IN THE FAMILY COURT OF NOVA SCOTIA
Citation: Nova Scotia (Community Services) v. L.B., 2009 NSFC 8

Date: 20090402
Docket: FLPCFSA-050954
Registry: Bridgewater

Between:

Minister of Community Services
(formerly Family and Children's Services of Queens County)

Applicant

v.

L.B., by her guardian ad litem, A. Franceen Romney,
and S.B.

Respondents

Publication restriction: 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.

Revised Decision: The text of the decision has been revised to protect the identity of certain parties. This revised version is released on April 14, 2009.

Judge: The Honourable Judge William J. Dyer

Heard: February 11, 2009 at Liverpool, Nova Scotia
February 18, 2009 at Lunenburg, Nova Scotia
February 26, 2009 at Liverpool, Nova Scotia

Counsel: Alan G. Ferrier, Q.C., for the Applicant
Janus E. Naugler, for the Respondent, L.B., by her guardian ad litem, A. Franceen Romney
Tim A. M. Peacock, for the Respondent, S.B.

By the Court:

The Issues

[1] This is a review of disposition under the **Family and Children's Services Act (CFSA)** in which permanent care and custody of a child is sought by an agency, subject to an exceptional provision for access under section 47. The father seeks dismissal of the proceeding; the mother (by her guardian ad litem) takes no position but participated in the hearing. It is common ground that the statutory time limits are so far advanced that the only alternatives are dismissal or permanent care.

[2] A previous review decision [2008 NFC 29] canvassed the factual circumstances as of May, 2008.

The Parties

[3] Family and Children's Services of Queens County is the agency. L.B., or the mother) and S.B. are the parents of an eight year old child, D.B. L.B. appears by her court-appointed guardian ad litem, A. Franceen Romney.

History of Proceedings

[4] D.B. was taken into the care of the agency on January 26, 2007 when he was six years old. The interim hearings were completed by mid-February, 2007. There was a consent protection finding on May 23, 2007; and a consent disposition order was authorized on September 6, 2007 under the agency's prevailing plan for <u>temporary</u> care and custody. Findings were made under section 22 (2) (b) [substantial risk of physical harm] and (g) [substantial risk of emotional harm], respectively.

[5] By mid-December, 2007 the agency's amended plan was for <u>permanent</u> care. After a delay occasioned by a change in the father's employment status, and his unavailability to instruct counsel and to sooner participate in a hearing, a review was conducted in May, 2008. A written decision followed; the child has remained in the agency's temporary care.

The Evidence

Dr. James Rafferty, physician

[6] Dr. James Rafferty's general medical practice includes service at a Queen's County Hospital. He has been consulted several times regarding D.B. since he was taken into the agency's care. He disclosed nothing unusual about D.B.'s general medical history. However, in September, 2008 Dr. Rafferty was at a local fair when he observed a woman collapse from either the heat or a possible seizure. He and two other doctors and a nurse practitioner provided medical aid. It was later learned that the affected adult was L.B. D.B. was not at his mother's side when the incident occurred but was located a few minutes later. D.B. was apparently under the supervision of another adult, likely his grandmother. In any event, Dr. Rafferty reported that D.B. was quite upset and worried about his mother. He subsequently saw D.B. at his clinic regarding routine ailments.

[7] In January, 2009 D.B.'s counselor, Jan Cressman, expressed concerns to the doctor about facial tics, muscle spasms, and the like. Reportedly Ms. Cressman was concerned about possible Tourette's Syndrome and, as a consequence, Dr. Rafferty made a referral to a specialist at the IWK Hospital in Halifax. As at the hearing, a formal assessment had not been completed.

[8] Dr. Rafferty mentioned in his testimony that he had noticed a distinct change in D.B.'s presentation after September, 2008. In his observation, D.B. was much more nervous and presented with many more facial spasms than previously. Understandably, Dr. Rafferty did not want to jump to any conclusions or label D.B. with any particular disorder or syndrome. Accordingly, he made an appropriate referral. He also suggested that a neurological assessment may be appropriate some time in the next year or so.

Dr. Andrew Blackadar, physician

[9] Dr. Andrew Blackadar has been L.B.'s primary care physician for over five years. Mental health issues have dominated the doctor/patient contacts and persisted. According to Dr. Blackadar, L.B. has mainly presented with issues of delusional thought and frequently with some evidence of psychosis. His evidence

at the last hearing was that there were persistent difficulties with delusional thought, paranoid ideation, and lack of any insight into her difficulties.

[10] An involuntary hospital admission occurred at one stage. A medication regime was imposed but did not eliminate the underlying disorder. In summary, L.B. historically presented as somebody with an inability to process reality and deal with current and real life problems, and with a tendency to have delusional thoughts and issues which have involved her children and involved her relationships with others. By his account, she has always been extremely suspicious and paranoid of medical professionals, and very dependent on her spouse.

[11] For the purposes of the current hearing, a report from Dr. Blackadar confirmed that L.B. experienced two generalized seizures in mid-September, 2008. Reportedly, the incidents involved complete loss of consciousness, significant confusion and profound fatigue, and significant tongue trauma. One of the incidents occurred in the outpatients department of the local hospital and was witnessed by an attending physician. Dr. Blackadar noted that L.B. had no prior risk factors for seizures.

[12] Following the episodes, L.B. was referred to a psychiatrist and a neurologist. Subsequently, a new risk factor with respect to seizures was identified - one of her medications. Dr. Blackadar wrote that L.B. has consistently demonstrated "reasonable compliance in taking her medications in the past". Investigations for the seizure disorder have not been completed. In summary, Dr. Blackadar said that L.B. has a new seizure disorder, the cause of which has not been precisely determined but a change in her medication regime might have contributed to her difficulties. Dr. Blackadar is unable to predict with any certainty the risk of possible further episodes.

Dr. Simon A. Brooks, psychiatrist

[13] Dr. Simon A. Brooks was a staff psychiatrist at the South Shore Regional Hospital and a consultant in adult mental health for the Mental Health Branch of the Department of Health. The parties agreed at the last hearing that L.B. has an extensive medical history and that there are voluminous records and files. Dr. Brooks was permitted to summarize L.B.’s mental health history. It is set out in the last decision.

[14] Dr. Brooks' last contact with L.B. was in mid January, 2008 when she self-disclosed that she was sleeping well, had gained some weight, and was generally coping with life. Dr. Brooks stressed that he did not substantiate or verify these disclosures.

[15] I accepted Dr. Brooks' evidence that L.B.'s presentation to him had always been "abnormal", that she was intensely dependent on her husband, that she clings to him physically on most occasions, that she tries to avoid answering questions directly if she can induce her spouse to do so on her behalf, and that she had a history of "inconsistency" with other mental health professionals. His opinion was that L.B. "suffers from a chronic recurrent psychotic disorder, probably best understood as bipolar disorder, manifesting itself in episodes of mania and of depression, and apparently fairly responsive to mood-stabilizing medication...." He said her chronic psychotic disorder will continue but, as long as she continues to take appropriate medication, it is unlikely she will have major manic or depressive episodes. In short, he said that the disorder is not curable but it can be managed.

[16] Dr. Brooks took pains to distinguish L.B.'s psychotic disorder from her attachment problems and said the latter were running parallel to the bipolar disorder and not caused by it. The attachment issues were largely seen as psychological in origin and he opined that they may be responsive to long term psychotherapeutic services which, as noted elsewhere, she has not pursued. Last May, it was his opinion that there was little likelihood of her problems resolving themselves in the near future (i.e. next year or two).

[17] In terms of potential long term psychotherapy, if L.B. decided to re-engage in services, Brooks foresaw years of therapy; but she would have to acknowledge her difficulties and be prepared to seek out and continue with help. While retained, Brooks stated that he had only seen a slight improvement in her interactions with him and that she is still poor by comparison to other patients in terms of progress. Asked about the availability of psychotherapy and related services in the local area, Brooks stressed that available services are as good as anywhere else in the Province.

