

Case Name:

Catholic Children's Aid Society of Hamilton v. J.I.

**IN THE MATTER OF The Child and Family Services Act
R.S.O. 1990, c. C.11, as amended
AND IN THE MATTER OF the Children: O.V.I.O. - Born:
30 June, 2003, E.S.N. - Born: 04 September, 2004
Between
The Catholic Children's Aid Society of Hamilton,
Applicant, and
J.I. (Mother), I.N. (Father of E.S.N.) and V.I.O.
(Father of O.V.I.O.), Respondents**

[2006] O.J. No. 2299

Court File No. C-1707-04

Ontario Superior Court of Justice
Family Court

W.T. Stayshyn J.

Heard: March 20, 22-24, 27-31 and April 3 and 4,
2006.

Judgment: May 23, 2006.

Amended judgment: July 26, 2006.

(279 paras.)

Family law -- Child protection -- Children's Aid Societies -- Public trustee or guardian -- Appointment, considerations -- Best interests of child -- Child in need of protection -- Physical or mental illness of parent -- Permanent appointment or Crown wardship -- The two children in question were ordered Crown wards with no access to either parent -- The mother, who was H.I.V. positive, was unable to meet her parental responsibilities with regard to the two children.

Both children were ordered Crown wards with no access to the parents -- The children's aid society argued that the two children in question were in need of protection and sought an order of Crown wardship with no access to the parents -- The mother, who had come to Canada from

Nigeria, was H.I.V. positive, as was the second child, E. -- The mother was facing outstanding criminal charges with regard to failing to disclose her illness to E.'s father, who had contracted the disease -- HELD: An order for Crown wardship with no access to the parents was made, as it was in the best interests of the children as it would allow them to be adopted -- The evidence overwhelmingly supported a finding that the mother did not have the ability to meet her parental responsibilities to the children and that she consistently rejected most of the assistance offered to her by the society and the staff at the S.I.S. clinic to meet the needs of the children -- The child O. was found in need of protection as she was at risk of suffering physical harm on account of her developmental stage and the mother's demonstrated lack of ability to ensure her safety even during access visits, her potential exposure to the HIV virus, as well as her past failure to follow medical advice -- Furthermore, O. was at risk from suffering emotional harm based on the mother's lack of ability or willingness to be responsive to O.'s behaviour and need for attention during access visits, and her failure to work with society and daycare staff to facilitate the child's speech and language development -- The child E. was in need of protection as he had become infected with H.I.V. as a result of the mother's deliberate actions, including her failure to obtain the recommended medical care, and E.'s ongoing need to ensure that his medications were taken regularly -- E. was also at risk of suffering emotional harm, in part because of the issues he would be facing being H.I.V. positive and the inability of the mother to provide and/or arrange the support he would inevitably require -- There was no air of reality to the mother's plan of care for the children.

Statutes, Regulations and Rules Cited:

Child and Family Services Act, R.S.O. 1990, c. C.11, s. 1(1), s. 37(2), s. 37(3), s. 40(1), s. 47(1), s. 54, s. 57(1), s. 58(1), s. 59(2), s. 70, s. 140(1), s. 140(2)

Counsel:

Susan O'Rourke, counsel on behalf of the Applicant

Donald Kwon, counsel on behalf of the mother, J.I.

Margaret McCarthy, counsel on behalf of the father, I.N.

No one Appearing on behalf of V.I.O.

[Editor's note: A corrected version was released by the Court July 26, 2006; the corrections have been made to the text and the corrigendum is appended to this document.]

AMENDED REASONS FOR JUDGMENT

[Editor's note: The note "[Text deleted by LexisNexis Canada]" indicates the removal of information which may identify individuals protected under

I: OVERVIEW

1 W.T. STAYSHYN J.-- The children who are the subject of the proceedings herein are O.V.I.O., born June 30, 2003 and E.S.N. (hereinafter referred to as E.S.N.), born September 4, 2004. The mother of the children is the respondent, J.I., born June 10, 1976. The father of the child O.V.I.O. is identified as V.I.O. The father of the child E.S.N. is identified as I.N.

2 The children were brought into the care of the Society on September 7, 2004 and have remained in the temporary care of the Society since this date to the present time.

3 The legal issues raised in this case with respect to the child O.V.I.O., are whether she is a child in need of protection and, if so, whether or not the Society's plan of care that she be adopted is in her best interests.

4 The legal issues raised in this case with respect to the child E.S.N., who has already been found to be a child in need of protection by this Honourable Court, pursuant to sections 37(2)(b)(i) and (e), are whether he is in need of protection pursuant to other grounds and whether or not the Society's plan of care that he be adopted is in his best interests.

5 It is the Society's position that the evidence, as set out below, supports a finding that O.V.I.O. and E.S.N. are in need of protection pursuant to sections 37(2)(b)(i)(ii) and (g.1) and 37(2)(a)(i)(ii); (b)(i)(ii); (e) and (g.1) respectively, and further, that an order of Crown Wardship with no access for both O.V.I.O. and E.S.N. would be in their best interests. Such an order would allow the Society to implement a plan for the children to be adopted by families that would ensure the children's needs, including their needs for permanency and nurturance would be met.

II: CHRONOLOGY OF THE PROCEEDINGS

6 E.S.N. was apprehended from his parents' care on September 7, 2004. O.V.I.O. was apprehended from the mother's care on the same day. On September 13, 2004, the Children's Aid Society of Hamilton commenced a Protection Application seeking findings that the children be found to be in need of protection pursuant to sections 37(2)(b)(i) and (ii); (e) and (g.1) and an Order that the children be made Society Wards for six months and an Order that access to the parents be at the discretion of the Society and supervised at the discretion of the Society.

7 On September 13, 2004, Madam Justice LaFreniere granted an Order that the children remain in the temporary care of the Children's Aid Society of Hamilton and that access be at the Society's discretion and supervised in the Society's discretion.

8 On September 15, 2004, the respondent mother, Ms. J.I., signed an Answer and Plan of Care seeking an Order that the children be returned to her care and, alternatively, that O.V.I.O. be returned to her care and E.S.N. be returned to the care of the respondent father, Mr. I.N. In the further alternative, Ms. J.I. sought liberal, generous and unsupervised access with the children, O.V.I.O. and E.S.N.

9 On October 8, 2004, the respondent father, Mr. I.N., signed an Answer and Plan of Care seeking an order that the child, E.S.N., be placed in his care.

10 On October 13, 2004, Madam Justice LaFreniere made findings and an interim Order pursuant to Interim Minutes of Settlement filed, namely, that the children were found to be non-Native and to be of the Roman Catholic faith and that the child, E.S.N., was placed in the temporary care of the respondent father, Mr. I.N., subject to Society supervision with terms and conditions. The Order of September 13, 2004 was continued with respect to O.V.I.O. remaining in the temporary care of the Society and further, with respect to Ms. J.I.'s access remaining in the discretion of the Society and supervised at the discretion of the Society.

11 On October 13, 2004, Madam Justice LaFreniere granted an Order transferring the proceedings to the Catholic Children's Aid Society of Hamilton.

12 On November 15 and 22, 2004, a Temporary Care Hearing took place before Mr. Justice Czutrin. On November 22, 2004, Mr. Justice Czutrin granted a temporary Order that the children remain in the care of the Society.

13 On December 6, 2004, Mr. Justice Czutrin granted an Order allowing the applicant Society to serve the respondent father of O.V.I.O., Mr. V.I.O., by way of fax transmission. Mr. V.I.O. was served by way of fax transmission to the number set out in his correspondence to the Society; however, he did not file an Answer or Plan of Care or retain counsel to represent him in these proceedings.

14 On February 7, 2005, Mr. Justice Czutrin granted an Order, on consent, that the respondent mother, J.I., attend before and undergo, an assessment of her mental health by Dr. Zamora, who consented to perform an assessment, in accordance with the principles set out in section 54 of the *Child and Family Services Act*.

15 On March 7, 2005, Mr. Justice Czutrin made findings, on consent, that the child, E.S.N., be found to be a child in need of protection pursuant to paragraphs 37(2)(b)(i) and (e) of the *Child and Family Services Act*. Mr. Justice Czutrin granted a temporary Order, on consent, that the respondent father, I.N., have access to E.S.N. at the discretion of the Society and that Ms. J.I. have access to the children at the Society's discretion and supervised at the Society's discretion.

16 On March 7, 2005, Mr. Justice Czutrin made an Order, on consent, and pending the scheduled trial in this proceeding, that Ms. J.I. shall:

- (a) continue to be involved and attend all appointments at the Special Immunology Services Clinic at McMaster Hospital;
- (b) continue to take her HIV medication as recommended by health professionals;
- (c) follow and implement the recommendations suggested in Dr. Zamora's mental health assessment dated February 7, 2005;
- (d) sign a Form 14 to allow the Society worker to speak with the SIS clinic at McMaster and other service providers;
- (e) agree to participate in all recommended community programmes as arranged through the Society;
- (f) attend scheduled visits with her children and ensure these visits remain positive and the children are not put at any risk;
- (g) work co-operatively with the Society; and
- (h) provide the Society with any current or change of address as well as a phone number where she can be reached.

17 On November 28, 2005, Mr. Justice Steinberg granted the Society leave to amend its disposition claim to Crown Wardship.

18 The Society issued an Amended Protection Application on February 15, 2006 and returnable February 22, 2006 seeking an Order that the children be made Crown Wards with no access.

19 On February 17, 2006, Madam Justice Genesee granted an Order allowing the Society to effect substitutional service of the Amended Protection Application on the respondent father, Mr. V.I.O. by way of fax and abridging the time for service from 60 days to 30 days.

20 On March 22, 2006, Ms. J.I. signed an Answer and Plan of Care which was served on the Society on March 28, 2006. Ms. J.I. requested an Order that O.V.I.O. and E.S.N. be placed in her care under terms of supervision as specified by this Honourable Court and in the alternative, an

Order for access to the children should they be made wards of the Crown.

21 Neither of the respondent fathers to E.S.N. or O.V.I.O. filed an Answer/Plan of Care to the Society's Amended Protection Application.

III: STATUTORY FRAMEWORK: *THE CHILD AND FAMILY SERVICES ACT*

22 Pursuant to section 40(1) of the *Child and Family Services Act*, (hereinafter referred to as the "*Act*") the Society may apply to the court to determine whether a child is in need of protection.

23 Section 47(1) requires the court to hold a hearing to determine whether a child is in need of protection and make an order pursuant to section 57(1) of the *Act*.

24 Section 37(2) set out, defines the circumstances where a child is in need of protection, including:

(a) *The child has suffered physical harm, inflicted by the person having charge of the child or caused by or resulting from that person's,*

(i) *failure to adequately care for, provide for, supervise or protect the child, or*

(ii) *pattern of neglect in caring for, providing for, supervising or protecting the child.*

(b) *There is a risk that the child is likely to suffer physical harm inflicted by the person having charge of the child or caused by or resulting from that person's*

(i) *failure to adequately care for, provide for, supervise or protect the child, or*

- (ii) *pattern of neglect in caring for, providing for, supervising or protecting the child;*

- (e) *The child requires medical treatment to cure, prevent or alleviate physical harm or suffering and the child's parent or the person having charge of the child does not provide, or refuses or is unavailable to consent to the treatment;*

- (g.1) *There is a risk that the child is likely to suffer emotional harm of the kind described in subclause (f) (i), (ii), (iii), (iv) or (v), namely:*

- (f) *the child has suffered emotional harm, demonstrated by serious,*

 - (i) *anxiety,*

 - (ii) *depression,*

 - (iii) *withdrawal,*

 - (iv) *self-destructive or aggressive behaviour, or*

(v) *delayed development*

and that the child's parent or the person having charge of the child does not provide, or refused or is unavailable or unable to consent to, services or treatment to prevent the harm.

25 Where the court finds that a child is in need of protection and is satisfied that intervention through a court order is necessary to protect the child in the future, the court shall, pursuant to section 57(1) of the *Act* make one of the following orders, in the child's best interests:

1. That the child be placed with or returned to a parent or another person, subject to the supervision of the Society, for a specified period of at least three and not more than 12 months.
2. That the child be made a Ward of the Society and be placed in its care and custody for a specified period not exceeding 12 months.
3. That the child be made a Ward of the Crown, until the Wardship is terminated under section 65 or expires under section 71(1), and be placed in the care of the Society.
4. That the child be made a Ward of the Society under paragraph 2 for a specified period and then be returned to a parent or another person under paragraph 1, for a period or periods not exceeding an aggregate of 12 months.

26 Pursuant to section 58(1) of the *Act*, the court may, in the child's best interests,

(a) *when making an order under this Part or*

(b) *upon an application under subsection (2),*

make, vary or terminate an order respecting a person's access to the child or the child's access to a person, and may impose such terms and conditions on the order as the court considers appropriate.

27 The Court's jurisdiction under section 57(1) is limited by section 70 of the *Act*, which provides that the Court shall not make an order for Society Wardship that results in a child being a Society Ward for a period exceeding 12 months, if the child is less than six years old on the day the order is

made. The 12-month period may be extended by a period of up to six months, if it is in the child's best interests to do so.

28 In the present case, E.S.N. and O.V.I.O. will have been in care for 18 and 19 months respectively (between September 2004 to April 2006). Accordingly, the statutory time guidelines for a Society Wardship Order have expired.

29 The criteria to be considered by the Court in making an order in the best interests of a child are set out in section 37(3) of the *Act* and are as follows:

- 1. The child's physical, mental and emotional needs, and the appropriate care or treatment to meet those needs.*
- 2. The child's physical, mental and emotional level of development.*
- 3. The child's cultural background.*
- 4. The religious faith, if any, in which the child is being raised.*
- 5. The importance for the child's development of a positive relationship with a parent and a secure place as a member of a family.*
- 6. The child's relationship by blood or through an adoption order.*
- 7. The importance of continuity in the child's care and the possible effect on the child of disruption of that continuity.*
- 8. The merits of a plan for the child's care proposed by a Society, including a proposal that the child be placed for adoption or adopted, compared with the merits of the child remaining with or returning to a parent.*
- 9. The child's views and wishes, if they can be reasonably ascertained.*
- 10. The effects on the child of delay in the disposition of the case.*

11. 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.

