



COMMISSION OF INQUIRY INTO THE CIRCUMSTANCES
SURROUNDING THE DEATH OF PHOENIX SINCLAIR

The Honourable Edward (Ted) Hughes, Q.C.,
Commissioner

Transcript of Proceedings
Public Inquiry Hearing
held at The Fort Garry Hotel,
222 Broadway, Winnipeg, Manitoba

WEDNESDAY, JANUARY 23, 2013

APPEARANCES

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MR. R. MASCARENHAS, Associate Commission Counsel

MR. G. MCKINNON and **MR. S. PAUL**, for Department of Family Services and Labour

MR. T. RAY, for Manitoba Government and General Employees Union

MR. K. SAXBERG, for General Child and Family Services Authority, First Nations of Northern Manitoba Child and Family Services Authority First Nations of Southern Manitoba Child and Family Services Authority Child, Family All Nation Coordinated Response Network, and Mr. Daniel Berg

MR. H. KHAN, for Intertribal Child and Family Services

MR. J. GINDIN, for Mr. Nelson Draper Steve Sinclair, Ms. Kimberly-Ann Edwards

MR. J. FUNKE and **MS. J. SAUNDERS**, for Assembly of Manitoba Chiefs and Southern Chiefs Organization Inc.

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3

4 THE COMMISSIONER: Good morning.

5 MR. OLSON: Good morning.

6 THE COMMISSIONER: All right, Mr. Olson?

7 MR. OLSON: We're ready to proceed with our next
8 witness, who's on the stand. I'll have him sworn in.

9 THE CLERK: Sir, is it your choice to swear on
10 the Bible or affirm without the Bible?

11 THE WITNESS: I'll swear on the Bible.

12 THE CLERK: Okay. Could you stand for a moment?
13 State your full name to the court.

14 THE WITNESS: Daniel Rodney Berg.

15 THE CLERK: And spell me your first name.

16 THE WITNESS: D-A-N-I-E-L.

17 THE CLERK: And your middle name.

18 THE WITNESS: R-O-D-N-E-Y.

19 THE CLERK: And your last name.

20 THE WITNESS: B-E-R-G.

21

22 **DANIEL RODNEY BERG,** sworn,

23 testified as follows:

24

25 THE CLERK: Thank you.

1 THE WITNESS: Thank you.

2

3 DIRECT EXAMINATION BY MR. OLSON:

4 Q Morning, Mr. Berg.

5 A Good morning, Derek.

6 Q You received your Bachelor of Social Work from
7 the University of Manitoba in 1980?

8 A I did.

9 Q And then in 1980 you began as a frontline family
10 services worker at the Children's Aid Society of Manitoba?

11 A Central Manitoba, yeah.

12 Q Sorry, Central Manitoba.

13 A Yeah.

14 Q Then in '82 till August '85, you worked for the
15 Alberta Social Services?

16 A That's correct.

17 THE COMMISSIONER: Mr. Olson, just speak into the
18 mic, please.

19 MR. OLSON: Is that better?

20 THE COMMISSIONER: Yes.

21

22 BY MR. OLSON:

23 Q So you were -- were you actually in Alberta at
24 that time?

25 A Yes, for about three -- little over three years.

1 I worked for the Alberta Social Services out of Peace
2 River, Alberta.

3 Q Out of Peace River, okay.

4 A Yeah.

5 Q And then from August 1985 until January '89, you
6 worked for the City of Winnipeg Social Services.

7 A That's correct.

8 Q And then from there you went to the Children's
9 Aid Society of Eastern Manitoba?

10 A Um-hum.

11 Q And that was in a shared school position?

12 A That's correct.

13 Q Can you just explain what that, what that was?

14 A It was a shared school position with the Lord
15 Selkirk School Division and the Children's Aid of Eastern,
16 and we had a social work position that was based out of two
17 schools, one in the East Selkirk area and one up at Walter
18 Whyte School, working with children and families in the
19 school system.

20 Q So you were a school social worker then?

21 A Officially, I was actually a child welfare
22 worker, but the position was created between the school
23 division and, and the agency at that time.

24 Q Okay. That was to deal with child welfare issues
25 that arose with students in the school division?

1 A That's correct, but it was very much a
2 preventative role.

3 Q Okay.

4 A Yeah.

5 Q Then from November 1992 you accepted a family
6 services supervisory position at Children's Aid Society of
7 Eastern Manitoba.

8 A That's correct.

9 Q Now, that's a predecessor of Winnipeg Child and
10 Family Services?

11 A That's correct.

12 Q You held that position until 1999, at which time
13 you were with Winnipeg Child and Family Services in the
14 east area?

15 A That's correct.

16 Q Was that basically a continuation of the previous
17 position, just a different agency?

18 A No, I was a permanent ward supervisor at that
19 time.

20 Q In 1992.

21 A In 1992, I was the family service supervisor.

22 Q Okay.

23 A 1999, I was a permanent ward supervisor, and I
24 was there from '99 until I went to the intake, 835 Portage,
25 as assistant program manager in 2003.

1 Q 2003, and you remained in that position until May
2 16, 2005.

3 A That's correct.

4 Q It was during that time that you would have had
5 -- you would have overseen some of the supervisors that
6 were involved in this particular matter.

7 A That's correct.

8 Q From May 16, 2005 until April 2006, I understand
9 you were -- now, were you seconded to the Animikii ...

10 A Yeah. Yes, I was seconded to a small agency,
11 Animikii Child and Family. We had to develop and, and
12 create and put the mandate together for that agency.

13 Q Okay. Just for the period of time you were the
14 assistant program manager, who was your employer?

15 A When I was assistant program manager, it was
16 Winnipeg Child and Family Services, yeah.

17 Q Was that the case when you were seconded to
18 Animikii?

19 A Yes.

20 Q Okay. So you stayed at Winnipeg.

21 A That's correct.

22 Q Okay. Some point you became a service manager
23 for Winnipeg Child and Family Services?

24 A Right.

25 Q Can you explain for the Commissioner what a

1 service manager does?

2 A I was actually an assistant program manager.
3 Currently I'm a service manager, but at 835 Portage I was
4 an assistant program manager, reporting to Pat Harrison,
5 who was my program manager, and my responsibilities were to
6 oversee half of the program functioning at 835 Portage. So
7 I had one of the CRU teams, crisis response unit teams
8 under me, I had two tier two intake teams under me, I had
9 one abuse unit and two community program units where the
10 respective supervisors reported directly to me.

11 Q Okay.

12 THE COMMISSIONER: And all of that was what
13 years?

14 THE WITNESS: That would have been April -- I
15 think I went the 28th of April in 2003, and I left there --
16 May 16th, 2005, I started at Animikii and that was a
17 Monday, so it was the Friday before that.

18

19 BY MR. OLSON:

20 Q Just so -- and just so it's clear, you were
21 assistant program manager between 2003 and 2005.

22 A That's correct.

23 Q You went to Animikii.

24 A Yes.

25 Q And then after Animikii became a service

1 manager --

2 A When I went to Animikii, I was, I was over there
3 on secondment but it was more in a supervisory kind of a
4 role --

5 Q Okay.

6 A -- at Animikii. And then I came back to Winnipeg
7 Child and Family as a service manager.

8 Q When you came back as a -- for a service manager,
9 was that a similar position to being assistant program
10 manager?

11 A It's one, one level higher.

12 Q Okay, I see.

13 A Yeah.

14 Q Who did you report to as a service manager?

15 A I reported to Darlene MacDonald at Winnipeg Child
16 and Family.

17 Q Is that the position you currently hold?

18 A Yes.

19 Q I also understand that you're the Winnipeg Child
20 and Family Services representative on the ANCR steering
21 committee?

22 A Yes, I am.

23 Q First of all, what is the ANCR steering
24 committee?

25 A The ANCR steering committee was set up resultant

1 of the devolution process. All Nations Coordinated
2 Response reports directly to the Southern Authority and
3 there was a belief by standing committee and the four CEOs
4 at standing committee that ANCR needed to have a steering
5 committee made up of representatives of the 16, 17 agencies
6 in the City of Winnipeg, and they meet quarterly to talk
7 about the programs and functions at 835 Portage. We are
8 the receivers of their work, so their work gets sent on to
9 the various agencies and so we're there to give them
10 feedback, you know, in regards to the, to the work that
11 they're doing, the quality of the work, to troubleshoot
12 areas that are problematic, and to see if we can continue
13 to have a good process going forward with the designated
14 intake agency, which ANCR is for the City of Winnipeg.

15 Q Okay. Is -- and is that more of a high level
16 position in terms of you don't get down to what's happening
17 on individual files, it's more policy and procedure?

18 A It's, it's kind of a bit of both. You know,
19 there, there certainly is lots of folks representing
20 different agencies that go there, so some of the
21 individuals that go will raise scenarios, case scenarios
22 that they feel are problematic or practices at ANCR that
23 they feel don't, don't mesh with the practice in the
24 receiving agency. So it's a bit of both.

25 Q Okay. Now, I want to ask you -- the next

1 questions I'm going to ask you are going to focus on your
2 position as assistant program manager from 2003 to 2005.

3 A Okay.

4 Q First, did you receive any training for that
5 position?

6 A Before I went into the ...

7 Q Before you went into the position.

8 A No.

9 Q How about after you went into the position?

10 A Just let me think. I certainly attended
11 training, but not specific to that particular position.

12 Q Okay. So no specific training focused on being
13 an assistant program manager.

14 A That's correct.

15 Q Was that sort of training available to, to you if
16 you wanted it?

17 A Not specifically for assistant program managers,
18 no.

19 Q Okay. Can you give the Commissioner an overview
20 of what you did as a, as an assistant program manager?

21 A Sure. One of the things, I think, that, that
22 happened, Rob and myself tried to do fairly early, is we
23 tried to --

24 Q Just, just before you go on --

25 A Sorry.

1 Q -- you said Rob. We don't know who Rob is yet.

2 A Oh, I'm sorry. Rob Wilson was the other
3 assistant program manager, and Patrick Harrison was the
4 program manager.

5 Q Okay.

6 A So we made up the senior management group that
7 was in existence at 835 Portage.

8 Q Just, just to give -- before you go on, and I'm
9 sorry to interrupt you --

10 A Okay.

11 Q -- but just to give the Commissioner idea of, of
12 how the setup worked, if we could pull up Exhibit 15 on the
13 monitor, please?

14 THE COMMISSIONER: What was the name of the
15 manager you said?

16 THE WITNESS: Patrick Harrison.

17 MR. OLSON: Now, Mr. Commissioner, this is a
18 document we've looked at previously. You'll see that the
19 headings at the top of the document have the date, the
20 social worker, supervisor, assistant program manager,
21 program manager, et cetera.

22 THE COMMISSIONER: And what ...

23 MR. OLSON: So it's basic -- this is Exhibit 15.

24 THE COMMISSIONER: Exhibit 15.

25 MR. OLSON: Fifteen.

1 THE COMMISSIONER: All right.

2 MR. OLSON: So this is basically the chain of
3 command at the relevant times according to openings on, on
4 Phoenix's file.

5

6 BY MR. OLSON:

7 Q You appear first February 28, 2003.

8 MR. OLSON: Sorry, go to the next page, please.
9 And if you could just show the whole page on the screen?

10 Okay, that's good.

11

12 BY MR. OLSON:

13 Q Do you see where I'm referring to?

14 A Yes.

15 Q So you appear, it's --

16 THE COMMISSIONER: Where, where, where -- I
17 don't.

18 MR. OLSON: It's this -- if you look at the first
19 column, Mr. Commissioner, the date would be February 28,
20 2003.

21 THE COMMISSIONER: Yes.

22 MR. OLSON: Sorry, 28.

23 THE COMMISSIONER: I see.

24 MR. OLSON: Okay.

25 THE COMMISSIONER: Yes.

1 MR. OLSON: And you see next to that there's
2 Laura Forrest. She would have been the worker involved at
3 that --

4 THE COMMISSIONER: Yes.

5 MR. OLSON: -- that time, and then there's Andrew
6 Orobko --

7 THE COMMISSIONER: Yes.

8 MR. OLSON: -- who would have been her
9 supervisor.

10 THE COMMISSIONER: Yes.

11 MR. OLSON: And then the next column, it's split
12 between Rhonda Warren and Dan Berg.

13 THE COMMISSIONER: Yes.

14 MR. OLSON: And it says Dan Berg after March
15 22nd, 2003.

16 THE WITNESS: Yeah, that, that's when it was
17 announced in the agency that we were the successful
18 candidates, but we didn't go there till, till April.

19

20 BY MR. OLSON:

21 Q Till April, okay.

22 A Yeah.

23 Q So you -- as of April 2003, you would have been
24 the assistant program manager, and then in terms of
25 organizational structure, this is where you would have fit

1 in, between the supervisors of CRU and intake, and the
2 program manager --

3 A That's --

4 Q -- who was Patrick Harrison.

5 A That's correct. That's correct.

6 Q Okay. And then -- so you would have reported to
7 Patrick Harrison?

8 A That's correct.

9 Q And he would have reported to Elaine Gelmon, and
10 so on.

11 A I think Pat reported to Linda Trigg.

12 Q Okay.

13 A If I remember correctly.

14 Q And she was the CEO at that time?

15 A That's correct, yes.

16 Q Okay. So that should give an indication of where
17 you fit in.

18 A Yes.

19 Q So if you want to just continue on, based, based
20 on that understanding.

21 A Okay. Derek, could you ask me that question one
22 more time?

23 Q I was just asking you to give us a -- the
24 Commissioner an overview of what you did as assistant
25 program manager.

1 A Okay. When we, when we first went to 835
2 Portage, early on we, we set aside a team day to meet with
3 the supervisors. We had kind of three or four agenda
4 items, so I'd like to start there if I could, Derek.

5 One of the things that we wanted to do was to
6 make sure that all of the supervisors, you know, first of
7 all, knew who Pat was and Rob was and I was. You know,
8 joining their team at 835 Portage, we were, were wanting to
9 be clear with them in our respective roles. Rob and I were
10 responsible -- Rob Wilson and I were responsible for
11 overseeing the service that was provided at 835 Portage so
12 we wanted the supervisors to know that we had expectations
13 from them to ensure that we were kept abreast of any of the
14 high risk cases that we were managing at 835 Portage. So
15 that could have been child deaths, both past and present;
16 could have been high risk, politically sensitive cases that
17 were in the media; would have been involvement with cases
18 that were high profile that were in the General Authority
19 or there were ministerial inquiries about; and, and serious
20 complaints. So we were trying to establish, you know, a
21 connection with the supervisors but at the same time
22 letting them know that we needed to be, you know, in the
23 loop of the know of information and we wanted to have a
24 very, you know, hands-on management style, you know, with
25 the supervisors and with the staff.

1 THE COMMISSIONER: Did you and Wilson each have
2 so many supervisors reporting to you?

3 THE WITNESS: That's correct. Rob had exactly
4 the same programs, Mr. Commissioner, that I did. I just
5 had one more community unit supervisor that reported to me
6 than Rob did.

7 THE COMMISSIONER: How many did you have in all?

8 THE WITNESS: I had one CRU, two intake, one
9 abuse, four; two community, six.

10

11 BY MR. OLSON:

12 Q So one CRU, two intake -- two intake and one
13 abuse --

14 A And two community.

15 Q -- and then two community.

16 A That's correct.

17 Q And Mr. Wilson would have had a similar -- or
18 sorry, Mr. Harrison would have had a similar -- he would
19 have overseen a similar number of people?

20 A Rob Wilson --

21 Q Sorry.

22 A Yeah, Rob Wilson would have had five supervisors
23 that would have reported directly to him, and then Patrick
24 as the -- Patrick Harrison as the CEO, he was our CEO but
25 he also would oversee the after-hours program. So that was

1 Pat's additional responsibilities.

2 Q Okay. And just before you go on, was, was the
3 introduction of yourself and Mr. Wilson a significant
4 change from what the structure was prior to that?

5 A I'm, I'm not sure that we, we really knew
6 entirely what the structure was prior to that. There was
7 actually only one assistant program manager that had been
8 working over at 835 Portage before the three of us went
9 there. It was a huge, huge responsibility, a very, very
10 big job, and I think we were really short-staffed in terms
11 of senior management and the view was that, you know, we
12 needed to change that. There were a lot of morale related
13 challenges. So we were going there, the three of us, and
14 trying to do a lot more hands-on work than was even
15 possible for the one previous individual who was there. I
16 mean, my hat is off to her for the work that she did and
17 the job that she did, but it was, it was a very big
18 responsibility and it was clearly enough work for three
19 people, if not for more.

20 Q So, so prior to your coming on --

21 A Yes.

22 Q -- and -- you, Wilson, and Harrison, it was --
23 Rhonda Warren would have been the assistant program
24 manager.

25 A That's correct.

1 Q And you're saying under her there were a lot of
2 morality -- sorry, there were a lot of morale --

3 A I, I want to be careful how I choose my words.
4 Under her responsibility, I think she was, she was
5 understaffed at the senior management level. I believe she
6 did the best she could. I think she did, you know, a
7 remarkable job given there was only one person there that
8 was doing a job that it took three of us to do. And at the
9 end of the day, she did a very nice handoff of the
10 information for us in regards to, you know, who are our
11 managers, how was the place functioning, troubleshooting
12 the issues that we needed to pay attention to. So I think
13 it was a really nice bridge that she was able to do for us.

14 Q I see. When you came on, what was the morale in
15 the units you were supervising like?

16 A It was a struggle. It was a struggle when we
17 first came on. The morale was, was, was down. I think the
18 supervisors were -- in some senses, they had, they had kind
19 of come together, but perhaps they'd come together not in a
20 way to work hand in hand with senior management. So our,
21 our walk initially over there was -- it was kind of a
22 delicate walk, you know, when we first were all together
23 there.