Dr. Neal Morgan, psychiatrist

[18] Accompanying Dr. Blackadar's last report was a report from psychiatrist Dr. Neal Morgan. Dr. Morgan briefly summarized L.B.'s mental health history. L.B. and her spouse self-reported improvements in their circumstances and L.B.'s general state of health. He also recounted the seizure episodes and the aftermath; and recommended a change in L.B.'s medication regime. Some recommendations were also made with regard to her weight gain.

[19] Based on the self-disclosures, Dr. Morgan wrote that L.B. appeared to be doing quite well from a psychiatric point of view in the context of her past history. He cautioned her regarding warning signs for the onset of manic and psychotic episodes. Like his predecessor, Dr. Morgan has constrained his role to consultations if and when requested by his patient. And, there is no mention of the psychological aspects of her case which Dr. Brooks had suggested would be amenable to long-term therapy.

Dr. Bernhard Pohlmann-Eden, neurologist

[20] Also appended to Blackadar's last report is a report from neurologist Dr. Bernhard Pohlmann-Eden who confirmed that L.B. had suffered two generalized seizures. He postulated a number of possible provoking factors but drew no firm conclusions. He recommended further investigation and reassessment, and a follow-up consultation.

Dr. Susan Hastey, parenting assessor

[21] Dr. Susan Hastey was qualified to give expert opinion evidence regarding parenting capacity, custody and access issues, and individual and family counseling. She testified regarding her Parenting Capacity Assessment Report at the last hearing. An in-depth summary of her findings, conclusions, and recommendations will be found in my last decision. Her experience with the family goes back to 1999. She is quite familiar with the parents and their evolving circumstances.

[22] The respondents did not request an assessment or "second opinion" by a different qualified professional. Nor did they seek a supplementary assessment by Dr. Hastey, or scrutiny of her report by another expert regarding methodology, findings, or recommendations.

[23] Dr. Hastey was very concerned that (apart from some professional and church contacts) there had been little in the way of community support efforts made by S.B.. She thought such efforts might have decreased L.B.'s resistance to seeking and accepting counseling through Mental Health Services or otherwise. S.B.'s shortcomings in providing firm direction and support to L.B. were seen as a major contributor to the family's stalled progress.

[24] Dr. Hastey previously identified a long list of concerns. They are repeated here because in Dr. Hastey's opinion, then and now, they would place D.B. at risk if he is returned to the day-to-day care of his parents:

> She is incapable of parenting on a one-to-one basis. She continues to have problems with communication, impulse control and boundary formation.
> There have been some improvements in L.B.'s mental health condition, but many of the dynamics in her relationship and interaction with her spouse continue to be problematic.
> She has disclosed limited tolerance for interaction with D.B..
> She has little insight or understanding into her mental health issues.
> She does not have the ability to differentiate herself and her own needs from those of her son and her family.
> She continues to be overwhelmed with anxiety and fears and presents with an inappropriate affect which may be detrimental to parenting and may lead to dysfunction in the child.
> She is intolerant to the presence of other individuals, apart from her spouse, in the home environment. She has little ability to make her own choices and decisions and has limited ability in regard to social contact and activities outside the home and her relationship with her spouse.
> She has weak communication with and interaction with her son even during access visits.
> She is unable to state and may not understand her son's social, emotional and physical needs and is largely out-of-touch with her son's developmental history, his schooling and friends, and general well-being.
> She holds unreasonable expectations for D.B. having regard to his age. There is concern that she, in the past, may have isolated the child physically within the home and may have engaged in corporal punishment.
> Her communication skills and patterns still exhibit significant levels of dysfunction including difficulty listening and focusing on questions, or responding to routine questions.
> She is neither physically nor emotionally available to her son. She is unlikely to be able to set or to encourage appropriate routines for her son in the absence of her spouse.
> She is unlikely to be able to respond in a timely manner, or in an appropriate manner to physical or general emergencies affecting D.B. or herself.

> Her overall mental health status precludes either co-parenting or individually parenting D.B..
> She continues to be obsessed with her spouse. She has questionable ability to share schedules and responsibilities within the home without her spouse. She is unlikely to be able to share in a cohesive discipline or parenting plan with her spouse, in her spouse's absence. Manipulation and obstruction by L.B. within the household is likely should the child be returned to the care of the parents.

[25] On the issue of L.B.'s inability or unwillingness to follow through with services, Dr. Hastey said she repeatedly stressed to L.B. and to S.B. the importance of taking some initiatives and following-through, but this has not happened.

[26] As noted, Dr. Hastey concluded that L.B. is incapable of parenting her son on a one-to-one basis, notwithstanding some improvements in her mental health condition as a result of prescription medications. Of particular concern was L.B.'s belief that she could parent D.B. on her own, if S.B. was necessarily absent from the home due to work or community activities. Dr. Hastey characterized this as unrealistic; her guardian agrees.

[27] The parents did not give Dr. Hastey the names, etc., of any potential helpers/supervisors (other than a grandmother) who could be contacted as collateral sources and Dr. Hastey was very guarded about the prospects for success should third parties become involved. I observe that the failure of the parents to identify possible assistants and to facilitate routine and timely background investigation by professionals, such as Dr. Hastey, has persisted throughout the proceedings.

[28] Dr. Hastey opined that D.B. should not be left alone with his mother and cautioned that is an almost impossible task without a 24 hour care-giver or assistant in the home. She stated that if L.B. was left alone to care for her son he would be at physical risk, that she could not respond quickly enough to a crisis situation, and that she could not identify safety issues that might be life-threatening quickly enough and respond with alternative measures quickly enough to prevent significant potential harm. That opinion was not disputed by the guardian.

[29] Other than for a visible facial tic that seemed to be exacerbated by stress and for some tendency to be fidgety, D.B. was assessed as a bright and friendly boy of average intelligence who has significant fear of his mother to the extent that he has

developed his own plan for removing himself from the family home if he is left alone with her and if she should become physically aggressive with him. D.B. also disclosed a strong bond with his maternal grandparents and his successful adjustment to his current foster home placement.

[30] Incidental to the present hearing, Dr. Hastey reviewed S.B.'s Plan of Care. In her opinion, regardless of who was caring for him (other than his father), D.B. would still view L.B. as his mother and would turn to her for the appropriate parenting behaviour one would expect from any mother. However, Dr. Hastey remains convinced that L.B. is unable to meet that need.

[31] From reports made available to her, Dr. Hastey observed there has really been no progress in S.B.'s and L.B.'s basic preparations for D.B.'s return or otherwise. Dr. Hastey was aware that L.B.'s guardian had been unsuccessful in finding a personal "mentor advocate", but submitted the parents also have a responsibility to be their own advocates, to educate themselves, and to surround themselves with whatever community supports might be available.

[32] Dr. Hastey noted there are outreach programs, and discussion and self-help groups in the local area. And, the agency has been prepared to underwrite transportation and related costs. She stated that the individual parent must advocate for herself/himself just as the parent must advocate for her/his child when necessary. Dr. Hastey repeated that the lack of initiative in this case was apparent and troubling from the outset, and that it continues. She was mindful that L.B.'s presentation likely fluctuates and could affect her willingness to engage in services but, for that very reason, ongoing supports from others are needed. Unfortunately, L.B. has chosen not to engage in many services and discontinued others and those choices, according to Dr. Hastey, have been endorsed or condoned by her spouse.

[33] According to Dr. Hastey, Donna Murphy (discussed elsewhere) is just one example of a professional who could have counseled L.B. and advocated for her, but who was shut out by L.B.. Dr. Hastey described such work as "absolutely crucial".

[34] Importantly, Dr. Hastey opined that D.B. has become bonded to his foster mother; and that this is very positive - because there was not a positive relationship between himself and his own mother. Should he be removed from the foster home, Dr. Hastey believes this bonding would be in jeopardy. In the meantime, progress

by L.B. has been minimal, in her opinion. Dr. Hastey restated her finding that there is an “anxious attachment” between L.B. and her son which would not change without a lot of work. This would involve professionals working with L.B. alone, with mother and son, and with father and son. She said this has not happened and is unlikely to happen consistently, if at all. She pointed to the parents’ track record since the proceeding started. Moreover, as D.B. becomes older, Dr. Hastey believes the dynamics of the trio will become much more complicated such that D.B., without a positive attachment with L.B. and without any expectation that she will change, may come to resent her more.