12. The degree of risk, if any, that justified the finding that the child is in need of protection.

13. Any other relevant circumstance.

30 Subsection 1(1) of the *Act* provides:

The paramount purpose of this Act is to promote the best interests, protection and well being of children.

The additional purposes set out in subsection (2) of section 1 are applicable only "*so long as they are consistent with the best interest, protection and well being of children*".

31 Where a Crown Wardship Order is made, section 59(2) of the *Act* provides that no access order shall be made unless the Court is satisfied that:

(a) *the relationship between the person and the child is beneficial and meaningful to the child; and*

(b) *the ordered access will not impair the child's future opportunities for a permanent or stable placement.*

32 Subsection 140(1) of the *Act* requires a Society to make all reasonable efforts to secure the adoption of every Crown Ward in its care. Subsection 140(2) provides that a child may not be placed for adoption until any outstanding access order has been terminated.

33 In these proceedings I have carefully observed and listened to all the witnesses, have considered all exhibits filed, heard some periodic submissions of counsel and have, with care and considerable concern, reviewed my notes and the helpful and detailed written submissions filed by very able, conscientious and learned counsel.

34 I note that a Crown Wardship order is probably the most profound order that a court can make. Cases are virtually unanimous in postulating that there is no order that any judge can possibly make that so profoundly affects the lives of the people involved. Thus, "*to take someone's children from*

them is a power that a judge must exercise only with the highest degree of caution, and only on the basis of compelling evidence, and only after a careful examination of possible alternative remedies" (Catholic Children's Aid Society of Hamilton-Wentworth v. G.(J.), 23 R.F.L. 4th 79. I have, in my deliberations, carefully reflected on these considerations.

35 I am aware that the *Child and Family Services Act* mandates and prioritizes the statutory pathway to be followed in keeping with its recognition of the importance of keeping a family unit together as a means of fostering the best interests of children.

36 In considering the evidence I have taken into account that the mother is poor.

37 Clearly the mother falls into that class of persons described in *New Brunswick Ministry of Health and Community Services v. G.(J.)* (2000) 50 R.F.L. (4th) 63, at 116, as "*the most disadvantaged and vulnerable within the family law system*".

38 Thus, I have taken care to avoid judging the mother by a "*middle class yardstick*", in other words, one that imposes unrealistic and unfair middle class standards of child care upon a poor parent of extremely limited potential.

39 I have considered that although the standard of living and the care to be provided to a child may not be considered acceptable by others, if those standards conform to those considered average in a particular class or group to which the parent belongs, and such standards would not be contrary to the best interest of the child, a court ought not to interfere.

40 The real issue to be determined herein is whether, in light of their individual capabilities, the mother, through her plan of care, is able to eventually meet their parental responsibilities as is her hope.

41 I should then consider whether the mother can be provided with the necessary tools to adequately care for her child or children. The issue of whether or not proper assistance and intervention is available and appropriate deserves greater consideration than merely noting the obstacles to securing such help and I have attempted to seriously reflect upon same.

42 I am aware that the Society has a statutorily mandated obligation to provide services to families for both the protection of children and the prevention of circumstances requiring the protection of children. Services also need to be implemented to maintain the integrity of the family unit.

43 I further note that the duty to provide services is an integral part of determining whether or not the risk to a child can be adequately addressed if that child were to be returned to his mother. Without having made efforts to provide such services, and availing parents of every reasonable opportunity to take advantage of those services, their ability to benefit from them cannot be assessed.

44 In this regard, case law is replete with dicta supporting the proposition that the Society's obligation to provide services has a broader component than merely pointing out to a parent that a particular service exists.

The Court recognizes that the Society's requirement to provide services is not an ongoing obligation to hold the hand of its clients and the Court recognizes that the Society often operates under budgetary and staffing constraints but when such an obvious and specific problem exists with a particular client, the Society must provide individually-appropriate services in order to satisfy its mandate.

C.C.A.S. v. L.M. and V.M. [1989] O.J. No. 659, April 28, 1989, Wallace J. (S.C.O.)

45 Moreover, it may be that the essence of a Society's duty to provide services is to create a unique agenda that is sensitive and responsive to an individual parent's needs. If necessary, this entails setting aside a worker's own agenda, reaching beneath a parent's refusal to accept services and "walking with" them "through the assistance".

46 I am mindful of the fact that the appropriate standard of parenting is not perfection. Rather, it is the minimum allowable standard of parenting to be met in order to ensure that the best interests of the child are met and that the child is protected in the sense intended by the provisions of the *Child and Family Services Act*.

47 I am as well aware that in *Re Brown* 9 O.R. (2d) 185 at 189, it was indicated that "Society's interference with the natural family is only justified when the level of care of [the child] falls below that [to] which no child in this country should be subjected ..." (*Catholic Children's Aid Society of Hamilton-Wentworth v. G.(J.)*, 23 R.F.L. 4th 79, p. 93).

48 It would appear therefore that the authorities have indicated that the court should not be persuaded to permanently sever the parental tie merely because Crown Wardship without access, and subsequent adoption, may be able to offer O.V.I.O. and/or E.S.N. greater opportunity to achieve their potential.

IV: FACTS

49 In or about mid-April 2003, Ms. J.I. entered Canada and applied for refugee status with the claim being based upon abuse by her spouse or partner, V.I.O.

50 In or about April 2003, Ms. J.I. had a screening test called an ELISA and a confirmation test called the Western Blot Test. The screening test for HIV was positive, however, the Western Blot Test was indeterminate. Ms. J.I. was referred to the Special Immunology Services Clinic at McMaster University Hospital (hereinafter referred to as the "S.I.S. Clinic") by Dr. Shapiro.

51 The S.I.S. Clinic is a multi-disciplinary clinic comprised of physicians, nurses and social workers, including: Dr. Shariq Haider, a physician and infectious disease specialist; Ms. Carolyn Kezel, registered nurse; and Ms. Caroline Redden, registered social worker.

52 Ms. J.I. had her first intake visit at the S.I.S. Clinic on May 15, 2003. At this time, two further confirmatory tests were done by Dr. Haider, namely, a P24 antigen test and the second, an HIV One PCR to confirm that Ms. J.I. had HIV One infection. The results subsequently confirmed she had a diagnosis of HIV One infection.

53 The severity of the disease in a patient who has been identified as being HIV One positive can be assessed by a patient's CD4 count and viral count. AIDS is the definition used to describe the end stage of the disease of HIV One infection. The CD4 counts are an important prognosticating marker of a patient's risk of developing AIDS. The CD4 count of a patient and their risk of progression to AIDS are influenced by a patient's viral load. Accordingly, a patient's CD4 count and viral load are equally important in determining their risk of developing AIDS.

54 According to the medical studies, a patient with CD4 count under 200 has a 35 percent risk that their infection will develop into AIDS in three years without treatment, whereas a patient with a CD4 count above 350 has a risk of about 14 to 15 percent of developing AIDS in three years without treatment. If, however, the patient with a CD4 count under 200 has a viral load under 2,000, the risk of the infection developing into AIDS is reduced to 9 percent in three years without treatment. Further, if the patient with a CD4 count under 200 has a viral load over 55,000, the risk of the infection developing into AIDS without treatment would be increased to 50 percent.

55 When Ms. J.I. was first assessed at the Clinic she had a viral load of 21,432 copies/ml and a CD4 count of 9. Based on these counts, her three year risk of developing AIDS in the next three years without treatment would be assessed, based on current medical studies, to be 35 to 40 percent.

56 On May 15, 2003 while at the S.I.S. Clinic, Ms. J.I. was seen by Dr. Haider, Ms. Kezel and Ms. Redden. On this day, Ms. J.I. received counselling with respect to the issues of safe sex practices, routes of transmission for the virus and minimizing the risks of transmissions. The counselling included the different modes of transmitting the virus, namely, mother to baby, man to a woman, woman to a man and transmission through sexual exposure, namely, vaginal and oral intercourse and the use of at least two forms of contraception, but at least, at a minimum, condoms.

57 The S.I.S. Clinic, in conjunction with the obstetricians who deliver the babies of mother's who are HIV positive, and the pediatricians who care for the newborns, provide counselling to expectant mothers regarding the use of antiretroviral medications for the mother and baby before and during delivery, the benefits of a caesarean section delivery and not breastfeeding, in order to minimize the risk of an infant being infected with the HIV virus. In addition, there is a protocol that is shared between the infectious disease and obstetric physicians from which standard orders are prepared, including orders for the mode of delivery and the medications to be received by the expectant mother and newborn at delivery and which are contained in the respective patient's record.

58 On May 28, 2003, Ms. J.I. was seen by Dr. B. DeFrance, an obstetrician. According to the clinic note of the same date, he had the following discussion with Ms. J.I. regarding the management of HIV in pregnancy:

Risk of vertical transmission without any intervention is about 25% which can be reduced by antiviral treatment, which is triple therapy, down to 8%. This risk could be further reduced by scheduled cesarean section at 38 weeks to reduce the risk of vertical transmission down further to 2%. She should avoid breast-feeding afterward ... We told her that she is having a heavy viral load with low CD4 counts and the recommendation is to avoid vaginal delivery if it is possible but still the patients autonomy is respected.

59 On May 15, 2003, Dr. Haider interviewed Ms. J.I. regarding previous medical conditions and treatments, including treatments for sexually transmitted diseases. According to Dr. Haider, based upon the information he was provided by Mrs. J.I., he concluded she became infected with the HIV virus by way of heterosexual contact.

60 On May 15, 2003, Dr. Haider spoke to Ms. J.I., who was pregnant at the time with O.V.I.O., how her pregnancy would be managed through the S.I.S. Clinic to reduce the risk of transmission of the HIV virus by the following interventions: medications to reduce her "viral load" prior to, and at the time of, delivery, giving birth by way of caesarean section, providing the newborn with AZT immediately following delivery and for a period of six weeks following delivery and no breastfeeding.

61 On May 15, 2003, the S.I.S. Clinic made arrangements for Ms. J.I. to be seen by obstetrician, Dr. B. DeFrance.

62 On May 15, 2003, Ms. Redden interviewed Ms. J.I. who reported that she came to Canada from Nigeria and left an abusive relationship.

63 On June 16, 2003, Ms. J.I. met Ms. Redden who reviewed the Public Health Contact Tracing Form with her and explained to Ms. J.I. that she would have to inform anyone she chose to be intimate with that she was HIV positive. On the same day, Ms. J.I. met with the Public Health Nurse at the S.I.S. Clinic who provided Ms. J.I. with counselling on safer sex practices and the requirement that she notify persons who may be at risk of acquiring HIV infection as a result of contact with Ms. J.I.

64 On June 27, 2003, Ms. J.I. met with Dr. Barbara Brennan after Ms. J.I. presented at the hospital indicating that she had decided against a caesarian section. Ms. J.I.'s CD4 count as of June 10, 2003 was 12 and her viral load was 214 copies/ml. Dr. Brennan had a long discussion with Ms. J.I. regarding the risks of transmission of the virus to the baby by way of vaginal delivery which could be in the range of eight percent and which could be lowered to one to two percent hopefully with a caesarean section. Ms. J.I. agreed to the caesarean section after the discussion with Dr.

Brennan and it was scheduled for June 30, 2003.

65 On June 30, 2003, Ms. J.I. gave birth to O.V.I.O. at McMaster University Medical Centre by way of a scheduled caesarean section done by Dr. Brennan. At the time of delivery, Ms. J.I. had been on anti-retrovirals for about two months; two weeks prior to delivery, her viral load was 214. She received two hours of intravenous AZT prior to the caesarean section.

66 On June 30, 2003, following the birth of O.V.I.O., Dr. Sandra Seigel, Pediatrician, met with Ms. J.I. to review the factors that would decrease the chance of HIV transmission to O.V.I.O., including Ms. J.I.'s viral load being decreased by medication prior to, and at delivery, and the baby being delivered by caesarean section. Dr. Seigel explained the medical care she would provide to O.V.I.O., including blood tests at birth, six weeks, and at three to four months of age to rule out the HIV virus in the baby, follow up at the S.I.S. Clinic and that Ms. J.I. would have the cost of formula covered for a year through the Theresa Group.

67 On July 2, 2003, Ms. Redden met with Ms. J.I. in the hospital and discussed the process of obtaining formula for O.V.I.O. and Ms. J.I.'s desire to obtain housing through the Community Housing Network. On the same day, Ms. Redden contacted the pharmacist to make arrangements for Ms. J.I. to be provided with formula funded through the Theresa Group and called the Community Housing Network on Ms. J.I.'s behalf and was advised that Ms. J.I. had priority and would be offered new accommodation within two weeks to two months.

68 On July 9, 2003, Ms. J.I. attended at the S.I.S. Clinic for an unannounced visit with Ms. Redden at which time Ms. Redden provided her with baby supplies, clothing and a food voucher from the Miriam Group. On the same day, Ms. J.I. reported that she had been offered new accommodation for the beginning of August 2003 in the west end of Hamilton. Ms. J.I. subsequently confirmed her new address as [text deleted by LexisNexis Canada].

69 On November 12, 2003, Ms. J.I. attended at the S.I.S. Clinic and met with Ms. C. Redden. At that time, Ms. J.I. reported she had met with a man at which time Ms. Redden discussed safe sex practices and the availability of supplies at the S.I.S. Clinic.

70 On January 23, 2004, Ms. J.I. attended at the Wilson Medical Clinic and was seen by Dr. Dada. Ms. J.I. reported that her last menstrual period was October 28, 2003. On the same appointment, Dr. O. Dada did a pregnancy test and told Ms. J.I. she was pregnant. An ultrasound was also ordered by Dr. Dada.

71 On January 28, 2004, Wilson Medical Centre confirmed to Ms. J.I. that she was 8.1 weeks pregnant.

72 On February 4, 2004, Ms. J.I. attended at the S.I.S. Clinic and met with Ms. Redden during which time she asked Ms. Redden if she could be pregnant if she used a condom. She confirmed that she had been intimate with her boyfriend. An appointment with Dr. Haider and an ultrasound

was subsequently booked for Ms. J.I. for February 6, 2004.

73 On February 6, 2004, Ms. J.I. had an ultrasound which confirmed that she was 9.6 weeks pregnant. Dr. Haider was not aware when he saw Ms. J.I. on this date she had already been told by Dr. Dada she was pregnant and that an ultrasound had been done on January 28, 2004. On February 6, 2004, Ms. Kezel met with Ms. J.I. and discussed "*multiple issues*". Ms. J.I.'s second pregnancy was treated as a "*new occurrence*". Ms. Kezel reviewed teaching previously provided to Ms. J.I. regarding how the HIV virus is transmitted, including through sexual contact and that it was Ms. J.I.'s responsibility to inform her sexual partner due to the risk of him being exposed to the virus.

