T.C.C.) Rip T.C.J.

[28]"Foreseeable" is defined in the Judy Pearsall, ed, *The New Oxford Dictionary of English*, 9th ed (New York: Oxford University Press, 1999) at p. 718, s. v., as follows:

Foreseeable - **adjective** able to be foreseen or predicted ...

[29] In this context, it is helpful to review the cases submitted to the court by counsel. Circumstances which have been identified as important in determining if a change can be made in a reasonably foreseeable time are as follows:

(a) *Whether other children have been placed in the permanent care and custody of the agency, or in the permanent custody of other adults*. In **Nova Scotia (Minister of Community Services) v. G.R.** ***supra***, three of the respondent's children were in the custody of paternal grandparents; another child was in the permanent care of the Minister; and a fifth child was apprehended at birth and remained in the temporary care of the Minister.

(b) *Whether the children have a lengthy history of being in the temporary care of the agency*. In **Children's Aid Society of Halifax v. D.H.** 2006 NSSC 1, three separate court proceedings had been initiated. As a result, the four and five year old children had only been in the unsupervised care of her parents for five months; and the youngest child had not been in the unsupervised care of her parents at any time.

(c) *Whether the parent lacked meaningful insight into the issues that gave rise to the protection finding*. In **Nova Scotia (Minister of Community Services) v. G.R.**, ***supra***, the mother minimized the abusive and dysfunctional nature of her relationship with the father. The mother was unable to identify the changes she had to make in her lifestyle to ensure a safe environment for the child. In **Nova Scotia (Minister of Community Services) v. P.M.D.,** 2002 NSSF 38, the mother lacked insight into her addiction to cocaine, which led to a life of prostitution and crime. The mother failed to

become involved in a meaningful drug rehabilitation program. In **Nova Scotia (Minister of Community Services) v. S.W.** 2010 NSSC 472, the court held that maximizing the statutory time limits would not result in the mother effecting necessary changes. The mother severed all relationships with each of the doctors who sought to reduce her addiction to pain medication.

(d) *Whether the parent exercised access*. In **Nova Scotia (Minister of Community Services) v. G.R.**, ***supra***, the mother lacked commitment to the child, having only exercised access on five occasions. In **Nova Scotia (Minister of Community Services) v. S.W.** , ***supra***, the mother was late for approximately 25% of all scheduled visits, and another 17% were cancelled as a result of her actions or inactions.

(e) *Whether the parent lacked basic parenting and housekeeping skills*. In **Children's Aid Society of Halifax v. D.H.**, ***supra***, the mother's parenting skills were so pervasively and extensively inadequate, that no hope of change was probable. In **Nova Scotia (Minister of Community Services) v. S.W.**, ***supra***, the mother made limited progress in developing even basic parenting skills, such as feeding, diapering, or securing the child correctly in a car seat.

(f) *Whether an expert provided opinion evidence confirming an inability to parent*. In **Children's Aid Society of Halifax v. D.H.**, ***supra***, the assessor recommended permanent care because of filthy living conditions, drug and alcohol abuse, and chronic neglect. In contrast, in **Nova Scotia (Minister of Community Services) v. E.C.** 2007 NSSC 37, the court placed little weight on the expert report because of the erroneous information that it contained.

(g) *Whether the parent was effecting positive changes that resulted in lifestyle improvements*. In **Nova Scotia (Minister of Community Services) v. E.C. supra**, the mother's parenting skills had improved. The mother was focussed and open to learning new skills by participating in services. The request for a permanent care order was denied.

... I must be attentive to the present and not get swept away with the past, and that the main focus now is the child ... I am alert to the practicalities of so-called "front-end loading" and proceeded cautiously in this subject area. [See **C.A.S. of**

> **Regional Municipality of Waterloo v. R.C.** [1994] O.J. No. 2955 (Ont. Prov. Div. *per* Katarynych Prov. J.] at paragraphs 14 - 21."

