FAMILY COURT OF NOVA SCOTIA

Citation: *Nova Scotia (Community Services) v. M.K.*, 2020 NSFC 8

Date: 2020-10-01
Docket: FT No. 111627
Registry: Truro

Between:

Minister of Community Services

Applicant

v.

M.K. and P.K.

Respondents

Restriction on Publication: Pursuant to s. 94(1) of the *Children and Family Services act*, S.N.S. 1190, c.5.

Judge:	The Honourable Justice S. Raymond Morse, exercising concurrent jurisdiction
Heard	July 13, 14, 15, 17, 20, 27 and 29, 2020, in Truro, Nova Scotia
Counsel:	A. Melvin, for the Applicant B. Bailey, for the Respondent, P.K. M.K., Self-represented J. Cox, *Amicus Curiae*

By the Court:

Introduction

[1] The Minister is requesting permanent care and custody of the child, T. K., born in 2010, hereinafter referred to as "T.".

[2] T. is the daughter of M.K. and P.K.

[3] At a pre-hearing conference held June 30, 2020, counsel for the Respondent father confirmed that P.K. was no longer contesting the Minister's request for permanent care and custody. Mr. Bailey advised that the father was admitting that T. continued to be in need of protective services as per subparagraphs (b), (e), (h), (j), and (k) of S. 22(2) of the *Children and Family Services Act* (hereinafter referred to as the *CFSA*).

[4] In recognition of P.K.'s position, counsel for the Minister confirmed that the Minister would no longer be seeking a protection finding pursuant to subparagraphs (c) and (d) of the s.22(2) of the *CFSA*.

[5] The mother, M.K., opposes the Minister's request for permanent care and custody.

[6] Initially, the Respondents were represented by Lloyd Berliner and then subsequently by Michael Owen. After Mr. Owen's retainer was terminated Mr. Bailey initially appeared on behalf of both Respondents, but at the July 9, 2019 review hearing advised that he would only be representing the father. Since that appearance M.K. has participated as a self-represented Respondent.

[7] On several occasions the court discussed with M.K. the importance of her having appropriate legal representation and encouraged her to make application to Nova Scotia Legal Aid.

[8] Pursuant to Review Application and Notice of Hearing dated December 20, 2019, the Minister requested an order for permanent care and custody.

[9] Following submissions at time of the January 9, 2020 review hearing, the court confirmed its intention to provide an oral decision on whether appointment of state-funded counsel, appointment of *guardian ad litem* or appointment of *amicus curiae* would be appropriate in light of M.K.'s involvement as a self-represented respondent.

[10] On January 30, 2020 the court confirmed its decision to appoint *amicus curiae* (see *Nova Scotia (Minister of Community Services) v. M.K. and P.K.*, 2020 NSFC 7). Subsequently, the court was advised that Jennifer Cox, had agreed to act as *Amicus*.

[11] Following my appointment to the Nova Scotia Supreme Court Family Division the week prior to the March 9 hearing, I continued as the presiding judge exercising concurrent jurisdiction in accordance with an Order in Council dated February 28, 2020.

Proceedings

[12] Pursuant to the Protection Application and Notice of Hearing dated September 26, 2018, the Minister maintained that the child T. was in need of protective services pursuant to subparagraphs (b), (e), (h), (j), and (k) of S. 22(2) of the *CFSA*.

[13] The child T. was taken into care on September 27, 2018 immediately prior to the interim hearing.

[14] An initial order for temporary care and custody was granted at the conclusion of the initial hearing and the matter was adjourned for completion on October 25, 2018.

[15] A further order for temporary care and custody was granted on October 25.

[16] The court completed the protection hearing on December 18, 2018, finding that the child to be in need of protective services as per subparagraphs (b), (e), (h), (j) and (k), subject to a reservation of the Minister's right to call evidence in relation to (c) and (d) at some future point in the proceeding. The Respondents took no position in relation to the Minister's request for a protection finding. The order for temporary care and custody was extending pending disposition.

[17] The initial disposition hearing was held March 12, 2019. Both Respondents participated without legal representation and took no position in relation to the Minister's request for an order for temporary care and custody by way of initial disposition order. The court granted the disposition application, subject to a reservation of rights in favor of the Respondents.

[18] Further orders for temporary care and custody were granted at the review hearings held May 2, 2019, July 9, 2019, September 5, 2019, October 22, 2019, January 9, 2020 and March 9, 2020.

[19] A final review hearing to determine the Minister's application for permanent care and custody was commenced on a *pro forma* basis on March 9, 2020. An initial exhibit was tendered on behalf of the Minister consisting of the final Review Application and Notice of Hearing dated December 20, 2019 and attached Revised Agency Plan for the Child's Care.

[20] Based upon estimates provided by counsel, the court assigned ten days for hearing of the final review application.

[21] Following the onset of the pandemic in March, the court confirmed that the dates set for trial would be vacated.

[22] During a telephone pre-trial held May 26, 2020, the court confirmed new dates for trial commencing July 13, continuing July 14, 15, 17, 20, 27, 29 and 31.

[23] The parties and counsel participated in a settlement conference with His Honour Judge Wilson on May 25, 2020. The settlement conference was not successful.

[24] The parties then agreed to a further settlement conference before Judge Wilson on June 29, 2020. The second settlement conference did not resolve the matter.

[25] The final review hearing commenced on July 13, 2020. Neither P.K. or his counsel participated in the hearing as a result of the agreement between P.K. and the Minister confirmed at the pre-hearing held June 30, 2020.

[26] Twelve witnesses testified on behalf of the Minister. The Minister's case on direct concluded on July 27. M.K. called one witness and testified on her own behalf. By consent, she also filed one exhibit, an email character reference letter, which was entered as Exhibit 11.

[27] A total of eleven exhibits were entered during the hearing.

[28] Following closing submissions on July 29, the court reserved decision.

Evidence Summary

[29] The paragraphs that follow provide a summary of the evidence that was introduced during the final review hearing. It is a summary and therefore not comprehensive. I have carefully considered all the evidence for the purposes of this decision.

Elementary School Principal

[30] The principal identified Exhibit 2 as his affidavit sworn on July 9, 2020.

[31] T. was a student at the school between 2016 and 2018.

[32] The principal had contact with child protection social workers during the 2016-2017 school year after T.'s teacher made a referral to the Agency.

[33] The principal reported to the investigating social workers that T. was missing a lot of school. The child was not toilet trained and, as a result, the school purchased appropriate cream to apply to a rash which developed on the child's buttocks.

[34] As a result of the child's absenteeism and toilet training issues, arrangements were made for the child to take the special needs bus.

[35] The principal had further contact with child protection social workers during T.'s second year. The principal indicated that the school was concerned because T. was demonstrating ongoing health issues.

[36] M.K. had shut down communication with the school and was refusing to accept support for the child. M.K. was dismissive of the school's concerns.

[37] M.K. had instructed the school that T. was not to be permitted to speak to child welfare workers.

[38] The principal testified that M.K. refused the school's request that they be given permission to speak with T.'s doctor.

[39] During cross-examination by M.K., the principal acknowledged that T. came to school well dressed and with proper lunches.

[40] The principal agreed that most days the child appeared happy at school, but indicated that on a lot of days the child was in tears because of the problems she had going to the bathroom and, again, he confirmed that they had wanted to speak with the child's doctor in an effort to help her.

[41] During cross-examination by the *Amicus*, he agreed that M.K. was, for the most part, a cooperative parent. However, again he expressed concern about M.K.'s refusal to authorize services which the school felt were needed, like occupational therapy and speech therapy.

[42] The principal indicated that the school wanted to do what was best for T.. The issues with respect to bowel movements were very concerning and the child soiled herself a lot at school.

Chelsea Cullingsworth, Social Worker

[43] Ms. Cullingsworth identified and confirmed tab 37 of Exhibit 3 as her affidavit sworn April 21, 2020.

[44] During cross-examination by M.K., Ms. Cullingsworth acknowledged that she had not met M.K. prior to her telephone conversation with M.K. on April 25, 2018.

[45] Ms. Cullingsworth acknowledged that her case notes contained positive comments made by the child during the at-school interview she completed with the child on April 25, 2018 that were not included in her affidavit.

[46] The inability to arrange a meeting with M.K., despite repeated efforts to do so, resulted in a decision to seek a s. 26 Investigative Order to enter the home.

[47] Ms. Cullingsworth confirmed that the Investigative Order was attached as Exhibit B to her affidavit and could not explain why the order did not have a court case number on it.

[48] During cross-examination by Ms. Cox, Ms. Cullingsworth agreed that her affidavit did not mention that the child's school attendance improved.

[49] Ms. Cullingsworth's affidavit outlines her initial telephone conversation with M.K. on April 25 starting at paragraph 10.

[50] In reference to the referral concerns, M.K. indicated that it was a false report by the school. M.K. also maintained that the interview with the child was illegal and that the worker needed a warrant to meet with the child.

[51] The affidavit outlines Ms. Cullingsworth's unsuccessful efforts to arrange a meeting with the respondent parents.

[52] During a telephone conversation on May 1, 2018, Ms. Cullingsworth mentioned that the child had an EPA at her school. M.K. responded by indicating that she did not and then indicated that she was not aware that the child had an EPA and commented the school did not tell her anything.

[53] On May 22, 2018, Ms. Cullingsworth spoke with M.K. over the phone and during this conversation M.K. advised that she did not have to meet with her and that their business could be done over the phone.

Dr. Robyn McLaughlin, Pediatrician- IWK Health Centre

[54] Dr. McLaughlin was qualified to give opinion evidence in relation to pediatrics, including child abuse pediatrics.

[55] She testified that she was responsible for T.'s care during the Fall of 2018.

[56] Her Consultation Report dated May 14, 2020 was entered as Exhibit 5.

[57] The first issue identified by Dr. McLaughlin in her report was anemia.

[58] On October 2, 2018 T. had bloodwork collected at the IWK which confirmed a critically low result and resulted in her admission to the IWK Pediatric Medical Unit on October 3.

[59] In her report Dr. McLaughlin notes that T. had hemoglobin of 43 (normal range 106-132) and indicates her opinion that T.'s anemia was chronic not acute. Her report confirms that T. had a low retic-hemoglobin and very low ferritin, supporting a diagnosis of iron deficiency as the cause of T.'s anemia.

[60] T. required a transfusion of red blood cells on October 9 in preparation for dental surgery and received an infusion of intravenous iron on October 4, 2018. She responded positively to iron replacement and had normalization of her hemoglobin by November 2018 and it remained normal throughout her IWK stay.

[61] Dr. McLaughlin offered the following opinion:

> Her laboratory findings and response to treatment are supportive of the diagnosis of iron deficiency anemia cause by poor oral intake of iron. This diagnosis is further supported by other features relating to poor nutrition including a history of picky eating, oral aversion, short stature and low weight. While parents may note extreme pallor or fatigue

> in children with anemia, sometimes because of slow onset parents do not recognize anemia in their children until laboratory testing identifies the diagnosis.

[62] The second medical issue identified in the report was nutritional deficiencies. Dr. McLaughlin indicated:

> These nutritional deficiencies each have a number of possible causes that were considered, however for each individual deficiency, the most likely cause in (T.'s) case is a lack of dietary intake. Taken in totality, the finding of low zinc, low vitamin C, and low vitamin D is best explained by a severely limited diet leading to poor intake of multiple nutrients.

