**SUPREME COURT OF NOVA SCOTIA**
**(FAMILY DIVISION)**

**Citation:** Mi'kmaw Family and Children's Services v. C.G., 2013 NSSC 296

**Date:** October 1, 2013
**Docket:** SFPACFSA - 079197 and SPFACFSA - 083540
**Registry:** Port Hawkesbury

**Between:**

Mi'Kmaw Family and Children's Services

Applicant

v.

C.G., A.P (also known as A.G.)

Respondent

**Editorial Notice**

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

**Restriction on publication:** Publishers of this case please take note that s. 94(1) of the ***Children and Family Services Act*** applies and may require editing of this judgment or its heading before publication.

Section 94(1) provides:

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

**Judge:** The Honourable Justice Moira C. Legere Sers

**Heard:** June 18, 2013; June 21, 2013 and July 4, 2013, in Port Hawkesbury, Nova Scotia

**Counsel:** Robert Crosby, Q.C., for the Mi'kmaw Family and Children's Services Agency

**By the Court:**

[1] This application by the Mi'kmaw Family and Children's Services began on January 26th, 2012. The final disposition hearing began June 18th, 2013 ending July 4th, 2013. The parents were not present for the hearing.

[2] The respondent parents have five children: C., born October [...], 2005; I. born May [...], 2007; W. born March [...], 2009; K. born July [...], 2010; and A., born after apprehension of the older children but during this proceeding on November 1, 2012.

[3] This case raises critical questions concerning the child protection process, the efficacy and timeliness of the interventions, the resources or lack thereof available to autistic children in particular and children with special needs in general.

[4] These questions must be asked in relation to the stated objectives of the ***Children and Family Services Act*** 1990, c.5, and the definition of best interests.

[5] The first question the community and local agency must ask is:

> **Why did these children live in these circumstances for as long as they did without intervention ?**

[6] The second and third question is asked within the context of sections 3(2)(a), (b), (d), (e), (f), (g) and (k) of the ***Act***:

> **In light of the per diem costs expended for a 19 month period why was it necessary to remove this 7 year old child to a place of safety more than three hours from his home and community?**
>
> **Why were local resources not put in place to address the children's needs sooner? In light of the costs expended keeping C. in a place of safety at a cost of $1,200 per day why were these resources unavailable locally.**

[7] There are local doctors, local pediatricians and access through the IWK Hospital to the expertise required to assess and recommend supplementary services.

[8] These questions are important generally and in the particular in order to address the specific cultural context wherein parents and this community have struggled to absorb the consequences of the historic removal of children to residential schools; the significance of the removal of this child from their community; the separation of family largely due to poverty of resources; and the resounding impact on the extended family and on society.

[9] This is not a critique about the necessity for intervention. Indeed, intervention and support were long overdue.

[10] Nor is it fair, profitable or just to blame the front line social workers who clearly struggle to find workable solutions to misery and overwhelming health care and social problems.

[11] It is a critique of the efficacy of the process, a critique that flows from observations of these child protection cases. While well intentioned, at many levels, the system of child protection appears to be fundamentally flawed.

[12] Critical questions need to be asked and answered in order to protect these children on a long term basis and to protect this generation of children.

[13] These questions demand an intensive scrutiny of child protection and the priorities of resources and management.

[14] In asking the question how children in 2013 can live in such circumstances for such a period of time, one must also ask why and how this could occur without public scrutiny and outrage?

[15] Does part of the answer lie in the legislated ban on publication?

[16] Has this ban become a double edged sword; meant initially to protect children and families from harsh public scrutiny but evolving as the protector of an institutional and systemic poverty of priorities and management?

[17] Ironically, section 92 of the ***Act*** underscores one of the fundamental principles of the Canadian justice system, the transparency and openness of the court process. It states:

> 93. Except where this Act otherwise provides a proceeding pursuant to this Act shall be held in public except where the court (for reasons of protection of the child or the administration of justice) demand otherwise.

[18] However, section 94(1) imposes a ban on publication of these proceedings. Section 94(1)states:

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

Section 94(2):

> Where the court is satisfied that the publication of a report of a hearing or proceeding , or a part thereof, would cause emotional harm to a child who is a participant in or a witness at the hearing or is the subject of the proceeding the court may make an order prohibiting the publication of a report of the hearing or proceeding, or the part thereof.

And (c):

> Where the court makes an order pursuant to subsection (2) no person shall publish a report contrary to the order. (*Upon pain of a summary conviction punishable by a fine of not more than $10,000 or imprisonment for 2 years or both. )*

[19] Has this ban effectively blocked public scrutiny? How does this continue without intervention of some sort? Are we sleeping while our children suffer?

[20] Is there a way to better balance the differing interests to preserve and protect the privacy and integrity of families and children while maintaining the transparency of government intervention?

[21] What intervention in this case did provide to C., although **not in a timely fashion,** was long overdue essential resources: a family doctor (although C.'s

family doctor no longer sees him due to his behaviour); a pediatrician; a medical on November 2012; dental check-up (his first) on November 2nd , 2012; oral surgery on May 1st, 2013; a vision test on April 30th, 2013 and a follow up with cardiology on May 1st, 2013; assessors through the local autism group and the IWK experts and daily support caregivers to manage the children and their developmental needs.

[22] 'Not in a timely fashion' must be understood in the legislative context of a complex child protection scheme where an obligation is imposed by the state to intervene intrusively if necessary where the life, health and safety of children are at risk; **within** the legislated section 45 time constraints.

[23] Wait times for services and resources become significant impediments to compliance with section 45. Time literally runs out.

**Was the intervention too little, too late?**

**and**

**What of the future for these children?**

[24] Independent judicial scrutiny is unavailable in our legislative framework. After this case leaves the court system in accordance with section 45 of the ***Act***, the welfare of the children depends on the Child Protection system itself absent public scrutiny or independent review. Do we know what will happen to these children?

[25] What institutional safeguards exist that allow us to be informed and know what happens to our children in care?

[26] How can we protect these five children from the inevitable future deficiencies in our system of child protection?

[27] Why raise these critical questions? Because silence is acquiescence.

[28] The facts of this case must be set within our legislated values as expressed in the preamble to the ***Children and Family Services Act***.1990,c.5,s.1

[29] The ***Act*** states in its preamble:

> WHEREAS the family exists as the basic unit of society, and its well-being is inseparable from the common well-being;
>
> AND WHEREAS children are entitled to protection from abuse and neglect;
>
> AND WHEREAS the rights of children are enjoyed either personally or with their family;
>
> AND WHEREAS children have basic rights and fundamental freedoms no less than those of adults and a right to special safeguards and assistance in the preservation of those rights and freedoms;
>
> AND WHEREAS children are entitled, to the extent they are capable of understanding, to be informed of their rights and freedoms, to be heard in the course of and to participate in the processes that lead to decisions that affect them;
>
> AND WHEREAS the basic rights and fundamental freedoms of children and their families include a right to the least invasion of privacy and interference with freedom that is compatible with their own interests and of society's interest in protecting children from abuse and neglect;
>
> AND WHEREAS parents or guardians have responsibility for the care and supervision of their children and children should only be removed from that supervision, either partly or entirely, when all other measures are inappropriate;
>
> AND WHEREAS when it is necessary to remove children from the care and supervision of their parents or guardians, they should be provided for, as nearly as possible, as if they were under the care and protection of wise and conscientious parents;
>
> AND WHEREAS children have a sense of time that is different from that of adults and services provided pursuant to this Act and proceedings taken pursuant to it must respect the child's sense of time;
>
> AND WHEREAS social services are essential to prevent or alleviate the social and related economic problems of individuals and families;
>
> AND WHEREAS the rights of children, families and individuals are guaranteed by the rule of law and intervention into the affairs of individuals and families so as to protect and affirm these rights must be governed by the rule of law;

AND WHEREAS the preservation of a child's cultural, racial and linguistic heritage promotes the healthy development of the child.