[210] On the evidence, in the **M.A.B.** case, I found that the circumstances which led to imposition of the last temporary care and custody had changed. I was persuaded that the mother's psychotherapy regime has sparked significant positive changes in her mental health which were not fleeting, trivial or feigned. On a balance of probabilities, I found there was good reason to believe the mother was capable of, and should, resume parenting of her child, provided her therapy continued in conjunction with other supports and services. I noted the result was influenced by, but not confined to, several considerations - such as strong expert opinion medical evidence regarding the specialized therapies, including progress since the last order, its efficacy and the prognosis for "success", as compared to past generalized treatment recommendations and efforts; the mother's consistent cooperation and acceptance of services and supports throughout, coupled with her improved insight into the underlying issues; the mother's impeccable access record (frequency, duration, and quality); evidence that basic parenting and housekeeping skills were present; the mother's assurances that she will abide by any terms and conditions imposed by the court (including contact prohibitions or constraints) to allay ongoing agency concerns; evidence that breaking the very strong bond between mother and daughter may cause significant emotional harm to the daughter; speculative evidence of risk that the child may suffer (emotional) harm after repatriation should she later be reapprehended compared to the risk of emotional harm incidental to permanent care and breaking the parent/child bond; the child's wish to be returned to her mother's care and to enjoy a secure place as a member of her own family, immediate and extended; and the absence of special or exceptional physical, mental or emotional needs or demands by the child. I also found an absence of cogent evidence to support the agency's propositions that the effect of delay on the child and the risk of other (negative) effects - if she was returned to her mother, if the proceeding was continued, and if final disposition was delayed until later in the year - outweighed the risk of emotional harm and other negative effects should she be placed in permanent care immediately. So, I ordered return of the child to the care and custody of her mother under agency supervision, on specified terms and conditions.

[211] Many times (as now) the legal principles are not disputed, and outcomes are driven by the facts of the particular case. The facts in the present case are very different than those in **M.A.B.** - where permanent care was not granted. And they

are different than those before Justice Douglas Campbell in **Nova Scotia (Community Services) v.P.J.**, 2014 NSSC 87 when he wrote - before granting permanent care:

> [50] When the statutory deadline has not been reached, that same section allows the court other options including the return of the children to parents but subject to a Supervision Order - which is being suggested by both respondents.
>
> [51] In this case, the outside statutory deadline occurs on June 13, 2014 some 3.5 months from these trial dates. Both respondents have urged the court to order a supervision regime until the outside statutory deadline to allow the parents to prove their abilities.
>
> [52] The case law makes it clear that 1) there is no principle that requires that a case should be extended to the maximum statutory deadline; and that, 2) permanency planning for children is a priority.
>
> [53] I have concluded that such a short period (3.5 months) given the lengthy history of Agency intervention and services will not afford the parents the opportunity to reverse the child protection concerns by proving their capabilities given their past history and that nothing would promote the best interests of these children by deferring today's decision for such a short period of time instead of making an order for permanency planning in favour of either the Applicant or the Respondents
>
> [54] Section 42 (4) of the CFSA states that an otherwise appropriate permanent care order should not be declined when the concerns are unlikely to be resolved in the time allowed by the statutory deadline.
>
> [55] In this case, I am satisfied that a continuation of Agency involvement even if it included appropriate services would be unlikely to allow the parents to reverse the concerns by the outside date of June 13, 2014. Therefore, I see the Court's practical options as being those statutory alternatives mentioned above; namely, termination of the proceeding or Permanent Care and Custody.
>
> [56] Section 42 (2) of the CFSA requires that no order for permanent care should be made when less intrusive measures could succeed. From my above

comment, it follows that there are no less intrusive measures available that could reasonably be expected to succeed within the statutory timelines.

[57] It is not surprising that a body of decided cases makes it clear that the test for returning children to parents is not whether those parents have the best possible plan and can provide the best possible environment for the children. In other words, the fact that alternative plans might benefit the children to a greater extent, is not a reason to deny the children a return to their parents. I must therefore not inquire whether these parents have the best possible plan; the real test is whether the children would continue to be in need of protection if returned to the care of their parents.