[63] The third medical issue involved a diagnosis of severe dental caries and ulcerated teeth in association with severe dental decay and severe gingivitis. The gingivitis was treated by a course of oral antibiotics. On October 10, 2018 the child had 17 teeth extracted by a pediatric dentist. Dr. McLaughlin commented as follows at page 3:

> (T.) had several dental caries which were clearly visible on examination. During her admission she reported pain in her teeth with eating. The condition of her teeth would be expected to cause pain, and difficulty with eating. These caries would have developed over a prolonged period. In my opinion, I would expect that a layperson caring for (T.) could tell that her teeth appeared abnormal, and I noted based on in-hospital observations that (T.) could express that she had pain in her teeth and mouth verbally.

[64] The next issue identified by Dr. McLaughlin was feeding aversion.

[65] She confirmed that even after the extractions and healing, T. continued to be averse to solid or even pureed foods. Due to lack of adequate oral intake she was given a nasogastric (NG) feeding tube, described as a soft plastic tube inserted through the nose into the stomach, for feeds. She was eventually discharged from the IWK with an NG in place. It was determined that if her feeding did not advance she would be referred for a more permanent tube, called a G-tube, to be inserted through the abdominal wall directly into the stomach.

[66] T. was re-admitted to the IWK on December 18, 2018. Initially an NJ tube (a soft tube inserted through the nose, passing through the stomach and into the first part of the bowel) was placed and then subsequently a GJ tube (a tube placed through the abdominal wall into the stomach and first part of the bowel) was placed on January 25, 2019. Dr. McLaughlin's report indicates that over time the child was able to learn to eat a varied diet and her tube feeds were decreased.

[67] In October 2019 tube feeds were stopped and all her nutrition was by mouth. Unfortunately, T.'s growth slowed and tube feeds had to be resumed March 2020.

[68] In her report, Dr. McLaughlin acknowledges that it is not possible to determine the etiology of T.'s feeding aversion or its causal relationship to other symptoms. She does however indicate the following:

> Regardless of cause, (T.) had a severely restricted diet at time of presentation and had an aversion to eating all foods except milk at time of her admission in October 2018. Her poor diet resulted in iron deficiency anemia, vitamin C deficiency, vitamin D deficiency and zinc deficiency. (T.) had poor growth as a result of her nutrition. Once brought to the attention of medical professions upon being taken into the care of DCS, her feeding aversion required treatment by a multidisciplinary feeding team including a psychologist, a dietitian, an occupational therapist and her pediatricians.

[69] The fifth issue identified by Dr. McLaughlin was failure to thrive and short stature. She confirmed as follows:

> Failure to thrive is defined as a child who exhibits a decline in growth velocity, exhibited by weight that is less than the 5th %, or weight that has crossed two percentile lines on a growth chart. At the time of admission to the IWK in October 2018 (T.) weighed 15 kg and was 103 cm tall. Both values are below the 3rd percentile for girls her age. Her BMI was 14.1, which is on the 13th percentile for her age. (T.) was 8.5 years old at that time. For comparison, her weight is the average of a 3.5 year old girl, and her height is the average height of a girl who has just turned 4.

[70] In discussing T.'s failure to thrive Dr. McLaughlin indicated:

> As (T.) gained weight well when provided with adequate nutrition at the IWK, and showed great growth in the year after presentation, the most likely explanation for her failure to thrive is that she was not receiving adequate nutrition prior to admission in October 2018. There may have an issue or multiple issues including- food insecurity (family not having food), lack of offering of age-appropriate foods from a variety of food groups, inability to eat due to dental pain or oral aversion, or neglect…

[71] The next issue identified was constipation. Her report notes that on admission, T. was noted to have a distended abdomen with palpable stool and an abdominal x-ray confirmed the presence of a large amount of stool in her bowel. She was noted to have overflow incontinence of stool. She was treated with enemas and medications.

[72] Dr. McLaughlin indicated that constipation is one of the most common conditions seen by pediatricians and by far the most common cause is functional constipation for which no organic cause is found. No organic cause was found for T.'s constipation. Dr. McLaughlin noted that T.'s constipation was difficult to manage and that T. required "clean-outs" of constipation intermittently and is still followed by IWK Gastroenterology Service.

[73] Dr. McLaughlin confirmed that T. was noted as having an unusual gait. X-rays showed hip dysplasia and slight valgus deformities. T. was referred to and is followed by the IWK orthopedic team, but Dr. McLaughlin notes that she is comfortably able to run and walk such that no surgical intervention is planned at present. Physiotherapy has been recommended.

[74] Finally, Dr. McLaughlin noted that, while T. received appropriate immunizations during her first year, it appeared unlikely that she received additional recommended immunizations and that a consult letter from the family doctor in January 2017 advised that M.K. had chosen to

decline further immunizations. Dr. McLaughlin confirmed that during the admission to the IWK pediatricians recommended that T. receive the routine childhood vaccines and that the immunizations were administered and tolerated well.

Robyn Byrne, Intake Supervisor

[75] Ms. Byrne identified and confirmed her affidavit in Exhibit 3 at tab 2.

[76] During cross-examination by M.K., Ms. Byrne acknowledged that she had first met M.K. September 11, 2018. During that meeting they discussed the importance of a pediatrician appointment T. had scheduled for early September. Ms. Byrne advised M.K. that it was important that the appointment be kept and explained that if she cancelled the appointment the agency would be concerned.

[77] Ms. Byrne testified that when the pediatrician's office was contacted to confirm the appointment had been kept, the office advised that M.K. had cancelled the appointment. As a result, the agency decided to proceed with a taking into care.

[78] The agency encountered difficulty in attempting to locate and take the child into care and as a result T. was not taken into care until September 27, 2018.

[79] Ms. Byrne's affidavit of September 26, 2018 reviews the history of agency involvement commencing in December 2016. The affidavit describes in some details the history of the agency's efforts to make contact and communicate with the parents, particularly, M.K.

[80] Paragraph 80 of the affidavit outlines what transpired on September 1, 2018 when social workers attended at the Respondents' home accompanied by an RCMP officer. M.K. would not allow the workers to enter her home and when she came out of the home to speak with the workers she was provided a copy of the investigative order. Only when a RCMP officer intervened was a worker able to make entry into the home. Photographs of the home are attached as Exhibit A to Ms. Byrne's affidavit.

[81] Both Respondent parents refused to sign consent forms for the agency to speak with their family doctor.

[82] A worker indicated that the agency would like to see T. taken to IWK emergency. The Respondents refused and indicated that they had an appointment at the IWK for September 17 to meet with a pediatrician. The workers emphasized how important it was to attend that appointment and to follow through with medical services for T..

[83] The affidavit also reviews Ms. Byrne's conversation with M.K. on September 11, 2018 during which M.K. advised that she had decided to move to a different school district to get away from the harassment at T.'s prior school.

[84] They discussed T.'s constipation issues and M.K. suggested that T. was good now because she no longer screamed when she used the bathroom. M.K. refused to let the worker see T. until she had spoken with a lawyer.

[85] The affidavit reviews in detail the agency's unsuccessful efforts to effect a taking into care prior to September 27, 2018, which resulted in the issuance of a Canada-wide alert on September 19, 2018.

Dr. Lindsay Vellacott, Pediatrician

[86] Dr. Vellacott was qualified to given opinion evidence as an expert in pediatrics.

[87] Dr. Vellacott was referred to tab 6 of Exhibit 7 and identified her reports as contained within tab 6.

[88] Dr. Vellacott confirmed that she has been T.'s pediatrician since November 2018. She continues to see the child on an almost monthly basis to review her weight and other ongoing medical concerns.

[89] Dr. Vellacott testified that the medical issues that T. presented with included significant constipation, severe malnutrition causing various nutritional deficiencies, blood transfusions due to low hemoglobin and 17 tooth extractions due to dental caries, which made it difficult for her to eat.

[90] Constipation is an ongoing issue which requires medication and hospitalization for clean-outs. Consistent monitoring of the child's stool is required in order to adjust or titrate her medication.

[91] Dr. Vellacott noted that the child experiences occasional accidents due to the enlargement of her bowel due to constipation and probable nerve damage to the bowel due to stretching.

[92] T. suffers from congenital hip dysplasia which may require surgery at some future point.

[93] While acknowledging that the child has come a long way, Dr. Vellacott testified that T. continues to have emotional dysregulation and requires sensory options to help her regulate.

[94] Despite gains in weight and height, Dr. Vellacott testified that T. remains in the 3rd percentile for weight and an even lower percentile for height. Dr. Vellacott noted there is currently a concern that puberty will limit her potential growth.

[95] At this point, T. is doing well and the biggest challenge is managing her nutrition and constipation. T. continues to have gait abnormalities and some hip discomfort.

[96] During cross-examination by M.K., Dr. Vellacott acknowledged that T. had had three hospitalizations for constipation in 2019 but has not been hospitalized since April 28, 2020. Dr. Vellacott testified that T. has experienced extension, or stretching, of her bowel in association

with constipation and as a result the nerves have lost sensitivity and do not send the usual signal of a bowel movement. This is an issue that takes a long time to resolve and some of the damage might be irreversible.

[97] During cross-examination by Ms. Cox, Dr. Vellacott was referred to correspondence from Dr. Merritt addressed to Dr. Aubrey which contained a handwritten entry referring to the fact that Dr. Merritt, the family physician, indicated that he had only seen the child twice.

[98] Dr. Vellacott testified that she has seen T. fairly frequently. Since March, she has seen her each month for weight and height checks to ensure that she is growing.

[99] Dr. Vellacott confirmed that T. had been in hospital at the IWK for over two months starting October 3, 2018 and was not discharged until November 30, 2018. She referred to the length of stay as unusual.

[100] She explained the necessity for subsequent hospitalization for clean-outs in relation to constipation on the basis that the medication provided causes explosive diarrhea and uncontrollable urges to stool and therefore hospitalization was required to administer medication and to help clean and monitor.

[101] Dr. Vellacott testified that T. eats well for the most part and she is now receiving significantly more calories by way of feeding tube and that the increase in calories would be the primary cause of her growth.

[102] Dr. Vellacott described T. as a very bright and very kind little girl, small in stature but big in personality, who has made extensive gains since coming into care.

[103] She expects T. to grow but not reach her genetic potential. She expects significant improvement in T.'s academic performance.

[104] When asked what type of parenting is required, Dr. Vellacott testified that T. requires close supervision and monitoring and a parent who will ensure her medications are provided consistently and facilitate her ongoing visits to the pediatrician and other health care providers. T.'s parents should provide consistency and ensure she is attending school and doing schoolwork.

[105] Dr. Vellacott went on to indicate that T. requires a parent who is mentally and emotionally healthy and can provide the healthy environment that T. requires to grow and express her emotions, who can respond to her dysregulation appropriately and understand and implement coping strategies, including the sensory strategies recommended by the occupational therapist.

[106] In her report dated April 28, 2020, Dr. Vellacott noted that T. continues to have a list of food restriction due to difficulty chewing and swallowing some foods. This relates to the dental extractions and the lack of exposure to solid food at an early age. T. continues to require daily medication to regulate her bowel function and the foster mother in constantly monitoring the

frequency and consistency of the child's bowel movements and adjusting the dose of prescribed medications as necessary to maintain at least one "easy to pass" bowel movement per day.

[107] With respect to the child's development, she noted that T. is behind in some of her developmental areas and struggles with some aspects of speech, particularly pronunciation, but has been making progress in speech therapy. T. is behind in terms of her fine motor skills and an occupational therapy assessment provided a list of recommendations made to assist in development of fine motor skills.

[108] She indicated that a psychoeducational assessment was completed in June 2019 and that the child displayed abilities ranging from very low to average across a variety of cognitive areas and her academic skills were extremely low to average. T. continues to show growth academically.

[109] In relation to T.'s gait she noted that, while still abnormal, there continues to be improvement which she attributed to growth and strength development associated with regular physical activity.