[30] Section 2 of the ***Act*** states:

2 (1) The purpose of this Act is to protect children from harm, promote the integrity of the family and assure the best interests of children.

(2) In all proceedings and matters pursuant to this Act, the paramount consideration is the best interests of the child. 1990, c. 5, s. 2.

Section 2(2) reminds us that **the Court, the Agency, the relevant Minister and Department, as well as all parents,** are individually and collectively bound to seek and determine 'the best interests of the child' as our paramount consideration.

[31] The best interests is further defined by section 3(2):

(2) Where a person is directed pursuant to this Act, except in respect of a proposed adoption, to make an order or determination in the best interests of a child, the person shall consider those of the following circumstances that are relevant:

(a) the importance for the child's development of a positive relationship with a parent or guardian and a secure place as a member of a family;

(b) the child's relationships with relatives;

(c) the importance of continuity in the child's care and the possible effect on the child of the disruption of that continuity;

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

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

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

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

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

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

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

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

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

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

(n) any other relevant circumstances.

## THE FACTS

### Conditions on Apprehension

[32] When contacted in January 2012, the agency went to the home to investigate referrals related to the children's living circumstances. (Case Recording Report - November 1st, 2012)

[33] There was also an expression of concern about the father's mental health.

[34] In his Affidavit (February 13th, 2012) Darrell Comer advised that he attended with his co-worker to observe the respondents' home and the children. He sought police assistance.

[35] The police wanted to wait until the following morning for additional backup and dog control.

[36] On February 9th, two child protection workers with the assistance of six RCMP officers went to the home.

[37] Two of the officers attempted to convince C.G. (the father) to allow the workers into the home. They were initially refused entry.

[38] When the agency entered with the assistance of police, they described the home as presenting significant risks to the children's safety.

[39] The agents advised C.G. of the reasons for the agency's concern. The workers explained that the children would be coming into care.

[40] The parents cooperated with the workers and helped dress the children. The workers left with the children, without further incident.

[41] The description of the home is contained in Daryl Cormer's January 26th, 2012 Affidavit. The following is an excerpt:

> There was a mattress on the floor with no blanket; there was no furniture of any type in the home; there was no gyproc on the walls in the kitchen area and, in the living area, there was some gyproc with numerous holes and spaces in between; there was nails or staples protruding through the floor and most of the gyproc had the paper peeled off. The back rooms were locked and one room had two bull mastiffs in it.

[42] The Parental Capacity Assessment would later report that the father and the three boys slept on a queen size mattress in the corner of the living room. One of the workers added that there were no cupboard doors and no flooring. They were unable to gain entrance to the bedrooms. The home had mold issues.

[43] The children initially appeared to be in good health

[44] The two oldest children, despite being school age, were not enrolled in school. The parents were trying to teach the oldest at home with limited practical support.

[45] On the proposed DSM V-Autism Spectrum Disorder, the oldest child C. was later diagnosed in the third category, the highest level of severity, requiring "very substantial support" (Exhibit 6). He requires 24/7 care.

[46] The parents admitted to being overwhelmed. They had to lock their doors and windows because the oldest child was a flight risk. They modified the home to remove hazards to the children given C.'s behaviour. They isolated themselves in part due to C.'s behaviour. It was the way they coped.

[47] The mother advised that C. had been followed by a doctor since his infancy, that he had a severe sensitivity to touch. She advised that she had contacted the Autism Society and was placed on a waiting list for two years.

[48] The mother reported that the family has secluded themselves because of the oldest child's disability and conduct. Both parents acknowledged that they needed help with their oldest child because of his special needs.

[49] They acknowledged that it was hard to give their other children what they needed. Much of their time was focussed on caring for C.

[50] The mother advised that she and her husband had been attempting to get help to fix their trailer since 2005 but received help from no one.

[51] The parents had tried to make renovations and arrangements to move. They had moved frequently throughout different communities. They state they had been involved in a variety of services since C.'s birth and since his initial diagnosis with Autism.

[52] Despite the perception that the parents would respond aggressively at apprehension, all assessors and workers noted that each of the parents presented as polite, cooperative, initially willing to engage, intelligent and peaceful.

[53] While they were devastated at the apprehension and did not agree that it was necessary, they acted peacefully and respectfully with the interveners.

[54] In all this time, with the multiplicity of intervention requests, the worker assigned to the mother noted that only on one occasion did she express anger.

**Placements**

[55] When first apprehended, the three younger children were placed in a kinship placement with the maternal grandmother.

[56] However, on February 12th, 2012 the three children were taken from the kinship foster home by their mother A.P. and paternal aunt C.G.

[57] The RCMP and the agency workers retrieved the children from the aunt's home. The child C. was with his father in another nearby community. The father attended the police station with C. and C. was taken into care.

[58] The first Interim Order was issued on February 2nd, 2012 in relation to the first four children. The home in which the children were living was considered unfit.

[59] By subsequent Order of February 20th, 2012, the three children were placed in the interim care and custody of the applicant with supervised access to the respondents. This was continued by Order dated the 12th of March, 2012.

[60] Access visits were arranged locally, although access for the oldest and his parents was not instituted until much later. These visits were not successfully maintained.

[61] The three younger children were placed with their maternal grandmother who was approved as an eligible kinship foster placement.

[62] After the fifth child was born during these proceedings, she was also placed with the grandmother.

[63] The mother was permitted to live in her mother's home after her fifth child was born to assist in the care of her children.

[64] This continued until a dispute occurred between the mother and the grandmother in March 2013.

[65] The mother then moved out of her mother's home leaving the four children with the maternal grandmother under the supervision of the agency.

[66] Early on in these proceedings, a maternal aunt indicated her interest in caring for C.

[67] However, the maternal aunt and her partner have three children and would require more space and resources to care for him. They did not then have a home in which to welcome C.

[68] The second possible placement for C. was a small options home in Sydney.

[69] This home already houses three children. There is a two year wait list for this home. C. has been on the waiting list for this home for the duration of these proceedings. Due to an absence of adult placements for one of the residents, there is no " bed" to transfer C. into this home.

[70] The third possibility for this young child was an out of province placement.

[71] C. first moved briefly into foster care with an attempted transition to the grandmother's for a weekend with his siblings. This was unsuccessful due to his high needs and those of the other children, two of whom would later be assessed as Autistic.

[72] Another foster home was tried unsuccessfully. He was removed within hours of his arrival.