24 Q Do you -- was it your impression that the morale
25 at the time affected the services being provided?

1 A Well, I think morale always affects the service.
2 Did it place children at risk? No. But was there areas
3 certainly where we, when there was three of us there, could
4 potentially do some things differently in terms of having a
5 different ability to be able to support the supervisors in
6 the respective units and, and, and make, you know, an
7 effort to ensure that we could try to change that from more
8 of a negative morale base to more of a positive morale
9 base. It was certainly high on Pat's priority list, and
10 that was sort of the direction that he provided to Rob and
11 I, that he wanted us to run the service, he expected us to
12 be out there, he expected us to be down with the teams,
13 with the supervisors, and be available to them independent
14 of what their needs are, whether they were case related or
15 personnel related.

16 Q In terms of your, your role there, what did you
17 see your position being in terms of your relationship with
18 the supervisors of the intake and abuse units and the other
19 units you were overseeing?

20 A Yeah. Probably, probably different for each one,
21 Derek, to be honest with you. For the crisis response
22 unit, it was, you know, a 24-hour immediate response of
23 all the high-risk related cases that were coming into the
24 branch and the new cases, so my involvement there with the
25 CRU supervisor was much more of a crisis kind of

1 consultation basis. Every day, at least two or three times
2 a day, I'm probably talking to the CRU supervisor because
3 the volume that they were dealing with and the crisis
4 nature of the calls that they were dealing with, supervisor
5 wanted to have an extra head to bounce things off. And if
6 we had to make some branch related, you know, decisions at
7 that point in time that would have been my, my role and my
8 area of responsibility.

9 Q Okay. That CRU supervisor, by the way, that was
10 Diva Faria.

11 A It was Diva Faria for both Rob and I when we both
12 started, and then we were fortunate enough to be able to
13 expand the CRU program and hire a second CRU supervisor.

14 Q Okay. And that --

15 A But initially that was --

16 Q -- would have been Ms. Verrier.

17 A That was, yeah, Diana Verrier.

18 Q And he would have been -- sorry, she would have
19 been on Rob Wilson's --

20 A Yes, she reported directly to Rob.

21 Q Okay.

22 A And then for --

23 THE COMMISSIONER: Who, who did?

24 THE WITNESS: Diana Verrier.

25 THE COMMISSIONER: But Faria, Faria to you.

1 THE WITNESS: Yes, Diva Faria reported directly
2 to me.

3 THE COMMISSIONER: Yes.

4 THE WITNESS: And then tier two intake would have
5 been less crisis driven because they're generally managing
6 cases for a four- to eight-week period of time, but they,
7 they, too, would be receiving the cases from CRU so the
8 challenge of their cases were there as well.

9 So I would be there in my role there to do
10 consultations with the supervisors. I would be there to
11 meet with them on a supervisory related capacity for some
12 sit-down supervision. And beyond that, we would -- if they
13 were at training, if they had double duties, they had
14 court, if they had different experiences, both Rob and I
15 would take turns, you know, with our respective teams going
16 in and covering the units, so meeting with the staff,
17 discussing cases, signing off closures and transfers, that
18 kind of thing.

19

20 BY MR. OLSON:

21 Q So you would do some of that work?

22 A Yes, for sure.

23 Q Would you -- would it be accurate to describe
24 your position as a supervisor of those supervisors?

25 A That's correct.

1 Q So as their supervisor, would you be responsible,
2 then, for ensuring that they, for example, were applying
3 best practices in the way they handled cases and their
4 workers, and followed policies and --

5 A As best as possible, Derek. I mean, they were a
6 very, very skilled, experienced group of supervisors that
7 we had --

8 THE COMMISSIONER: Are you talking about the
9 intake supervisors?

10 THE WITNESS: I'm referring actually to all the
11 supervisors.

12 MR. OLSON: All, right.

13 THE WITNESS: All of them.

14 MR. OLSON: Right.

15 THE WITNESS: They have lots of experience. They
16 were very experienced. They were very skilled in their
17 respective areas --

18 THE COMMISSIONER: But let me just interrupt you.

19 THE WITNESS: Sorry, sir.

20 THE COMMISSIONER: After you detailed your
21 relationship with the CRU supervisor --

22 THE WITNESS: Right.

23 THE COMMISSIONER: -- you then went on and --

24 THE WITNESS: Yes.

25 THE COMMISSIONER: -- talked about the others.

1 And were those the --

2 THE WITNESS: Yes.

3 THE COMMISSIONER: -- intake supervisors you --

4 THE WITNESS: Yes.

5 THE COMMISSIONER: -- were talking about?

6 THE WITNESS: Yes, sir.

7 THE COMMISSIONER: All right. That's fine.

8 THE WITNESS: Intake supervisors.

9 THE COMMISSIONER: Right.

10 THE WITNESS: Yes. And then abuse supervisors
11 would be next and, you know, abuse supervisors, it's a real
12 speciality, the area that they work in. I, myself, going
13 there had a fairly steep learning curve, to be very honest
14 with you. I had --

15

16 BY MR. OLSON:

17 Q You had no experience in abuse prior to that?

18 A I had experience in abuse, but not in the volume
19 of abuse that they were dealing with at 835 Portage. And
20 so the front end intake -- I'd run intake units before, but
21 more as a family service supervisor rurally. The magnitude
22 of the intake program at 835 Portage compared to anything
23 that I had experienced was, was definitely an opportunity
24 for me to grow and expand, you know, in a number of areas.
25 And you certainly had enough cases there to get experience

1 fairly quickly.

2 Q As, as the type of supervisor your -- you were,
3 you had the -- you could see what was happening at CRU at
4 the CRU level.

5 A Yes.

6 Q You could also see what was happening at the
7 intake level --

8 A Yes.

9 Q -- and abuse intake, right?

10 A Yes.

11 Q So if there were issues or problems in, in any of
12 those or how they're working together, that's -- you would,
13 you would be the person who would know that.

14 A Both Rob and I would be the people that would
15 know that. On my area of responsibility, we both had
16 established a consistent approach. We expected the
17 supervisors, that if there were challenges on case
18 transfers, that at the end of the day if they were not able
19 to resolve the professionally, respectfully, then they were
20 to call a halt. If they had differences of opinion, they
21 were to involve either of us as the respective assistant
22 program managers, and then we would become involved.

23 Q Okay. And I don't want to get too far ahead of
24 myself --

25 A Okay.

1 Q -- and that's something we will talk about.

2 A Okay, for sure.

3 Q Just, just in terms of your role, I'm just trying
4 to get an idea of, of --

5 A You bet.

6 Q -- what it is you would do.

7 A Yeah, yeah.

8 Q So the supervisors of the units that you oversaw
9 would come to you when they had issues or problems --

10 A Right.

11 Q -- or whatever.

12 A Right.

13 Q And you would provide supervision and direction
14 to them.

15 A That's correct.

16 Q Okay.

17 A I would also perhaps get some of those calls or
18 complaints or concerns from the minister's office directly
19 to me, Derek, and then I would go looking for them and do
20 the same thing.

21 Q And address it with them --

22 A Exactly.

23 Q -- and that's part of your role and
24 responsibility.

25 A That's correct, yes.

1 Q Now, if you saw a supervisor of yours or a worker
2 that they were supervising, someone on the front lines -- a
3 CRU worker, whatever -- that wasn't meeting standards or
4 meeting best practice, would you address that with the
5 supervisor?

6 A I think my, my, my general style and my general
7 practice would be to put that responsibility back directly
8 on the supervisor. That would have been the super's --
9 supervisor's responsibility. They had program
10 descriptions. They were very clear on what the roles and
11 functions and the expectations were around the day-to-day
12 delivery of service in the respective units. Certainly, if
13 something came to my attention that they weren't aware of,
14 it wouldn't be my, my style to go back directly to their
15 staff. I would always go back and work through them and,
16 and provide the information to them, and then leave that
17 with them to deal directly with their staff about -- unless
18 it was a situation of such magnitude that I felt I needed
19 to be part of that.

20 Q Okay. But you would take those kinds of issues
21 to the supervisor involved --

22 A Definitely.

23 Q -- and ask them to address it.

24 A Definitely, yes.

25 Q And if, if the supervisor proves deficient in

1 what they know or how they're responding, is it your job
2 then to educate them and steer the in the right direction?

3 A For sure.

4 Q Okay.

5 A Or to join, or to join with them with their
6 staff, if, if they were comfortable with that and accepting
7 of that.

8 Q Would you do any sort of performance reviews of
9 the supervisors?

10 A I wasn't really at 835 Portage for that long, so
11 when I did the performance reviews was after my second year
12 there, just before I left. There were many changes
13 happening for all the staff with the devolution process.
14 Many staff were, were going other places to different jobs,
15 and Pat Harrison, Rob Wilson, and myself decided that one
16 of the things that would make some sense was for us to meet
17 with the management group and for us to develop performance
18 appraisals for each of the respective positions at 835
19 Portage. And so we actually did performance appraisals on
20 all our supervisors, and our supervisors did on all their
21 staff, before many of us left to go on to other different
22 positions. That was something that was important to the
23 three of us to do.

24 Q So that would have been, then, just around mid-
25 May 2005?

1 A Yes, it would have been around March, April,
2 May --

3 Q Okay.

4 A -- of 2005.

5 Q So between when you came in on March 2003 and
6 March or May 2005, there would have been no formal
7 appraisals of the supervisors.

8 A I did not do a formal appraisal of the
9 supervisors. Certainly would have had sit-down dialogues
10 with them, but nothing formally where pen touched paper and
11 it was become part of a permanent HR record.

12 Q Just in terms of evaluating how the supervisors
13 were doing, I mean, because you, you would want to gauge
14 their competence as well, right?

15 A Absolutely, yeah.

16 Q How would you do that?

17 A Well, I would do that a number of ways. I mean,
18 first of all, I'm probably dealing with -- other than the
19 community program, Derek, I'm probably dealing with all of
20 the other supervisors at least on a daily or every second
21 day basis, and it was just part of who I am by nature. And
22 as a manager, I go around each morning, say hello to
23 people, ask them how they're doing, make a connection, see
24 if they've got anything on that day that they need to touch
25 base with me about, make sure they know what my schedule is

1 about, I get a sense of what their schedule is about.

2 And then if they have activity related to cases
3 that they want to search me out about, or personnel related
4 issues, or anything involving the day-to-day running of
5 their respective unit, we had -- initially when we went,
6 the entire system was structured on an ad hoc supervision
7 basis where you basically had an open door policy and they
8 initiated and they came to you when they felt that there
9 was a need. I personally wasn't comfortable with that, to
10 be honest with you. It's a necessary function of all the
11 programs at 835.

12 But as a new person and a new manager and a new
13 senior manager coming to 835 Portage, I really didn't know
14 a lot of the staff at 835 Portage so it wasn't conducive to
15 really getting to know staff the way setting a supervision
16 time where you have an hour and a half, two hour sit-down
17 every three weeks, or once a month, where you sit down, you
18 get to know each other, you get to know a little bit about
19 someone's, you know, professional outlook on the business,
20 their personal lives and what's going on, and at the same
21 time it's, it's uninterrupted protected time. So --

22 Q So you're saying you weren't comfortable when you
23 first came on with the fact that there was no formal
24 supervision.

25 A Exactly. Exactly. It was all ad hoc, and so

1 Pat, Rob, and myself sat down, we talked about that, and
2 then Rob and I instituted the, the need for formal sit-down
3 supervision with our supervisors, and then we put that as
4 an expectation on the supervisors that we expected them to
5 do that with their staff.

6 Q You told the supervisors that.

7 A Absolutely.

8 Q Because they weren't doing that previously?

9 A No. It was, it was all on an ad hoc crisis basis
10 that they were doing their supervision.

11 Q I see. So when a -- only when a problem arose, a
12 crisis arose, would a --

13 A Yes.

14 Q -- worker get the supervision.

15 A Generally speaking, yes.

16 Q Okay. That, you're saying, was not best
17 practices.

18 A I don't think that's, that's necessarily what we
19 needed to do. We just needed to remind people that, yes,
20 we're busy and, yes, there's a huge volume that we're
21 managing, but this is an equal priority, to make sure that
22 we make time for each other so that when -- we're building
23 relationships with each other by doing that.

24 Q Okay.

25 A And sometimes, sometimes when you have to make a

1 decision that a case is going to go from CRU, CRU up to
2 tier two intake, and you're telling the tier two intake
3 supervisor you have to take this case, you want to make
4 sure you have a bit of a relationship with them because you
5 just, you just lost some things at that moment.

6 Q When you came on as the assistant program manager
7 and oversaw these units, did you know any of these workers
8 previously, any of the supervisors or their staff?

9 A I have to be honest with you, not that many.

10 Q Okay.

11 A I was shocked at how many I didn't know. A lot
12 more that I didn't know than I did know.

13 Q Okay. So in terms of their practice or what they
14 did or their experience, you wouldn't have that knowledge
15 coming in.

16 A That's correct.

17 Q And you wouldn't also have any performance
18 reviews or anything to look at to, to see how they were or
19 what their -- what issues there might be.

20 A None were produced for me when I arrived at 835
21 Portage.

22 Q Okay. You said you, you and Rob Wilson and
23 Patrick Harrison met to talk about some sort of a
24 formalized, sit-down, protected supervision time.

25 A Yes.

1 Q When was that?

2 A I, I would, I would be speculating, Derek, but I
3 would say probably within the first couple months that I
4 joined Pat and Rob at 835 Portage.

5 Q Okay.

6 A So I would probably say summer, fall, probably,
7 of, of 2003.

8 Q Was there a formalized decision that this would
9 be implemented?

10 A It would have been communicated directly to the
11 supervisors in one of our regular CRU, intake, abuse, and
12 community meetings that we held on a monthly basis.

13 Q Okay. Would -- did that actually -- did that
14 protected supervision, as you call it, did that actually
15 ever come into being?

16 A Yes.

17 Q When was that?

18 A Well, I'd like to believe it came into being
19 shortly after we discussed it and, and agreed on it, but
20 certain places are harder to implement that. It's harder
21 to implement at CRU that practice than it is -- because of
22 the volume and the immediacy of everything that they're
23 dealing with, so it was a little bit more of a struggle at
24 CRU. And CRU at the time, when Rob, Pat, and I were there
25 initially, was only a single supervisor and she was

1 covering ten CRU staff.

2 Q Who was that?

3 A That was Diva Faria.

4 Q Okay.

5 A And so we didn't have the same expectation of her
6 being able to do these additional tasks until such time as
7 we expanded the program to 12 CRU staff and two CRU
8 supervisors, and then that expectation was there for her
9 equal to what it was to the other supervisors.

10 Q So when you came on as the program manager, was
11 there a staff shortage, then, in CRU?

12 A There, there wasn't a staff shortage. They, they
13 had -- over the years, the CRU had grown to being ten CRU
14 staff and an EA liaison worker for children transitioning
15 from Child and Family Services into the welfare system.
16 Part of the meeting that I described earlier that we had
17 where we talked about the importance of the nature of cases
18 we wanted the supervisors to be clear with us about, we
19 also talked about CRU, the crisis response unit, and some
20 thoughts that Pat, Rob, and I had, as well as Diva had, and
21 the changes that we wanted to incorporate at CRU by
22 expanding it to 12 CRU staff and breaking that into two
23 teams, one team of six that would be answering the phones
24 and a backup team of six that would be dealing with the
25 callouts.

1 Q Is that something you implemented as a --

2 A Yes, we did.

3 Q Okay.

4 A But we implemented that only when we had a second
5 CRU supervisor in place.

6 Q And what was the impetus for that change?

7 A Well, I think it -- there was probably a number
8 of reasons for it. First and foremost, I think it was very
9 unrealistic for us to believe that one supervisor could
10 actually -- as competent and skilled as Diva was, it was
11 unfair to have one supervisor supervising ten staff on such
12 a high risk and high volume area of our business, so we
13 knew we needed to change that.

14 We were confident that we can move some staff
15 around. We had to take some inventory a little bit on all
16 the programs first, but we actually moved two staff out of
17 two of the abuse units and put two additional staff at CRU
18 so we could have a comparable six staff for each of the CRU
19 units, and we asked Diva to take the lead.

20 It was actually my responsibility for that
21 meeting. I was presenting on CRU with Diva and Rob Wilson
22 was presenting, you know, our -- on our best spots in
23 regards to proposed changes at tier two intake around
24 managing workload. So Diva and I put a presentation
25 together, we presented to the management group, and at the

1 end of the day our recommendations were adopted and the
2 agreement was that we would have two CRU units, two
3 supervisors. They would be on -- three days they would be
4 on phones, one unit, and then they would flip over and they
5 would become the backup unit and the backup unit would then
6 go on phones. And that's a program that has remained
7 consistent to the way they operate today at ANCR.

8 Q It's still in place.

9 A Yes. It's, it's a little bigger today, like
10 everything's a little bigger than we were there, but it's,
11 it's the same model.

12 Q When you say it was unrealistic to have one
13 supervisor handling that many workers and that volume of
14 calls --

15 A Yes.

16 Q -- there were a lot of calls coming in, there
17 were always a lot of calls coming in.

18 A Oh, yes.

19 Q And one supervisor couldn't possibly be familiar
20 with everything going on. Is that --

21 A Well, I don't know if I'd want to say that. This
22 was a pretty remarkable supervisor that we had in place
23 there, very, very skilled, very experienced. But any best
24 practice approach around staffing of staff members to
25 supervisory ratio is usually around one to six. So one to

1 ten, you're really stretching that envelope for that
2 particular supervisor and there is a danger that you are
3 going to not be able to deal with the volume because you're
4 only one person and therefore you could be missing some
5 things in terms of cases because you simply can't get to
6 everybody.