Doreen Coady Shadbolt, Psychologist

[110] Ms. Coady Shadbolt was qualified to testify as an expert in psychology, including child psychology.

[111] When referred to Exhibit 3, tab 3, she identified her resume as well as her progress reports submitted from September 2019 to April 2020. She identified Exhibit 9 as an update for May 2020 and Exhibit 10 as an update for June 2020.

[112] When asked about current psychological needs of the child, Ms. Coady Shadbolt indicated that T. needs stability and structure and attachment, noting the child still has significant medical needs.

[113] She referred to T. as being petite and underdeveloped, noting that she is now 10 years old and that the child will have a lot of medical needs as puberty approaches.

[114] She testified that T. needs to maintain positive attachments and attend school, noting that T. loves to do well in school and appears to be self-driven as far as academics are concerned, so maintaining an encouraging atmosphere is important. T. has done well in attending school and developing peer relationships.

[115] When asked about home environment, Ms. Coady Shadbolt said that the child needs kindness, firmness, opportunity for independence, age-appropriate risk-taking, and that her caregivers need to be attuned to her needs. T. needs to feel safe and secure, not only physically but emotionally, and be able to go to people for help knowing that they are not going to overreact. T. needs to be safe psychologically and still have her medical needs met.

[116] Ms. Coady Shadbolt referred to T. as being a delightful and sprightly child, but very reticent to talk about her family. She expressed her belief that T. was exposed to things that were too much for her.

[117] During cross-examination by Ms. Cox, Ms. Coady Shadbolt confirmed her belief that T. has experienced trauma. When asked what signs of trauma she had observed, she indicated trauma would be indicated by the lack of emotional regulation, hypervigilance and the child being attuned to adult mood.

[118] Ms. Coady Shadbolt indicated her belief that T. demonstrated signs of having experienced both neglect and trauma, noting that the issues are intertwined and overlap and that T. presented with characteristics of trauma and neglect consistent with when basis needs have not been met. Neglect would be associated with T.'s issues with her gastrointestinal system, poor sleeping, poor eating and being obsessed with food, indicating poor food security. Indications of trauma included extreme hypervigilance and poor regulation skills wherein T. has become upset easily and could not calm herself.

[119] When asked to explain T.'s positive personality, she indicated that while some of it would relate to genetics, she felt T. must have experienced positive attachment early on in her life.

[120] On re-direct, Ms. Coady Shadbolt testified that children do better with predictability and that the need for permanency planning is important. She acknowledged that T. might do okay if she knows she is going back with her mother, but again noted a need for permanency planning and indicated the importance of the adult's needs not overwhelming the child's. Ms. Coady Shadbolt expressed her belief that T. has been watching, observing and taking care of the adult emotional needs for a significant period of time.

[121] Ms. Coady Shadbolt indicated that the current foster home has provided structure, expectations and boundaries noting that the child she met a year ago was much different than the child she is dealing with now. T.'s confidence has blossomed in the care of the foster home. When asked about risk if that type of parenting is not available on a go-forward basis, she stated that the risks would be fairly significant.

<u>Carolyn McNally, Speech Pathologist</u>

[122] Ms. McNally identified her evaluation report, as well as subsequent progress reports, as found within tab 4 of Exhibit 3.

[123] She testified that the child has made great improvement regarding her speech, reading skills and language. She testified that T. has made very good progress on some sounds but that some sounds can not be made because of her lack of teeth causing her to lisp, however T.'s rate of speech is good.

[124] T. had mild to moderate delay in articulation at the outset of her involvement and was below-average with receptive and expressive language and had problems with working memory. Ms. McNally testified that T. has made progress during the course of therapy.

[125] She said that T.'s foundational skills in a couple areas were delayed and, by way of example, indicated that T. was not able to rhyme at time of her initial evaluation. When asked about the cause for such delay, she explained that physical health issues can have impact as well as neglect in any areas. Environmental and psychosocial factors may also play a part. To address such a delay what is required is a supportive home, implementation of strategies and provision of support, in a positive encouraging environment.

Caitlin Neily, Psychologist

[126] Ms. Neily was qualified to give opinion evidence as a school psychologist.

[127] She identified her Psychoeducational Report for the child T. as contained in Exhibit 7 at tab 5(b).

[128] In discussing her report, she noted that part of T.'s profile is in the average range but other parts, such as verbal comprehension, are below. Based upon the assessment results, Ms. Neily testified that T. was at risk for a learning disability.

[129] She explained that T.'s profile was very complex and that other factors, including absenteeism from school, may have had an impact on the test results.

[130] When asked about the causes of T.'s profile, she testified that there were two primary possible causes, the first being a learning disability and the second being adverse emotional and environmental experience. In T.'s case, Ms. Neily expressed her belief that the situation was complicated by her early childhood experiences.

[131] When asked what sort of home environment would best provide support for improvement in T.'s learning profile, she testified that T. would benefit from a stable and nurturing home environment, very patient caregivers as well as exposure to language, learning and literacy. T. will need additional support in and out of school including access to speech language therapy, occupational therapy and tutoring.

[132] During cross-examination by Ms. Cox, Ms. Neily agreed with the suggestion that this was a critical time for T. to have in-home support but that even if she has in-home support it may not entirely prevent a learning disability. While indicating her hope that T.'s verbal comprehension and reading skills will improve, Ms. Neily indicated that she believes T. will always have some learning challenges.

[133] If T. receives the appropriate in-home supports she will reach her potential but without that she has less chance to reach her potential.

[134] Ms. Neily recommended a follow-up psychoeducational assessment be undertaken to determine whether or not T. meets criteria for a learning disability.

Jennifer Goguen, Pediatric Occupational Therapist

[135] Ms. Goguen was qualified to give opinion evidence as a pediatric occupational therapist. Ms. Goguen's report is found in Exhibit 7 at tab 7(b).

[136] Ms. Goguen testified that T. presents as lovely and very social but struggles with daily function for a variety of tasks.

[137] When looking at the child's fine motor skills she observed that T. struggled with tasks such as printing and forming letters. She also noted issues relating to sensory processing and anxiety.

[138] She expressed her belief that T.'s brain did not grow or receive stimulus to grow due to complex trauma. Complex trauma can arise from a variety of things including the child's concerns with respect to security and not feeling safe, which can impact upon brain development.

[139] When asked about what sort of home environment and caregiver would be required to address T.'s issues, she testified that T. requires a stable and secure environment and a caregiver who is patient and available to work with her deficits daily because T. requires daily support and help. T.'s caregivers need a lot of patience, stability and the ability to provide routine and structure within the home environment.

[140] During cross-examination, Ms. Goguen testified that T. would benefit from continued occupational therapy and emphasized the importance of daily work.

[141] Ms. Goguen's assessment report includes specific recommendations for development of fine motor skills as well as recommendations for sensory processing and anxiety strategies for home.

Dr. Risk Kronfli, Psychiatrist

[142] Dr. Kronfli was permitted to testify via video conference.

[143] He was qualified to give opinion evidence in the area of psychiatry and psychiatric assessments.

[144] He identified and confirmed his Psychiatric Assessment for M.K. dated April 22, 2019, as contained in Exhibit 7 at tab 2(b).

[145] Dr. Kronfli testified that M.K. suffers from a psychotic illness evidenced by delusions and paranoid thought patterns. He thought it was most likely that M.K. was suffering from a delusional disorder.

[146] Dr. Kronfli indicated that M.K. was capable of engaging in society, in general, with little indication of illness as long as certain subject matter is not touched upon and she is not challenged.

[147] He testified that M.K. is totally consumed by the belief that there is an ongoing conspiracy with the school board and other people involved in the care of her child who are working against her for unclear and non-logical reasons.

[148] When asked about the impact of her disorder on her parenting, Dr. Kronfli indicated that while it is generally considered that a caregiver should be predictable and consistent in their parenting, with delusional disorder the individual has difficulty providing consistency and predictability.

[149] By way of example or illustration, he indicated that if the child requires care for an illness and the parent is suffering from a delusional disorder and does not believe it is a true illness then the well-being of the child can be dramatically impacted.

[150] Dr. Kronfli testified that even with treatment there is no absolute guarantee of a change in the individual's level of functioning. He pointed out that with mood disorders there is ebb and flow and an individual can regain or recover after an episode, however with a psychotic illness it is more difficult.

[151] Dr. Kronfli explained that in the case of a psychotic illness, the illness is toxic to the brain and is quite insidious. If the illness is controlled with medication the individual also needs to engage in some type of therapy to regain the ability to develop coping skills. The prognosis without treatment is negative and it is very hard to effect change. Medication provides the best tool to effect change in function, but there are no guarantees.

[152] In his psychiatric assessment for M.K. he indicates as follows commencing at page 21:

> (M.K.)'s delusional thought patterns, resistance to accept clear information and documentation, avoiding any detailed discussion and becoming overinclusive in her presentation and discussion, are all characteristics of a diagnoses of Delusional Disorder and Psychosis. (M.K.) also suffers from hoarding behaviors, in addition to Avoidant personality traits.
>
> …However, due to her mental state presentation, her ability to place (T.)'s physical and emotional needs ahead of her own has not been demonstrated. At this time, (M.K.) is unable to provide any level of acceptable care to meet (T.)'s high needs and protect her.
>
> Recommendations:
>
> From a Psychiatric standpoint, (M.K.) requires Psychiatric treatment, including a trial of a Psychotropic medication like Risperidone or Aripiprazole (Abilify). He efficacy of this medication regime should be closely monitored under the supervision of a Psychiatrist. Having said that, it is extremely difficult to treat delusional Disorders and (M.K.) has total lack of insight and no acceptance that there is anything wrong with her perception. The chances that she would accept treatment is in my opinion very slim. The prognosis for a change is very limited.

> If she accepts medications and efficacy is established, by a psychiatrist who is aware of all the delusional thought patterns, (M.K.) would benefit from long-term Cognitive Behavioral Therapy (CBT) to assist in addressing the ineffective coping and interpersonal skills that she has developed in order to cope on a limited basis, including her Avoidant personality traits…

Michelle McLean, Social Worker

[153] Ms. McLean is a child protection Social Worker.

[154] She identified and confirmed her affidavits as contained within Exhibit 3 at tabs 10, 13, 18, 22, 25, 28 and 43.

[155] During cross-examination by M.K., Ms. McLean was asked why in-home supports were not provided. Ms. McLean confirmed that the original plan was to provide family support services but because M.K. refused to follow Dr. Kronfli's recommendations and remained adamant that T. was healthy prior to being taken into care, it was decided that family support services would not be appropriate.

[156] Ms. McLean testified that she has seen a dramatic change in T.'s appearance since she was taken into care. She indicated that when the child was taken into care she was very sick, her hair was straw-like and the child was very thin and her coloring was grey. T. walked bent over and appeared to be in pain.

[157] Ms. McLean referred to T. now as a social butterfly indicating that T. has made tremendous gains and appears significantly healthier and happier.

[158] In her affidavit of December 4, 2018, Exhibit 3, tab 10, she confirms that her first conversation with M.K. occurred on October 4, 2018 when she introduced herself as the long-term worker. When she contacted M.K. on October 5 to provide an update regarding T.'s hospitalization, M.K. informed her that T. had been eating well in her care, had had large bowel movements and her belly was not distended and rounded.

[159] When she spoke with both parents on October 10, both parents advised Ms. McLean that all the information in the agency file was false and referred to the principal of the child's school as being slanderous.

[160] Ms. McLean's affidavit of April 29, 2019, Exhibit 3, tab 18, confirms a home visit with the Respondents on February 27, 2019. Ms. McLean advised the parents that T. was a very sick little girl and they responded by indicating that she was not.

