SUPREME COURT OF NOVA SCOTIA
(FAMILY DIVISION)

Citation: Nova Scotia (Community Services) v. JH, 2013 NSSC 151

Date: 20130510
Docket: SFSNCFSA-076576
Registry: Sydney

Between:

Minister of Community Services

Applicant

v.

JH and WB

Respondents

Editorial Notice

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

Judge:	The Honourable Justice Theresa M. Forgeron
Heard:	March 22 and 28, 2013, in Sydney, Nova Scotia
Written Submissions:	April 5, 2013, Adam Neal April 12, 2013, Alan Stanwick
Oral Decision:	May 10, 2013
Written Decision:	May 13, 2013
Counsel:	Adam Neal, for the applicant Alan Stanwick, for the respondent JH WB, respondent, not participating

By the Court:

[1] **Introduction**

[2] Mental health concerns arising from schizophrenia, OCD, and suicide attempts, coupled with inappropriate relationships and parenting issues resulted in L, an infant, being taken into care by the Minister of Community Services. L's mother, JH, actively participated in these proceedings, while WB, L's father, did not.

[3] At this stage, the Minister is seeking an order for permanent care and custody, with no provision for access. The Minister suggests that no other order is possible because L remains in need of protective services, and the legislative time lines have expired. In contrast, Ms. H states that L is no longer a child in need of protective services because Ms. H's mental health is stable and there are no presenting protection problems. Ms. H urges this court to dismiss the proceedings and return L to her care.

[4] **Issues**

[5] The court will determine the following two issues in this decision:

- Should a permanent care order issue?
- If yes, should access be granted to Ms. H?

[6] **Background**

[7] The Minister became involved with the parties in April 2011. Ms. H was pregnant at the time. A referral, based on Ms. H's attempted suicide, was investigated by the Department of Community Services. Ms. H and Mr. B refused the voluntary services offered by the Minister.

[8] The Minister next connected with the parties after L's birth on *, 2011. The department was investigating the referrals received from hospital staff. No court action, however, was initiated. Ms. H consented to a safety plan that stipulated that neither she, nor Mr. B, would have unsupervised contact with L. Ms. H's mother would primarily be responsible for L, or another suitable adult, should Ms. H's mother be unavailable.

[9] This safety plan was short lived. On July 22, 2011, agency social worker, Wendy Campbell, attended the H residence to investigate a referral. The maternal grandmother was not home. Ms. Campbell found Ms. H to be in a care giving role to two small children, L, and Ms. H's two year old niece, Ha. The two other adults present in the home were sequestered in a bedroom and high on marijuana. Within minutes of Ms. Campbell's arrival, Ms. H severed her wrist with a knife in another suicide attempt. The two young children were immediately apprehended.

[10] The protection finding involving L was entered on November 15, 2011 based on s. 22(2)(b) of the *Children and Family Services Act*. The disposition order of February 6, 2012 confirmed that L would remain in the temporary care and custody of the Minister, a situation which has not changed. This disposition order mandated the following services for Ms. H:

- supervised access;
- participation in family support services, Transition House outreach programming, and mental health counselling;
- psychiatric treatment and medication compliance; and
- forensic testing for drugs and alcohol, coupled with the prohibition against the consumption of alcohol and illegal drugs.

[11] A number of disposition reviews maintained these conditions. The disposition reviews were held on April 30, 2012; June 26, 2012; August 20, 2012; September 18, 2012; and December 5, 2012, although no order appears to have issued for the December 5th hearing. The permanent care hearing was scheduled for January 16, 17, and 18, 2013. The permanent care hearing did not proceed at that time. On January 17, 2013, the matter was adjourned and rescheduled to February 27, 2013. The protection, disposition, and all review hearings were held before Justice Haley.

[12] On February 27, 2013, the court, on its own motion, declared a conflict, and Justice Haley recused himself. I, therefore, was assigned carriage of this matter in mid-March 2013. By the time this matter was scheduled before me, the time lines stipulated in the *Act* had been breached.

[13] The final disposition hearing was scheduled to begin on March 21, 2013, however, Ms. H did not appear in the morning. Mr. Stanwick advised that his client was ill. The trial proceeded on March 22 and 28, 2013. The court heard evidence from Jo-Anne MacCormick, Nicole Sheppard, Ms. Campbell, Ryan Ellis, Dr. Uhoegbu, and Ms. H. Written submissions were prepared by counsel, and the last submission was received on April 12, 2013. The oral decision was rendered on May 10, 2013.

