SUPREME COURT OF NOVA SCOTIA
FAMILY DIVISION

Citation: *Nova Scotia (Community Services) v. G.M.*, 2021 NSSC 186

Date: 2021-05-31
Docket: *SFT.* No. 118470
Registry: Truro

Between:

Minister of Community Services

Applicant

v.

G.M. and J.R.

Respondents

and

T.R., by guardian *ad litem*, Harvey Bate

Party

Restriction on Publication: Pursuant to s. 94(1) of the *Children and Family Services Act,* S.N.S 1990, c.5.

Judge:	The Honourable Justice S. Raymond Morse
Heard:	April 12, 16, 19, 2021 in Truro, Nova Scotia
Counsel:	S. Gerami, for the Minister of Community Services P. Boubnov, for the Respondent, G.M. J.R., Self-represented K. Killawee, for the Guardian *ad litem*, Harvey Bate

By the Court:

Introduction

[1] The Respondents are the parents of T.R., born in 2005, hereinafter referred to as "T.".

[2] T. identifies himself as a transgender male.

[3] T. was taken into care by the Minister on June 19, 2020.

[4] A protection application was commenced pursuant to Notice of Child Protection Application dated June 24, 2020 by which the Minister maintained that T. was in need of protective services pursuant to subparagraphs (g) and (ka) of s.22(2) of the *Child and Family Services Act*, (hereinafter referred to as the *CFSA*).

[5] T. had been the subject of a prior protection proceeding that was concluded by way of a termination order granted May 6, 2020. At time of termination the Court also granted an order pursuant to the *Parenting and Support Act* placing T. (then known as J.R.) in the primary care and custody of his father. T.'s placement with his father had broken down as of June 19, 2020.

[6] Following commencement of the new protection proceeding, Harvey Bate was appointed as Guardian *ad litem* for T. Mr. Bate had also acted as Guardian *ad litem* for T. in the prior protection proceeding.

[7] Pursuant to a Notice of Motion for Disposition order dated September 3, 2020 the Minister requested an order for permanent care and custody.

[8] T.'s father, J.R. was self represented throughout the proceeding. J.R. consistently indicated his willingness to consent to an order for permanent care and custody.

[9] T.'s mother, G.M., consistently indicated her opposition to permanent care and custody and proposed a plan of care whereby she would assume responsibility for the day-to-day care and custody of the child.

[10] At the initial disposition hearing held November 19, 2020 the court granted an order for temporary care and custody and scheduled the matter for contested final review hearing on February 8 and 10 and March 2 and 3, 2021.

[11] A pre-hearing conference was held on January 28, 2021. The court confirmed that it was no longer possible to proceed on the dates that had been previously assigned and that new dates would be required. The existing trial dates were vacated and the matter was scheduled for contested final review hearing on April 12, 16, 19 and 20, 2021. The court confirmed that the existing order for temporary care and custody would remain in force and effect pending the determination of the Minister's application for permanent care and custody.

[12] G.M. did not personally participate in the January 28, 2021 pre-hearing but was represented by her counsel, who advised that he was having difficulty contacting his client.

[13] A further pre-hearing was held March 25, 2021. G.M.'s counsel advised that he had still not had the opportunity to speak directly with G.M., but shortly thereafter G.M. joined the pre-hearing conference call. The court informed G.M. that the matter would be proceeding to a final review hearing commencing April 12, 2021. The court reviewed the COVID-19 protocols relating to an in-person hearing and encouraged G.M. to contact her counsel as quickly as possible.

[14] The matter proceeded to final review hearing on April 12, 2021.

Review of evidence

[15] Prior to the commencement of the final review hearing the Respondents and Guardian *ad litem* consented to the Minister's request for an order pursuant to s.96(1) whereby evidence from the prior protection proceeding would be admitted as evidence in the current proceeding.

[16] The court granted the Minister's request for a s.96 order subject to the condition that the Respondents and the Guardian *ad litem* would have the right to require any affiant to any affidavit filed during the course of the prior proceeding, as well as the author of any report submitted during the course the prior proceeding, to be made available for cross-examination.

[17] Exhibit Book 3 as filed on behalf of the Minister contained the evidence from the prior proceeding.

[18] Neither respondent required the attendance of any affiant of any of the affidavits included within Exhibit Book 3 for purposes of cross-examination.

[19] The other documentary exhibits entered for purposes of the hearing included Exhibit Book 1- Pleadings, Exhibit Book 2 - Reports, Exhibit Book 4 - Supplemental Pleadings and Exhibit 5, the CV of Dr. Emma McDonald.

[20] At the conclusion of the Minister's case on direct Ms. Gerami confirmed once again that Exhibit 3 was being entered by consent. In addition, Ms. Gerami advised that Tabs 3, 5 and 6 of Exhibit 2 were being entered by consent, as well as, Tabs 1 and 2 of Exhibit 1.

Dr. Pamela Chenhall

[21] Pamela Chenhall, PhD, Psychologist, testified on behalf of the Minister.

[22] Dr. Chenhall identified her initial assessment at Tab 2A of Exhibit 2 as well as her progress note at Tab 2B.

[23] The assessment was identified by Dr. Chenhall as a Choice Appointment.

[24] The assessment report reviews G.M.'s history of involvement with Mental Health and Addictions at page 2 indicating as follows:

> … G was seen for a psychiatric assessment in June 2017, by Dr. Cecelia Robichaud, Dr. Kathleen Singh and Dr. Ronald Fraser. Significant history was gathered regarding possible Concurrent Disorders as well as a psychiatric and social history and the DSM – 5 diagnosis was Attention Deficit Hyperactivity Disorder in the severe range, Opiate Use Disorder on Methadone, Cannabis Use Disorder, moderate, Nicotine Use Disorder, moderate and Stimulant Cocaine Use disorder in remission. It was indicated that they did not feel she met the criteria for Bipolar II Disorder as there was no major mood episode. Recommendations included medication intervention and psychosocial support. G's chart was closed in October 2017 due to non-attendance and then she was reopened and then re-closed again in January 2018 when she called for an appointment and then did not follow through. The next involvement was a referral from Dr. Kronfli at East Coast Forensic Hospital where she was referred after the charges were laid for assessment of whether she was not criminally responsible. She was determined to be fit to stand trial with an indication that she suffers from serious ADHD in the context of Substance Use disorder and otherwise again confirmation of no evidence of Bipolar II and otherwise issues seem directly related to drug use at the time.

[25] In the Provisional Diagnosis and Treatment Plan portion of the assessment report Dr. Chenhall indicated as follows:

> …. This writer in completing the assessment is no clearer on what is the best course of treatment for G because of the bizarreness of her presentation. This writer feels her medication may be inadequate medical treatment for her ADHD and at the very least, if not for other symptoms, there is so much that is unclear. This writer has consulted with the team prior to dictating this assessment and has the support of the team in referring her to psychiatry hopefully, as semi-urgent to have her assessed and properly treated so that further treatment recommendations can be made….

[26] In her subsequent progress note dated February 21, 2019, Tab 2B, Dr. Chenhall indicated:

> …. G remains stuck on the fact that she has severe ADHD and this explains her behaviour. She is unwilling to see there is any connection between her withdrawing from her methadone and an increase in problematic behaviour. She continues to blame others for all that has happened to her, feels that other people should have had charges pressed against them for things that have happened, etc….