7 Q In terms of the business of intake, which you
8 said was a little less busy, it sounds like you were
9 saying --

10 A Yes.

11 Q -- than CRU --

12 A Yes.

13 Q -- was -- do I have that right, intake was less
14 busy than CRU typically?

15 A Definitely, yes.

16 Q And did that remain the case even when you made
17 the change to having two CRU supervisors and two teams?

18 A Yeah. It, it, it wouldn't change the volume of
19 what's coming through the door in terms of business. The
20 fact that there was two supervisors, you're, you're, you're
21 much better able to deal with the ad hoc crisis related
22 consults that ten staff -- and now 12 staff, as we had
23 increased it to -- are going to need. So this way you're
24 responsible for six staff, it's a reasonable workload, and
25 at the end of the day the staff can get what they need in

1 terms of the immediacy of availability of the supervisor to
2 do crisis consultation with them on, on immediate case
3 responses.

4 Q In terms of the time required to do some
5 preliminary investigation on a new referral, would, would
6 typically a CRU worker have more time to do that than an
7 intake worker, or would an intake worker have more time?

8 A Well, clearly, an intake worker would have more
9 time. A CRU worker was generally dealing with emergent and
10 up to 24-hour responses. On occasion we would keep cases
11 48 hours. Sometimes we would keep cases even a short
12 period of time longer than that, but those were scenarios
13 only where we believed that we could close the case off by
14 end -- you know, a certain piece of work that we could
15 still do so the case wouldn't have to go up to intake. But
16 our timeline was -- generally it was, you know, zero hours
17 to 24 hours, 48 tops, whereas tier two intake, on receiving
18 a case they could keep a case open from six weeks to eight
19 weeks. Sometimes they would keep cases even longer than
20 that.

21 Q Okay. So the intention was if a case could be
22 dealt with within 48 hours, the max, it would be dealt with
23 at CRU. Right?

24 A Absolutely, but generally it would be up to 24
25 hours, generally.

1 Q Generally up to 24.

2 A Yes.

3 Q And beyond that it should go to intake.

4 A Yes. And anything 48 hours and beyond would be
5 going to tier two intake or abuse.

6 Q And so it's not the case that CRU was really an
7 investigation unit, whereas intake was more of an in-depth
8 unit. That would be wrong.

9 A No, no, it's a fair, it's a fair comparison.
10 There's, there's no question it was an investigative unit.
11 I mean, they were, they were doing safety assessments, you
12 know, on cases that met the bar to be open to the branch
13 where there were protection concerns related to children.
14 So they were investigators.

15 Their job was different than intake. They didn't
16 have the time to form relationships with families. They
17 had to be extremely skilled at going out and assessing
18 where the family was at, assessing where the children were
19 at, you know, determining, you know, priority responses and
20 their assessments, determining whether kids were safe or
21 not safe. And, and if they were unsafe, they were to do
22 safety plans they needed to put in place, come back, then,
23 with a recommendation the very next day to the supervisor
24 on, on closure or on going to the backup unit at CRU.

25 Q So you reported to Patrick Harrison.

1 A That's correct.

2 Q And what type of -- how would you report to him?
3 What would you be reporting to him?

4 A My reporting structure to Pat was more around --
5 from a case perspective, it was more around making sure
6 that Pat was in the loop of, of politically and media
7 sensitive related cases. Pat travelled in some circles
8 that, you know, in the, in the, in the higher up level,
9 government-wise, that Rob and I did not go to some of the
10 meetings that Pat did. So Pat at times would be asked
11 about certain things so we wanted to make sure that he was
12 in the loop of information.

13 He knew what some of the higher risk matters that
14 we were managing were all about. Sometimes we would go to
15 Pat to say, Look, you know, I'm not quite sure, I think
16 we'd better put all our heads together on that, and
17 sometimes Pat, Rob, and myself would all sit together
18 because the risk was so great. We wanted to have, you
19 know, a final line position that all three of us were
20 involved with. So that's how I'd report to Pat on a, on a
21 case perspective.

22 Q So in terms of cases, neither yourself nor Pat
23 would be aware of what I'll call the routine or typical
24 types of cases dealt with by your unit.

25 A No, certainly not.

1 Q Okay. We've heard a number of workers in this
2 particular matter call this, for lack of a better term, a
3 routine or a typical type of a case.

4 A Referring to the --

5 Q The Phoenix Sinclair matter.

6 A -- the Phoenix Sinclair case? If you ask my
7 opinion, 32 years in child welfare, I would say it's
8 probably -- it was average.

9 Q Okay.

10 A Slightly above average in terms of risk possibly
11 in some areas at certain points in the case, certainly up
12 until the point where Karl Wesley McKay became involved,
13 and I think that might have tipped the balance at that
14 point in terms of it being a higher risk.

15 Q Higher risk case.

16 THE COMMISSIONER: Mr. Olson, I didn't hear your
17 question. I wish you could speak better into that mic.
18 What were you speaking about, what you just said?

19 THE WITNESS: Mr. Olson asked me in regards to
20 this particular case that we're speaking to today --

21 THE COMMISSIONER: Yes.

22 THE WITNESS: -- whether in comparison to the
23 cases that came in as new intakes into our program, whether
24 it would have been at the high risk end or average risk,
25 sort of medium risk type case.

1 THE COMMISSIONER: And what was your answer?

2 THE WITNESS: And my answer was that generally it
3 would have been, it would have been different at different
4 points but, generally speaking, it would have been an
5 average case in terms of the degree of severity and
6 vulnerability of the children that we were dealing with.
7 And I said that it would have been an increased risk when
8 Karl Wesley McKay entered the picture.

9 THE COMMISSIONER: Thank you.

10

11 BY MR. OLSON:

12 Q Now, even if it was an increased risk at the
13 point McKay entered the picture, still not the type of case
14 that you would have had knowledge about, is it?

15 A That would have been the call of the supervisor,
16 to determine whether or not she felt there was a need for a
17 consultation. That particular case has been managed at, at
18 several of our programs. Some of the programs were under
19 my responsibility. You know, CRU, Central intake,
20 Northwest intake, had managed that particular case; they
21 were under my area of responsibility. And then there was
22 involvement from, from Central intake and there was
23 involvement from the other CRU unit, and those were under
24 Rob Wilson's area of responsibility.

25 Q Okay. Were you ever -- prior to the discovery of

1 the death of Phoenix Sinclair, did -- were you ever aware
2 of this case, made aware of this case?

3 A No. No, I was not.

4 Q When you talk about your responsibility, am I
5 right that as a -- as the assistant program manager you
6 would have been responsible ultimately for the work done by
7 the units you supervised?

8 A Absolutely.

9 Q When we were talking about your meetings with Mr.
10 Harrison, were these meetings you would make notes of?
11 Would you have notes taken during the meetings?

12 A Yeah, I probably would have taken notes if they
13 were -- certainly, if they were direction related meetings
14 where I was getting direction from my immediate superior in
15 regards to what we needed to do planning-wise on the case,
16 I certainly would have taken notes of that and I would have
17 followed up with the respective supervisor to ensure that
18 the supervisor would have known that, you know, this is the
19 best thoughts of Rob, Pat, and myself, and we think we need
20 to go in this direction, what do you think, and then try to
21 see if I could get the supervisor on board with that
22 direction.

23 Q Why is it you would keep notes of those types of
24 meetings?

25 A Well, I think it's -- well, certainly, from my

1 perspective, it's, it's for consistency of information
2 exchange, first and foremost --

3 Q Right.

4 A -- from myself back to the supervisor. But also,
5 then, it becomes -- once, once you involve a higher up
6 level -- like Patrick was our final line of responsibility
7 as the program manager, then that's a decision on behalf of
8 the entire 835 Portage office and all our programs. So
9 ultimately, that's, that's not just direction, that's a
10 directive. So at the end of the day I would want to make
11 sure I captured that accurately, make sure I relayed that
12 accurately to the supervisor, make sure there was an
13 agreement with the supervisor that we were all on the same
14 page, and then let the supervisor do what they needed to do
15 in terms of implementing that with their staff.

16 Q So if I'm, if I'm hearing what you're saying
17 correctly, you want to capture what you discuss with Mr.
18 Harrison and then relay that accurately to the supervisor,
19 make sure the supervisor captures what you're telling --

20 A Absolutely.

21 Q -- the supervisor.

22 A Absolutely. And then my practice on that would
23 have been to expect the supervisor to do the same thing
24 that I did, so --

25 Q To also take notes.

1 A So they would take notes and then they would have
2 the same information I had, and then those notes would be
3 come part of, you know, of our record between themselves
4 and the worker.

5 Q So there'd be a record of what was discussed.

6 A Yes.

7 Q Those notes, I take it, would be preserved, then?

8 A I'd hope they would be preserved. We had a --
9 well, I'm sure you're going to speak to me about our
10 supervision policy and that, but there, there was a
11 supervision policy that, that did come in at, at some point
12 in our tenure there.

13 Q So we were talking first about the notes that you
14 would take when you had meetings with Mr. Harrison.

15 A Right.

16 Q Now, you would have -- you said you would have
17 had meetings then with the supervisors of the various
18 units.

19 A Yes.

20 Q And during those meetings you would expect them
21 to take notes as well?

22 A Absolutely.

23 Q And as you would take notes as well.

24 A Yeah, well, I would -- in that particular
25 scenario I'd be bringing the notes. But I would expect

1 them -- when we're having a conversation, I would be
2 reminding them, you need to take notes if this is a
3 directive because we need to ensure that this is followed.
4 I wouldn't generally go to Pat or to Rob, you know, if --
5 unless I was, you know, really stuck on a case. I would go
6 to Pat to let him know what would be happening, but if I
7 went to Pat because I was stuck on a case and asked for Rob
8 to be a part of that, it's because it's something that's
9 really complicated and I want an extra set of heads in
10 there from the most experienced people that I was working
11 with.

12 Q When the supervisors had meetings with their
13 workers, was the expectation that they would keep notes of
14 those meetings as well?

15 A That's, that's a, that's a really hard question
16 for me to, to answer. I almost have to answer it by
17 program. In the CRU, most of your discussion related to
18 cases is on an ad hoc crisis related basis. So they are --
19 you know, they're, they're doing a CFSIS opening, they're
20 doing a CRU after-hours report where their information and
21 their direction in regards to what they're doing on the
22 case is captured, and, and they're doing a safety
23 assessment. And then individual workers were expected, as
24 well, to do, to do contact notes. So, yeah, there, there
25 would be an expectation there, but it would be different

1 than when they sat down for that monthly supervision where
2 they might, you know, talk about a lot of different things
3 beyond just the cases. So at CRU, that, that would be my
4 thought for the CRU, and it'd be different for intake.

5 Q Okay. Well, just for CRU. I'm not --

6 A Sure.

7 Q -- sure if I, if I understood what your answer
8 was.

9 A Right. Okay.

10 Q The question was whether there'd be an
11 expectation that both the supervisor and the worker would
12 keep notes of those discussions.

13 A If it was pertinent related cases where they were
14 sitting down, having a discussion, yes. If it was a
15 hallway conversation, I can guarantee you, in the system
16 today and back then, not all those conversations would get
17 recorded and find their way into the record.

18 Q Okay. And that being the case, that, that's what
19 was happening, you're saying?

20 A No, some of that did happen, but some of the ad
21 hoc that I'm referring to would be a worker coming with
22 their information outside the supervisor's office, coming
23 in for five minutes, doing a consult. That would be, you
24 know, something that there, there may, indeed, be a record
25 kept of that.

1 Q We've heard a fair amount of evidence from
2 different workers and supervisors that there were notes
3 kept but they were often shredded either when they left the
4 agency or when a file was closed. Is that something you're
5 aware of?

6 A You know, it was a bit of a, it was a bit of a
7 struggle. We didn't have a very -- I want to say this
8 respectfully, but we didn't have a very good supervision
9 policy around note taking and record keeping and my hat's
10 off to the people that, that were on the committee that
11 brought in the supervision policy, because it was, it was a
12 lot of work. They, they did a lot of, of, of excellent
13 work and there was direction that was supplied in regards
14 to the supervision policy and what you should be doing with
15 your notes. I'm not sure that it was uniformly agreed with
16 across all the supervisors and senior managers within the
17 branch. And a year later a survey --

18 THE COMMISSIONER: When was it brought in?

19 THE WITNESS: In 2004, I believe.

20

21 BY MR. OLSON:

22 Q Maybe what I can do is -- and I was going to take
23 you to there, now.

24 A Okay.

25 Q There's a supervision policy at Commission

1 disclosure 1634. I think you have it in -- on your desk.

2 A Okay.

3 Q Beginning at page 29040.

4 MR. OLSON: You should have that as well, Mr.
5 Commissioner.

6 THE COMMISSIONER: Yes, I have it.

7 THE WITNESS: Sorry, Derek, could you say that
8 number one more time?

9

10 BY MR. OLSON:

11 Q The Commission disclosure is 1634.

12 A Okay.

13 Q And then the page is 29040.

14 A I have 1635. I don't have four.

15 Q If you look on the screen in front of you --

16 A Okay.

17 Q -- you should see it.

18 A I'll -- I can do it on the screen, that's fine.

19 Q Is this -- take a look at it and tell me, is that
20 the supervision policy you're talking about? You'll see
21 implementation date on the top there of March 1st, 2004.

22 A Could you do me a favour, Derek, and just run
23 through it all for me, just scroll down?

24 Q Scroll through it?

25 THE COMMISSIONER: Why don't you -- do you want

1 to borrow my copy?

2 THE WITNESS: No, sir, this is fine. I just
3 wanted to see it all before I commented.

4 Yes, that's, that's --

5

6 BY MR. OLSON:

7 Q That's the one.

8 A -- supervision policy, yeah.

9 Q So this came in in 2004, then?

10 A That's correct.

11 Q Would you have been made aware of it?

12 A Certainly, I was made aware of it, the
13 supervision policy, and it, and it did follow training that
14 a number of the supervisors and managers went to by a
15 reputable child welfare person by the name of Tony
16 Morrison.

17 Q Um-hum.

18 A And that was sort of the, the precursor to us
19 realizing that we were behind and we needed to put a
20 supervision policy in place.

21 Q Did you attend that training as well?

22 A Unfortunately, I didn't. I covered at 835
23 Portage. I believe we let Rob go, and Pat and I stayed
24 behind to cover.

25 Q Okay. Did the supervisors of the units you were

1 supervising go to that training?

2 A As many as we could send there went to the
3 training. There were a couple of opportunities for the
4 training. Some had gone earlier to the Tony Morrison
5 training, and then we brought him back. And then -- so a
6 number of them had gone. But if I was asked did all the
7 supervisors or all the senior managers get to attend, the
8 answer would be no. Certainly, the majority did.

9 Q So this supervision policy was brought into place
10 because of that.

11 A Yes.

12 Q That training.

13 A Yes.

14 Q And it was intended to apply to whom?

15 A I'm sorry?

16 Q Who, who did you -- who does the supervision
17 policy apply to, or who did it apply to?

18 A I mean, it applied -- the supervision policy in
19 my read of it applied to supervisors that were directly,
20 directly supervising line staff across all our programs at
21 Winnipeg Child and Family Services.

22 Q So CRU supervisors like Ms. Faria.

23 A Yes.

24 Q And, and intake supervisors like Carolyn Parsons.

25 A Yes. Andy Orobko. All, all of them, and then

1 all of the family service supervisors across Winnipeg Child
2 and Family and, you know, permanent ward supervisors and
3 foster care. Everybody that was supervising, you know, was
4 expected to follow this policy.

5 I should be careful with that. Probably
6 shouldn't have said foster care because they didn't --
7 foster care probably would not have had the same degree of
8 expectation. It was still a model that they could follow
9 and they could use, but because they -- they're not case
10 carrying. It was, it was more aimed at, at case carrying,
11 is my understanding, the supervision policy.

12 Q Did you follow this policy?

13 A You know, without sounding arrogant, we had
14 already decided -- Pat, Rob, and I -- before this policy
15 came in and before there was any discussions around this,
16 we had instituted at 835 Portage our own kind of
17 supervision policy around meeting with the supervisors on a
18 regular basis, having the supervisors meet with their staff
19 on a regular basis, so a good portion of this work we, we
20 had started. But this was just, this was just a much more
21 thorough process. So we did take the supervision policy,
22 review it with our respective supervisors and, you know,
23 and, you know, implemented this to the best of our
24 abilities. It was a really good piece of work.

25 Q So you would have met with your -- the

1 supervisors that you supervised --

2 A Yes.

3 Q -- and reviewed this policy with them.

4 A Yes.

5 Q That would have been some time around March 1st,
6 2004?

7 A It certainly would have been after March 1st,
8 2004, but give or take two or three months following, for
9 sure.

10 Q Then would you expect your supervisors to comply
11 with the policy?

12 A That was the expectation, is that people would be
13 in compliance with the supervision policy. The only, the
14 only piece of business on the supervision policy that was a
15 challenge to implement was the, the supervisory contracts
16 that were done at the end. They were very, very
17 prescriptive and found a lot of the experienced supervisors
18 would prefer to just negotiate, you know, your meeting
19 times, you know, with yourself and your respective
20 supervisors, as opposed to having such a detailed kind of
21 supervisor-supervisee contract. So that part was a
22 struggle to be implemented.