[58] I have concluded that, despite the practical redundancies of the two triggering events that brought on this agency's third apprehension, and the somewhat exceptional commitment by both parents to change their lifestyle, their questionable judgment measured against the somewhat questionable progress made by both parents in the first two apprehensions when considered in the context of all of the expert opinions and their reasons (which reasons this Court adopts), these two children would face long-term protection concerns if returned to the parents.

[59] Of at least equal significance is the uncontradicted evidence that the children have prospered (against all odds, given their special needs) in foster care. The opinion evidence, and the Court's conclusion, is that they are unlikely to cope well with their emotional, social and educational development if responsibility for those environments were left to their parents. While their future may be uncertain in a combination of foster care and adoptive care homes, their prognosis in those settings is clearly more likely to promote their best interests and to eliminate their otherwise continued need for protection.

[60] The Agency plan is to place the children for adoption if this Court should order Permanent Care and Custody in favour of the Agency. There was evidence from an adoption specialist which suggests that, despite the special needs of these children, their prospect for adoption is positive. I accept that proposition.

...

> [62] The actual placement of the children following a Permanent Care Order is beyond the mandate of the Court and falls instead within the mandate of the Agency. This Court should not pre-judge how the potential adoption might unfold after the Court has completed its involvement
>
> ....
>
> [64] Considering all of the evidence, and after paying special attention to the contextual circumstances mentioned above, I have concluded that there is no less intrusive solution to promote the pursuit of these children's best interest than to place them in the Permanent Care and Custody of the Agency with a plan for adoption and I so order.

[212] Regrettably, in the present case, the dim prospects for a different outcome as forecasted by many of the professionals - but, notably Cox and Shepherd - have proven to be accurate. Much of the mother's "failure" (to exercise responsibility and self-control, to consistently and fully engage in services, to discontinue drug use, to sever ties with contemporaries and others she knows are a bad influence, etcetera) - appears to be connected to serious family of origin issues and deep-seated personality traits. The former are still unresolved; and the latter are highly unlikely to change within the brief time left.

[213] As guardedly recommended by Cox and Shepherd, the mother was afforded extra time to prove by her actions that things could and would significantly change. Giving credit where it is due, access visits in recent months have generally gone well, her residence is outwardly stable and much-improved, and the mother professes she is committed to her daughter's return. But, with respect, this is a far cry from what is needed to parent full-time. The evidence, to paraphrase Shepherd, is that something is still drastically interfering with the mother's capacity to parent (full-time) and that she still does not understand or appreciate that providing stable, safe and appropriate care involves a lot more than having your own place to live and keeping it clean. What was (and is) needed was spelled out in fine detail by Shepherd many months ago; , but I find still has not been achieved. Even therapist Cindy Hall (who is a relatively new service provider whom the mother highly regards), perceives a need for a minimum of six more months work - but carefully (and properly) avoided predicting the results.

[214] As at the hearing, the child is admittedly still in need of protective services. I find the circumstances have not changed materially since the last order and that the agency's final plan will best meet the child's needs. Although it runs counter to the mother's wishes, I conclude that further delay in implementing the plan will not advance the child's interests. I reiterate that the circumstances giving rise to the protection finding are unlikely to change before the expiration of the maximum available time under **CFSA** section 45 (1), such that the child might be returned to her mother. I find there is no reasonable prospect that the mother will accomplish in less than three months the wholesale changes needed and that she has been unable to achieve since her daughter was taken into care.

[215] Applying the law as stated above to the facts, I determine it is in the child's best interests that she be placed in the agency's permanent care and custody. There is no foundation in the evidence to make an exceptional access award under section 47: **Nova Scotia (Community Services) v. T.H.**, 2010 NSCA 63; **Children and Family Services of Colchester County v. K.T.**, 2010 NSCA 72; **Mi'kmaw Family and Children's Services v. B.L.**, 2011NSCA 104; **P.H. v. Nova Scotia (Community Services)**, 2013 NSCA 83.

[216] I make no finding regarding the child's religious faith.

[217] Mr. Gruchy shall submit an appropriate order.

Dyer, J. F. C.