[27] Dr. Chenhall testified that at the end of the meeting on February 21, 2019 G.M. agreed to sign the support plan prepared for purposes of Wellness Court. She had no further direct contact with G.M..

[28] During cross-examination by Mr. Boubnov, Dr. Chenhall confirmed that she was never asked to assess G.M.'s parenting capacity and that the goal was to refer G.M. to further services.

[29] During cross-examination by Ms. Killawee, Dr. Chenhall testified that she thought it would be helpful if G.M. was referred to psychiatry indicating that she felt G.M. needed a recommendation respecting medication and she was concerned about other possible causes for her presentation.

Dr. Emma McDonald

[30] The next witness to testify was Dr. Emma McDonald, PhD, psychologist. By consent Dr. McDonald was qualified to provide opinion evidence as an expert in psychology with expertise in the area of psychological assessments for children and adolescents.

[31] Dr. McDonald identified Exhibit 5 as her CV. She was then referred to Tab 7A of Exhibit 2 and identified that as a copy of her report respecting T., pointing out that the date of 2018 was incorrect and that the report was prepared October 2019.

[32] Dr. McDonald explained that she had been asked to undertake an assessment by way of consult, by the team at the IWK Garron Centre, to assist with treatment planning and diagnostic clarification for T., then known as J.R.. She explained that at the time of her assessment T. was described as having maladaptive personality traits resulting in emotional and cognitive behavioural dysregulation.

[33] In her psychological assessment Dr. McDonald makes the following comments under the heading Overall Impression and Treatment Implications:

> J. is a 14-year-old female adolescent who was referred for psychological assessment to assist with diagnostic clarification and treatment planning. On the MACI clinical scales J.'s responses suggest predominant maladaptive personality features include Doleful (i.e. Depressive), self demeaning (i.e. Masochistic), inhibited (i.e., Avoidant) and borderline tendency (i.e. Borderline) characteristics. Her responses indicate that Identity Diffusion, self Devaluation, and Family Discord are major areas of concern for her. J.'s responses also suggest a high probability that she exhibits clinical syndromes related to Depressive Affect and Suicidal Tendencies.

[34] Dr. McDonald testified that she was not part of treatment planning for T.

[35] She explained that youth with T.'s profile need a stable home life to be successful, as well as treatment, and a parent/caregiver willing to participate in the treatment process. Without this T.'s problems would continue.

[36] During cross-examination Dr. McDonald confirmed that she did not make any treatment recommendations.

[37] Dr. McDonald also testified that it would be quite important for T.'s caregiver to be stable and attentive. Dr. McDonald noted it would be very important that T.'s caregiver referred to T. as "T." and if the caregiver was unable to do so it would prolong T.'s dysregulation.

Trevor Moores

[38] Trevor Moores, Registered Counselling Therapist, testified as to his involvement with T.

[39] Mr. Moores has been and continues to be involved in providing therapy for T.

[40] He identified Tab 4B as a progress report submitted to T.'s social worker dated December 7, 2020.

[41] Mr. Moores explained that one of the goals of therapy was to work on dysregulation. DBT therapy is used during therapy sessions with T.

[42] Mr. Moores offers the following comments in his letter of December 7, 2020:

> Although T can present as aggressive, he seems to be sensitive to emotional stimuli and reports having intense emotions that hit like a ton of bricks and can be long-lasting. T seems to be impulsive during these moments and often, without thinking, can do things to get into trouble. T reports it challenging to be effective and that moods/behaviours seem to get in the way of organizing or achieving goals, and that it is challenging to control behaviours linked to the moods surrounding the fight or flight response and that a feeling of being unsafe us a usual occurrence.
>
> During sessions we have been focusing on self-regulation, finding ways to self validate and seek validation and connection from others through appropriate positive communication. T is intelligent and resourceful and I am hopeful he can continue to make progress in therapy while changes continue with his environment and living situation…

[43] Mr. Moores testified that the topic of family has not come up during sessions.

[44] When asked how long therapy would be needed he responded by acknowledging that it is challenging but he and T. will continue to push ahead moving towards therapeutic goals.

[45] During cross-examination Mr. Moores explained DBT therapy and indicated that the therapy is being used to build awareness, learn about emotions and how to self calm and to communicate. He expressed his belief that T. has made progress during therapy.

Lisa Hayden

[46] Lisa Hayden, Registered Psychologist, identified her CV as set forth in Exhibit 4 at Tab 2A, as well as her assessment report found at Tab 2B.

[47] When asked to provide an overview of her assessment Ms. Hayden indicated that T. shows really strong problem-solving ability but the primary concern is T.'s social emotional functioning.

[48] In the Summary and Impressions portion of her report Ms. Hayden indicates as follows:

> T was referred for a psycho – educational assessment in order to better understand his cognitive profile. He has long-standing social emotional challenges, including diagnoses of PTSD, ADHD, and identified Cluster B personality traits…
>
> Reports from everyone involved indicate that T's most pressing challenges at this time fall in the social – emotional and behavioural domains. He has been diagnosed with PTSD, adjustment disorder, and gender dysphoria and Cluster B personality traits have been identified. T also report symptoms of anxiety. He endorsed several items relating to tension and restlessness, and generalized anxiety disorder. T is currently participating in therapy for similar concerns, and he is encouraged to continue. As his living situation changes, it will be important that similar counselling and behaviour supports continue to be provided.
>
> Finally, T has identified that having his gender identity invalidated by others is a major stressor and contributing cause of his chronic suicidal ideation. It is imperative that those working with and supporting T accept and validate his gender identity (e.g. by using his chosen name and pronouns).

[49] Ms. Hayden testified that when others don't validate his gender identity T. feels it very personally. She went on to indicate that she believes it is a very important part of T.'s well-being and that lack of validation of T.'s gender identity would be a problem.

[50] Ms. Hayden also indicated that T.'s success during his stay at Wood Street Centre shows the level of support he requires and the benefits of a stable environment where he can engage in therapy. She also indicated that if that type of environment were not available and T.'s needs were not being met, it would put T. at risk of increased harm associated with high-risk behaviours.

[51] During cross-examination, Ms. Hayden testified that T. described his home environment when living with his mother as chaotic but shut down when asked difficult questions, indicating that he did not want to discuss it.

[52] Ms. Hayden also testified that T. understands that members of his family did not support his gender identity and when pressed for clarification indicated that T. said his parents did not support his gender identity.

[53] Ms. Hayden testified that T. requires stability and understanding. She acknowledged that he was getting in trouble a fair bit at group homes and when asked why she indicated that there would be two factors, T.'s own identity struggles and the fact that he requires a great deal of supervision and support which not all group homes provide.

[54] During cross-examination by Ms. Killawee Ms. Hayden confirmed that G.M.'s practice of calling T. "J" or "her" would be upsetting to T. and not supportive. Ms. Hayden testified that T. needs a parent who can regulate their own emotions. She testified that if T. worried about his mother it would make things more challenging for T. indicating that T. needs time to focus on his own identity.