[14] **Analysis**

[15] **Should a permanent care order issue?**

[16] *Position of the Agency*

[17] The Minister seeks a permanent care order because the department states that L continues to be a child in need of protective services. The Minister notes that although services have been completed, circumstances have not changed significantly. From the agency's perspective, mental instability and poor parenting practices continue to raise protection concerns. The Minister states that the only safe and viable option is a permanent care order, without access.

[18] *Position of JH*

[19] Ms. H opposes the Minister's plan. In support of her position, Ms. H notes as follows:

- She completed all services requested of her, including engaging with a family support worker, and is continuing with mental health treatment;

- She discontinued her relationship with Mr. B, which was considered a risk factor in the circumstances;

- She is not abusing alcohol or drugs, and only takes medication that is prescribed for her, and then according to the prescription;

- Dr. Uhoegbu states that Ms. H's mental health is stable. She has responded well to the current treatment and there has been no manifestation of the positive symptoms of schizophrenia for months. Dr. Uhoegbu indicates that Ms. H has generally been compliant with medications, and that she is attending all regularly scheduled appointments;

- There is no significant risk that she will attempt suicide in the future;

- She has been consistent with access; and

- All protection risks have either been reduced or eliminated such that it is safe for L to be returned to her care.

[20] *Discussion of the Law*

[21] When a court conducts a disposition review, the court assumes that the orders previously made were correct based upon the circumstances existing at the time. At a review hearing, the court must determine whether the circumstances which resulted in the original order still exist, or whether there have been changes such that the child is no longer in need of protective services: s. 46 of the *Act*; **Catholic Children's Aid Society of Metropolitan Toronto v. M.(C.)**, [1994] S.C.J. No. 37, at para 37; and **Children's Aid Society of Halifax v. V.(C.)**, [2005] NSJ No. 217 (C.A.) at paras 8 and 9.

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

[23] Further, in making my decision, I must be mindful of the legislative purpose. The purpose of the *Act* is to promote the integrity of the family, protect children from harm, and secure the best interests of children. However, the paramount consideration is always the best interests of the child, as stated in s. 2(2) of the *Act.* The *Act* must be interpreted according to a child centred approach in keeping with

the best interests principle, as defined in s. 3(2) of the *Act.* This definition is multifaceted, directing the court to consider various factors unique to each child, including those associated with the child's emotional, physical, cultural, and social developmental needs, and those associated with risk of harm.

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

[25] *My Decision*

[26] I have reviewed the totality of the evidence, the submissions of counsel, the burden of proof, case law, and the *Act*. Based upon this review, I find that the Minister has discharged the burden of proof. LHB, born *, 2011, continues to be a child in need of protective services. It is in L's best interests that a permanent care order issue.

[27] I will now outline my reasons for this conclusion.

[28] *JH's Mental Health Status*

[29] Although Ms. H's mental health is significantly more stable than when the protection finding was entered, mental health issues will continue to negatively impact on Ms. H's ability to parent L safely. When the protection finding was entered, Ms. H was diagnosed with schizophrenia, of the paranoid type, and OCD. She also had attempted suicide. Two of these mental health conditions do not currently pose protection risks, while the symptoms associated with the other condition have not dissipated to the extent necessary.

[30] I accept that the OCD diagnosis is not a significant concern because it manifests as a trait, and not as a disorder. In explaining this statement, Dr. Uhoegbu noted that Ms. H reports no associated distress with her obsessive compulsive actions. For example, she reports frequently counting steps, but not becoming distressed when climbing stairs. Ms. H's OCD diagnosis does not raise protection concerns.

[31] Further, the Minister did not produce clear, convincing and cogent evidence that Ms. H was currently suicidal. Dr. Uhoegbu stated that it is difficult to predict the likelihood of suicide presenting in any individual. He noted that a diagnosis of schizophrenia does not generally increase the likelihood of suicide. Past suicide attempts, however, raise the risk of potential, future suicide attempts. Despite this statement, there is insufficient evidence before me to conclude that Ms. H will attempt suicide in the near future. Suicide is not a current protection concern.