23 And, and it's recently even to this day been a
24 struggle and currently my, my supervisors in my, you know,
25 working relationship today, we don't have that particular

1 piece of the supervision policy in place. And there, there
2 isn't really an agreement across our senior supervisors to
3 do that, but the majority of the rest of it was, was able
4 to be implemented.

5 Q So on the page in front of you, if we could
6 scroll down under the heading Components, where it says
7 Nature of Supervision. It says:

8

9 "While supervision or consultation
10 occasionally needs to occur on an
11 ad-hoc basis, quality supervision
12 occurs when supervisor and
13 supervisee meet regularly, for an
14 interrupted period of time, to
15 facilitate the development of a
16 strong supervisory relationship."

17

18 That's something that you thought -- you said you
19 thought was a good idea that should be implemented.

20 A Yes, and is an excellent idea, for sure, and
21 really necessary.

22 Q It says:

23

24 "The frequency of regular
25 supervision varies around the

1 supervision needs of both the
2 staff and Supervisor. At a
3 minimum, scheduled supervision
4 should occur on a monthly basis."

5

6 A That's, that's what was recommended.

7 Q Was that --

8 A That we --

9 Q And was that, that being followed after the
10 implementation of this policy?

11 A I can't speak to all the units, but I can speak
12 to the units under my responsibility. And as, as much as
13 possible, we were trying to adhere to the supervisory
14 meeting with staff on a monthly basis. It was a struggle
15 at CRU to do that.

16 Q Okay. As the supervisor of a -- supervisor of
17 CRU --

18 A Yes.

19 Q -- what steps did you take to ensure it was being
20 done, if any?

21 A Well, I certainly would have talked to my
22 supervisor about, you know, whether or not she was able to,
23 you know, meet with each of the staff on a monthly basis
24 and still handle the volume of business that she was doing.
25 And we might, we might aim for her doing that every five

1 weeks. We might have compromised on that, as opposed to,
2 you know, forcing her to do this monthly and then
3 overwhelming her workload more than it already was.

4 Q But in terms of your ensuring it was being
5 followed to some degree, at least, even if it was every
6 five weeks, did you do anything to --

7 A It was part of my -- part of my review with my
8 supervisors in supervision was to ask them about the
9 supervision policy and how we were doing that. Sometimes
10 our supervisors -- not all of them, but the ones that were
11 very organized, had supervision schedules that we would get
12 a copy, either Rob for some of his folks or me back in --
13 from my folks in regards to actual schedules that they had
14 set up, which is, which is what we, we really were aiming
15 for, that they had schedules, they were fulfilling that
16 obligation and, you know, and we had some ...

17 Q Would -- do you recall whether or not Ms. Faria
18 would have had a schedule like you're describing?

19 A No, I don't believe so.

20 Q She didn't have one.

21 A No.

22 Q Was there a reason why she wouldn't have?

23 A Hers probably would have been just more on the
24 fact that we, we couldn't even do it once a month given the
25 volume that they were dealing with there, and, and we

1 needed to kind of move that, you know, to once, once every
2 five weeks or so, but I know that she made every effort to
3 try to do that with her staff. Wasn't always possible.

4 Q What is it you would have expected a supervisor,
5 like Ms. Faria, for example, to review in these supervision
6 sessions?

7 A Well, I'm sure in her supervision sessions that
8 she would have a better idea than I do of what she should
9 be doing from a CRU perspective, but I'm assuming part of
10 the, the supervision session would be to see if they've got
11 any current existing cases that they're working on that are
12 challenging or problematic.

13 Certainly, if there was any activity that came
14 from the General Authority or the Advocate's office or the
15 Ombudsman's office or, or, or many of the other overseeing
16 -- oversight bodies that we have, if the supervisor had
17 those concerns that were brought to her attention, if they
18 weren't immediate and pressing she may just keep those for
19 when they met at supervision where they would have that
20 hour and a half to two hour uninterrupted time, you know,
21 to, to, to chat about in supervision.

22 Other things would be around performance, you
23 know, how were the workers doing, what was their skill set,
24 what were they good at, what did they have some
25 shortcomings on, what were their training needs in regards

1 to those shortcomings, did they need to be partnered up
2 sometimes on callouts with a more experienced worker.

3 And then if there were any HR personnel issues,
4 you know, do we have somebody who's not getting to work,
5 has, you know, got all sorts of personal life problems that
6 are spilling over into the workplace.

7 It would be that entire range, and I, and I'm
8 sure she could speak to more detail than I can, but, but
9 that would be the, the, the average range of what you'd be
10 looking at.

11 Q Did you have an expectation that the supervisors
12 would go through standards and best practice with the
13 workers at these supervision sessions?

14 A It's a very fair question, Derek. This -- I'm
15 trying to think how to answer that. I have to answer that
16 by the fact that the standards that we had in place at the
17 time were -- I'm just going to use the word problematic.

18 I like to be very, you know, careful with
19 ensuring that I was, you know, up on the standards that
20 were in place at the time. We had '99 case management
21 standards. We used to get new standards practically every
22 year that were given to us. Almost all of them were in
23 draft; we were given mixed messages about whether or not we
24 were to use them or not use them. Some senior managers
25 said we were to use them, the 2001 standards, as an

1 example. Others said, no, that with the coming on board of
2 a standing committee that training was going to be provided
3 for ourselves as managers, for our supervisors, for our
4 staff. So at the end of the day, those standards -- we
5 didn't even choose to circulate those standards.

6 So the '99 standards, the late 2004, early 2005
7 standards, we knew much more solidly going in that those
8 were standards that were going to stay for a period of time
9 so we, we shared that information with our supervisors and,
10 and our supervisors were given -- we received -- from our
11 General Authority I received a very, very large binder. It
12 was probably about yea thick, and it had the Child Welfare
13 Act and it had the child welfare regulations; it had the
14 Authorities Act and the authorities regulations; the
15 Adoption Act, the adoption regulations. It had the child
16 abuse guidelines, the child abuse regulations. It had the
17 '99 standards and it had the beginning of the standards
18 that were going to stick around for a while in 2004.

19 So I made that -- a copy of that available to Rob
20 Wilson, who was my, my partner at the time, and we made
21 that package of information available to all the
22 supervisors so that they had, you know, a really well put
23 together, organized document of the Act, the regulations,
24 the standards that were in place at the time. Those were
25 made available to all our supervisors.

1 Q So did you -- would you expect your supervisors,
2 then, to be familiar with those standards, the 1999
3 standards, the Act, the regulations? Aren't those what
4 would govern practice?

5 A I have to say yes and no to that. I think
6 everybody would -- in the room would probably agree that,
7 yes, they do govern our practice and the way that we do
8 business, but we had policies and procedures, we had
9 program manuals that were developed and designed with those
10 standards in mind when we put them together. So we were
11 operating -- all your standards talk about minimum
12 standards that you have to deliver on and I think for the
13 majority of all our programs, our policies, our procedures,
14 we had a greater expectation that was built into what we
15 were doing than actually what existed in the standards.

16 So would I expect my supervisors to know that
17 binder, that thick, cold? No, but I would expect them to
18 know how to be able to find what they needed in those
19 standards at various times. And generally, their day-to-
20 day governance of what they did on a day-to-day basis would
21 have been, would have been provided through our intake
22 program manual and our March 2004 child welfare orientation
23 manual.

24 Q I see. And --

25 A That would have guided our practice, I think,

1 more than anything else.

2 Q And those manuals, then, they were based on the
3 standards, right?

4 A They were, they were based on the standards and
5 they were based on best practice within the standards. So
6 at CRU, as an example, the standards would say that -- in a
7 typical protection investigation at CRU and at intake, the
8 standard would say that you had to see the person or the
9 family within a ten day timeline. That was not good enough
10 for us because we were dealing with protection stuff that
11 was way too risky to leave for ten days. So we had set up
12 our own system where at the end of the day we were
13 responding to cases within 24 hours, within 48 hours,
14 within five days, and within ten days. So --

15 Q So I just want to be sure I'm understanding you
16 correctly. The standards were sort of basic. You went
17 beyond the standards --

18 A Yes, yes.

19 Q -- and, and in doing that, sometimes you'd have
20 -- the workers or your supervisors would have to use their
21 professional judgment, making a decision.

22 A Yes, that's correct.

23 Q They'd also have to use common sense.

24 A That last one's a funny word for me. I really
25 don't know what it is. You know, in the first six months

1 that I was over there people would say that my previous
2 twenty-some years that maybe I was lacking common sense.
3 It's a word I want to steer clear of because the, the, the
4 programs and policies guided our, our folks. The
5 supervisors were trained, very skilled, very knowledgeable,
6 very experienced in those areas, and felt a real comfort
7 zone in guiding people in the area where they had developed
8 an expertise. So I was real confident, you know, in the
9 supervisors I had under my responsibility.

10 Q Just to go back, though, the standards in place,
11 was there any confusion between 1999 and 2004 as to which
12 standards would have been in effect?

13 A There was no confusion in my mind that I wasn't
14 going to use the 2001 standards, but there was confusion
15 throughout the system and throughout all the higher ups and
16 through the child protection branch, and mixed messages
17 given in writing to Winnipeg Child and Family after
18 numerous requests over a three-year period. We
19 consistently got different responses in regards to
20 direction of what we should do.

21 Q But if Ms. Faria came to you, for example, as her
22 supervisor and said, You know, Dan, I'm, I'm not sure which
23 standards I should be applying here, 1999 or 2001, you
24 could -- you would be able to tell her the answer.

25 A Her and I would both agree that we would be using

1 the 1999 standards and we would use the 2004 standards, and
2 we wouldn't use the 2001 standards because they were never
3 passed.

4 Q Okay. And in any case you probably want to make
5 sure you're meeting at least the highest standard and the
6 one the most appropriate for the circumstances.

7 A Well, again, I want to repeat as much as
8 possible, we hope that we would have had that in our
9 regular day-to-day practice, you know, in terms of our
10 programs and procedures, which, again, were, were, were
11 scripted and developed with the standards in mind when they
12 were developed.

13 Q Okay. If a particular standard wouldn't be in
14 accordance with what you view as best practice, you, you'd,
15 you'd strive for best practice, then?

16 A Well, we, we'd certainly highlight that for the
17 staff if we found anything like that, and definitely there
18 would have been a discussion then around what would our
19 practice be if they -- if we were lower on the response
20 time than what was in the standards.

21 Q You, you expected supervisors, though, to adhere
22 to best practice.

23 A Absolutely.

24 Q And you expected their workers to adhere to best
25 practice.

1 A Yes.

2 Q Wasn't that you're just trying to do the basic
3 work, the bare minimum. It was, you're trying to do the
4 best, best practice.

5 A Best practice for each of the programs, which
6 would be somewhat different depending on which program
7 you're in.

8 Q Okay. Just getting back to the document that's
9 on the screen in front of you, that's the supervision
10 policy. Under Recording and Documentation --

11 MR. OLSON: At the bottom of the page, Mr.
12 Commissioner.

13

14 BY MR. OLSON:

15 Q -- it says both -- this is 29040 -- says:

16

17 "Both supervisor and staff will
18 maintain notes regarding key
19 decisions and themes that are
20 discussed in supervision. The
21 supervisor will maintain
22 supervision records that will
23 document case discussions and
24 discussions regarding the
25 employee's professional

1 development and personnel issues."

2

3 That was a pretty clear policy.

4 A Yes.

5 Q Was, was this policy -- was it your understanding
6 that your supervisors would be following this policy?

7 A That would have, that would have been my
8 understanding. I mean, that was the expectation, and
9 that's what we were trained on and that's what we followed
10 up with the supervisors on, and that was, you know, a
11 policy that we were, we were asked to, to implement.

12 Q Do you know if they actually did adhere to the
13 policy?

14 A Do I know that each of my supervisors adhered to
15 all aspects of the supervision policy or --

16 Q To --

17 A -- related to just the note taking?

18 Q Just to the recording and note taking.

19 A Just to the recording. I believe that the
20 majority of the supervisors adhered to that.

21 Q Okay. Some didn't, though?

22 A I'm not sure. I'm hearing through some of the
23 information exchange that's come out resultant of the
24 proceedings that, that there had been some challenges with
25 that, so I, I can't say for certainty.

1 Q You've, you've heard about supervisors destroying
2 their notes or shredding notes, or not even keeping notes.

3 A Yeah, I've heard some of that.

4 Q That wouldn't have adhered to this policy.

5 A No.

6 Q Would you have been aware of that at the time
7 that you were supervisor of any these -- any of the
8 supervisors that you supervised?

9 A That supervisors were shredding or destroying
10 file related information?

11 Q Shredding, destroying, or not even keeping notes
12 in the first place.

13 A I would, I would not have been aware of that.

14 Q Had you been aware, what would you have done
15 about it?

16 A Well, shredding or destroying file related
17 information would have been somewhat problematic for us
18 because the file information is fairly important to be
19 keeping as part of the record because we never know if a
20 situation is, is going to result in a court related
21 process, we never know whether a matter is going to
22 escalate and we're going to be in an inquest or we're going
23 to be in an inquiry, so that --

24 Q This situation today.

25 A Yeah. So that information becomes part of the

1 client record.

2 Q Yeah.

3 A So it's, it's important, you know, to have that
4 information.

5 Q Those notes would, would be important to either
6 know what was said or what was done or what wasn't said or
7 what wasn't done.

8 A Absolutely. Now, in terms of whether or not --
9 you had asked me as well whether or not people were
10 adhering to all the things that were on the supervision
11 policy in terms of, you know, documenting that full range
12 of responsibilities. I'm not sure if all my supervisors
13 were.

14 Q In terms of ensuring that supervisors were
15 complying with those policies, though, that would fall on
16 you in terms of being their supervisor.

17 A Correct.

18 Q We've, we've heard that the work -- some of the
19 workers -- any of the workers involved in this particular
20 matter would take handwritten notes or other notes that
21 would eventually get transferred into CFSIS or into a
22 report, and then the notes would be discarded or destroyed.
23 Do you know, are you able to say as a supervisor, whether
24 that was in accordance with policy, that practice?

25 A Are -- which program are you referring to, Derek?

1 Q Pardon me?

2 A Which program are you referring to? Are you
3 talking across the board?

4 Q Either CRU or intake, tier two.

5 A I'm not, I'm not sure and I'm reticent to give
6 you an answer on that. But as long as there was an
7 accuracy of the record that was available -- I know that,
8 for me, there'd need to be an accuracy of the record that's
9 available. Generally, generally, we kept both. Generally,
10 we kept it on CFSIS and generally we had also put that on
11 the hard copy file. But the, the, the question about there
12 being a record, absolutely.

13 Q So having a record is key.

14 A Yeah.

15 Q An accurate record is key.

16 A Yes.

17 Q And so if the notes that workers were taking
18 differed from what they put in the report --

19 A Yes.

20 Q -- that could be problematic.

21 A Well, I'll give you an example. Like, today it's
22 a different world we're all in. The social workers we're
23 hiring today are totally computer savvy so we're having
24 social workers today that instead of doing duplication of
25 recording and duplication of note taking, a lot of them are

1 doing their note taking directly onto the system, you know,
2 and at the end of the day it saves them time when they're
3 challenged with so many other workload related challenges.

4 Q Sure.

5 A So as long as --

6 Q But, but with reference to what was occurring at
7 that time --

8 A Yeah.

9 Q -- when workers were keeping notes --

10 A Yeah.

11 Q -- and the question is just simply, if there was
12 more in the notes they were keeping that were eventually
13 getting destroyed or shredded or whatever --

14 A Yeah.

15 Q -- if there was more information in those notes
16 than what finds their way into a report or the
17 documentation, that could be problematic.

18 A Yes. And it should have been kept, then, if
19 there was more information.

20 Q Okay.

21 A However it was recorded, it should have been
22 kept.

23 Q I take it that's not something you would have
24 been aware of.

25 A I'm not aware that that happened, no.

1 Q Okay. I've asked you a few questions about
2 performance reviews. We've heard workers, I think, say
3 that they either received no performance reviews or they
4 hadn't received -- you know, maybe one or two in an eight-
5 year period, not, not very regularly or consistently. And
6 I think you, you agreed with me that that was the case.

7 A Yes.

8 Q Based on that, were issues with respect to
9 workers' performance ever brought to your attention?

10 A Certainly, yes. Big part of my, part of my role,
11 you know, having that larger number of units reporting
12 directly to me is that if there were performance concerns,
13 be they case related performance issues or be they
14 personnel related concerns in regards to staff, I would
15 have been the first person in line, then, that my
16 respective supervisors would have spoken to.

17 Together we would have determined whether it was
18 something that we could resolve at our level through
19 meetings directly with the staff and resolve the issues and
20 get them back on track. If they were not something that I
21 believed that we could resolve at my level, then we would
22 contact human resources, and the human resources department
23 would assign an HR consultant to join the supervisor and
24 myself to plan accordingly in regards to potential
25 progressive discipline steps that we needed to take on a go

1 forward basis.

2 Q With respect to the Phoenix Sinclair matter, were
3 any performance concerns brought to your attention with
4 respect to any of the workers?

5 A Not in the time that I was at 835 Portage.
6 Remember, I was, I was gone from 835 Portage when the case
7 surfaced in regards to the child's death.

8 Q Okay. Since, since you, you left -- and you've
9 been involved in this process, you've seen all the various
10 reports and documents that related to your workers'
11 involvement in this matter.

12 A Certainly seen all the documents related to, to
13 my workers' involvement in this matter.

14 Q Based on what you've reviewed, would you have
15 expected any, anything in those documents, any of the --
16 any, anything in those documents to have raised performance
17 issues with respect to the work done?