74 Ms. J.I. did not tell Mr. I.N. of her HIV positive status and had unprotected sexual intercourse from on or about November 2003 until in or about May 2004 when they stopped residing together.

75 On March 24, 2004, Ms. J.I. was seen by Dr. B. Brennan, Obstetrician from the 4F Clinic. At that time, Ms. J.I. reported in addition to being pregnant with O.V.I.O. in 2003, having two pregnancies while in Africa that she terminated; one being at 12 weeks and one at six weeks. Dr. Brennan had a discussion with Mrs. J.I. on this day which is reflected in the clinic note as follows:

Discussion today centred around management of the remainder of J.I.'s pregnancy. She is aware that she needs to maintain her antiretroviral therapy to prevent transmission to her baby. She was hoping that she might have a chance at a vaginal delivery, however, due to her low CD4 count and that fact that she has never had a vaginal delivery would mean a long process which would increase transmission risks to her baby. She also had a lower segment cesarean section; although it was a double layer closure it will be only just over a year prior to her next delivery, which would increase her risk of uterine rupture. As a result, we have counselled her that we would recommend a repeat cesarean section and we will plan the timing of the delivery as we get closer to her term. She will be having some exams most likely due to her schooling at that time, which hopefully we will be able to accommodate. She is aware that we usually try to plan elective cesarean deliveries at around 38 weeks gestational age. J.I. is also aware that we will eventually link her with the pediatrician, Dr. Sandy Seigel, who will follow the baby and prescribe AZT to the baby after delivery. J.I. will continue to be followed with the SIS Clinic in addition to ourselves in the pregnancy. She is familiar with routines and was counselled today regarding maternal serum screening, which she has accepted and will also be completed today with her regular blood work. She is aware that she will have a few more ultrasounds completed in the pregnancy to review fetal growth and well-being. She will also have a detailed ultrasound performed at 19 weeks gestational age to review fetal anatomy and growth.

76 On June 9, 2004, Ms. J.I. was seen by Dr. Brennan. Dr. Brennan reiterated her

recommendation for a caesarean section; Ms. J.I. was adamant about having a vaginal delivery.

77 On June 11, 2004, Ms. J.I. was seen by Dr. Haider. At that time, he reported that her antiretroviral medication had been modified about one month ago because of resistance to her prior medication regime. He indicated that at the time the goal of the antiretroviral therapy was to get her viral load undetectable as Ms. J.I. "*planned*" on having a vaginal delivery. Ms. J.I.'s last viral load and CD4 counts available to Dr. Haider at this appointment were just under 600 copies/ml and 130, respectively.

78 Dr. Brennan testified her recommendation to Ms. J.I. was always to deliver E.S.N. by way of an elective caesarean section, regardless of her having an undetectable viral load. Dr. Brennan was concerned about the risk of Ms. J.I.'s caesarean scar rupturing and precipitating a haemorrhage and a life-threatening situation for both the mother and child.

79 On June 23, 2004, Dr. Brennan saw Ms. J.I. in her office with a man who was identified as being E.S.N.'s father. Dr. Brennan recalled the emotional reaction of the "*father*" who described his anger at being betrayed by Ms. J.I. when he had unprotected sex with her and she did not inform him of her HIV positive status.

80 On July 28, 2004, Ms. J.I. was seen by Dr. Haider. He reported that she was continuing to do well on her modified antiretroviral regime and that she had an undetectable viral load of less than 50 copies/ml and a CD4 count of 130.

81 On August 17, 2004, Ms. Kezel obtained the results from the blood test taken from Ms. J.I.'s S.I.S. Clinic appointment on July 28, 2004. The test results showed a viral load of 16,256 copies/ml. On the same day, Ms. Kezel spoke with Ms. J.I. who denied missing any doses of her medication and arranged for Ms. J.I. to have further blood work taken on August 18, 2004. Ms. Kezel informed Dr. Haider of the results.

82 On August 18, 2004, Ms. Kezel met with Ms. J.I. when she came to 4F Clinic and accompanied her to have blood work done for her viral load and CD4 count. Ms. Kezel spoke to Ms. J.I. of the need for her to have a caesarean due to her viral load. On the same day, Dr. Haider requested genotype testing to be done to ascertain whether Ms. J.I.'s increased viral load was the result of a virus mutation. The results of the testing confirmed that the increased viral load was due to the failure of Ms. J.I. to take her medications.

83 On August 20, 2004, the S.I.S. Clinic received a verbal report from the Toronto Public Health Department that Ms. J.I.'s viral load had increased to 88,736. Dr. Haider was notified of the results.

84 On August 23, 2004, Ms. Kelly Campbell, Registered Nurse, from the S.I.S. Clinic spoke to Ms. J.I. to advise her that she would have to have a caesarean section as her viral load was 88,736 during which time Ms. J.I. admitted that she may have missed one or two doses a week of the antiretroviral medication.

85 On August 23, 2004, Ms. Redden met with Ms. J.I. at the S.I.S. Clinic at the request of the clinic nurses, Ms. Campbell and Ms. Juliet Hurd. Ms. J.I. confirmed that she had been missing doses of her medication as she had been busy. During the meeting, Ms. Redden discussed the chances of passing the HIV virus to the baby with a vaginal delivery and Ms. J.I. agreed to think about her choices and meet with Ms. Redden when she came to the 4F Clinic on Wednesday, August 25, 2004.

86 Ms. J.I. did not attend her appointment at the 4F Clinic on August 25, 2004 and it was rebooked for August 26, 2004. On August 26, 2004, Ms. J.I. met with Dr. Brennan, who was aware that her viral load had increased above 88,000. During this appointment, Dr. Brennan had a long discussion with Ms. J.I. and explained the importance of her having a caesarean section to reduce the risk of transmission to the baby. Dr. Brennan booked the caesarean for August 27, 2004 at which time Ms. J.I. reported to her she did not have child care. Dr. Brennan then told her to come after 1:00 p.m. and the caesarean section would be done some time in the afternoon.

87 On August 27, 2004, Dr. Brennan called Ms. J.I. at 11:00 a.m. and reported that Ms. J.I. was taking her daughter for care and would come as soon as she could.

88 When Ms. J.I. did not attend McMaster Medical Centre at 1:00 p.m. on August 27, 2004, Dr. Brennan called Ms. J.I.'s home and spoke with an individual. He told Dr. Brennan that Mrs. J.I. was not there and he did not know where she was but he would tell her that Dr. Brennan called. Dr. Brennan called Mrs. J.I.'s home again at 5:00 p.m. when she had still not heard from Ms. J.I. There was no answer.

89 Dr. Brennan contacted Ms. Valerie Fines on August 30, 2004 to ask that she complete a referral to CAS as Ms. J.I. did not attend the hospital and she had not heard from her and due to her concern that Ms. J.I. and the newborn required AZT and that it was important that she disclose her HIV positive status if she went to another hospital.

90 On August 30, 2004, a referral was made to Ms. Melanie Williams at Hamilton CAS from Ms. Valerie Fines, Social Worker at McMaster University Medical Centre, reporting that Ms. J.I. had HIV, had one child at home and had not shown up for a scheduled caesarean appointment on August 27, 2004. Ms. Fines advised Ms. Williams of the need for Ms. J.I. and the newborn to have the AZT medication and that the risk of Ms. J.I. passing on the HIV was increasing as her viral load increased.

91 On August 30, 2004, the CAS completed and faxed Alerts to local hospitals, including St. Joseph's Hospital with respect to Ms. J.I.

92 On August 30, 2004, Ms. J.I. attended St. Joseph's Hospital. She was interviewed by a nurse and physician. She was asked to sign a consent for a blood test to be done for HIV testing; she signed the consent for the testing to be done. She was admitted and discharged the same day.

93 On August 30, 2004, Ms. J.I. did not report to either the nurse or physician that she had been diagnosed through the S.I.S. Clinic as being HIV positive, that she was on medications and that she was followed through the 4F Clinic at McMaster University Medical Centre for prenatal care and the management of her labour and delivery. She reported having two children, both being born in Nigeria, one in 1998, male, and delivered by way of caesarean section and the second, a female, born in 2001, by way of vaginal delivery. She did not report having a child, female, O.V.I.O., being born in 2003 by way of caesarean in Hamilton, Ontario.

94 On August 31, 2004, Ms. C. Redden contacted Ms. J.I. at home at the request of Ms. V. Fines and spoke to Ms. J.I. about her high viral load and the need to connect with Dr. Brennan and the 4F Clinic. Ms. C. Redden advised Ms. J.I. of Dr. B. Brennan's directions that she should be prepared to come into the hospital as soon as there is time available. Ms. C. Redden reported that Ms. J.I. assured her she would find care for O.V.I.O. by a friend or the father of the baby and would call Ms. C. Redden once she was given a time to come into the hospital.

95 On August 31, 2004, Dr. Brennan called Ms. J.I. and spoke to her on the telephone. Ms. J.I. reported that she wanted a "*natural delivery*" and Dr. Brennan concluded that no amount of further counselling regarding the risks of transmission to her child by way of vaginal delivery would change her mind. Dr. Brennan counselled Ms. J.I. about the importance of obtaining medical care shortly after the rupture of her membranes if that occurred before her labour started and the need for her to receive AZT medication. Ms. J.I. told Dr. B. Brennan that she would come to her clinic appointment scheduled for Thursday, September 2, 2004.

96 On August 31, 2004, Ms. Carrie-Ann MacNeill, Child Protection Worker at Hamilton CAS attended at Ms. J.I.'s home and met with her to discuss the risks of not having a caesarean immediately. Ms. J.I. reported to Ms. MacNeill that she had planned to attend the appointment for her caesarean but that Mr. I.N. had been in Toronto and had been unable to care for O.V.I.O. as planned. Ms. J.I. refused to provide Ms. MacNeill with contact information for the fathers of O.V.I.O. or the baby she was carrying.

97 Ms. J.I. did not ask Mr. A.E. to care for O.V.I.O. so she could attend for the caesarean section at McMaster University Medical Centre. Mr. A.E. was living at Ms. J.I.'s apartment at that time and had taken care of O.V.I.O. as recently after August 16, 2004 to allow Ms. J.I. to complete the clinical part of her personal support worker course as O.V.I.O. was no longer in daycare as of that date.

98 On August 31, 2004, Ms. J.I. told Ms. MacNeill that she no longer wanted a caesarean section and that her child would be born naturally. Ms. J.I. further told Ms. MacNeill that she continued to receive treatment for HIV.

99 Ms. J.I. did not advise Ms. C. Redden, Dr. B. Brennan or Ms. C.A. MacNeill when she spoke with them on August 31, 2004 that she had attended St. Joseph's Hospital on August 30, 2004.

100 On September 1, 2004, Ms. C.A. MacNeill tried to reach Ms. J.I. by telephone two times but received no response.

101 On September 2, 2004, Ms. J.I. did not show for her appointment as she indicated she would to Dr. Brennan. Dr. Brennan and 4F Clinic staff called Ms. J.I.'s home on the same day; there was no answer and a message was left.

102 On September 3, 2004, Ms. MacNeill attended at Ms. J.I.'s home for a second time. Ms. MacNeill spoke to Ms. J.I. about the risks of passing HIV to the baby if she did not have the caesarean section. Ms. J.I. reported that she did not want to have a caesarean section and was adamant about giving birth naturally. Ms. MacNeill counselled Ms. J.I. on the importance of ensuring that both herself and the newborn received AZT medication.

103 On September 3, 2004, Ms. J.I. reported to Ms. MacNeill that she would deliver the baby at the nearest hospital but did not confirm she would deliver at McMaster University Medical Centre. She further reported to Ms. MacNeill that a friend by the name of Sylvia would babysit O.V.I.O. while she was in the hospital. Ms. MacNeill asked for Sylvia's address and telephone number which Ms. J.I. would not provide. Ms. MacNeill asked Ms. J.I. to have Sylvia call her regarding the child care arrangement, however, neither Sylvia or Ms. J.I. called Ms. MacNeill.

104 On September 3, 2004, Ms. MacNeill asked Ms. J.I. for Mr. I.N.'s telephone number, however, Ms. J.I. refused to provide Ms. MacNeill with the information stating that she had spoken with Mr. I.N. the previous day and did not want to speak with Ms. MacNeill.

105 On September 3, 2004, Ms. J.I. called Mr. I.N. from her home to request that he take her to the hospital. Mr. I.N. attended at Ms. J.I.'s apartment at [text deleted by LexisNexis Canada] and accompanied Ms. J.I. to St. Joseph's Hospital where she indicated she was to deliver.

106 The trip by car from Ms. J.I.'s apartment to St. Joseph's Hospital is approximately 20 minutes whereas the trip from Ms. J.I.'s apartment to McMaster University Medical Centre is less than five minutes or walking distance. On the way to St. Joseph's Hospital on September 3, 2004, Ms. J.I. and Mr. I.N. passed in front of McMaster University Medical Centre.

107 On September 3, 2004, when Ms. J.I. attended St. Joseph's Hospital she was seen by at least one nurse and one physician. She was admitted and then discharged home on the same day. At no time did she advise either the nurse or the physician that she was HIV positive, that she was on medication or that she had received medical care at McMaster University Medical Centre for her HIV condition and her antenatal care.

108 On September 4, 2004, Mr. I.N. accompanied Ms. J.I. to St. Joseph's Hospital as she requested. Again, they had to pass directly by McMaster University Medical Centre to get to St. Joseph's Hospital. Ms. J.I. was admitted to St. Joseph's Hospital at approximately 1:30 p.m. and delivered E.S.N. at 9:30 p.m. I note that although the fax from the CAS to St. Joseph's Hospital was

transmitted on August 30, 2004, staff, for some reason, were unaware of its existence.

109 Ms. J.I. was seen by at least three physicians on September 4, 2004, namely, Dr. Sankat, Dr. Persadie and Dr. Zieba and a number of nurses. At no time, however, did she advise any of the nursing or medical staff that she was HIV positive, had antenatal care at McMaster University Medical Centre and that both herself and the baby required AZT medication to reduce the risk of transmission of the HIV virus to the baby.

