SUPREME COURT OF NOVA SCOTIA
(FAMILY DIVISION)
Citation: Nova Scotia (Community Services) v. S.W., 2010 NSSC 472

Date: 20101231
Docket: SFHCFSA-067471
Registry: Halifax

Between:

Minister of Community Services

Petitioner

v.

S.W. and A.S.

Respondent

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 the 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 Elizabeth Jollimore
Heard:	November 22 - 26, and December 22, 2010
Written Decision:	January 5, 2011
Counsel:	James Leiper for M.C.S. Shelley Hounsell-Gray for S.W.

By the Court:

Introduction

[1] This is an application by the Minister of Community Services for permanent care and custody of fourteen month old B. The Minister made its application on June 11, 2010.

[2] Ms. W is B's mother.

[3] The Minister's application identified Mr. S as B's father based on information provided by Ms. W. Mr. S has played virtually no part in this proceeding. He was personally served with notice of the initial application. On the sole occasion when he attended court, two further court dates were scheduled. He didn't attend either of those, though he signed the adjournment slip and would have been aware of them. Mr. S has never had counsel appear on his behalf. He was personally served with notice of this application for B's permanent care and custody and he was encouraged to contact the Minister's counsel so he could participate in this trial. Mr. S didn't contact the Minister's counsel and he didn't participate in this trial.

[4] Ms. W asks that the current order continue: she wants me to order that B remain in the temporary care and custody of the Minister so that she may address the Minister's concerns in the time that remains before the statutory deadline for concluding this proceeding is reached. Ms. W's plan is that before the deadline is reached, B would be returned to her, to live in her home where her mother would live with them.

History of this proceeding

[5] On November 25, 2009 the Minister of Community Services filed an application to determine whether B, who was then less than seven weeks old, was in need of protective services. The Minister's application was pursuant to sections 22(2)(b), (g), and (ja) of *Children and Family Services Act*, S.N.S. 1990, c. 5.

[6] The Minister became involved with Ms. W during her pregnancy when there were concerns about substance abuse, prescription drug abuse and domestic violence between Ms. W and Mr. S. Following this, Ms. W voluntarily worked with the agency during her pregnancy. She was in contact with individuals at the IWK Heath Centre, where she took part in pre-natal care and weekly drug tests. An opiate, presumed to be the hydromorphone prescribed to Ms. W to combat her chronic back pain, was identified by these tests. When B was born, he was placed in the neo-natal intensive care unit and treated with morphine for one month until his opiate withdrawal symptoms subsided. Initially everyone anticipated that B would be discharged from the hospital to his mother's care. This didn't happen.

[7] According to the Minister, a number of concerns led to the decision to take B into care:

a. Ms. W had failed to arrange full-time and long-term care for B on his discharge from the hospital;

b. though she had signed a memorandum of understanding with the agency and agreed to take part in certain services, Ms. W hadn't started the services;

c. Ms. W hadn't attended addictions counselling for several weeks;

d. despite past domestic violence, Ms. W was allowing Mr. S to stay with her; and

e. Ms. W's attendance at the hospital to spend time with B wasn't consistent and was only for brief periods.

[8] On December 2, 2009, Ms. W consented to an initial order that there were reasonable and probable grounds to find that B was in need of protective services. She consented to the Minister's request that B live with her sister and brother-in-law under the agency's supervision. Her sister consented to this placement.

[9] The interim hearing was concluded on December 7, 2009. Ms. W again consented to the relief the Minister was seeking, including a requirement that she abstain from the use of alcohol and illegal drugs and from the abuse of prescription drugs. Ms. W was ordered to refer herself to Capital Health Addiction Prevention and Treatment Services for counselling and she was ordered to follow through with all treatments recommended by her counsellor. She was ordered to participate in individual counselling and she was to refer herself to New Start for domestic violence counselling. An order was also granted, pursuant to section 96(1) of the *Children and Family Services Act* for the admission of evidence in other child protection proceedings relating to Ms. W as evidence in this proceeding.

[10] A pre-trial conference was scheduled for January 21, 2010. Before the conference, everyone anticipated that B would be going home with his mother and there would be strict terms governing this: Ms. W would be supervised at all times and she would participate in programs, treatment and random urine drug testing. The prospect of B's return to his mother was short-lived: just one day before the pre-trial conference, the Minister took B into care and served a Notice of Taking Into Care and a Variation Application and Notice of Hearing on Ms. W.

[11] In its Variation Application, the Minister sought an order that B be placed in its temporary care and custody. B's aunt and uncle were no longer willing to provide a home for him. The Minister sought an order with many requirements of Ms. W. Specifically, she was to abstain from the use of alcohol and illegal drugs and from the abuse of prescription drugs, she was to refer herself to Capital Health Addiction Prevention and Treatment Services for counselling and treatment as might be recommended and she was ordered to follow through with

all treatments recommended by her counsellor. Ms. W was ordered to take part in individual counselling and she was to refer herself to New Start for domestic violence counselling. These terms were continued from the December 2009 order. New relief sought by the Minister included having Ms. W refer herself to the public health support program New Beginnings, ordering Ms. W to work with a family skills worker and requiring her participation in random urine drug testing. Finally, production orders were sought for two doctors' files. Ms. W consented to the Minister's application and the protection order was granted on February 9, 2010. The protection order contained all the relief I've noted.