[35] Dr. Hastey believes D.B. still has a significant fear of being alone with his mother which is also unlikely to dissipate unless circumstances significantly change - an unlikely prospect. Dr. Hastey described fear (by D.B.) as a secondary emotion which might well turn into anger. This anger could result in D.B. projecting the normal frustrations of a child or an adolescent onto L.B. because she is the parent who is least likely to set appropriate consequences and be able to follow through with them. Dr. Hastey went on to express concern that D.B. would model L.B.’s behaviours which, in turn, could affect his own development; and also that L.B. would again become jealous and view D.B. as a competitor for S.B.’s attention, thereby putting her son in an emotionally complicated situation.

[36] As she was last time, and now, after many months, Dr. Hastey is concerned (as already mentioned) that there has not been any vetting of proposed supervisors or any ongoing evaluation of how well L.B. herself would tolerate the presence of other adults in the home, with or without S.B. there. Dr. Hastey opined that the greater the number of individuals who might become involved the more confusing and complicated it would be for the D.B.. She reminded that L.B. had stated in the past that she does not like other people in their home, and that she has asked people to leave and not come back. Dr. Hastey sees the situation as one without ongoing services and without individuals who are ready, willing, knowledgeable and prepared to act appropriately, especially should L.B. go into crisis. No explanation has been forthcoming about why the parents did not sooner present a comprehensive list of proposed helpers for scrutiny.

[37] Dr. Hastey said D.B. needs age-appropriate education and explanation about his mother’s condition and the unique problems faced by his family. Her evidence was that there is mental health literature available to parents and their children. Counselors can assist with this. In the absence of additional help in the schools or

community, she said the family has to assume responsibility. She stated intense education along these lines by the B.s should have begun already - as it has for the child and the foster parents - but it has not except for some cursory internet efforts by S.B.. Dr. Hastey believes S.B. still does not appreciate, or has simply minimized, the importance of D.B. understanding the situation at an age appropriate level or the importance of continuing to educate himself as a parent. She stressed the most responsible path is a continuation of services to the family by professionals who will assist them in educating themselves and in educating D.B. - but this has not happened.

[38] Dr. Hastey allowed that S.B. may articulate some understanding of the seriousness of the mental health diagnoses which have been given but she said S.B. reverts to seeing himself as handling it as best as he can, that he has been a good father to his son, that he now has a steady job and is supporting his family, and that it is sufficient that he has encouraged (but not insisted) that L.B. engage in mental health services.

[39] Dr. Hastey continues to support the notion of parental access should a permanent care and custody order be granted:

> ... I do believe that given the number of crises that have occurred in this family and given the number of losses that D.B. has experienced in regard to siblings, given his closeness to his father and his father's ongoing attention to D.B.'s needs during access, that it would strengthen an adoptive relationship, particularly this adoptive relationship, if that is the one that goes forward. I do believe that it is a case where an exception should be made that we would have an open adoption, if you will.

[40] Dr. Hastey said that in her seventeen years of experience the present case is unique because she has known L.B. since she was 16 years old, she has been involved with the family many times and knows the situation very well - perhaps more than she would if she was coming in and doing an individual assessment. This is one of the few so-called open adoption recommendations she has ever made.

[41] Finally, given the long-term outlook advanced by Dr. Hastey in her original report, I dismiss any suggestion that it should be afforded less weight now because

there has been no formal update or reassessment. More to the point, no updates were sought by the respondents, in any event.

Yves Bouchard, child protection worker

[42] Yves Bouchard (Bouchard) is the lead case worker for the agency. His extensive involvements with the family, and perspective on the agency's intervention and progress were outlined in the last decision. Bouchard endorsed the agency's original Plan of Care on February 13, 2008. In setting forth the explanation as to why D.B. cannot be adequately protected while in the care of his parents, the agency had placed a lot of weight on the findings and recommendations of Dr. Susan Hastey.

[43] Bouchard's earlier evidence was that in the agency's opinion D.B. has suffered emotionally and that he has had his emotional and social development impaired by his mother's mental health issues and by his father's inability to protect him. Bouchard's stated belief was that the father had continuously minimized his spouse's mental health condition and the impact on his son. Bouchard acknowledged the unquestioned love of S.B. for his spouse and son.

[44] Bouchard learned that S.B. obtained full-time employment and that S.B.'s plan was to hire care-givers to assist L.B. and D.B. if the child is repatriated. However, even when the last hearing was pending, specifics of S.B.'s plans were noticeably absent and it was unclear as to whether L.B. would permit or cooperate with S.B.'s plans. His evidence was that the importance of L.B. engaging in and following through with mental health appointments had been emphasized throughout. The agency was prepared to provide transportation but took the position that it was up to the parents to make and keep the appointments and that the agency should not have to brow-beat them into compliance.

[45] Bouchard said that the agency was looking for permanent care and custody, subject to access. By allowing contact with the child, Bouchard stated that the "best of both worlds" may be achieved. D.B.'s dilemma was (and is) that he is very anxious about his mother's long term future; and he very much wants to be with his father. However, he is well-settled with the foster family, and well-bonded to them and to the community.

[46] Last time, Bouchard stated an overriding concern about the state of L.B.'s mental health, even under managed medications, and the potential risk to D.B.'s emotional health in a home setting which had experienced few significant changes since the case started. The spousal relationship was characterized as chronically dysfunctional.

[47] As noted in the last decision, the agency did not trust that S.B. would contact the agency if and when problems did surface within the home; and in that context perceived an ongoing risk of physical harm to the child which, in the past, had been spurred by jealousy and led to domestic violence. But, Bouchard also confirmed that since D.B. was taken into care, there have been no other reported incidents of domestic violence as between the parents. He also agreed that L.B. was capable of providing for her son's basic physical care. But, he pointed to other important aspects of parenting in which she has had deficiencies and continues to have.

[48] I wrote that Bouchard's rationale for the agency's position last day was deeply rooted in Dr. Hastey's findings, conclusions and recommendations. Bouchard wrote that while L.B. continued to attend psychiatric appointments as required, she has not participated in therapy since August, 2007.

[49] After the last hearing, D.B. continued to have weekly supervised contact with his parents and daily telephone contact with his father. Last summer, weekend access at D.B.'s maternal grandmother's home (A.D.) was changed from overnight to day access. L.B.'s contact has had to be monitored because of (among other things) the agency's ongoing concern about inappropriate communications by L.B. with D.B. about the foster parents. At S.B.'s request, the agency's concerns were brought by him to his spouse's attention and there has been no recent reoccurrence.

[50] Starting in June, 2008 the foster parents agreed that they would facilitate the respondent's access at the foster home on weekends to accommodate S.B.'s work schedule. Bouchard reported that during access visits at the foster home (which were monitored by family support worker, Julie Nickerson) there were no fundamental changes in the dynamics of the visits - that is, most of the communication and contact, game playing, etc. occurred between D.B. and his father. Relying on the support worker's reports, Bouchard said L.B. generally watched but did not positively interact with her son in any meaningful way. By

early September, 2008 the foster parents were reporting that D.B. was doing well in their home although he appeared to be "conflicted regarding his loyalties when the respondents visit at the foster parents home".

[51] Issues surrounding seizures that L.B. experienced in mid-September were addressed. S.B. was alert to the agency's concern about the seizures and also expressed his own concern about his spouse's unhealthy weight gain which he attributed to her medications. Both have received medical attention and advice. S.B. therefore minimizes their present significance.

[52] By mid-November, 2008, the guardian ad litem had disclosed to Bouchard that several attempts by the guardian to schedule appointments with L.B. had proven unsuccessful. Since L.B. was at home most days, it is unclear why she did not respond to these efforts. The result was delayed release of confidential medical information regarding the seizure episodes. At that time, the guardian also confirmed that she had contacted the local mental health authority to inquire about advocacy services for L.B. but had learned that because L.B. was living with a spouse who could advocate and was expected to advocate for her, that no additional services would be provided.

[53] Bouchard asserted that he had not received any request for assistance with services from S.B. or his lawyer since mid-May, 2008. Similarly, there were no communications through the guardian on behalf of L.B., or the guardian's solicitor, for services which potentially could be invoked and cost-underwritten by the agency.