110 On September 4, 2004, Ms. J.I. requested and received an epidural to relieve the pain associated with her labour. At no time prior to, or at the time of delivery, did she advise the nurses or the physicians attending to her that she required the AZT medication to reduce the risk of transmission of the HIV virus to the baby. Unfortunately, as Ms. J.I. had been advised by Dr. Brennan, the caesarean scar ruptured, precipitating blood haemorrhaging, putting mother and child at risk as well as putting at risk hospital staff who, to this day are subject to testing for HIV.

111 On September 4, 2004, there were physicians and NICU staff in the delivery room to care for E.S.N. At no time during, immediately following his birth, or at any time while he was being cared for in the delivery room, did Ms. J.I. tell any physician or nurse that E.S.N. needed the AZT medication or that she could not breastfeed him to minimize the risk of the HIV virus being transmitted to him.

112 On September 4, 2004, while in the delivery room and in the presence of Mr. I.N., Ms. J.I. put her nipple in E.S.N.'s mouth and he was sucking for about one minute. Ms. J.I. indicated to the labour and delivery nurses that she would be breastfeeding E.S.N.

113 E.S.N. "*roomed-in*" with Ms. J.I. from about midnight on September 4, 2004 until the following afternoon at about 12:30 when his respirations increased and he was transferred to the Neonatal Intensive Care Unit ("*NICU*"). He was placed on an intravenous and his fluid intake and output was being closely monitored due to his respiratory rate. There was an order that he could breastfeed if his respiratory rate was less than 70 per minute.

114 On September 6, 2004, Ms. J.I. advised the nurse in the NICU that she intended to breastfeed E.S.N. Ms. J.I. had earlier indicated, in the presence of Mr. I.N. that it was not her intention to breastfeed.

115 Ms. J.I. attended the NICU on September 7, 2004 at 1:00 a.m.; 6:45 a.m.; and 9:45 a.m. and breastfed E.S.N. 35 cc, 75 to 80 cc and 55 cc, respectively. The amounts of breast milk received by E.S.N. were recorded in the nursing progress notes and neonatal intensive care unit patient flow sheet.

116 On September 7, 2004, Ms. Jodi Pereira, Social Worker at St. Joseph's Hospital was asked to see Ms. J.I., in part due to her reported lack of prenatal care and the apparent conflict observed between Ms. J.I. and Mr. I.N. with respect to her breastfeeding E.S.N. Ms. Pereira met with Ms. J.I.

on September 7, 2004, explained her role as a social worker and asked Ms. J.I. questions about her lack of prenatal care.

117 Ms. J.I. advised Ms. Pereira that she was not sick during the pregnancy and did not need to see a doctor. She reported she lived alone with her two children, L., who was six years of age and O.V.I.O., who was three years of age. Ms. J.I. was adamant that she was wanting to breastfeed. When Ms. Pereira told Ms. J.I. that she was concerned about her lack of prenatal care and described the role CAS played in assessing any other risk factors, Ms. J.I. responded by laughing and saying "*what risk factors*". Ms. Pereira advised Ms. J.I. that she would be calling CAS to inquire if they needed to do a follow up visit with her.

118 When Ms. Pereira called CAS on September 7, 2004, she was informed by the intake worker, Ms. Grenier, that Ms. J.I. had been referred to the CAS by Ms. Fines last week and had refused a caesarean section which was scheduled on August 27, 2004 due to her high viral load.

119 Ms. Pereira spoke with Ms. J.I. after the phone call to CAS and confronted her about her HIV status and refusal to disclose this information despite being aware of the risks. Ms. J.I. responded to Ms. Pereira by gesturing to spit; Ms. Pereira responded with both a verbal and physical warning, by raising her hand; that she not spit. Ms. J.I. stated she did not want a caesarean section and it was in God's hand.

V: SEPTEMBER 7, 2004 - APPREHENSION OF THE CHILDREN BY THE CAS

120 On September 4, 2004, Ms. McNeill attended the hospital and met with Ms. J.I. When Ms. MacNeill asked Ms. J.I. why she had delivered at St. Joseph's Hospital she stated that she had gone into labour at Mr. I.N.'s home which was closer to St. Joseph's. Ms. J.I. confirmed to Ms. MacNeill that she did not "*verbalize*" to St. Joseph's staff that she was HIV positive but thought that the staff would "*figure it out*".

121 When Ms. MacNeill asked Ms. J.I. why she had not told hospital staff that she was HIV positive after E.S.N. was born she said it was because she wanted to deliver him "*naturally*". Ms. J.I. said that in July 2004 she felt that her medication was not working because there were no improvements so she stopped taking it.

122 On September 7, 2004, the CAS provided St. Joseph's Hospital with an Apprehension Notice to the Hospital Administrator that as a result of an investigation by the Society, the Society had reason to believe that the child, E.S.N., a patient in the hospital was in need of protection and that Ms. MacNeill was apprehending him and placing him in the care of the Society.

123 On September 7, 2004, a Child Abuse Support meeting was held at the CAS and a decision was made to apprehend the child, O.V.I.O., due to Ms. J.I.'s deceptive behaviour with the hospitals, including her not disclosing that she was HIV positive, her poor judgment and choices in failing to protect E.S.N. from the risk of being infected with the HIV virus, her limited care giving skills and

her failure to ensure she received the medical care that had been recommended.

124 On September 7, 2004, Ms. MacNeill attended at St. Joseph's Hospital to advise Ms. J.I. that E.S.N. would be placed in the Society's care due to her lack of medical follow-up. When Ms. MacNeill asked Ms. J.I. where O.V.I.O. was, Ms. J.I. reported that she was staying with her friend, Yvonne, whose last name was unknown.

125 During a telephone conversation later in the evening on September 7, 2004, Ms. J.I. advised Ms. MacNeill that O.V.I.O. was still at Yvonne's and she was not sure whether or not she would arrange for O.V.I.O. to return home that night. Ms. J.I. gave Ms. C.A. MacNeill the name of the street she lived on.

126 On September 7, 2004, Ms. C.A. MacNeill attended the home of Yvonne and was advised that she was aware of who Ms. J.I. and O.V.I.O. were but denied babysitting O.V.I.O. Ms. C.A. MacNeill then attended Ms. J.I.'s address with Hamilton Police Officers Knapp and Carter. Ms. J.I. was present in the home along with O.V.I.O., Mr. A.E., a friend of Ms. J.I. and Mr. I.N.

127 O.V.I.O. had been in the care of Mr. A.E., a friend of Ms. J.I.'s on September 3, 2004 when Ms. J.I. attended at St. Joseph's Hospital and again between September 3 to September 7, 2004 when Ms. J.I. was admitted to St. Joseph's. Mr. A.E. brought O.V.I.O. to Mr. I.N.'s home on or about 5:00 p.m. on September 7, 2004. Mr. I.N. cared for O.V.I.O. between 5:00 p.m. on September 7, 2004 and brought her to Ms. J.I.'s apartment at [text deleted by LexisNexis Canada], later that same evening.

128 Mr. A.E. attended at St. Joseph's Hospital with Ms. J.I. at about 6:30 p.m. and returned to Ms. J.I.'s apartment with her later that evening. He was residing at Ms. J.I.'s address at that time.

129 On September 7, 2004, Ms. MacNeill advised Mr. I.N. that E.S.N. had been taken into the Society's care earlier in the day and would be placed in foster care due to the neglect of his medical needs and Ms. J.I.'s limited caregiving skills. Ms. MacNeill apprehended O.V.I.O. on September 7, 2004.

130 On September 8, 2004, Mr. I.N. stated that he had not known that Ms. J.I. was HIV positive and that he understood that she had diabetes and that was the reason he did not want Ms. J.I. to breast feed E.S.N.

VI: MS. J.I.'S HEALTH STATUS AT OR ABOUT SEPTEMBER 4, 2004

131 On October 20, 2004, Ms. J.I. resumed attending her appointments at the S.I.S. Clinic. Her most previous appointment with Dr. Haider had taken place on July 28, 2004 and her last recorded CD4 count and viral load was as of August 18, 2004 which was 90 and 88,736 copies/ml. Based on these results, Ms. J.I.'s risk of being infected with AIDS in three years in the absence of treatment was at least 50%. On October 20, 2004, Dr. Haider's clinic note reported that Ms. J.I. was "very

non-compliant" during her current pregnancy, unlike her first pregnancy and that in fact she did not maintain compliance and certainly had a detectable viral load at the time of delivery. He further reported that unfortunately, she did not disclose her status to the admitting hospital and therefore underwent a vaginal delivery.

VII: THE CHILDREN'S MEDICAL FOLLOW-UP THROUGH THE S.I.S. CLINIC

132 On September 10, 2004, Dr. Seigel advised Ms. MacNeill that she had concerns that Ms. J.I. was not able to provide for the medical needs of the children.

133 There are a number of interventions recommended to an expectant mother who has been identified as HIV positive to reduce the risk of transmission of the HIV virus to her infant, including:

- (a) receiving comprehensive prenatal care by seeing both an HIV specialist and an obstetrician;
- (b) receiving antiretroviral or anti-HIV medications to reduce the amount of virus in their blood;
- (c) in the absence of a mother having a fully suppressed viral load at around the time of delivery, an elective caesarean section before the onset of labour;
- (d) not breastfeeding the infant; and
- (e) the infant receive six weeks of AZT, an anti-HIV medication.

The risk of transmission, with all these interventions, is less than two percent and is based upon information from the Canadian Pediatric Society and the National Institute of Health in the United States.

134 On June 30, 2003, Dr. Seigel met with Ms. J.I. and spoke to her about the positive things that had taken place that would decrease the transmission of the HIV virus to O.V.I.O. including Ms. J.I. being on medication to decrease her viral load, her having an elective caesarean and not breastfeeding O.V.I.O.

135 In addition to O.V.I.O. being formula fed, she received six weeks of AZT medication and a medication called Septra to prevent a type of pneumonia and significant illness which can develop if a child is HIV positive. O.V.I.O. underwent blood tests at birth, four to six weeks of age (September 9, 2003) and again at three to four months of age (October 21, 2003). O.V.I.O.'s test results were negative for HIV PCR and P24 antigen at six weeks and four months of age thereby excluding the HIV virus in O.V.I.O. The Septra was discontinued when a negative result from O.V.I.O.'s three to four month testing was received.

136 Although O.V.I.O. was HIV negative, all children born to HIV positive mothers are followed through the S.I.S. Clinic because of the unknown possible late side effects of the antiretroviral

mediation taken by mother's who are HIV positive. A follow-up appointment was made for O.V.I.O. to see Dr. Seigel at the S.I.S. Clinic on February 24, 2004, however, it was not attended. Ms. J.I. brought O.V.I.O. to her next S.I.S. Clinic appointment on May 4, 2004 when she was 10 months of age.

137 Since O.V.I.O. has been in care up until the present time, she has been seen by Dr. Seigel at the S.I.S. Clinic for two appointments, namely, December 14, 2004 and November 29, 2005. O.V.I.O. will continue to need to be seen by Dr. Seigel at the S.I.S. Clinic on an annual basis and her regular medical care will be provided through her family physician.

138 E.S.N. is HIV positive. His diagnosis was confirmed by Dr. S. Seigel on November 16, 2004, following the receipt of two positive PCR tests taken September 21, 2004 and October 5, 2004.

139 Dr. Seigel confirmed that E.S.N. acquired his HIV positive status through Ms. J.I. The risks of the HIV virus being transmitted to E.S.N. from Ms. J.I. as a result of the following factors:

- (a) Mrs. J.I.'s high viral load at the time of delivery as she was not taking her medication;
- (b) As most of the transmission of the virus is believed to actually occur around the time of delivery, the vaginal delivery in the context of a high viral load increased the risk of transmission which could have been reduced by an elective caesarean section;
- (c) The AZT medication was not given to E.S.N. until over two days following his birth and well beyond the first 24 hours following birth with the result it was *"too late"* to decrease the chance of the virus being transmitted; and,
- (d) Ms. J.I. breastfeeding.

140 Initially E.S.N. had a viral load of over 100,000 copies/ml which is considered quite a high viral load.

141 Once E.S.N. was diagnosed as being HIV positive, the medical recommendation was to treat him with medication to preserve his health as there is no way to know whether he would be among the 20 to 30 percent of infants who are known as rapid progressors (as opposed to slow progressors), who, without treatment, would become sick very fast with different infections or pneumonia, with many of the infants dying quite young.

142 At the time that E.S.N. was diagnosed as being HIV positive, he was already taking AZT and Septra. Dr. S. Seigel prescribed two further medications for him to take, namely, 3TC and Nevirapine. All three medications, AZT, 3TC and Nevirapine are anti-HIV mediations which work to decrease the HIV virus. The Septra was given to E.S.N. to decrease the risk of him developing pneumonia.

143 Dr. Seigel has seen E.S.N. regularly at the S.I.S. Clinic; initially he was seen every month but since March 2005 he has been and will continue to be seen every three months unless any problems arise at which time he would be seen more regularly. His last appointment was on March 7, 2006. At each appointment Dr. Seigel performs a physical examination, including his weight and length to ensure his appropriate growth and development and blood is taken to assess his viral load, his CD4 count and different blood chemistries.

144 The results of E.S.N.'s blood work, in addition to the history taken at the appointment, allow Dr. Seigel to assess the status of his HIV and also any potential side effects from the medications. She looks at his CD4 count as a good CD4 count means his ability to fight infection is good. If his CD4 goes down, E.S.N. would be more vulnerable to different types of infection as the CD4 is a type of white cell that is primarily attacked by the HIV virus. Similarly, Dr. Seigel monitors his viral load as a low number, namely an undetectable level, reflects the effectiveness of the medication in reducing the virus.

145 At present, Dr. Seigel reports that medication has reduced E.S.N.'s initial viral load from 100,000 to an undetectable level of virus and attributes this to the strict adherence with which he is receiving his medications, his tolerance to the medications and absence of side effects. Any disruption to the medication regime, even missing a few doses could be enough to have a resistant virus develop, reducing the effectiveness of the medication and requiring a change of medication.