[12] The disposition order was granted, also with Ms. W's consent, on April 29, 2010. While the disposition order was similar in many ways to the protection order, it no longer contained requirements for Ms. W to participate in random urine drug testing or for her to refer herself to the public health support program, New Beginnings. Random urine drug testing was not part of this order because Ms. W had not participated in the earlier ordered random urine drug testing. The disposition order did require her to seek medical care and treatment for her longstanding chronic pain since Ms. W attributed her drug use to managing this pain.

[13] After the disposition order was granted, further production orders were granted: Ms. W consented to the production of materials from the local methadone clinic, Direction 180, the Nova Scotia Hospital, Capital Health Addiction Prevention and Treatment Services, Dr. Harding, MSI, New Start, Emergency Medical Services, the Centre for Pain Management, the Dartmouth General Hospital, the Queen Elizabeth II Health Sciences Centre and Dr. To.

The hearing

[14] I heard evidence from three doctors, each of whom was qualified to give expert opinion evidence in his or her area of specialty. Dr. Fraser treated Ms. W during the latter months of her pregnancy and until December 2009. He works at Dalhousie University, the North End Community Health Clinic and the methadone clinic, Direction 180. His specialty is chronic pain and addictions. Dr. Scott treated Ms. W at the IWK Health Centre during the summer of 2009 and through to B's discharge from the Health Centre. Her specialty is obstetrics/gynecology and maternal and fetal medicine. Dr. Avery works at the IWK Health Centre, the Dartmouth Centre for Pain Management and in her own private practice. She treated Ms. W through the Dartmouth Centre for Pain Management during the four month period from June 22, 2010 to October 25, 2010. Her specialty is chronic pain.

[15] In addition, I heard from Ms. Hankin who is Ms. W's long term social worker, two workers who supervised B's visits with his mother and Ms. W's family skills worker. I received an affidavit from Ms. W's mother who was not required to testify. Lastly, I heard from Ms. W.

[16] As is the practice, Ms. W filed an affidavit before the hearing. In organizing how the hearing would proceed, Ms. W asked that she be allowed to offer some evidence through direct examination, saying that this would let her become accustomed to giving evidence and respond to new information from Ms. Hankin's testimony. I was told this would take five to ten minutes. Ultimately, Ms. W's direct examination continued for approximately seventy-five minutes, during which she had a fifteen minute break.

[17] Ms. W's cross-examination proceeded slowly. During the presentation of the Minister's case, I invited Ms. W to sit or stand, as suited her. She was encouraged to do the same during her own testimony. Typically, she was questioned for no more than an hour before she took a break. Many times, her breaks came at intervals of twenty to forty minutes. Most of her testimony came over two consecutive days and, on these days my schedule and counsels' meant that Ms. W was able to have an extended break of approximately two hours over the lunch period. We adjourned for the day on the second day of her testimony just a half hour after returning from the lunch period because Ms. W felt ill. The hearing was scheduled to be concluded on the next day but Ms. W failed to attend. Her absence was unexplained. The hearing was adjourned for approximately three and one-half weeks until counsel were available to re-attend. Ms. W's testimony was completed at that time.

Protection concerns

[18] The Minister contends that Ms. W hasn't resolved its concerns and the circumstances which justified the order are unlikely to change within a reasonably foreseeable time which doesn't exceed the maximum statutory time limit of April 29, 2011. The Minister's concerns and the circumstances which justified the order were described as:

a. Ms. W's drug use;

b. Ms. W's parenting; and

c. Ms. W's history of poor choices in her romantic partners which has lead her to relationships involving domestic violence.

Drug use

[19] Ms. W has a twenty-five year history of drug use. Ms. W admits that in the past she has double-doctored, she has lied to obtain drugs from doctors, she has lied about her drug use and she would get drugs on the street. Ms. W says these are the behaviours of an addict. She says these behaviours are in her past and she is no longer an active addict: she doesn't do these things any longer.

[20] In her affidavit, Ms. W says that she has been experimenting with illegal drugs since she was about 15 and she began to use cocaine on a regular basis in 1996 - 1997. Ms. W says she's participated in many forms of detoxification programs in the past. Six or seven years ago, she took part in a methadone program. She says this helped with her pill use, but she returned to using cocaine on a regular basis because she would come into contact with drug dealers at the methadone clinic.

[21] Ms. W gave various different timelines for her drug use history. Her evidence was vague and conflicting when it came to time frames. Ms. W says that she was clean when her back was injured two years ago. Following that injury, she had a CT scan and was told that she had herniated discs in her back. She was given a prescription for painkillers and a referral to Dr. Christie, a neurosurgeon. Since this injury, she has used prescribed medication, particularly hydromorphone, to manage her pain. Initially, she was prescribed a formulation which was effective for short periods and, then, a longer-acting formulation. She says the time-release formulation leaves her more alert and it better manages her pain.

