SUPREME COURT OF NOVA SCOTIA
FAMILY DIVISION

Citation: Nova Scotia (Community Services) v. E.U., 2015 NSSC 4

Date: 20150106
Docket No. SFSNCFSA85244
Registry: Sydney, NS

Between:

Minister of Community Services

Applicant

v.

E.U.

Respondent

To the Publishers of this case:

Please take note that Section 94(1) of the Children and Family Services Act applies and may require editing of this judgment or its headings before publication. Section 94(1) provides:

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

Editorial Notice:	Identifying information has been removed from this electronic version of the judgment.
Judge:	The Honourable Justice Kenneth C. Haley
Heard:	July 22nd, July 23rd, Sept. 3rd, Sept. 4th, Sept. 5th, Oct. 9th, Oct. 10th, Oct. 14th and Oct. 17th, 2014, in Sydney, Nova Scotia
Final Written Submissions	December 12, 2014
Written Release:	January 6, 2015
Counsel:	Danielle Morrison, Counsel for the Applicant Coline Morrow, Counsel for the Respondent

By the Court:

[1] This is the application of the Minister of Community Services, hereinafter called "the Minister", seeking an Order pursuant to s. 42(1)(f) of the *Children and Family Services Act of Nova Scotia* (CFSA), that the child, A.U., born March 2013, be placed in the permanent care of the Minister, with no provision for access.

[2] The Respondent, E.U., is the biological mother of the child. She opposes the Application and seeks return of the child to her care. The biological father, D.R., has passed away and no longer is a named party to this proceeding.

[3] The history of the file is as follows:

March 11, 2013

[4] The child, A.U., was taken into care by the Minister at birth.

March 13, 2013 – Interim Hearing

[5] An Interim Hearing (5-Day) was held, pursuant to s. 39 of the CFSA. The child was placed in the interim care and custody of the Minister with supervised access to the Respondent, E.U.

April 2, 2013 – Completion of the Interim Hearing

[6] A completion of the s. 39, Interim Hearing, was held.

[7] Court ordered that the child remain in the temporary care and custody of the Minister, with supervised access to the Respondent.

May 7, 2013 – Protection Hearing

[8] The child, A.U., was found to be in need of protective services pursuant to s. 22(2)(b) of the CFSA.

[9] The status quo was to continue, with supervised access to the Respondent.

July 19, 2013 – Disposition Hearing

[10] Status quo to continue with supervised access to the Respondent.

[11] Minister's Plan of Care dated July 18, 2013, filed with the Court.

[12] The Minister agrees to review the Respondent's request to transfer the file to Ontario where the Respondent wished to relocate and live with a family member.

August 27, 2013 – Disposition Update

[13] The Minister advised that the Ontario Child Welfare Authority did not support a transfer of the file to Ontario and did not support placement of A.U. with the Respondent's family member.

[14] The Respondent had already moved out of the jurisdiction for work purposes and her counsel had no instructions.

October 2, 2013 – Disposition Review

[15] Status quo to continue, with supervised access to the Respondent.

[16] The Respondent was still in Ontario for work purposes and, as a result, was not exercising access and/or engaging in services.

November 19, 2013 – Disposition Review

[17] Status quo to continue, with supervised access to the Respondent.

[18] The Respondent was still in Ontario and not exercising access and/or engaging in services.

[19] The Minister advised it will be amending its plan to seek permanent care of A.U., with no provision for access.

[20] The Court directed the Respondent to return to the jurisdiction of the Court within thirty (30) days, at which time dates will be scheduled for hearing.

December 18, 2013 – Disposition Review

[21] Status quo to continue, with supervised access to the Respondent.

[22] Minister confirmed its intention to seek permanent care.

[23] The Respondent, E.U., was present and requested that access and services be recommenced immediately.

[24] Final deadline - July 19, 2014.

March 12 – 13, 2014

[25] Counsel for the Respondent requested an adjournment of the March 21st and March 24th, 2014 hearing dates.

[26] Adjournment by consent.

[27] New hearing dates assigned – April 10th and 11th, 2014.

April 14, 2014

[28] Matter re-scheduled for Final Hearing to July 22nd, July 23rd, July 24th, 2014, by consent.

[29] Both the Minister and counsel for the Respondent agreed to exceed the statutory times, as it was in the best interests of the child to do so.

[30] Status quo to continue, with supervised access to the Respondent.

[31] On July 22nd and July 23rd, 2014 the Minister put forth the following witnesses and evidence as follows:

1. **Cst. Dwight Miller** – Cape Breton Regional Police

2. **Dr. Stephen Farrell** – Respondent's physician. Dr. Farrell tendered Exhibit #1, which included, *"Correspondence and Copies of Prescriptions Issued and Drug Testing Results".*

3. **Joanne McCormick –** Access Facilitator. She tendered Exhibit #2 and Exhibit #3, which were her *"Access Notes, Volume 1 and Volume 2".*

4. **Mr. Joe Gareri** – Hair and Drug Analyst. He tendered Exhibit #6, "*Drug Testing Results"* for the Respondent. The following exhibits were filed subsequent to the witness's testimony, namely, *"MotherRisk Laboratory Report"* of Joey Gerari, dated October 9, 2014, re Review of Hair Test Results for G.H and *Curriculum Vitae* of Joey Gareri,

along with Exhibit #18, "*Bell Aliant email"* dated Friday, October 10, 2014, from Joey Gareri to Jim MacCormack and Coline Morrow, re Review of Hair Test Results for G.H. These exhibits were tendered on October 17, 2014, while the Respondent, E.U., was subject to examination.

[32] The proceeding was then adjourned to September 3rd, 4th and 5th, 2014 by consent of the parties since there was not sufficient time to conclude the proceeding by July 24, 2014.

[33] On September 3, 2014 the Minister called the following witnesses and evidence:

5. **Dr. Salim Hakeem** – Respondent's physician.

6. **Paula MacMullin-Beaton** – Clinical Therapist with Addiction Services. Ms. Beaton tendered into evidence the "*Addiction Services Records"* of the Respondent, which were marked as Exhibit #7. The missing Page 8 was subsequently marked Exhibit #8.

7. **G.H.** – Respondent's boyfriend.

8. **J.M.** – Respondent's friend.

[34] On September 4th and 5th, the following witnesses testified:

9. **Ainslie Elgebeily** – Child Protection Social Worker. Ms. Elgebeily tendered Exhibit #9, "*Book of Pleadings"*, which consists of the following:

Tab 1	**Notice of Child Protection Application with the Affidavit of Ainslie Kehoe sworn to March 11, 2013, attached thereto.**
Tab 2	**Affidavit of Ainslie Kehoe sworn to May 6, 2013.**
Tab 3	**Notice of Motion for Disposition Order dated July 17, 2013, with the Agency's Plan for the Child's Care dated July 17, 2013 and the**

Affidavit of Ainslie Kehoe sworn to July 17, 2013, attached thereto.

Tab 4 **Notice of Motion for Disposition Order dated September 30, 2013, with the Affidavit of Ainslie Kehoe sworn to September 30, 2013, attached thereto.**

Tab 5 **Notice of Motion for Disposition Order dated November 15, 2013, with the Affidavit of Ainslie Kehoe sworn to November 15, 2013, attached thereto.**

Tab 6 **Notice of Motion for Disposition Order dated April 11, 2014, with the Affidavit of Ainslie Kehoe sworn to April 11, 2014, attached thereto.**

10. **Donna Mikkelsen** – Child and Care Worker.

[35] The case required more time to complete and with the Respondent being pregnant and due to deliver her new baby on September 20, 2014, the matter was further adjourned, by consent, to October 9th, October 10th and October 14th, 2014.

[36] On October 9th & October 10th, 2014, the Minister continued with the following witnesses:

11. **Dr. Neil Christians** – Clinical Psychiatrist. Dr. Christian is the treating psychiatrist for the Respondent. During the course of his evidence, the following exhibits were introduced into evidence.

Exhibit #10 ***Curriculum Vitae***

Exhibit #11 ***Cape Breton District Health Authority Chart for the Respondent***

Exhibit #12	***Report of Dr. Christians, dated July 22, 2014***
Exhibit #13	***Report of Dr. Christians, dated October 6, 2014***
Exhibit #14	***Report of Dr. Christians, dated August 18, 2014***
Exhibit #14(b)	***Report of Dr. Christians, dated September 16, 2014***

[37] On October 14th and 17th, 2014, the Respondent called the following witnesses:

12. **Heather Gouthro:** Outreach Coordinator at Transition House

13. **E.U.**, the Respondent. "Exhibit #15" and "Exhibit #16" were tendered into evidence.

[38] The Respondent does not contest and, indeed, acknowledges her past lifestyle and conduct, which caused the Minister's concern about her ability to parent.

[39] Nevertheless, the Respondent now claims to be drug free, in a stable relationship and has engaged in services, some at the instance of the Minister and others that have been self-initiated.

[40] The Respondent is of the view that her previous, unacceptable, lifestyle is a thing of the past and that she now presents no risk to her child in a care giving role.

[41] It should be noted that earlier, on July 22nd, 2014, the Respondent called:

14. **Lisa Carr** – who works at the Cape Breton Family Place Resource Centre. Ms. Carr provided parenting programs to the Respondent (see "Exhibit #2).

[42] The evidence was thus concluded, with written submissions to be submitted by counsel to the Court.

[43] Counsel requested additional time in order to obtain a transcript of the 9-day hearing. Original dates for submissions were November 10th for the Minister and November 25th for the Respondent. The dates were later extended to November 25th and December 12th, 2014 respectively.

Minister's Evidence

Cst. Dwight Miller

[44] Cst. Miller has been employed by the Cape Breton Regional Police for fourteen (14) years. He testified about an incident involving the Respondent on June 22, 2012, in response to a 911 call.

[45] The Respondent was residing with her husband, D.R., at the time. The officer noted damage to the apartment walls, apparently done as a result of Mr. R. punching same.

[46] The Respondent was threatening to jump from her upstairs window and was arrested under the *Involuntary Psychiatric Act*. While awaiting the ambulance, the Respondent attempted to run up the street yelling that she would have to be dragged to the hospital and, if Cst. Miller touched her, she would have his job.

[47] Cst. Miller found the Respondent to be "stressed out" and "agitated". He formed the opinion that the Respondent was under the influence of a narcotic.

Dr. Stephen Farrell

[48] Dr. Farrell has been a family physician for thirty-eight (38) years. The Respondent has been his patient since June 10, 2013.