[73] After advertising in the local area for a foster home identified as capable of meeting this child's high needs, the workers completed a province wide search.

[74] Finding no available resources or suitable placement for this 7 year old, he was then placed in a motel in Truro, some three hours from his home and community.

[75] This "place of safety" designed to protect this child from himself was staffed with round the clock custodial care.

[76] C. was later moved to another place of safety, a two bedroom apartment in Truro.

[77] In or about May of 2013, C. moved to a one bedroom apartment in the same area.

[78] This move took place because C. spent a large part of his day jumping, rocking, ripping and rolling paper. The noise level in his previous apartment disturbed his neighbours. To avoid eviction, they moved to a smaller apartment.

[79] During this "safe" placement, he was cared for and supervised by **12** staff/workers from a private company. They worked on a rotating basis (two workers per shift) as his care givers.

[80] This was intended to be a short term placement, while more suitable placement options were found.

[81] After 12 days, a renewal is necessary to continue this placement. After 28 days, extensions are required from their head office to extend the stay.

[82] This placement lasted from February 2012 to and through most of the summer of 2013, a period of 19 months, at significant cost. I was informed that the per diem cost was $1,200 per day.

[83] The Final Plan dated June 18th, 2013 seeks to continue the placement of all except the oldest child with the maternal grandmother with supports in place for their safe management.

[84] After 19 months in the place of safety, the agency was given an ultimatum. The Mi'Kmaw Family and Children Services agency has been directed to find C. a placement in the community, or absent other suitable placements, risk having him placed out of province.

[85] Faced with having him removed from family and community, the family and the agency put together the latest plan to transition C. to the care of this maternal aunt provided the required supports are in place. This is expected to occur by the end of September 2013.

[86] C. was 6 at the beginning of this proceeding and is now seven years old.

[87] **This transition is being done contrary to the advice of medical experts, his care givers as well as the local agency.**

**Participation in Court Proceedings**

[88] For the February 20th, 2012 court appearance, the parents could not be located. Both had been served with the Notice of Hearing and advised of the first court appearance.

[89] The protection finding took place on April 19th, 2012. The mother consented to the finding. The father was not present.

[90] The Order continued by order of July 5th, October 31st, December 3rd, 2012, January 22nd and March 13th, 2013.

[91] The mother appeared at some of the subsequent court reviews. The father did not participate in the legal process except for a few initial appearances.

[92] Early in the proceedings, on February 17th, the agency worker met with the father to see if he wanted a lawyer and if he needed help in accessing one. He declined their offer.

[93] Subsequently, both parents had access to lawyers. Ultimately, both lawyers withdrew due to lack of contact with their clients.

[94] Neither parent participated in the final hearing despite having counsel appointed to represent them and despite **considerable efforts** by the agency (some at the direction of the Court) to ensure they were notified, had an opportunity to be present and had transportation provided to assist them to come to Court.

[95] I do not conclude the parents failed to attend because they were disinterested. They have maintained to the end they want their children back and as late as the June 2013 Affidavit, the agency, but for the lack of housing, intended

to return some of the children to the parents' care. (Agency Disposition Affidavit June 3, 2013)

[96] The history of their efforts would suggest there are far more complex reasons for their decision not to participate in this process.

[97] Having reviewed all the evidence and the testimony, I am satisfied that these parents struggled unsuccessfully to address their children's needs.

**The Plan of Care**

[98] Initially, the agency planned to provide services to the family, encourage the parents' participation and return the children to their care.

[99] The services included a Parental Capacity Assessment; a mental health assessment for the father; counselling for the mother; hair samples and drug analysis for both parents; an assessment for three of the children and a requirement that the parents participate in a parenting instruction program and services.

[100] The agency reviewed the case Plan with the parents on February 21st, 2012 and urged them to cooperate. Both parents were given a copy of the case plan. Both parents were cooperative with this Plan, knew of it and signed the case Plan.

[101] In late February 2012, the agency made a referral to the supervisor of family services for parental skills training focussed on effective parenting, stress management, household maintenance and healthy living.

[102] Except for one visit in April 2012, the family skills worker was unable to meet the parents due to her illness. Family support services were still largely unavailable by June 14th, 2012.

[103] The agency promised a parent program as well as family support which would begin for six hours per week to discuss safety in the home. This was finally started on **October 3rd, 2012.** The worker reported that both parents were cooperating.

[104] Access arrangements for the three youngest were initially proposed to be unsupervised at the home of the maternal grandmother three times per week.

[105] While apprehension took place in early February, by April 15th a visit between the parents and the oldest child in Truro had still not taken place despite the mother's request. For part of that time the agency had no address for the mother.

[106] The parents were encouraged to visit in Truro with the child C. once per week. Sibling access was arranged.

[107] Access visits in Truro did not go well. Eventually these access visits between the parents and C. were stopped because the parents found them too difficult. Even when C. was transported to their community, they could not proceed with the visits.

[108] The sibling access was stopped for two months in early 2013 due to the illness of the children. When reinstated, the visits resulted in problematic behaviour by C. which the care givers found hard to manage. The visits were them moved outside the safe placement.

[109] As of **June 18th, 2012**, the Plan of Care noted that the two children, W. and I., were awaiting an appointment for a child's needs assessment.

[110] The oldest child, C., was taken to a family doctor in Truro who referred him to a Pediatrician. They awaited an appointment with Child and Adolescent Services and with the Autistic Society and a Speech Pathologist.

[111] Each child was assigned a child in care worker to monitor their progress and development.

**Drug Testing**

[112] Ms. Anderson's second Affidavit, dated the 19th of April, 2012 outlines the number of drug tests to which the parents voluntarily complied.

[113] From the date of the first collection on February 29th, 2012 which was unsuccessful, to the final collection of March 16th, 2012 the testing results were negative.

[114] By June 1st, 2012 the agency called off the drug testing.

[115] By June 13th, 2012 unsupervised visits began.

[116] By September 10th, 2012 the mother had complied with all aspects of the intervention including participating in the Parental Capacity Assessment. She was, they said, fully engaged in the process.

**Counselling**

[117] The mother also attended three counselling sessions. When the counsellor was no longer available, the agency asked and the mother refused to begin again with a second counsellor.

[118] The agency asked the father to submit to a mental health assessment. He agreed to attend. This assessment was undertaken in October 2012.

**Housing**

[119] All parties anticipated the parents would have the children returned when housing had been obtained.

[120] One of the biggest obstacles for the parents, and ultimately for the maternal aunt who was prepared to take C. into her care, was finding appropriate housing to live in to facilitate a return of the children.

[121] The mother advised that they had not heard back from the band Housing Department regarding a home. She advised that she had her name on the list for housing in another community for seven years.

[122] The worker promised to call to determine the status of her application.

[123] Two weeks after the children were removed, the parents left the home in which the children had been apprehended to live with the father's sister. Their original plan was to take over her home. This did not occur.

[124] Sometime in February 2012 the mother moved and the agency temporarily lost contact with the parents.

[125] By June 12th, 2012 the mother had not had any luck in obtaining appropriate housing. She was advised that the trailer in which they lived would not be fixed by the [...] Band and she contacted the [...] Band but she said she had not received any return phone calls.