[22] Ms. W attended a day detoxification program during the summer of 2009 while she was pregnant. She left the program against medical advice.

[23] She was referred to Dr. Fraser, a doctor with special expertise in chronic pain and addictions, during her pregnancy. She discontinued treatment with Dr. Fraser after he told her that he would be switching her to a daily witnessed prescription of morphine because of irregularities in her then-current prescription. At that point B was two months old.

[24] The production orders provided a large volume of records and documents. The Minister winnowed through the material to provide me with extracts reflecting Ms. W's own reports of her drug use. At various times she has described her drug use to doctors from whom she sought treatment, to counselors with whom she was working and to the police. The drug use she reported to these individuals revealed a history of using drugs including crack cocaine, Demerol, methadone, marijuana and, as she once reported to Dr. Avery, "whatever [I] could get". The records reflect Ms. W saying she injected and snorted drugs.

[25] In her testimony, Ms. W says she lied when reporting her drug use. She says she lied to those assessing her for admission to detoxification programs because admission to programs is reserved for active drug users and if she told them she wasn't using, she wouldn't be admitted to the program. She says that lied to the police so that she would be held at a hospital overnight rather than at the police department, when she feared the cold, hard steel bed would exacerbate her back injury. Sometimes Ms. W questioned the accuracy of the records: for example, she said that her recounting of her *historic* drug use was incorrectly noted in records as *current* information. She noted this particularly in the records of Capital Health Addiction Prevention and Treatment Services, though she had also testified that these same reports were actually her lies portraying herself as an active drug user to secure admission to treatment programs. As a result, it is difficult to attach any value to Ms. W's reports of her own drug use.

[26] If I accept what Ms. W says - that is, if I believe she is now telling the truth about lying in the past, the only reliable indicator I have about her past drug use is the results of her drug tests.

[27] Ms. W referred herself to Capital Health Addiction Prevention and Treatment Services in June 2009. Since she tells me I cannot rely on the information she gave to admitting personnel (that she had used crack cocaine), I must rely on objective information. Her urine test at that point was positive for opiates, cocaine and cannabis and injection tracks were observed on her neck. She was six months pregnant. While Ms. W tells me she lied to admitting personnel, her drug test results confirmed what she had said to them.

[28] One month later, in July 2009, Ms. W was admitted as an in-patient in the detoxification program. Two days after her admission, she was taken to the Dartmouth General Hospital. Staff at the in-patient detoxification program confirmed with Dartmouth General Hospital's emergency room staff that Ms. W had left the emergency room against medical advice: the emergency room staff had planned to admit her. When she returned to the in-patient program from Dartmouth General Hospital, Ms. W's urine was tested and the test was positive for opiates, cocaine and methadone.

[29] Just four days after she was admitted to the in-patient detoxification program, Ms. W chose to leave it. Before being discharged, her urine again tested positive for opiates. She left the program against medical advice. She was seven months pregnant.

[30] Ms. W says that during her pregnancy she had a couple puffs from a joint of marijuana. She couldn't remember when she did this. She was clear that she didn't know the joint contained anything other than marijuana. She was adamant there was just one occasion when this happened. As each additional positive test result was revealed in her cross-examination, each was attributed to this single occasion of drug use, regardless of when the drug test was done.

[31] As Ms. W began her treatment with Dr. Fraser on September 10, 2009, she tested positive for cocaine, methadone and opioids. At that time, she was in the eighth month of her pregnancy. Ms. W saw Dr. Fraser until December 2009. For six weeks following B's birth, Ms. W was to participate in random urine drug testing at the IWK Health Centre. It appears that neither Dr. Scott nor Dr. Fraser was monitoring the test results. Dr. Fraser was unsure that he was seeing the results. When asked, he did say that if he'd seen anything of concern, he would tighten the controls of Ms. W's treatment. When the controls on her treatment were tightened it was in relation to an irregularity in the collection of her prescription.

[32] Ms. W was compelled to participate in random drug testing by the February 2010 protection order. She did not participate in any tests. Her testing was discontinued because of her lack of cooperation.

[33] At a review hearing on September 8, 2010, Ms. W asked that random urine drug testing be put in place. She wanted a second chance. The Minister acceded to the request and reminded Ms. W of what she had to do to ensure testing was done: to be at home every day during the agreed upon time frame, to answer the door and to let the tester into the building and into her apartment. Though Ms. W had requested that testing be re-instated, she didn't participate in any tests. Testing was discontinued a second time.

[34] At a pre-trial conference on October 4, 2010, Ms. W asked again to be given a third chance to participate in random urine drug testing. The Minister was reluctant to re-instate the testing because Ms. W had not participated in the previous two rounds of testing. It was at my less-than-subtle urging that the Minister put testing into place at the beginning of October 2010. This was Ms. W's second request for testing. She again failed to participate.