[49] The Respondent's initial complaint was that of dental pain [caused by her long-time use of crack cocaine]. Dr. Farrell prescribed Tylenol 3 for pain on April 11, 2013 and June 10, 2013 (see Exhibit #1). Each prescription provided the Respondent with thirty-six (36) tablets. The April 11, 2013 prescription provided the Respondent with a 9-day supply; the June 10, 2013 prescription provided a 12-day supply.

[50] Reportedly, the Respondent was also taking Tylenol 1 for pain. Tylenol 1 can be obtained without a prescription, but must be issued by a pharmacist (see Exhibit #1, page 5).

[51] Dr. Farrell testified that an excessive use of Tylenol 1 would be problematic and would not be in the best interests of the Respondent if, indeed, she was taking one hundred (100) tablets per week.

[52] Dr. Farrell saw the Respondent seven (7) times from April 11, 2013 – April 25, 2014. On January 28, 2014, the doctor made a mental health referral to Dr. Christians, who saw the Respondent in June 2014.

[53] Also, on January 28, 2014, the Respondent advised Dr. Farrell that she was pregnant. As a result, a referral was made to an obstetrician.

Joanne McCormick

[54] Ms. McCormick has been employed by the Department of Community Services as a Case Aid and Access Facilitator for seven (7) years. She became involved with the Respondent's file on April 12, 2013.

[55] The witness's notes were tendered with the Court as Exhibit #3, Exhibit #4 and Exhibit #5, which references the Respondent's access visits from April 12, 2013 – June 27, 2014.

[56] Counsel for the Minister was very thorough in referencing the witness's notes and bringing forth the details and/or concerns of the Minister with regard to the Respondent's visits with her infant daughter, A.U.

[57] Access was interrupted from July 17, 2013 – January 13, 2014 since the Respondent had moved back to Ontario. Suffice to say, the witness did agree that upon the Respondent's return in 2014, she did a very good job with access.

Joey Gareri

(a) The Respondent, E.U.

[58] Mr. Gareri is a Laboratory Manager and Researcher at the Hospital for Sick Children in Toronto, Ontario. Mr. Gareri was qualified, without contest, as an expert in the area of hair, urine and meconium analysis with regard to drugs and alcohol.

[59] Mr. Gareri has testified in the Nova Scotia Supreme Court on a regular basis and his qualifications have been accepted by the court to testify as an expert witness. Mr. Gareri's C.V. was tendered as Exhibit #17

[60] Exhibit #6 is the Report of Mr. Gareri regarding the drug use of the Respondent with regard to three (3) samples taken on April 9, 2013, February 15, 2014 and May 31, 2014. He concluded that the meconium sample of the newborn child, A.U., collected one (1) day after birth, tested positive for codeine at the very high end of the calibration scale, namely in excess of 1600 nana grams (i.e.) numbers are not given past 1600. The sample also tested positive for morphine at a concentration of 727 nana grams per gram of meconium, which is a substantial amount. Mr. Gareri testified:

> **This result indicates use of codeine by this baby's mom likely during the third trimester of pregnancy, either relatively frequent codeine use during this time, or codeine use very close to the time of labour and delivery. Morphine is a metabolite of codeine…so the morphine present is likely due to the codeine. It is also important to note that the morphine could be there from independent use of morphine, or even from use of heroine which is also metabolized to morphine. So there are possible explanations for the morphine finding.**

[61] Mr. Gareri further testified:

> **Q: …let's say if the mother took Tylenol 3 on the day of delivery, would that result in that kind of codeine response?**
>
> **A: I couldn't rule that out.**
>
> **Q: Now, within the time frame we're looking at here, you said this would be the last trimester of pregnancy?**
>
> **A: Yes.**
>
> **Q: So this would be items consumed by the mother, if the birth of the child was March 6, the period the mother could have taken codeine and/or morphine would be from January, December?**
>
> **A: I'd say December 2012 to February 2013 inclusive.**

[62] Regarding hair samples provided by the Respondent on April 9, 2013, Mr. Gareri testified:

> **A: …A total of six centimetres of hair was tested. Hair grows at an approximated rate of one centimetre per month, and this six month period was tested in three, two month segments. So the zero to two centimetres essentially represents February and March, 2013.**

[63] Mr. Gareri found that it tested positive for cocaine at a level of 1.42 nana grams/milligram. For the time period February – March 2013, Mr. Gareri testified:

> **...the level of cocaine we detected is in the medium range. It's around 30th percentile for our population, so this would indicate repeated use of cocaine during that two month time frame.**

[64] For the time period December 2012 to January 2013, the two (2) to four (4) centimetre section of hair also tested positive for cocaine in a higher concentration. Mr. Gareri testified:

> **…so this result of 4.25 nana grams per milligram of hair is above the 50th percentile, indicating also a repeated use of cocaine for this two (2) month period, at a greater intensity than the repeated use demonstrated in the February – March time period.**

[65] For the time period October – November, 2012, or the four (4) to six (6) month segment of hair sample analysis, E.U. also tested positive for cocaine at a concentration of 8.81 nana grams/milligram. Mr. Gareri testified:

> **…this cocaine concentration is in the high range, so amongst cocaine-positive individuals from our laboratory population, which is 95% child welfare related cases, this result is in the top 25% of values and is indicative of frequent or intensive use of cocaine during this two (2) month time period.**

[66] Regarding codeine levels of the Respondent from October 2012 – March 2013, Mr. Gareri testified:

> **…so, we've looked at three distinct two month periods from October (2012) to March (2013) inclusive, and in each two month period, there appears to be a similar overall level of codeine use.**

[67] The next hair sample analysis was provided by the Respondent on February 21, 2014. It covers the time period from August 2013 to January 2014. Mr. Gareri testified:

> **Q: So looking at the November to January 30th segment, that would be zero to three?**
>
> **A: Yes.**
>
> **Q: And, what do we have a positive there for? Codeine?**
>
> **A: Yes, so this section of hair is positive for codeine only, at a concentration of 0.65 nana grams/milligram of hair, indicating some use of codeine during this three (3) month time period. The concentration is relatively low, and looking at Ms. E.U.'s previous sample, it's substantially lower than her other**

> **samples, so overall it indicates a decrease in the average intensity of codeine use during this three (3) month period, as compared to her previous tests.**
>
> **Q: Alright then, can we go to the three (3) to six (6) month segment from February?**
>
> **A: …this three (3) to six (6) month centimeter section represents approximately August to October 2013, inclusive. This segment of hair was positive for cocaine in trace amounts. Trace, meaning a very low concentration of cocaine…**

[68] Mr. Gareri went on to testify that this trace positive amount of cocaine is consistent with one (1) of two (2) scenarios:

> **…the first scenario is isolated or infrequent use of cocaine, on as little as one occasion between August and October 2013.**
>
> **…the second primary scenario that would be consistent with these results would be frequent past exposure to cocaine during this time through either exposure to second hand smoke on a regular basis, um, drug residues in a regular environment, such as touching the head. So, for example, if she had a friend who smoked crack in their living room and she's sitting on the couch a few times a week, her hair is touching the couch which is smoked around often, that kind of direct contact with contaminated services on a regular basis, or frequent direct physical contact with a heavy cocaine user.**

[69] Mr. Gareri agreed that this trace amount of cocaine could be the result of a person blowing cocaine on the Respondent while sleeping, which was identified as a possible source when the Respondent was living with J.M.

[70] The third and final hair sample was provided by the Respondent on May 31, 2014, representing the three (3) month period from mid-February to mid-May, 2014. This sample was positive for codeine at a level of 0.59 nana grams/milligram. Mr. Gareri testified:

> **This result would indicate some use of codeine during this three (3) month period.**

[71] Ms. Gareri considered this result to be similar to, and consistent with, codeine used by the Respondent between November 2013 and January 2014.

[72] During cross-examination, Mr. Gareri testified as follows:

> **Q: So, if Ms. E.U. had told the Agency that her use of drugs, that she stopped using drugs such as cocaine in or around the end of October, 2013, these results would back that up? Other than codeine, correct?**
>
> **A: Other than codeine, I have no evidence of use of any of the other drugs tested after October 2013.**
>
> **Q: …And you would agree with me that the amount of codeine is a low level result in 2014?**
>
> **A: The concentration in this sample is in the low range for our codeine reference range.**
>
> **Q: Showing infrequent use?**
>
> **A: Yeah, it would suggest relatively infrequent use…**

[73] Mr. Gareri concluded his evidence by stating the Respondent's later results showed "a very good progress with regard to illicit drug use". He confirmed that all her levels are going down and she has had a relatively consistent amount of testing.

(b) G.H.

[74] At the close of proceedings on October 17, 2014, counsel for the Minister and the Respondent tendered by consent a further Report of Mr. Gareri, dated October 9, 2014 with regard to hair sample analysis for Mr. G.H. This report also contained Mr. Gareri's C.V. and was marked Exhibit #17.

[75] The hair sample was collected July 4, 2014 and represents approximately six (6) months of drug exposure from late December 2013 to late June 2014. The sample tested positive for trace amounts of cocaine, benzoylecgonine, codeine (very low range), cannabinoids and alcohol. Mr. Gareri reported at pages 1 and 2:

> **Cocaine: The positive cocaine findings in each segment suggest a history of cocaine exposure in this individual. The very low-level findings in both segments do not provide conclusive evidence of active cocaine use by this individual during the six-month time period tested.**
>
> **Benzoylecgonine: The presence of benzoylecgonine (cocaine is converted to benzoylecgonine by the body after administration of the drug) is generally a confirmation of active cocaine use in adult hair samples. This test helps distinguish between passive (i.e. second-hand) and active exposure to cocaine in samples containing low levels of cocaine. The absence of detectable cocaine metabolites in the 0-3 cm segment means that active cocaine use by this individual, while possible, is not conclusively proven by these findings.**

> **The presence of benzoylecgonine in the 3-6 cm segment, while suggesting active cocaine use, does not provide clear evidence of use due to the very-low level cocaine result.**

[76] Mr. Gareri provides three (3) scenarios which could explain his findings. He opines at page 2-3 of his report that based upon the pattern of results observed that scenario (ii) provides the best explanation for the current findings, although all three (3) scenarios are possible. Scenario (ii) states as follows:

> **(ii) Higher-level (i.e. repeated) use of cocaine in the recent past (within 1-2 months prior to late December 2013) and these results are residues left over from previous use….**
>
> **…**
>
> **Codeine: This hair sample tested positive for codeine, suggesting use of codeine during each three-month time period tested, with a slighter lower average level of use in the more recent three-month period. Based on the "trace" findings in the 0-3 cm section, it remains possible that codeine use was limited to the single time period from late December 2013 to late March 2014 as described for cocaine in scenario (ii) above.**
>
> **Please note, since codeine is a prescription medication, it is important to determine whether this individual filled any legitimate codeine-containing prescriptions during the tested time period. Low-dose codeine formulations (i.e. Tylenol 1) are also available without prescription.**
>
> **Cannabinoids: …Our cannabinoids analysis reflects the concentration of THC, the primary psychoactive component of marijuana/hashish…This hair sample tested positive for "trace" concentrations of THC, indicating frequent use of cannabis by this individual during each three-month time period tested….**
>
> **Alcohol: …analysis of Mr. H.'s hair sample provides suggestive evidence of frequent heavy alcohol use between late March and late June 2014….These findings in and of themselves should not be considered conclusive proof of frequent heavy alcohol use during this time in the absence of additional supporting evidence.**

[77] In addition to Mr. Gareri's formal report, he also provided an email response in answer to a question posed by counsel for the Respondent on October 10, 2014. This email has been tendered by consent and marked Exhibit #8.