18 A It's, it's a tough comment. I mean, you're
19 talking -- I had lots of staff that were involved, lots of
20 different scenarios. There's nothing that I read that
21 jumps out at me that would cause me to believe that if I
22 were there and if I was the manager that I would believe
23 that I had a performance issue to discipline a staff over.
24 I, I would say no to that.

25 MR. OLSON: I notice it's just about eleven

1 o'clock. Would it be an appropriate time to break?

2 THE COMMISSIONER: Yes. We'll take a 15-minute
3 break.

4

5 (BRIEF RECESS)

6

7 THE COMMISSIONER: All right, Mr. Olson.

8

9 BY MR. OLSON:

10 Q We've heard a number of workers talk about
11 workload, that workload was high, very high, in both intake
12 and CRU. Was that your experience as well?

13 A Yes. I would have to say that it was, it was
14 high in both CRU and intake, and it was higher at different
15 periods of time when I was there than others.

16 Q During the period beginning of 2005, was it --
17 how was the workload?

18 A It was, it was quite busy in, in 2005. At that
19 time there were, there were a lot of things happening. We
20 were preparing for, for devolution at that time. Winnipeg
21 Child and Family Services had a number of, of their family
22 service units -- in fact, all their 16 family service
23 units, some from the org chart on December of 2004 -- that
24 were closed down to do file recording in preparation for
25 the file transfers to the First Nation agencies. So at

1 that time we at that time were referring to one
2 preservation unit initially from late December, early
3 January, till around the end of January, and then at that
4 point in time we were referring to two other preservation
5 units from February going forward until the devolution
6 process was over around the 25th of April, so it was, it
7 was really, it was really a busy time.

8 Q There was a lot going on in the --

9 A Yeah.

10 Q -- agency at the time.

11 A There was a lot going on across the agency at
12 that time.

13 Q Do you recall Ms. Faria coming to you with
14 workload concerns?

15 A Well, I, I would have to say yes, definitely
16 coming to me with, with workload concerns. Certainly, when
17 I first started, when she had ten staff, you know, under
18 her responsibility, you know, there were lots of workload
19 related challenges she had managing that.

20 And, you know, and periodically throughout I
21 think there were workload related challenges, particularly
22 -- you know, I think people managed -- they managed when
23 they had their full staff complement, but you couldn't
24 always guarantee that you were going to have your full
25 staff complement. You know, when staff were sick or staff

1 were on leave and -- those were particularly problematic or
2 challenging times because you need to as much as possible
3 keep six people at all times on the phones over at CRU to
4 keep it running.

5 Q So she did come to you, though, with these
6 workload concerns.

7 A Yes.

8 Q Did you attempt to address them in any way?

9 A Well, workload at CRU, as I spoke to earlier,
10 what we did from very early on when we went there was
11 expand the CRU to 12 staff from ten. We --

12 Q That would have been right at the beginning,
13 right, of your --

14 A That would have been within first six months,
15 about the first six months. Would have been around October
16 that --

17 Q But she still --

18 A -- we did that.

19 Q -- came to you, though, with workload issues
20 following that?

21 A Yes. Yes. So there were workload issues there.
22 We expanded, got the second CRU supervisor. We tried
23 wherever possible to take advantage of opportunities that
24 were there. We were approached by the Metis authority and
25 they had a number of students that needed to get years -- a

1 year of experience under their, their, their belts before
2 they could graduate and be full-fledged social workers, so
3 we, we brought some of that staff on board to assist at
4 tier two intake and at CRU. We took students also from --

5 THE COMMISSIONER: Was this during the
6 transition?

7 THE WITNESS: From -- I think Derek's just saying
8 from 2003 going forward, yes, in that period. And we had
9 students that we also took from, from Winnipeg Child and
10 Family to assist us with extra workload. We would bring in
11 casual staff. Pat had -- through his leadership and also
12 through his oversee of the after-hours program, he had
13 access to bringing in after-hours staff on a casual basis.

14

15 BY MR. OLSON:

16 Q Into CRU?

17 A We could bring casual staff at time into CRU.

18 Q Did that happen very often?

19 A Not that often, but we, we did try to do that
20 over, over peak periods. Sometimes they helped out at tier
21 two intake; I believe sometimes they helped out at CRU.

22 Q Anything else? You mentioned students and ...

23 A Think for a second ...

24 I, I think, you know, workload is -- one is about
25 cases, but also is about sort of supervisory kind of

1 support. You know, when we had the second supervisor,
2 that, that made it easier. We tried to get the supervisory
3 -- the two units to, to meet themselves to take training
4 related activities. When supervisors were at training, we
5 would, we would cover off their units so to assist with
6 coverage and, and workload challenges in that regard.

7 Q So am I right, though, that the -- it was -- you
8 brought on some students to help out and you also very
9 infrequently had some casual staff, you're saying, would
10 come in to help?

11 A Sometimes we would bring in casual staff.

12 Q My understanding was that casual staff weren't
13 brought in until later on. Do you know when that was
14 occurring?

15 A I'm not, I'm not sure when we did that. I, I
16 know that we had brought in casual staff when we first
17 started. Over the summer and into September we brought
18 three casual staff in to assist, but I believe that was at
19 tier two intake our very first summer there. But we used
20 to try to do that over the, over the summer breaks, but I
21 don't believe we did that the first summer that we were
22 there.

23 Q Okay. Whose responsibility was it to ensure that
24 the workload was balanced and reasonable for the workers?

25 A Well, I, I think that was certainly my

1 responsibility in conjunction with the supervisor. You're
2 looking at workload across, you know, your entire
3 organization. You're not just looking at it one program at
4 a time. So if you've got, if you've got challenges, say,
5 at CRU, we took -- the two staff that we brought in to
6 build the CRU up from ten to 12 staff, we actually took the
7 two staff from the abuse unit. So from the abuse unit,
8 they had less staff, CRU got more staff.

9 Q So these weren't actually additional hires. They
10 were brought from within another unit.

11 A That's correct. Those were, those were existing
12 staff that we brought in.

13 Q So by doing that, you, you decrease somewhat the
14 capacity of abuse, but you increase the capacity of CRU.

15 A We would, we would sit together and we would look
16 at what the priorities were, and if we had workload
17 challenges in a particular area, then we would put our
18 heads together and come up with the best plan we thought
19 that we could do for the resources that we had.

20 We were able to hire -- we hired Mark Szewczyk
21 early on in the process, around September of '03. He
22 assisted at CRU for a period of time, but eventually the
23 workload where we wanted him to go to was at Northwest
24 intake. So we, we looked at the workload across the intake
25 program and placed him at Northwest intake.

1 Q Okay.

2 A So it was one of those where you're -- if you've
3 got an opportunity to get staff, took advantage of that,
4 we'd prioritize what our priority hot spot areas were where
5 we needed to try to put additional staff in.

6 Q Okay. The evidence we heard from Ms. Faria was
7 that workload remained an issue right up till she -- right
8 up till when she left and went to Animikii.

9 A Yes.

10 Q Why not just hire some new staff from outside of
11 the existing system?

12 A Well, I wasn't in charge of that decision, to
13 make that decision whether we could hire new staff.
14 Certainly, we would bring those kinds of concerns forward
15 to senior management, have that discussion with Pat. Pat
16 would have those wider discussions at the senior management
17 table at Winnipeg Child and Family. I --

18 THE COMMISSIONER: Was the situation such that
19 you saw the need for more new staff?

20 THE WITNESS: It's, it's hard to say. I mean,
21 ANCR today, you know, had an assessment unit besides the
22 two CRU staff that they had working down as part of the,
23 the CRU initiative but they've since moved. That
24 particular unit has now become an additional intake unit.

25 So it was, it was busy. Was it, was it too busy

1 beyond what people could manage when they were at full
2 staff? I don't think so. They seemed to be managing okay,
3 and I certainly wasn't hearing a lot that they couldn't
4 manage when they were at full staff complement. I think
5 the problem came in is that if they had a run on people,
6 you know, that had left and gone to another job, and then
7 they had people that were sick, now you start to get down
8 two or three people. That was, that was where CRU started
9 to get into an area where the workload was greater than
10 what they could manage.

11

12 BY MR. OLSON:

13 Q Could that -- that would have an impact, I take
14 it, then, on the services provided to clients.

15 A It could have an impact because we always wanted
16 to have six people on phones, and so if you had six people
17 on callout, if everybody was there, all 12 of them, and you
18 lost three staff, so that means you leave six, you know,
19 that are still on phones and you actually have only three
20 additional staff, then, you've got to deal with your
21 callouts at that point. So --

22 Q So some callers might go without the service they
23 need during that period.

24 A We, we'd prioritize. If at the end of the day
25 there were situations that were significant enough, we

1 always had the ability at our level, if it was brought to
2 our attention, that we could make some decisions about
3 moving cases around from CRU to tier two intake if -- you
4 know, if we had something was really urgent. But if it, if
5 it wasn't urgent, it's possible that it got a delayed
6 response time.

7 Q Ms. Faria testified that work -- that she thought
8 workload would have had an impact on the services delivered
9 to Phoenix Sinclair, but she wasn't aware that workload
10 placed Phoenix Sinclair at risk. Are you able to comment
11 on that?

12 A Can you do that one more time for me, please?

13 Q She stated that workload had an impact on the
14 services provided to Phoenix Sinclair, but she wasn't aware
15 that workload placed Phoenix Sinclair at risk. Is that
16 something you'd agree with?

17 A Well, I'd have to look at the case and, and in,
18 in my, in my -- look at the case. Are you referencing any
19 particular time of the case, are you talking about the
20 March incident, or what specifically are you reference --

21 Q Talking about the services provided to Phoenix
22 Sinclair and her family.

23 A It's hard for me to answer that question that
24 way.

25 Q Okay, you --

1 A I mean, I'd have to trust her judgment, I mean,
2 you know, the life of that case was -- it was over a
3 lengthy period of time, with many, many openings, you know,
4 and closings that happened, family service or at CRU. So
5 it's difficult for me to generalize, and if that's the
6 response she's given, I think she was closer to this case
7 than I would have been, so I --

8 Q So you're not in a position to disagree with
9 that.

10 A I'm not in a position probably even to comment
11 because I wasn't involved directly with the case.

12 Q You said, with respect to workload, you had, you
13 had a meeting with a senior manager.

14 A Right.

15 Q Who was that? Who was the manager?

16 A Who was the senior manager?

17 Q That you met with?

18 A About?

19 Q Workload issues.

20 A Well, we would have discussed that amongst
21 ourselves. Rob and Pat and I used to -- we had individual
22 supervision. We would have touch base times ourselves to
23 catch up on what's going on across the units, and if there
24 were workload related challenges, those would be discussed
25 amongst the three of us and we would brainstorm what were

1 possible options that we could do.

2 Q Did, did any of you bring the, the workload
3 situation to the attention of senior management?

4 A Well, we were senior management there, but senior
5 management for Winnipeg Child and Family Services, we, we
6 left any of those kinds of decisions to Pat, but tried our
7 best to try to keep him aware of what the challenges were
8 across each of the programs.

9 Q Okay. But you couldn't bring on new staff
10 yourself.

11 A I didn't have the authority to bring on new
12 staff. You mean to hire new --

13 Q To hire new staff.

14 A -- staff myself? No, no. No, I didn't have that
15 authority.

16 Q But could you make the request to do that?

17 A Sure.

18 Q Did you make that request?

19 A We certainly did make that request at various
20 times, in particular around those peak periods, you know,
21 where you've got, you know, holiday coverage over the
22 summer holidays, over Christmas, over different places like
23 that, and, and we were -- you know, quite frankly, I think
24 we were quite successful at, at Pat being able to negotiate
25 and get us additional support invariably at different

1 times.

2 Q That's what you referred to earlier, bringing on
3 some students and --

4 A No. No, that's, that's --

5 Q Something different?

6 A That's bringing on someone to help out, say, for
7 a six- to eight-week period over the summer months with a
8 fixed number of hours.

9 Q Okay. So someone to replace a worker that was
10 maybe --

11 A Might be on holidays, that kind of thing. And as
12 I said, the first summer were brought -- we were able to
13 get three staff the first summer, which was, which was
14 really huge, and they continued on with us into September.

15 Q When would that have been, sorry?

16 A That would have been over the summer months and
17 through into September of 2003.

18 Q 2003.

19 A Yes.

20 Q What about 2004?

21 A Again, I would have to probably suggest that it
22 was more over those peak periods if we did get assistance
23 in that time. I can't tell you for sure whether we did or
24 didn't, but it would be generally over the summer months or
25 those peak periods, you know, where we were staff down due

1 to holidays. Lots of times across the system were operated
2 about 50 percent down over the summer months, so when
3 you're 50 percent down somewhere like CRU, you have to plan
4 into that.

5 Q Right.

6 A So ...

7 Q Despite whatever efforts you made, the workload
8 always was a constant issue.

9 A Yeah, and I think it always will be. It's, it's,
10 it's a very, very busy place.

11 Q The case specific reports -- and I understand
12 you're familiar with them now -- they talk about the
13 services provided to Phoenix and her family were generally
14 provided on a crisis basis rather than as ongoing family
15 service basis. Is that, is that something you agree with,
16 having reviewed the documents?

17 A Well, the, the case was managed at both places.
18 I mean, it was, it was managed, you know, at CRU, it was
19 managed at family service, so there was ample opportunity
20 for family service to manage, you know, the case in
21 whatever way they saw fit. But certainly on a family
22 service caseload, which is the bulk of where my experience
23 has been over the years, is we can have families open for,
24 you know, as long as we're working with the family. Some
25 families we're with for two, three years. So they had a

1 much longer time frame and capacity to be able to work with
2 the family. But the, the last -- I don't know exactly the
3 last period of time that family service was involved, but
4 at least probably 18 months, the last 18 months, the case
5 appeared to me to be managed, you know, at CRU and at tier
6 two intake and didn't go on over to family service.

7 Q Never got passed over to family service.

8 A It never got passed over to family service. The
9 interventions and involvement and decisions around closure
10 were made, and it didn't go to family service.

11 Q So, sorry --

12 A I don't know exactly where that period of time
13 was.

14 Q Right. So for at least that period of time,
15 though, it was managed more on a crisis basis rather than
16 ongoing family service basis.

17 A It would have been managed on a crisis basis at
18 CRU for sure, because that was all crisis driven. It would
19 have been managed at intake on less of a crisis basis than
20 it would have been managed at CRU, and that service is
21 generally, you know, a six- to eight-week period of time.
22 So I'm not sure that one would have been viewed as, as much
23 crisis as you would see in the activity at CRU with the
24 family.

25 Q Okay. Ask you about another document. This is

1 Commission disclosure 992, which starts at page 19625.

2 MR. OLSON: Just put that on the screen. Sorry,
3 19625.

4

5 BY MR. OLSON:

6 Q This is called the Winnipeg Child and Family
7 Services, Intake Program Description and Procedures.

8 A You know what, the screen is so clear I'll just
9 go from the screen.

10 THE COMMISSIONER: Well, I seem to have two
11 copies of this.

12 THE WITNESS: Maybe you have mine? Just kidding.

13 THE COMMISSIONER: Do, do you want one? Why
14 don't you take this?

15 THE WITNESS: You know what, I will take it.
16 It's fairly lengthy, this one.

17

18 BY MR. OLSON:

19 Q Do you recognize this document?

20 A 0992. Yes.

21 Q Can you explain to the Commissioner what it is?

22 A It's the -- it's called the Intake Program
23 Description and Procedures document. And basically, what
24 the document is, is it's, it's kind of a compilation of the
25 services that we had at that time at 835 Portage, with CRU

1 and tier two intake and abuse related services and abuse
2 coordination related services.

3 THE COMMISSIONER: You said "at that time." What
4 time?

5 THE WITNESS: When I was there from 2003 to 2005.

6 THE COMMISSIONER: Thank you.

7

8 BY MR. OLSON:

9 Q So would this be one of the policy manuals that
10 would have governed sort of the practice at intake and CRU
11 at the time?

12 A Yes, definitely.

13 Q When you go -- if you just go to page 19628 ...

14 A Okay.

15 Q This is crisis response unit and after-hours
16 unit.

17 A Yes.

18 Q And it has a program description. I won't read
19 it out for you, but you're familiar with that.

20 A Yes.

21 Q And does that basically describe the program at
22 the time?

23 A Yes, it does.

24 Q Okay. And under Service Provision and
25 Assessment, it says:

1

2

"With respect to the day-to-day provision of services the CRU and AHU will" ...

4

5

6 Talks about interfacing with intake and abuse units, responding to any crisis involving assessing and intervention in situations where a child may be at acute risk of abuse or neglect.

9

10 A Right.

11 Q

12 "The CRU will respond to all situations where a response is required within 24 hours or within 48 hours (on cases not open to other agency units)."

16

17

18 You, you confirmed that for us before, that's how CRU operated.

19

20 A And I, I think I confirmed for you as well, though, that, generally speaking, we would have handled 24-hour related emergencies, not so much going to the 48 but we could go up to the 48.

23

24 Q Same document, if you go, please, to page 19634, under the heading -- it's the third heading there,

25

1 Recording Outline: Closings - CRU.

2 A What number are you under?

3 Q 19634.

4 A Okay. Okay.

5 Q Do you see where I'm referring to?

6 A Yes.

7 Q So this is talking about closing files at CRU.

8 A Right.

9 Q And this would be the, the procedure to follow
10 then when a file is being considered for closing.

11 THE COMMISSIONER: Yes.

12 THE WITNESS: Yes.

13 A SHERIFF'S OFFICER: Is it possible for the
14 witness to turn the microphone closer to his mouth? It's
15 difficult to hear in the back.