[35] A few days before the trial started, Ms. W went to Dr. Avery's office and provided a urine sample for testing. She chose the date and place of this test. The test was not random. The sample was clean. Ms. W returned the day before the trial began for another test and was turned away.

[36] As a result of Ms. W's repeated failure to participate, I don't have random urine drug test results in the context of this proceeding.

[37] When it became apparent in the spring of 2010 that Ms. W was not participating in random urine drug testing, the order that she participate in those tests was replaced with an order requiring her to "seek medical care and treatment for the longstanding chronic pain" for which her medication is prescribed. The Minister attempted an alternate approach to Ms. W's drug use.

[38] The Minister's concern was Ms. W's failure to pursue alternate means for alleviating her pain and her preference to rely on drugs. Ms. W has long avoided options which threaten her drug use. For example, when she first saw Dr. Fraser in 2009, she rejected his suggestion that she take part in the methadone program, saying methadone was a trigger for cocaine use and not wanting to change her medication while she was pregnant. When her pregnancy ended, she said she wanted to get through the initial period of adjustment before changing her opioid. Then she didn't want to change anything until things settled down and B was at home. Then she stopped seeing Dr. Fraser.

[39] In her testimony, Dr. Avery said that she suggested Ms. W have "nerve blocks". Dr. Avery says she brought this up quite a bit, but whenever she did, Ms. W never had time for the treatment which takes five to ten minutes. When Dr. Avery mentioned nerve block treatments, Ms. W would say, most times, that she had to leave.

[40] In her affidavit of October 14, 2010, Ms. W said that she would be starting cortisone treatments "next week". Ms. W did see Dr. Avery that week, but there was no cortisone treatment and, according to Dr. Avery, Ms. W did not return to see her after October 25, 2010

and there were no cortisone treatments prior to that date. There was no evidence that any doctor has provided Ms. W with cortisone shots.

[41] Ms. W's current prescription dosage is less than half the dosage she was taking when B was born fourteen months ago. This is not a result of any effort by Ms. W. When Ms. W began seeing Dr. Avery, the doctor adjusted Ms. W's prescription by adding different drugs. By doing this, Dr. Avery was able to accentuate the impact of Ms. W's pre-existing prescription, so that a lesser dose of hydromorphone would have the same effect as the greater dosage.

[42] Ms. W points to the fact that she no longer "double doctors" as an indication that she has progressed in addressing her drug use. However, when she became involved with Dr. Fraser it was part of her doctor/patient relationship with him that he became the sole doctor to write prescriptions for her. Ms. W did not stop double doctoring: it was stopped by external forces.

[43] After she initially injured her back, Ms. W was referred to Dr. Christie, a neurosurgeon. As her appointment with Dr. Christie neared, she was pregnant and she says his office cancelled her appointment when this became known. She says that she has been trying to see Dr. Christie ever since B was born. There was no explanation why she did not request a new appointment at the time her initial appointment was cancelled or why she took no steps to arrange an earlier referral by one of her other doctors, either Dr. Scott at the IWK Health Centre, who followed her during the latter months of her pregnancy or Dr. Fraser at the North End Community Health Clinic. She says that she has been referred to him again, by the Dartmouth General Hospital, the Queen Elizabeth II Health Sciences Centre and by her family physician, Dr. To. At no point has Ms. W seen Dr. Christie for a surgical consultation.

[44] I was provided with the contents of Dr. Christie's file. It contains no record of Ms. W's appointment being cancelled. However, the file copy of the letter to Ms. W, notifying her of her appointment, bears the hand-written notation "NO SHOW". Despite Ms. W's testimony about the many referrals made to Dr. Christie on her behalf, his file contains just two: the initial referral from Dr. Harding and current one from Dr. To.

[45] Despite court orders, Ms. W has ensured that there is no objective confirmation that she is not using illegal drugs. She has avoided all efforts to end her prescription drug reliance. Her prescription drug reliance has been reduced only as the result of Dr. Avery's efforts. Ms. W has made no progress in dealing with her drug use.

Parenting

[46] The Minister's evidence regarding Ms. W's parenting was provided by Ms. W's long-term social worker, Ms. Hankin, the two workers who supervised B's visits with his mother and Ms. W's family skills worker. Ms. Hankin’s evidence was contained in the affidavits she provided during the course of this proceeding. Each of the other women provided her notes of the visits she supervised or records relating to the cancellation of visits. All were cross-examined.

[47] Dating from B's stay at the IWK Health Centre, the Minister has had concerns about Ms. W's commitment to B. During the month that B remained at the IWK Health Centre, Ms. W was noted to spend little time there - not visiting often and not staying long. Ms. W attributes this to ill treatment she received from Health Centre staff and her own feelings of guilt about B's drug withdrawal. B was later found to have hepatitis C which he contracted from Ms. W.