146 E.S.N.'s current medications, as of his last appointment with Dr. S. Seigel on March 7, 2006, were: Nevrapine - 100 mg, by mouth, two times a day; AZT - 85 mg, by mouth, three times a day; 3TC - 50 mg, by mouth, two times a day, and Septra - 3.8 ml. by mouth two times a day on Monday, Wednesday and Friday. On this same appointment, Dr. Seigel increased his dosage of Septra to 4 ml. from 3.8 ml. His CD4 count was 2750 and he had a fully suppressed viral load. From a developmental standpoint, he was running, climbing, feeding himself with a spoon, had about 20 to 25 words and was starting to put words together.

147 At present E.S.N.'s growth and development is on the upper limit of the growth curve and his present situation is sort of ideal because he is taking his medication, he has no appreciable side effects and his viral load is fully suppressed. Although he is doing extremely well, there may be issues arise due to normal development, including E.S.N. deciding he does not want to take his medication when he is two to three years of age or as he gets older him asking why he needs to see Dr. Seigel at the Clinic or dealing with issues of sexuality and being HIV positive all of which may impact upon the ability of his caregivers to keep him as health as he is now.

148 In order for E.S.N. to obtain his optimal level of health, it is important that his caregivers ensure his ongoing adherence to his medication and address any health issues promptly by advising Dr. Seigel as well as ensuring he is developing appropriately and dealing with school and behavioral issues. This would include a caregiver who is pro-active to issues that are going to arise and able to work as part of a partnership with members of the S.I.S. team to address issues that will

arise to comply with the care required by E.S.N. and to do the best for him.

149 Dr. Seigel described Ms. J.I.'s actions at the time of E.S.N.'s birth as unpredictable and since she could not have predicted that behaviour at that time, there could be something else that would be unpredictable down the road.

150 According to Dr. Seigel, parents who are HIV positive are provided with information to reduce the chance of HIV transmission to their children. The transmission does not happen through casual contact; it comes through contact with blood or sexual contact. They are counselled about common sense things of not sharing toothbrushes, not sharing sorts of utensils, those sorts of things would be the things that she would recommend with precautions around blood in particular. So it is common sense recommendations around not having any contact, blood contact.

151 Dr. Haider testified that there would be risk of the HIV virus being transmitted through instruments, such as razors or toothbrushes that have blood on them. Patients are taught not to share these type of instruments because of this risk of exposure to the blood from such instruments. Generally, transmission through the use of shared utensils is not discussed because it has not been shown to be a mode of transmission to the virus. Dr. Haider, however, confirmed there would be a risk of transmission from a utensil containing the blood of an infected child if it was used by another child who was not infected with the virus and that child had some break in the skin.

152 Dr. Seigel had concerns at the and following the dates of the children's apprehension regarding Ms. J.I.'s ability to exercise good judgment to ensure the children received the necessary medical care and follow up of their medical needs. She had concerns regarding Ms. J.I.'s ability to make good decisions regarding the children's ongoing care needs in the future in view of her actions at the time of E.S.N.'s birth and the knowledge she had of the protocol to reduce the transmission of the HIV to children at birth.

VIII: THE CHILDREN'S GROWTH AND DEVELOPMENTAL NEEDS

153 In January 2005, O.V.I.O. was referred to the Early Words Hamilton Preschool Speech and Language Service by Ms. Justine Bodendistel, O.V.I.O.'s Children's Service Worker at the time.

154 On January 25, 2005, the Society received confirmation of receipt of the referral from Early Words with an audiology appointment for O.V.I.O. on February 25, 2005 at St. Joseph's Community Health Centre and a further appointment for O.V.I.O. to be seen by Ms. Joyce Van Egmond, Speech-Language Pathologist with Early Words, at the foster home on February 25, 2005. The results of O.V.I.O.'s hearing test were in the normal range and accordingly ruled out any hearing loss.

155 Ms. Van Egmond saw O.V.I.O. in the foster home on February 25, 2005 and provided recommendations to address O.V.I.O.'s speed and language development, including O.V.I.O. attending a structured child care programme and strategies to encourage her speech and language

development at home. The strategies she provided to the foster home including simplifying language, using visual aids with O.V.I.O. and pairing objects with words to make words more meaningful for O.V.I.O. O.V.I.O. started attending Red Hill Day Care on May 10, 2005 on Mondays, Wednesdays and every other Friday.

156 On August 11, 2005, Ms. Van Egmond arranged for the Communication Resource Team to attend Red Hill Day Care to provide strategies to the teachers at O.V.I.O.'s day care to encourage her speech and language development, including the use of visual aids to promote comprehension.

157 On February 24, 2006, Ms. Van Egmond, in consultation with Ms. Vanessa Jones, Family Service worker at the Society, and Ms. Tracy Gula, Member of the Communication Resource Team, referred O.V.I.O. for a complete developmental and psychosocial assessment. It is scheduled to be done by Dr. Bill Mahoney on June 28, 2006. The results of the assessment will help to determine the nature of further services to be provided to O.V.I.O. in terms of her speech and language, emotional and cognitive development.

158 O.V.I.O., at 33 months of age is a child of black racial heritage, who can be happy, affectionate, and loveable as well as stubborn, manipulative, defiant and determined to have her own way. At times her behaviour can be challenging and difficult to manage. She requires parenting that is firm and consistent as well as patient, calm and reassuring. She responds to limits for her behaviour.

159 O.V.I.O.'s self-help skills appear to be age-appropriate. O.V.I.O.'s pronunciation of words is not clear and her vocabulary is limited to one word vocalizations.

160 E.S.N., at 18 months of age, is a happy, lovable and even-tempered toddler who shows age-appropriate caution with strangers, responds well to simple instructions. He is of black racial heritage.

161 His foster mother finds that she must be firm and insistent as well as patient, resourceful and creative to persuade E.S.N. to take his medication, particularly the medication that has a bitter taste. In addition, his regime of four medications requires diligence and organization to ensure he receives them as prescribed.

162 O.V.I.O. and E.S.N.'s primary need at this time is for a family who can make a long-term commitment to them in which they will experience a sense of security and stability as well as have their day to day developmental, physical and emotional needs met.

163 Both children have an overwhelming need for a parenting relationship on which they can rely to meet their individual needs for nurturing, acceptance, stimulation, security and permanence, which can be provided through adoption.

164 The Society networks with other Societies throughout the Province to successfully place

children for adoption and will endeavour to use any and all means at the Society's disposal to place O.V.I.O. and E.S.N. with adoptive families.

165 The Society would endeavour to place the children in a home that is a racial match and to secure adoptive families who will make a commitment to maintain a relationship between the children should they not be able to be placed in the same home, in view of their individual needs.

166 On September 21 and 29, 2004, Ms. MacNeill told Ms. J.I. that the Society would be requesting that she attend for counselling and that it be made a condition of a court order. Ms. J.I. said she did not need counselling.

167 The Catholic Children's Aid Society of Hamilton requested and arranged for Ms. J.I. to have a mental health assessment done by Dr. Zamora due to concerns regarding Ms. J.I.'s poor judgment in not ensuring both her and E.S.N.'s medical needs were met.

168 On January 24, 2005, Dr. E.N. Zamora conducted a mental health assessment of Ms. J.I.; he completed a report on February 7, 2005. He did not find that Ms. J.I. had any serious mental or personality disorder, however, she had some traits that required some work in counselling. He found Ms. J.I. to be avoidant of any uncomfortable situation and that she may well have a tendency to not tell the truth or to deny or withhold information when she is confronted with difficult situations and this required some work. Dr. Zamora indicated that counselling would be important for Ms. J.I. to zero in on her adjustment to HIV infection and her coping strategies and resources with a focus on her tendency to avoid and clam up when she experienced stressful life events.

169 Dr. Zamora assessed Ms. J.I. to have a depressive adjustment reaction and suggested that she would benefit from a course of antidepressant medication for about a six month period.

170 Dr. Zamora recommended counselling for Ms. J.I. to help her deal with and express her anger properly. He explained that a person's willingness to change can be explored within the counselling itself. A person needs to want to change; change will not happen if a person does not want and/or see a need to change.

171 Dr. Zamora described the type of counselling required to address the behaviours that were "*getting [Ms. J.I.] into trouble*" as a "*tough*" type of counselling. He said that a trait such as honesty is a difficult trait to deal with and that therapy can take years. It is the persistence and inflexibility of a personality trait that creates distress and trouble. The person with such a personality trait may not recognize the need to change in spite of the chaos it creates.

172 Dr. Zamora indicated that if Ms. J.I. had not identified a need to obtain counselling since he saw her that this was a "*bad sign*". An unwillingness to make any change in the face of behaviour that was creating dysfunction and chaos could be indicative of a personality disorder. If she had not received any counselling since the time that he assessed Ms. J.I. on January 24, 2005, he would expect that her behaviours identified as concerning in his assessment would continue to be present.

173 Dr. Zamora chose not to characterize Ms. J.I.'s religious beliefs as pathological but indicated, according to the information she provided him, that she reached for God in a fantasy way and that this could be described as a "*sick belief*" which "sat on the border".

174 Dr. Zamora had Ms. J.I. complete a Personality Assessment Inventory (PAI) on January 24, 2005 which was interpreted by Dr. Bruce Baxter, Psychologist. Dr. Baxter prepared a report dated February 4, 2005. Dr. Baxter found that Ms. J.I. scored significantly higher than a typical person would score on the subscale that measured grandiosity. Ms. J.I.'s rating on this subscale indicated that she had an inflated view of herself.

175 Dr. Baxter described certain inconsistencies in Ms. J.I.'s test results and, in particular, her test result that showed her willingness to make changes in her life even though she was not testing positive for any psychological symptoms or difficulties that would account for her willingness to want or need to make changes.

176 Dr. Baxter indicated that Ms. J.I.'s test results on the PAI would be consistent with a diagnosis under Axis II - DSM-IV-TR that she had traits of a narcissistic personality type. He indicated, however, that he would not have been able to make that determination in the absence of an interview with Ms. J.I.

177 On March 16, 2005, Ms. Redden met with Ms. J.I. who advised her of the recommendations made by Dr. Zamora, including the need for her to receive counselling. Ms. Redden arranged for Ms. J.I. to be seen by Dr. A. Carvalhal, a psychiatrist who is part of the multi-disciplinary team at the S.I.S. Clinic.

178 Dr. Carvalhal saw Ms. J.I. for a psychiatric assessment over five appointments which took place on April 11, 20, 27 and May 18 and 24, 2005. These appointments were not for counselling but were to allow Dr. Carvalhal to complete a psychiatric assessment including ruling out a personality disorder and exploring Ms. J.I.'s beliefs. Ms. C. Redden was present for all of the appointments. The results from that assessment indicated that Ms. J.I. did not meet the criteria for any mental illness in Axis I, according to the DSM-IV-TR. Dr. Carvalhal did not find Ms. J.I. to be depressed and did not find any indication to prescribe medication.

179 Dr. Carvalhal advised Mr. D. Kikulwe, CCAS Family Service Worker, on April 29, 2005, that Ms. J.I. did not seem remorseful that she exposed others to HIV.

180 Dr. Carvalhal assessed Ms. J.I. as having traits associated with a narcissistic personality and indicated that there were many important points around beliefs and behaviours that should be addressed by Ms. J.I. through intervention such as psycho-dynamic therapy. She found that Ms. J.I. did not have any insight into her situation or acknowledge her responsibility and involvement in her current situation.

181 Dr. Carvalhal identified psycho-dynamic therapy as the best approach for the treatment of

personality traits; it is long term treatment. Treatment is aimed at assisting a person to become more responsible with respect to their decision making and in their relationships. It may require years to be effective as the therapy is aimed at trying to change defense mechanisms and coping strategies that have been with an individual since his or her childhood.

182 Narcissistic personality traits would include, but not be limited to, the following traits: lack of responsibility, lack of insight, lack of ability to empathize, lack of capacity to put oneself in another's situation and a focus on one's own needs and feelings.

183 On May 24, 2005, Dr. Carvalho recommended that Ms. J.I. attend psycho-dynamic therapy on a weekly basis with Ms. Redden at the S.I.S. Clinic. There was no cost to Ms. J.I. to attend for therapy. Dr. Carvalho told Ms. J.I. she did not meet the criteria for depression and therefore she did not need medication. Ms. Redden was present when Dr. Carvalho explained to Ms. J.I. that she lacked insight into her behaviour and its consequences and therapy was being recommended to help her with this.

184 Motivation of the patient is necessary for therapy to take place and be effective. It was Ms. J.I.'s responsibility to book an appointment after she met with Dr. Carvalho and Ms. C. Redden and Ms. J.I. chose not to book an appointment or attend for therapy.

185 On October 5, 2005, Ms. C. Redden met with Ms. J.I. during her clinic visit. At that time Ms. J.I. told Ms. C. Redden that she did not need therapy. On the same date Ms. C. Redden called Ms. Vanessa Jones on behalf of Dr. Carvalho and in response to the letter written to Dr. Carvalho of September 29, 2005. Ms. Redden advised Ms. Jones that Dr. Carvalho thought it would have been beneficial for Ms. J.I. to have ongoing psychotherapy, however, Ms. J.I. was competent to make her own decisions and chose not to work with Dr. Carvalho.

186 On February 8, 2006, Ms. J.I. told Ms. Jones that she did not feel counselling was necessary and she was not seeing Dr. Carvalho. Ms. J.I. reported, however, attending for counselling at Family Services since January 2006 and that she saw a person by the name of "*Mona*". Ms. J.I. would not sign a consent for Ms. Jones to speak with *Mona* so Ms. Jones could confirm her attendance. Ms. J.I. did not provide Ms. Jones with a letter from *Mona* that she said would to confirm her attendance.

187 On February 10, 2006, Ms. Jones suggested that Ms. J.I. see Dr. Carvalho for counselling as this had been recommended and there was an expectation as outlined in the last court order that she follow through with the recommendations that had been made. Ms. J.I. said she has not needed counselling and that she will not do anything and "*that the Judge can decide in March*".

188 When Mr. A.E. met with Ms. MacNeill in September, 2004, he indicated that he was not a pastor, but a life coach and that he did not provide counselling. He said he ran a Bible group to which Ms. J.I. belonged. Mr. A.E. testified that he became a "*believer*" sometime in 2002, did not have any formal theological type of education, and was pursuing self-directed study to establish his

own ministry. Prior to coming to Canada in 1998 he testified that he worked as a businessman in the retail trade. Dr. Zamora testified that the tough counselling that Ms. J.I. required could not be provided by someone like "*Pastor*" A.E.