[161] When Ms. McLean suggested that the IWK would not have kept the child in hospital for two months unless there was a reason, M.K. indicated that the child had a growth delay which runs in the family and both parents continued to maintain that T. was healthy when she came into the care of the agency.

[162] When Ms. McLean pointed out that when T. came into care she had a large rounded belly, could not walk long distances, had thinning hair and grey complexion, M.K. continued to insist that T. was healthy.

[163] During the visit the parent's accused T.'s school of deleting six months of her school records and also alleged that the school had allowed strangers to take T. out of school to have prescriptions filled and had changed the names of her teachers and educational assistants.

[164] Ms. McLean's affidavit sworn April 28, 2020, Exhibit 3, tab 43, confirms that T. has flourished in foster care and has made significant progress.

[165] The affidavit also confirms Ms. McLean's understanding that M.K. has not followed up on any of the recommendations made by Dr. Kronfli.

Amanda Hemsworth, Social Worker

[166] Amanda Hemsworth, Child in Care Worker, identified tab 44 of Exhibit 3 as her affidavit sworn April 29, 2020.

[167] During cross-examination by M.K., Ms. Hemsworth was asked why the child had been taken out of the IWK by someone and she responded by indicating that she believed that the child had remained consistently at the IWK after being admitted to the hospital and did not leave the IWK until date of discharge.

[168] M.K. wanted to know why P.K. seemed to know a lot about the foster parents and what the child was wearing and Ms. Hemsworth responded by indicating that there would be no basis for P.K. to have such knowledge.

[169] During cross-examination by Ms. Cox, Ms. Hemsworth acknowledged that T. loves her parents.

[170] She acknowledged that T. had been seen by the family doctor while in M.K.'s care.

[171] She also acknowledged that the family doctor had made a referral to a pediatrician but noted that that appointment had not been kept and that was a major factor in the decision to take T. into care. She also acknowledged that T. had been taken to a dentist at Micmac Mall prior to the taking into care.

[172] Ms. Hemsworth was referred to hospital records relating to the child's discharge from the IWK which indicated that the child's parents had shown up at the IWK and stated that the court had granted them permission to take the patient home. When IWK staff informed the parents that they had to follow DCS direction the parents took the staff person's name and stated that they would call the RCMP and left the unit.

[173] Ms. Hemsworth confirmed that M.K. struggled to understand the length of the child's IWK hospital stay and believed that the stay was only one to two days.

[174] M.K. also believed that the child was not eating because she had been taken into care.

[175] Ms. Hemsworth testified that M.K. does not believe the child needs a feeding tube because the child always ate when in her care.

[176] She noted that while T. had first used a toddler's bike after being taken into care she now rides a two-wheel bike, enjoys swimming and is very active and loves to be outdoors. She indicated the child loves school, loves being social and is a great reader.

C.P.

[177] C.P., a Licensed Practical Nurse, testified on behalf of M.K.. She and M.K. have known each other for approximately 30 years.

[178] C.P. testified that she had no knowledge of M.K. ever abusing her children or leaving her children unattended nor had she ever observed the children doing without. She indicated that M.K. always took care of her children and referred to the family as happy and close knit.

[179] During cross-examination by Ms. Cox, C.P. indicated that she and M.K. have not lived in the same community for at least ten years. The last time she saw T. was five years ago when she encountered T. and M.K. out shopping. The encounter was for five or ten minutes. She had not seen T. much prior to the taking into care.

M.K.

[180] The respondent M.K. testified on her own behalf.

[181] M.K. testified that T. first started to have trouble with constipation when she was an infant. She took the child to see Dr. Merritt and testified that he really did not recommend anything but suggested that T. would be fine and that she could use a laxative.

[182] M.K. testified that she used a laxative and it worked but as soon as she wasn't using it the child would get constipated again.

[183] M.K. confirmed that presently her husband lives in one of their homes and she lives in another with her autistic adult child. When asked how she will financially support herself, M.K. testified that she needs to get a separation from her husband.

[184] She indicated that T. had a yearly checkup with Dr. Merritt in July 2018 and that he made a referral to a pediatrician, Dr. Trider.

[185] She acknowledged that the original appointment was September 17 but that she rescheduled it indicating that it conflicted with the first day of T.'s attendance at school. It was rescheduled to October 31, but M.K. indicated subsequently an earlier appointment was confirmed for October 3.

[186] She acknowledged that T. was not toilet trained when she started elementary school in 2016 because of her constipation. T. wore a pull-up at school to deal with what she referred to as leakage. She was concerned about that.

[187] When asked if she took T. to see a doctor from September to December 2016, she said she did not. She testified she took her to Dr. Merritt in January 2017 and when asked if she took the child to any other doctors between January and July 2017 and she said she could not recall doing so.

[188] M.K. confirmed that she provided supplies to the school such as pull-ups and zincofax cream, as well as changes of clothing.

[189] She could not recall anyone at the school talking about the need for involvement of an occupational therapist.

[190] She could not recall being asked to sign a form from the school authorizing services for T. but recalled the school wanted medical records for herself and T., but did not know why the school wanted the records.

[191] When asked if she had any concerns with respect to T. as of April 2018, she indicated that constipation was always a concern and that she was also concerned about spina bifida occulta because T. walked funny.

[192] She testified that the first time T. saw a dentist was when she was eight years old. When asked if there was any reason why T. didn't see a dentist earlier, she could not provide any explanation. She testified that T. did not complain about her teeth and that she brushed them every day.

[193] M.K. acknowledged that she had heard the evidence of doctors McLaughlin and Vellacott.

[194] When asked her understanding of T.'s current medical needs she responded by indicating T. had high needs. When asked what the needs were, she responded by indicating that she didn't get to talk to the doctors. She then again acknowledged that she had heard their evidence. She then commented that she has seen T. run around and she is fine.

[195] When asked once again about the child's medical needs she responded by indicating speech therapy, an occupational therapist, a feeding tube and the possibility T. may have to have something done with her hip.

[196] In relation to constipation, she said she understands T. needs a laxative. When asked what else, she stated she did not know the foster parent's routine.

[197] M.K. confirmed her willingness to continue the child's speech therapy and to see that the child would be followed by a dentist. She also agreed that the child would need to continue to be followed by Ms. Coady Shadbolt.

[198] M.K. hasn't been able to figure out how Dr. Kronfli arrived at a diagnosis based upon an interview of less than an hour. She believes that he concluded she was delusional because she expressed her belief that someone was taking her child out of school. When asked if she does believe that, she said she absolutely believes that someone was taking T. in and out of school.

[199] She acknowledged that Dr. Kronfli had recommended medications and that she had not followed through on that recommendation. M.K. indicated she was going to get a second opinion but acknowledged that she had not done so yet.

[200] She confirmed that she had not provided a copy of Dr. Kronfli's report to her family doctor, Dr. Merritt. When asked why not she responded that she didn't know why, she just didn't do it.

[201] M.K. testified that she does not believe she is delusional.

[202] When asked if she believes her daughter requires a feeding tube, she testified that if she had had the opportunity to talk to the doctors she feels there would have been a less invasive way to deal with the situation. She testified that she feels that she would have been able to get T. to eat.

[203] When asked about her plan for herself and T., she confirmed that she plans for them to live in her current home which she described as a three bedroom, two bathroom, two-story home. T. would travel to school by bus and she would pick her up at the end of the school day. She would attend to the child's supper and bath. She would ensure that doctors appointments were scheduled around school hours.

[204] She indicated that she would like her daughter to take skating lessons and attend Brownies and participate in whatever activities other children in the neighbourhood are participating in. When asked if she knew any of the neighbourhood children she said she did not at this point.

[205] When asked what her understanding was of what T. requires every day, she testified that T. needs to be looked after every day.

[206] When asked if she felt she had done anything wrong in caring for T., she testified that she probably should have been more on top of the doctor in dealing with the constipation issue and should have pushed the doctor to look into the issue further.

[207] She confirmed that she never took T. to emergency at the IWK and when asked why not, she said she never saw the child being sick enough to have to go. When asked if she had thought to take the child to emergency in relation to her constipation issues she said she had not.

[208] When asked if she should have taken T. to the dentist sooner, she agreed that perhaps she should have.

[209] M.K. testified that she wanted the court to send T. home with her. When asked to explain why, she indicated that she is T.'s mother and that she loves T. and that they have a connection. She also indicated that she believes she knows what is best for T. and that she absolutely believes she can look after her.

[210] While acknowledging that she would have to learn to adjust T.'s laxative medication, she would not agree that there was a lot to learn in order to be able to care for T..

[211] While indicating a willingness to take direction or advice from doctors, she testified that she knows how to calm her child down and that T. did eat before the taking into care.

[212] During cross-examination by counsel for the Minister, M.K. denied that she did not know about the involvement of an EPA.

[213] She acknowledged that she did not follow up with the school after hearing that they wanted the service of an occupational therapist because she assumed that the social worker would relay her position. She denied any knowledge of the school requesting physiotherapy or involvement of a speech language pathologist.

[214] She indicated she was not aware T. was missing a significant amount of school time due to bowel issues and confirmed that she was at the school every day and indicated that no one mentioned it.

[215] She also testified that she didn't believe that the child missed as much time as the school had reported. She suggested that the school was exaggerating a little.

[216] When asked to confirm that she refused to let the school communicate with her family doctor, she indicated that she told the school that the information should be available on a need to know basis. She acknowledged that she understood the request for information was intended to help T. but she took the position the information was confidential. She said she never saw T. in pain.

[217] When asked why she was not willing to meet with social workers at her home, she said that the issue was a school issue and did not pertain to home because the complaint originated from the school.

[218] She testified that as of April 2018 the family was doing great and they had a good income and everything they needed and the only issue was constipation.

[219] In discussing the investigative order she indicated that she had attended at the Family Court to look into the order and testified that staff at the Devonshire courthouse could not find the order. She was then asked if she believed the order was a fraudulent order and she answered in the affirmative and explained that the order was false because it did not contain a court file number.

[220] M.K. stated that T. ate fine before coming into care and that she doted on her children.

[221] The question was repeated and she then indicated she believed it was a combination of genetics and picky eating and that constipation may have played a role as well as other factors.

[222] Initially, she said that she did know how many nights T. had stayed at the IWK after being admitted but then testified that a doctor told her that it was only two days and that she believes what the doctor told her.

[223] M.K. could not provide any explanation as to why the agency would mislead her as to the length of the child's IWK hospital stay indicating that she believes the agency had misled her in a way yes, but in a way no. When asked what she meant, she testified that the agency wants her child and the IWK was just there to do "doctoring".

Exhibit 11

[224] By consent of the parties an email character reference letter was entered as Exhibit 11. The character reference was submitted by S.S.. In the character letter S.S. indicates that she first met the respondent mother in 2005. She indicates that at that time the respondent had three children living at home and she witnessed M.K. being a loving mother. All the children did well in school. She never witnessed any abuse within the home. M.K. made sure all her family were taken care of. After S.S. moved away in 2015 she did not get to see the family much.

Submissions

[225] M.K. submitted that she's been a mother for thirty-two years and that all her children were very loved, always dressed to a tee, there was always plenty of food in the house and that the child T. had plenty of toys. She admitted that she was not perfect and had made mistakes but submitted that mistakes are meant to be learned from and she realizes now that she should have pushed T.'s doctors.

[226] M.K. submitted that the child is no longer in need of protective services because she will make sure she attends every appointment and make sure her needs are met. She confirmed her willingness to seek out therapy, follow through with the IWK and other recommendations for the child. She confirmed that if returned to her care, T. would attend school and church and participate in normal childhood activities. She confirmed that she loved her daughter and dearly misses her and expressed hope that she would be returned to her care.