16 THE WITNESS: Is that better?

17 MR. OLSON: Maybe just pull it up a little.

18 THE WITNESS: How's that?

19 A SHERIFF'S OFFICER: Better.

20 THE WITNESS: Okay.

21 A SHERIFF'S OFFICER: Thank you.

22 THE WITNESS: Thank you.

23 THE COMMISSIONER: Thank you. You keep us
24 informed, Sheriff, if --

25 THE WITNESS: Yes.

1 THE COMMISSIONER: -- there's any more problems.

2 A SHERIFF'S OFFICER: Of course.

3 THE COMMISSIONER: Thank you.

4 THE WITNESS: Yes, Derek, thank you.

5

6 BY MR. OLSON:

7 Q Okay. So that -- your --

8 A Yes. It says that, that:

9

10 "Cases warranting no response or
11 no further response after AHU or
12 CRU intervention may be closed.
13 If there is a previous case
14 history, a file review shall be
15 conducted prior to closing."

16

17 Q That's something you were familiar with at the
18 time as the program -- assistant, assistant program
19 manager --

20 A Yes.

21 Q -- that period --

22 A Yes.

23 Q -- 2003 to 2005?

24 A Right.

25 Q Can you explain for the Commissioner, please,

1 what the last sentence means?

2

3 "If there is a previous case
4 history, a file review shall be
5 conducted prior to closing."

6

7 First of all, when it talks about a previous case
8 history, what's that referring to?

9 A That's referring to whether there was a previous
10 involvement with this family prior to this most recent
11 incident where we're making a decision to close.

12 Q I see. So in this particular case, we know that
13 Ms. Kematch had long history with CFS, as did Mr. Sinclair.
14 That would tell you that, that -- I mean, that would be an
15 example of a previous history.

16 A Exactly.

17 Q And then it goes on to say, "a file review shall
18 be conducted prior to closing"?

19 A Yes.

20 Q What does that mean?

21 A It means that you're expected before you close
22 that case -- if you're dealing with Samantha's file, as an
23 example, it's expected that you will go back and, and have
24 a perusal of the information that was on that file prior to
25 making the decision to close, and that could be part of the

1 CFSIS record, that could be part of the file records that
2 we had in storage in the basement over at 835 Portage.

3 Q So partly CFSIS, partly copies of any hard copy
4 file, right?

5 A Yeah.

6 Q How about related files?

7 A Well, it doesn't, it doesn't speak to all related
8 files, so --

9 Q Okay.

10 A -- I, I would be more comfortable suggesting that
11 it would be on the file you're currently working on that
12 you would be closing.

13 Q So if you're looking at closing, for example,
14 Samantha Kematch's case, you look at her file.

15 A Yes.

16 Q And does this mean you look at the entire history
17 of the case?

18 A It, it's, it's, it's a look-see to see if there's
19 anything there that still might be current in the way of
20 concerns that would cause you to perhaps reconsider your
21 decision --

22 Q That's the --

23 A -- to close.

24 Q -- purpose of doing this.

25 A That's, that's the purpose, yeah.

1 Q It's before you close, you want to make sure --

2 A Yeah.

3 Q -- that it's the right decision to make.

4 A Yeah.

5 Q That's why you look at the history.

6 A Yeah. I, I think that's a fair way to say it.

7 Q Based on that, you want to look at enough history
8 to know if there are concerns still existing.

9 A It's, it's to, it's to ensure you know if there
10 were risk concerns in the past, whether they were
11 addressed, whether or not the current issues that have
12 resurfaced that you've done the work on that you've made a
13 decision to close, would be altered in any way by looking
14 at past history.

15 Q Okay. And who, who is expected to do this review
16 of the, the case history?

17 A I believe the workers -- we're talking CRU. I
18 believe the workers would be doing that unless it was a
19 case that came in for closure from after-hours. I believe
20 the cases that came in from after-hours with a
21 recommendation to close, which would have been reviewed by
22 the CRU supervisor, I believe those files would have been
23 pulled by the admin and the supervisor would review those
24 closures.

25 Q Okay. All other cases, though, it's the worker

1 assigned the file.

2 A It's the worker, it's the worker and it's the
3 supervisor, and I'm not sure if one of them owned that more
4 than the other did.

5 Q Okay.

6 A But the information from after-hours generally
7 would not have been assigned to anybody at that point
8 because their recommendation would be closure, so the
9 supervisor of CRU would look at those ones.

10 Q In terms of the timing of the -- this review, it
11 says, it says, "a file review shall be conducted prior to
12 closing." Is your understanding that that's when the
13 review is to occur, just before the file's closed?

14 A I'm sure as, as quickly as the CRU supervisor
15 could get to it.

16 Q Do you know whether or not this was being done?

17 A Well, it, it certainly, it certainly was being
18 done, you know, on the information that came from after-
19 hours, and I believe that that was a fairly regular
20 occurrence that we did. Was it being done in, in every and
21 all situations? I can't say that for absolute certainty,
22 but that was the policy that was in place and that was the
23 expectation.

24 THE COMMISSIONER: But was it the responsibility
25 of the CRU worker or the supervisor of that worker, or

1 both?

2 THE WITNESS: I, I believe it was both unless it
3 came as a closure from the after-hours unit --

4 THE COMMISSIONER: Yeah, I, I, I --

5 THE WITNESS: -- and then it --

6 THE COMMISSIONER: I understand that.

7 THE WITNESS: -- was the supervisor.

8 THE COMMISSIONER: You made that clear.

9 THE WITNESS: Yeah.

10 THE COMMISSIONER: But I'm talking about a case
11 that --

12 THE WITNESS: Yeah.

13 THE COMMISSIONER: -- that didn't, didn't come
14 with a recommendation for closure but was --

15 THE WITNESS: Yeah.

16 THE COMMISSIONER: -- taken up --

17 THE WITNESS: Yeah.

18 THE COMMISSIONER: -- for, for consideration by
19 the CRU supervisor in assigning it to a worker.

20 THE WITNESS: Right.

21 THE COMMISSIONER: Then when it came time to
22 close, in that short period of time --

23 THE WITNESS: Yes.

24 THE COMMISSIONER: -- whose responsibility --

25 THE WITNESS: Yes.

1 THE COMMISSIONER: -- was it under that
2 provision?

3 THE WITNESS: Under your example, it would be the
4 worker's responsibility to recommend closure on that
5 existing case, and they would need to do that from one day
6 of completing their report, and within two days the
7 supervisor would have to do the closing on that case. But
8 where I'm a little stuck is whether the worker -- I know
9 the admins often used to go downstairs, pull the record,
10 but I'm not sure if the worker reviewed it first or the
11 supervisor. It's been seven years, I've kind of --

12 THE COMMISSIONER: That was my question --

13 THE WITNESS: I'm not sure.

14 THE COMMISSIONER: -- where that responsibility
15 lay --

16 THE WITNESS: Yeah.

17 THE COMMISSIONER: -- with respect to --

18 THE WITNESS: Yeah.

19 THE COMMISSIONER: -- compliance with that
20 sentence.

21 THE WITNESS: Yes, it's either, either worker or
22 supervisor. Sorry, I'm not quite sure.

23 THE COMMISSIONER: Thank you.

24

25 BY MR. OLSON:

1 Q One of them had the responsibility to do that,
2 though.

3 A Yes.

4 Q Just to ground it in the facts of this particular
5 matter, we know that, for example, Mr. Zalevich recommended
6 the closing of the, the file at CRU. You're aware -- and
7 you're aware about the facts surrounding that from what
8 you've read.

9 A In March of 2005?

10 Q In -- right, March 9, 2005.

11 A Yes, I'm aware of that.

12 Q In that case, would it be your expectation that a
13 file review of this nature would have been conducted before
14 the file was closed?

15 A Well, he certainly could have completed his
16 report, put his recommendation in for closure, and the
17 supervisor would then decide whether she supported that
18 recommendation for closure. But in that window of time
19 there, there should have been a review of that file to see
20 if there was anything, past history-wise, that would have
21 caused them both to reconsider whatever decision they made
22 at that time.

23 Q And so I guess the corollary to that is that if
24 this file review isn't conducted, it's not complying with
25 the policy.

1 A That's correct.

2 Q Would you agree that this type of a file review
3 is pretty important before closing a file?

4 A I think it's important.

5 Q Okay. And another example is where Ms. Wiebe --
6 Willox, now -- closed the file after speaking with the
7 public health nurse, Mary Wu. You're familiar with that as
8 well, right?

9 A I am, yes.

10 Q Would you expect the same sort of review to have
11 been undertaken in that case?

12 A If I remember the case correctly, I believe that
13 she had, had done a review with that file, if I remember it
14 correctly, when she made the decision for that case to go
15 up to tier two intake initially.

16 Q Okay. So the -- her decision, then, was to go up
17 to tier two intake.

18 A It was -- I believe it was a 48-hour response,
19 and the plan was for that case to go up to tier two intake.

20 Q Just to, just to keep looking at the -- this --
21 the document, the policy here, under (b) in that same
22 section, says:

23

24 "Generally speaking, if a matter
25 may be resolved and the case

1 closed with limited further
2 intervention [you know] (a few
3 phone calls or a field) the case
4 may be kept by the CRU beyond 48
5 hours to facilitate the case
6 disposal."

7

8 What, what -- in what circumstances would that be
9 appropriate, rather than going to intake?

10 A That, that could be an example where the
11 individuals have taken the call, for instance, at CRU on
12 the phones, they have assessed the situation to be a matter
13 that could be resolved in short order, and they make a
14 decision to pass it to the callout unit. And the backup
15 unit is then able to say: Look, I've got one more piece of
16 business that I need to do on this case. I need to talk to
17 the school. I'm satisfied with everything else that I've
18 seen vis-à-vis the family, but I want to do a follow-up
19 call with the school. It's five o'clock at night.
20 Nobody's around the school. I've passed my 48 hours. I'm
21 going to keep that till the next day. I'm going to follow
22 up with the principal or the guidance counsellor at the
23 school, and at the end of the day, now I'm satisfied that I
24 have all the information I need and I'm going to make a
25 decision to recommend to the supervisor closure.

1 That, that'd be the kind of example.

2 Q Right. So, logically, doesn't make any sense --

3 A Yeah.

4 Q -- sending it up to intake --

5 A No.

6 Q -- in that case because --

7 A No.

8 Q -- it can be closed pretty quickly.

9 A Yeah. And the same thing could be about
10 demographic information that they need from various
11 government offices that could be closed, that could be
12 examples.

13 Q But whenever you close a case, you, you do want
14 to make sure the children are safe.

15 A Well, when --

16 Q That would be the overriding concern.

17 A Yeah. I mean, whenever you close a case where
18 there were protection concerns initially that were
19 identified, yes, you want to, you want to make sure that
20 you take a look at whatever information is available to
21 you.

22 Q Okay. Look at the next one here, (c), says:

23

24 "All cases opened to Intake, Abuse
25 or any other unit shall remain

1 with that unit for assessment,
2 intervention [and] closing. Cases
3 shall not be returned to the CRU
4 except when the receiving unit
5 cannot reasonably respond in the
6 time frame required to ensure
7 safety. Such a return shall be
8 negotiated between receiving unit
9 supervisor and the CRU supervisor.
10 Once cases are opened to an Intake
11 or Abuse Unit they shall not be
12 returned for the sole purpose of
13 further information gathering."

14

15 Was this, was this policy followed in practice?

16 A I, I believe we tried as much as possible to
17 follow this policy. You know, an example of that would be
18 that we assigned -- intake cases from CRU went to the
19 respective four units based on geography. So you might
20 have, say, the Central unit, which was under my
21 responsibility at intake, and they might be three staff
22 down. You might have put a response time on a family's
23 situation, a client's situation that's referred that
24 requires, you know, a 48-hour response. And so what could
25 happen at that point is the intake supervisor could

1 approach the CRU supervisor, let them know about the
2 staffing challenge that they have, and together make a
3 decision whether or not that case could return back to CRU,
4 whether there is one or two pieces that could be done in
5 terms of the Central intake unit following up on and the
6 CRU doing the rest. So sometimes it was negotiated, then,
7 between the two supervisors, and that was strictly because
8 every unit sort of took its turn staffing-wise where they
9 were in staffing related challenges and were not up to full
10 staff, staffing complement. And that's when they had
11 difficulties meeting the expectations around workloads for
12 the respective program.

13 Q That last sentence in this policy seems pretty
14 clear. It comes after the section where it talks about
15 returning and negotiating cases between the, the
16 supervisors.

17 A Yes.

18 Q And it says:

19

20 "Once cases are opened to an
21 Intake or Abuse Unit they shall
22 not be returned for the sole
23 purpose of further information
24 gathering."

25

1 Was that -- that part of this provision or
2 policy, was that being followed?

3 A Yes, and no, because there were times if, if tier
4 two intake, you know, one particular unit was getting more
5 cases than they felt that they could manage, if, if you're
6 sending me cases from CRU and I can negotiate with you
7 around some things that are not complete in terms of the
8 work that you've done, and you agree that you're at a full
9 workload complement and you can handle the case coming back
10 to CRU or remaining with CRU, then at the end of the day,
11 you know, an intake supervisor might agree that, that
12 that'd be okay with them if CRU took the case back. But
13 you weren't supposed to do that strictly for information
14 gathering.

15 Q Okay.

16 A And generally, as a rule, that, that wasn't
17 allowed unless the CRU supervisor decided that for whatever
18 reason -- you know, might be a slow, slow week for them,
19 they might have all their staff there, they might feel
20 sorry for the tier two unit that the case has gone to, and
21 they might agree to take it back. And so sometimes they
22 would make their own arrangement, and as long as they
23 worked it out between the two of them, we were satisfied
24 with that.

25 THE COMMISSIONER: Mr. Olson, I want to just get

1 something clarified.

2 THE WITNESS: Yes, sir.

3 THE COMMISSIONER: That, that speaks to cases
4 being opened at intake.

5 THE WITNESS: Yeah.

6 THE COMMISSIONER: Is there such a situation of a
7 case going to intake but it not being open but rather
8 coming back to CRU?

9 THE WITNESS: Yes, there's -- and there certainly
10 were in some of the examples, you know, in this case
11 where --

12 THE COMMISSIONER: And what, what would prompt
13 that to occur?

14 THE WITNESS: I think what would prompt that to
15 occur sometimes would be that -- some of the examples that
16 I gave would prompt that if they were staffing down and if
17 they couldn't complete the callout in the response time
18 that was recommended by CRU. If they said it's a 48-hour
19 response or a five day response, and, and the tier two
20 intake unit who has already received the case because it's
21 been transferred up to them by the admin at CRU -- they
22 just go on the computer system and transfer it to them --
23 and they might not be able to deploy the staff to be able
24 to meet those needs in that time frame.

25 And they, they had instruction from us to, to be

1 careful not to change, at tier two intake, that response
2 time, because they could change that response time and
3 maybe in ten days they could do that, but the response time
4 was based on the protection needs and the concerns that
5 were assessed at CRU so we didn't, we didn't want them to
6 change that time.

7 THE COMMISSIONER: Was there a requirement that
8 if it was coming back unopened in intake, that the reason
9 for it coming back unopen to CRU was taking place?

10 THE WITNESS: Yes. The, the rationale, you mean,
11 being provided?

12 THE COMMISSIONER: Yes.

13 THE WITNESS: Yes, sir. They --

14 THE COMMISSIONER: Was there a form to be filled
15 out?

16 THE WITNESS: Yeah, they had, they had to bring
17 the file back down and talk with the CRU supervisor about
18 the fact that they were not going to keep the file, and
19 they had to work that out between the two of them.

20 THE COMMISSIONER: It would be a verbal
21 communication.

22 THE WITNESS: It would be a verbal communication.
23 Sometimes they brought the file with them just to have the
24 information or in the hope that if you were the CRU
25 supervisor you would take the case back.

1 THE COMMISSIONER: But the reason would be made
2 known.

3 THE WITNESS: Yes, the reason would be made known
4 to them.

5 THE COMMISSIONER: Thank you.

6 MR. OLSON: Thank you.

7

8 BY MR. OLSON:

9 Q I just want to, I want to explore that a little
10 bit more.

11 A Yeah.

12 Q It says -- and we're looking at (c) here. It
13 says, "Once cases are opened to an Intake or Abuse unit."
14 Now, my understanding -- I, I could be wrong about this,
15 but the file gets opened at CRU. Comes in, CRU deals with
16 it, they open a file, they do their investigation,
17 determine, okay, this is not a case for us, this is a case
18 for intake, requires more than 48 hours, 24 hours.

19 A Yeah.

20 Q We're going to send it up.

21 A Yeah.

22 Q So the report's written up by CRU.

23 A Yes.

24 Q Have I got that right so far?

25 A Absolutely, yeah.

1 Q That case is already open.

2 A Well, it, it will go to the, the secretary to
3 open it on CFSIS to the tier two intake unit.

4 Q Okay. So the worker who worked on the CRU case
5 does a report. We've seen many examples of those CRU
6 reports. They make a recommendation that the case be
7 opened.

8 A Right.

9 Q Do they come up with a time -- a response time
10 for the case?

11 A They, they will in their case disposition give
12 their response time, and if it's, like you said, 48 hours
13 or more, it would go up to tier two intake. There were two
14 processes, though, that were happening.

15 Q Okay.

16 A That is one process, the one I'm describing to
17 you, and, and usually we would use the two admin that were
18 there at CRU at the time to assist with that.