IX: ASSESSING PLANS OF CARE FOR THE CHILDREN

189 During Ms. MacNeill's first contact with Ms. J.I. on August 31, 2004 and subsequent contacts with her, Ms. MacNeill attempted to ascertain the identity and contact information for the fathers of O.V.I.O. and E.S.N. Ms. J.I. did not provide information to allow Ms. MacNeill to contact the respective fathers to assess any plans for care for the children prior to the children being brought into care on September 7, 2004.

190 On September 3, 2004, Ms. J.I. told Ms. MacNeill that she had spoken with Mr. I.N. on the previous day and that he did not want to speak with Ms. MacNeill. Mr. I.N. was not aware that CAS was involved until September 7, 2004 when he received a phone call from Ms. J.I. and Ms. MacNeill and the police officers attended at Ms. J.I.'s apartment at [text deleted by LexisNexis Canada].

191 Mr. I.N. identified himself as the father of E.S.N. to the Society and having been in an intimate relationship with Ms. J.I. from on or about November 2003 up to May 2004. He presented a plan of care to the Society for E.S.N. His plan was subsequently investigated, including a home study being completed by Ms. MacNeill. His plan was accepted by the Society and the child, E.S.N., was placed in his care subject to terms and conditions of a temporary supervision order, on October 13, 2004.

192 The CCAS continued to support Mr. I.N.'s plan of care for E.S.N. Mr. Kikulwe, Family Service Worker, assisted Mr. I.N. by accompanying him to appointments at the S.I.S. Clinic and providing support and encouragement for him to continue to care for his son after confirmation of his HIV diagnosis was made by Dr. Seigel. The Society continued to facilitate access for Mr. I.N. to see E.S.N. after he decided he was no longer able to continue with his plan to care for his son on November 17, 2004.

193 Mr. I.N. last visited E.S.N. at the Society offices on or about March 30, 2005. Mr. I.N. has indicated that he is in support of the Society's plan for E.S.N. to be adopted should an order for Crown Wardship with no access be granted by the Court.

194 On November 2, 2004, Mr. Kikulwe asked Ms. J.I. for the identity and contact information for O.V.I.O.'s father. Ms. J.I. identified O.V.I.O.'s father as V.I.O. and said that he resided in Nigeria, however, she did not have an address for him and preferred he not be informed that O.V.I.O. was in foster care. Mr. Kikulwe told Ms. J.I. that the father of O.V.I.O. needed to be notified.

195 On November 9, 2004, Ms. J.I. told Mr. Kikulwe she had not been able to contact Mr. V.I.O.

She further stated that O.V.I.O.'s father was a threat to her and that before he did not even know she was in Canada.

196 On November 12, 2004, Mr. Kikulwe asked Ms. J.I. again if she had contacted Mr. V.I.O. to which she responded by saying she had called someone who promised to send her contact information to V.I.O.; she told Mr. Kikulwe she would provide him with the information regarding the contact for Mr. V.I.O. by November 19, 2004.

197 On November 17, 2004, Mr. I.N., while with Mr. Kikulwe, received a telephone call from Mr. V.I.O.; Mr. I.N. told Mr. Kikulwe that Mr. V.I.O. was in Italy. At no time up until Mr. Kikulwe spoke directly with Mr. V.I.O. on November 24, 2004, did Ms. J.I. provide Mr. Kikulwe with information to contact Mr. V.I.O.; advise Mr. Kikulwe that Mr. V.I.O. was in Italy and that he had provided her with financial assistance for O.V.I.O. since 2003. The Society subsequently received documents from Mr. V.I.O. which indicated he was providing Ms. J.I. with money.

198 On February 8, 2006, Ms. J.I. told Ms. Jones that she had always been in contact with O.V.I.O.'s father, Mr. V.I.O., and that she planned to reconcile with him.

199 Mr. V.I.O. has been provided with information and documentation regarding the proceedings by the Society and has had contact with Mr. Kikulwe and Ms. Jones, however, did not respond or retain counsel to present a plan on behalf of O.V.I.O.

200 On December 8, 2004, Mr. Kikulwe contacted Mr. R.O., a family member that Mr. V.I.O. had proposed to care for O.V.I.O. Mr. R.O. advised Mr. Kikulwe that it would not be practical for O.V.I.O. to be placed in his care.

201 The CCAS has provided services to the parents and children between October 27, 2004 to the present pursuant to the plans of service that have been filed with the court. The services provided to Ms. J.I. have included a family service worker and family resource workers. The Society has attempted to continue to work with Ms. J.I. to determine whether integration of the children into the care of Ms. J.I. was a possibility.

202 Mr. Kikulwe was the family service worker to Ms. J.I. between October 27, 2004 to on or about September, 2005. Mr. Kikulwe set up Ms. J.I.'s access visits with the children at the Society. The visits, which were at all times supervised, were initially scheduled to take place two times per week for two hours each time at the Society offices. In or about March 2005, one of the supervised visits was moved to Ms. J.I.'s home at [text deleted by LexisNexis Canada] and the Society arranged for the transportation of the children to and from the visit. In or about May, 2005, a decision was made to move both the visits to Ms. J.I.'s home and increase the duration of one of the visits to three hours.

203 Mr. Kikulwe arranged a mental health assessment of Ms. J.I. by Dr. Zamora and advised and encouraged Ms. J.I. to follow up on the recommendations to receive counselling. Mr. Kikulwe

explained to Ms. J.I. that it was the Society's expectations that she make an appointment with the S.I.S. Clinic to attend for training about E.S.N.'s medications and how they were to be administered, in addition to attending his regular appointments at the S.I.S. Clinic. Ms. J.I. agreed to do so, however, did not make any arrangements to receive training through the S.I.S. Clinic.

204 During two of the appointments Mr. Kikulwe attended at the S.I.S. Clinic with Ms. J.I., February 22 and May 17, 2005. He noticed that Ms. J.I. did not ask Dr. Seigel questions about E.S.N.'s medical care or medications.

205 On May 17, 2005, Mr. Kikulwe informed Ms. J.I. that O.V.I.O. was starting daycare on May 30, 2005 and that the Society expected her to be involved by attending the daycare. On the same day, Ms. J.I. indicated that she might not be able to attend the daycare because of her work. Ms. J.I. never attended at O.V.I.O.'s daycare.

206 Mr. Kikulwe also informed Ms. J.I. on or about May 24, 2005 that her two weekly supervised access would take place in her home and that one of the visits would be increased from two hours to three hours to allow her to administer E.S.N.'s medications.

207 Ms. J.I. was criminally charged with criminal negligence causing bodily harm and failing to provide the necessities of life and endangering health on May 28, 2005 by Detective Brian Smyth of the Hamilton Police Service. She was placed in jail and released on a recognizance of bail dated May 30, 2005. The bail conditions required Ms. J.I. to comply with any present or future family court order relating to E.S.N. and O.V.I.O. and to participate in all recommended community programmes as arranged by the Hamilton CCAS. Ms. J.I. was subsequently charged with the further offence of assault causing bodily harm. Ms. J.I.'s criminal proceedings remain outstanding with no known hearing date.

208 The Society implemented the plan for increased access in Ms. J.I.'s home following her release from jail. The first visit was scheduled for June 7, 2005. Following the visit, a safety conference was held at the Society on account of Ms. J.I.'s behaviour and safety concerns that arose during the visit which was supervised by Ms. L. Gianetti, Family Resource Worker.

209 On June 7, 2005, Mr. Kikulwe informed Ms. J.I. of the Society's decision to return to the previous access schedule, namely her access would take place two times per week for two hours each at the Society offices and was to be supervised. Ms. J.I. indicated to Mr. Kikulwe that she would not co-operate with the Society. Mr. Kikulwe encouraged Ms. J.I. to continue to work with the agency as her children were still in care.

210 On June 9, 2005, Mr. Kikulwe met with Ms. J.I. during which time she denied the safety concerns which were reported by the Society on June 7, 2005, including: O.V.I.O. being left unsupervised on the balcony and in a highchair with food that she could choke on; E.S.N. being in distress as a result of the way she bathed and shaved his head and her unwillingness to respond to the direction provided by Ms. Gianetti. Mr. Kikulwe testified that prior to Ms. J.I. being charged,

she did not fully co-operate with the Society, however, after she was charged, she was more difficult to deal with and she was *"never the same"*.

211 In February, 2006, Ms. Jones attempted, but was not successful, in obtaining an interpreter who spoke Ms. J.I.'s language, Ibo, to attend during access visits. Ms. J.I. insisted on speaking to the children in Ibo and refused to speak English. Ms. Jones also attempted but was not successful in arranging services to address Ms. J.I.'s interactions and responsiveness to the children, including services for attachments issues, in addition to what was being provided through the Society's Family Resource Workers during access visits.

212 On September 29, 2005, Ms. Jones recommended parenting programmes for Ms. J.I. to attend and offered to assist her in providing transportation to the programmes if necessary. Ms. J.I. initially refused and then said she could not attend because she worked all day. She would not, however, tell Ms. Jones where she worked and said it was in the *"documentation"*. Ms. Jones explained the programmes she was recommending Ms. J.I. attend. Ms. J.I. agreed to check her work schedule and call Ms. Jones back regarding her attendance at the programmes, however, did not do so.

213 To the date of trial Ms. J.I. had not provided the Society with information about her employment that could be verified as either existing or being a place where her employment has been confirmed. On March 30 and 31, 2006 Ms. J.I. testified that she had worked at Bullock Nursing Home, however, Ms. Jones was not able to locate an agency with this name, nor was it shown as a licensed agency with the Ministry of Health and Long Term Care. Ms. J.I. subsequently provided Ms. Jones, through her counsel, with a telephone number, namely, 416-620-7202, which she said was for Bullock Nursing Home.

214 On March 31, 2006, Ms. Jones called the telephone number provided by Ms. J.I. for Bullock Nursing Home. The telephone was answered by a gentleman who indicated, when asked by Ms. Jones that the address for the Nursing Home was 610 Mackland Avenue. He did not answer the phone with a greeting saying that Ms. Jones had reached Bullock Nursing Home. Ms. Jones did a 411 search of the telephone number; the results of Ms. Jones' search revealed that the telephone number belonged to someone by the name of Mr. O. with an unknown address in Etobicoke, Ontario. Ms. Jones was not able to locate an address of 610 Mackland.

215 On April 3, 2006, Ms. J.I. testified that the telephone she had previously given for Bullock Nursing Home was a telephone number for an agency by the name of Life-Line and that the person from the agency she spoke with was Mr. O. Ms. Jones completed a 411 search and again, was not able to locate an agency under the name of Life Line. Ms. Jones' 411 search for a telephone number under the name of Mr. O.; the search did not reveal the number 416-620-7202 as being one assigned to either a business, Life Line, or Mr. O.

216 On April 3, 2006, Ms. J.I. provided Ms. Jones with the name of the place where she was employed as Billings Court Manor. On April 3, 2006, Ms. Jones called the telephone provided to

her by Ms. J.I. and was advised by the receptionist that they did not have anyone by the name J.I. employed at their place of business. On April 4, 2006, Ms. J.I. confirmed in her testimony that the name and telephone number that was provided to Ms. Jones on April 3, 2006 was the information she had provided regarding her employment.

217 Ms. J.I. did not attend a parenting programme other than to attend five weeks of an eight week Coping with Toddler Behaviour Programme. On February 10, 2006, Ms. J.I. told Ms. Jones she did not need any parenting programmes and that she was not willing to do anything and that she was going to wait until March to let the Judge decide. Ms. Jones provided Ms. J.I. with written information about the parenting programmes that were being recommended by the Society in the form of a letter.

218 Ms. J.I. attended her access visits with the children on a regular basis and from time to time was accompanied by Mr. A.E. or individuals she identified as friends. When Mr. A.E. or Ms. J.I.'s friends came to the visits, they frequently assisted Ms. J.I. to groom the children. On one occasion, namely, February 23, 2006, Ms. J.I. asked to bring an individual who she identified as her brother, E.O., to a visit and said he was known to the children. According to the family resource worker, Ms. Alice Kneebone, who supervised the visit that day, the children did not appear to know him.

219 A significant number of access visits that took place from November 2004 to the time of trial and have been supervised by the following Family Resource Workers: Ms. Alice Kneebone, Ms. Lori Gianetti and Ms. Sabrina Sayegh. These three resource workers have supervised 90 visits. All three workers had the following observations of the access visits and Ms. J.I. during the visits:

- (a) She did not demonstrate a consistent willingness or ability to implement the instruction and direction that the resource workers provided to assist her to be responsive to the needs and behaviour of the children;
- (b) She repeatedly ignored direction provided by the resource workers to ensure the safety, comfort and security of the children, for example, she repeatedly lifted the children by one arm in spite of being told of the risk of injury from handling the children in this manner and changing the children's diaper on her lap instead of a flat surface;
- (c) She either did not intervene promptly or at all to ensure the safety of the children resulting, on at least one occasion, July 15, 2005, O.V.I.O. falling from the couch and hitting her head on the floor;
- (d) She was not attentive or responsive to the children's cues for food, no more food or to be comforted by being held and/or picked up;
- (e) She did not redirect the children's behaviour when it was inappropriate, including when O.V.I.O. removed things from E.S.N.;
- (f) She experienced difficulty managing the children's behaviour and being consistent with the children;
- (g) The visits were often chaotic and she did not appear motivated or energetic

toward the children;

- (h) She did not follow through and use parenting techniques that were taught and modeled, such as time-outs for O.V.I.O.;
- (i) She did not intervene when the children, particularly O.V.I.O., would scream for no particular reason or throw things;
- (j) She displayed inappropriate affect, for example, laughing when either O.V.I.O. or E.S.N. were in distress;
- (k) She did not interact by playing with the children and if she did it was for a very limited period of time;
- (l) She frequently sat and watched the children instead of engaging and playing with them;
- (m) She remained non-verbal for significant periods during the visit;
- (n) She frequently ignored the children when they sought comfort or her attention;
- (o) She kept the children in their highchairs for lengthy periods of time during the visit;
- (p) She spend a significant period during the visit feeding the children or grooming the children despite their protest and discomfort with the grooming she did;
- (q) She seemed indifferent to the distress displayed by the children and the potential risk of harm to the children in an unsupervised situation as occurred during the June 7, 2004 visit, supervised by Ms. L. Gianetti;
- (r) She reacted angrily and impatiently to the children's behaviour by yelling, speaking sternly and in harsh tones, looking at the children with an angry face and making "tsk" type sounds, removing items from the children that they are playing with or taking them away from an activity in which they were engaged without warning and/or preparation;
- (s) She disregarded the direction provided by the foster mother's correspondence for the timing and/or nature of food to be given to E.S.N.;
- (t) She used the same utensil to feed both children and would also eat from the same utensil herself;
- (u) She displayed behaviour, including the tone and manner of her speech, which was distressing to the children;
- (v) The children expressed physical and emotional distress in response to Ms. J.I.'s behaviour, including E.S.N. screaming and crying to the point when he threw up during a visit supervised by Ms. Kneebone on November 24, 2005 when Ms. J.I. removed his pasta from him before he had finished it;
- (w) Ms. J.I. did not change her behaviours even when her actions were causing the children significant upset;
- (x) The children were observed to engage in self-soothing behaviours such as sucking their thumbs during visits; and

- (y) Her behaviour towards resource workers, while in the presence of the children, has been rude, defiant and dismissive.