> **Q: …Mr. H. reports using cocaine in 2013 starting in September 2013 and ending in or around October 13, 2013. He reports no use of cocaine since that time. Is this consistent with your findings?**

A: I would consider a last cocaine use in October 2013 to be consistent with these findings as described in scenario (ii) of the cocaine section of my letter.

Dr. Saima Haleem

[78] Dr. Haleem is the physician who treated the Respondent during her pregnancy and delivered the baby, A.U., in March 2013.

[79] Dr. Haleem testified that the baby was "jittery", "restless" and had "involuntary movements". The doctor attributed these symptoms to withdrawal from drugs. The newborn baby was kept in the hospital for ten (10) days.

[80] Dr. Haleem testified that the baby, A.U., has both physical and developmental delay, which she again attributed to maternal drug use.

[81] Dr. Haleem further testified that the baby, A.U., will require a lot of follow up, including the possibility of specialized care through the I.W.K. Hospital in Halifax, Nova Scotia, although no trips are currently planned.

[82] Dr. Haleem testified that she sees A.U. every two (2) to three (3) months and that the child is speaking, walking and catching up on her developmental milestones.

Paula McMullen-Beaton

[83] Ms. Beaton works with Addiction Services as a Clinical Therapist. She has been involved with the Respondent since January 16, 2014. Ms. Beaton filed Addiction Records with the Court, which were marked as Exhibit #7.

[84] The Respondent has met with Ms. Beaton on five (5) occasions, which included: January 16th, January 30th and April 31st, 2014. These were primary assessment sessions. Ms. Beaton outlined her treatment recommendation at Tab 3, Page 5 of Exhibit #7 as follows:

*** Continue to attend CBS counselling in order to examine ways to remain substance free and in a steady recovery.**

*** Attend self-help recovery activities in order to develop the support of others in maintaining her sobriety.**

*** Participate in a women's structured relapse prevention program on the next offering of the program.**

[85] The Respondent has since participated in only two (2) cognitive training sessions with Ms. Beaton on May 22nd and June 17th, 2014. Cognitive Therapy focuses on trying to change a person's beliefs by challenging their behaviour. This is a standard practice of an addiction counsellor and can be a long process.

[86] The Respondent had reported a past history of illicit drug use, domestic violence and childhood abuse. The Respondent did not discuss her history of child welfare proceedings in Ontario or her history of prostitution.

[87] Based upon the Respondent's self-reporting, Ms. Beaton was of the opinion that the Respondent had not used illicit drugs since July 2012 and had not used marijuana since the late Fall of 2013. Ms. Beaton understood that the Respondent was currently not abusing or taking any substance other than Tylenol 1 for her severe dental pain.

[88] Ms. Beaton was of the opinion that the Respondent was very open to receiving help and was very sincere in wanting to never use drugs again.

[89] During her five (5) meetings with the Respondent, Ms. Beaton was impressed by the Respondent's level of engagement, commitment and focus.

G.H.

[90] G.H. is currently the partner of the Respondent and they have been together as a couple since October 2013. They met in […] while both were working with the […].

[91] G.H. and the Respondent moved to Cape Breton, December 17th, 2013. He testified he has his own place but is always at the Respondent's residence.

[92] The Respondent recently gave birth to a new son and G.H. is the biological father. Prior to knowing that the Respondent was pregnant with his child, G.H. acknowledged that there was a plan in place whereby the Respondent agreed to be a "surrogate mother" for J.M. and C. M., a couple who had befriended them in December, 2013 and who themselves could not have children.

[93] Upon learning that the Respondent was pregnant, she and G.H. then agreed to have the J.M. and C.M. adopt their baby. This plan has since changed and G.H. and the Respondent are intent on keeping and raising their new baby [who is currently in the temporary care of the Minister].

[94] G.H. testified that he is supportive of the Respondent. He does not judge her for her past. He states he is protective of the Respondent but is not possessive of her.

[95] G.H. testified that he is a social drinker and may have one (1) or two (2) beer per week. He testified he no longer has "poker night" at the Respondent's residence.

[96] G.H. acknowledged he used cocaine the end of 2013 and now smokes marijuana on a casual basis only and has not done so the last two (2) months.

[97] G.H. intends to seek out counselling and, in particular, will be seeing Dr. Christians on October 23, 2014. He testified that he wants to talk about dealing with his emotions, i.e. "get into stuff that happened in my life".

[98] G.H. testified that he has a good relationship with the Respondent. There is no physical violence between them and when there is an issue they now talk things out.

J.M.

[99] J.M. is a […] and is forty-two (42) years of age. Her husband, C.M., does not work and is fifty-one (51) years of age. J.M. and C.M. have no children of their own.

[100] Mrs. M. knew D.R., the Respondent's late husband, from earlier days in […], Nova Scotia. After learning of Mr. R.'s death, Mrs. M. contacted the Respondent to express her sympathies and they subsequently became friends.

[101] When the Respondent offered to "carry a child" for J.M., Mr. and Mrs. M. agreed. Several attempts at artificial insemination in the M.'s basement failed.

[102] When the Respondent learned that she was pregnant, she and the M's agreed to have J.M. and C.M. become the adoptive parents. A lawyer was retained to assist with a private adoption.

[103] On July 18, 2014, the Respondent advised the M's that there was a change in plans and that the Respondent and G.H. planned to keep their baby.

[104] In spite of this decision by the Respondent, Mrs. M. still remained supportive of the Respondent. When it was suggested to Mrs. M. that the

Respondent had referred to her as "psycho", was abusive to […] and was "intimidating and threatening", Mrs. M. testified:

> **This is crazy.**

[105] At the close of her testimony, Mrs. M. was uncertain whether or not she would remain friends with the Respondent.

Ainslie Elgebeily

[106] Ms. Elgebeily has been a Child Protection Social Worker with the Department of Community Services for seven (7) years. She became involved in the Respondent's file in August 2012 as the result of a referral from Cst. Dwight Miller of the Cape Breton Regional Police.

[107] Initially, when the Respondent was still living with D.R., the couple had no interest in attending Addiction Services and refused to cooperate with hair testing.

[108] The Minister was concerned about drug use and domestic violence. The Respondent had disclosed that she used cocaine during the first trimester of her pregnancy.

[109] After the death of D.R., due to an accidental drug overdose in April 2013, the Respondent became more committed to the Minister's Plan of Care. She was prepared to participate in counselling, attend Outreach and Addiction Services Programs, work with a support worker and consent to hair follicle testing.

[110] In discussing the plan with the Respondent on April 24, 2013, Ms. Elgebeily explained the importance of the Respondent being honest about her issues. The Respondent indicated that she was clean of drugs since April 2012, other than prescribed drugs of Tylenol, Clorazepam and Ritalin.

[111] On May 30, 2013, the Respondent left a voice mail with Ms. Elgebeily explaining that she was not in a good place at this time and was having suicidal thoughts. Ms. Elgebeily followed up the next day and found the Respondent to be okay during A.U.'s access visit. In July 2013, there was some discussion that the Respondent may move back to Ontario as she had no support in Nova Scotia. The Minister agreed to look into a possible placement of A.U. with the Respondent's cousin in Ontario, K.W. Without knowing the result of this inquiry, the Respondent moved back to Ontario.

[112] On August 20, 2013, the Minister was advised that the Ontario Child Welfare Agency did not support the placement of A.U. with K.W. The Respondent was now in Ontario working with […]. She did not contact Ms. Elgebeily until September, 2013 at which time the Respondent advised she would return to Nova Scotia on October 14, 2013. Ms. Elgebeily advised the Respondent that the Ontario placement was no longer an option.

[113] The Respondent did not return to Nova Scotia on October 14, 2013 and was not engaging in services. She contacted Ms. Elgebeily on November 15, 2013 and was angry about the expectation that she attend the November 19, 2013 court date.

[114] Ms. Elgebeily testified that the Respondent was conflicted about where she needed to be at this time. Ms. Elgebeily advised the Respondent of her concern that the statutory timeline in this matter would expire in July 2014 and that at this point in time, the Respondent had not yet engaged in any services and had not seen her daughter for five (5) months. Ms. Elgebeily advised the Respondent that based upon these concerns, the Minister was now seeking permanent care of A.U.

[115] The Respondent arrived back in Cape Breton on December 17, 2013 immediately demanding to have access with her daughter. The Respondent also requested that J.M. be approved as a foster placement which the Minister did not support.

[116] By January 3, 2014, efforts were in place to assist the Respondent with services. The Respondent and her partner, G.H., were temporarily residing with J.M. and C. M.

[117] Ms. Elgebeily met with the Respondent on January 10, 2014 to confirm appointments were made with both the Outreach and Addiction Services Programs. Ms. Elgebeily found the Respondent to be well groomed and "looked healthier".

[118] The Respondent denied that she was pregnant and advised that she looked healthier because she was no longer using drugs.

[119] The Respondent agreed to drug/hair testing, however, advised Ms. Elgebeily that she was taking Tylenol 1 and smoking marijuana to alleviate the dental pain. The Respondent indicated that she stopped smoking marijuana in December, 2013.