[227] Counsel for the Minister submitted that the medical care provided for the child was totally inadequate and that she needed to be in hospital. Mr. Melvin submitted that the Respondent mother has no insight into her mental health issues. He suggested that this bodes poorly for her future ability to mitigate protection concerns.

[228] Mr. Melvin submitted that T. has flourished since being placed in care and has grown significantly faster and referred to the child as catching up as far as her growth is concerned. He submitted that the child had also made up lost ground attributable to chronic neglect.

[229] Mr. Melvin maintained that the Minister had discharged the burden of proof based upon balance of probability and that the best interests of the child would be met if the child were placed in permanent care and custody of the Minister.

[230] Ms. Cox, at the outset of her submissions, indicated that she saw her role as *Amicus* as twofold. Firstly, she had an obligation to test the Minister's evidence and secondly, to assist M.K. in presentation of evidence to the extent that she was able to do so.

[231] Ms. Cox indicated that she had a lot of difficulty undertaking her role as *Amicus* because M.K. was mostly unwilling to speak with her and therefore she wasn't able understand her side of the story except as elicited through the testimony presented at trial. She attempted to assist the trial process by trying to deal with specific issues as they arose on a real-time basis.

[232] While attempting to test the evidence of the Minister she also attempted to ask questions of both M.K. and other witnesses about T.'s needs and the prognosis going forward to facilitate assessment of the child's best interests.

[233] Ms. Cox submitted that the combination of untreated mental health illness on the part of M.K., combined with the high needs of the child, is an unfortunate combination. She submitted that it was not so much refusal to provide medical care but a lack of appreciation of the child's medical needs noting that M.K. simply does not understand the needs of the child.

[234] Ms. Cox submitted that from her perspective she believed that M.K. did the best she could but it did not rise to an adequate standard, perhaps well-meaning, but not adequate.

[235] With respect to future risk she submitted that M.K. wasn't able to articulate a plan of care and appears to lack the ability to understand or appreciate what she needs to do to prevent T. from having future problems, noting that the mother has resistance or reluctance to accept advice or support.

[236] Following submissions the court confirmed its intention to reserve decision.

Issues

1. Is the child T. in need of protective services?
2. In the event the Court determines that T. is in need of protective services, is an order for permanent care and custody in the best interests of the child?

Legal Analysis

[237] In *Mi'kmaw Family and Children Services v. KDo*, 2012 NSSC 379, Justice Forgeron considered an application for permanent care and custody. Justice Forgeron identified the following principles commencing at paragraph 19:

> [19] In making my decision, I must be mindful of the legislative purpose. The threefold purpose is to promote the integrity of the family, protect children from harm, and ensure

> the best interests of children. The overriding consideration is, however, the best interests of children as stated in sec. 2(2) of the *Act*.
>
> [20] The *Act* must be interpreted according to a child centred approach, in keeping with the best interests principle as defined in sec. 3(2). This definition is multifaceted. It directs the Court to consider various factors unique to each child, including those associated with the child's emotional, physical, cultural, and social development needs, and those associated with risk of harm.
>
> [21] In addition, sec. 42(2) of the *Act* states that the Court is not to remove children from the care of their parents, unless less intrusive alternatives have been attempted and have failed, or have been refused by the parent, or would be inadequate to protect the children.
>
> [22] When a Court conducts a disposition review, the Court assumes that the orders previously made were correct, based upon the circumstances existing at the time. At a review hearing, the Court must determine whether the circumstances which resulted in the original order, still exist, or whether there have been changes such that the children are no longer children in need of protective services: sec. 46 of the *Act*; and Catholic Children's Aid Society of Metropolitan Toronto v. M. (C.) [1994] 2 S.C.R. 165.

[238] The Minister is requesting an order for permanent care and custody pursuant to s. 47 of the *CFSA*.

[239] The Minister bears the burden of proof with respect to the application. The burden of proof is the civil burden based upon balance of probabilities (See *C.R. v. McDougall*, 2008 SCC 53).

[240] In determining whether the Minister has adequately discharged the burden of proof in any given case, it is the responsibility of the trial judge to carefully consider and review all the evidence.

[241] In determining this application, I have considered the preamble to the legislation which confirms the objectives and philosophy of the *CFSA*.

[242] The legislation clearly emphasizes that children are only to be removed from the care of their parent when all other measures are inappropriate.

[243] The purpose of the *CFSA*, as set forth in s. 2(1), namely, to protect children from harm, to promote the integrity of the family and assure the best interests of the children, must be kept in mind throughout.

[244] In all proceedings under the *CFSA*, the paramount consideration is the best interests of the child as per s. 2(2). That provision underscores the need for a child-focused or centric approach to the determination of child protection proceedings.

[245] I have taken note of the relevant provisions of s. 22(2) of the *CFSA* in determining whether T continues to be in need of protective services.

[246] A finding that the child continues to be in need of protective services requires the Court to consider s. 42, 45, 46 and 47 of the Children and Family Services Act.

Outside Limit

[247] The outside limit for disposition orders in this proceeding was March 12, 2020.

[248] Case authorities clearly establish that, if a child is still in need of protective service when the outside limit is reached, the matter cannot be dismissed and the Court has no jurisdiction to order either supervision or temporary care and custody.

[249] In *Nova Scotia (Community Services) v. R.F.*, 2012 NSSC 125, Justice Jollimore indicated as follows commencing at paragraph 165:

> [165] According to Justice Saunders in *Children's Aid Society of Halifax v. B.(T.)*, 2001 NSCA 99 at paragraph 19, I'm to consider each of the possible dispositions in section 46(5) and, by virtue of section 46(5)(c), section 42(1). His Lordship's reasons limit my considerations. At paragraph 23, he explained:
>
> > As the proceeding nears a conclusion, the opportunity to grant disposition orders under s. 42(1)(c) diminishes until the maximum time is reached at which point the Court is left with only two choices: one or the other of the two "terminal orders". That is to say, either a dismissal order pursuant to s. 42(1)(a) or an order for permanent care and custody pursuant to s. 42(1) (f).

[250] Given the outside limit applicable to this proceeding has now been reached, the Court must determine whether to dismiss the Minister's application or place the child in permanent care and custody.

Protection Finding

[251] Pursuant to Protection Application and Notice of Hearing September 26, 2018 the Minister maintained that the child was in need of protective services pursuant to subparagraphs (b), (e), (h), (j) and (k) of S. 22(2) of the *Children and Family Services Act*. Those provisions read as follows:

> 22 (2) A child is in need of protective services where
> (b) there is a substantial risk that the child will suffer physical harm inflicted or caused as described in clause (a)
> [Clause (a) states :(a) a child has suffered physical harm, inflicted by a parent or guardian of the child or caused by the failure of a parent or guardian to supervise and protect the child adequately;]
> …
> (e) a child requires medical treatment to cure, prevent or
> alleviate physical harm or suffering, and the child's parent or guardian
> does not provide, or refuses or is unavailable or is unable to consent to the treatment
> …

> (h) the child suffers from a mental, emotional or developmental condition that, if not remedied, could seriously impair the child's development and the child's parent or guardian does not provide, refuses or is unavailable or unable to consent to, or fails to cooperate with the provision of, services or treatment to remedy or alleviate the condition;
> …
> (j) the child is experiencing neglect by a parent or guardian of the child;
> (k) there is a substantial risk that the child will experience neglect by a parent or guardian of the child, and the parent or guardian does not provide, refuses or is unavailable or unable to consent to, or fails to co-operate with the provision of, services or treatment to remedy or alleviate the harm;

[252] Section 22(1) indicates that "substantial risk" means "a real chance of danger that is apparent on the evidence".

[253] In *Nova Scotia (Minister of Community Services) v. S.C.*, 2017 NSSC 336, Justice Jollimore commented upon the meaning of "substantial risk", indicating as follows at paragraph 35 :

> [35] "Substantial risk" is a real chance of danger that is apparent on the evidence: subsection 22(1) of the *Children and Family Services Act*. It is the real chance of physical or emotional harm or neglect that must be proved to the civil standard. That future physical or emotional harm or neglect will actually occur need not be established on a balance of probabilities: *MJB v. Family and Children Services of Kings County*, 2008 NSCA 64 at paragraph 77, adopting *B.S. v. British Columbia (Director of Child, Family and Community Services)*, 1998 CanLII 5958 (BC CA), at paragraphs 26 to 30.0
>
> [36] If the Minister establishes that there is a real chance of harm, the question is purely one of D's best interests, as between permanent care and a return to the parents. If the Minister does not establish this that there is a real chance of harm, then D must be returned to her parents.

[254] In *C.R. v. Nova Scotia (Community Services)*, 2019 NSCA 89, Justice Hamilton indicated the following with respect to the test to be applied in determining substantial risk under s. 22;

> …the test is as set out previously by this Court in *M.J.B. v. Family and Children's Services of Kings County*, 2008 NSCA 64:
>
> > [77] The *Act* defines "substantial risk" to mean a real chance of danger that is apparent on the evidence (s.22(1)). In the context here, it is the real chance of sexual abuse that must be proved to the civil standard. That future sexual abuse will actually occur need not be established on a balance of probabilities. (*B.S. v. British Columbia (Director of Child, Family and Community Services*) (1998), 160 D.L.R. (4th) 264, [1998] B.C.J. No. 1085 (Q.L.)(C.A.) at paras. 26 to 30)
>
> (Emphasis in original)
>
> When deciding whether there is "substantial risk", a judge must only be satisfied that the "chance of danger" is real, rather than speculative or illusory, "substantial", in that there

> is a "risk of serious harm or serious risk of harm" (*Winnipeg Child and Family Services v. K.L.W.*, 2000 SCC 48, paras. 104, 106 and 117), and it is more likely than not (a balance of probabilities) that this "risk" or "chance of danger" exists on the evidence presented.

[255] In determining whether T. remains in need of protection it is important to acknowledge once again that P.K. has admitted to all of the grounds relied upon by the Minister. M.K. maintains that T. is not in need of protection.

Consideration of Section 22(2)(e)

[256] During her grade primary year at school (2016-2017), T.'s teacher made a referral to child welfare based upon the teacher's observation that T. was not toilet trained and was suffering from a painful rash which was impacting on her ability to learn. The school became concerned that T. was not receiving medical attention and her parents were unwilling to give the school permission to provide services such as an occupational therapist.

[257] The principal of the school testified that the school had sent forms home authorizing occupational therapy and physiotherapy, but M.K. refused to sign the documents.

[258] In 2017 M.K. was contacted by the schools Learning Center teacher who expressed concerns about the child's language development and mobility and suggested that T. should be referred to student services. M.K. did not follow up with the school to initiate any services.

[259] During the 2017-2018 school year, the principal confirmed that there was further contact with social workers due to the school's continuing concerns that T. was demonstrating ongoing health issues. The child was presenting with constipation issues resulting in the child missing a large portion of the school day. The principal testified that she would spend up to one hour in the school bathroom screaming from pain at least a couple of times a week. He testified that M.K. had shut down communication with the school and was refusing to accept support for the child and was dismissive of the school's concerns.

[260] The school provided EPA assistance for the child to assist her in using the bathroom and to ensure her safety while at school because she presented as fragile. The evidence indicates that at one point in time M.K. admitted to a social worker that she was unaware of the appointment of an EPA to assist the child and maintained that the school didn't tell her anything.

[261] The principal also testified that M.K. declined to provide the school with access to the child's medical information or to speak with the child's family physician. M.K. took the position that medical information was confidential and would only be provided on a need to know basis.

[262] Efforts by child protection social workers to arrange meetings with M.K. to discuss the school's concerns were met with resistance. M.K. took the position that the reports by the school were false and maintained that the principal was trying to ruin her life.