220 Ms. MacNeill supervised Ms. J.I.'s initial access visits in September and October 2004. During these visits, she made observations that Ms. J.I. was not responsive to O.V.I.O.'s crying and need for attention and comforting. She further experienced Ms. J.I. to be argumentative with her as well as to be non-responsive to Ms. MacNeill's questions.

221 Ms. MacNeill noted that during one of the access visits she supervised, Ms. J.I. was upset regarding some bloody discharge she noticed from O.V.I.O.'s vaginal area. Ms. J.I. yelled at Ms. MacNeill and tried to hold O.V.I.O.'s legs apart to show Ms. MacNeill what she meant by the discharge. Ms. MacNeill observed that Ms. J.I.'s physical handling of O.V.I.O. and her yelling in itself, created upset and disturbance for the child.

222 In February 2006, the Society amended its Protection Application and Ms. Jones prepared a plan of care reflecting a plan for the children to be adopted given the children's length of time in care, Ms. J.I.'s lack of follow through with the current plan of care and court order and the ongoing concerns observed during access visits.

223 Ms. J.I. testified that it was her request that the children be placed in her care. She said that as part of her plan to care for the children, it was her intention to reconcile with Mr. V.I.O. She had been in a relationship with Mr. V.I.O. when she became pregnant with O.V.I.O. but then reported to have left the relationship on account of its abusive nature and began residing with the parents at the end of December 2002. She subsequently met Mr. I.N. in or about June 2003 when she was pregnant with O.V.I.O. She developed an intimate relationship with Mr. I.N. in or about November 2003, and which relationship ended in or about May 2004.

224 Ms. J.I. also reported meeting Mr. A.E. after she came to Canada from Nigeria in April 2003. Mr. A.E. resided in Ms. J.I.'s two bedroom subsidized apartment at [text deleted by LexisNexis Canada] from at least in or about February 2004 up to the end of December 2004. Ms. J.I. and Mr. A.E. both lived in her rent subsidized apartment from at least between in or about May 2004 to December 2004, following which time Mr. A.E. obtained his own accommodation.

225 Ms. J.I. testified that she would continue to work if the children were placed in her care and that she would arrange for them to go to daycare. She testified that she worked shift work, three different shifts, day, afternoon and night and including weekends. The shifts were reported to change every week and her work days included all seven days per week. Her written plan of care provided that she worked Monday to Friday during regular business hours.

226 Ms. J.I. reported being employed by various nursing homes and then an agency, however, the names or telephone numbers that she provided in her testimony for her employer or agency did not exist, or her employment was not verified. She did not provide documentation to confirm her employment.

227 Ms. J.I. reported a plan for the children to be placed in daycare, however, testified she had not yet made an application for the children to attend nor did she make inquiries about whether a daycare would accept a child who had HIV positive status. Ms. J.I. was not able to describe E.S.N.'s current medications.

228 In these proceedings it is clear that the respondent, Ms. J.I., consented to the finding on March 7, 2005 by the Honourable Mr. Justice Czutrin that the child, E.S.N., be found to be a child in need of protection pursuant to paragraphs 37(2)(b)(i) and (e) of the *Child and Family Services Act* (hereinafter the "*Act*").

229 Ms. J.I., however, denies that O.V.I.O. is a child in need of protection pursuant to section 37(2)(b)(i)(ii) and (g.1) of the *Act*. Ms. J.I. has attempted to establish to the Court that she never demonstrated a lack of ability to ensure O.V.I.O.'s safety and that the evidence of apprehending worker, Ms. Carrie MacNeill, showed that this child was apprehended as a result of concerns stemming from Ms. J.I.'s actions concerning her other child, E.S.N.

230 She urges me to find that O.V.I.O. is not a child at risk for suffering from emotional harm pursuant to section 37(2)(g.1) and she testified that she is aware of O.V.I.O.'s delay in speech development and feels she is capable of addressing any future issues that may arise and that the Society has not met the onus of proving, on a balance of probabilities, that the child, O.V.I.O., is a child in need of protection.

231 It would appear that Ms. J.I.'s Plan of Care, as outlined in her cross-examination by Society counsel, is for the children to live with her at her current residence.

232 It is indicated that Dr. Zamora confirmed that he found no reason why Ms. J.I. could not parent her children and further, did not feel that the children would be harmed if in her care. Dr. Zamora, however, did state in his evidence that Ms. J.I. should participate in counselling to address her depressive adjustment reaction diagnosis and that this counselling would be a caveat to his recommendation of her ability to parent her children.

233 The evidence of Carol Redden, and Dr. Carvalhal was clear in that Ms. J.I. refused this recommendation of counselling as she believed that "*she didn't need it*". However, in her testimony at trial, Ms. J.I. did advise the Court that she would resume counselling in order to have her children returned to her care.

234 Furthermore, the evidence of Dr. Carvalhal showed that despite J.I.'s refusal to commence counselling she would allow counselling sessions to begin if Ms. J.I. requested them.

235 It is urged upon me that given Ms. J.I.'s change in attitude with respect to the recommended counselling, the original assessment by Dr. Zamora should stand, i.e. the children be placed in her care.

236 It is further urged upon me that Ms. J.I.'s Plan of Care for the children should be considered as she:

- (a) Has demonstrated remorse for her decisions which resulted in E.S.N. being infected with the HIV virus;
- (b) Has advised the Court that she is now willing to commence the counselling as recommended by Dr. Zamora and Dr. Carvalhal;
- (c) Has shown to be responsive to the needs of the children during access visits; and
- (d) Has accepted responsibility for the past choices she has made with respect to her HIV infection.

X: RELEVANT CASE LAW

Relevant Time to Find a Child in Need of Protection

237 It is important to understand, in order to respect the wording, as well as the spirit of the legislation [*Child and Family Services Act*] which governs every aspect of child protection proceedings in Ontario and which has as its paramount objective to promote the best interests, protection and well-being of children, it is crucial that this child-centred focus not be lost at any stage of the proceedings. The procedural steps and safeguards which govern the entire process under the *Act* must always be construed in light of the clear purposes of section 1.

C.M. v. Catholic Children's Aid Society of Metropolitan Toronto and Official Guardian, 2 R.F.L. (4th) 313, S.C.C. at page 336.

238 One must also grasp that the *Act* must be looked at as a global legislative scheme whose purpose and rationale should not be overshadowed by an unduly restrictive and strict interpretation of the sections of the *Act*, which would be at cross purposes with the whole philosophy of the *Act*. A flexible approach [to the determination of whether a child is in need of protection] is in line with the objectives of the *Act*, as it seeks to balance the best interests of children with the need to prevent indeterminate State intervention, while at the same time recognizing that the best interests of the child must always prevail.

C.M. v. Catholic Children's Aid Society of Metropolitan Toronto and Official Guardian, *supra*, at pages 339, 343.

239 As well, the Court should consider whether the child is in need of protection at the commencement of the proceedings or at the hearing date, or for that matter some other date, depending on the circumstances. There cannot be an absolute rule as to the relevant date. In my view this is consistent with the *Act* and certainly consistent with the Supreme Court of Canada decision [in *C.M. v. Catholic Children's Aid Society of Metropolitan Toronto and Official Guardian*,] *supra*.

Children's Aid Society of Hamilton-Wentworth v. K.R. [2001] O.J. No. 5754, O.S.C.J. Family Court at para. 50

240 For example, if, under the *C.F.S.A.* the only time that can be considered when determining protection is the start date, it might result in the court returning a child to a person even if the court came to the conclusion the child was in need of protection at the time of the hearing as opposed to the date of apprehension. This would potentially put a child in need of protection and potentially at risk, and would require a new apprehension after return. Surely, this could not be in the best interests of a child.

Children's Aid Society of Hamilton-Wentworth v. K.R. supra, at para. 49

241 As well, restricting the relevant date for a finding that a child is in need of protection to the start date would be an interpretation of the *C.F.S.A.* that conflicts with the other sections of the *Act* and that would be contrary to the best interests of protecting children from harm and is certainly contrary to the direction of the Supreme Court of Canada.

Children's Aid Society of Hamilton-Wentworth v. K.R. supra, at para. 49

242 I am also aware that the evidence to be considered by the court in a determination of whether a child is in need of protection was not only the evidence existing at the time of the apprehension, but also the evidence existing after the apprehension.

Children's Aid Society of Hamilton v. M.C. [2003], O.J. 1271, O.S.C.J. Family Court, Hamilton, at para. 15.

243 It is clear that events in a child's life are ever evolving and not frozen to events that existed at the beginning of the court process. In my view the Court may find a child in need of protection where the evidence supports the facts that fall under any subsection of section 37. Failure to consider additional and new risks established after the commencement of an application could potentially leave children vulnerable and at risk of harm if the court could not consider those subsequent events.

Children's Aid Society of Hamilton-Wentworth v. K.R., supra, at paras. 37 and 39

XI: BURDEN OF PROOF TO OBTAIN A PROTECTION FINDING

244 I again reiterate that the issue of whether children are in need of protection is to be proved on simple balance of probabilities.

Children's Aid Society of Niagara Region v. D.P. [2003] O.J. 619, O.S.C.J. Family Court, St. Catharines at para. 36.

245 A child will be found to be at risk of physical harm under section 37(2)(b) and therefore in

need of protection as a result of a mother's inability to properly attend to his physical day-to-day needs, her inability to develop a consistent and proper long-term plan for herself and the child, her potentially volatile, undiagnosed and untreated mental health problems and need for a prolonged course of intensive therapy without which her difficulties would persist, her lack of family support and her poor judgment about her personal care and relationships.

Catholic Children's Aid Society of Hamilton-Wentworth v. C.L. [2002] O.J. No. 4255, O.S.C.J. Family Court, Hamilton at paras. 32, 36 and 37.

246 As I indicated earlier in these reasons a Crown Wardship Order is probably the most profound Order that a Court can make because it so profoundly affects the lives of the people involved. To take someone's children from them is a power that a judge must exercise only with the highest degree of caution and only on the basis of compelling evidence, and only after a careful examination of possible alternative remedies.

Children's Aid Society of Hamilton v. M.(M.A.) [2003] O.J. No. 1274, O.S.C.J. Family Division, at para. 12.

247 As well, I acknowledge that the burden of proof on the applicant Society seeking a disposition order of permanent Crown Wardship (with adoption as placement), and no access to the biological parents, is one of a high degree of probability.

Children's Aid Society of Niagara Region v. D.P., *supra*, at paras. 34, 35 and 122.

248 I again note that one of the real issues to be determined in an application where the applicant Society is seeking an order for Crown Wardship with no access and the parent is seeking to have a child placed in his or her care, is whether, in light of a parent's individual capabilities, the parent would even be able to meet his or her parental responsibilities. This would include a consideration of whether the proper assistance and intervention in the nature of services was available, including availing a parent of every opportunity to take advantage of the services.

Children's Aid Society of Hamilton v. M.(M.A.), *supra*, at paras. 18, 19, 20 and 21.

Children's Aid Society of Niagara Region v. D.P., *supra*, at paras. 101, 104, 111, 126 and 129.

249 In my view a court may determine the issues of Crown Wardship and access without the need for the Society to prove that the children are adoptable.

Children's Aid Society of Niagara Region v. D.P., *supra*, at paras. 140 and 141.

XII: APPLICATION OF THE LAW TO THE FACTS OF THE CASE

250 As I see it, the position of the applicant is that the Society has proved, on a balance of probabilities, that the children are in need of protection based on the totality of these proceedings.

251 In my view O.V.I.O. is a child in need of protection pursuant to section 37(2)(b)(i)(ii) and (g.1) of the *Act*. O.V.I.O. is at risk for suffering physical harm on account of her developmental stage and Ms. J.I.'s demonstrated lack of ability to ensure her safety even during access visits, her potential exposure to the HIV virus and Ms. J.I.'s refusal to acknowledge even the possibility that O.V.I.O. could, in certain circumstances, which have been confirmed by Dr. Haider, become infected through the use of shared utensils between herself and E.S.N. and Ms. J.I.'s past failure to follow medical advice, including attending a clinic appointment for O.V.I.O. in February 2004.

252 As well I find that O.V.I.O. is a child at risk for suffering from emotional harm pursuant to section 37(2)(g.1) based upon Ms. J.I.'s lack of ability or willingness to be responsive to O.V.I.O.'s behaviour and need for attention during access visits and her failure to be involved in learning how she could work with Society and daycare staff to facilitate O.V.I.O.'s speech and language development by using the techniques that had been taught.

253 In my view Ms. J.I. has not demonstrated an ability to be responsive to O.V.I.O.'s need for attention during access visits. She has ignored O.V.I.O. or demonstrated anger and impatience toward O.V.I.O. even though she only spent two hours two times per week with her children. O.V.I.O. responded behaviorally by becoming upset, throwing toys, screaming and crying or alternatively, engaging in self-soothing behaviours such as sucking her thumb.

254 E.S.N. is a child in need of protection pursuant to sections 37(2)(a)(i)(ii) and (e) as he was infected with the HIV virus from Ms. J.I. as a result of her deliberate actions, including but not limited to her failure to obtain the medical care that had been recommended for both herself and E.S.N. at all times in light of her HIV positive status and recent caesarean delivery with O.V.I.O. in June 2003 and her breastfeeding E.S.N.