[120] By February, 2014, the Respondent was engaging in all services, including some self-referral programming. At this time, the Respondent acknowledged that

she was pregnant and the plan was to have the M's adopt the new baby. Ms. Elgebeily testified that the Respondent said that she did not want the baby; that her partner was not prepared or ready to have a child and that she was experiencing pressure from Mrs. M. to give up the baby. Ms. Elgebeily also learned of the earlier plan to artificially inseminate the Respondent so as to provide a child to J.M. and C.M.

[121] On February 24, 2014, the Respondent confirmed with Ms. Elgebeily that she did not want the baby and was unhappy with the plan to give the child to Mrs. M., said plan being attributed to her partner, G.H.

[122] Ms. Elgebeily had additional contact with the Respondent on March 24th, 2014, at which time the Respondent presented certificates she had earned. Ms. Elgebeily viewed these as helpful, but stressed with the Respondent the importance of focusing on the recommended services of the Minister.

[123] Ms. Elgebeily continued to meet with the Respondent from April to July 15th and 16th, 2014. At the July meeting, the Respondent indicated she considered Mrs. M. to be one of her supports, but stated she was upset with Mrs. M. and was having difficulty trusting her. She said she felt pressured by Mrs. M. but did not want to lose her friendship. The Respondent stated that Mrs. M. threatened to take her to court if she did not go through with the adoption plan. The Respondent referred to Mrs. M. as a "psycho" and disclosed that the M's were abusive to […]. The Respondent stated to Ms. Elgebeily that Mrs. M. should never be given care of a child.

[124] Ms. Elgebeily continued to testify that the Respondent had stated that her partner was insecure about her past and complained that G.H. was controlling. The Respondent told Ms. Elgebeily that G.H. was both verbally and emotionally abusive, and generally disrespectful. Ms. Elgebeily testified that the Respondent subsequently attempted to qualify some of her comments about G.H.

[125] Ms. Elgebeily testified that initially the Minister's concerns were that of substance abuse and domestic violence. She now sees the Respondent more as a mental health concern which, in Ms. Elgebeily's opinion, will take some time to resolve.

[126] Under cross-examination, Ms. Elgebeily acknowledged that since her return from Ontario, the Respondent has cooperated fully with the Minister and that there

"has been a significant change for the better". She testified that the Respondent has gained good insight into her parenting issues and is very committed.

[127] Regarding the Respondent's plan with the M's to adopt the baby, Ms. Elgebeily further acknowledged that there was no evidence it was a sinister plan to "snatch a baby". Ms. Elgebeily referenced the fact that the parties had consulted a lawyer with a view to proceeding by way of private adoption.

[128] Nonetheless, Ms. Elgebeily expressed concern about the willingness of the Respondent to assist the M's with initially artificial insemination and then later, upon learning she was pregnant, with adoption. Ms. Elgebeily testified this conduct has amplified her concerns about the Respondent's mental health, especially when one considered the evidence of the past year for the Respondent, which included, death of her partner, unstable relationship with one J.M., use of drugs, bad influences at […], moving around and concerns about her current partner, G.H.

[129] Ms. Elgebeily testified that currently the Respondent is "putting into practice" the things she is learning from services and programming. The Reports from Mr. Gareri, Addiction Services and Transition House in terms of the Respondent's progress are all very good. Ms. Elgebeily, nonetheless, testified:

> **…If there was a major change we could have reconsidered our position…we feel Ms. U. needs more time to address her issues before entrusting childcare to her…there was a lot of available time wasted and her current progress is good but in early stages…more really needs to happen.**

[130] In addition, Ms. Elgebeily testified there is work to be done with G.H., who has yet to engage in services and programs.

[131] Ms. Elgebeily concluded her evidence by testifying that it would be a risk to place the child, A.U., in the "uncertain environment" of the Respondent.

Donna Mikkelson

[132] Ms. Mikkelson has been a Child and Case Worker for eight (8) years and overall has worked in the protection field for fourteen (14) years.

[133] Ms. Mikkelson testified that the child, A.U., is a "happy, healthy and very active" baby. The child is making progress, but not without her challenges, both physically and developmentally.

[134] Ms. Mikkelson confirmed the Minister's plan for A.U. is one of permanent care with no access since access would impede the adoption process. The adoption process will help the child settle more; to achieve permanency; and move on with her life with her new adoptive parents.

Dr. Neil Christians

[135] Dr. Christians was qualified to give expert evidence in the field of general psychiatry (see Exhibit #10). He has practiced psychiatry for twenty-eight (28) years and first met with the Respondent on July 25, 2012 as a crisis admission. He subsequently saw the Respondent on March 20, 2013; April 4, 2013; April 5, 2013; April 18, 2013; April 26, 2013; June 2, 2014; July 7, 2014; August 18, 2014; September 16, 2014; and October 6, 2014. During the course of his evidence, Dr. Christians referenced Exhibit(s) #11, 12, 13, 14(a) and 14(b).

[136] Dr. Christian testified that the Respondent has had a history of depression, anxiety and attempted suicide, but has no suicidal thoughts at this time. He testified that her child was taken into care due to concerns about substance abuse and domestic violence.

[137] Upon the death of her husband, D.R., in April 2013, the Respondent was "acutely distressed" and as a result was referred to counselling by Dr. Christians.

[138] Although Dr. Christians was supportive of the Respondent moving back to Ontario where she had more support, the decision to leave by the Respondent was not discussed with the doctor. As a result, he did not see the Respondent again until June 2, 2014. In his report dated July 22, 2014, (Exhibit #12), Dr. Christians stated at page 4:

> **She is still struggling with insight concerning her mental disorders.**

[139] The doctor stated his "impression" at page 4 of his report as follows:

> **The assessment is of a lady who has had an extremely difficult childhood, numerous traumatic events, has a history of co-morbid Generalized Anxiety, Social Anxiety, Attention Deficit with Mood Disorders with no clear identified type of mood disorder. She reports substances, last being 2013, and now struggling with her mental disorders as described above.**

[140] The doctor states his opinion and recommendation at pages 4-5 as follows:

> **This lady has significant undiagnosed and untreated psychiatric conditions. The undiagnosed condition would be the type of depression, whether it is Major Depression, Cyclothymia or Bipolar. This will be addressed by collecting information over a period of time and watching her mood disorder. She is presently depressed and is on Prozac (low dose) in the meanwhile just to "tie her over" during the pregnancy. She has untreated Attention Deficit, Hyperactivity, Generalized Anxiety, Social Anxiety, as well as Cluster B Personality Traits.**
>
> **In other words, she has not had proper adequate psychiatric treatment at the present moment. The previous visits were usually crisis events.**
>
> **…**
>
> **I would recommend that she be followed up regularly by psychiatry to address the conditions as described above…**

[141] In Dr. Christians' Report dated August 18, 2014, and marked as Exhibit #14(a), he states:

> **E.U. reports that she still has mood swings. She is now in the present circumstances, her relationship has his own issues [sic]. He is almost very controlling, doesn't give her the element of freedom. Unfortunately, he is also smoking cannabis. So far the pregnancy seems to be going reasonably well. They go to court the 2nd and 3rd of September.**
>
> **…**
>
> **She is depressed with mood swings, with elements of Depression, that is down days, feeling worthless, useless, but no suicidal thoughts.**

[142] Exhibit #14(b) identifies Dr. Christians report dated September 16, 2014. He states:

> **…She is still connected with R. [G.H.] who is also coming for help here. He recognizes he has his own issues.**
>
> **She comes in generally pleasant, heavily pregnant; makes good eye contact and tearful when she speaks about the previous relationship with D.(R.). She still has features of Post-Traumatic Stress related to that. She still has more down days than up days and worried about the future.**
>
> **She is still depressed major (moderate in nature). One is not sure how much is Bipolarity, Cyclothymia but will address it appropriately.**

[143] And, Dr. Christians' final written report is dated October 5, 2014 and marked Exhibit #13. (The Respondent has since given birth.)

> **…She comes over as pleasant, interactive, emotionally responsive, not significantly depressed, almost frustration which is understandable especially with what she is going through at the present moment. She is clearly overwhelmed with what is actually happening. In some ways she is fighting for the lives of the children…**

[144] Dr. Christians testified that the Respondent is now compliant with her medications and appointments. She is "fully engaged" and the doctor has seen a change in the Respondent. She is learning more about the conditions and has more direction and purpose in her life.

[145] Dr. Christians testified that it will be 3-6 months before the Respondent can recommence her medication because she is presently breastfeeding her newborn baby. He expects continued treatment will take 1-2 years. He testified:

> **People can change their lives completely.**

Respondent's Evidence

Lisa Carr

[146] Ms. Carr has been employed by the Cape Breton Place Family Resource Centre for seven and one-half (7 ½) years. She has experience in the field dating back twenty (20) years, providing parent education.

[147] The Respondent has attended fourteen (14) Parent Connection Sessions up to July 15, 2014. Ms. Carr found the Respondent to be appropriate and engaged well in the sessions. She testified:

> **She was no different than anyone else in the group.**

[148] Exhibit #2 represents the Respondent's Certificate of Participation dated May 2014, which confirms she attended fourteen (14) sessions from January 28th to July 15, 2014 on Discipline, Nutrition, Helping Kids Cope With Stress, Dental Hygiene, Home Safety, Summer Safety, Attention Deficit Disorder, Car Seat and Booster Seat Safety and Bullying.

Heather Lynn Gouthro

[149] Ms. Gouthro has worked at Transition House for twelve (12) years, the last three (3) of which she has acted as the Outreach Coordinator. She works with

women on a one-on-one basis and deals with the issue of domestic violence, anger awareness and the effects of domestic violence on children.

[150] The Respondent was a self-referral who first met Ms. Gouthro on January 7, 2014. The Respondent completed the Domestic Abuse Program, which included sessions on domestic violence, healthy relationships, boundaries, red flags for relationships, cycle of abuse, power and control and abusive relationships. The sessions were conducted from January 28 - March 5, 2014.

[151] Ms. Gouthro described the Respondent's level of engagement and participation as "excellent". Ms. Gouthro testified:

> **…you could tell she absorbed a lot of information.**
>
> **…she learned a lot from this program.**

[152] Ms. Gouthro testified that the Respondent took the course for a second time, which demonstrated to her a high level of commitment by the Respondent.

E.U., the Respondent

[153] The Respondent is twenty-six (26) years of age and is the mother of five (5) children. Three (3) of her older children reside with family as a result of child welfare proceedings in the jurisdiction of Ontario. The fourth child, A.U., is the subject of this proceeding. Her fifth child is a newborn, who was taken into care by the Minister at birth in September, 2014.