[263] Various excuses were offered by M.K. to avoid meeting with child protection workers at her home, including that she was too busy, that she wanted to speak with legal counsel prior to meeting with the worker, and that there was no need for workers to attend at M.K.'s home because the issues had arisen from the school and did not relate to the home. M.K.'s non-cooperation resulted in the agency making an *ex parte* application for a s. 26 investigative order in August 2018.

[264] When child protection workers attended the home with RCMP under the auspices of the order, initially M.K. would not allow entry to the home. Only after an RCMP officer spoke with M.K. was a worker permitted to enter the home. Both respondents refused to sign consent forms authorizing the agency to speak with the family doctor. M.K. advised that the child had an appointment with a pediatrician on September 17, 2018. M.K. was advised that the agency would like the child taken to IWK emergency for medical examination. The Respondents declined that request and again referred to the pediatric appointment scheduled for September 17. The social worker explained to the respondents the importance of their attendance at the pediatric appointment as well as follow through with medical services.

[265] During the attendance at the home one of the social workers observed T. to be very pale and white. The child walked with her legs buckled inwards at the knees. The child appeared uncomfortable when speaking with the worker and at one point was bending over and twisting her body as if in pain. T. had to hold onto the railing of the step and crouched over while walking up the steps going back into the home.

[266] On September 11, 2018 social worker Byrne spoke again with M.K.. They discussed the child's constipation issues and at one point during the conversation M.K. suggested that T. was good now because she no longer screamed when she used the bathroom.

[267] Ms. Byrne also made it clear to M.K. that the agency would be very concerned if she cancelled T.'s September 17 appointment with the pediatrician. M.K. refused to let social workers see T. until she had spoken with a lawyer. M.K. was advised of the likelihood of a protection application requesting a supervisory order given M.K.s lack of cooperation.

[268] Despite two successive conversations with social workers emphasizing the importance of keeping the scheduled September 17 pediatric appointment, M.K. subsequently cancelled the September 17 appointment and rescheduled it to October. Accordingly, the agency determined that a taking into care was necessary.

[269] The Respondents were resistant to the taking into care and the child was not able to be taken into care until September 27, 2018 when the respondents brought T. with them to attend the initial interim hearing, following the commencement of a protection application on behalf of the Minister.

[270] Immediately following the taking into care the agency arranged for the child to undergo a medical examination. Blood testing confirmed a critically low result resulting in the child's admission to the IWK pediatric medical unit on October 3, 2018. T. was suffering from chronic anemia due to iron deficiency. She responded appropriately to treatment during hospitalization

resulting in normalization of her hemoglobin by November 2018. T. was not discharged until November 30, 2018.

[271] Dr. McLaughlin's report, Exhibit 5, acknowledges that sometimes because of the slow onset of symptoms associated with anemia parents do not recognize anemia until it is confirmed by laboratory testing.

[272] Other medical issues were identified during hospitalization as noted in Dr. McLaughlin's report exhibit 5.

[273] The concerns included nutritional deficiencies involving low zinc, low vitamin C and low vitamin D which Dr. McLaughlin indicated would be attributed to a severely limited or poor diet leading to poor intake of multiple nutrients.

[274] T. had dental caries and ulcerated teeth in association with severe dental decay and severe gingivitis. The report confirms that the condition of the child's teeth would be expected to cause pain and difficulty with eating and that the caries would have developed over a prolonged period. The child underwent dental surgery involving the extraction of seventeen teeth during her admission to the IWK.

[275] Feeding aversion was also identified as an issue and persisted even after dental surgery. The feeding aversion required treatment by a multidisciplinary feeding team including a psychologist, a dietitian, an occupational therapist and pediatricians.

[276] Various types of feeding tubes were utilized to ensure adequate food intake. In October 2019 tube feeds were stopped and all nutrition was by mouth but unfortunately the child's growth then slowed requiring the resumption of tube feeds in March 2020.

[277] Another issue identified by Dr. McLaughlin was failure to thrive. The evidence confirms that at time of the T.'s admission to the IWK in October 2018 she weighed only 15 kg and was only 103 cm tall, both values being below the 3rd percentile for girls her age. Dr. McLaughlin confirmed that T.'s weight would be average for a three and a half year old girl and her height would be average for a four year old.

[278] In Dr. McLaughlin's opinion the most likely explanation for T.'s failure to thrive is that she was not receiving adequate nutrition prior to her hospital admission. Dr. McLaughlin indicated that there could be multiple causes or factors contributing to inadequate nutrition including lack of food, lack of offering of age-appropriate foods from a variety of food groups, inability to eat due to dental pain or oral aversion, or neglect.

[279] Constipation was another issue. On admission to the IWK T. was noted to have a distended abdomen with palpable stool and an x-ray confirmed the presence of a large amount of stool in her bowel. She was also noted to have overflow incontinence. No organic cause was identified for T.'s constipation. Dr. McLaughlin confirmed that the constipation has been difficult to manage and that T. has required "clean outs" intermittently and continues to be followed by IWK gastroenterology.

[280] Due to the child's unusual gait x-rays were arranged which confirmed hip dysplasia and a slight valgus deformity in the knee on the right leg, which Dr. McLaughlin concluded were likely congenital deformities. Surgery may be a possibility at some future point, but Dr. McLaughlin noted that the child is able to run and walk such that no surgical intervention is planned at present. Physiotherapy has been recommended.

[281] Dr. McLaughlin concluded her report, Exhibit 5, by indicating the following:

> … Based on the information available to me, it appears that prior to admission (T.) had a number of symptoms which could be seen by a layperson, and for which she was not receiving medical care: visible dental decay and dental pain, food aversions and severely limited diet, short stature and failure to thrive, constipation causing abdominal distention and incontinence and abnormal gait

[282] I acknowledge that not all the medical issues identified following the taking into care would have been apparent to M.K.. However, I accept and rely upon the evidence of Dr. McLaughlin in concluding that several of the child's medical issues should have been obvious and apparent to M.K..

[283] Dr. Vellacott is the pediatrician currently responsible for T.'s care. Dr. Vellacott confirmed that T. remains in the third percentile for weight and an even lower percentile for height. Dr. Vellacott indicated that the child is doing very well at present and the biggest challenge is managing her nutrition and her constipation.

[284] Dr. Vellacott testified that T. has experienced extension or stretching of her bowel in association with constipation and as a result the nerves have lost sensitivity and don't send the usual signal of a bowel movement. She indicated that this is an issue that takes a long time to resolve and that some of the damage might be permanent or irreversible.

[285] Dr. Vellacott indicated her opinion that had T. received proper nutrition for the first eight years of her life she would not require a feeding tube. She commented that T.'s current caregivers are trying to catch up for lost time.

[286] While acknowledging that T. had made extensive gains since coming into care, Dr. McLaughlin also indicated she expects that while T. will grow, she will not reach her genetic potential.

[287] T. continues to have a list of food restrictions due to difficulty chewing and swallowing some foods as a result of the dental extractions and lack of exposure to solid food an early age.

[288] The child requires daily medication to regulate her bowel function. The foster mother is constantly monitoring the frequency and consistency of the bowel movements and adjusting the dose of prescribed medications to ensure that T. has at least one "easy to pass" movement per day.

[289] Dr. Vellacott noted that T.'s gait, while still abnormal, continues to improve. She attributes the improvement to growth and strength development associated with regular physical activity.

[290] Jennifer Goguen, Pediatric Occupational Therapist confirmed that T. struggles with daily function for a variety of tasks. She struggles with fine motor skills for tasks such as printing and forming letters and has issues relating to sensory processing and anxiety. Ms. Goguen indicated that the issues she had identified related to complex trauma affecting brain development. Ms. Goguen testified that T. would benefit from continued occupational therapy and emphasized the importance of daily work.

[291] During her evidence M.K. was asked if she had any concerns with respect to T. as of April 2018 and she responded by indicating that constipation was always a concern and that she was also concerned about spina bifida occulta because the child walked funny.

[292] M.K. talked with her family doctor about the constipation issue on at least one occasion before the child started school but according to M.K. the doctor really didn't recommend anything but suggested that she could use a laxative and that the child should be fine. M.K. testified that she used a laxative and that it worked. However, she also testified that as soon as she would stop using it the child would get constipated again. There was no evidence of any follow-up medical appointments to deal with ongoing constipation issues.

[293] M.K. denied any understanding as to how long T. was spending in the bathroom at school. During cross-examination she stated that she didn't believe T. missed as much time as the school had reported. She suggested that the school was exaggerating a little. When asked if she believed the evidence that T. had been in pain due to constipation while at school, she said that the school had exaggerated the child's pain.

[294] M.K. admitted that the first time T. saw a dentist was when she was eight years old. She could not provide any explanation as to why the child hadn't seen a dentist earlier. She testified that T. did not complain about her teeth and that she brushed her teeth every day. She would not agree with the suggestion that T.'s teeth were rotten and again maintained that the child never said she was in pain.

[295] M.K. denied any knowledge of the school requesting physiotherapy or the involvement of a speech language pathologist for T..

[296] During her cross-examination, M.K. asserted that T. ate fine before coming into care.

[297] When asked if anything she did contributed to the child's small size she indicated that she would not go that far and commented that she could not force the child to eat but again suggested the child ate fine before coming into care.

[298] When asked if she felt she should take any responsibility for the child's small size, she acknowledged that she could have pushed the doctor to look into it further but then commented

that she couldn't make T. grow. She then went on to comment that she had no concerns about the child's size or development noting that all her children were small.

[299] T. required medical treatment to cure, prevent or alleviate physical harm or suffering related to several serious medical issues including severe constipation, inadequate or poor dental hygiene resulting in severe dental decay and severe gingivitis, inadequate or poor nutrition and associated failure to thrive.

[300] The evidence of the elementary school's concerns relating to T.'s health indicates that the need for appropriate medical treatment to cure, prevent or alleviate physical harm or suffering should have been readily apparent to M.K., long before the child was taken into care.

[301] While the evidence does indicate that M.K. did arrange for the child to be seen by the family physician on a couple of occasions, it is clear that the contact with the family physician was limited, inadequate and did not occur as frequently as required.

[302] Similarly, M.K.'s admission that the child had her first dental appointment at age eight and at a point where the child had developed significant dental health issues constitutes an admission of failure to provide required medical treatment. M.K. was unable to provide any explanation for why the child had not seen a dentist at any earlier point in time.

[303] M.K.'s repeated assertions that T. was not experiencing any pain due to significant dental decay prior to the taking into care is inconsistent and incompatible with the medical evidence.

[304] Similarly, her assertions that T. was eating well before the taking into care is also contradicted by the medical evidence and the observations of involved social workers.

[305] M.K.'s evidence that she was unaware that T. was experiencing significant pain in association with her constipation is inconsistent with and contradicted by the evidence of the school principal as well as the observations of social workers. It is inconsistent with the information M.K. provided to Ms. Byrne on September 11 when M.K. suggested to Ms. Byrne that there had been some improvement with respect to the constipation because the child was no longer screaming in pain when going to the bathroom.

[306] When asked during cross-examination to describe her daughter's physical appearance at time of the taking into care she acknowledged that T. was pale but then stated that she appeared fine other than constipation and stated that she was used to seeing that and to her it was just T.

[307] This evidence is in stark contrast to the evidence of the elementary school principal and the evidence confirming social workers' observations of the child's physical appearance prior to and at time of taking into care. It must also be considered in the context of the evidence of the pediatricians who attended to the child following the taking into care and identified multiple medical issues, requiring appropriate treatment and prolonged hospitalization.

[308] M.K.'s evidence suggests a disturbing degree of complacency with respect to the child's health and wellness.