[126] In June 2012 the mother obtained a two bedroom unfurnished apartment in Sydney. They proposed C. have one bedroom, the children the other and they would have the living room. This plan was not accepted.

[127] By August 15th, 2012 the mother continued to seek an apartment.

[128] The mother was advised by the agency that it would be more beneficial for her to stay as close to [...] as possible in order to have services provided to the family.

[129] They returned to the paternal sister's home, a three bedroom home. She and her partner have eight children living there. They proposed to have the children returned to them. This plan was not accepted.

[130] In December 2012 the mother advised the court she had a home and hoped to move in before Christmas. That did not occur.

[131] They began to look for housing in the [...] community.

[132] The worker advised the court there is a five year wait list for housing.

[133] The agency worker advocated for them, contacting the band office on a weekly basis, hoping they would get priority so they could have their children returned to their care.

[134] The worker contacted the housing director. Except for the last meeting in April 2013, which the mother attended, the parents did not attend the meetings

[135] The mother and agency worker were advised that the mother would have to be a registered band member. This required a criminal records check. The mother was encouraged in March 2013 to apply and obtain a criminal registry check.

[136] Due to the lateness of her application and forgetting to sign the paper, her application was not processed until April 2013.

[137] In May 2013 the mother advised the band office that she no longer wanted to have a home in [...]; rather she was looking for a home in [...] . The agency was unable to verify this information.

[138] The parents were unable to obtain housing despite the agency's advocacy.

**Progress Reports within the context of Section 45**

[139] By June 13th, 2012, the agency began discussing unsupervised contact as the parents were doing well with the services being provided.

[140] As of July 10th, 2012 the agency *believed* that:

> -the parents had completed all components of the Parental Capacity Assessment and the agency awaited the recommendations of Dr. Landry (in fact, the father, C.G. had not participated in the Parental Capacity Assessment);
>
> -the parents had fully engaged in random drug testing with no positive results and the service was terminated;
>
> -the father was waiting a mental health assessment with C.B.R.H. and the worker acknowledged that could take six months to a year;
>
> -the parents had been willing to participate in family support instruction; however, due to a lack in family support workers that service had not yet begun; and

> -the parents had been having regular access with all four children and this was described as a positive experience for the children. The parents still had housing issues and were waiting a home in either [...] or [...] First Nations. The mother was considering getting an apartment off reserve.

[141] As of August 8th, 2012 the worker believed and was advised that C. would be returning to the home of his maternal grandmother on August 12th, 2012.

**Parental Capacity Assessment**

[142] The Parental Capacity Assessment was well underway by May 15th, 2012. Only the mother participated in this assessment. The father had engaged in one session only.

[143] On August 31st, 2012 the assessor's report was completed and on September 7, 2012 it was filed with the court.

[144] The assessor described the mother as open to the assessment and forthcoming with information. While more comfortable speaking Mi'kmaw, the mother was able to articulate in English and able to communicate effectively.

[145] Dr. Landry recommended the following:

> 1. The mother may benefit from some counselling to help develop better coping skills;
>
> 2. The parents may benefit from the support of other parents with children with Autism through the Autism Society of C.B.;
>
> 3. The children would benefit from thorough development assessments to identify the range and severity of the their needs;
>
> 4. The parents would benefit from connecting with supports to assist in the development of skills to support their children and reduce any existing behavioural difficulties; and

> 5. The parents may benefit from some hands-on support, learning more effective behavioural management strategies and strategies to stimulate child development. This would include the use of language to support child development and how to structure play activities to stimulate development and encourage better behaviour regulation.

[146] Dr. Landry advised that the oldest child presents with severe "autistic behaviours". There was concern about the younger children having developmental challenges.

[147] This contributed to a great deal of stress in the family system.

[148] He identified that supports were required to adequately care for the children.

[149] Dr. Landry noted that the mother and father have a strong, stable relationship and rely on each other for support.

[150] The mother comes from a family in which her parents had a long term, close relationship.

[151] There is no history of criminal activity.

[152] The mother generally enjoys good health, except having been diagnosed with Obsessive Compulsive Disorder (OCD) and anxiety.

[153] She presented no specific psychological issue that would interfere with her ability to provide parental care.

[154] She presented as a very intelligent and caring person.

[155] The mother achieved an overall full range I.Q., falling in the high average range. The results indicate that her thinking skills are above average.

[156] The testing showed no significant pathology on the MCMI-3 scale.

[157] On the Child Abuse Potential Inventory-4th edition, she was found **not to** be likely to physically abuse a child in her care.

[158] Dr. Landry concluded that the mother had some positive coping strategies and reported having a strong relationship with her husband.

[159] She was committed to her role as parent to her children and she has some insight into her challenges and is likely capable of more insight. He concluded:

> given Ms. P.'s ability to have insight and general level of stability presently, she would be a good candidate for a more structured.....in which specific skills are taught to enhance coping. This would include strategies to cope with anxiety and negative affect...etc., etc. She would be a good candidate for a more formal therapeutic program.

[160] Dr. Landry recognized the limitations in the assessment in that the father did not participate.

[161] He concluded that these four children "would likely present with a great deal of demands and put significant stress on parental resources...". He advises that:

> there are reports that raising children with Autism can be more stressful than raising children with other developmental disabilities (Schieve et. al 2007). In addition, the amount of stress can increase both with the number of children close in age and having other children with developmental disabilities (Pezzot-Pearce & Pierce, 2004)

[162] He observed that consideration "of the parental environment may contribute to some understanding to the current situation."

[163] He concluded that part of the problem was that the couple was socially isolated, trying to deal on their own with the oldest child's problems and had participated in very few community activities or addressed any type of community support in recent years.

[164] He concluded that the mother did not present with any specific psychological issues that would interfere with her ability to provide parental care. He saw no concerns that she was unable to provide care to the children and meet their general needs.

[165] Unfortunately, the parents distanced themselves from a strong extended family and did not or could not reach out for support.

[166] Dr. Landry noted that while the father terminated his participation, he observed that the father was very appropriate and polite and appeared to be able to interact appropriately. Dr. Landry asked:

> What obstacle or what factors prevent this family from connecting with supports and trying to cope themselves and having difficulty coping under the strain.

[167] Dr. Landry suggested that some therapeutic efforts would be beneficial to address some of these concerns and to facilitate their (the parents) willingness to work with professionals who could help to deal with some of the behavioural issues they are currently facing.

[168] He acknowledged that the family system was quite stressed, resulting in a chaotic home environment, characterised by few routines that would provide structure to the family unit and reduce the stress.

[169] On August 28th, 2012 at a meeting at the agency, the workers agreed:

> -that C. would be gradually moved back to [...] from the place of safety beginning August 31st, 2012;
>
> -that the children would reside in the maternal grandmother's home;
>
> -that several services would be put in place by the worker to assist the family in caring for all four children; and
>
> -the parents would be able to attend the home on a regular basis to provide care for the children.

[170] By August 28th, 2012 family support services had still not connected with the parents to provide the services promised by the agency.

[171] Dr. Baker, a registered Psychologist, was contracted to conduct a diagnostic assessment on the father. This was conducted in *October 2012.* She reported by letter dated November 29th, 2012.