[54] Bouchard met with the respondents in early January, 2009. The respondents self-reported that L.B. had not experienced any seizures since September and that further medical investigation was pending. L.B. self-disclosed that she was feeling in good health. Indeed, she appeared to Bouchard to be happy. It was only then that he learned that L.B. was no longer under the care of psychiatrist, Dr. Simon Brooks, but was being seen by another psychiatrist, Dr. Neal Morgan. The respondents claimed that Dr. Morgan thought it was unnecessary to schedule any formal appointments, except on L.B.'s request.

[55] Bouchard learned from the parents that there had been no recent contact by either with their respective lawyers, despite the pending review hearing. And, they confirmed to Bouchard that L.B. was not accessing mental health services (therapy

or outreach services). When Bouchard asked them directly if they thought there was a need, the response was “no”. I accept his testimony in this regard. Bouchard alerted the respondents to a recommendation that D.B. be assessed for possible Tourette’s Syndrome.

[56] S.B. informed Bouchard that he still had no specific plans for D.B.’s care in the event that his son was returned. Instead, he informed Bouchard that his plan was basically the same as at the time of the last hearing. However, S.B. claimed he had made arrangements with his employer to work only 9:00 a.m. to 6:00 p.m. weekdays and that he anticipated having at least one weekend day off. He informed Bouchard that his plans generally included that care would be provided by A.D., a neighbour (L.F.), and some co-workers but S.B. allowed that he had not discussed this with his lawyer.

[57] As mentioned elsewhere, Bouchard summarized in written form his efforts to secure community based mental health services for L.B. After a case conference in early January, 2009, Bouchard said that he had not received any information, communications or requests from either the guardian or the guardian’s counsel regarding L.B. or from S.B. or his counsel as to what services they thought might be available to either one or both of them, or how the agency could otherwise assist. He wrote that the agency was at a loss as to how it could potentially advocate for services when neither parent was interested. Bouchard stressed that until S.B.’s lately filed affidavit, the agency really had no sense of the parents’ proposed plan for the care and adequate supervision of D.B. while S.B. is away for employment or other purposes.

[58] In summary, Bouchard wrote that the agency “is not in any different position than it was during the last review of disposition”. Bouchard formally introduced the agency’s final Plan of Care dated February 6, 2009 (Exhibit 4) at the current hearing. In testimony, Bouchard stressed that from the agency’s perspective there had been no significant changes in the risks presented to D.B. or the parents’ circumstances such as to warrant a change in the agency’s Plan. He acknowledged that the agency did not have the benefit of the father’s affidavit when it made its final decision but, understandably, thought the onus was on S.B. to sooner disclose the evidence he intended to rely on.

[59] Bouchard conceded that S.B.’s plan in general terms might reduce the risk of physical harm somewhat, but reasserted that the father’s own ability to assess and

to predict future risk of harm was still in question. That lack of appreciation or understanding of future risk - even if D.B. is under around-the-clock care and supervision by his father and/or others, is part of the foundation for the agency's stance on risk. When asked whether he thought S.B. was unwilling or unable to act and to effect positive change, Bouchard opined that S.B. does not fully understand and appreciate the severity of L.B.'s problems. Bouchard does believe that S.B. has the skills and intelligence to take steps to effect change, but he has not done so. While acknowledging some superficial changes in L.B.'s presentation, Bouchard stated that the agency also still believes the underlying family dynamics have not materially changed. Bouchard said S.B. can verbalize his own concerns and give assurances, but he cannot get his spouse to engage in rehabilitative or remedial services, and he doubts his own need for help. Indeed, until the current hearing, Bouchard said S.B.'s position was that neither he nor his spouse needed counseling or therapy.

[60] Bouchard reemphasized that neither S.B. nor his counsel had contacted him for any assistance or help after the last hearing and downplayed any responsibility by the agency to pursue the parents along these lines. And, as noted above, he said that the agency was unable to interview potential care-givers as put forward by S.B. because of the last-minute disclosure. He agreed that other individuals could provide some respite care to the B.s, but he carefully drew a distinction between that kind of care and supervision and full-time parenting and care. Bouchard agreed that L.B. has had no other seizures since last fall and stated that there were no reported problems during access since then. Bouchard said that community outreach mental health workers were potentially available to L.B. but, as noted many times before, she was not interested in the service. As far as voluntary services within the community are concerned, Bouchard conceded that he personally had not made any formal inquiries. On the other hand, he said that neither the guardian nor the parents or their counsel had made any suggestions in this regard or asked for his advice or help.

J.F., foster parent

[61] As I wrote previously, J.F. lives with her spouse in a small rural community. Both have jobs in the vicinity. They have over ten years experience as foster parents. D.B. is the only child living with them.

[62] The last decision summarized the child's placement and progress as of the last review. It need not be repeated. It was decided that access would be "an open situation". Visits started and have continued throughout the proceedings. The arrangements have been informal but quite effective. D.B. enjoys time and privacy with his birth-parents. Every effort is made to make the visits as normal as possible.

[63] I accepted J.F.'s evidence that D.B. loves having visits and is happy when his parents are there; and that there was little interaction between mother and son but lots between father and son. There are no identified concerns surrounding access and every reason to believe the child derives benefit.

[64] Since the last decision, the F.s have continued to encourage contact and cooperation with the B.s. Visits occur at their residence, once weekly for two to three hours; and there are periodic weekend visits by D.B. with his maternal grandmother. In her testimony, J.F. elaborated on the usual routines. As noted in my earlier Decision, she tries to ensure privacy but also feels she has some responsibility to monitor the visits. Overall, J.F. believes that not much has changed since the court's last Decision. The J.F.s are prepared to continue to promote family access even in the face of a possible permanent care and custody order.

[65] In an affidavit, J.F. said that D.B. remains confused as to "where his home is". She stated that he continues to be anxious about the outcome of the court case. She said D.B. continues to enjoy his visits with his father who is very proactive in their contacts. By comparison, J.F. has observed that L.B. "continues to be blank in presentation, unable to communicate with D.B. and watches while he plays with his father". In J.F.'s observation, there is a "wall around D.B.'s mother" and that although D.B. occasionally initiates communication or contact with her, that L.B. is still unable to return communication and does not really parent her son in any way. I accept her evidence in that regard.

[66] J.F. has also noted unusual physical movements by D.B. which she characterized as physical tics with neck movement and accompanied by noises. When the concern was discussed with D.B.'s therapist, Jan Cressman, there was speculation that he may have Tourette's syndrome. Late in 2008, J.F. said that the physical movements extended to the neck and shoulder and included distorted facial movements. She said this was vividly displayed at the school Christmas

concert in mid-December. J.F. said that the tics are more settled recently. She attributes this to D.B.'s return to a regular routine at home, at school, and elsewhere. She noted again that the most dramatic difficulties surfaced around the time of the school Christmas concert.

[67] Last September, it was learned from the maternal grandmother that L.B. had experienced one or more seizures. As a result of that contact, J.F. went immediately to the local fairgrounds and was present while medical attention was administered. L.B. was taken from the scene by ambulance. According to J.F., the incident greatly frightened D.B. who, according to her, has continuously overdramatized illnesses in the past. By way of example, she said that D.B. often believes that he cannot breathe or that he has cancer or a tumour in his throat even if he has just has a sore throat or mild infection.

[68] J.F. ventured that D.B. "lives in two worlds". She noted that he is very excited to have contact with his parents "but when it's over, it's over". During access visits, she acknowledged that D.B. is completely focused on his parents and very much enjoys contact with them.

[69] J.F. believes that routine is very important to D.B.; she exemplified what she means by this. She also confirmed that D.B. is involved in a number of activities including karate, skating, Sunday School and church groups.

