IN THE FAMILY COURT OF NOVA SCOTIA

Citation: Nova Scotia (Community Services) v. K.B., 2009 NSFC 9

Date: 20090414
Docket: 059273
Registry: Yarmouth

Between:
Minister of Community Services (Digby County)
Applicant

v.

K.B. and H.B.
Respondents

Editorial Notice

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

Restriction on publication: PUBLISHERS OF THIS CASE PLEASE TAKE NOTE that Section 94(1) of the Children and Family Services Act applies and may require editing of this judgment or its heading before publication. Section 94 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 a guardian, a foster parent or a relative of the child.

Judge: The Honourable Chief Judge John D. Comeau

Heard: March 4, 2009, Yarmouth, Nova Scotia

Written Decision: April 14, 2009

Counsel: D.B. MacMillan, for the Applicant
Amber Snow, for the Respondent, K.B.
H.B., Respondent, not present nor represented

The Application:

[1] This is a disposition hearing pursuant to Section 41 of the Children and Family Services Act.

[2] The child, J., born June *, 2008, is the daughter of K.B. and H. B. and was taken into care on the 16th day of June 2008, alleging she was in need of protective services pursuant to Section 22(2)(b)(d) and (ja) of the Children and Family Services Act.

[3] Details of the concern, supporting the application were set out in the Affidavit of Crystal Barr, agent of the Minister, dated June 20, 2008.

[4] Referral was made to the Minister concerning the Respondent/mother's pregnancy and due date. This contact was made on February 4, 2008 and made reference to her disability due to emotional problems, epilepsy and borderline intelligence as well as a history of mental health and the requirement that she needs medication for her asthma and seizures.

[5] At the time of birth, the Respondent parents did not live together but resided in the same apartment building. Discussions by the agent with the Respondent/mother indicated she had started to prepare for the baby by buying a carrier and planned to deliver the baby at the Yarmouth hospital. She was provided with information about the public health nurse, Family Resource Center and Healthy Beginnings. Material to read for expecting mothers was also given to her.

[6] Possible supports for the Respondent/mother were family and friends within the Yarmouth community. The agent discussed with her possible services that would

have been helpful to her but she indicated she had enough support within the community. She has no concerns about the parenting ability of the Respondent/father, H.B.

[7] During further conversations with the agent, the Respondent/mother did not appear to understand the necessity of providing consent to speak to her family doctor or the purpose of talking to collaterals. The feeling was the agent should take her word for it. She refused a referral to Bethany Bin (for necessities for the baby) stating that the Respondent/father and others would provide everything she needed.

[8] The Respondent/father refused to talk to the agent (due to their involvement with his other two children). She explained to the Respondent/mother that there was concern he sexually abused his two other children, therefore, posed a risk to the newborn.

[9] The agent's contacts with the Respondent/mother prior to the birth of the child was one of un-cooperation and she finally relented, signing a consent. At first she did not understand it, believing she had signed away her baby. It was further explained to her but she was very concerned that the Respondent/father might find out about it.

[10] Information received from her Income Assistance worker as to why she was unable to work was because she was being treated for seizures. Medical assessments revealed a history of psychological disorder and emotional problems. She was also diagnosed with personality disorder, seizures/epilepsy and Stein Lavanthal Syndrome, borderline intelligence. It was also noted that she has poor coping mechanisms and poor social functioning.

[11] The Agency (April '08) decided to notify the appropriate hospitals about the pending birth. When the Respondent/mother was called by the agency, she told her to stop harassing her and that she has everything she needed for the baby and that the Respondent/father

was supporting her.

[12] On May 7, 2008, it was decided at the Agency Risk Management Conference that the baby would be apprehended because of the Respondent/mother's challenges and limitations and the risk the Respondent/father posed to the child who was apprehended on June *, 2008.

Issue:

[13] Disposition respecting the long term care of the child, J., born June *, 2008.

Minister's plan for the child's care

[14] The Minister filed two plans with the Court. The first is dated November 24, 2008 and requests temporary care and custody. On February 4, 2009, the plan was revised, requesting permanent care and custody pursuant to Section 42(1)(f) of the Children and Family Services Act.

[15] In the early plan, the Minister's agents were concerned about long term child protection issues and they were reviewing the Parental Capacity report completed for this purpose.