IWK discharge summary June 29, 2020

[55] Exhibit 2 Tab 6 was entered by consent. Tab 6B is a discharge summary from the IWK dated June 29, 2020. The following is an excerpt from the discharge summary as found at page 5 under the heading Diagnostic Impression at Discharge:

> T is a 14-year-old transgender male with a history of childhood trauma, abandonment, an early exposure to substance use, that has been struggling chronically with suicidal ideation and periods of emotional and behavioural dysregulation. He was admitted voluntarily following an impulsive suicidal gesture, in the context of ongoing psychosocial stressors which involve: coping and managing with feelings of gender dysphoria, feeling unsupported in a new "family home", and ongoing difficulties with family dynamic… He presents as a youth that has experienced significant sequelae from trauma and struggles to cope with new challenges and relationships because of this…

[56] The discharge summary confirms a diagnosis on admission of Adjustment Disorder with Cluster B Personality Traits and a diagnosis on discharge of Adjustment Disorder with mixed disturbance in mood/conduct, ClusterB Personality Traits and Gender Dysphoria.

Amanda Hemsworth

[57] Amanda Hemsworth, Child in Care Worker, identified Tab 20 of Exhibit 1 as her affidavit sworn January 22, 2021.

[58] Ms. Hemsworth confirmed that T. remains suspended for the rest of the school year and arrangements were made for T. to commence home-based schooling with the assistance of a tutor.

[59] Ms. Hemsworth advised that T. attended hospital twice in February 2021 due to suicidal and self harming behaviours. She explained that T. had been admitted to the IWK on April 11 because he was threatening to do something to get admitted. Ms. Hemsworth indicated that T. had been asking for a psychiatric assessment for some time and at this point she is not sure as to the length of T.'s current IWK stay.

[60] During cross-examination Ms. Hemsworth explained that T. had been admitted to the IWK because he had been in a heightened state of anxiety and had indicated that he would do something to get admitted.

[61] Ms. Hemsworth indicated that clearly T. does wish to see his mother and confirmed that T. had not seen his mother since December noting that it was difficult to contact G.M. and that G.M.'s presentation has been concerning. Ms. Hemsworth stated that in the past contact between T. and his mother has impacted upon T.'s mental health.

[62] Ms. Hemsworth supervised the initial visit between T. and his mother that took place at the Wood Street Centre. She noted that G.M. arrived late and the interaction with G.M. was pleasant but when the visit was over G.M. collapsed and began to rant about her residence and her neighbours. Ms. Hemsworth explained that the visit was supervised because G.M. has demonstrated challenges with her emotional regulation in the past and the agency felt that it would not be in T.'s best interests to expose T. to that.

[63] Ms. Hemsworth acknowledged that the agency is supportive of access post permanent care and custody but that the access would be subject to supervision. The need for supervision would be assessed by the agency on an ongoing basis.

[64] Ms. Hemsworth explained that T. was admitted to Wood Street Centre due to risk-taking behaviours, noncompliance, risky sexualized behaviours, drug use and being regularly GWP from his placement. The agency concluded that T.'s

behaviours required secure treatment to alleviate risk. She noted that since being discharged from Wood Street T. has taken some positive steps to make changes.

[65] Ms. Hemsworth testified that she had attended G.M.'s residence on two occasions, but G.M. had never initiated contact with her. On both occasions G.M. said things that did not make sense and were incongruent with what was going on.

[66] Ms. Hemsworth expressed her belief that T. needs consistent response and to be busy. T. requires that his needs be consistently met such that if he is having outbursts or a bad day he needs to be met with the same consistent response.

Carolyn Jeppesen

[67] Carolyn Jeppesen has been the Long-term Protection Worker for the agency.

[68] She identified her affidavits as contained in Exhibit 1 and other documentation including the agency's plan of care as found at Tab 11 of the exhibit. She also identified her affidavit as contained within Exhibit 4.

[69] Ms. Jeppesen confirmed her understanding that G.M. had been evicted from her apartment in March and is now boarding in a private home.

[70] She indicated that the agency was also willing to be supportive of access for G.M. post permanent care and custody providing such access would be in T.'s best interests. The agency is very mindful of T.'s mental health and recognizes that T. worries about his mother and wants to know that she is okay. Ms. Jeppesen testified that T. wants access providing G.M. is stable and sober and the access is a positive experience. The agency is open to contact by way of phone calls as well as in person access providing the access is appropriate.

[71] While acknowledging that G.M. expresses wanting to see T., Ms. Jeppesen also indicated that conversations with G.M. are very chaotic and difficult to follow and there generally is not a lot of productive conversation.

[72] Ms. Jeppesen noted that T. has had a chaotic upbringing and there are continuing concerns regarding G.M.'s metal health.

[73] In commenting upon the history of agency involvement Ms. Jeppesen noted that T. had called 911 after G.M. had threatened T. with a knife and that T. was taken into care by the agency in January 2019 and subsequently in December 2019 transitioned to the care and custody of his father J.R. He remained in his father's

care till June 2020 when the placement broke down and T. again came into care. (The history of agency involvement is outlined in more detail in the affidavit of Kathryn Gate, Intake Casework Supervisor, as found at Tab 2 of Exhibit 1, paragraphs 8 to 33.)

[74] During cross-examination Ms. Jeppesen confirmed that she had had a couple of conversations with G.M. in October/November 2020 as well as a couple of phone calls, but that she has not spoken to G.M. in several months.

[75] During cross examination Ms. Jeppesen was referred to her affidavit as found at Tab 15 of Exhibit 1, paragraph 21. The paragraph confirms contact between Ms. Jeppesen and G.M. on October 1, 2020 when G.M. attended the agency office unannounced. Ms. Jeppesen testified that it was unclear if G.M. was sober at time of this contact. She described G.M. as very erratic in her speech and made all sorts of comment including that she had been raped, stalked, and that people were coming into her apartment via the window. Ms. Jeppesen described it as a very difficult conversation which caused her to be extremely concerned for G.M.'s metal health.

[76] Ms. Jeppesen was also referred to paragraph 26 of her affidavit and indicated that that telephone conversation was reminiscent of her in-person meeting with G.M. in October.

[77] During cross-examination by Ms. Killawee, Ms. Jeppesen testified that she had never had a conversation with G.M. where she wasn't concerned about G.M.'s metal health.

[78] Ms. Jeppesen testified that T. clearly requires consistency and structure where his needs will be met. She would be very concerned if T. is not in a consistent and structured environment where the responsible caregiver will be able to meet his needs.

[79] When asked by the court about the possibility of a less intrusive option having regards to the timeline Ms. Jeppesen testified that she did not believe a less intrusive alternative would be appropriate emphasizing T.'s need for finality. She indicated that further delay or uncertainty would not be in T.'s best interests.

Dr. Risk Kronfli

[80] Dr. Risk Kronfli, Psychiatrist, testified by videoconference link.

[81] Dr. Kronfli is the Clinical Director at the East Coast Forensic Hospital. All parties consented to Dr. Kronfli providing opinion evidence.

[82] At the outset of his direct examination Dr. Kronfli confirmed that the relevant report for purposes of his evidence was his report of July 12, 2018, as found at Tab 1C of Exhibit 2.

[83] Dr. Kronfli explained that the assessment of G.M. was undertaken to determine whether G.M. met the criteria for exemption from criminal responsibility as per s. 16 of the Criminal Code.