[172] Dr. Baker found the father pleasant, intelligent and articulate, as well as compliant with all requests.

[173] As a result of her findings regarding a provisional diagnosis of Paranoid Schizophrenia, she suggested he be referred to a psychiatrist for treatment.

[174] The report identified the father's delusional belief system, more fully described in the doctor's letter.

[175] He is aware of socially accepted responses over time. His responses revealed delusional beliefs that indicate a psychotic thought process.

[176] Dr. Baker advised that stress has a substantial impact on the symptoms experienced by those with psychotic disorders. She advised that he was under a great deal of stress relating *to the loss of his children, his wife's recent delivery of another child, his uncertain housing situation and his current lack of employment*.

[177] She concluded that once these stressors were reduced, the symptoms may diminish.

[178] The father confirmed on February 21st, 2013 that he was taking his medication and felt well. It was his hope to continue to secure appropriate accommodations in [...] and live with his wife.

[179] In the final Plan of Care, the agency acknowledged that the family support worker attended the home (albeit very late in the game) to address parenting education, life skills and education with respect to proper safety procedures. They acknowledged that this service was successfully completed.

[180] Ms. Anderson in her March 12th, 2013 Affidavit noted that the family support services had ended. She noted there were *no parenting issues* identified in the Parental Capacity Assessment.

[181] Before returning the child C. to his parents, as was the plan, the agency decided to contact another specialist to review the file regarding C. and make

recommendations as to whether his parents could adequately care for him, given his needs. The parents declined to participate further.

[182] Time had run out. The parents did not have a home. The final agency Plan of Care filed for the June 18th, 2013 disposition review hearing provided notice to the parents that they were applying for an order placing the children in the permanent care and custody of the agency with a provision for access.

**THE CHILDREN'S ASSESSMENTS**

**C. (The oldest child)**

[183] The workers were not always successfully in accessing appropriate services for C. while he was in their care.

[184] The worker explained that she did not know he would be denied so many services because of his age. She has difficulty getting him enrolled in early intervention programs because he was school age, even though he was not attending school.

[185] They were able to obtain the services of a family doctor in early March 2012. Three workers accompanied C. to the office of his Truro physician. This doctor made the initial referrals.

[186] C. was then referred to a Pediatrician who subsequently referred him to local resources and the IWK Hospital for further assessment.

[187] C. was referred to Nova Scotia Hearing and Speech, Early Intervention Program, as well as the Autism Intervention Program with the Cape Breton District Health Authority.

[188] These Assessments for Autism were delayed.

[189] C. was seen by a Speech Pathologist at the Doc 'n Talk Clinic in April 17th 2012. He was seen for eight therapy sessions from April 23rd to June 14, 2012. At that time, his speech and language skill was determined to be well below the first year of development. An Autism assessment was recommended.

[190] These sessions were terminated when the Speech Psychologist concluded she could make no progress. An assessment was needed to better understand C.'s difficulties. These sessions were to be restarted in June 2013.

[191] C. was referred to the IWK. team in July 2012 and immediately denied service because the Autism Intervention Program with the Cape Breton District Health Authority was closer.

[192] The local team assessed him in July 2012 but denied him service because of his age. He did not fall within their mandate for service.

[193] The worker found out in November 2012 that he has been refused service at the IWK. She then asked the IWK to reconsider. They agreed to do so and preformed an assessment in April 2013.

[194] C. was denied a pre-school seat due to his age.

[195] As a result of a April 5th, 2012 referral from his attending Pediatrician, Dr. Wornell, C. was next seen by Dr. Moss, a Child and Adolescent Psychiatrist with Colchester East Hants Health Authority.

[196] Dr. Wornell provided the following information concerning C:

> He spoke neither English or Mi'kmaw words. The report notes he makes noises which "seem to have no meaning" and "do not seem to be used to communicate". He does not point nor wave. He is not toilet trained. If he wants to eat or drink, he will walk to the refrigerator. He does not respond to his name and it is unclear whether he understands any speech. He makes minimal eye contact and he refuses to eat using utensils. He does not seem to have texture preferences. He frequently puts things in his mouth
>
> He is "somewhat helpful in terms of getting dressed and undressed". He has little interest in television. He has odd behaviours such as holding his hand cupped very close in front of his face. He frequently rips paper up and rolls the pieces into small balls. He does not look through books and workers have not been able to read to him. He is quite busy and a challenge to control, he has a tendency to climb on furniture. As of May 29th, 2012, he has not been in school.

> ...he appeared well. He was difficult to examine because he was upset and uncooperative. He was at the 18th percentile of his weight.

[197] On July 12th, 2012 Dr. Moss provided her report.

[198] She noted that neither the Cape Breton social worker nor the local social worker were able to attend the appointment and, despite her requests, no background information was provided. Therefore, a complete assessment was not possible.

[199] Dr. Moss was unable to complete an ADIR because she had no information available for the time between his fourth and fifth birthdays.

[200] Dr. Moss noted that C. could have been in school about two years earlier and was not. Due to the open issue of placement, it was unclear whether C. would start in September of 2012.

[201] Her assessment was restricted to observing C. and his interaction with the Autism skills worker, Occupational Therapist, and Clinical Intervention Psychologist in the play room. The doctor was able to interview two of the workers who were responsible for looking after him. Both of them knew C. for six months. They describe his significant difficulties:

> C. certainly does display significant qualitative impairment in social interaction. He does not use eye-to-eye gaze, he has little facial expression. He does not use gestures. Body posture can be fairly unusual and he frequently stands in the manner of a figure in an Egyptian frieze. He has not developed appropriate peer relationships and indeed has developed very few relationships even with the adults that work with him. He does recognize people that he has seen before and will demonstrate that he his happy to see someone, usually someone who's male, by running and leaping on them but never seeks to share enjoyment, interests or achievements with them. He does not empathize and lacks social and emotional reciprocity.

[202] Dr. Moss also advised as follows:

> C. had very little sense of danger. He is a flight risk and he is not aware of the dangers, for example, of deep waters or vehicles on the road. He climbs, likely to be as high as possible, and will take unnecessary risks in doing so; for example trying to climb across the back of a chair to the knob of an open door without

> realizing that the door would probably swing. When he does fall and hurt himself, he seems indifferent to pain.

[203] She details C's significant impairments including his broken language. At that time in his development he has two words or sounds (as she described them). He had restricted interests.

[204] Significantly (for placement considerations), she noted he had little tolerance for routine changes. When his daily set routine is broken, he can become quite distressed.

[205] This bears considerable reflection considering the apprehension and placement decision put into effect by the Plan of Care, particularly when one worker described C.'s response to the placement **"banging his head on the floor for a few days until he settled."**

[206] Dr. Moss concluded that C's delays had onset prior to the age of three years. He was not then functioning at a three year level with regard to social interaction, social communication and symbolic or imaginary play.

[207] She noted he requires close supervision, at least two person care 24/7 due to the risk of flight and danger to himself and others. It is a risk they identify that arises out of his inability to assess risk or judge danger and not a risk due to any intent to harm himself or others.

[208] She advised that at home, besides two person care, he would need a safety system at night to alert his caregivers should he awake during the night. Such systems, she advises, are available.