19 Q Okay, let me just -- before you --

20 A Sorry.

21 Q -- explain both processes --

22 A Okay.

23 Q -- let me just finish where I was going with
24 that.

25 A Sure.

1 Q Once a CRU report's handed in and the supervisor
2 of CRU -- for example, Ms. Faria or Ms. Verrier -- signs
3 off on the report, gets handed in to administrator --

4 A Yeah.

5 Q -- okay, that administrator opens a case on
6 CFSIS --

7 A Yes.

8 Q -- the computer system.

9 A To tier two.

10 Q To tier two.

11 A Yeah.

12 Q Once that's, once that's entered into the system,
13 it's opened to intake, right?

14 A That's right. It's, it's intake's case at that
15 point.

16 Q That point.

17 A Yes.

18 Q And so when we look at the standard, the intake
19 supervisor only becomes aware of that intake opening when
20 it appears on their desk or however they access it, right?

21 A Yeah, the file will go up to them.

22 Q The file goes up, physically --

23 A Yes.

24 Q -- goes up to them.

25 A Yes.

1 Q That's when they become aware of it?

2 A Yes.

3 Q And once they become aware of that, they look at
4 it -- and what this standard seems to be saying is they
5 can't go: You know, I think there should be some more work
6 done on this. I, I want you to gather some more
7 demographic information. I want, you know, CRU to do
8 additional work. I'm going to, I'm going to reject it and
9 send it back down.

10 According to this policy, it seems to me that
11 that shouldn't happen.

12 A Well, it says:

13

14 "[It] shall not be returned for
15 the sole purpose of further
16 information gathering,"

17

18 but it does say in the above paragraph:

19

20 "... except when the receiving
21 unit cannot reasonably respond in
22 the time frame required to ensure
23 safety."

24

25 And that's where the second process comes in.

1 Diva and Diana always had to know, you know, what was going
2 on in each of the four intake units staffing-wise, how
3 backed up were they, you know, case-wise, what was
4 happening for the two intake units the same, and then they
5 would know at times that, Look, I'm going to send this to
6 Andy Orobko's unit and they'd say, Oh, geez, Andy's two
7 staff down. Rather than just do the regular process, they
8 might -- she might take that case and she might go and --
9 go up to see Andy, have a discussion with him, and the two
10 of them figure out how that's going to get managed. Is it
11 going to stay, you know, at tier two intake? Is Andy able
12 to do any pieces at all? Could CRU do -- CRU keep the case
13 for another day or two and do a couple more pieces, and
14 then send it to Andy? Some of those were negotiated
15 related processes.

16 Q Now, would that occur before the case is ever
17 opened in CFSIS?

18 A That --

19 Q The process that I explained about the
20 administrator opening the case to intake.

21 A Yes. Your process, it would be opened by the
22 admin on CFSIS and the hard copy file would go up to Andy.
23 My second example to you, Diva would not take the file to
24 Trudy Carpenter, her admin, and Trudy wouldn't even know
25 about that. She would take that -- she would go up to Andy

1 so it's not on the CFSIS system open to tier two intake
2 because --

3 Q So the --

4 A -- Trudy was our person that -- you know, Trudy
5 or Jolene were the people that put the information on CFSIS
6 for us at CRU.

7 Q Right. And just so we're perfectly clear -- and
8 we probably are, but --

9 A Yeah.

10 Q -- just want to be sure.

11 A That's fair.

12 Q In, in an -- this example, Diva Faria -- for
13 example, in, in the -- well, in the Buchkowski, it was --
14 Ms. Verrier was the supervisor.

15 A Right.

16 Q Ms. Verrier looks at it and she knows that it
17 says open to intake.

18 A Yes.

19 Q Recommendation's open intake.

20 A Yes.

21 Q She can then make the decision, I, I know that
22 intake is particularly busy right now --

23 A Yes.

24 Q -- so I'm going to walk this up to the, to the
25 intake supervisor, Ms. Parsons or whoever it was --

1 A Yeah.

2 Q -- and see if they can take it or if they want us
3 to do more work on it. Is that sort of how the -- how it
4 would work?

5 A Well, or what she could do in that scenario --
6 they went out on a couple of calls, if I've got it straight
7 in my mind, and they were not able to track down the
8 family, put a response time on, sent it up, and I --
9 assuming they sent it up the first way we spoke of, through
10 the admin and up to intake, and then intake would have had
11 that case and had the responsibility for the case.

12 And it was unclear to me in the, in the reading
13 of the record as to how the case ended up back at CRU,
14 whether it was negotiated by, you know, the tier two intake
15 supervisor with Diane Verrier, or whether it was negotiated
16 between the tier two supervisor and Diva Faria, who
17 ultimately had responsibility for the case with Chris
18 Zalevich.

19 Q Right. And do you agree with me that on the
20 facts that we have and what we know, there's no evidence of
21 the case ever being open to intake on the system. Is that
22 your understanding?

23 A I, I --

24 Q Or you don't know.

25 A -- honestly don't know. I just saw the paper

1 related --

2 Q Okay.

3 A -- record so I, I don't know. I didn't see the
4 stuff related to the CFSIS, whether it was open.

5 Q But on the --

6 A I'm not sure.

7 Q -- paper related records -- and you're referring
8 -- you were referring to the -- Mr. Buchkowski's record,
9 and Mr. Zalevich's CRU report, right?

10 A Right.

11 Q And it doesn't say anywhere on there what
12 happened with this case, how it got back down to Mr.
13 Zalevich.

14 A Right. It just says that they transferred it to
15 tier two intake, is what I recall.

16 Q Okay.

17 A If I'm off on that, I, I have to look at the
18 records. I'm just going by memory.

19 Q That's fine. So if it's not reflected on the
20 computer system -- just assume that for a moment -- what
21 you're saying probably happened is somehow Ms. Faria agreed
22 to do more work on, on the file in CRU, rather than have
23 intake do the work.

24 A I, I would be, I would be speculating because it
25 could have been, it could have been Diana Verrier with a

1 tier two intake supervisor, I'm not sure.

2 Q One of them would have negotiated, though, with
3 the tier two supervisor --

4 A The --

5 Q -- as to how to handle the file.

6 A The tier two intake supervisor did not accept the
7 case and it, and it ended up back at CRU, which means that
8 somebody at CRU, one of the two supervisors, accepted the
9 case back.

10 Q Okay. Now, when you talk about tier two not
11 accepting the case, that suggests to me that it's -- and I
12 don't want to put words into your mouth, but it sounds like
13 more of a rejection of the case: We're not going to deal
14 with it, you deal with it, CRU.

15 A Yes.

16 Q Is that how it worked in some cases?

17 A Well, it seems to be in this situation, because
18 at the end of the day it appears to, at least on paper,
19 have been referred to them, and then the commentary from
20 CRU is it's not ended up with tier two intake, it's ended
21 up with the callout unit at CRU.

22 Q Right. So -- but you don't know if that was a
23 negotiation between --

24 A I really --

25 Q -- supervisors or not.

1 A I really wish I could help, but I don't have the
2 answer to that.

3 Q We have heard -- we've heard some evidence, from
4 Ms. Faria in particular, that there was this phrase, walk
5 of shame.

6 A Right.

7 Q And she said that's a phrase that you used. Is
8 that right?

9 A Well, I think you asked me that when I met with
10 you guys the last time and with Commission counsel, and I
11 think it's important for me to perhaps give, give a context
12 around that, that term, walk of shame. Certainly, isn't a
13 term that was used widely across 835 Portage.

14 Diva was struggling at times with getting a
15 number of the supervisors to accept cases transferred from
16 CRU and there was pressure always seemingly coming back
17 CRU's direction to take the cases back. And one particular
18 day I believe she'd been involved with the -- one of the
19 abuse supervisors and things had escalated, you know, quite
20 strongly. And her and I -- I met with her in supervision
21 in my office and we talked about that.

22 And, first of all, I wanted to get a bit of a
23 barometer check on, on how she was doing and what was going
24 on because it was apparent to me that she was, you know,
25 upset about what had transpired, you know, and, and she

1 felt, she felt strongly that, you know, once CRU made the
2 decision to send a case anywhere, it, it should absolutely,
3 you know, hundred percent of the time should stay there.

4 I commented to her that, you know, she looked,
5 you know, she looked really beaten down that particular
6 day. She looked like she was embarrassed and, and she was
7 feeling bad about having to go back to her staff and
8 basically say that good work that she believed had been
9 done and she believed at the end of the day that, you know,
10 the case should have gone up to, you know, to the abuse
11 unit, as it turned out at that instance. And, and in my
12 discussion with her, I said, So is it, is it embarrassing
13 for you that you have to kind of walk the case back down,
14 you know, to, to CRU and your staff will be wondering,
15 like, sort of, you know, why as a manager aren't you able
16 to make cases, you know, that we'd done the work on, go to
17 any of the programs? Are the other program supervisors in
18 charge of you or, or, you know, when our work is done
19 shouldn't that speak for itself?

20 So I, I can't honestly tell you, at the end of
21 the day, who coined the phrase, "walk of shame." It's an
22 irrelevant comment. But at the end of the day, what's
23 important about it is that there's been significant
24 tension, you know, in the time where we were at CRU that
25 the transfer points of cases have been a challenge. So

1 when CRU is running on, on, on, on all cylinders and has
2 all 12 people there and they know another unit is in
3 trouble, lots of times CRU -- Diva, Diana, their staff --
4 jump in, help the other people, you know, and take on more
5 responsibility.

6 But there were -- and I'm going to say that there
7 were a lot more times where both Rob, Rob Wilson and myself
8 had to institute directives to the supervisors -- verbal
9 directives, you know -- when we sat and met with them in
10 our, in our team meetings, and said to them that we need to
11 be careful because these debates about who's taking which
12 case, I mean, these are families we're talking about. So
13 we're, we're debating and we're not taking cases, and time
14 is going on and families aren't being serviced, and that's
15 not okay. So our messaging, you know, is what's really
16 important, and that important messaging is you try to work
17 it out amongst yourself. If you can't work it out amongst
18 yourself, and it's a matter of child safety -- you know,
19 response times not being done within the time frame that
20 has been assessed at CRU, that's child safety.

21 So if those were the kinds of issues, all the
22 supervisors were very clear that if it was under my area of
23 responsibility, they could approach me. Got trickier when
24 some were in my area of responsibility and some were in
25 Rob's area of responsibility. In those scenarios, wherever

1 possible Rob and I would both meet with the two supervisors
2 and we would figure it out, we would give a directive, make
3 a decision, and get the case settled.

4 Q But this term, walk of shame, she said that's a
5 term that you used. Would you have used that term, walk of
6 shame?

7 A I believe in, in a dialogue with her that day,
8 she said -- I said, You're embarrassed, it looks like
9 you're, you're embarrassed and, and you look like you're
10 shamed to go back to talk to your staff. How that got into
11 the word "walk of shame," and how that got, you know,
12 signifying at the end of the day that that was our pressure
13 point, I can't speak to that. I, I didn't really have any
14 conversations much beyond that other than with Diva in
15 supervision. So whether it, whether it got generated other
16 places ... But it, it was not common knowledge that was
17 used all across 835 Portage. More so perhaps in Diva's
18 unit, I'm not sure.

19 Q How that -- however you describe that process or
20 that term, what it meant was that either abuse intake or
21 regular tier two intake rejected the file, they weren't
22 going with the recommendation of CRU to open the file,
23 right?

24 A Right. And remember, there's a difference with
25 abuse than there is with tier two intake.

1 Q Okay.

2 A Because abuse is, is -- it's really complicated
3 and complex work. So even in, in the orientation manual
4 and in, in, you know, this intake procedural manual when
5 you look at abuse, there are times where we had extremely
6 serious abuse situations and if abuse, you know, had the
7 staffing component to deal with that, we would take that
8 case -- Diva or Diana -- they would walk upstairs, they
9 would talk to the abuse people, and if the abuse people had
10 the staffing complement to manage that, they would take
11 that case right now, immediately.

12 Q Okay.

13 A And --

14 Q For intake, though, that wasn't happening? There
15 wasn't a walk of shame? Cases would go up and they would
16 get accepted or negotiated back down?

17 A I mean, both processes happened, but abuse was
18 different. There was many more walks from the supervisor
19 and they just weren't -- the first response we talked about
20 with tier two intake where you would go to Trudy, Trudy
21 would put that automatically on the system and send it to
22 tier two intake, we didn't do that near as much with abuse.
23 Usually --

24 Q Okay.

25 A -- the abuse -- maybe if it was a straight-up

1 real predictable kind of situation in abuse we might have
2 done that. But generally, when you're talking about foster
3 home abuse investigations which might take three or four
4 months to complete, are extremely complicated and need to
5 be managed carefully, a lot of those were walked up by the
6 supervisor.

7 Q My understanding of the evidence we've heard to
8 date -- of course, I could be wrong, but my understanding
9 is that the, the facts of this particular matter, Phoenix
10 Sinclair's matter, wouldn't have qualified it as an abuse
11 case or abuse referral. It never would have been sent to
12 abuse intake.

13 A That's correct.

14 Q Okay. So you agree with me on that.

15 A Yes. Yes, you're right.

16 Q So this case would have been what workers
17 described as a fairly typical routine sort of matter, and
18 you agreed with that before, right?

19 A Yes, average.

20 Q So this average sort of case is going to go, the
21 recommendation is that it be sent to intake.

22 A That's correct.

23 Q Which means tier two intake.

24 A That's correct.

25 Q Normally you're saying that would be done through

1 the process I describe, where it goes through Trudy
2 Carpenter, the administrative person --

3 A Right.

4 Q -- to open on the computer, and that's how the
5 intake supervisor learns of it.

6 A Yes.

7 Q Here we don't know what happened --

8 A Right.

9 Q -- because there's not a record.

10 A That's right.

11 Q So for some, some reason the speculation's been
12 that, that intake rejected the file.

13 A That's, that's what was on Richard Buchkowski's
14 notes, and he appeared in his notes to -- sounded like from
15 reading his notes that he was surprised it ended up back
16 at, at CRU callout.

17 Q When you're referring to Richard Buchkowksi's
18 notes, are you referring to his, his CRU form?

19 A I'm referring to the notes that, that we have in,
20 in the records.

21 Q With -- the notes with meeting with Mr. Koster?

22 A I mean, I'm going by memory so I'd have to find
23 them. Do you want to find them?

24 Q Yeah. Let's get -- we'll, we'll pull up Mr.
25 Buchkowksi's CRU summary, 36926.

1 A Okay.

2 UNIDENTIFIED PERSON: Oh, that's in the binder.

3 UNIDENTIFIED PERSON: That's the binder, 1795.

4 THE WITNESS: Oh, thanks. Okay, (inaudible) I
5 thought I was doing something wrong here. 1795. Okay.

6

7 BY MR. OLSON:

8 Q Okay. Take a minute, look at that.

9 A Okay.

10 Q And when I read it, I didn't see any reference to
11 how this file ended up back at CRU. And maybe if, if you
12 have some other information, you can let us know.

13 A I think it just, it just references Richard
14 saying that it's recommended this file be opened to intake.

15 Q Okay. And when, when Mr. Buchkowski testified
16 that intake to him -- he always put intake. It could mean
17 CRU, it could mean tier two.

18 A Yeah.

19 Q Supervisor said she would have expected that to
20 be tier two but, in any case, we know it ended up back at
21 CRU.

22 A Right.

23 Q We just don't know why, right?

24 A Yeah. I don't, I don't know what he testified
25 to, so ...

1 Q When, when, when cases would be rejected by tier
2 two intake, and you -- I think you said that did happen.

3 A That cases were --

4 Q Rejected by --

5 A -- rejected?

6 Q -- tier two.

7 A Right.

8 Q Now, I'm not talking about abuse, but tier two.

9 Is that right?

10 A Yes.

11 Q Okay. That Ms. Faria or Ms. Verrier, they
12 wouldn't -- they, they would complain about that. They
13 didn't like that happening?

14 A Rejected means we got the case --

15 Q Yeah.

16 A -- we don't believe we can manage the case, we're
17 going to come down and have a discussion with you about it
18 and see if we can agree to work this out in terms of
19 dividing out tasks or in terms of seeing if you at CRU will
20 take it back.

21 Q So in other words, this is not an outright
22 rejection of the case.

23 A Right.

24 Q CRU wouldn't have to not take the case back.

25 A That's correct.

1 Q It was an agreement that CRU would do more work.
2 Or --

3 A I don't know, because if Richard has testified
4 that it didn't even go up to tier two but went across to
5 CRU backup, that's not how I would have interpreted that.
6 But if that's what he's testified to, then I have to
7 respect that.

8 Q I just mean the situation itself. When, when
9 these cases are -- end up back at CRU after the
10 recommendation was, was that it go to intake, that was --
11 that would be by agreement, by negotiation.

12 A Yes.

13 Q Not by actual refusal by intake.

14 A Well, not the ones that were through Trudy
15 carpenter, put onto CFSIS. Once it's on CFSIS, that's a
16 tier two intake's case. Now they got to come back and
17 negotiate that with the CRU supervisor to take it back.
18 But if, if Diva or Diana were to walk up a case themselves
19 without giving it to Trudy, without putting it on CFSIS,
20 they could end up having a dialogue with the supervisor.
21 The supervisor at tier two may refuse to take that case.
22 By the fact that they physically took the file up there,
23 they opened a dialogue as opposed to sending it to them.

24 Q If there was a refusal like you're describing,
25 where intake doesn't want to take the case --

1 A Right.

2 Q -- would you -- would it be your expectation that
3 that would be documented by the supervisor?

4 A Which supervisor? Both supervisors at both ends?

5 Q Whoever's, whoever's dealing with the rejection.

6 A I guess I, I wouldn't really have an issue with a
7 supervisor putting a notation on the file that sent this
8 case up to tier two intake, intake refused, and it's back
9 at CRU. I, I wouldn't have a problem with that being on
10 the file. I would have a problem putting something on a
11 client's file where we -- she, she said this and he said
12 this and we got into a lot more information like that. I
13 would have a problem with that.