[70] J.F. heard about an incident last summer when L.B. reportedly voiced dissatisfaction with the quality of foster care. Because this was done in the child's presence, the agency, in consultation with the J.F.s, took steps to ensure that L.B.'s contact with her son was carefully supervised. Nonetheless, J.F., went as far as to say that she still considers L.B. to be a friend. She continues to try to engage in conversation and to generally make L.B. feel as comfortable as possible whenever the families have contacts. However, she insisted that based on her observations there has really been no improvement in L.B.'s general presentation and conduct. I accept this evidence in preference to that of the father, as far as L.B.'s progress is concerned. To her credit, J.F. certainly recognizes that L.B. may feel threatened by her and that she is likely more guarded with J.F. than she might be with others (for example, the maternal grandmother).

[71] J.F. mentioned that D.B. is doing well academically and that he is presenting no problems from a behavioural or conduct standpoint in the school setting.

Franceen Romney, litigation guardian

[72] Franceen Romney is an experienced lawyer and L.B.'s guardian ad litem. She previously submitted a series of affidavits regarding L.B.'s circumstances and the agency's intervention. Ms. Romney described L.B. as a parent who is concerned about her plight but who has a limited understanding of the scope of the concerns and challenges she faces. She gave helpful suggestions to the agency which improved the quality of the mother's access visits. By September, 2007, it was recommended that the mother should be given more time to respond to her medications and to obtain meaningful therapy. Around the same time, Ms. Romney took the position that L.B. had a mental illness which prevented her from interacting with her son in the same way and to the same extent that most parents do. She noted a clear bonding between father and son consistent with the observations of others involved in the case.

[73] By mid December, 2007, Ms. Romney had taken the position that the bulk of the recommendations by Dr. Hastey (discussed elsewhere) were in L.B.'s best interests.

[74] Ms. Romney continued to have access to the full range of court and agency documents and participated in agency case conferences which she had access to during the course of the proceedings. She explored and ruled out the possibility of some type of community placement for L.B. to assist her in dealing with her mental health issues. By the time of the last hearing, she was satisfied that there are no other services, resources or treatment options available other than that which have already been provided or offered to L.B. during the proceedings.

[75] Ms. Romney was satisfied that L.B.'s mental health issues continued and that while she appeared to respond to medication and to treatment at one stage, her progress appears to have plateaued.

[76] L.B. has made it clear to Ms. Romney that she wanted D.B. to come home. But, Ms. Romney's opinion was that it would not be in L.B.'s best interests for that to occur. Rather, Ms. Romney advocated last day for L.B. staying at home with S.B. but without D.B. there.

[77] After the court's last decision, Ms. Romney made inquiries with the local hospital to determine if there might be any mental health advocacy services available through its psychiatric unit. She was informed that such a service is unavailable unless an individual is a group home resident. L.B. does not fall into this category. Ms. Romney learned that counsel for the agency had also made an inquiry as to whether a mental health advocate might be available under the auspices of another agency, the South Shore Health Early Response Service. The answer was to the effect that an advocate would only be provided if an individual is hospitalized against her will under a mental health certificate and had nobody available to make decisions for her. Again, L.B. did not fit the criteria. Importantly for our purposes, it was learned that no services would be provided to a client unless she agreed to participate. (The only exception would be if an individual presented as being a risk to herself or to others.) As discussed elsewhere, L.B. has been disinterested in and disavowed services.

[78] Ms. Romney followed up the matter yet again in late November, 2008. She wished to satisfy herself as to whether or not a mental health advocate of some sort could be supplied for L.B.'s benefit. The response she received was that there are patient advocates available under the **Involuntary Psychiatric Treatment Act** but that L.B.'s situation does not fall under this category and as such there is no entitlement. It was thought that further inquiries would be made by health officials and that Ms. Romney would be advised. But, there was no further communication.

Tina Peddle, adoption worker

[79] Tina Peddle (Peddle) is a social worker employed by the agency as an adoption worker. Her evidence regarding potential adoption placement was given at the last hearing. There are no reported changes.

[80] As I wrote previously, Peddle characterized the agency's Plan as "unusual" in the sense that the agency's intention is to place D.B. in an adoptive home which promotes and facilitates birth family contact including, in this instance, direct access with his father, S.B., and indirectly with his mother, L.B., for as long as it is in the child's best interests. The agency sees the present foster parents as "the cornerstone" of their Plan. However, if for some unforseen reason the current foster parents are not approved as an adoptive family (an adoption assessment has not been done), then the agency would seek out another adoptive family who would be willing to support birth family contact.

[81] Peddle referred to section 78A of the **Children and Family Services Act** and the provision for "Openness Agreements". Her evidence was that the section means an agreement for the purpose of facilitating communication with or maintaining a relationship between adoptive parents and birth relatives. Peddle wrote that Openness Agreements are not legally binding, however. She said they have no effect on the legal status of an adoption order. From the agency perspective, openness in adoption is seen as a continuum ranging from the sharing of non-identifying information to direct contact.

[82] Ms. Peddle disclosed that there have not been many changes in the number of potential adoption homes since May, 2008. As of early January, 2009, across the province, there are approximately 49 families approved to adopt children of D.B.'s age and gender. Three of those families are in the local area.

[83] Ms. Peddle is aware of the agency's Plan for D.B.. The current foster parents may apply to adopt him but the process cannot be started unless and until there is an order for permanent care and custody. She is unaware of any barriers to a potential application by the foster parents. Ms. Peddle is also aware of the agency's plan to proceed with a so-called open adoption should a permanent care and custody order be granted. The current foster family is open to such an arrangement but Ms. Peddle is unaware of the preferences of other potential adoptive families.

Jan Cressman, counsellor

[84] Jan Cressman (Cressman) provides professional services including counseling for youth and families and has acted as a guardian ad litem in other cases. I accepted her earlier evidence that she was impressed with the foster parents and their willingness and ability to work with the B. family. Her evidence was that communication between the foster parents and S.B. is very clear and positive. Cressman previously described the father/son relationship as loving and consistent. By contrast, she saw the relationship between D.B. and L.B. as distant and described it as a "careful watching". Because he is periodically anxious, she said D.B. requires a predictable home life that includes routines and a daily schedule that works with his energy.

[85] At the last hearing, Cressman said D.B. had expressed worry and concern about where he will be in the future. However, she underlined that he has a "steady, clear loyalty to his parents". She ventured that it is very important for him to have a clear understanding about where he is going to live and how his relationship with his parents will ultimately look.

[86] Cressman has continued to counsel D.B.. She submitted a brief series of written reports, the last of which is dated December 18th, 2008. She reaffirmed that D.B. has become quite attached to his foster mother and that their bond has grown stronger since events at the local exhibition last September. Unfortunately, D.B. witnessed his mother having a seizure. Subsequently he presented with his own complaints and symptoms which were medically investigated. It turns out that he had no problems except for anxiety or panic.

[87] Cressman believes that D.B. has started to internalize his mother's illness. She said he has been complaining and expressing fears about dying, choking, having tumours, etc. Cressman and the foster parents have worked to deal with these issues as they arise.

[88] It was on Cressman's speculation that D.B. may be presenting with symptoms of Tourette's syndrome that medical referrals were made. As mentioned elsewhere, investigations are incomplete.

[89] Cressman still believes that D.B. needs to have "closure" and to have his final placement established. She thinks he is in a state of flux insofar as so-called maternal attachments are concerned. She believes that there is still a lot of work to do and that the scope and direction of counseling hinges largely on the outcome of the court case. Once the outcome is known, she can then tailor her work to deal with attachment and other issues which may arise. For example, because of the unique relationships between D.B., his biological parents and his foster parents, Cressman believes there are grief issues which will also need to be addressed. In the same vein, D.B.'s interaction with his peer group will need much more work.

[90] Based on her observations and reports from others, Cressman believes that D.B. very much loves his visits with his father but she does not get the same sense of connection between mother and son. She is quite concerned that if D.B. is returned to his mother he will be overly worried about his mother and that he will internalize her problems because he (D.B.) does not see her as being able to care

for him or for herself. In a repatriation, Cressman believes that her own work would be back to “square one”.

[91] With a court decision, Cressman believes that D.B. will achieve some certainty in his life. She acknowledged that if he is returned to his parents that she could assist with transition issues on a voluntary basis.