[209] She advises that even a well educated family unit with resources would have difficulty meeting his needs.

[210] He will likely never be independent; needing ongoing basic daily care for his life as well as a consistent routine. He needed someone to develop a communication system he could use. At his age he is unlikely to learn language. She was unsure whether he will be able to communicate by way of a picture exchange.

**Diagnosis and Management**

[211] Dr. Moss confirmed the diagnosis of Autism. She was unable to assess whether his I.Q. was in the normal range:

> His gross motor development appeared to be normal. Fine normal motor skills are not at an age appropriate level. He uses primitive grasps for cutlery and for markers. He has little experience that would allow him to develop more appropriate ways of holding such implements..."

[212] In conclusion, however, Dr. Moss advised that C. **was not eligible** for the EIBI program because that program concluded on school entry, expected to be on the 6th birthday. She advised:

> that Family and Children Services in the area in which he will be living will need to look at the possibility of setting up local services. If he is to return to Cape Breton there is a **Neuro Developmental Service** available through the Cape Breton Regional Hospital; **however, services will not be as intensive as those that he would have received had he been diagnosed when younger.**

[213] Dr. Moss suggested in 2012 that placement be sorted out prior to September 2012 because he would benefit from time in an educational establishment.

[214] Dr. Wornell referred C. to the IWK Developmental Pediatric Clinic.

[215] Despite being removed form his community and his family due to the lack of proper care and service, the only services provided to C. between September 2012 and January 2013 were two play groups he was permitted to attend; each once a week for two hours. These services terminated in May and June 2013.

[216] I do not mean to exclude the daily caregivers from any due credit. Besides the obvious, I have no information that would allow me to draw any conclusions about their contribution to his daily needs. It did not, in the end, appear necessary to have these workers attend for the purposes of this hearing.

[217] Other than this and his custodial care, there were no summer interventions.

[218] In November 2012 the agency workers applied for admission to the local elementary school. In school he would have access to more resources.

[219] He was not granted admission until January 2013 and then only for two hours a day. It appears that his admission to school in January in 2013 opened up some assessment possibilities. In May 2013, as a result of a school based program, he was seen by an Occupational Therapist. He was awaiting a referral to Occupational Therapy as of April 2013.

[220] His social workers and his caregivers noticed a marked improvement in his behaviour and development in the four months preceding this final hearing. They attribute this to his attending school.

[221] The delay in enrolling him in school arose in part due to the uncertainly of his placement.

**Historical Development**

[222] C.'s records of the early years show that an echo cardiogram was performed while in the Intensive Care Unit in Cape Breton to investigate a heart murmur. This revealed mild pulmonary valve stenosis and a small apical muscular VSD. He had hyper tension and hypercalciuria. He was transferred to the IWK on January 4th, 2006 with a right inguinal hernia.

[223] It was recommended that he have follow up with Cardiology a year after he was seen by a Pediatric Cardiologist in September 2006. The records do not reveal what, if any, followup occurred.

[224] He was subsequently referred to Dr. Abenheimer in May of 2010 due to his family physician's concern about Autism. The Pediatrician agreed that he was developmentally delayed and had traits suggestive of Autism. He did have field testing in June of 2010 with the responses within normal limits.

[225] Dr. Kawchuk did assess C. in the Developmental Pediatric Clinic at the IWK.

[226] C. was 7 years and 4 months old. C.'s social worker and the main support worker from his placement accompanied him.

[227] Dr. Kawchuk recounted a part of the history of apprehension. She stated:

> At that time C. had no interest in others. He hid in corners and ate with his hands . He avoided all communication and ignored others if they approached him. He preferred to be in the dark on his own , and rocked for prolonged periods of time at nighttime. He had very little variation in vocalizations and when he first entered care, he threw himself on the floor and banged his head for the first few days. This is now resolved.
>
> ...he is sometimes aggressive towards (his caregivers) and will pinch them or pull their hair.

[228] She confirms his gains as reported to her since enrollment in school:

> In the past two weeks he has enjoyed playing with a particular girl on the slide in the playground and laughs with her. He is starting to sign more with some prompts and says "hi" "mom" and "n-n-n" for no . He has been more responsive in the past 4 months and will turn towards others when they speak to him.

[229] **Given his recent gains, she recommended he continue in his current respite care for another year**. Her extensive recommendations are important guides for his caregivers.

[230] She advised that at this time, psycho educational testing was premature.

[231] She suggested that the behaviour described to her suggests "the possibility of quite extreme lack of stimulation". She advised as follows:

> It is important to monitor his progress over the next couple of years . It often takes at least a couple of years in a very structured and consistent program before some of the behaviours reflecting these early years start to subside.

[232] She noted C. requires Speech Language Pathology which ought to be continued over the summer months as well as during the school year. She recommended increasing his time in school so that by year end he could attend full time.

[233] She recommended field trips to promote development of social skills. She recommended EPA coverage.

[234] She recommended a structured home program.

[235] Children with Autism Spectrum Disorders are usually more successful when they have *fewer major transitions and changes in their lives*. A gradual transition back to his family may be appropriate after another year in his current home but will depend on his progress.

[236] She advised on sibling access and placement options.

[237] She referred him for dental, Ophthalmology and Cardiology followup.

[238] In November 2012 the workers referred him to the IWK for his first dental checkup and he had oral surgery in April 2013.

[239] The assessor advised he should be seen again in the clinic in one year.

[240] These necessary assessments took place within the period of his temporary placement and while some were significantly delayed, they did occur as a result of the apprehension.

[241] I am informed that C. was not registered in a summer program in 2013 as recommended due to placement uncertainly and the requirement that he be moved back to his community during the summer.

[242] I am also informed that the school was not prepared to enroll him full time for the 2013 semester.

[243] The Department /persons from whom the Agency received their directions has decided against following the experts and his care givers recommendations, that he stay where he is for another year so as to avoid regression in his recent gains.

**Assessment of W. and I**.

[244] Dr. Landry was also contracted to assess the two children W. and I.

[245] His Report is dated September 26th, 2012 regarding 3 year old W.

[246] W. was in the Early Intervention Program. He had a great deal of difficulty with language and with reciprocal social interaction, as well as emotional regulation.

[247] The report described W.'s frailties. It ends with the conclusion that:

> W. clearly presents with the Autism Spectrum Disorder, experience delays in the use of language which are not compensated by more sophisticated gestural use. He initiated few examples of reciprocal social communication. It is recommended that he would benefit from participation in the Autism Intervention Program and that he be assessed by an Occupational Therapist to develop his adaptive abilities and ensure a smooth development of his health skills.

[248] Dr. Landry recommended W. would benefit from structured play activities, ongoing assessment and follow up by Speech Language Pathology and Occupational Therapy. Other very important interventions and recommendations are contained in his report. He advised that he would benefit from a more structured development assessment prior to school entry.

**I.(The third child)**

[249] I. was five years old at the time of the Assessment and Report. He has a great deal of difficulty with language but was able to use some verbal language to make some requests. He has very little functional language skills. His care takers have difficulty managing his behaviour.

[250] He presented as having some emerging skills in the domains of communication and social interaction.