[16] The final and revised plan which asked for permanent care and custody outlined why "the child cannot be adequately protected while in the care of the parent, K.B."

5. Where the agency proposes to remove the child from the care of a parent or guardian:

(a) Explanation of why the child cannot be adequately protected while in the care of the parent or guardian (refer to the condition or situation on the basis of which the child was found to be in need of protection services)

Since the child's apprehension, I, Cystal Barr, Child Protection Worker have had ongoing contact with J. and

will continue to do so. She was placed in the care of an approved foster family who have provided for all her physical needs. The foster family's committed nurturance has encouraged J.'s development and to date she seems to be meeting her milestones on target. J. has regular appointments with her family doctor, Dr. *.

I have continued to have regular contact with K.B. at least once per month to discuss K.B.'s ability to parent J., what she has done in preparation for J.'s return home, and the Agency's identified concerns for her to adequately parent J.. As well, I have informed K.B. of the Agency's position and explained the meaning of Permanent Care and Custody to her. I have also stressed the importance of discussing this with her legal counsel.

There have been no changes to the supervised access arrangements. Visits between K.B. and J. continue on a weekly basis.

Initially, the Agency considered J. to be in need of protective services based on K.B.'s involvement with J.'s father, H.B., who has a history of child sexual abuse. K.B. both denied and minimized this about H.B. and took no actions. She refused to meet and discuss same with Agency. It was not until the Agency had intervened, that she was willing to consider this. She continued to have a relationship with H.B. up until the time J. was apprehended.

However, more fundamentally, the Agency has concerns for K.B.'s ability to adequately parent and protect J. due to inappropriate lifestyle choices such as not taking any action when made aware of Agency's concerns for her relationship with H.B. K.B. denied her lengthy medical history, which raised questions concerning her ability to parent J..

During the investigation, K.B. could not identify any supports and suggested she had no family members she was close to. Following J.'s apprehension, K.B. identified family members as an option to placing J. but the identified relatives have indicated they are no longer willing or able to care for J.. These family members have also not been consistent in supporting K.B. throughout the Agency's involvement. This lack of identified support was further reported in the parental capacity assessment, authored by Stephen Theriault, referred to below.

To better understand K.B.'s situation, the Agency requested a parental capacity assessment, which has clearly outlined these same issues and how they will stand in the way of K.B. providing for J..

K.B. met with Stephen Theriault, psychologist, for the purpose of conducting the parental capacity assessment. This completed report has been provided to the Family Court. I reviewed this report with her but

felt K.B. was having difficulty understanding the contents. I felt it would benefit K.B. to meet with Dr. Theriault for further clarification regarding the purpose and results of the report.

Shortly after J.'s birth, she was seen by a pediatrician and continues to have regular doctor appointments with Dr. * since being in foster care. Initially, upon discharge from hospital, J. appeared to be jittery and hyperactive but this was resolved quickly. From all doctor's reports, J.'s growth and development appears age appropriate.

I have asked her if she has sought out information on what services are available in the Yarmouth area if J. were to return to her care. K.B. was not aware of any services. I identified the local Family Resource Centre but she has not followed through with this to date. Previous to J.'s birth I had conversations with K.B. as to how she was preparing for that event. K.B. suggested she had some items such as a carrier and crib but that there was still a need for further preparation. I have since discussed with her what she has done to prepare for J. if she were to return to her care and K.B. has indicated she would only do so once she knew J. would be returning to her care.

[17] There are only two people that she can rely on. She lived with V.D. and B.D. for awhile, V.D. was recently ill.

[18] In support of her plan to have the child

returned to her, the husband of V.D., B.D., provided an affidavit indicating the Respondent/mother and his wife, V.D., were like sisters (they are cousins) and he has known the mother for 25 years. He says the Respondent/mother babysat his two children when they were just five and six which was full time care even when they were infants. There was no problem with her parenting. During the time the Respondent/mother had the baby (3 days) he says there was good interaction. As to the Respondent/mother's plan, which depends on him and his wife for support, in his December 2008 affidavit he says:

> At the start of these proceedings my wife and I were in a position to assist K. with anything that she needed and we wanted to be considered as a place for the baby to be placed with us in the interim. Due to a deterioration in my wife's health we are no longer in a position to take the baby into our home, however we will continue to support K. in any way we can. If the baby were to be placed with K. , she can call us anytime and we will do everything we can for her.