Julie Nickerson

[92] Julie Nickerson (Nickerson) is a veteran social worker who has worked extensively with the family as an access/family support worker. Her role and detailed observation reports were canvassed last time. I found that Nickerson’s observations of L.B.’s interaction with her son in various settings was consistent with those of most other observers and at odds with S.B.’s characterizations. Last March she received reports (from A.D.) that L.B. did not want a “babysitter” looking after her when she was alone with D.B. (i.e. when S.B. is at work).

[93] Nickerson spoke highly of the foster parents and exemplified the uniquely positive dynamics between the two families.

Jan Porter, mental health worker

[94] Jan Porter (Porter) is a community support services worker with the South Shore Health Mental Health Program whose involvement was summarized in the last decision. There were no recent reports from her because there was no request for resumption of her services. At the last hearing, Porter confirmed that her services are provided upon a client’s request. L.B. would be welcome to re-engage if she wanted but no request has been forthcoming.

A.D., grandmother

[95] A.D. is D.B.’s maternal grandmother. She is unable to put forward a Plan of Care for him because of her age. I discussed the prevailing arrangements for access by her in the last decision. I found that by all accounts, A.D.’s access visits with her grandson were going very well and there were no protection issues.

[96] I previously accepted her evidence that she would be very concerned about L.B.’s ability to care and supervise D.B. in the absence of her spouse, although she

would be less concerned if someone else was present when S.B. is absent, particularly for employment.

[97] A.D. and her husband continue to see D.B. once monthly for an extended visit which usually lasts about one day. On those occasions, S.B. and L.B. will usually come and visit for a couple of hours. Reportedly, D.B. continues to enjoy these visits as, of course, do the adults. A.D. keeps Yves Bouchard informed about the happenings, as need be. According to A.D., D.B. enjoys visiting his grandparents independently from his parents, so that he has quality time with each.

[98] She said D.B. is always glad to see both of his parents but "clings" to S.B. more than to L.B.. According to A.D., L.B. is generally "a little better" than at the time of the last hearing but tends to still follow her husband's lead. This obviously contrasts with S.B.'s reports of significant progress. A.D. testified that D.B. hugs and plays with his mother and that he is more involved with her now than before.

[99] D.B. is permitted telephone contact with his grandmother who also has some telephone contact with S.B. and L.B.. However, she said that she lets them lead their own lives and that she tries not to interfere.

[100] A.D. testified that the B.s did not directly approach her to assist with child-care; rather, she offered to occasionally babysit. Her husband works in the local area and is quite busy as a school bus driver and at another job, part-time.

[101] A.D. characterized D.B. as a child who needs consistency and routines in his life. Asked about what role she might perform should D.B. be repatriated to the B.s, she said that she might be able to help out occasionally, if asked, but she could not take on any day-in-day-out responsibilities. She did not think this would be good for herself or the child.

[102] A.D. also gave her version of the events last summer when L.B. experienced seizures. She speculated that the seizures were related to heat (but this is contrary to the medical evidence so far).

[103] The D.s have a motor vehicle; they are about five minutes by car away from the B. residence. She has assisted in transportation arrangements for some of L.B.'s medical appointments and assessments.

[104] Since last May, A.D. has been an infrequent visitor to the B. residence. She freely admitted that she is not familiar with their day to day routines and schedules. However, she has observed that the B. home is generally clean and tidy; and she has no concerns in this regard.

[105] On cross-examination, she reiterated that she could help out with D.B.'s care and supervision "occasionally" but she could not do this every day. In any event, she said that she would only be available for a few hours and volunteered that she is "not that well either". She did not elaborate.

[106] As she had done previously, A.D. characterized S.B. as a really good husband to L.B. and a good father to D.B.. A.D. agreed that D.B. is "very, very happy where he is now (i.e. at the F.s)". She generally characterized D.B. as "a little boy who wants to satisfy everybody".

[107] Asked about her knowledge of the individuals named by S.B. who might assist with D.B.'s care and supervision, A.D. professed some familiarity with some of them but, I conclude, she has limited knowledge of their circumstances and the extent that they might be able to assist. A.D. was candid in stating that she has not discussed L.B.'s mental health issues with the couple. She also said that they have not asked her for any help in this regard, nor has she volunteered any of her own initiative.

[108] A.D. confirmed that D.B. is actively involved at his school and in the community. She confirmed that the foster parents routinely invite her to special occasions and events. She described the foster mother as a wonderful person.

[109] In answer to a short series of questions put to her by the solicitor for the guardian ad litem, A.D. said that she could be at the B. residence twice a week for two to two and a half hours or so after D.B. returns from school and before his father gets home from work just after 6:00 p.m. (This is in the hypothetical scenario in which S.B. is working 9:00 a.m. to 6:00 p.m. weekdays.)

J.M.

[110] J.M. is a married man with two children who works as a part-time adult education instructor. He lives about a five minute drive away from the B.s' and has know S.B. for about 15 years and L.B. for about eight years.

[111] J.M. testified that when D.B. was residing with the B.s, his family had contact with theirs two or three times monthly. J.M. knows S.B. better than L.B. whom he perceives to be the quieter of the two. He is aware that L.B. has a mental health condition and that she is taking medications. He does not know the full particulars of her condition but understands that she is "bipolar". He has only a general knowledge of the condition. He is also aware that S.B. seeks to regain custody of D.B..

[112] When last seen, D.B. presented as a normal child to J.M. but conceded that he has not spoken a lot to D.B. and really does not know him that well. J.M. also perceived the parents' relationship as "normal". He insisted that he had observed nothing irregular in the S.B./L.B. relationship which would cause him any concern and that he had never observed any unusual behaviours by L.B..

[113] S.B. approached J.M. and asked him if he would occasionally care for D.B. After consulting with his wife, J.M. said that he would. However, J.M. volunteered that his wife is not interested helping out the B.s full-time and that if they were to assist with D.B.'s care in any significant way they would have to first sort out the details between themselves. They have had no serious discussions on the subject and he admitted that his wife had not been asked by S.B. to testify. Moreover, depending on the demands, he said he or they may need to be financially compensated. Yet, there has been no serious discussion about this either.

[114] Surprisingly, J.M. said that he was "not much of a care-giver or a babysitter but he wouldn't have a problem" watching D.B. for a few hours occasionally, at the B.s' residence or at his own home. But, he stressed that he would have to consult some more with his wife before making any commitments because of their own routines and schedules. Pressed on his possible availability, he stated that he could be available for a couple of hours, without compensation, occasionally, but certainly not every day. He also conceded that he probably would not be much help to D.B. with his school work should he be called upon to do so.

[115] With respect, as J.M.'s direct testimony developed it became increasingly obvious that he had no clear understanding of what was being expected of him in terms of D.B.'s care or supervision in S.B.'s absence. He was unable to articulate why S.B. or the agency might require supervision of D.B. while his mother is in the home but his father is at work. He does not know A.D. very well and he had

little or no knowledge of some of the other individuals that S.B. proposes to provide additional assistance.

Donna Murphy, clinical social worker

[116] Donna Murphy (Murphy) is a clinical social worker with the South Shore Mental Health Program. She testified before. L.B. was referred to her in early 2007. She was to provide support and grief counseling in relation to agency intervention in regard to another child. By mid January, 2007 Murphy was also discussing L.B.'s "attachment" to S.B. and the impact on their son, D.B.. Soon after, D.B. was taken into care.

[117] Murphy continued her work after D.B.'s apprehension but by mid June, 2007 had learned that L.B. did not wish to continue with services. In early August, 2007 sessions had resumed but they stopped completely by the end of the month.

[118] I previously accepted Murphy's evidence of L.B.'s episodic perception that she (Murphy) was coming between her and her spouse and otherwise questioning the worker's motives, that she was obliged to respect L.B.'s decisions, and that it is not her role to pursue voluntary patients to engage in or to re-engage in services.

J.R., friend

[119] J.R. is a long-time friend of S. B. A summary of his evidence will be found in the last decision. He did not testify during the current hearing. It is unclear what, if anything, he is now prepared to do to assist the B.s.

S.B.