[48] The Minister complained that Ms. W missed or was late for "many" access visits. From the records provided, it appears that Ms. W was scheduled for between 105 and 110 supervised visits. This isn't exact because some reports are written to cover a period of time rather than individual visits, but it's sufficient to reflect the general situation. Of these visits, the access workers' notes indicate that Ms. W was late for twenty-eight visits and nineteen visits were cancelled, either by Ms. W or by the agency as a result of Ms. W's failure to confirm a visit two hours in advance of its start time. Ms. W was late for approximately twenty-five percent of her visits and another seventeen percent were cancelled as a result of her action or inaction. To be sure, people run late and they miss appointments: by times the access workers were late and the agency cancelled access sessions. However the comparison is marked. While agency workers were late for access or access was cancelled by the agency for its reasons on thirteen occasions (approximately twelve percent of the time), Ms. W's behaviour abbreviated visits or caused them to be cancelled approximately forty-two percent of the time.

[49] In the highly structured setting of supervised access at the agency's office, Ms. W was generally capable of meeting B's needs. On a few occasions she had difficulty in preparing B's bottle (heating it too much, trying to heat the bottle with the nipple on it, and questioning her judgment about the bottle's temperature). She was easily and frequently pre-occupied by her grievances against the agency and its personnel during visits. She would spend the visit discussing her concerns about the agency, rather than focussing on B. She frequently used inappropriate language around B. She was capable of feeding and changing B and she was appropriately affectionate and loving toward B and he responded to her.

[50] The family skills worker, Joanne Kelly, says that "for the most part" she had no concern with Ms. W meeting B's physical needs. Her concerns related to those times when Ms. W was physically unable to diaper B: she was sweaty, shaky and unfocussed. In her September 30, 2010 report, Ms. Kelly wrote that when Ms. W "is without her medications, she finds it difficult to function [Ms. W] becomes excessively sweaty, anxious and unable to cope with the needs of the baby". At that date, Ms. Kelly concluded that Ms. W wasn't making considerable progress and many of the subjects that Ms. Kelly was to address with Ms. W had not been addressed.

[51] Ms. W's MSI prescription records were produced. From December 9, 2009 to September 24, 2010 (when the records end), Ms. W was prescribed single day doses of her medication. This continued until mid-July when she began to receive both her Saturday and Sunday doses on Saturday. This dispensing regimen would control Ms. W's drug intake and ensure that she would not experience any withdrawal. At three access visits she claimed that she was going through withdrawal: on each of these days the MSI records show that her prescribed medication was dispensed. Once she said that she hadn't had a pill in more than a week, but had found a pill that

morning and taken one-half of it. The dispensing records show that her medication was being dispensed daily during this week and Ms. W should not have been experiencing withdrawal symptoms. Ms. W didn't explain why she was experiencing withdrawal symptoms when her medication was being dispensed as prescribed.

[52] Initially, Ms. Kelly was excected to teach Ms. W about B's developmental stages; to teach her the importance of providing structure and safety for B; to link Ms. W with services and supports in the community; and to assist Ms. W in understanding the effect of domestic violence on a child's development. When Ms. Kelly's work with Ms. W concluded most of their time had been spent on child development. Domestic violence had not been addressed at all. From the visit records it seems that structure and safety for B and services and supports for Ms. W weren't addressed in any meaningful way, despite seven months of work with Ms. Kelly.

[53] B is fourteen months old. He babbles, but doesn't yet speak. He continues to wear diapers. There is no indication that he walks. He feeds himself with his fingers and, according to Ms. W, the size of his food morsels needs to be monitored to prevent choking. Access workers' notes indicate that his diet isn't fully developed. He drinks from a sippy cup. Of course, he must be secured in a car seat when in a car. In her access visits, Ms. W was not consistently able to meet these needs. While she has observed that certain food might not be a safe size for B to eat, she has allowed him to eat it. She has been repeatedly unable to secure his car seat. She has disturbed his developing skills in feeding himself.

[54] In all, B is still highly dependent on a care-giver to meet even the most basic of his physical needs. For the last eleven months, Ms. W has never provided for B's needs for longer than ninety minutes. All her contact with B remains supervised and she has never had unsupervised contact with him. There has been limited progress in developing Ms. W's parenting skills and there are notable deficits that are tied to her drug withdrawal.

Domestic violence

[55] Ms. W has a history of involvement in abusive relationships. Concerns have been expressed in prior proceedings about her relationships with abusive partners: *Nova Scotia (Minister of Community Services) v. S.Z.* [1998] N.S.J. No. 255 (F.C.); and *S.Z. v. Nova Scotia (Community Services)*, 1999 CanLII 18575 (NS S.C.), affirmed in *Nova Scotia (Minister of Community Services) v. Z. (S.) et al.*, 1999 NSCA 155. Ms. W has, in the past, used her married surname.

[56] In her cross-examination, Ms. W testified that her two most recent relationships both involved domestic violence. Ms. W, in her affidavit, says that she met abusive partners through her drug use and she recognizes that these were not healthy relationships. One abusive partner was B's father, Mr. S.