[309] The photographs attached to Ms. McLean's affidavit of October 15, 2019 (Exhibit 3 tab 28) provide an opportunity for some comparison of the physical appearance of the child as of the date of taking into care and approximately one year later October 9, 2019. The change depicted by the photographs is obvious and quite remarkable.

[310] I find that the child T. is in need of protective services pursuant to s.22(2) (e).

[311] I am satisfied that M.K. did not provide or refused to provide medical treatment required to cure, prevent or alleviate physical harm or suffering.

[312] In reaching this conclusion I want to make it clear that the standard of parenting required of any parent is not perfection but adequate parenting consistent with a child's needs. The standard of parenting provided by M.K. was not adequate. As a result, T. experienced chronic pain and discomfort and sustained harm that in some instances may be permanent and irreparable.

Consideration of Section 22(2)(k)

[313] It is important to acknowledge the definition of "neglect" as found at s.3(1)(p) of the *CFSA*;

> (p) "neglect" means the chronic and serious failure to provide to the child
>
> (i) adequate food, clothing or shelter,
> (ii) adequate supervision,
> (iii) affection or cognitive stimulation, or
> (iv) any other similar failure to provide;

[314] In this case consideration of s.22(2)(k) involves consideration of substantial risk of failure to provide appropriate care, including medical care.

[315] Dr. Kronfli testified that M.K. suffers from a delusional disorder. When Dr. Kronfli was asked about the impact of the disorder on M.K.'s ability to parent he testified that a parent with a delusional disorder has difficulty providing consistency and predictability.

[316] Dr Kronfli explained that in the case of a psychotic illness such as delusional disorder the illness is toxic to the brain and is quite insidious. The prognosis without treatment is negative. While medication provides the most effective tool to effect change in function there are no guarantees. Even if medication controls the illness the individual also needs to engage in some type of therapy to regain the ability to develop coping skills.

[317] In his report Dr. Kronfli indicated as follows:

> She presents with delusional and paranoid thought patterns, with fixed, false beliefs that cannot be proven; however, she will go to any length to seek evidence to support them and avoids any information that refutes her beliefs. These false beliefs have significantly

> impaired Ms. K's judgement, rationale, insight, and ability to function adequately in order to make logical, organized decisions with respect to parenting her child…

[318] Dr. Kronfli offered the following opinion with respect to M.K.'s ability to parent;

> … However, due to her mental state presentation, her ability to place (T.'s) physical and emotional needs ahead of her own has not been demonstrated. At this time, (M.K.). is unable to provide any level of acceptable care to meet (T.'s) high needs and protect her.

[319] Later in his report Dr. Kronfli offered the following prognosis:

> Until (M.K.'s) symptoms of delusional disorder and psychosis are under control and she is capable of developing insight and appreciates the impact of her past actions and lack of care on her daughter, she is unlikely to be able to make the changes that are required to improve her ability to parent her child and meet the conditions set out by the agency. At this point, she is incapable of providing any consistent and predictable level of care to a child in serious need of physical and psychological care and the prognosis for her to be able to change that is limited as I mentioned before.

[320] M.K. has not followed through on Dr. Kronfli's recommendations. She has not taken any prescription medication as recommended by Dr. Kronfli. She has not arranged to participate in cognitive behavioural therapy as recommended by Dr. Kronfli. She did not consult with her family doctor in relation to Dr. Kronfli's recommendations or reports. M.K. could offer no explanation as to why she did not provide her family doctor with a copy of Dr. Kronfli's report.

[321] M.K. clearly indicated that she does not believe she has a delusional disorder.

[322] The court recognizes and acknowledges that a mental health illness does not equivocate to an inability to provide adequate parenting or justify a presumption of such inability. There are many parents who experience mental health issues and have been diagnosed with a mental health conditions who are excellent parents.

[323] The evidence in this case supports and justifies the conclusions that M.K.'s psychotic illness has impacted negatively upon her ability to parent.

[324] Her delusional disorder appears to have played a part in her inability to communicate and cooperate appropriately with school officials who expressed ongoing concerns respecting T.'s health. As noted by Dr. Kronfli, the respondent mother's false beliefs significantly impaired M.K.'s judgement and created an obstacle or impediment to her ability to place her daughter's physical and emotional needs ahead of her own.

[325] Similarly, M.K.'s disorder appears to have played a part in her failure to engage appropriately with child welfare authorities.

[326] The evidence supports and justifies the conclusion that there is a substantial risk that T will experience neglect by M.K. and that T. will not provide or will refuse to provide or cooperate with the provision of services or treatment required to remedy or alleviate harm.

[327] The evidence confirms a failure or refusal the part of M.K. to provide adequate medical care or services for the child prior to the taking into care in September 18, 2018. Contact with the family doctor was infrequent. The child did not have any dental appointments until age eight. M.K. refused to authorize provision of school support services as well as occupational and physiotherapy. This evidence of past behavior is relevant to the assessment of future risk.

[328] M.K. was asked if she believed that T. requires a feeding tube and she testified that if she had had the opportunity to talk to the doctor she feels there would've been a less invasive way to deal with the situation and she indicated that she feels she would have been able to get T. to eat.

[329] M.K.'s testimony that she feels she would have been able to get the child to eat so as to avoid use of feeding tubes demonstrates significant lack of insight with respect to the evidence confirming significant nutritional deficiencies and failure to thrive at time of the child's admission to the IWK in October 2018.

[330] M.K. maintained that the child never indicated she was experiencing any pain due to her poor oral hygiene.

[331] M.K.'s denial that the child was experiencing pain because of inadequate dental hygiene is incompatible with the evidence of Dr. McLaughlin who confirmed that T. self-reported experiencing pain in her teeth while eating.

[332] M.K. also testified that the school had exaggerated when reporting that the child was experiencing pain in association with her chronic constipation. M.K. testified that she never saw the child in pain. However, on September 11 she told social worker Byrne that the child's constipation issues had improved because T. no longer screamed when going to the bathroom.

[333] At another point during her cross-examination she was asked if anything she had done had contributed to T.'s small size and she indicated that she would not go that far noting that she could not force the child to eat but again maintained that the child ate fine before coming into care. While acknowledging that she could have pushed the doctor to look into it further she also commented that she could not make the child grow. She also testified she had no concerns about T.'s or development noting that all of her children were small.

[334] While acknowledging that T. was pale at time of the taking into care she said that otherwise she was fine except for constipation and she was used to seeing the child like that and to her, it was just T..

[335] Again, M.K.'s evidence suggests significant lack of insight respecting her inadequate parenting and the associated impact upon T.. Clearly, the evidence establishes a disturbing lack of understanding or appreciation of the need to provide timely medical care for her child.

[336] M.K.'s willingness to tolerate or ignore what should have been obvious, and to accept as normal what should have been readily recognizable as requiring action and attention caused T. to suffer significant harm.

[337] M.K.'s mental illness remains untreated. She is not accepting of Dr. Kronfli's diagnosis and as a result has not followed through with respect to his recommendations.

[338] I find that there continues to be a substantial risk of harm associated with M.K.s inability to provide adequate parenting as a result of M.K.'s untreated delusional disorder.

[339] Based upon careful consideration of the evidence I am satisfied on balance of probability that there is a substantial risk that T will experience neglect if returned to the care of M.K..

[340] Based upon the evidence I find there is a real chance of danger that M.K. will not provide necessary medical care, treatment or services, or will refuse to provide necessary medical care, treatment or services or fail to cooperate with the provision of necessary medical care treatment or services to remedy or alleviate harm.

[341] The chance of danger is real and not illusory or speculative. I am satisfied the Minister has adequately established that there is a real risk of future harm based upon the evidence presented.

Consideration of Sections 22(2)(b), (h) and (j)

[342] I am satisfied that the evidence supports a finding that the child is in need of protection pursuant to subparagraphs (h) and (j).

[343] In relation to (h), I am satisfied that the evidence establishes that the child T. does suffer from developmental conditions that, if not remedied, could seriously impair the child's development. In reaching this conclusion I refer to and rely upon the evidence of the Pediatric Occupational therapist, Jennifer Goguen.

[344] I would also refer to the evidence of Ms. Coady Shadbolt, Psychologist, as well as the evidence of Dr. Vellacott, Pediatrician. Both experts testified to the child's ongoing difficulties with respect to self-regulation and the need for appropriate services and treatment. Their evidence supports and justifies a conclusion that the child suffers from a mental or emotional condition that if not remedied could seriously impair the child's development.

[345] While M.K. indicating her willingness to follow through with services such as therapy with Ms. Coady Shadbolt, M.K. demonstrated little insight into the child's emotional or developmental issues.

[346] I accept Dr. Kronfli's conclusion that M.K. is unable to provide the necessary and required parenting to meet T.'s high needs, including her physical and psychological needs.

[347] I am satisfied on balance of probability that T. is also in need of protective services per s. 22(2)(h).

[348] With respect to s. 22(2)(j), I would refer to my findings respecting subparagraph (k).

[349] In concluding that a substantial risk of neglect had been established on balance of probability I referred to the evidence indicating and confirming a chronic and serious failure to provide medical care. This evidence would also support and justify a finding that the child is in need of protective services pursuant to s. 22(2)(j).

[350] I am not prepared to find that the child is in need of protective services pursuant to subparagraph (b). There is certainly no evidence that T. ever suffered physical harm inflicted by M.K. or as a result of M.K.s failure to supervise the child. While the Minister might maintain that M.K.'s failure to provide appropriate and timely medical treatment or services constitutes a failure to protect, I believe that such issues or concerns are more appropriately dealt with under subparagraph (k).

[351] Based upon careful consideration of the evidence, I am satisfied that the Minister has discharged the burden of proof and established on balance of probability that the child, T., is in need of protective services pursuant to subparagraphs (e), (h), (j) and (k) of s. 22(2).

Assessment of Credibility

[352] In *G.L.T. v. Nova Scotia (Community Services)*, 2017 NSCA 68 the Nova Scotia Court of Appeal referred approvingly to the trial decision of Justice Forgeron, identifying various case authorities setting forth legal principles and guidelines applicable to the assessment of credibility including, *C.R. v. McDougall*, 2008 SCC 53 (S.C.C.), *Baker-Warren v. Denault*, 2000 9 NSSC 59, and *Novak Estate, Re*, 2008 NSSC 283 (N.S.S.C.).

[353] I have attempted to undertake the credibility assessment required in this case in accordance with the principles and case authorities as referred to by Justice Forgeron and approved by the Nova Scotia Court of Appeal in *G.L.T.*, supra.

[354] I have no significant credibility concerns respecting the Minister's witnesses. The social workers who testified did so forthrightly and were responsive to questions during cross-examination.

[355] Ms. Cullingsworth readily acknowledged during cross-examination that some positive comments made by the child during an in-school interview which were not included in her affidavit.

[356] Ms. Hemsworth indicated during cross-examination that she had no doubt as to T.'s love and admiration for her parents and acknowledged that one of the doctors had indicated that the child must have been very well loved due to her personality.

[357] Ms. McLean confirmed that M.K. has participated regularly and consistently in supervised visits with T..

[358] Similarly, the Court has identified no credibility issues respecting the experts who were qualified to give opinion evidence during the course of trial.

[359] The Court does have some concerns respecting the credibility of M.K.. While the Court believes that M.K., for the most part endeavored to be truthful during her testimony, the Court has significant reservations regarding the reliability of her evidence. The paragraphs that follow provide some specific examples of credibility concerns.

[360] M.K. repeatedly asserted that T. never indicated she was experiencing any oral pain or discomfort.

[361] Dr. McLaughlin confirmed that T. herself reported that she was experiencing mouth pain following her admission to the IWK. Dr. McLaughlin's evidence indicates that extensive dental decay and severe gingivitis would have resulted in pain and contributed to the child's food aversion.