[32] In contrast, the Minister has proven on a balance of probabilities, that the schizophrenia diagnosis continues to raise protection concerns. Dr. Uhoegbu indicated that Ms. H was diagnosed with schizophrenia. The medical record suggested that Ms. H's schizophrenia may have been induced by past drug abuse which occurred when Ms. H was younger. Dr. Uhoegbu described schizophrenia as a chronic disorder which involves a patient losing "touch with reality." He indicated that schizophrenia has both negative and positive symptoms. Negative symptoms are often associated with a lack of enjoyment for things which previously provided pleasure, personality changes, cognition changes, and a lack of motivation to engage in basic human activities, such as grooming and sociality. Negative symptoms often produce functional impairments. Positive symptoms include such features as delusions and hallucinations. Dr. Uhoegbu noted that schizophrenia is usually not associated with violence. Persons diagnosed with schizophrenia may be stable for a lengthy period of time, and can nonetheless decompensate when presented with stressors, such as substance abuse, relational issues, or social issues.

[33] Dr. Uhoegbu noted that Ms. H has not experienced any positive symptoms of schizophrenia since he assumed carriage of the file in the summer of 2012. The last delusional thoughts were noted by Dr. Rogers in May 2012. I accept that statement. I must, nevertheless, discount some of Dr. Uhoegbu's other comments because he spends limited time with Ms. H, approximately 30 minutes per visit, and because he relies heavily on the self-reports of Ms. H. Ms. H did not mention the seriousness of the presenting symptoms of disconnecting until her last appointment with Dr. Uhoegbu, which occurred in March 2013. Her failure to do so is troubling and underscores Ms. H's lack of insight into the problems associated with her illness.

[34] I find that Ms. H is experiencing serious difficulties which can be attributed to the schizophrenia disorder itself, or which can also be attributed to the medication used to treat the disorder. These difficulties include the following:

- Ms. H continues to regularly disconnect while L is in her care during access visits. I accept the evidence of Ms. MacCormick, the access facilitator, who repeatedly raised this concern with Ms. H. Access visits are scheduled for only 5.5 hours a week. Ms. H exhibited periods of disconnect during 27.05% of the access visits. (Disconnect was noted on 57 occasions during 56 access visits. Ms. H exercised access on 207 occasions). These periods of disconnect varied in duration and scope. Sometimes Ms. H would quickly reconnect after receiving a prompt, and on other occasions, she did not.

- From August 2011 until April 2012, there were 26 instances when Ms. H disconnected during access visits. From May 2012 until March 2013, there were another 31 instances when Ms. H was noted to be disconnected. During Ms. H's lapses, L has hit her face on the floor, chewed inappropriate items, fell over on multiple occasions, and had many mishaps. The direct intervention of Ms. MacCormick resulted in other injuries being circumvented.

- In addition, sedation was another problem exhibited during the access visits. This was likely caused by Ms H's medication. Ms. H fell asleep during seven access visits, the last time being March 1, 2013. Ms. H nearly fell asleep on seven other access visits, the most recent of which occurred on October 17, 2012. Ms. H did not appear to have control over her need for sleep.

[35] Clearly, Ms. H continues to experience symptoms, either from the disease itself, or the medication, or both, which raise protection concerns. Currently, L is only in Ms. H's care for minimal periods, and in a supervised access setting. Within this structured and defined environment, L had many mishaps and many potential mishaps. I find that if L was returned to Ms. H's unsupervised care, L would, on a balance of probabilities, suffer physical harm caused by Ms. H's failure to provide L with adequate supervision and protection. There continues to be a substantial risk of harm that is apparent on the evidence, as stated in secs. 22(2)(b) and 22(1) of the *Act*.

[36] I recognize that Dr. Ohoegbu has not observed Ms. H disconnecting in his presence. Ms. H, however, is nonetheless doing so during access visits. Ms. MacCormick gave credible, unbiased, and professional evidence. Further, Ms. H readily admitted that her friends have also noticed her staring off. Ms. H stated that Dr. Ohoegbu would also likely observe this feature if she spent more time in his presence.

[37] *Other Protection Concerns*

[38] Further, other protection concerns exists. They are as follows:

- Ms. H lacks meaningful insight into the nature of the original and ongoing protection concerns. Because Ms. H lacks insight, she has not been able to effect the lasting changes that are required. For example, when questioned about the night of L's apprehension, Ms. H had great difficulty admitting the existence of any protection concerns. She saw no problem with Ms. C. and Mr. G., who were ostensibly in charge, smoking marijuana, although Ms. H said that Mr. G. was not high. Ms. H reasoned that she never saw anyone hurt another person while high on marijuana. Ms. H said that although she knew that Ms. C. was a user, she did not tell her to smoke a joint. She also said that infant L and her two year old cousin were asleep, so it did not matter that the other adults were unavailable to provide care. Ms. H minimized the dangers that existed on the night of the apprehension.