[84] G.M. was admitted on June 25, 2018 for a 30 day assessment. The assessment was intended to assess the impact of any psychiatric disorder or symptoms on G.M.'s capacity to know what they did was wrong and alternatively to assess G.M.'s fitness to stand trial based upon her current circumstances.

[85] Dr. Kronfli confirmed that his diagnosis was ADHD in the context of a serious substance abuse disorder.

[86] Initially staff had difficulty interacting with G.M. and Dr. Kronfli suggested that this was probably secondary to her substance use disorder. G.M. took some time to stabilize and get the drugs out of her system.

[87] Dr. Kronfli indicated one caveat with respect to his testimony noting that this was a focused assessment with respect to fitness and criminal responsibility. He noted that the charges against G.M. were serious charges.

[88] He expressed his opinion that there was a high likelihood of other factors impacting on G.M.'s ADHD, in particular substance use. He noted that ADHD hampers an individual's ability to adapt or learn coping skills and focus, especially if not properly treated. However, even if treated there is no guarantee of success and even use of medication does not mean automatic success.

[89] Dr. Kronfli explained that treatment is very important in order to allow a person the ability to develop skills and to be more predictable and consistent in their approach. In relation to treatment of ADHD the success rate is high in ability to control symptoms but again there is no guarantee of a better life or life improvement.

[90] In the case of G.M., Dr. Kronfli expressed his opinion that treatment would allow her the best chance of success but pointed out that G.M. has to show or

demonstrate success, i.e. benefit of treatment, in an objective way. Dr. Kronfli noted that the situation was complicated by G.M.'s substance use and stated that all bets were off in the event of continued substance use.

[91] During cross-examination by Mr. Boubnov, Dr. Kronfli confirmed that he had not made a diagnosis of bipolar disorder and saw no evidence of bipolar disorder on the part of G.M.

[92] During cross-examination by Ms. Killawee Dr. Kronfli stated that hallucinations would be attributable to substance use disorder.

[93] He was then referred to Ms. Jeppesen's affidavit as found at Tab 15 of Exhibit 1 and Ms. Killawee read out loud paragraphs 20 through to and including 23.

[94] When asked to provide his impression of the excerpts from the affidavit Dr. Kronfli noted that it was being made without an assessment. Dr. Kronfli then explained that where patients suffer from psychotic illness it is usually a continuous process unless it is due to extreme mood such as manic or full depression. Dr. Kronfli then indicated that the other explanation is substance use disorder.

[95] Dr. Kronfli noted that when he had assessed G.M. she cleared from hallucinations without medication explaining that if it had been due to psychosis she would have unlikely cleared without medication.

[96] Dr. Kronfli then suggested that the conversations referred to by Ms. Killawee were probably another episode involving use of substances noting that G.M., during her assessment, had indicated that she really liked "Shatter" which can cause psychosis. Dr. Kronfli indicated that if this sort of presentation is not continuous it is likely a psychotic episode, not caused by ADHD, but likely due to substance use.

[97] Dr. Kronfli went on to explain that Vyvanse, which is used to treat ADHD, is an amphetamine and if it is abused it can cause a psychotic illness close to schizophrenia. If you overuse it, you will become psychotic.

Harvey Bate

[98] Harvey Bate, identified the reports that he had submitted as Guardian *ad litem* for T. in the prior protection proceeding, as contained and set forth in Exhibit

3. Mr. Bate noted that T. was referred to as J.R. at that point in time. As a result of his involvement with T. in the prior proceeding he got to know T. quite well.

[99] Mr. Bate confirmed that Tabs A, B, C, and D as found at Tab 8 of Exhibit 2 are copies of the reports he had submitted as Guardian *ad litem* during the current proceeding.

[100] Mr. Bate testified that T. is a great young man, very intelligent who has a lot of anxiety and some realistic fears. He referred to T. as struggling to figure out where he belongs in the world noting that T struggles with his past and relationships. Mr. Bate expressed concern that T. will likely always have mental health issues but then commented that being male seems to suit T. and fits him.

[101] Mr. Bate indicated his belief that T. has a good understanding of what is taking place in the current child protection proceeding. He noted that sometimes he and T. are on the same page and sometimes not. Mr. Bate stated that there were days when T. says he wants to go home with his mother and other days where he says doing so would have to be subject to certain conditions and acknowledges that G.M. is not ready.

[102] Mr. Bate confirmed his support for the Minister's request for permanent care and custody noting that T. has been the subject of two successive protection proceedings. Nothing makes him think that extending the time would see any different result or outcome. While acknowledging that T. may struggle with permanent care and custody Mr. Bate expressed his belief that permanent care would allow T. to get on with his life sooner rather than later.

[103] Mr. Bate noted that G.M. had not filed a plan of care in support of her request that T. be returned to her care. Mr. Bate expressed his belief that G.M. does not have a real plan, she just wants T. back. Mr. Bate also testified that even if G.M. had a home, it would not change his mind.

[104] Shortly after Mr. Boubnov's cross-examination of Mr. Bate commenced G.M. abruptly left the courtroom requiring the court to adjourn.

[105] Following resumption of cross examination Mr. Bate acknowledged that T. did say on several occasions that he would like to return to live with his mom.

[106] When asked why T. had gotten into trouble at his group home Mr. Bate indicated that it was complicated. Mr. Bate noted that sometimes kids placed in

group homes act out due to change in placement or loss of control. Mr. Bate noted that T. has mental health issues and gender identity issues and is 15 years old. In his opinion all of these factors together explain why T. gets in trouble.

[107] Mr. Bate does not support T. returning to the care of his mother based upon consideration of all the information and his belief that it would not be in T.'s best interests. His position is based upon personal observation, his experience as a social worker, and his conclusion that G.M. is not ready to take on the responsibility of caring for T. and has her own mental health issues to deal with. Mr. Bate noted that his opinion would not change in 5 or 6 months.

Testimony of G.M.

[108] At the outset of her direct examination G.M. confirmed that she is currently renting a room in a family home which she described as a small two-bedroom home.

[109] She is on income assistance but trying to find work.

[110] She testified that Dr. Brian Steeves is her family physician and that he has prescribed medication for her including Vyvanse and Xanax.

[111] G.M. stated that Dr. Kronfli was correct in his diagnosis. She then commented that she had not had any problems with the law in 3 ½ years and added that she was taking her medications as prescribed and using marijuana to control seizures.

[112] G.M. testified that she loves T. unconditionally and that she loves her baby, her daughter.

[113] G.M. identified her affidavits as found within Exhibit 1.

[114] When referred to her affidavit of November 18, 2020 G.M. confirmed that she was no longer residing in the apartment depicted in the photographs attached as an exhibit to her affidavit.

[115] When asked to explain why T. was in care, G.M. provided a rambling response in which she indicated she had been prescribed methadone when T. was 12 and that the methadone made her sick and when she went off the methadone her ADHD went into overdrive. She also explained that her mother passed away and then noted that when she was in hospital she was diagnosed with ADHD. She

suggested that she had been stable for 3 ½ years and is now healthier than she was. She didn't deny that she'd had a break but that she just couldn't recall it due to all the drugs in her system. G.M. then began to cry noting that she had lost everything the hard way.

[116] At one point G.M. commented that her daughter is her everything indicating that she would have to get used to calling her T. and noting that it is hard for her to get used to that but indicating that she wants her daughter to be comfortable in her own skin.