[362] M.K. also denied any understanding or awareness that the child was missing a significant amount of class time as a result of constipation while at the same time maintaining that she was at the school every day and that no one mentioned it. Given the evidence of the school principal and social worker Cullingsworth, the Court is not prepared to accept or rely upon M.K.'s assertion that she had no knowledge or understanding that T.'s constipation issues were a major concern at school and interfering with her class time.

[363] M.K. repeatedly indicated that she was not aware of T. experiencing pain due to constipation. This is inconsistent with the evidence of T.'s school principal. It is also inconsistent with M.K.'s conversation with social worker Byrne when M.K. reported improvement in the child's constipation because she no longer screamed when she used the bathroom.

[364] M.K. maintained at trial that she was always well aware that T. had an EPA at school, yet Ms. Cullingworth's affidavit confirms at para 34 that during a phone conversation with M.K. on May 1, 2018 M.K. advised that T. did not have an EPA and then indicated that she was not aware that T. had an EPA and complained that the school didn't tell her anything.

[365] In other instances, M.K.'s testimony appeared consistent with the diagnosis of delusional disorder as confirmed by Dr. Kronfli.

[366] During her cross-examination M.K. testified initially that she did not know how many nights the child stayed at the IWK after being admitted in October 2018, but then testified that a doctor told her that it was only two days and that she believes what the doctor told her. Initially, she could not provide any explanation for why the agency would mislead her as to the length of the child's hospital stay but then indicated that she felt the agency would mislead her because the agency wants her child and that the IWK was just there to do the doctoring.

[367] During examination by the *Amicus*, M.K. indicted that Dr. Kronfli felt she was delusional because she expressed her belief that someone was taking T. out of school without her knowledge or permission. When asked if she did indeed believe that she responded by indicating she absolutely believes that someone was taking T. in and out of school. There was no evidence to support or justify this belief.

[368] In assessing credibility of M.K. I would confirm that I have not considered M.K.'s testimony in isolation but in relation to the totality of the evidence.

[369] In any instance where M.K.'s evidence directly conflicts with or contradicts the testimony of other witnesses I have concluded that I cannot accept or rely upon the testimony of M.K..

Best Interests

[370] Section 2(2) of the *CFSA* confirms that the best interests of the child is the paramount consideration.

[371] The circumstances listed in s. 3(2), as applicable, are to be considered in determining best interests.

[372] I would confirm the following findings with respect to the circumstances as referred to in s. 3(2) :

> (a) I find that it would be in the child's best interests that T. have the opportunity for development of a positive relationship with a parent or guardian as a member of a family in accordance with the Minister's plan of care premised upon adoption.
>
> (b) There was little evidence offered as to T.'s relationship with family members other than her parents. The Court is certainly aware that members of her extended family did express serious concerns with respect to T.'s welfare and in two instances members of the extended family did come forward expressing an interest in providing a placement for the child. However, after being advised and informed as to the child's continuing special needs these family members concluded that they would not be able to assume responsibility for the child's care.
>
> (c) The Minister's evidence clearly supports and justifies the conclusion that disruption of T.'s current placement would be contrary to T.'s best interests. T. has made significant progress since coming into the care of the Minister. Clearly, she has received the support required to deal with her multiple health issues. Her caregivers have ensured consistent and appropriate follow through with respect to medical treatment and services. They have provided the type of day-to-day care that has been required in order to facilitate T.'s progress, improvement and positive change. Based on the evidence, I am satisfied that disruption in the continuity of the child's care at this point in time would not be in the child's best interests as it could potentially disrupt the child's progress or negatively impact upon child's prognosis.
>
> (d) The evidence does indicate and confirm a positive bond between the child and her parents. However, it is also clear that the child has developed a very positive relationship with her current caregivers.

(e) Considerable evidence was placed before the court confirming T.'s physical mental and emotional needs and the appropriate care or treatment required to meet those needs. To indicate that T. is a special needs child would be an understatement given the evidence. A myriad of medical issues have been identified. The child is dealing with significant psychological and developmental challenges. Initially a two month period of hospitalization at the IWK was required to deal with T.'s medical issues. The issues that were identified following the child's taking into care necessitated treatment by a multidisciplinary team including a psychologist, a dietitian, an occupational therapist and pediatricians. She continues to require regular follow-up by medical specialists for a number of ongoing health issues. She has been involved in counselling with a psychologist to deal with emotional issues including dysregulation. The attending therapist/psychologist has clearly indicated that continued therapy is essential. A pediatric occupational therapist has made specific recommendations to address developmental issues relating to fine motor skills and to assist with strategies and interventions intended to alleviate anxiety and sensory regulation believed to be connected with complex trauma. A psychoeducational report resulted in very specific recommendations to address learning challenges and academic development while expressing the need for further evaluation to determine whether the child meets criteria for a learning disability.

(f) The evidence establishes that the child is significantly compromised in relation to her physical development. The medical evidence supports and justifies a diagnosis of failure to thrive. Despite the significant medical services and consistent care that the child has received since coming into care there are continuing issues and ongoing challenges respecting the child's future development. There is a significant risk of negative or, less than optimum, outcome if the child does not continue to receive the level of care that she so clearly requires given her continuing needs. T. requires the opportunity to live in a home where her physical, mental and emotional needs will be consistently and appropriately met at all times.

(g) No evidence was offered during the course of the trial with respect to the child's cultural, racial and linguistic heritage.

(h) No evidence was offered with respect to the child's religious faith.

(i) Based upon careful consideration of all the evidence I am satisfied on balance of probability that the Minister's plan premised upon permanent care and custody has more merit than M.K.'s plan placed upon the child being returned to her care.

(j) No evidence was presented with respect to the child's views and wishes. I am satisfied that it would not have been appropriate in the circumstances of this case to have attempted to ascertain the child's views.

(k) There was some delay encountered in moving this matter to final review hearing as a result of the pandemic. The matter was able to proceed to contested hearing as soon as practicable having regards to the need to comply with all applicable health regulations

> and to make every effort to ensure the health and safety of all participants. The court does not believe there has been inordinate delay in the disposition of this case.
>
> (l) The court is satisfied that the risk of harm associated with potential return of the child to the care of M.K. is obvious and substantial based upon the evidence presented. The court is satisfied that the child would be placed at significant risk if returned to the care of the respondent mother.
>
> (m) The degree of risk that justified the finding that the child is in need of protective services is substantial. Given the evidence presented I'm satisfied that the risk is not tenuous or uncertain but real and significant.

[373] I am satisfied that it would be in T.'s best interest to be placed in the permanent care and custody of the Minister.

Consideration of Section 42(2)

[374] The Minister's original Plan of Care dated January 24, 2019 was premised upon a request for an order for temporary care and custody. The issues of concerns identified in the Plan of Care included untreated parent/emotional mental health. The Plan of Care confirmed the Minister's expectation that upon completion of Dr. Kronfli's assessment M.K. would follow through on any recommendations made by Dr. Kronfli.

[375] The Revised Plan of Care filed by the Minister dated December 19, 2019 again confirmed that the agency's willingness to provide family support services and refer M.K. to a therapist had been contingent upon M.K. following through on Dr. Kronfli's recommendations.

[376] M.K. was not accepting of Dr. Kronfli's opinions or recommendations. While consistently indicating an intention to obtain a second opinion M.K. never did so. She did not provide the report to her family doctor or discuss the report with her family doctor. She could not explain why she did not do so.

[377] M.K. never followed through on Dr. Kronfli's recommendations. As a result, the agency never provided M.K. with the opportunity to participate in therapy or family support services. The only service provided by the agency was facilitation of supervised access.

[378] Despite understanding that appropriate follow through on Dr. Kronfli's recommendations was a prerequisite to provision of services, M.K. was not prepared to embark upon a course of medication as recommended by Dr. Kronfli.

[379] I am satisfied that the Minister did indicate a willingness to provide services intended to assist in addressing the ministers protection concerns but that such services or supports were unable to be provided because of the respondent mother's steadfast refusal to follow through on Dr. Kronfli's recommendations, even in the absence of any second opinion contradicting or challenging Dr. Kronfli's conclusions.

[380] I am also satisfied that less intrusive alternatives including services to promote the integrity of the family pursuant to s. 13 would be inadequate to protect the child.

Consideration of Section 42(3)

[381] I am satisfied that the Minister gave reasonable consideration to family placement options. Unfortunately, while members of the family did express an interest in assuming responsibility for care of the child they subsequently concluded that they would not be able to provide the level of care required to address the child's ongoing medical issues and other special needs and withdrew their placement proposals.

[382] I find that it is not possible to place the child with a relative, neighbour or other member the child's community or extended family at this point in the proceeding.

Consideration of Section 42(4)

[383] The outside limit for this proceeding was March 12, 2020 and therefore a finding under s. 42(4) is not required.

Consideration of Section 46

[384] The Minister's request for an order for permanent care and custody was made pursuant to s. 46 of the *CFSA*.

[385] I would confirm the following findings with respect to s. 46(4):

(a) There has been no meaningful or material change in circumstance since the original disposition order dated March 19, 2019.
(b) The original plan of care as filed on behalf of the Minister was premised upon the respondent M.K. following through appropriately on any recommendations made by Dr. Kronfli. Following receipt of Dr. Kronfli's report the respondent mother was not accepting of Dr. Kronfli's diagnosis or the associated treatment recommendations. The minister was unwilling to provide services unless and until M.K. had followed through appropriately on Dr. Kronfli's recommendation for medication. Accordingly, services contemplated for M.K. as per the original plan of care were never able to be implemented or carried out.
(c) I am satisfied that the Minister's Revised Plan of Care premised upon permanent care and custody is appropriate and consistent with the best interests of the child and the least intrusive option capable of ensuring the safety and welfare of the child and alleviating substantial risk of harm.
(d) Given the expiration of the outside limit, this is not a case where the court must consider the requirements of s. 46 (4) (d).

Access

[386] In accordance with s. 47(2), the order for permanent care and custody will not include a provision for access.

Determination of Religion

[387] No evidence was offered with respect to the religious denomination of the child. The religious denomination of the child is therefore noted as undetermined.

Conclusion

[388] I am satisfied that the Minister has adequately discharged the burden of proof in requesting an order for permanent care and custody. The minister has established on balance of probability that it would be in the best interests of the child T that she be placed in the permanent care and custody of the Minister.

[389] The Minister's application is therefore granted.

[390] The court would like to thank counsel for the Minister and the *Amicus* for their participation and assistance.

[391] In particular, the court recognizes and acknowledge the challenges Ms. Cox was met with in association with her role as *Amicus*. The court is satisfied that Ms. Cox discharged her duties as *Amicus* in accordance with the court order confirming her appointment. Ms. Cox's involvement was of considerable assistance to the court.

[392] I would also like to acknowledge M.K.'s participation as a self represented respondent. M.K. certainly struggled with some of the technical legal issues during her participation as a self represented respondent. It was unfortunate, but perhaps not surprising, that M.K. was not prepared to communicate more readily or consistently with the *Amicus* during the proceeding.

[393] M.K. appeared able to follow the evidence that was presented during the hearing. She was able to undertake reasonable cross-examination of the Minister's witnesses, including expert witnesses. It was also evident to the court that M.K. had undertaken some appropriate preparation prior to cross examination of witnesses.

[394] The Court acknowledges that M.K. will be extremely disappointed by the Court's decision to grant the Minister's application for permanent care. I recognize that M.K. loves her daughter dearly and sincerely believes that it would be in her daughter's best interest to be returned to her care. However, based upon consideration of the evidence, I have concluded that it would be in T.'s best interest that she be placed in the permanent care and custody of the Minister.

Morse, J.