[120] S.B.'s evidence at the last hearing has already received considerable attention and need not be restated. He opposed placement of D.B. in the agency's permanent care and custody and believed his son's best interests would be served by his return to the family home where he could be parented by both parents. He acknowledged his wife's ongoing struggles with mental health problems which he conceded (at the time) needed to be monitored through the continued involvement of mental health professionals and/or treated with medications. The submission of his counsel was that this could be accomplished <u>without</u> agency or court supervision. The court found otherwise.

[121] S.B.'s evidence last time was that he wanted was a chance to show that he could come up with a viable plan for D.B.'s return to his home. S.B. had been employed for several months as an on-line support worker at a local call centre, working 40 to 44 hours weekly from 4:30 p.m. until 1:00 a.m. He was usually at his workplace by 4:00 p.m. This shift was the most stable option for him having regard to his seniority. S.B. said that if D.B. is returned to him, it was his intention to establish a regular and consistent routine for his son and to engage a babysitter for those times when he is at work. However, he was lax in providing particulars to the agency. He stated that any helpers would have to understand that his wife could not be left unsupervised with their son and he agreed that L.B. or a supervisor would have to help with schoolwork and other duties, except for those times when he is at home. Regrettably, he was vague about what that might entail.

[122] S.B. acknowledged that the helpers might have to be paid, but I concluded he had given little thought to the cost or how he would pay for the services. He conceded L.B. is "not overly happy about the prospect of someone else assisting her with D.B.'s care and supervision".

[123] I received with skepticism S.B.'s version of why services by Jan Porter and Donna Murphy lapsed. He admitted the agency was prepared to provide transportation for L.B.'s benefit, and for his benefit, so they could access supports and services. Because of his late work shift, he conceded L.B. and he could have scheduled weekday appointments, but did not do so. The last decision spelled out his rationale for L.B.'s failure to take advantage of services. And, despite the observations of others, S.B. insisted his spouse was making significant progress on most fronts.

[124] At the present hearing, S.B. once again identified some individuals who he said would assist him from time to time as part of his parenting plan. They included J.M., who testified, and L.M., S.P., N.W. and J.R., none of whom testified at this final hearing. S.B. claimed he had general discussions with each potential helper about the proceedings, L.B.'s medical condition, why she cannot be left alone at home with D.B., and his expectations for their duties.

[125] S.B. continues to work a "late shift" but said he has spoken to his immediate supervisor and his Human Resources Manager who advised him that if D.B. comes home that his shift could be changed to 9:00 a.m. - 6:00 p.m., weekdays, with no

change in his wages. However, he brought no written confirmation of this and neither official testified or filed an affidavit.

[126] S.B. said he admonished L.B. for negative things she reportedly had said about the foster parents on one occasion. In response, he said she agreed that she would not say anything similar again and that she seemed to understand the implications of such conduct, especially in their son's presence.

[127] Asked directly if he sees any need for counseling, he broadly replied there would be a need for "services in every aspect if D.B. comes home - family and individual". Asked about the need over the past several months, he dodged the issue and cited lack of time for such services. Pressed by his own lawyer to be more precise, he floundered and could only say that "some sort of services would be helpful', perhaps once a week, "just to talk to someone". Asked if he previously recognized any need, S.B. conceded it had been "put on the back burner".

[128] He recalled telling the court that working a late shift would temporarily help and actually make it easier to schedule appointments but conceded that from last May onward the only appointments made and kept were with doctors and not with mental health service providers. Neither he nor L.B. asked the doctors to help with referrals; and S.B. placed much emphasis on the fact Dr. Morgan did not insist on regular appointments for L.B. with him.

[129] S.B. admitted he was aware of a support group which meets at a local church and that neither he nor his spouse had made any contact or inquiries. He admitted there has been no contact with Ms. Porter since the last decision. As far as mental health services and outreach programs are concerned, S.B. weakly conceded he was aware of them, that they were of potential value to his family, that the agency was concerned about the lack of engagement, yet they were not actively pursued. He admitted he did not contact Mr. Bouchard or L.B.'s guardian to ask for help in this regard.

[130] Assuming his shift is changed to 9 a.m. until 6 p.m. daily, S.B. confirmed help would be needed with D.B. each weekday from the time D.B. gets home from school until he gets home from work, during school breaks and the summer vacation etc.

Discussion/Decision

[131] I have considered the following under the **CFSA**, most of which were also relevant at the time of the last review:

- The preamble.
- The purpose of the **Act** [section 2 (1)]; and paramount consideration [section 2 (2)].
- Best interests of the child [section 3 (2)].
- Agency functions [section 19].
- Services to families and children [section 13].
- Substantial risk [section 22 (1)] and need of protective services [section 22 (2)].
- Disposition hearings [section 41.
- Disposition orders [section 42] and duration of disposition orders [section 45].
- Restrictions on removal of children [section 42 (2)];
- Placement considerations [section 42 (3)]; and time limitations [section 42 (4)].
- Review applications [section 46 (1)]; court powers on review [section 46(5)]; and factors to be considered upon review [section 46 (4)].
- Consequences of a permanent care and custody order [section 47 (1)]; access upon such an order [section 47 (2)].
- Termination of a permanent care and custody order [section 48].

[132] The relevant issues and scope of evidence upon review of disposition are found in the Supreme Court of Canada decision **Catholic Children's Aid Society of Metropolitan Toronto v. M.(C.)** [1994] 2 S.C.R. 165. I have again directed my attention to section 46 which requires the court to consider whether the circumstances have changed since the last order, whether the plan for the child's care that was applied is being carried out, what is the least intrusive alternative that is in the child's best interests, and the requirements of subsection 6. Section 46 (5) sets out the court's options on review.

[133] Under section 42 (1) (e) of the **CFSA**, the total period of duration of all disposition orders for D.B., who was six years of age but under 12 years of age at the time proceedings were started, is 18 months calculated from the date of the first disposition order. The anniversary date of the first disposition order was September

6, 2008. Because the child was not placed in the permanent care and custody of the agency at the last hearing, alternate review of disposition orders could run only until early March, 2009. In the child's best interests and by consent, the maximum duration has been exceeded pending release of this final decision. The only options now left are permanent care and custody or return of the child to his parents. "Maximizing the time-lines" was important last day because (among other things) the court had to be satisfied that the circumstances justifying an order were unlikely to change within a reasonably foreseeable time not exceeding the maximum time limits such that the child could be returned to one or both of his parents.

[134] As I stated before, the combined effect of the relevant **CFSA** sections and the Supreme Court's directions is that evidence at a post-disposition review hearing is usually limited to an examination of the circumstances since the last order was imposed. The circumstances at the time of each order are a matter of record. The normal starting point will be the last review order, not the original disposition order. Nonetheless, all reviews must be conducted against the background of accumulated evidence because it is one, continuous proceeding. It is in light of the past evidence that change (or lack of change) is measured. Once the evidence has been delineated, the "twofold examination" called for in **M. (C.)** Is conducted.

[135] The first issue is whether D.B. continues to be in need of protection. This includes an examination of the events that triggered agency intervention or its continued intervention. The second consideration is the child's best interests against the entirety of the situation.

[136] The father's position continues to be that there is no substantial risk of harm to his son and that he should be returned. As before, implicit in S.B.'s submission is that the parents will live under the same roof with their son and that the father can be trusted (without a court order) to have appropriate care, support and supervision arrangements in place for his son when he is at work or otherwise unable to provide them personally. It was also submitted that there are limited supports within the community and that he should not be chastised for failing to take advantage of supports and services that simply are not there. Moreover, it was argued that L.B.'s symptoms are not as pronounced or serious as at the last hearing. It was said that S.B. does understand the risks to his son. And, it was pointed out there have been no recent incidents of misconduct of L.B. toward her

son or her spouse and that there is therefore no current risk of physical harm. Further, it was argued that there is no current risk of emotional harm. It was said that S.B.'s characterization (ie., that his spouse is doing really well) has not been undermined by any medical evidence before the court. So, the court was invited to conclude that L.B.'s current medications have stabilized her mental health, that she has made significant improvements, and that there is a degree of stability now present that obviates the need to place D.B. in the agency's permanent care and custody.