[19] The Respondent/father has not participated in this disposition hearing and the Respondent/mother, K.B.'s, plan has been conveyed to the Court by her Affidavit and *viva voce* evidence together with that of a supporting witness.

[20] She presently has no relationship with the father, H.B., and has her own apartment in Yarmouth having previously lived with V.D. and B.D. in Yarmouth. She continues to see Dr. *, a psychologist who has treated her since the birth of the child. There has been no epileptic seizures since the apprehension of the child (presently on medication for this). Medication is also taken for blood pressure, asthma and sleeping. She admits that she gets stressed because of medication and cannot work. Alcohol is not used but she smokes a pack of cigarettes in two and a half days.

[21] It is admitted by her that the Minister (Agency) cannot do anything more for her except "give me back my loved one (the child)." Although the Respondent/mother has indicated to agents she has much support in Yarmouth, the evidence discloses otherwise.

[22] At the time of this hearing, B.D., testified he is illiterate and his wife is still ill (on date of the hearing he had to take her back to the hospital for further tests). They had recently moved because he had financial difficulties (disability cheques cut off but now returned).

[23] Although B.D. says they will do all they can for the Respondent/mother, everything is up in the air with his disability (back problems) and his wife being ill. They cannot have the mother move back in with them.

Professional Report (Parental Capacity Evaluation)

[24] Psychologist, Stephen W. Theriault was commissioned by consent of the parties to prepare a Parental Capacity Evaluation. His report is dated October 29, 2008 and its purpose is stated as a referral of the Respondent/mother, K.B. "For a psychological assessment to determine her ability to independently parent her daughter, J. (DOB: June *, 2008). Interviews were conducted with professionals and the Respondent/mother. He had an opportunity to observe the interaction between her and the child at a supervised visit.

[25] The Respondent/mother has no work history. She has received a disability pension since she was 18 or 19. She finished grade 7 before leaving school and has a significant health history, one issue described by her doctor as "unclassified cryptonic epilepsy with complex partial seizures." There has been treatment for heart disease and she takes medication for high blood pressure and asthma but according to the assessor, still smokes.

[26] She had a problem with alcohol and cannabis

use but quit this a number of years ago. Her family physician felt her medical problems were under control and they "did not preclude her from being a competent parent." He did have concern that when she first came to him, she was already 22 weeks pregnant although she had been aware of it. He found this to be "irresponsible" and that her lack of insight would impose significant barriers regarding her ability to parent.

[27] Dr. * a psychiatrist who treated the Respondent/mother, K.B., for epilepsy describes her "interactions with the child, J., prior to her removal as positive and he reported finding K.B. to be competent regarding her epilepsy treatment and the care of the baby.

[28] The child, J., was reported as doing well in the foster home, her temperament has improved due to the foster mother's intensive work with the baby.

Parenting (interactions) Observations

[29] The access facilitator felt that the Respondent/mother would need some intensive skills teaching but that she did basic activities competently. After working with her further, she noted significant memory details in that K.B. appeared to forget instructions she had received and even simple instructions had to be repeated several times. The overall impression is that she was concerned about her own needs (having the baby returned to her) than what was best for the child and this included lack of understanding of "J.'s developmental stages and her capabilities."

[30] During the assessor's home visit, the Respondent/mother was defensive, hesitant and confused about the purpose of the assessment. The assessor had to explain it to her several times, she was defensive, probably because she was being observed.

[31] The assessor concluded, after testing, that the Respondent/mother's "responses reflect a broad

deficit in introspectiveness perhaps due to typically vague or concrete thought processes. Also evident was a tendency to see herself in what may be unrealistically moral terms, perhaps out of a naive attempt to portray herself in a positive light."

ANALYSIS AND INTERPRETATION:

While it is clear that K.B. intently wishes to parent her daughter, there are several factors that should cause concern in this regard. A significant finding of the current assessment is that K.B.'s intellectual capacity was estimated to be very low (Full Scale IQ of 66). This would meet the first of the current criteria for mild mental retardation (an IQ of less than 70). The second criteria, significant difficulty functioning in such areas as academic achievement and work, would also appear to have been met in K.B.'s case. In the context of the current assessment question, her very low cognitive abilities would mean (as has already been noted) that K.B.'s ability to learn new skills and especially to generalize from a specific instance to a larger group of similar instances would be very limited.