255 E.S.N. is also a child in need of protection pursuant to sections 37(2)(b)(i)(ii) and (g.1). He requires ongoing medical supervision to ensure his medications are taken regularly and that they are effective in "*fighting*" the virus. If there is any disruption to his medication, even briefly, this could impact adversely on his health as a mutation of the virus could develop, rendering his existing medications ineffective. Ms. J.I. has not followed through to arrange an appointment at the S.I.S. Clinic to learn how to administer his medications and, in fact, was not even able to name his current medications.

256 E.S.N., as well, is a child who is at risk of suffering emotional harm pursuant to section 37(2)(g.1), in part on account of the issues he will face being HIV positive and the inability of Ms. J.I. to provide and/or arrange the support he will inevitably require, including the lifelong need to take medications; side effects from medications; attending for medical follow up; undergoing repeated medical tests such as intrusive and painful blood work, addressing how he became infected with the virus and the sexuality issues, including that he may not be able to father children of his own.

257 E.S.N. is also at risk of suffering emotional harm as Ms. J.I. has not demonstrated an ability

to consistently respond to E.S.N.'s needs for nurturance, comfort and attention. He has displayed distress in response to Ms. J.I.'s behaviour and presentation, including crying, vomiting, and self-soothing behaviours.

258 In my view, having regard to the totality of these proceedings the Society has proven on a high degree of probability an order for Crown Wardship with no access is in the best interests of both children as it would allow them to be adopted.

259 For example, unlike Ms. J.I.'s plan of care, there is compelling evidence in support of the merits of the Society's plan. Ms. J.I.'s plan, including her assertion that she fully intends to heed the Society's recommendations in the future is clearly void of having any merit given her outright refusal to participate in the many services that have been recommended to her.

260 In my view the evidence is clear that there is no air of reality to Ms. J.I.'s plan of care for the children. She has not explored the type of caregiver that would need to be available for E.S.N. to give him his medications, what type of preschool would be available to address O.V.I.O.'s speech and language needs and how she would arrange childcare for two small children as a single parent in light of the hours and shifts, which include nights, she would have to work. Further, she has not proposed a budget with any information about her income or benefits or how she would propose to cover the costs of E.S.N.'s medications or the daycare costs for the children.

261 The evidence overwhelmingly supports a finding by this Court that Ms. J.I. does not have the ability to meet her parental responsibilities to the children and that she consistently rejected, with the exception of the subsidized housing, most of the assistance offered to her by the Society and the staff at the S.I.S. Clinic to meet the needs of the children. As well, Ms. J.I. is facing outstanding serious criminal charges arising out of her decisions and actions regarding E.S.N.

262 In my view the Society's plan of care would ensure that the children's physical, mental and emotional needs, as identified by their current caregivers, and more specifically set out above, would be met by obtaining parents who were prepared to adopt the children. The prospective parents to the children would be individuals who are sensitive to the children's background, including their heritage and religion and would demonstrate skills that would enable them to work with professionals to ensure that the children maintain their optimum level of health and development in the context of their special needs.

263 As I see it, the Society's plan would strive to provide the children with the benefit of a loving, safe and stable family environment in which their individual needs for nurturance, acceptance, stimulation and permanence would be met. The Society would work to have a plan for adoption finalized as soon as practically possible. The Society's plan, in view of the children's ages and time that they have already been in care is consistent with the objectives of the legislation, namely the avoidance of delay in permanency planning for the children.

264 As I see it, the totality of the evidence clearly demonstrates that the degree of risk that

justified the Society apprehending the children from Ms. J.I.'s care and placing the children in care was significant and it continues to be present, to the extent that there would be a risk that the children would suffer both physical and emotional harm if they were placed in Ms. J.I.'s care because:

- (a) Ms. J.I. has not demonstrated remorse for the decisions which resulted in E.S.N. being infected with the HIV virus;
- (b) Ms. J.I. has not obtained the counselling, namely the psychotherapy recommended to address the traits in her personality that had been identified by two psychiatrists, Dr. Zamora and Dr. Carvalhal;
- (c) Ms. J.I. has not demonstrated a willingness or ability to implement the instruction and direction provided through the resource workers to assist her to be responsive to the needs and behaviour of the children; follow through with the recommendations made by the family service workers; be responsive to the needs of the children on a consistent basis during access visits or develop any insight into her anger and how it impacts upon her behaviour toward the children;
- (d) Mr. I.N.'s evidence that the mother never advised him that she was HIV positive during the time that they lived together and had sexual relations (January to May of 2004) as was confirmed by the mother in her testimony;
- (e) Ms. J.I.'s secretiveness in this regard was repeated with other individuals the mother came into contact with. Mr. A.E., called as a witness by the mother, was a personal friend of the mother since her pregnancy, also sharing an apartment with her from time to time. He also confirmed that the mother never advised him that she was HIV positive until just before E.S.N.'s delivery.
- (f) Ms. J.I.'s purposeful deception continued with McMaster University Medical Centre Hospital staff when she skillfully avoided attending there for the pre-scheduled C-section on August 27th, 2004 by misleading Dr. Brennan that she could not come then because she did not have child care for O.V.I.O.
- (g) The mother could have relied on Mr. I.N., as well as others, for child care assistance but she chose not to. Ms. J.I. failed to ask any of her alleged available helpers for child care assistance for her August 27th scheduled C-section delivery because she had no intention of attending at McMaster University Medical Centre for a C-section delivery. Instead, she used Mr. I.N. to circumvent the planned health services that were available to her at McMaster and had him drive her to St. Joseph's Hospital where staff were not familiar with her health history and current HIV status.
- (h) Prior to E.S.N.'s birth Ms. J.I. was fully aware of the implications of having a C-section birth because her first child, O.V.I.O., had been

delivered by C-section in June of 2003, for the specific reason of avoiding HIV transmission to O.V.I.O. at birth. Mr. I.N. knew of the mother's previous C-section but was not aware that it was because of the mother's HIV positive status.

- (i) In August, prior to E.S.N.'s birth on September 4, 2004, the mother testified that she got "*mad*", when her doctor changed her anti-viral medication, and so she stopped taking it. When asked why, she stated that she was mad that the medication was not working.
- (j) This immature reaction on the part of Ms. J.I. put not only her own health, but the health of her unborn child at risk of harm.
- (k) Ms. J.I.'s deceptions continued when she attended at St. Joseph's Hospital to prepare for E.S.N.'s delivery on September 4th, 2004. She did not advise any of the hospital staff of her prior health history or her HIV status. She lied about two previous pregnancies she said she had in Nigeria. After delivery she continued her willful deception by not advising hospital staff that her newborn baby boy required anti-viral AZT drugs. She did not advise hospital staff that he should not breastfeed her new baby with her infected breast milk and, in fact, put forth the pretense that she should breastfeed her baby. She in fact put her baby to her breast immediately after delivery for about one minute, as testified by the father. Hospital staff later recorded her breastfeeding E.S.N. on three occasions.
- (l) Ms. J.I. exposed other babies in the hospital nursery to possible HIV transmission by accident or mistake, in that she placed a bottle of her pumped, HIV infected breast milk into a refrigerator in a common kitchen to which other nursing mothers had access.
- (m) Ms. J.I. simply did not wish to be inconvenienced by the surgical intervention of a C-section. She was determined to have the baby delivered vaginally, as she repeatedly advised Dr. Brennan, despite Dr. Brennan's warning that vaginal delivery would increase the baby's chance of HIV transmission.
- (n) At trial Ms. J.I.'s evidence completely lacked credibility in explaining her irresponsible and egocentric behaviour. When challenged about her behaviour, she repeatedly feigned ignorance about the significance of her actions.
- (o) At trial Ms. J.I. made outright denials of evidence already proven in the medical reports filed as exhibits. In the face of overwhelming evidence against her at trial, the mother still refused to acknowledge the damage she had done to the young life of her son E.S.N. When asked what being HIV positive would mean for E.S.N., her flat and emotionless response was that he would have to take drugs every day.
- (p) Ms. J.I. appears indifferent to the distress displayed by the children during

visits with them.

- (q) Ms. J.I. is proposing to reconcile with O.V.I.O.'s father, an individual she reported separating from because of the abuse within the relationship and which was the basis of her refugee claim, with such reconciliation taking place in the absence of any information explaining how the abuse has been addressed to ensure the safety of herself and the children. She, as well, tendered no evidence as to how the abuser, cause of her refugee claim, could be permitted to immigrate to Canada.
- (r) Ms. J.I. could remove the children from the jurisdiction without regard for the impact that would have on the children's needs being met.
- (s) Ms. J.I. has not followed through with the terms of the March 7, 2005 supervision order which was also incorporated into her bail conditions dated May 30, 2005, including attending services recommended by the Society.
- (t) Ms. J.I. has ignored the advice and recommendations of medical and other community health professionals, including but not limited to, safe sexual practices and the care required by the children.
- (u) Ms. J.I. has not been co-operative or forthright with service providers, including having the benefit of a subsidized apartment while residing in another location.
- (v) Ms. J.I. has provided conflicting and vague information with respect to her housing, employment, services she has received and her finances.
- (w) Ms. J.I. has not accepted responsibility for the poor choices she has made, including but not limited to not advising her sexual partners of her HIV positive status and not following the advice provided to her regarding her obligations to disclose her HIV status to sexual partners.
- (x) Ms. J.I. blames others or circumstances for things that have and have not happened; for example, not attending for counselling because Dr. Carvalhal did not call her; "*thinking*" St. Joseph's would find out she was HIV positive because they swiped her OHIP card; stopping her medications because she was mad it was not working; not having a caesarean because Mr. E.E. told her she would be healed.
- (y) Ms. J.I. has, and continues to demonstrate, poor judgment with respect to decisions regarding the children and how their needs are met; for example, not attending O.V.I.O.'s daycare or going to parenting programmes.
- (z) Ms. J.I.'s behaviour has been deceptive as demonstrated as recently as March 30, 2006 by the way she testified regarding the place and nature of her employment and the swearing of an Affidavit on September 13, 2004 which was not true, and
- (aa) Ms. J.I. places her own needs before her children's needs, for example, wanting a vaginal delivery.

265 In my view it is clear that the mother's above-described behaviour demonstrates a skillful and purposeful deception with the father of her child, her family, friends, and health care providers, to suppress health care intervention that was not in accord with her selfish personal preferences and which would have been in the best interests of her child.

266 It is also clear that the mother's ongoing willful and clever deceptions demonstrated repeatedly throughout her pregnancy and up until the baby, E.S.N., was apprehended, and her vague and unhelpful testimony at trial, foreshadows the kind of dishonesty and obstinence that would surely continue in her dealings with the supervising Children's Aid Society were the mother to be given the care and custody of her children.

267 The father's attachment to his son, E.S.N., and the sorrow that he felt in returning his son to the care of the Children's Aid Society were demonstrated in the affidavits of Daniel Kikulwe filed in this proceeding. This father wants what is best for his son, and it is his position that the best plan for E.S.N. is that he be made a Ward of the Crown and placed for adoption in a permanent home. The father accordingly agrees with the Plan of Care that the Children's Aid Society is proposing for his son.

268 In conclusion, I particularly note the words used by Dr. Siegel, which words provide a vivid description of how Ms. J.I.'s behaviour was experienced by not only Dr. Siegel but by many of the helping professionals and other lay persons who testified and were referred to in these proceedings. If mature, capable and educated adults could not have predicted Ms. J.I.'s behaviour or protected themselves from the risk posed by being in a relationship with her, it is unimaginable to think that her already vulnerable children could ever be safe in her care.

... I was quite upset; ... I mean the one thing that's really concerning for me is the unpredictability of her actions at the time. And why I was so shocked about what had happened because it was so out of character of my previous contact with her. And since I couldn't predict what happened at that time, what worries me a little bit is if things were good, there could be something else unpredictable that would happen down the road because it came out of left field when this happened ...

269 In my view, based upon the overwhelming evidence recited above, I can make no finding other than both O.V.I.O. and E.S.N. are children in need of protection as described above and pursuant to the authorities.

270 Also, because of the totality of such evidence it clearly is in the best interests of both O.V.I.O. and E.S.N. that they both be made Crown Wards pursuant to s. 57(1)(3) of the *Child and Family Services Act*, and I do so order.

271 As well, one must remember that the word "and" between sections (a) and (b) means the test is conjunctive, therefore, Ms. J.I. must satisfy both parts of the test.

272 It is also evidence that the only factor which could frustrate adoption for O.V.I.O. and/or E.S.N. would be an access Order. Ms. J.I. led no evidence to counter this assertion.

273 Pursuant to s. 57(1) of the *Child and Family Services Act*, the Court is required to make a disposition Order in the best interest of the children, in these proceedings being O.V.I.O. and E.S.N.

274 In my view the totality of the evidence makes clear that an Order for Crown Wardship, no access, is the only reasonable disposition to meet the best interests of both O.V.I.O. and E.S.N.

275 When the Court grants such an Order, the Court is precluded from making an access Order and the onus shifts to the mother under s. 59(2) of the *Act* to prove that:

- (a) the relationship between the mother and O.V.I.O. and/or E.S.N. is beneficial and meaningful to O.V.I.O. and/or E.S.N.; and
- (b) the ordered access will not impair O.V.I.O. and/or E.S.N.'s future opportunities for permanent or stable placement.

276 Ms. J.I., in my view, led little credible evidence to illustrate that the relationship would be beneficial and meaningful to O.V.I.O. and/or E.S.N.

277 In my view no evidence was adduced to satisfy s. 59(2)(a) of the *Act*.

278 I therefore direct the following Orders:

1. An Order that the child O.V.I.O., born on June 30, 2003 be made a Ward of the Crown, without access and be placed in the care of the applicant Society;
2. An Order that the child E.S.N., born on September 4, 2004 be made a Ward of the Crown, without access, and be placed in the care of the applicant Society.

279 I may be spoken to within seven days of this date, if there is any issue as to costs or a clarification of these Orders.

W.T. STAYSHYN J.

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Corrigendum

Released: July 26, 2006.

A correction was made to para. 194, the word "declined" is replaced by the word "identified". Also, in para. 264 (x), the name "Mr. I.N." is replaced by "Mr. E.E".

cp/qi/e/qw/qlrxl/qlrsg/qltxp/qlrme/qlmll