[251] He presents with a severe developmental language disorder. He has made some gains in recent months but early history was marked by significant difficulties. He presents with an Autism Spectrum Disorder.

[252] The assessor recommends participation in the Autism Intervention Program, continued opportunities to participate in structured play that will allow him to develop communication and social skills, that he have ongoing assessment and follow up by Speech Language Pathology, an assessment by an Occupational Therapist, and a review by way of a developmental assessment prior to school. His caretakers should have access to these recommendations.

**Perspective**

[253] It is, therefore, not a surprise when all is said and done that the parents were unable to address each of their children's significant needs without substantial assistance from community resources.

[254] Given the community's lack of resources, those services necessary for the oldest child did not always come in a timely fashion, even at the agency's request or with agency intervention.

[255] Given each of the parent's disposition, they grew increasingly isolated and unable to reach out to family and community to obtain the assistance they needed to address the children's developmental and psychological needs.

**The Current Plan**

[256] At final disposition, the agency now presents a Plan that calls for significant ongoing 24/7 intervention to assist family placements in safely maintaining the children within their extended family.

[257] After over a year of living in a place of safety away from his family, and **contrary to his care takers and doctors recommendations**, the oldest child is being moved back into his community to live with an aunt with in home supports 24/7.

[258] There is conflicting testimony from the agency and the experts as to the wisdom of this move.

[259] His current caregivers and the expert psychiatrist evidence suggests that this move is premature and does not appear to reflect the best interests of C.

[260] The child protection workers employed by the agency, and ultimately responsible to their head office, must respond to the directives they receive from head office.

[261] The costs of the current placement, I am informed, is prohibitive and this placement must come to an end.

[262] To the extent any plan with children can be permanent, Section 45 time limits demand an end to the court proceedings and a permanent placement plan.

[263] A child welfare placement specialist Mari McLean Handly testified about placement options.

[264] She was responsible to find placements for hard to place children; finding placements within or outside the province. She is also responsible for monitoring places of safety arrangements.

[265] She testified regarding the initial placement efforts, their failures and successes. They advertised in the local area for possible higher level placements (more highly skilled foster parents). Receiving no response, they looked province wide for a suitable placement with no results.

[266] The maternal aunt, who is now the designated kinship placement for C., initially indicated her interest and continued to express an interest as a foster placement.

[267] This maternal aunt is the same person assisting the maternal grandmother on a daily basis to care for the other children in this family.

[268] At the time of apprehension she would have needed supports and housing as she has three children and her current home would be too small for C. and the family.

[269] I am unaware of **what if any supports** were offered to her to create a placement for C.

[270] The family was advised, as they approached final disposition, that should the parents not obtain housing or a family member come forward for C., he could potentially be removed from Nova Scotia to be placed in another province due to insufficient resources in province.

[271] If this failed to materialize without extended family placement, C. would have to be considered for out of province placement.

[272] As of the final disposition, the placement specialist advised that C. will need to have access in his community to a Speech Language Pathologist, a school with a designated teacher's aid to assist him, a Pediatrician, respite care, 24/7 care in home, Occupational Therapy, family support, and early intervention services, all of which they believe they have in the local area.

[273] As of the final hearing in June 2013, the agency advocated with the local Band counsel to find appropriate housing.

[274] Just before the hearing, the aunt and her family were of the belief they had a home designated and awaited power hook up.

[275] I am informed subsequent to this hearing, and prior to this decision, that the family was finally able to move into this home on August 19th, 2013.

[276] Three visits are scheduled for C., one on the August 21st, 28th and 29th. Depending on the outcome, they intend to move to overnight visits, and if all goes well, he will move in full time by the end of September.

[277] The temporary child in care worker Lydia Gould is also the worker responsible for the other children placed in the grandmother's home.

[278] She visits them once a week. She described the circumstances in the grandmother's home with an infant, and three other children, two of whom are also autistic.

[279] **One child was wrapped around the grandmother's legs, the second banging his head, the third running circles around the home and the baby needing attention**.

[280] These children need early intervention, Occupation Therapy, Hearing and Speech specialists and ongoing in home services.

[281] In May of 2013 this worker met with the local Autism team to seek in home assistance.

[282] If the maternal aunt's placement breaks down, C. could be still institutionalized effectively without outside independent scrutiny.

[283] This would effectively put this 7 year old child at risk of a life time of care either in an institution or provided for by long term care workers, without any access to kinship placement, extended family or independent review.

[284] The objectives of the ***Children and Family Services Act*** require the Minister and the Court to initiate a "least interventionist" approach to first address the possibility of placement within the family, then the community and then lastly when no other suitable placement occurs, in the permanent care of the Minister in a third party placement.

[285] I am not clear why with the infusion of money invested in this place of safety, the services ultimately provided and the interventions recommended could not have taken place in or near his community, given the legislated objectives of the ***Act.***

[286] Obtaining the proper housing remained a concern for the parents, for the maternal aunt and for the agency. While the agency provided a supportive letter to the [...] Housing Department to assist the respondents in seeking adequate housing, that assistance was not enough.

[287] The protection worker was there to arrange services, to assist the respondent's in addressing protection concerns, monitor the family's progress and provide support to the family through the agency's involvement.

[288] Page three of the Plan of Care notes that the mother attended some counselling sessions with a social worker. The agency provided no reports, received no reports and these sessions ended when the social worker left [...] social work.

[289] The agency admits that the parents have made progress through cooperation and participation in some agency recommended services.

[290] The agency recognized that First Nation housing is a challenge.

[291] Due to the time constraints in section 45 of the ***Act,*** the agency acknowledged they are unable to transition the younger children back into the home with the parents without adequate housing.

[292] It is clear that the parents are without adequate housing to meet the needs of the children.

[293] While there are a multiplicity of problems arising out of personal and institutional frailties, the children's needs are overwhelming, the parents were unable to orchestrate the creation of a complex support system capable of housing and protecting these children. In the end, the parents withdrew from the agency interventions.

[294] Thus, the agency has made a decision to seek permanent care and custody.

[295] They have advised that all access will be at the discretion of the agency.

[296] The mandate of court ordered intervention has come to an end in accordance with section 45 of the ***Act;*** the Court has two options, to place the children in the permanent care of the agency or return the children to their parents all without imposing conditions on either the agency or the parents.

[297] The parents have not been able to obtain adequate housing for their children. They appear to have accepted most of the services that were offered.

[298] While the mother maintained regular contact with the children until March 2013, the breakdown in the relationship between her and the grandmother interrupted the contact between her and the children. I understand that some efforts are being made to repair family ties.

[299] The father has not maintained visits.

[300] The children cannot be returned to the parents without adequate housing and adequate services in place to assist them in the care of their five children, each with significant needs.

[301] The assessors for the children indicate that ongoing **significant interventions** are necessary to try to keep these children with their grandmother and C. back with his extended family.

[302] Dr. Kawchuk recommends C. not be moved for at least another year to build on his progress. She advised he requires at least two years of stability to "retain and regain" the skills he is being taught. Moving him may cause a setback.

[303] On the totality of the evidence, the agency has satisfied me that the children continue to be in need of protective services and may well be in need for their dependant lives.