[57] According to Ms. W, her relationship with Mr. S was abusive "pretty much from the first" when the abuse took the form of "controlling possessiveness". Regardless, according to Ms. W, the relationship continued on an off and on basis for approximately two years.

[58] While B was still living with his aunt and uncle, Mr. S visited with Ms. W at her home. According to Ms. W's affidavit "Mr. S kept coming by my house and tried to kick in the door. When I told my sister about his behaviour **she [Ms. W's sister] decided** that it was not safe for her to bring B to my place." I have added emphasis to that quotation. Despite her professed awareness of the impact of domestic violence on a child, Ms. W did not recognize that bringing B to her home for access in these circumstances was inappropriate. It was necessary for her sister to make this decision.

[59] I was provided with copies of the Halifax Regional Police materials documenting its involvement with Ms. W and Mr. S. I was also provided with a copy of Ms. W's 2006 undertaking to have no contact with Mr. S and the information relating to her charge, in May 2010, for breaching her undertaking to have no contact with Mr. S.

[60] Both Mr. S and his mother reported to the agency that Mr. S continued to stay with Ms. W even after she told agency staff that this relationship had ended. Halifax Regional Police records indicate that when Mr. S was arrested in May 2010, he was arrested at Ms. W's home. Police records report that Mr. S said he had been staying with Ms. W for over one week when he was arrested.

[61] The December 7, 2009 order required Ms. W to self-refer to New Start for counselling about domestic violence and its impact on children. She did not do this while this order was in place. This term was repeated in the February 9, 2010 order and Ms. W referred herself to New Start for counselling on February 11, 2010. She had an initial appointment on February 23, 2010. She had one further appointment on April 21, 2010. According to the New Start file, she arrived late for this appointment and left early. New Start records show that she failed to attend three appointments (on March 2, 2010, April 13, 2010 and April 28, 2010). Ms. W phoned New Start after missing her April 28, 2010 appointment and, according to the file notes, said she couldn't call earlier to cancel her appointment because her access visit that day didn't end until one o'clock. She was told that there would be no further appointments at New Start unless she attended regularly and stayed long enough to work. Access notes for April 28, 2010 show that her visit was from ten o'clock until eleven o'clock. Ms. W admits she was untruthful in her comments to the New Start counsellor.

[62] Following the April 29, 2010 order, Ms. W attended two meetings at New Start and failed to attend two others. She repeated this pattern following the September 8, 2010 order: attending two appointments at New Start and missing two.

[63] Like her drug use, Ms. W has a long history of involvement in abusive relationships. Her actions do not demonstrate an ability to protect B from exposure to domestic violence and she has not engaged in services which would educate her about it.

Ms. W's position

[64] Ms. W asks that I continue the current order so that she has further opportunity to address the Minister's concerns in the time that remains prior to the statutory deadline for final disposition on April 29, 2011.

Analysis

[65] The purposes of the *Children and Family Services Act* are to protect children from harm, to promote the family's integrity and to assure children's best interests. These purposes are expressed in the *Act*'s preamble and they are also echoed in the articulation of "best interests" found in section 3(2).

[66] In *Children and Family Services Act* proceedings, B's best interests are paramount. In various regards, the *Act* directs me to make an order or a determination "in the best interests of a child". When that is the case, section 3(2) of the *Act* directs that I consider those of enumerated circumstances which are relevant. The enumerated circumstances fall into five different general areas of consideration: the child's existing relationships; the child's present needs; the child's preferences, if they are reasonably ascertained; future risk; and other relevant circumstances.

[67] I am mindful of the statutory provisions governing the duration of disposition orders relating to B. Section 45(1)(a) says that where I have made an order for temporary care and custody, the total duration of all disposition orders, including any supervision orders, shall not exceed twelve months where a child was less than six years old at the time of the application commencing the proceedings. For B, this twelve month period expires on April 29, 2011, approximately four months from now.

[68] Section 46 of the *Children and Family Services Act* outlines the process in an application to review an order placing a child in the Minister's temporary care and custody. Before I make an order in a review application, I must consider: whether the circumstances have changed since the previous disposition order was made; whether the plan for the child's care applied in that order is being executed; the least intrusive alternative that's in the child's best interests; and whether the requirements of section 46(6) have been met. Section 46(6) deals with temporary care and custody orders and says that I may make a further temporary care and custody order unless I am satisfied that the circumstances which justified the earlier order are unlikely to change within a reasonably foreseeable time that doesn't exceed the April 29, 2011 deadline.

[69] With regard to section 46(4), there was no contest from Ms. W whether the circumstances have changed since the previous disposition order was made and whether the plan for B's care that I applied in my decision was being executed. I do find that the circumstances have not changed since the previous disposition order was made and the plan for B's care was being executed. Ms. W takes issue with whether there is a less intrusive alternative that is in B's

best interests. She asserts that her plan, that B remain in the agency's temporary care while she improves her circumstances, is less intrusive.

[70] A disposition order is one that requires me to consider B's best interests.