A second area of concern is the evidence, provided by test validity scales and the reports of collateral sources, that K.B. has defensively minimized her current psychological problem and denied a significant mental health history. To a lesser extent, she has also downplayed her medical problems. The issue is not

so much that she has such histories but that she may be predisposed (as suggested by MCMI III results) to deny any and all problems. The risk here is that she may deny or minimize problems with J., should they occur, and fail to seek help. This risk factor is compounded by K.B.'s very limited insight. As an example, during the observation of mother and daughter, K.B. was asked by the assessor what she might need if she were caring for J.. Her response was to express confusion as to what was being asked. Several restatements of the question did not prompt K.B. to identify anything she felt she might need and finally she denied that she would need anything. It is possible that she feels that any indication that she may lack the skills or resources necessary to parent would be seen as a reason to deny her the opportunity.

Thirdly, there are indications from both test results and collateral sources that K.B. lacks empathy where her daughter is concerned. This should not be interpreted as meaning indifference but instead the incapacity to accurately understand the child's needs and the developmental facts that underlie them. There is also evidence that K.B. does not grasp the idea that her child's interests may not be the same as her own.

Despite her own perceptions, it is clear that K.B. would require substantial support on an ongoing basis if she were to parent J.. Unfortunately, her only natural support, V.D. and her husband, would appear to be no longer in a position to act in this capacity. K.B. was clear in stating that her immediate family was not willing or is unable to support her. This lack

of natural support would mean that social service agencies would be required to provide an intensive level of support for the foreseeable future, given that J.'s changing needs are likely to continuously outpace her mother's ability to understand and respond to them.

The Law:

Children and Family Services Act

Disposition Hearing

41(1) Where the Court finds the child is in need of protective services, the Court shall, not later than ninety days after so finding, hold a disposition hearing and make a disposition order, pursuant to Section 42.

Evidence

(2) The evidence taken on the protection hearing shall be considered by the Court in making a disposition order.

Plan for child

(3) The Court shall, before making a disposition order, obtain and consider a plan for the child's care, prepared in writing by the Agency and including,

(a) a description of the services to be provided to remedy the condition or situation on the basis of which the child was found in need of protective services;

(b) a statement of criteria by which the Agency will determine when its care and custody or supervision is no longer required;

(c) an estimate of the time required to achieve the purpose of Agency's intervention;

(d) where the Agency proposes to remove the child from the care of a parent or guardian;

(i) an explanation of why the child cannot be adequately protected while in the care of the

parent or guardian, and a description of any past efforts to do so, and

(ii) a statement of what efforts, if any, are planned to maintain the child's contact with the parent or guardian; and

(e) where the Agency proposes to remove the child permanently from the care or custody of the parent or guardian, a description of the arrangements made or being made for the child's long-term stable placement.

Disposition Order

42(1) At the conclusion of the disposition hearing, the Court shall make one of the following order, in the child's best interest;

(a) dismiss the matter;

(b) the child shall remain in or be returned to the care and custody of a parent or guardian, subject to the supervision of the Agency for a specified period, in accordance with Section 43;

(c) the child shall remain in or be placed in the care and custody of a person other than a parent or guardian, with the consent of that other person, subject to the supervision of the Agency, for a specified period, in accordance with Section 43;

(d) the child shall be placed in the temporary care and custody of the Agency for a specified period, in accordance with Section 44 and 45;

(e) the child shall be placed in the temporary care and custody of the Agency pursuant to clause (d) for a

specified period and then be returned to a parent or guardian or other person pursuant to clauses (b) or (c) for a specified period, in accordance with Section 43 to 45.

(f) the child shall be placed in the permanent care and custody of the Agency, in accordance with Section 47

Restriction on Removal of Child

(2) The Court shall not make an order removing the child from the care of a parent or guardian unless the Court is satisfied that less intrusive alternatives, including services to promote the integrity of the family, pursuant to Section 13,

(a) have been attempted and have failed;

(b) have been refused by the parent or guardian; or

(c) would be inadequate to protect the child

[32] In *F.C.S. of Yarmouth County v. T.S. and W.S. [2003] N.S.F.C. 15*, this Court discussed the general law with respect to the Children and Family Services Act.