[117] At times G.M.'s evidence on direct was extremely difficult to understand because of her tendency to ramble at a rapid pace and jump from topic to topic.

[118] At one point during her cross-examination G.M. denied that she had placed T. at risk.

[119] G.M. suggested that Dr. Kronfli agreed that her break was induced by the methadone. She testified that she wanted to show her daughter that it was possible to get off methadone and that she had done that.

[120] During G.M.'s testimony some of her answers appeared somewhat incoherent and not responsive or related to the question asked.

[121] G.M. testified that she believes she can meet T.'s needs. When asked to explain T.'s needs she indicated that T. needs someone to listen to him or her and that she and T. need to get to know each other.

[122] G.M. testified that she recalled the evidence that had been given with respect to T.'s gender identity and indicated that she was getting used to calling her "T." but that she prefers "J "indicating that in time she can get used to "T.". She indicated she had no difficulty with T.'s identity and was willing to take "her" to services. At one point she suggested that they would talk about it as "mother/daughter or son, whatever". She stated "My daughter is so beautiful and such a good girl and I'm so proud of her."

[123] During cross-examination G.M. was asked again about T.'s needs and responded that she knows he needs a counsellor. She then added that she feels that counselling would definitely be necessary for both she and T. She indicated that she feels she needs counselling to get used to T.'s gender identity and

acknowledged that she needs to keep reminding herself to call him T. She admitted that she doesn't know a lot about it and needs to learn.

[124] When asked what T. needs are right now she responded by indicating "Me." She added that "We love each other and T. is my baby."

[125] G.M. acknowledged that she has seen T. about six times in the last three years.

[126] At one point she referred to the incident between herself and T. in 2018 as "one little incident" and stated that "nobody is giving me a chance".

[127] G.M. confirmed that she is now on Vyvanse and Xanax and uses CBD oil.

[128] When asked if she understood that T. was aware that Mr. Bate, as Guardian *ad litem*, was consenting to permanent care and custody G.M. acknowledged awareness of Mr. Bate's position but stated that she wanted her daughter or her son and that her daughter belongs to her. G.M. maintained that she has no anger issues and asserted that she has kept it together.

[129] When asked how it would make T. feel if she called him "J" or "her daughter" G.M. responded by indicating that "She (referring to T.) didn't bring it up once."

[130] G.M. suggested that maybe if she had seen her daughter more over the last three years it would be easier.

[131] At another point she suggested that T is her child and that gender has nothing to do with it because T is her baby.

[132] G.M.'s affidavit prepared June 24, 2020 (Exhibit 1, Tab 3) confirms her circumstances as of June 24, 2020. G.M. is no longer residing in the two-bedroom apartment described in the affidavit.

[133] In her affidavit she denied using any street drugs indicating that she has been clean of drugs for the last two years. She acknowledged using some marijuana products but also asserted that she was not using any marijuana products as of June 24, 2020. She acknowledged having been diagnosed with ADHD and states that with the exception of ADHD, she was never diagnosed with any mental health problems.

[134] In her affidavit G.M. disputes the allegations as set forth in the affidavit of Katherine Gate (Exhibit 1, Tab 2) and indicates that she disagrees with the position of the agency and confirms her request for T. to be returned to her care and custody.

[135] In her affidavit prepared June 27, 2020 (Exhibit 1, tab 5) G.M. again disputes and denies the information contained in Ms. Gates affidavit, sworn June 24, 2020.

[136] G.M.'s affidavit prepared October 29, 2020 (Exhibit 1, Tab 13) provides an update with respect to her circumstances. In the affidavit G.M. again asserts that it would be in T.'s best interest to be returned to her care and custody.

[137] In her affidavit prepared November 18, 2020 (Exhibit 1, Tab 16) she maintains at paragraph 6 that she was never diagnosed with anything but PTSD and indicates that in her recollection it was Dr. Kronfli who diagnosed her with only PTSD during her stay at the East Coast Forensic Hospital. G.M. also maintains that the affidavit of Caroline Jeppesen sworn November 3, 2020 (Exhibit 1, Tab 15) is full of ungrounded allegations which have no air of reality and specifically denies the information as contained and set forth in paragraph 21, 22 and 23 of Ms. Jeppesen's affidavit.

[138] Exhibit 3 contains the evidence from the prior protection proceeding admitted pursuant to s.96 of the *CFSA*.

[139] The affidavit of social worker Katelyn Walsh (sworn January 4, 2019) is found at Tab 2 of Exhibit 3. The affidavit contains a detailed summary of the events that led to the decision to take T., then known as J.R., into care on January 1, 2019. Child protection concerns included emotional/mental health of G.M., physical neglect, emotional neglect, substance abuse, risk of physical harm, emotional abuse and inadequate parenting skills.

[140] Tab 26 of Exhibit 3 is a termination order granted May 6, 2020 which confirms that at time of termination the court granted an order pursuant to the *Parenting and Support Act* placing T. in the primary care and custody of his father J.R.

Issues

1. Is T. in need of protective services?

2. If T. is in need of protective services, would it be in T.'s best interest to be placed in permanent care and custody of the Minister?

Credibility

[141] In relation to credibility, I would refer to the decision of the Nova Scotia Court of Appeal in *G.L.T. v. Nova Scotia (Community Services)*, 2017 NSCA 68 (CA). In denying the appeal, the court referred approvingly to the trial decision wherein Justice Forgeron identified various case authorities which set forth legal principles and guidelines applicable to the assessment of credibility including, *C.R. v. McDougall*, 2008 SCC 53 (S.C.C.), *Baker-Warren v. Denault*, 2000 9 NSSC 59, and *Novak Estate, Re*, 2008 NSSC 283 (N.S.S.C.).

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

[143] In assessing the Respondent mother's credibility, I want to emphasize and make clear that I have considered the Respondent mother's testimony having regard to the totality of the evidence adduced and not in isolation.

[144] G.M.'s presentation as a witness during director cross-examination was challenging for both counsel and the court. On several occasions she became emotional and appeared to become tearful but then she would quickly compose herself and continue her evidence frequently changing topics midstream. Her responses to questions were usually rapid, with a tendency to provide rambling or somewhat chaotic or disorganized answers that were not necessarily responsive to the questions being asked. I acknowledge that G.M.'s presentation may in large measure be attributable to her ADHD.

[145] G.M.'s assertion in her affidavit prepared November 18, 2020 (Exhibit 1, Tab 16) that she was never diagnosed with anything but PTSD is clearly incorrect and inaccurate.

[146] Dr. Chenhall's choice appointment assessment report as found in Exhibit 1, Tab 2 confirms that G.M.'s medical history includes a psychiatric assessment in June 2017 which confirmed DSM – 5 diagnosis of Attention Deficit Hyperactivity Disorder in the severe range, Opiate Use Disorder on Methadone, Cannabis Use Disorder, moderate, Nicotine Use Disorder, moderate and Stimulant Cocaine Use disorder in remission.

[147] G.M.'s recollection as per her affidavit that Dr. Kronfli diagnosed her with PTSD is also inaccurate. Dr. Kronfli was very clear in indicating that he diagnosed G.M. as suffering from adult ADHD in the context of a serious substance use disorder. Dr. Kronfli's assessment report dated July 12, 2018 (Exhibit 1, Tab D) makes no reference to a diagnosis of PTSD and he did not refer to a diagnosis of PTSD during his testimony.