[71] In a review application, the options open to me under section 42(1) are:

a. dismissing the Minister's application and returning B to Ms. W;

b. returning B to Ms. W, subject to agency supervision for a specified period;

c. placing B in the care of a third party, subject to agency supervision for a specified period;

d. placing B in the agency's temporary care and custody for a specified period;

e. placing B in the agency's temporary care and custody for a specified period after which he would be returned to Ms. W or another person for a specified period; or

f. placing B in the agency's permanent care and custody.

[72] As directed by Justice Saunders in *Children's Aid Society of Halifax v. B.(T.)*, 2001 NSCA 99 at paragraph 19, I am to consider each of these possible dispositions. Ms. W does not advocate for B's return to her. I do not consider this option because the concerns about Ms. W's drug use, her parenting and her involvement in violent relationships are unresolved and B's best interests, particularly, his physical, mental and emotional needs would be compromised if the Minister's application was dismissed and B was placed with Ms. W.

[73] Ms. W asks that I continue the current order so that she has further opportunity to address the Minister's concerns in the time that remains prior to the statutory deadline for final disposition on April 29, 2011. Ms. W has had more than one year to address the Minister's concerns. The concerns are not new. They were identified to her in earlier proceedings more than a decade ago.

[74] In asking that I maximize the statutory time limits, Ms. W says that there is evidence which shows that providing her with an opportunity to engage in services with New Start and to further reduce her use of pain medication would give her an opportunity to demonstrate her ability to care for B appropriately. I do not accept that this opportunity would result in demonstrating that Ms. W has improved her ability to care for B. Her attendance at New Start has been half-hearted. She has lied to her counsellor at New Start. This behaviour does not auger well for constructive therapy. I heard no evidence as to how additional time would allow Ms. W to further reduce her pain medication. She terminated her relationships with each of the doctors who sought to help her with her drug use. Dr. Avery modified Ms. W's medications so as to reduce her hydromorphone dosage, but Ms. W hasn't seen Dr. Avery in over two months.

There's no evidence that she is working with her general physician to reduce her medication dosage.

[75] My comments address the issue of maximizing time limits from Ms. W's perspective. Such an approach ignores B. Seen from B's perspective, maximizing time limits stalls him in a situation which shows no indication of improving. In *Nova Scotia (Minister of Community Services) v. L.L.P.*, 2003 NSCA 1 at paragraph 31, Justice Bateman, with whom Chief Justice Glube and Justice Oland concurred, made clear that the *Children and Family Services Act* doesn't require me to defer a permanent care decision until the maximum time limits have expired. As Justice Williams wrote in *S.Z. v. Nova Scotia (Community Services)*, 1999 CanLII 18575 (NS S.C.) at paragraph 59, whether a parent should be given more time must be resolved by balancing "the child's needs, best interests and protection including the need to be as a matter of first choice with a family and parents and the issues enunciated by s. 42(4)." This decision was affirmed in *Nova Scotia (Minister of Community Services) v. Z. (S.) et al.*, 1999 NSCA 155.

[76] The Minister asks that I order B be placed in its permanent care and custody pursuant to section 42(1)(f). In response, Ms. W refers me to sections 42(2) and 42(4) of the *Act*. The former section mandates that I do not make an order that removes B from Ms. W unless I am satisfied that less intrusive alternatives have been tried and have failed, have been refused, or would be inadequate to protect him. The latter section instructs that I shall not make a permanent care and custody order unless I am satisfied that the circumstances which justify the order are unlikely to change within a reasonably foreseeable time, not exceeding the maximum time limits.

[77] Taking these sections in turn, section 42(2) requires that I do not make an order that removes B from Ms. W unless I am satisfied that less intrusive alternatives have been tried and have failed, have been refused or would be inadequate to protect B. When the Minister's involvement began, it began with less intrusive measures: B lived with Ms. W's sister and brother-in-law and Ms. W had visits supervised in her home. This arrangement came to an end in January 2010 because it wasn't adequate to protect B: Ms. W's sister was unwilling to remain involved and Ms. W did not recognize the risk of having access with B in her home while her violent former partner was harassing her. More intrusive measures were required. Since then, Ms. W has not progressed in her control of her drug use. She had not progressed in any considerable way in her parenting, according to her family skills worker and, in fact, most of the areas where the family skills worker was to work with Ms. W hadn't been broached. Ms. W was still maintaining some contact with her abusive former partner and she was making only a half-hearted attempt to pursue counselling about domestic violence. I am satisfied that less intrusive alternatives have been tried. To the extent Ms. W engaged in them, they have failed.

[78] In the context of section 42(2), I am referred to section 13 of the *Act* which enumerates services which promote the integrity of the family. Some of these services are relevant: for example, counselling, assessment, self-help and empowerment of a parent whose child is in need of protective services.