[304] The parents have not been able, on their own, to address these significant needs or engage in community services and supports.

[305] The kind of care the children need at this stage has been described to me and it is significant.

[306] The parents have refused to participate in the legal process.

[307] The agency recognizes the attachment between the parents and the children and recommends access continue at their discretion both to preserve the attachment and connection and to protect the integrity of the kinship placements.

[308] There is evidence to support that the continuation of access as recommended by the agency is the most appropriate conclusion.

[309] The last child was born while this proceeding was ongoing. The interim hearing for this child took place November 13th, 2012. The time lines for the latest child extend beyond the date required for final disposition for the first four children.

[310] However, the testimony establishes that there is unlikely to be sufficient changes in the parents circumstances in accordance with section 46 (6) of the ***Act*** before the deadline imposed by statute and case law to allow for a return to the parents to delay this final disposition

[311] The Mi'Kmaw agency workers, the experts and his care givers all support Dr. Kawchuk's recommendations as meeting C.'s best interests.

[312] The Department /persons responsible for long term planning has issued an ultimatum that he be moved quickly to his aunts home or face the possibility of

placement in Ontario. I have no evidence as to why they have chosen to take this course of action.

[313] I have also been advised that despite the recommendations to have him enrolled in school full time, the school has not agreed to provide those extended hours. What happens in his home community school remains to be seen.

[314] The hearing commenced in accordance with limits imposed by section 45 of the ***Act*** .

[315] I have no parents or lawyers on their behalf present to contest the Agency's plan in spite of the fact that this plan has not followed the advice of all of the child's current caretakers.

[316] Concerns were expressed by the expert reports that placement with the siblings may overwhelm the grandmother. Indeed I am concerned about the responsibilities on both the grandmother and the maternal aunt.

[317] The very real concern on the evidence is that the aunt, who has three other children, will be overwhelmed with adding C. to her family.

[318] Dr. Landry confirmed what should be obvious, that any family regardless of available resources, would be hard pressed to manage C. or the other children with their presenting problems.

[319] The aunt will need significant supports on a daily basis. She will need access to Occupational Therapy, a teachers aid in school, pediatric and medical referrals and neurological assessment as recommended in the reports.

[320] Otherwise, the plan proposed simply sets both this child and the maternal aunt up for failure.

[321] All parties seem to be in agreement with the placement of the last four children.

[322] One can understand why continuation of the place of safety may not be sustainable in the long run.

[323] However, the investment of resources may well have created a brighter future for the children had that investment been placed in maintaining the integrity of the children's connections within the larger community.

[324] It becomes more difficult to justify the interim placement as a long term option from the apprehension forward when investment in the community where he lived could have better responded to the directives of the legislation.

[325] In this community, **carefully managed**, he could have access to local pediatricians, school resources and other recommended services deemed necessary for his development.

[326] The removal of C. to a safe home three hours away from his community was heart rending.

[327] This is not the only case where the lack of housing and residential resources has resulted in placement of a child in a residential facility far from home.

[328] The division of opinion respecting what reflects the best interests of C. reflects a conflict between these competing interests.

**Attachment**

[329] I have heard non-expert testimony on the attachment of C. to his siblings, suggesting that he had little capacity for attachment.

[330] This testimony came from a social worker not qualified as an expert in attachment theory.

[331] Other social workers have admitted that they are unaware at this point what C. understands in terms of his identity, being in care and what or how he feels about this family.

[332] I have had some other testimony from Dr. Moss describing his lack of *apparent* attachment. However, her assessment, she admits, was limited.

[333] The common theme for C. is that his routine must be consistent and stable and, as much as possible, preserved for two years.

[334] Clearly, his circumstances, and that of his siblings, had to be improved.

[335] At least some of C.'s current problems arise due to the fact he was not enrolled in school. This could have been alleviated with earlier services and intervention.

[336] He is now past critical developmental stages making adapting to a communication strategy much more difficult.

[337] The description of his first few days in custodial care, banging his head on the floor, are a compelling display of the effect of the disruption and break from his routine, such as it was.

[338] There was some suggestion that he had no attachment to his family, that he could not attach even after six years in their care.

[339] In light of what improvements have been observed with his current caregivers and school, it would be more accurate to conclude that there is insufficient knowledge of what C. is, in fact, thinking.or is capable of thinking.

[340] Given the advancements in our understanding of attachment theory, I am cautious and reluctant to draw any such conclusions on his capacity for attachment without consultation with an expert in attachment and Autism to draw what I would consider to be reasonable conclusions as to what, if any, attachment C. had with his siblings.

[341] I reject the suggestion without proof that one can disregard the notion that C. had developed some connection with his siblings or his parents over his six years of life.

[342] Determining where a child should live and with whom requires a global consideration of all relevant factors that places the paramount emphasis on this child's best interests.

[343] The thought that C. could be further removed from the province was an assault on the family and community senses, provoking the plan that they provide accommodation and care or lose him forever.

[344] While the cost of placement seems to be the compelling reason for this precipitous move, certainly the ***Act*** requires that the focus on family and community placement should have been a priority from the beginning.

[345] As the children's guardians, whether temporary or permanent, the agency and the Ministry responsible are obliged to consider not only the availability of resources; they must give meaningful consideration and weight to the values as expressed in the preamble of the ***Children and Family Services Act*** and to the best interests as defined in the ***Act***.

[346] Clearly, the bulk of the evidence supports a more gradual transition.

[347] Should the Court place the children in the permanent care of the agency, the agency can effect a gradual transition to ensure the placement is well supported and not sabotaged by a precipitous move.

[348] If permanent care is ordered, the agency, pursuant to section 47(1) of the ***Act,*** is under the same obligation as a parent or guardian.

[349] Having decided to support and maintain the interim 19 month placement, a decision to return him to his community comes with a positive duty as guardian to consider the best interests of the children as the paramount concern; sustain, maintain, support and preserve the integrity of the placement and meaningfully consider the therapists advice to ensure the transition is successful.

[350] This places the agency and the Ministry responsible as guardian, under the same constraints and obligations as those of the parent. These obligations have been explicitly defined in **Young v. Young**, [1993] 4 S.C.R. 3. They are obliged to consider the best interests of the children and obliged to consider their best interests as a paramount consideration.

[351] They are under no less duty than a parent.

[352] The concern here is that after permanent care, there is no meaningful judicial review of administrative management of children in care.

[353] For the reasons set out, in the absence of other options and in light of the Plan placing these children in the care of their extended family, I place all these children in the permanent care of the agency in accordance with their proposed Plan of Care.

**Access**

[354] There shall be access to the parents as arranged through the agency.

[355] In considering access between the parents and the children, I have considered the elements contained in section 47(2).

[356] I have considered that the placement planned is with family and I have been informed that adoption is not at this time contemplated.

[357] I agree with the representations of the Mi'kmaw agency workers that the integrity of the placements has to be protected and the family placements should be protected from the burden of negotiating family contact. Thus, the agency has agreed to take responsibility for negotiating and facilitating such access between the children and their parents as they determine appropriate. I have no doubt that they will do so in consultation with the kinship placements.

[358] Counsel for the agency shall draft the order.

Moira C. Legere Sers, J.