[148] In her affidavit of November 18, 2020 G.M. also maintains that the affidavit of Caroline Jeppesen sworn November 3, 2020 is full of unfounded allegations which have no air of reality. She specifically denies the information contained and set forth in paragraph 21, 22 and 23 of Ms. Jeppesen's affidavit.

[149] I am satisfied that Ms. Jeppesen gave her evidence in a forthright fashion. She was responsive to questions asked on direct and cross-examination.

[150] She readily acknowledged that T. wants G.M. to be sober, stable and safe and that T. worries about his mother.

[151] When referred to her affidavit of November 3, 2020 during cross-examination Ms. Jeppesen testified that it was unclear to her if G.M. was sober at time of their conversation on October 1, 2020. G.M. was very erratic in her speech and G.M. talked about being raped, stalked, people coming into her apartment via the window. Ms. Jeppesen referred to the conversation as a very difficult conversation and that as a result she was very concerned for G.M.'s mental health.

[152] The court is satisfied that the information contained in paragraphs 21, 22 and 23 of Ms. Jeppesen's affidavit of November 3, 2020 is an accurate and reliable account of Ms. Jeppesen's conversations with G.M..

[153] Paragraphs 21 to 23 of Ms. Jeppesen's affidavit were reviewed with Dr. Kronfli during his cross-examination. Dr. Kronfli testified that if the conversation was not part of a continuous presentation on the part of G.M. he believed it would likely be a psychotic episode not caused by ADHD but likely due to substance use. Dr. Kronfli also explained that Vyvanse can cause psychotic illness close to schizophrenia if it is abused. If an individual overuses Vyvanse it will cause psychotic episodes.

[154] It important to acknowledge that there was no evidence indicating or confirming that G.M. was abusing her prescription at time of her conversations with Ms. Jeppesen. Dr. Kronfli's explanation is a possible explanation for G.M.'s

bizarre conversations with Ms. Jeppesen. Regardless of possible explanations the conversations raise obvious concerns respecting G.M.'s mental health.

[155] I have significant concerns as to the credibility of G.M. in so far as her evidence in several instances is clearly inaccurate or unreliable.

[156] I accept the evidence of Ms. Jeppesen in preference to that of G.M. in any instance where there is conflict or contradiction between the evidence of Ms. Jeppesen and G.M.

Legal Analysis

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

> [19] In making my decision, I must be mindful of the legislative purpose. The threefold purpose is to promote the integrity of the family, protect children from harm, and ensure the best interests of children. The overriding consideration is, however, the best interests of children as stated in sec. 2(2) of the *Act*.
>
> [20] The *Act* must be interpreted according to a child centered approach, in keeping with the best interests principle as defined in sec. 3(2). This definition is multifaceted. It directs the court to consider various factors unique to each child, including those associated with the child's emotional, physical, cultural, and social development needs, and those associated with risk of harm.
>
> [21] In addition, sec. 42(2) of the *Act* states that the court is not to remove children from the care of their parents, unless less intrusive alternatives have been attempted and have failed, or have been refused by the parent, or would be inadequate to protect the children.
>
> [22] When a court conducts a disposition review, the court assumes that the orders previously made were correct, based upon the circumstances existing at the time. At a review hearing, the court must determine whether the circumstances which resulted in the original order, still exist, or whether there have been changes such that the children are no longer children in need of protective services: sec. 46 of the *Act*; and **Catholic Children's Aid Society of Metropolitan Toronto v. M. (C.)** [1994] 2 S.C.R. 165.
>
> [23] Past parenting history is also relevant as it may be used in assessing present circumstances. An examination of past circumstances helps the court determine the probability of the event reoccurring. The court is concerned with probabilities, not possibilities. Therefore, where past history aids in the determination of future probabilities, it is admissible, germane, and relevant: **Nova Scotia (Minister of Community Services) v. Z.S.** 1999 NSCA

> 155 at para. 13**; Nova Scotia (Minister of Community Services) v. G.R.** 2011 NSSC 88, para. 22, as affirmed at **Nova Scotia (Minister of Community Services) v. G.R.** 2011 NSCA 61.

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

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

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

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

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

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

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

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

[166] A finding that the child continues to be in need of protective services requires the Court to consider s.42, s.45, s.46 and s.47 of the *CFSA*.

Protection Finding

[167] The Minister maintains that T. is in need of protective services pursuant to subparagraphs (g), and (ka) of s.22(2) of the *CFSA*. Those provisions read as follows:

> 22 (2) A child is in need of protective services where

> …
> (g) there is substantial risk that the child will suffer emotional abuse and the parent or guardian does not provide, refuses or is unavailable or unable to consent to, or fails to co-operate with the provision of, services or treatment to remedy or alleviate the abuse;
>
> …
> (ka) the child's only parent or guardian has died or is unavailable to exercise custodial rights over the child and has not made adequate provision for the child's care and custody;

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

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

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

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

> …the test is as set out previously by this Court in *M.J.B. v. Family and Children's Services of Kings County*, 2008 NSCA 64:

> [77] The Act defines "substantial risk" to mean a real chance of danger that is apparent on the evidence (s.22(1)). In the context here, it is the real chance of sexual abuse that must be proved to the civil standard. That future sexual abuse will actually occur need not be established on a balance of probabilities. (*B.S. v. British Columbia (Director of Child, Family and Community Services*) (1998), 160 D.L.R. (4th) 264, [1998] B.C.J. No. 1085 (Q.L.)(C.A.) at paras. 26 to 30)
>
> (Emphasis in original)
>
> When deciding whether there is "substantial risk", a judge must only be satisfied that the "chance of danger" is real, rather than speculative or illusory, "substantial", in that there is a "risk of serious harm or serious risk of harm" (*Winnipeg Child and Family Services v. K.L.W.*, 2000 SCC 48, paras. 104, 106 and 117), and it is more likely than not (a balance of probabilities) that this "risk" or "chance of danger" exists on the evidence presented.

[171] I am satisfied that T. continues to be a Child in need of protection as per s.22 (2) (g) of the *CFSA*.

[172] G.M.'s current circumstances do not allow her to parent T. in a manner consistent with T.'s needs. G.M. is currently boarding in a two-bedroom home which she identified as a temporary arrangement without providing any specific timeline. The affidavit evidence filed on behalf of G.M. referred to her former apartment as suitable accommodations for herself and T. That evidence is no longer applicable given G.M.'s changed circumstances.

[173] G.M. did not offer any evidence as to where she and T. would reside if T. was returned to her care or how she would address the accommodation issue.

[174] G.M. is also presently unemployed albeit she is looking for work. G.M. did not identify any specific job prospects other than suggesting that she was prepared to do cleaning work.

[175] G.M. did not prepare or file a detailed plan of care in support of her request to have T. returned to her care.

[176] Clearly G.M. continues to struggle with her own personal circumstances including her housing needs.

[177] The evidence also confirms that G.M., despite her assertions to the contrary, continues to experience mental health difficulties based upon her interaction and

communication with agency workers. On more than one occasion G.M.'s interaction with agency workers can only be described as bizarre and irrational.