[137] Once again on behalf of S.B., it was argued that the agency's lead worker, Mr. Bouchard, had essentially adopted a "hands off" approach and, by implication, the agency is to some extent at fault for the current state of affairs. In terms of the intensity of care and supervision needed at the B. home should S.B. be returned, counsel for the father essentially reduced the need for close care and supervision to just two or three hours per day which could be accomplished without great difficulty. (The needs during longer and/or unexpected school breaks, summer vacation, etc. were glossed over.) It was submitted that S.B. is aware there will be transition challenges should D.B. be returned to his parents. The implication was that voluntary services could be accessed. (Return under agency supervision by court process is not a possibility in the circumstances.)

[138] The guardian did not support or oppose the agency's plan. Previously, she submitted that the agency's main concerns are not with S.B. but with his spouse. Importantly, the guardian did not challenge Dr. Hastey's original assessment of L.B.'s inability to parent. However, last time, the guardian submitted that advocacy for the mother's mental health plight had not received the kind of attention needed to bring about changes in the family's circumstances and that most of the professionals had not been focused on her problems, rather on concerns about the child, and that they had not been very proactive with L.B. who has been unable or unwillingly to take initiatives because of her mental health issues. This time, the guardian candidly submitted that the underlying factual circumstances had not materially changed since last day. Nonetheless, the guardian reminded the court of the principles that it must apply when considering permanent care and custody.

[139] The guardian seemed to align herself with some of the rhetoric surrounding the alleged failure of the agency's lead worker to push S.B. further and harder into locating and accessing supports and services. It was submitted by the guardian that

S.B. likely relied on the doctors who did not promote any further psychiatric interventions or other active medical treatment once the medications stabilized L.B.'s condition. It was also suggested that S.B. did not understand what he was supposed to do or what was supposed to happen. On the last point, however, S.B. professed that he did understand - an assertion repeated by his own counsel - and that there are no protection concerns, in any event. If there was any misunderstanding or confusion, one wonders what S.B. and his legal counsel were doing over the last several months to clarify any questions and the agency's expectations, and to address other issues (such as care and supervision in his absence), over which he would have some control. I also find, in fairness to Mr. Bouchard, there is no evidence that the guardian pushed the envelope by exerting pressure on S.B. or his counsel as weeks and months dragged by. Accordingly, I am not prepared to assign any "fault" to the worker or the agency in this regard.

[140] The agency's ultimate position is that there have been no significant changes in the circumstances since the last hearing. It was stressed that the respondents have been aware of the agency's plans for many months and knew its expectations if there was to be any favourable change in the agency's stance. However, the agency submits that the risks identified many months ago still exist, and that they have not abated. In particular, it was submitted that there has been little or no effort on the part of S.B. to increase his appreciation and understanding of the full scope and seriousness of the problems and that he is either oblivious to, or just does not appreciate, the importance of he and his wife having significant services and supports in place if D.B. is to be returned to their care. The agency pointed to the number of potential helpers who have not testified in support of S.B.'s Plan and argued that those individuals S.B. has put forward are really not aware of the situation, the responsibilities that would have to be assumed, and the like. Although S.B. has to some extent acknowledged his shortcomings and failures to act, the agency submits that his conduct borders on inaction.

[141] The agency further submitted that S.B. has a simplistic view of his wife's entire physical and mental condition and still does not understand what has to be done in order to protect his son's best interests. The agency submitted that there may be limited mental health resources within the community but that does not mean that there are no services and that the parents have no obligations. In the end, the agency submitted that S.B., in particular, should have been far more organized and proactive by now and that it is insufficient that he has offered up more promises and assurances. Not surprisingly, the agency reminded the court that the

respondents have had the benefit of legal counsel throughout and the benefit of a full written decision last year. The father's position, and to some extent the mother's position, was characterized as "finger pointing" and a diversion from their own inertia.

[142] I wrote before that substantial risk means a real chance of danger that is apparent on the evidence and that any identified risks of physical harm must be tethered to evidence that one or both parents have failed to, or are unlikely to, adequately supervise and protect their child; and the risk of emotional harm must be supported by evidence that one or both parents have failed, or are likely to fail, or refuse to obtain services or treatment to remedy or alleviate the harm. On the evidence as a whole, I reaffirm my previous finding that there is still substantial risk of emotional and physical harm to the child by the mother which she and the father have not remedied or alleviated. The current risks are still directly linked to the mother's mental health condition and are exemplified in my summary of Dr. Hastey's principle findings. Arguably there would not be substantial risk if S.B. did not leave D.B. at any time in the unsupervised care and control of L.B., but the unfortunate reality is that he cannot meet this standard because he must be away from the home for regular and significant blocks of time.

[143] And, unfortunately, the father's case continues to be based on generalities of what he will do to meet the risks and it is glaringly short on specifics. I previously wrote:

> Given the number of months that the matter has been before the court, it was surprising that he did not have very concrete plans, and a line-up of witnesses to verify them, by the time the already delayed hearing got underway. His solo affidavit and rather poorly organized presentation left more questions than answers at a stage when answers were called for.
>
> The evidence does not support S.B.'s contention that L.B. is fully cognizant of and comfortable with his stated plan to have other individuals within the home when he is absent. None of the proposed supervisors/caregivers have been vetted by the agency; and it was somewhat naive to think that the agency would modify or abandon its plan, or that the court would endorse a discontinuance, just on his assurances. I am cognizant that S.B. has had to make herculean efforts to manage all of the competing demands on his time, including those associated with ensuring his mentally ill wife keeps and maintains all professional appointments, that she adheres to her medication regime, and that she seek more or better services and supports etc - on top of his responsibilities as a father and breadwinner.

> Although no significant child protection concerns are tethered to his parenting capacity or abilities, and allowing that the father/son bond is demonstrably very strong, the child protection issues have not abated because S.B.'s plan calls for what amounts to co-parenting of the child under the same roof without, I have concluded, sufficient evidence that D.B. will be cared for and protected, especially in S.B.'s absence.

[144] I have directed myself that the exemplary role that the foster parents have played is not the standard by which to assess the respondents' roles or by which the outcome of the case should be guided. The foster parents are still temporary, substitute care-givers. I have again directed myself that possible adoption, whether by the present foster parents or others, is a relevant factor, but only one of many. Adoption processes cannot begin unless and until the issue of permanent care and custody is decided. Adoption planning and placement are entirely within the mandate of the agency, in any event.

[145] Removal of children from their parents is a last resort. Last day, I was prepared to grant the parents the maximum allowable time to address the agency's concerns. They had the benefit of a written court decision. Between hearings, there were no applications for directions or clarification, or for additional supports and services, if wanted. With respect, the father's case was weakly prepared and presented, despite the benefit of more time to ramp up his parenting plans and hearing preparations. I find there really was no viable plan for the child's day-to-day care and protection. At best, the father's case was that he could and would muster concrete plans, if and when he achieved a favourable result. Regrettably, against the accumulated evidence, I conclude that is insufficient.

[146] Under section 13 of the **CFSA**, mandated services to promote family integrity which can be provided by agencies, or by others with the assistance of agencies, are spelled out. One important goal of such services is to promote the principle of using the least intrusive means of intervention and to enable a child to remain with his /her parents or to be returned to them. Reasonable measures are expected from agencies but, in my opinion, they do not have to leave each and every stone unturned. [See **Min. C. S. v. L.L.P.** (2002), 211 N.S.R. (2d) 47 (C.A.); **S. (S.L.) v. C.A.S.** (Shelburne Co.) (2001), 15 R.F.L. (5th) 168 (N.S.C.A.)] Parents are primarily responsible for the welfare of their children. They too must take reasonable measures or steps to reduce or eliminate identified protection concerns if they want their children to remain with them or be returned, if apprehended.

[147] The legislation underscores that children have a sense of time that is different from adults and that this must be respected. There is no question that D.B. needs a final decision on his future without further delay. The present uncertainty is taking a demonstrable toll on him and cannot be allowed to continue. Having again found that the child protection issues are still present, the ultimate question is what outcome in all of the circumstances is in D.B.'s best interests. I conclude that the only answer is permanent care and custody with the agency; and I so order, subject to access as envisioned by the agency's Plan of Care.

[148] Mr. Ferrier shall submit an appropriate order.

Dyer, J.F.C.