THE CASE LAW GENERALLY:

C.A.S. (Halifax) v. Fairn (not reported) 1992 F.H. (CSA/CAS)(Daley, J.F.C.)

The purpose of the C.F.S.A. is the protection of children. As a result, with the exception of providing whether or not a child is in need of protective services, the welfare of the child is the top priority. See RE: Sarty (1974), 4 N.S.R. (2d) 93 and Children's Aid Society of Halifax v. Lake (1987), 4 N.S.R. (2d) 361 (N.S.C.A.). The C.F.S.A. promotes the integrity of the family but only in circumstances which will protect the child. When the child cannot be protected as outlined in the C.F.S.A. within the family, no matter how well meaning the family is, then, if its welfare requires it, the child is to be protected outside the family.

C.A.S. (Halifax) v. Emmerson (1991), F.H. CFSA/CAS, (Levy, J.F.C.)(Unreported), page 19:

The very obvious thrust and philosophy of the Act is to assure that parents and children are allowed to stay together unless for clear and important reasons such, a course, is antithetical to the child's best interest. Integral to the legislation is the reasonable provision of the services (Section 13) that are not necessary to accomplish this task.

The Act makes clear in a host of ways, not least in 42(2)... that the severing of parental rights is to be a last step when all reasonable steps to provide services have failed, been refused, or are clearly inadequate to protect the child.

Conclusions/Decision:

[33] The Respondent/mother, K.B., is technically a single mother (Respondent/father has no relationship with her or the child). She has no support from her immediate family and a cousin and her husband who had originally agreed to help are not unavailable because of illness and past financial difficulties. They reside too far away from the Respondent/mother to be of any regular help.

[34] The Respondent/mother, if the child were returned to her, would be in need of assistance on a continuous basis. One of the problems is that she fails to acknowledge this. Her desire to have the child with her ignores the child's needs and puts the emphasis on her own needs. She is incapable, for reasons mentioned in the evidence and the professional report, of retaining parenting instructions. Her physical problems

are not a bar to parenting, this is mostly under control. As the parental assessment indicates she "cannot think outside the box" and would be too rigid with respect to discipline and areas where flexibility is required.

[35] In his report the assessor describes the latter concern as follows:

> Ability to meet emotional needs of the children: Observation and responses to assessment instruments both suggest that K.B. feels emotional ties to J.. There is evidence that this attachment is shallow, however, in that it is not based on a well-grounded understanding of the reality of raising a child. There is evidence that K.B. lacks empathy in the sense that she does not recognize the developmental needs of her child and may have simplistic, black and white ideas as to how a child should behave. This suggests that K.B. may have real difficulties in responding to situations where the child does not meet her expectations or behaves in unexpected ways.

[36] The Respondent/mother, K.B., never gave the court or the assessor a long term concrete plan to parent. Her response is more of a desire to parent which the assessor describes as "an unrealistic one" given the results of the testing he did.

[37] Her desire to have the child is more or less to satisfy her own needs for companionship and love. In her testimony she said "I treat J. well and feed and change her, I love her." She admits that the Minister(Agency) cannot do any more for her except "give me back my loved one."

[38] Children are not born with instruction booklets. Parents acquire knowledge of how to care for children mainly from family and where that is not available or insufficient (as the evidence discloses here) the state has the ability to intervene and provide services that will help the parent to learn

proper parenting skills.

[39] In the case before the Court, the evidence is that the Respondent/mother is unable to retain instructions given to her or carry out skills shown to her. As children grow, parenting does not become easier and when one does not understand children's needs as the years go by, the attempt at parenting becomes a matter that is contrary to the child's best interest.

[40] The Respondent/mother does not have enough third party support (family/friends) in order for her to provide for the child's best interests. She would require intensive state services. This is not possible. Services have been tried but have failed for the reasons referred to earlier.

[41] The Court finds that the best interests of J. are served by ordering permanent care and custody with no access so that her long term interests will be served by adoption.

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John D. Comeau
Chief Judge of the Family Court
of Nova Scotia