[178] The evidence indicates continuing instability in relation to G.M.'s personal circumstances, including her mental health.

[179] G.M. has not demonstrated a consistent ability to adequately meet or address her own needs let alone T.'s.

[180] G.M. has demonstrated a lack of understanding and insight with respect to T.'s emotional needs.

[181] The evidence confirms a troubling history of emotional and behavioural issues on the part of T.

[182] As was indicated by Dr. Mejia in the IWK discharge summary dated June 29, 2020 (Exhibit 1, Tab 6B) T. has had a complex and traumatic upbringing with a history of childhood trauma, abandonment, and early exposure to substance use. T. has been struggling chronically with suicidal ideation and periods of emotional and behavioral dysregulation. It was also noted that T. presents as a youth that has experienced significant sequelae from trauma and struggles to cope with new challenges and relationships because of this.

[183] During his testimony Mr. Bate, Guardian *ad litem*, was asked why T. gets into trouble at his group home. Mr. Bate responded by indicating that "It's complicated" and pointed out that T. has mental health issues, gender identity issues and is 15 years old and altogether this explains why T. gets into trouble.

[184] Mr. Bate went on to testify that based on his observations as well as his experience as a social worker G.M. is not ready to take on T. right now, noting that she has her own mental health issues to deal with, and that T. also has mental health issues that he needs to address.

[185] G.M. struggled to identify T. as "T." during her evidence and repeatedly referred to T. as "her", or "her daughter". While I acknowledge that G.M. indicated she would have to learn to identify her child as T., the fact that she persisted in referring to the child in a manner inconsistent with the child's preferred gender identity is troublesome.

[186] Lisa Hayden psychologist made it quite clear in her report (Exhibit 4, Tab 2B), at page 9, that:

> "… T. has identified that having his gender identity invalidated by others is a major stressor and a contributing cause of his chronic suicidal ideation. It is imperative that those working with and supporting T accept and validate his gender identity (e.g., by using his chosen name and pronouns)."

[187] During her testimony G.M. demonstrated a persistent inability to validate T.'s gender identity by failing to use his chosen name and pronouns. G.M.'s inability to recognize, accept and consistently validate T.'s chosen gender identity creates a real and substantive risk of further or emotional harm for T.

[188] Although G.M. indicated that she believes she can meet T.'s needs she also testified that what T. needs is someone to listen to him/her and that she and T. need to get to know each other. G.M.'s admission that she needs to get to know her child is an acknowledgement of the lack of meaningful contact between G.M. and T. over the past three years. G.M. estimated that she had seen T. six times in the last three years.

[189] The evidence confirms significant lack of insight and understanding on the part of G.M. regarding T.'s emotional and mental health needs.

[190] Dr. McDonald testified that youth with T.'s profile need a stable home life to be successful in treatment and a parent/caregiver willing to participate in the treatment process. Without this she testified T.'s problems would continue.

[191] Ms. Jeppesen testified that she would be very concerned if T. was not in a consistent structured environment where the responsible caregiver will be able to meet his needs.

[192] Ms. Hemsworth stated quite clearly that T. requires that his needs be consistently met such that if he is having outbursts or a bad day he needs to be met with the same consistent response.

[193] The evidence in this case clearly supports and justifies the conclusion that the child T. would be exposed to substantial risk of emotional harm or abuse if returned to the care of G.M. based upon G.M.'s inability to adequately meet T.'s needs, her lack of understanding or insight with respect to T.'s needs and her continuing inability to consistently recognize and support T.'s gender identity.

[194] I find that G.M.'s lack of insight and inability to provide adequate parenting would seriously interfere with T.'s healthy development and emotional functioning.

[195] While G.M. clearly loves T. and is firm in her belief that it would be in T.'s best interest that he be returned to her care the evidence clearly indicates that G.M. does not have the ability to provide adequate parenting for T. on a consistent basis commensurate with his needs. Indeed, G.M. appears to be struggling to meet her own needs.

[196] I am satisfied that the minister has discharged the burden of proof in establishing on balance of probability a real chance of harm or danger for T. if returned to the care of G.M.

[197] The chance of danger or serious harm as established by the evidence is neither speculative or illusory, it is real and significant.

[198] I therefore find that the child T. to be in need of protective services pursuant to s.22 (2) (g) of the *CFSA.*

Determination of best interests

[199] Having concluded that T. continues to be in need of protective services I must also consider whether or not permanent care and custody or a less intrusive order would be in T.'s best interests.

[200] I make the following findings having regards to s. 3(2):

1. I acknowledge the importance of T.'s relationship with G.M. and J.R. The court recognizes that it would be helpful to T. to maintain a positive relationship with both his parents. T's relationship with G.M. has been subject to disruption due to G.M.'s mental health and substance abuse issues which necessitated agency intervention to ensure T.'s safety and welfare. The fact that T. worries about his mother is understandable given their history. T.'s relationship with his father has at times been difficult and strained. The current child protection proceeding was necessitated following breakdown of T.'s placement with his father. While maintaining contact between T. and his parents is important such contact should only be permitted and encouraged where the contact will be positive, supportive, and beneficial to T.
2. There was not a great deal of evidence presented regarding T.'s relationship with relatives. I acknowledge that Mr. Bate in his report of January 21, 2021 noted that T. has expressed interest in having

access contact with his sister, even if that contact has to be subject to supervision. Mr. Bate also noted that T. reported recent contact with members of his extended family and that T. had expressed pleasure that members of his extended family were accepting of him and had expressed hope that the contact with extended family would continue.

3. Continuity of T.'s care is a relevant consideration in determining T.'s best interests. The evidence indicates that T. has had a complex and traumatic upbringing and has been exposed to trauma and neglect. G.M.'s care of T. was disrupted due to G.M.'s mental health issues and substance abuse, resulting in T. being taken into care by the Minister to ensure T.'s safety and welfare. T.'s subsequent placement with his father broke down resulting in a further taking into care and commencement of the current protection proceeding. Continuing care and custody on the part of the Minister is required to ensure that T.'s emotional, developmental and physical needs are being consistently met and that T. continue to have access to the services and supports required to insure his health and safety.

4. The evidence does not permit the court to reach a clear conclusion with respect to the bonding that exists between T. and his parents. It is obvious that T. loves his mother and worries about her. Clearly G.M. loves T. However, there is an absence of evidence with respect to the nature of the bond or attachment between G.M. and T., especially given the infrequent contact between mother and child over the past three years. The relationship between T. and his father appears somewhat tentative at this point but the possibility or potential for an improved relationship certainly should be acknowledged.

5. T. has been diagnosed with PTSD, social anxiety and ADHD as well as Cluster B personality traits. T. has also been diagnosed with gender dysphoria. T. has identified that having his gender identity invalidated by others is a major stressor and contributing cause of chronic suicidal ideation. T. is involved in supportive therapeutic services including DBT therapy. It is essential that T. continue to have ongoing access to supports and services required to meet T.'s emotional and developmental needs while being cared for in an environment that will ensure his physical well-being and safety. Consistency on the part of involved caregivers is critical.