[154] The Respondent had a difficult childhood, which included abuse and drug use. She experimented with marijuana at age fourteen (14) and began her heavy use of cocaine/crack cocaine at age twenty (20). Her mother was also an addict and she had provided the Respondent with drugs.

[155] The Respondent's marriage to D.R. was one of domestic violence and continued drug abuse. It is apparent that Mr. R's death in April, 2013, although traumatic, was the triggering factor in the Respondent's decision to change her life around in a dramatic way. The Respondent testified that she has been drug free since July 2013, except for some marijuana use in October 2013.

[156] The Respondent testified that she now has a "brighter outlook" on life and realizes how much she has going for her without drugs and violence in her life. Since her return to Cape Breton on December 17, 2013, the Respondent has

immersed herself in services and programs, some recommended by the Minister and others by way of self-referral (see Exhibit #16).

[157] The Respondent testified:

Now I look forward to services…I use to dread it.

[158] The Respondent believes she now has a "very strong" support network which she did not have previously.

[159] The Respondent testified that she feels she can be a capable parent and there should be no concerns about placing A.U. in her care. She testified:

…I came back because of A.U.

…That little girl has changed my life a lot.

…Not a day goes by I don't think about her.

[160] Under cross-examination, the Respondent acknowledged her past history of child neglect, domestic violence, drug abuse, attempted suicide and prostitution. She made no effort to condone what she did and admitted it was a mistake and that she exercised bad judgment.

[161] When questioned about the arrangements made with the M's regarding artificial insemination and adoption, the Respondent testified:

I thought at the time it was a good idea.

[162] The Respondent did not specifically recall conversations with Ms. Elgebeily and Ms. McCormick, but did not dispute that she referred to Mrs. M. as "psycho" and "crazy". The Respondent agreed that she had said some terrible things about Mrs. M. She testified:

I did and I'm truly, truly sorry.

[163] Regarding her current partner, G.H., it was suggested to the Respondent that he was verbally and emotionally abusive. The Respondent testified:

…We are working on that.

…We are getting better at this.

[164] The Respondent was finally questioned about her mental wellness. She testified:

> **I do admit there are some issues I have to work on.**

Minister's Submissions

[165] The Minister submits, as noted in their Post-Hearing Submissions dated November 24, 2014, as follows:

* That the burden of proof upon the Minister is upon a balance of probabilities;

* That the evidence must always be sufficiently clear, convincing and cogent to satisfy the balance of probabilities test;

* That at a Status Review Hearing, it is not the Court's function to retry the original protection finding, but rather, the Court must determine whether the child continues to be in need of protective services;

* That in reaching a decision regarding the future care of the child, the Court must be guided by the child's best interest.

* That the decision by the Court, with agreement of counsel, to exceed the statutory timeline of July 19, 2014, was necessary to complete the evidence and in the best interests of the child.

* That the Respondent was encouraged by the Minister to engage in services with Addiction Counselling and Mental Health Services.

* That the Respondent had minimal engagement with these services and had initially reported she was drug free since July 2012, which is not consistent with the expert evidence of Mr. Joe Gareri.

* That the obligation of the Minister to provide reasonable services is not without limit.

* That the Minister took reasonable measures to provide services to the Respondent which meets its obligation under s. 13(1) of the Legislation.

* That the Respondent left the province in July, 2013 and did not return until December, 2013, during which time she had no access with the child, A.U.

* That the Respondent did not engage in services until January, 2014, but all reports are positive with regard to her efforts to address her issues and addictions.

* That the protection concerns of the Minister are domestic violence, substance abuse and mental health concerns.

* That the Respondent has a history of involvement with child welfare authority dating back to 2007 and 2011.

* That the Respondent's three (3) older children were apprehended at birth in Ontario for similar concerns regarding domestic violence and drug use, which resulted in permanent care placements.

* That the Respondent now acknowledges her past history of domestic violence and drug use.

* That the Respondent further acknowledges that her relationship with D.R., the father of A.U., was also drug and violence based.

* That the Respondent's subsequent relationship, after D.R.'s death, with J.M., from July – September, 2013, again placed her in an environment of domestic violence and drug use.

* That in July, 2014, the Respondent reported concerns about her current partner, G.H., citing examples of verbal and emotional abuse.

* That the Respondent now reports her relationship with G.H. has improved, but this is not consistent with the evidence of Dr. Christians, who testified the Respondent referred to G.H. as being "controlling" as late as August, 2014.

* That the Respondent has a history of failed relationships and the Minister has concerns about the stability of her relationship with G.H.

* That it appears that the Respondent does not yet have the ability to identify the healthy and unhealthy aspect of her relationships.

* That the Respondent does not show an appropriate understanding of her addiction issues and has not completed the services outlined in her treatment plan at the time of trial.

* That domestic violence has been a recurrent problem throughout the Respondent's involvement with child protection agencies.

* That the Respondent's mental health concerns still remain unaddressed.

* That Dr. Christians testified the Respondent had significant undiagnosed and untreated psychiatric condition.

* That Dr. Christians testified it may take six (6) months to clarify the Respondent's current diagnosis and determine the appropriate treatment plan.

* That Dr. Christians has, as yet, an incomplete picture of the Respondent's mental health situation and the risks that this may pose to a child in her care.

* That the Respondent has been dishonest with her treating physician, medical staff and service providers with regard to her use of drugs, relationships and mental health issues.

* That the Respondent has shown no capacity to act in a manner that she could be trusted to ensure the child's physical, mental and emotional needs are being met.

* That risk of physical and emotional harm from the Respondent's issues of domestic violence, drug use and mental health concerns continues to be a real and present risk for a child in the Respondent's care at the present time.

* That the outstanding protection concerns remain unchanged and, until addressed, relapse into addictions and domestic violence remains a palpable risk.

* That it is acknowledged the Respondent's level of engagement in services since January 2014 has been excellent and that significant progress has been made to date, particularly, with the risk associated with the Respondent's drug use.

* That the Respondent, nonetheless, still requires more services and treatment to successfully reduce or eliminate the Minister's risk concerns.

* That the Minister's concerns are unlikely to change with a reasonably foreseeable time.

* That the child, A.U., remains in need of protective services.

* That this proceeding has reached the end of the available time pursuant to the legislation and a permanent placement for A.U. in a family setting is necessary to provide stability in the child's life.

* That it is in A.U.'s best interest to be placed in the permanent care and custody of the Minister for the purposes of adoption, with no provision for access.

Respondent's Submissions

[166] The Respondent submits in the post hearing submissions dated December 12, 2014, as follows:

* That Ms. U. successfully made all of the changes and completed all of the services requested of her by the Minister.

* That ongoing treatment does not make Ms. U. a risk to parent her child.

* That there is no evidence that Ms. U. cannot look after A.U., despite having anxiety and moderate depression.

* That the submission of the Minister that Ms. U. was diagnosed with borderline personality is not accurate and should be disregarded by the Court.

* That Ms. U. has given up her addiction to drugs and, in particular, her addiction to cocaine.

* That Ms. U. has successfully completed all services requested by the Minister, she has a loving bond with her daughter, she has suitable living arrangements and she has learned to find community support with parenting.

* That since Ms. U's return to Nova Scotia in December 2013, the evidence is she was committed and focused during sessions with Addiction Services.

* That Ms. U's participation in counselling for domestic violence was excellent.

* That Ms. U. made good efforts to get to see Dr. Christians.

* That systemic delays in acquiring mental health treatment are not the fault of Ms. U.

* That Ms. U. is now participating in her treatment plan.

* That the Minister's desire to have Ms. U. undertake treatment for a longer period of time is not sufficient reason to place the child in the permanent care of the government.

* That Dr. Christians testified that Ms. U. is not a risk to herself or any other person.

* That Dr. Christians testified that Ms. U. was showing insight into her condition and that she was fully engaged and that he expected her to continue on that path.

* That the Minister dragged its feet providing any services when Ms. U. returned from Ontario.

* That Ms. U. sought services on her own initiative and was very committed to same.

* That it is not logical for the Minister to argue that Ms. U. has to complete more counselling before her child can be returned.

* That the Minister does not give enough weight to the fact Ms. U. has overcome her addiction, and this, along with her commitment to be a good parent to her daughter, and her commitment to mental health services, has led to a sufficient reduction of the risk of placing the child in her care.

* That Ms. U., in spite of the gap in time from July to December, 2013, made the changes required and sufficiently reduced the risk to have A.U. placed in her care.

* That Ms. U. was a sincere and truthful witness.

* That the Court can be satisfied that Ms. U. has sufficiently reduced the risk of having A.U. placed in her care.

* That the Court should give no weight to the artificial insemination story because there was no maliciousness intended.

* That the Minister has not made out a case for permanent care.

* That the Minister has not discharged the heavy burden upon it.

* That the child, A.U., should be returned to Ms. U.'s care.

* In the alternative, should the court award permanent care, access should continue until the time of any adoption.

The Law

Burden of Proof

[167] The burden of proof is on a balance of probabilities, which is not heightened or raised because of the nature of the proceeding. In the case of **F.H. v. McDougall,** [2008] 3 S.C.R. 41, the Supreme Court of Canada held at paragraph 40:

> **Like the House of Lords, I think it is time to say, once and for all in Canada there is only one civil standard of proof at common law and that is proof on a balance of probabilities. Of course, context is all important and a judge should not be unmindful, where appropriate, of inherent probabilities or improbabilities or the seriousness of the allegations or consequences. However, these considerations do not change the standard of proof.**

[168] And further at paragraph 45 and 46:

> **45. To suggest that depending upon the seriousness, the evidence in the civil case must be scrutinized with greater care implies that in less serious cases the evidence need not be scrutinized with such care. I think it is inappropriate to say that there are legally recognized different levels of scrutiny of the evidence depending upon the seriousness of the case. There is only one legal rule and that is that in all cases, evidence must be scrutinized with care by the trial judge.**
>
> **46. Similarly, evidence must always be sufficiently clear, convincing and cogent to satisfy the balance of probabilities test. But again, there is no objective standard to measure sufficiency. In serious cases, like the present, judges may be faced with evidence of events that are alleged to have occurred many years before, where there is little other evidence than that of the**

> **plaintiff and defendant. As difficult as the task may be, the judge must make a decision. If a responsible judge finds for the plaintiff, it must be accepted that the evidence was sufficiently clear, convincing and cogent to that judge That the plaintiff satisfied the balance of probabilities test.**

[169] The burden of proof is on the Minister to show that the Permanent Care and Custody Order is in the child's best interest.