[79] The various services that have been offered to Ms. W are: supervised access; individual counselling; a family skills worker; and random urine drug testing. Ms. W was to access addiction prevention and treatment counselling, domestic violence counselling, and public health support programming. Her participation in supervised access was marked by significant lateness and absenteeism. The family skills worker says that Ms. W made little, if any, progress in most areas they were to cover. Ms. W did not participate at all in random urine drug testing. Her participation in domestic violence counselling was similar to her attendance at access: marked by significant lateness and absenteeism. She demonstrated a disregard or ignorance of domestic violence by not relocating B's access visits when she was being harassed by Mr. S and by being in Mr. S's presence. She failed to participate in individual counselling. She was not eligible for public health programming.

[80] Some work was to be done by Ms. W on her own: she was to take steps to address the chronic pain which compels her reliance of prescription drugs. In her dealings with Dr. Fraser she rebuffed his efforts to engage her in a methadone program and she equally rejected Dr. Avery's efforts to address her pain without medication.

[81] Here the relevant services have been refused or have been attempted and have failed. I conclude that the provisions of section 42(2) are not effective so as to bar me from making an order for the permanent care and custody of B.

[82] Section 42(4) instructs me that I shall not make a permanent care and custody order unless I am satisfied that the circumstances which justify the order are unlikely to change within a reasonably foreseeable time, not exceeding the maximum time limits. The maximum time limit is four months from now. The total duration for all disposition orders is one year.

[83] There are four months before this matter must be finally resolved. There are three discrete deficits in Ms. W's parenting. The first deficit relates to her drug use. I use the phrase "drug use" with a certain imprecision because the independent documentation reflects that Ms. W is receiving her prescribed medication as directed. Ms. W doesn't dispute this though she demonstrates symptoms of withdrawal and describes herself as "in withdrawal" at certain times. There was no explanation why Ms. W would experience symptoms of withdrawal when taking her medication as prescribed. As well, on occasion her access visits were disturbed by her use of over the counter sleep aids which left her unable to stay awake during access, or caused her to sleep late and miss access or attend late for it. Whatever its explanation, Ms. W is unable to care for B while she is in withdrawal and she seems powerless to prevent this. Without an understanding of why withdrawal symptoms arise and a plan for addressing them, I have no hope that this deficit will be remedied before April 29, 2011.

[84] The second deficit is Ms. W's parenting. As I noted earlier, Ms. W has not progressed in her parenting skills. This includes the immediate parenting skills of feeding B, diapering him and placing him in a secure child car seat. These tasks are all compromised by Ms. W's drug use. Ms. W's shortcomings in parenting are also related to the third deficit: her failure to recognize circumstances where B might be exposed to domestic violence. I am satisfied on the

balance of probabilities that the circumstances which justify my order are unlikely to change within the brief time available.

[85] This decision is to be based on B's best interests, so I turn to consideration of section 3(2) of the *Act*. I am particularly mindful of the importance of continuity of B's care, and his family relations. B has had access with his mother, his maternal grandmother, his father and his paternal grandmother. He has lived with his aunt and uncle. B's care has primarily been in the context of his foster family. He has also experienced family life with his aunt and uncle. Each family seeks to become B's adoptive family. B's relationship with his mother, in the past eleven months, has been limited to less than five dozen visits of approximately ninety minutes. B's physical, mental and emotional needs are currently being met in his foster placement and there is risk that he may suffer harm through being returned to his mother.

[86] According to section 42(3) of the *Children and Family Services Act*, I am not to place a child in the agency's permanent care and custody without considering whether it's possible to place the child with a relative, neighbour or other member of the child's community or with extended family. Here, no plan for such a placement has been offered to me.

[87] The *Children and Family Services Act* seeks to promote the integrity of the family. One way in which it does this is by mandating significant preliminary considerations before I may order that a child be placed in the permanent care and custody of the agency. I have reviewed those considerations and I determine that it is in B's best interests that he be placed in the agency's permanent care and custody.

Access by Ms. W to B

[88] Ms. W has not specifically asked that I order access with B. The Minister has asked that I make an order which is clear that she shall have no access with B. Access following a permanent care and custody order is governed by section 47(2) of the *Act*. In *New Brunswick (Minister of Health and Community Services) v. L.(M.)*, 1998 CanLII 800 (S.C.C.), Justice Gonthier stated that once permanent care is ordered, the burden is on the parent to show an order for access should be made.

[89] Section 47(2) stipulates circumstances when access shall or shall not be ordered. According to section 47(2)(a), I should not make an order for access unless I am satisfied that permanent placement in a family setting hasn't been planned or isn't possible and access won't impair the child's opportunities for such a placement. Here, permanent placement in a family setting is planned for B. The Minister plans to place him for adoption and there are two families seeking to adopt him. There is no plan to place B with someone who does not wish to adopt him. Accordingly, a request for access could only be premised on section 47(2)(d) which requires there be some other special circumstance which justifies an access order. There has been no evidence of any circumstance which justifies making an access order and I confirm that my order for B's permanent care and custody include no provision for access.

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Elizabeth Jollimore, J.S.C. (F.D.)

Halifax, Nova Scotia