6. Lisa Hayden's psychoeducational report indicated that T.'s comprehension and reasoning skills fell in the average range for his age. Standardized academic assessment indicated that T. was achieving within the range expected for his age in all areas of reading and writing with particular a strong reading fluency. However, T. performed in the below-average range in all areas of math. Ms. Hayden noted that given the traumatic circumstances of T.'s childhood and frequent disruptions to his education it was not unexpected to find gaps in his math knowledge. Ms. Hayden also noted that reports from everyone involved indicated that T.'s most pressing challenges at this time fall in the social-emotional and behavioural domains. Ms. Hayden noted in her report that T. was currently participating in therapy and encouraged his continued participation. She also indicated that as T.'s living situation changes, it will be important that similar counselling and behaviour supports continue to be provided.

7. T. is a fifteen-year-old transgender child who has been diagnosed with gender dysphoria in association with other mental health diagnoses. The evidence clearly indicates the importance of recognizing and supporting T.'s sexual orientation, gender identity and gender expression. G.M. struggles with use of T.'s chosen name and appropriate pronouns and appears to have persistent difficulty recognizing the importance of accepting and validating T.'s chosen gender identity.

8. Having carefully considered the evidence I am satisfied that the Minister's plan premised upon permanent care and custody has more merit than G.M.'s plan.

9. Mr. Bate, Guardian *ad litem*, acknowledges that T. has from time to time expressed a preference for being returned to the care of his mother. Mr. Bate also made it clear that T. is aware of his mother's continuing mental health issues and some of her shortcomings. In his report dated November 16, 2020 Mr. Bate indicated that T. would like to return to his mother's care but that T. also understands why the agency takes the position that he cannot return to his mother's care. While acknowledging and appreciating T.'s wish to return to his mother's care I am satisfied based upon the evidence presented that a return to G.M.'s care would not be in T.'s best interests.

10. Ms. Jeppesen testified that she didn't believe a less intrusive alternative would be appropriate emphasizing T.'s need for finality and suggested that further delay or uncertainty would not be in T.'s best interests. Mr. Bate noted that T. has been the subject of two successive protection proceedings and indicated his belief that extending the time would not see any different result or outcome. Mr. Bate expressed his belief that permanent care would allow T. to get on with his life sooner rather than later. The court is satisfied that any further delay in final disposition would be inconsistent with T.'s best interests.

11. I am also satisfied that the evidence establishes a substantial risk that T. is likely to suffer harm if returned to the care of G.M. The risk of harm is real and significant. G.M. has not demonstrated an ability or capacity to adequately meet T.'s needs on a consistent basis. The evidence also indicates that G.M. does not appreciate or understand T.'s chosen gender identity or the emotional issues associated with his gender identity. Her lack of insight creates a serious and meaningful risk of significant harm.

12. The degree of risk that justified the initial finding that T. was in need of protective services was substantial. I am satisfied that T. remains in need of protective services and that the risk of harm remains real and substantial. I would reiterate my conclusion that the chance of danger or serious harm as established by the evidence is neither speculative or illusory, it is real and significant.

Consideration of Section 42(2)

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

[202] The outside limit for this proceeding is May 19, 2022.

[203] The timeline therefore permits or allows consideration of less intrusive options such as continued temporary care and custody or a supervisory order.

[204] I am satisfied that any less intrusive order at this point in the proceeding would not be in T.'s best interests.

[205] I am also satisfied that any further delay in the conclusion of the proceeding would be contrary to T.'s best interests. In reaching this conclusion I would acknowledge that T. has been the subject of two successive protection proceedings over the last three and half years. The need for finality is clear and obvious.

[206] The evidence clearly established that G.M. does not have the ability to provide adequate parenting on a consistent basis.

[207] There was no evidence presented that would justify the conclusion that G.M. would be able to demonstrate an ability to provide adequate parenting within a reasonably foreseeable time not exceeding the maximum time limit.

[208] The court's findings with respect to need of protective services and best interests preclude consideration of a supervisory order. I am satisfied that a supervisory order in favour of G.M. would be inadequate to ensure the safety and welfare of T. and therefore would not be in T.'s best interests.

[209] I am also satisfied that the circumstances justifying the current order for temporary care and custody are unlikely to change within a reasonably foreseeable time not exceeding the remainder of the applicable maximum time period. This finding precludes the granting of a further order for temporary care and custody pursuant to s.46(6).

[210] The Minister is not required to wait until the outside limit before deciding to proceed with an application for permanent care and custody. Case authorities recognize and confirm the right of the Minister to not wait on the expiration of the statutory clock before seeking an order for permanent care and custody, providing the Minister can discharge the burden of proof in requesting such an order at an earlier stage in the proceeding. (See Nova Scotia (Minister of community services) v. L. L. P., [2003] N. S. J. No.1 (C. A.)).

[211] I am satisfied that the Minister has successfully discharged the burden of proof in requesting an order for permanent care and custody well before the outside limit.

Consideration of Section 42(3)

[212] The Minister's plan of care confirms that there are no known alternative placements for the T.

[213] No family placement proposals were submitted on behalf of either Respondent.

[214] I am satisfied that is not possible to place T. with a relative, neighbour or other member of the child's community or extended family at this point in the proceeding.

Consideration of Section 42(4)

[215] I find that the circumstances justifying an order for permanent care and custody are unlikely to change within a reasonably foreseeable time not exceeding this maximum time limit.

Consideration of Section 46

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

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

(a) The respondent father has consistently supported the Minister's request for permanent care and custody. There has been no meaningful positive change on the part of the respondent mother since the commencement of the proceeding. She continues to struggle to meet her own emotional and physical needs and to maintain a semblance of stability in her own life. She has not demonstrated or established a positive change in circumstance that would justify the conclusion that she is now able to adequately parent T. on a consistent basis having regards to T.'s needs.

(b) The original plan of care was premised upon permanent care and custody.

(c) I find the Minister's Plan of Care premised upon permanent care and custody to be appropriate and consistent with the best interests of the child. It is the least intrusive option capable of ensuring the safety and welfare of the child and alleviating substantial risk of harm.

(d) I am satisfied that the circumstances which justified an order for temporary care and custody at time of initial disposition are unlikely to change within a reasonable foreseeable time not exceeding the remainder of the applicable maximum time limit.

Access

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

[219] The court acknowledges that the Minister's plan of care indicates that future contact between T. and his parents will be considered subject to the child's best interests.

[220] The Minister's willingness to exercise ongoing discretion with respect to future contact between T. and his parents, as well as members of T.'s extended family, based upon consideration of T.'s best interests, is appropriate in the circumstances of this case.

Determination of religion

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

Conclusion

[222] I am satisfied that the Minister has adequately discharged the burden of proof in requesting an order for permanent care and custody.

[223] I understand G.M.'s desire to have T. returned to her care. I recognize that G.M. loves T. and that T. obviously cares deeply about his mother.

[224] I also acknowledge that G.M. will be very disappointed with the court's decision. However, I hope that G.M. can appreciate and understand that in determining this matter the most important consideration is T.'s best interests.

[225] The minister has established on balance of probability that it would be in the best interests of T. that he be placed in the permanent care and custody of the Minister.

[226] The Minister's application is therefore granted. T. be and hereby is placed in the permanent care and custody the Minister.

[227] I sincerely hope that the minister will be able to conclude that future contact between G.M. and T., as well as, J.R. and T. will be in T.'s best interests.

[228] I thank counsel and the parties for their participation in this proceeding.

S. Raymond Morse, J.