Test on Statutory Review

[170] The Supreme Court of Canada set out the test to be applied on statutory Review Hearings in child protection proceedings in the **Catholic Children's Aid Society of Metropolitan Toronto v. C.M.,** [1994] S.C.J. No. 37 (SCC), where the Court held that, at a Status Review Hearing, it is not the Court's function to retry the original protection finding, but rather the Court must determine whether the child continues to be in need of protective services. Writing for the majority, L'Heureux-Dube, J. stated as follows at paragraphs 35, 36, and 37:

> **35. It is clear that it is not the function of the status review hearing to retry the original need for protection order. That order is set in time and it must be assumed that it has been properly made at that time. In fact, it has been executed and the child has been taken into protective by the respondent society. The question to be evaluated by courts on status review is whether there is a need for a continued order for protection...**
>
> **36. The question as to whether the grounds which prompted the original order still exist and whether the child continues to be in need of state protection must be canvassed at the status review hearing. Since the Act provides for such review, it cannot have been its intention that such a hearing simply be a rubber stamp of the original decision. Equal competition between parents and the Children's Aid Society is not supported by the construction of the Ontario legislation. Essentially, the fact that the Act has as one of its objectives the preservation of the autonomy and the integrity of the family unit and that the child protection services should operate in the least restrictive and disruptive manner, while at the same time recognizing the paramount objective of protecting the best interests of children, leads me to believe that consideration for the integrity of the family unit and the continuing need of protection of a child must be undertaken.**
>
> **37. The examination that must be undertaken on a status review is a two-fold examination. The first one is concerned with whether the child continues to be in need of protection and, as a consequence, requires a court order for his or her protection. The second is a consideration of the best interests of the child, an important and, in the final analysis, a determining**

> **element of the decision as to the need of protection. The need for continued protection may arise from the existence or the absence of the circumstances that triggered the first order for protection or from circumstances which have arisen since that time.**

Legislation

[171] The Court must consider the requirements of the *Children and Family Services Act*, S.N.S. 1990, c. 5 in reaching its conclusion. I have considered the preamble which states:

> **AND WHEREAS children are entitled to protection from abuse and neglect;**
>
> **AND WHEREAS parents or guardians have responsibility for the care and supervision of their children and children should only be removed from that supervision, either partly or entirely, when all other measures are inappropriate;**
>
> **AND WHEREAS children have a sense of time that is different from that of adults and services provided pursuant to this Act and proceedings taken pursuant to it must respect the child's sense of time.**

[172] I have also considered ss. 2(1) and 2(2) which provide:

> **Purpose and paramount consideration**
>
> **2(1) The purpose of this Act is to protect children from harm, promote the integrity of the family and assure the best interests of children.**
>
> **2(2) In all proceedings and matter pursuant to this Act, the paramount consideration is the best interests of the child.**

[173] I have considered the relevant circumstances of s. 3(2), which provide:

> **3(2) Where a person is directed pursuant to this Act, except in respect of a proposed adoption, to make an order or determination in the best interests of a child, the person shall consider those of the following circumstances that are relevant:**
>
> > **(a) the importance of the child's development of a positive relationship with a parent or guardian and a secure place as a member of a family;**
> >
> > **(b) the child's relationship with relatives;**
> >
> > **(c) the importance of continuity in the child's care and the possible effect on the child of the disruption of that continuity;**

(d) the bonding that exists between the child and the child's parent or guardian;

(e) the child's physical, mental and emotional needs, and the appropriate care or treatment to meet those needs;

(f) the child's physical, mental and emotional level of development;

(g) the child's cultural, racial and linguistic heritage;

(h) the religious faith, if any, in which the child is being raised;

(i) the merits of a plan for the child's care proposed by an agency, including a proposal that the child be placed for adoption, compared with the merits of the child remaining with or returning to a parent or guardian;

(j) the child's view and wishes, if they can be reasonable ascertained;

(k) the effect on the child of delay in the disposition of the case;

(l) the risk that the child may suffer harm through being removed from kept away from, returned to or allowed to remain in the care of a parent or guardian;

(m) the degree of risk, if any, that justified the finding that the child is in need of protective services;

(n) any other relevant circumstances.

[174] I have considered the relevant provisions of s. 22, and in particular s. 22(1) and s. 22(2)(b) of the *Children and Family Services Act*, which state:

Child in need of protective services

22(1) In this Section, "substantial risk" means a real chance of danger that is apparent on the evidence.

(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 (a). Subsection (a) states as follows:

(a) The 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.

[175] In addition, the Court has reviewed and considered s. 9 and s. 13 of the *Act*, which respectively state:

Functions of Agency

9. The functions of an agency are to:

(a) protect children from harm;

(b) work with other community and social services to prevent, alleviate and remedy the personal, social and economic conditions that might place children and families at risk;

(c) provide guidance, counselling and other services to families for the prevention of circumstances that might require intervention by an agency;

(d) investigate allegations or evidence that children may be in need of protective services;

(e) develop and provide services to families to promote the integrity of families, before and after intervention pursuant to this Act;

(f) supervise children assigned to its supervision pursuant to this Act;

(g) provide care for children in its care or care and custody pursuant to this Act;

(h) provide adoption services and place children for adoption pursuant to this Act;

(i) provide services that respect and preserve the cultural, racial and linguistic heritage of children and their families;

(j) take reasonable measures to make known in the community the services the agency provides; and

(k) perform any other duties given to the agency by this Act or the regulations, 1990, c. 5, s. 9.

Services to Promote Integrity of Family

13(1) Where it appears to the Minister or an agency that services are necessary to promote the principle of using the least intrusive means of intervention and, in particular, to enable a child to remain with the child's parent or guardian, the Minister and the agency shall take reasonable measures to provide services to families and children that promote the integrity of the family.

(2) Services to promote the integrity of the family include, but are not limited to, services provided by the agency or provided by others with the assistance of the agency for the following purposes:

(a) improving the family's financial situation;

(b) improving the family's housing situation;

(c) improving parenting skills;

(d) improving child-care and child-rearing capabilities;

(e) improving homemaking skills;

(f) counselling and assessment;

(g) drug or alcohol treatment and rehabilitation;

(h) childcare;

(i) mediation of disputes;

(j) self-help and empowerment of parents whose children have been, are or may be in need of protective services;

(k) such matters prescribed by the regulars. 1990, c.5, s. 13.

[176] Other relevant sections include ss. 42(1); 42(2); 42(3); 42(4) and 45, which provide as follows:

42(1) At the conclusion of the Disposition Hearing, the court shall make one of the following orders, in the child's best interest:

(a) dismiss the matter;

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

(c) the child shall remain in or be placed in the care and custody of a person other than a parent or guardian, with the consent of that other person, subject to the supervision of the agency for a specified period, in accordance with Section 32;

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

(e) the child shall be placed in the temporary care and custody of the agency pursuant to clause (d) for a specified period and then be returned to a parent or guardian or other person pursuant to clauses (b) or (c) for a specified period, in accordance with Sections 43 to 45;

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

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

(a) have been attempted and have failed;

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

(c) would be inadequate to protect the child.

(3) Where the Court determines that it is necessary to remove the child from the care of a parent or guardian, the Court shall, before making an order for

temporary or permanent care and custody pursuant to clause (d), (e) or (f) of subsection (1), consider whether it is possible to place the child with a relative, neighbour or other member of the child's community or extended family pursuant to clause (c) of subsection (1), with the consent of the relative or other person.

(4) The Court shall not make an order for permanent care and custody pursuant to clause (f) of subsection (1), unless the Court is satisfied that the circumstances justifying the order are unlikely to change within a reasonably foreseeable time not exceeding the maximum time limits, based upon the age of the child, set out in Section 45, so that the child can be returned to the parent or guardian.

Duration of orders

45 (1) Where the court has made an order for temporary care and custody, the total period of duration of all disposition orders, including any supervision orders, shall not exceed

(a) where the child was under six years of age at the time of the application commencing the proceedings, twelve months; or

(b) where the child was six years of age or more but under twelve years of age at the time of the application commencing the proceedings, eighteen months,

from the date of the initial disposition order.

(2) The period of duration of an order for temporary care and custody, made pursuant to clause (d) or (e) of subsection (1) of Section 42, shall not exceed

(a) where the child or youngest child that is the subject of the disposition hearing is under three years of age at the time of the application commencing the proceedings, three months;

(b) where the child or youngest child that is the subject of the disposition hearing is three years of age or more but under the age of twelve years, six months; or

(c) where the child or youngest child that is the subject of the disposition hearing is twelve years of age or more, twelve months.

(3) Where a child that is the subject of an order for temporary care and custody becomes twelve years of age, the time limits set out in subsection (1) no longer apply and clause (c) of subsection (2) applies to any further orders for temporary care and custody. 1990, c. 5, s. 45.

Analysis

Issue 1

[177] **Whether or not the Court has the jurisdiction to exceed the statutory timelines as prescribed in s. 45(1)?**

[178] In **Nova Scotia (Minister of Community Services) v. L.L.P**. [2003] N.S.J. No. 1 (C.A.), at paragraphs 24 and 25, the Nova Scotia Court of Appeal has stated as follows with respect to the legislative time limits:

> **24 The maximum statutory time limits for a proceeding are set out in section 45 of the Act: twelve months for children under six years of age and eighteen months for those between six and twelve years. At the end of these periods a court must either dismiss the proceeding or order permanent care and custody. The time frames within which the proceeding must be resolved are necessarily short in deference to the "child's sense of time", as is recognized in the recitals to the Act:**
>
> > **AND WHEREAS children have a sense of time that is different from that of adults and services provided pursuant to this Act and proceedings taken pursuant to it must respect the child's sense of time;**
>
> **25 The goal of "services" is not to address the parents deficiencies in isolation, but to serve the children's needs by equipping the parents to fulfill their role in order that the family remain intact. Any service-based measure intended to preserve or reunite the family unit, must be one which can effect acceptable change within the limited time permitted by the Act. If a stable and safe level of parental functioning has not been achieved by the time of final disposition, before returning the children to the parents, the court should generally be satisfied that the parents will voluntarily continue with such services or other arrangements as are necessary for the continued protection of the children, beyond the end of the proceeding. Ultimately, parents must assume responsibility for parenting their children. The Act does not contemplate that the Agency shore up the family indefinitely.**

[179] The extensive evidence in these proceedings necessarily required the Court to consider exceeding the statutory time limes as defined by the *Children and Family Services Act.*

[180] As a result, the Court found, with the consent of the parties, that it was in the best interests of the child, A.U., to exceed the statutory time lines to afford the

necessary time for the Respondent, E.U. to present all relevant evidence so as to permit the Court to fairly and properly adjudicate upon the matter.