- Ms. H did not cognitively retain the information that she received from the family support worker. This is likely due to the fact that Ms. H regarded the family support worker's task as unnecessary. Ms. H thought a family support worker had been assigned because she was a new mother. Ms. H was not initially cooperative with the family support worker. Most importantly, when asked about what the family support courses entailed, Ms. H was only able to identify one of the five booklets she said were reviewed. Ms. H could not identify most of the particulars of the sessions.

- Ms. H does not have a viable support plan. No family members or friends testified on Ms. H's behalf. Ms. H was living with her mother at the time of trial, although the evidence indicated her potential move away from the area. Ms. H's mother is not an appropriate support person because she too was involved in recent child protection proceedings. The niece, Ha, was in the care of Ms. H's mother. Ha was placed in the permanent care of the agency because of ongoing protection concerns associated with Ms. H's mother.

- Ms. H named other potential support persons. These persons were not viable based upon the evidence presented by Ms. H. The great grandmother is older and suffers from a number of infirmities. The aunt appears to be busy with her own life, and likely would be unavailable to the extent required to reduce the existing protection concerns. Further, neither testified as to their consent.

- Ms. H associates with people who likely are not good role models and who could create protection issues. For example, Ms. H saw no difficulty with Ms. C. or her boyfriend, Mr. G. being in the home with L in July 2011. On March 21, 2013, Ms. H also initiated an inappropriate verbal altercation with another man while in Tim Hortons, with L and the access facilitator. In addition, on February 26, 2013, Ms. H told Ms. MacCormick about a man who had to be "banished from their kingdom" because of his conduct at the H residence. Ms. H told Ms. MacCormick that her boy friend was on pills on November 2, 2012, and that she had to break up with her boyfriend when she discovered that he was on the sex abuse register on November 30, 2012. Further, on March 12, 2013, Ms. H told Ms. MacCormick that Ms. H's medication was stolen from her residence without any explanation as to how such occurred.

- Ms. H minimized the protection concerns associated with her disconnecting. She did not appreciate the substantial risk of harm that L could experience during her periods of disconnect. Ms. H reasoned that no-one could supervise their child "24/7" in any event. This lack of insight is deeply troubling and indicates that Ms. H cannot be trusted to develop an acceptable safety plan for L given

> these circumstances. Ms. H's minimization is also found in her failure to disclose to Dr. Uhoegba until March 2013, the many times that she was disconnecting while exercising access.

[39] In addition, the court is unable to assess the state of Ms. H's home environment because protection workers were denied entrance since approximately the summer of 2012. Ms. Sheppard had previously noted safety concerns related to a lighter, overflowing ashtrays, and clutter.

[40] *Summary*

[41] The above problems, combined with Ms. H's presenting mental health concerns, confirm that L continues to be a child in need of protective services. Whether changes in the administration of Ms. H's medication will produce positive outcomes is unknown and speculative. Ms. H should have discussed the ongoing problems identified during her exercise of access with Dr. Uhoegbu earlier than March 2013. She did not. The court must make a decision now. Legislative time lines have expired. It is in L's best interests to have the permanent care finding entered so that permanency planning can begin. The minister's application is granted.

[42] **Should access be granted to Ms. H?**

[43] The Minister is proposing adoption. Ms. H would like continued contact.

[44] Section 47(1) of the *Act* states that once an order for permanent care and custody issues, the agency becomes the legal guardian of the child, and has all the rights, powers, and responsibilities of a parent for the child's care and custody. Section 47(2) of the *Act* provides the court with the authority to make an order for access in limited circumstances: **Children & Family Services of Colchester (County) v. T. (K.)**, 2010 NSCA 72 (N.S.C.A.), at paras 40 to 42. In **Nova Scotia (Minister of Community Services) v. H. (T.)**, 2010 NSCA 63 (N.S.C.A.), Fichaud, J.A., states that after a permanent care order has issued, there is a de-emphasis on family contact, and instead priority is assigned to long-term stable placement at para. 46.

[45] It is in the best interests of L to be adopted. Access between L and Ms. H will therefore be terminated, subject to a final visit. It is in L's best interests to have a permanent home with a loving family who can provide an environment free from child protection concerns. Adoption is not possible if access is ordered. The Minister is free to pursue adoption, as the agency has stated in its plan. L is adoptable. L deserves the stability, love, nurture, and structure of a permanent family and home.

[46] **Conclusion**

[47] The Ministers's application for permanent care and custody is granted in L's best interests. There will be no provision for access so that adoption planning can proceed. Mr. Neal is to draft the order.

Forgeron, J.