[181] In the case of **D.G. v. Family and Children Services of Lunenburg County and T.M.C. and C.L.G.** [2006] N.S.J. No. 432, Justice Oland stated at paragraph 17, as follows:

> **17 However, the law is clear that exceeding that time limit does not always constitute an error of law. In Children's Aid Society of Cape Breton-Victoria v. A.M., [2005] N.S.J. No. 132, 2005 NSCA 58, in seeking to overturn an order placing her children in permanent care, the appellant parent argued first, that the judge had no jurisdiction to make a permanent care order once the s. 45(1)(a) time limits had been reached, and second, if the judge had discretion to extend the time, he erred in doing so because he failed to consider whether the extension was in the best interests of the children. Cromwell, J.A. for this court stated:**
>
> > **[28] Turning to the first submission, there was no loss of jurisdiction here. The Court made this clear in Nova Scotia (Minister of Community Services) v. B.F. (2003), 219 N.S.R. (2d) 41 (C.A.); [2003] N.S.J. No. 405 (Q.L.) (C.A.) at paras. 57 and 58 and The Children's Aid Society and Family Services of Colchester County v. H.W. (1996), 155 N.S.R. (2d) 334 (C.A.). The Act contemplates that there will be a judicial determination of the child's best interests. If a time limit, which is a milestone toward that determination, caused the court to lose jurisdiction to determine the child's best interests it would contradict the purpose of the Act. Therefore, the court did not lose jurisdiction by reserving its decision as to disposition for longer than the time limits for temporary care orders under s. 45.**

[182] In my view, it was necessary and appropriate for the Court to exceed the time lines in the best interests of the child. Not to do so would contradict the purpose of the *Act*.

Issue 2

[183] **What is the appropriate Disposition Order in the present circumstances, i.e., permanent care or dismissal?**

[184] I have reviewed and considered the evidence, together with the plans and submissions of the parties. Although I may not have specifically commented on all of the evidence in this decision, I have nonetheless considered the totality of the evidence in reaching this decision.

[185] I have applied the burden of proof to the Minister. There is only one standard of proof, and this proof is on a balance of probabilities, a burden which must be discharged by the Minister.

[186] I have considered the law and legislative provisions of the *Children and Family Services Act.*

[187] According to the legislation, which I must follow, the Court has only two (2) stark options available at this time:

(1) order permanent care, or

(2) dismiss the proceeding and return the children to the Respondent, E.U.

[188] There is no middle ground. As noted by the Nova Scotia Court of Appeal in **G.S. v. Nova Scotia (Minister of Community Services),** [2006] N.S.J. No. 52 (NSCA) at paragraph 20:

> **If the children are still in need of protective services the matter cannot be dismissed.**

[189] The law is clear that should a trial judge conclude at a Disposition Hearing or Disposition Review Hearing in relation to a Temporary Care Order, that circumstances are unlikely to change, the judge has no option ...but to order permanent care. **Nova Scotia (Minister of Community Services) v. L.L.P.,** [2003] N.S.J. No. 1 (NSCA).

[190] The need for protection may arise from the existence or absence of the circumstances that triggered the first order for protection, or from circumstances which have arisen since that time **G.S. v. Nova Scotia (Minister of Community Services)**, [2006] N.S.J. No. 52 (NSCA).

[191] It is not the Court's function to retry the original protection finding, but rather the Court must determine whether or not the child continues to be in need of protective services.

[192] I have scrutinized the evidence with care, and I am satisfied that the evidence of the Minister is sufficiently clear, convincing, and cogent to satisfy the balance of probabilities test. The contention that the Respondent poses a substantial risk of harm or real chance of danger to the child, A.U. has been proven on a balance of probabilities.

[193] I reject the plan put forth by the Respondent, E.U. Although progress has been made, her plan still does not address the long term needs of the child, A.U. I find that A.U. would be placed at substantial risk of harm if returned to her mother's care at this time. The proceeding cannot be dismissed.

[194] E.U.'s plan, in view of her progress to date, is one to which I have given due consideration. The unfortunate reality is that her plan still remains uncertain and speculative. It is not reasonable or realistic to place the child in her mother's care. As well intentioned as E.U. is, she lacks the necessary insight into the parenting skills which will be required for her child.

[195] The evidence with regard to the Respondent's past drug use problem is clear, convincing and cogent. Likewise, the evidence regarding E.U.'s past relationships and ongoing mental health issues is clear, convincing and cogent.

[196] Although the Respondent appears to be increasingly gaining insight into her past and present issues, she currently lacks the necessary insight into how her history of drug abuse and domestic violence, along with her, as yet unresolved, mental health issues impact upon her ability to care for her daughter without risk.

[197] The Respondent's decision to turn her life around began in April 2013, when her husband, D.R., died of a drug overdose.

[198] This, in the Court's view, was the triggering event that has resulted in the Respondent making great strides to address her past issues of drug abuse, domestic violence and mental wellness.

[199] Unfortunately, it was not until January 2014 that the Respondent was able to take the huge step of accepting and participating in services.

[200] The Court accepts that the Respondent may have needed time to grieve the loss of her husband, but her decision to leave Nova Scotia and move back to Ontario for five (5) months was ill advised in the circumstances.

[201] During this period of time, the Respondent further delayed her potential recovery and she became further estranged from her young daughter.

[202] The Respondent's recent commitment and focus to be a mother to her child cannot go unnoticed. Her progress in this regard has been excellent. The Court fully acknowledges and respects the Respondent's efforts in this regard.

[203] Simply put, however, it is too little, too late. The evidence is clear, convincing and cogent that the Respondent is not yet ready to undertake the important and challenging task of parenting. There are too many unresolved issues for her yet to address and I accept Dr. Christians' evidence in this regard.

[204] The Minister submits at page 33 of its Brief, as follows:

> **The fundamental element in Dr. Christian's testimony was that it was going to take a great deal more time to even fully diagnose Ms. U.'s mental health functioning, it was also going to take a great deal more time to stabilize with medication, and then to treat those issues which are not conducive to stabilization through medication, through other therapy.**
>
> **Dr. Christian, in his report and in his testimony, referenced "borderline traits" and the broader classification of "Cluster B Personality traits" which includes borderline personality traits. He could not rule out Borderline Personality. It appears that Ms. U. never disclosed to him that she had a prior diagnosis of Borderline Personality Disorder from Ontario in 2010, although she admitted this in cross-examination. Dr. Christians provided the DSM 5 criteria for Borderline Personality Disorder.**
>
> > **So the characteristics of a borderline personality is it's a pervasive pattern of instability in interpersonal relationships. So it's relationships. It's image. Ah, self…these, ah, image as well as impulsivity. Um and then it needs to be five of the following, okay. Um, a fear of being abandoned. Ah, a pattern of unstable relationships. Um, the emptiness or identity issue that I mentioned. Impulsivity in arears of, um, substances, reckless driving, binge eating. Ah, recurrent suicidal behaviour, um, effective instability in either words or mood swings. Ah, feelings of emptiness. Inappropriate anger or difficulty controlling anger, and um, paranoia, ah, or which is stress related.**
>
> **With or without a diagnosis of Borderline Personality Disorder, these aspects of Ms. U.'s conduct result in a risk to a child in her care.**
>
> **Ms. U. appears to live in the midst of an emotional whirlwind or anxiety and impulses, which results in some alarmingly poor decision making. This is not unusual in dealing with Respondents with borderline personality traits.**
>
> **The Court of Appeal considered a diagnosis of Borderline Personality Disorder and the impact of it on parenting in *K.B. v. Nova Scotia (Community Services)* 2013, NSCA 32.**
>
> **The Respondent, K.B., had two other children prior to the proceedings. She had struggled with alcohol abuse, suicidal ideation and suicide attempts, lack of child supervision and habitual neglect. She had periods of psychiatric**

inpatient treatment. She had periods of sobriety. The two older children were placed permanently in the care of others, in early 2011.

In 2010, K.B. underwent a detox program, and began being followed by a psychiatrist. In May of 2011, K.B gave birth to twins, and the Agency left the twins in her care subject to the Supervision of the Minister, provided K.B. did not relapse into substance abuse. In August, 2011, K.B. slipped once, and the children were taken into care.

A little more than one year later, in September 2012, the court made an order for Permanent Care and Custody.

On Appeal, K.B. argued too much emphasis was placed on the diagnosis of Borderline Personality Disorder, that the court had failed to acknowledge positive change in K.B. which had been noted by service providers, and that the taking of the twins was related to only one lapse with alcohol in August of 2011 and she had remained clean since that time.

Associate Chief Justice Wilson noted at paragraph 12 of his decision (unreported, quoted by the decision by the Court of Appeal at paragraph 46):

> **12… Certainly the substance abuse is most obvious, but the other one is Borderline Personality Disorder. A serious condition to have to live with, and one that is very resistant to change. The result of these two issues, the Borderline Personality Disorder and the substance abuse, explains the rather chaotic life that [K.B.] has experienced and the difficulty that results in her personal relationships….**

The Court of Appeal noted at paragraph 38 to 41:

> **[38] Borderline personality disorder is characterized by a chaotic lifestyle, difficulty with relationships, tendencies to manipulative behaviour and self-injurious conduct or suicidal gestures. It tends to be chronic and stable.**
>
> **[39] There was ample evidence for the trial judge's conclusion that K.B. suffers from borderline personality disorder. *Its importance relates to the behaviour with which it is associated and its resistance to treatment.***
>
> **[40] It is quite true that K.B. had demonstrated progress and was generally co-operative with the Minister and her service providers. But the events of August 25 when she abandoned her infant twins in search of a bar and more alcohol were illustrative of the concern about K.B.'s capacity for relapse which animated the trial judge's decision.**

> **[41] There was additional evidence to sustain the trial judge's concerns. K.B.'s brother testified that K.B. sought to enlist his aid in assuming temporary care of the twins to facilitate their ultimate return to K.B. Although K.B. denied her brother's account, she admitted concealing her plan from the Minister. Her own therapist, Meredith Burns, conceded that this was manipulative and controlling, if not dishonest behaviour. Ms. Power also expressed concern that K.B. was not always honest with her, consistent with manipulative behaviour.**
>
> **(emphasis added)**

The court upheld the decision for permanent care. The impulsive behaviour one year prior to the permanent care finding, and the manipulative behaviour in the months following that, were sufficient to support the trial Judges determination that A child could not safely be placed in K.B.'s care.

[205] The Minister continues at page 40 of its' written Submissions:

> **The Applicant submits that Ms. U. continues to engage in a chaotic lifestyle, exhibits a lack of impulse control and some manipulative behaviour. With the continuation of Ms. U.'s mental health concerns, partially undiagnosed and almost completely untreated, there continues to be a risk to the child, A.U., and she continues to be a child in need of protective services.**

[206] The Court agrees with the Minister's above submission noting that no formal diagnosis of the Respondent, as it relates to borderline personality disorder, has been made to date.

[207] The Court is obligated to assess risk of harm to the child in terms of the present and existing circumstances. I find that risk remains part of the equation in assessing the child's, A.U.'s, best interests.

[208] The Respondent appears to be drug free now. The stability of the Respondent's current relationship remains uncertain, although the Court is encouraged that E.U. and G.H. will remain together as a couple. Both the Respondent and G.H. still have to address issues which remain a concern to the Minister and, indeed, to the Court.

[209] Also, the Respondent's relationship with J.M. is a source of concern to the Court. The arrangements made between the parties to (a) act as a surrogate mother for J.M., which included failed attempts at artificial insemination, without medical

consultation and/or supervision, and (b) private adoption plans for the Respondent's as yet unborn child, are both disturbing and alarming. Accepting the Respondent's submission that no maliciousness was intended, this conduct is, nonetheless, bizarre and demonstrates, at a minimum, poor judgement which does not reflect well on the Respondent's ability to parent.

[210] After reviewing the evidence, I question the very nature and stability of the relationship between the Respondent and J.M. Should it continue, it is a relationship that would not be in A.U.'s best interests to be associated with.

[211] The Respondent's expressed good intentions to improve her life are simply not a sufficient basis upon which the Court can conclude that there has been a reduction or elimination of risk to the child, A.U.

[212] The Respondent's plan appears to the Court to be a work in progress and, therefore, must be rejected at this time. Many positive things have been achieved to date, but the Respondent's work is not yet complete. As a consequence, I am satisfied, on a balance of probabilities, that the child, A.U., would not be free from substantial risk of harm if placed in the environment where E.U. lives.

[213] The time limits in this proceeding have been both exhausted and exceeded. Nothing more can be done pursuant to the legislation to realistically change the existing concerns about the Respondent.

[214] A.U. has never resided in E.U.'s care. She has had sporadic access with E.U., all of which has been supervised.

[215] Ms. U. still has a host of mental health issues, which represent a risk to a child in her care and have not been meaningfully addressed. The evidence is that even addressing the outstanding mental health concerns through medication will require an additional three to six (3-6) months, assuming E.U. is compliant.

[216] While the Respondent has made great strides in addressing her addiction issues and completed programming relating to domestic violence, there continues to be issues of concern.

[217] The outstanding protection concerns relating to mental health remain unchanged, and until the mental health concerns are addressed, relapse into addiction, and domestic violence remains a palpable risk.

[218] I find that E.U. is not capable of assuming the demanding role of parenting at this time. The child, A.U., remains in need of protective services. It is not safe to return A.U. to the Respondent's care.

[219] I find the Order requested by the Minister is the appropriate one having considered the totality of the evidence. I agree with, and accept, the Minister's submissions. It is in the best interests of the child to be placed in the permanent care of the Minister, pursuant to s. 42(1)(f) and s. 47 of the *Act*.

[220] I further find that the circumstances justifying this conclusion are unlikely to change within a reasonably foreseeable time.

[221] Permanent care and custody of A.U. shall, thus, be placed with the Minister in accordance with s. 47, which states as follows:

> **47(1) Where the Court makes an order for permanent care and custody pursuant to clause (f) of subsection (1) of Section 42, the Agency is the legal guardian of the child, and as such, has all the rights, powers and responsibilities of a parent or guardian for the child's care and custody.**

Issue Three

[222] **Should access be provided to E.U.?**

[223] In view of the above finding, I must now consider the issue of access under the pre-conditions enumerated under s. 47(2) of the *Children and Family Services Act* which states:

> **47(2) Where an order for permanent care and custody is made, the court may make an order for access by a parent or guardian or other person, but the court shall not make such an order unless the court is satisfied that:**
>
> > **(a) Permanent placement in a family setting has not been planned or is not possible and the person's access will not impair the child's future opportunities for such placement;**
> >
> > **(b) The child is at least twelve (12) years of age and wishes to maintain contact with that person;**
> >
> > **(c) The child has been, or will be placed, with a person who does not wish to adopt the child; or**
> >
> > **(d) Some other special circumstance justifies making an order for access.**

[224] The Nova Scotia Court of Appeal has held that the onus to show access be granted under an Order for Permanent Care and Custody is upon the person requesting the right of access. In **G.S. v. Nova Scotia (Minister of Community Services)**, [2006] N.S.J. No. 52 (NSCA), Justice Cromwell noted that the access decision contemplated in s. 47(2) of the Act is a "delicate exercise that required the Judge to weight the various components of integrity of the child". Cromwell, J. further commented that the Court must consider the importance of adoption in the presented circumstances of the case and the benefits and risks of making an Order for access. At paragraph 36 he stated:

> **These submissions must be considered in light of three important legal principles. First, I would note that once permanent care was ordered, the burden was on the appellant to show that an order for access should be made: s. 47(2); New Brunswick (Minister of Health and Community Services) v. L.(M.), [1998] 2 S.C.R. 534 at para. 44 and authorities cited therein. Second, I would observe that, as Gonthier, J. said in L.M. at para. 50, the decision as to whether or not to grant access is a "...delicate exercise which requires that the judge weigh the various components of the best interests of the child". It is, therefore, a matter on which considerable deference is owed to the judge of first instance for the reasons I have set out earlier. I would note finally that, in considering whether the appellant had discharged her onus to establish that access ought to be ordered, the judge should consider both the importance of adoption in the particular circumstances of the case and the benefits and risks of making an order for access." [emphasis added]**

[225] The Nova Scotia Court of Appeal has considered s. 47(2) of the *Act* in **Children and Family Services of Colchester County v. K.T.**, [2010], N.S.J., No. 474 (Application for Leave to Appeal to SCC dismissed) at paragraphs 39-41 as follows:

> **Therefore, from my reading of s. 47, three conclusions relevant to this appeal are clear. First, the Agency effectively replaces the natural parents. This puts the onus on the natural parents (or guardian) to establish a special circumstance that would justify continued access. Second, by virtue of ss. 47(2)(a) and (b), an access order must not impair permanent placement opportunities for children under 12. Section 47(2)(c) is consistent with this. It provides that if no adoption is planned then access will be available. This highlights the importance of adoption as the new goal and the risk that access may pose o adoption. Third, for children under 12, the "some other special circumstance" contemplated in Section 47(2)(d), must be one that will not impair permanent placement opportunities.**

> **Therefore, to rely on s. 47(2)(d) as the judge did in this appeal, the (special) circumstances must be such that would not impair a future permanent placement. When then would s. 47(2)(d) apply? Consider for example a permanent placement with a family member which will involve contact with the natural parent. Presuming that the adopting parents would be content with that arrangement, the adoption would not be deterred. See Children's Aid Society of Cape Breton Victoria v. M.H., 2008 NSSC 242 at para. 34.**
>
> **In short, <u>access which would impair a future permanent placement is, by virtue of s. 47(2), deemed not to be in the child's best interest.</u> This presents a clear legislative choice to which the judiciary must defer." [Emphasis added]**

[226] This position is further highlighted by the comment of Chief Justice Michael MacDonald in **K.T.,** *supra*, at paragraphs 47 and 38:

> **Before the issuance of a permanent care order, the legislative focus in on preserving the family unit. This would understandably mean that when the children are in temporary Agency care, parental access is to be encouraged so as to hopefully rehabilitate the family. However, with a permanent care order, the focus shifts. Any hope of preserving the family within the legislated time limits is presumably lost and the focus becomes a stable alternate plan. Thus, upon securing a permanent care order, the Agency under the CFSA effectively becomes the parent:**
>
> > **47(1) Where the court makes an order for permanent care and custody pursuant to clause (f) of subsection (1) of Section 42, the agency is the legal guardian of the child and as such has all the rights, powers and responsibilities of a parent or guardian for the child's care and custody.**
>
> **This provision suggests the termination of the natural parents' relationship with the children. However, in special circumstances, post-permanent care access is possible although given the stark change in focus, such circumstances are rare and limited to those that would not jeopardize the new focus, namely an alternate stable placement. Thus, it is not surprising that the provision allowing for such access is highly restrictive.**

[227] Justice Fichaud in **Nova Scotia (Community Services) v. T.H.,** 2010 NSCA 63 also comments at paragraph 46 therein that after a Permanent Care Order has been issued, there is de-emphasis on family contact and instead priority is assigned to long term stable placement.

[228] Justice Oland in **Mi'kmaw Family and Children's Services v. L.(B.),** [2011] NSCA 104 nonetheless reminds us as follows at paragraph 42:

> **...Section 47(2) does not impose a blanket prohibition against access. Rather, a Judge must consider factors such as the likelihood of impairment of opportunities for permanent placement and whether there are special circumstances which would justify making an access order.**

[229] In this regard, I find there are no special circumstances which would justify the making of an Access Order. The Respondent's submission in this regard is rejected.

[230] The Minister has confirmed its plan to seek permanent placement for A.U. through the process of adoption, with no provision for access. In my view, the awarding of access to the Respondent would impair the contemplated long-term permanent placement, and, thus, by virtue of s. 47(2), I find that access is not in the best interests of A.U.

[231] A.U. is entitled to continuity and stability in her life. Permanent care with no provision for access will achieve this purpose.

Conclusion

[232] The requirements of ss. 42(2), (3) and (4) have been proven to the Court's satisfaction by the Minister.

[233] An Order for Permanent Care and Custody in favour of the Minister will issue, with no provision for access to the Respondent, E.U.

[234] The Court has an obligation to ensure the child's best interests are protected, and that is best achieved with this Order.

[235] Order accordingly.

_____

J.