14 Q But would you have expected there to be some
15 documentation reflecting that that's what happened here?

16 A I, I think it's fair if somebody chose to put
17 that on, because it shows the process that was followed,
18 and --

19 Q But --

20 A -- if they felt it was important --

21 Q But what I'm asking about is your expectation.
22 You're the supervisor of the, the supervisor, and she's
23 supervising the worker. What would your expectation have
24 been in terms of documenting what happened?

25 A Documenting that the file went to tier two

1 intake, was rejected, and came back.

2 Q Right.

3 THE COMMISSIONER: That, that's when it was put
4 in by administration and went up for an open file.

5 THE WITNESS: Yeah.

6 THE COMMISSIONER: What about when it went up as
7 a result of a walk up and a dialogue commenced, as you put
8 it, and --

9 THE WITNESS: Yes.

10 THE COMMISSIONER: -- and, and the resolution was
11 it should come back down.

12 THE WITNESS: Yes.

13 THE COMMISSIONER: Would you expect a recording
14 of that --

15 THE WITNESS: Right.

16 THE COMMISSIONER: -- that event?

17 THE WITNESS: Yes. First thing I would expect,
18 Mr. Commissioner, is if the CRU supervisor felt that this
19 was an important enough issue, safety of children was
20 there, they should have come to one of us as a service
21 manager to resolve that issue, and they shouldn't have
22 conceded taking the case back. But if they did take the
23 case back, they were well within their right to write: I
24 tried to take this up to tier two intake but they refused.

25 THE COMMISSIONER: But would, would, would it not

1 be expected they would write and make a notation of that?

2 THE WITNESS: Yes. Yes. Definitely. And, and,
3 and that's within their right, and they did. They wrote
4 that, you know, in the notes. And that was okay. But if
5 they wrote, This person said that and I said this, we don't
6 need that stuff in there. That, that's, that's irrelevant
7 stuff.

8 THE COMMISSIONER: I understand.

9 THE WITNESS: Yeah.

10

11 BY MR. OLSON:

12 Q That -- when you say you don't need that stuff in
13 there, was that a direction to the supervisors, don't
14 record that kind of information?

15 A It's not a directive that we put in writing, but
16 it certainly is a message that we, we tried to -- we're
17 trying to establish goodwill and good working relationships
18 across programs, and in particular across the supervisors
19 that are the leaders of those respective programs. So what
20 we're trying to do is model for them that they needed to be
21 able to discuss and work through these issues. And work
22 them through when you're calm. And if you can't work them
23 through when you're calm and neither of you are going to
24 concede on your points, then go down the hall, get one of
25 the respective assistant program managers, and we'll help

1 you, and we'll sort it out, and we'll make a decision. And
2 that's what we would do.

3 Q And that, that --

4 A And when that decision would be made, then that
5 would be the final decision.

6 Q See if you can help us understand what happened
7 in this case. If this was, as you said, a fairly typical
8 OR routine type of case, why, why would the supervisor from
9 CRU walk it up to the supervisor of tier two? There be any
10 reason to do that?

11 A Are you talking about a specific time frame on
12 this? I can't follow the --

13 Q No, I'm talking about the specific time frame
14 when Mr. Buchkowski recommended the file go to intake.

15 A March 7th, would there be a specific reason why
16 Diana Verrier would have walked that up?

17 Q Yeah, if a typical case, why not --

18 A Yeah.

19 Q -- just put it through the system, Trudy
20 Carpenter --

21 A Yeah.

22 Q -- opens it, if intake doesn't want it --

23 A Yeah.

24 Q -- comes back down.

25 A Yeah.

1 Q Your counsel just pointed something out. You --
2 when you said it was a typical case you meant overall?

3 A Yeah.

4 Q Is there something --

5 A When I said it was an average case, I was talking
6 about the average in regards to the, the risk and response
7 times that we generally would be seeing across the board in
8 terms of new cases that come into our system.

9 Q Was there anything unique about this particular
10 referral that Mr. Buchkowski was dealing with, that made it
11 somehow not usual or typical?

12 A Apart from the extensive history on this
13 particular referral -- and it's not uncommon for us at CRU,
14 and, and maybe not that well-known to the general public,
15 but lots of times people will use the word "abuse" for a
16 far, far-ranging amount of things, you know, from shouting
17 at your child. People will send in referrals to us and
18 will call that abuse. So a big part of this referral was
19 our ability to be able to access the direct information
20 from the source of referral, and in this, in this case it
21 was sort of -- it was a second-hand referral. The person
22 did not have any real information to shed some light on
23 whether or not this was, indeed, an abuse situation, and
24 didn't have a physical address. So (a) we didn't know, was
25 the child injured, how was the child injured, when was the

1 child injured, and we didn't even know the location of
2 where the family lived, so it was a, it was a fairly
3 atypical kind of referral for us, in --

4 Q We, we've, we've heard workers say that they got
5 even anonymous referrals fairly regularly.

6 A Yeah, yeah.

7 Q And also that clients of the system often had
8 extensive histories.

9 A Yeah.

10 Q Both fairly typical. So are you saying there's
11 something that was atypical about this particular referral?

12 A What, what's, what's atypical about this one is
13 the decisions that we made when the word "abuse" was used
14 is -- we have been asked and we've been challenged and
15 we've all talked about that in various, various
16 opportunities to meet with Commission counsel about why we
17 didn't view this as an abuse investigation, why did it go
18 to tier two as opposed to the abuse unit.

19 Q Yeah, we've, we've been over -- we understand --
20 I understand --

21 A Yeah.

22 Q -- that, and it --

23 A Yes.

24 Q -- doesn't meet the criteria, et cetera.

25 A Yes.

1 Q But the question I'm just trying to get from you
2 is how is this an -- if you're saying it's atypical, on
3 what basis would it be atypical such that it would --
4 there'd be a need to walk it up to the supervisor of intake
5 to see if they're going to take it or not.

6 A I don't think we established that it was -- have
7 we established that it was walked up to the tier two intake
8 supervisor?

9 Q I've asked you why -- what would be the reason
10 for doing that in a case like this?

11 A I, I, I mean, if it actually went to intake, it
12 would have been one of those that could have easily gone
13 through the admin.

14 Q Right.

15 A Admin opened on CFSIS and shot up.

16 Q That's my point.

17 A Absolutely. But I believe I heard you say
18 earlier that Richard had testified here to something
19 different, so I'm, I'm kind of getting a bit confused here.
20 I want to help you, but --

21 THE COMMISSIONER: I think maybe, I think
22 maybe --

23 UNIDENTIFIED PERSON: He hadn't said that.

24 THE COMMISSIONER: I was going to suggest we
25 adjourn for lunch and maybe you can get this clarified.

1 Did you want to say something, Mr. Saxberg?

2 MR. SAXBERG: No, I, I, I think that's a good
3 suggestion, to --

4 THE COMMISSIONER: Yeah.

5 MR. SAXBERG: -- adjourn for lunch.

6 THE COMMISSIONER: I, I think this might get
7 clarified in consultation so -- it's time for lunch in any
8 event, so we'll take a break till two o'clock.

9 MR. OLSON: Very good.

10 THE WITNESS: Thank you.

11

12 (LUNCHEON RECESS)

13

14 MR. OLSON: I'm told they're still having some
15 trouble hearing us in the back.

16 THE WITNESS: Oh, are they?

17 MR. OLSON: So I'm going to try to speak up, and
18 if you could do the same, maybe pull the microphone close.

19 THE WITNESS: Thank you.

20 MR. OLSON: You probably could probably pull it
21 even a little closer than that.

22 THE WITNESS: Okay. Can you hear in the back?
23 Okay.

24

25 BY MR. OLSON:

1 Q Earlier this morning you mentioned that CRU would
2 -- one of the responsibilities of CRU was to come up with
3 the response time. Right?

4 A Yes.

5 Q And you said that the response time they came up
6 with would be the response time that would be expected to
7 be followed at intake.

8 A Yes.

9 Q You said that there was a directive from -- it
10 was made very clear from, I guess, yourself and others that
11 that was the expectation on --

12 THE COMMISSIONER: What was? I missed what you
13 said in your second question.

14 MR. OLSON: The response time that CRU came up
15 with, whether it's --

16 THE COMMISSIONER: Yes.

17 MR. OLSON: -- five days, seven days --

18 THE COMMISSIONER: Yes.

19 MR. OLSON: -- that was to be followed at intake.

20 THE COMMISSIONER: Oh, be followed. That -- the
21 word I missed, was "followed." Okay, thank you.

22 MR. OLSON: Okay.

23

24 BY MR. OLSON:

25 Q And you said that was made clear to the

1 supervisors, that intake was expected to follow the
2 response time and CRU was to come up with the response
3 time. Do I have that -- that's right?

4 A Yes.

5 Q We heard evidence from Roberta Dick -- and I
6 appreciate this predates your tenure slightly.

7 A Right.

8 Q Her evidence was that the response time that she
9 would come up with would sometimes be made to accommodate
10 workload demands at intake. Was that -- had, had you heard
11 of that happening? Were you aware of that?

12 A I, I heard that it was happening, but wherever it
13 happened, if, if it was a shortened time, that would be
14 fine. If it was an extended period of time then what they
15 had provided as a response time at CRU, it shouldn't simply
16 be for a challenge workload related-wise. It, it needed to
17 be compared against what the, the merits of the need for
18 follow-up with the family should be.

19 Q Right. Response times should be determined by
20 the case as it presents itself.

21 A Right.

22 Q Shouldn't have anything to do with can intake
23 handle it or not. Right?

24 A Sometimes in that situation, that's where the
25 tier two intake supervisor might be talking to the CRU

1 supervisor.

2 Q Right, you get into that --

3 A Yes.

4 Q -- who's going to take the file.

5 A Yes.

6 Q Because intake doesn't want it if, if it turns
7 out they can't meet the response time.

8 A Right.

9 Q And CRU doesn't want it back because they're
10 already swamped.

11 A Yes.

12 Q So nobody wants this file. Is, is that sort of
13 -- intake doesn't want it, CRU doesn't want it.

14 A Well, I don't know if it's nobody wants it, but
15 people are having challenges to deliver on the service
16 within the response time that's been recommended at the CRU
17 level.

18 Q Was there any concern about the way files would
19 be handled if they were -- if they had come back down to
20 CRU to do further work, in terms of the worker -- CRU
21 workers thought, you know, we send this file up, we want it
22 to go to intake, they reject it and now we got to do more
23 work on it. Did that -- were you aware of that changing
24 approach to the, to the matter?

25 A No, I'm not aware of that.

1 Q And the whole issue about response times being
2 tailored to meet intake's ability, that is something you
3 said you had heard about happening?

4 A Yeah. I'd heard of it happening, but I, I didn't
5 see very many examples of that brought to my attention when
6 I was there.

7 Q Ms. Dick said that her supervisor, Diva Faria,
8 would give direction as to whether or not they should be
9 deciding on the response time based on workload demand.
10 Said they would often know that there were a lot of files
11 open, and based on that they would try and balance the
12 workload and that Ms. Faria was -- that was something she
13 was aware of happening.

14 A Are you referring to her commenting about that at
15 CRU in terms of CRU's workload or tier two's workload?

16 Q No, this is in the context of CRU, they're about
17 to send a file up to intake, they would adjust the response
18 time so that the file wouldn't necessarily go up to intake.

19 A Well, if, if they were to do that in conjunction
20 with the supervisor, and if at the end of the day the
21 supervisor and worker believed that they could do that
22 safely for the children that were involved in that
23 particular situation, then I guess that would be their
24 call.

25 Q Was, was the practice of adjusting response times

1 acceptable --

2 A I, I --

3 Q -- in that manner?

4 A I think you're talking about a difference between
5 -- the first question was about response time adjustment by
6 the tier two supervisor without consultation back with the
7 CRU supervisor. That, that would have been a challenge.
8 This one here would have been a discussion between the CRU
9 worker -- in this case, Roberta Dick -- and, and her
10 supervisor. And between the two of them they could have
11 made a determination whether the family situation that was
12 directly in front of them is something that could be
13 managed within an expanded time frame.

14 Q So instead of maybe the worker would have
15 assessed the response time as being based on the file, what
16 they've read, what they've seen, as being, you know, a five
17 day response time, knowing that intake can't handle a five
18 day response time they adjusted upwards to be something
19 longer than that. That's what I'm, that's what I'm trying
20 to ...

21 THE COMMISSIONER: Yes, Mr. Saxberg?

22 MR. SAXBERG: Thank you for stopping. I just
23 want to rise. I'm objecting to the question on the grounds
24 that that wasn't the evidence that Ms. Dick gave, what she
25 said. There might be one spot where it sounds like she

1 said that, but she was asked about this issue on several
2 occasions, and what she said was where it could have gone
3 either way between 48 hours and five day response time, she
4 would err on the side of giving intake some leeway if they
5 were busy. She wasn't saying she was picking the response
6 time based on workload, and that's what seems to be being
7 conveyed here. The transcript will be crystal clear on
8 that point.

9 THE COMMISSIONER: I'm just wondering whether Mr.
10 Olson has the transcript. I see he has something in his
11 hand.

12 MR. RAY: Mr. Commissioner, just while counsel is
13 discussing, I'm actually having problems hearing you now.

14 THE COMMISSIONER: Oh, okay, I'm sorry. I'm glad
15 you brought that to my attention.

16 MR. RAY: Thank you very much.

17 THE COMMISSIONER: Thank you.

18 MR. OLSON: Just so it's clear in terms of what
19 the transcript says, Mr. Commissioner --

20 THE COMMISSIONER: Well, show it to Mr. Saxberg
21 and see if you can reach some agreement on that if it's
22 down in the transcript.

23 Is your, your point, Mr. Saxberg, that what Mr.
24 Olson has there, you believe was subsequently modified by
25 the witness later on?

1 MR. SAXBERG: Yes.

2 THE COMMISSIONER: All right. Can, can we search
3 for that at some point?

4 MR. OLSON: I think the, the transcript will, of
5 course, speak for itself in, in due course.

6

7 BY MR. OLSON:

8 Q Maybe the best way to, to deal with this is, on
9 the version that Mr. Saxberg believes is, is accurate -- I
10 don't want to get into that -- would it be appropriate for
11 a worker, if, if it's a judgment call between, you know,
12 this could be a 24-hour, 48-hour response, or it could be a
13 five day response, to err on the side of the five day
14 response to give more time to the intake unit to get out to
15 see, to see the child, or whatever the issue was?

16 A Well, I, I think at the end of the day that might
17 be one of those where the CRU supervisor would have that
18 discussion with the intake supervisor, and if the intake
19 supervisor is, is not able to provide the staffing to be
20 able to do the follow-through, and if it doesn't pose an
21 increased risk for the children, increasing the response
22 time, that could be something that's negotiated between the
23 two supervisors and in which case the CRU supervisor would
24 inform the worker of that. That, that would be a plausible
25 explanation, I think.

1 Q That would be the explanation, but would that be
2 an acceptable practice, then?

3 A Sure. The same practice as it would be going up
4 to tier two intake and nobody goes out on the call, you
5 know, within that time frame because they've already
6 conveyed up front that they're not able to do that.

7 MR. OLSON: Could we put on the screen, please,
8 page 36934.

9 THE COMMISSIONER: You, you included in your
10 answer, Witness, providing there, there was no risk to the
11 children, did you not?

12 THE WITNESS: Exactly.

13 THE COMMISSIONER: Yes.

14 THE WITNESS: Yes.

15

16 BY MR. OLSON:

17 Q The response time, though, when you, when you --
18 when a worker looks at a file, they're basing response time
19 on the risk to the child, right?

20 A Yes.

21 Q And what you're saying is there may be some
22 judgment as to whether or not the risk is increased by
23 making the response time longer or not?

24 A I think what it boils down to is if we transfer
25 the case and we don't give it a reasonable time frame, and

1 it's sitting there and nobody's providing the service,
2 there are choices. You know, CRU could, you know, continue
3 to do some work, you know, for an extra day or two if they
4 wanted to do that. They can negotiate it between the two
5 supervisors, and if collectively they believe the matter
6 could be managed risk-wise, then they, then they would have
7 that ability to make that decision.

8 Q Risk-wise within a longer time frame.

9 A Yes. Or a shorter time frame. I mean, we've
10 seen that, too, with, you know, with some of the situations
11 where CRU has made a recommendation to go out, you know, in
12 five days and, and tier two intake has gone out on, you
13 know, in two days as opposed to the five.

14 Q Sure. The document that's on the screen in front
15 of you, do you, do you recognize it?

16 A Yeah, it's the -- it's part of the safety
17 assessment, Shelly Wiebe's --

18 Q Safety assessment.

19 A Yeah, from --

20 Q This --

21 A -- December 1st.

22 Q The form itself -- not, not necessarily the
23 content, but the form, was that something that workers were
24 required to fill out?

25 A If, if it was a protection related matter, then

1 that was the expectation, that you would fill out the
2 safety assessment. The standards had talked about if it
3 was a 24-hour response that you had to fill out the, the --
4 a safety assessment, and, and we had a stronger response
5 than that. We said that you needed to fill out a safety
6 assessment if there was protection related concerns and --
7 you know, and, and we didn't limit that just to the 24-hour
8 response.

9 Q So are you saying, then, workers were directed to
10 fill these forms out where there was a 24-hour response
11 time or something more than that?

12 A Yeah. Or 48-hour response. You know, if there
13 were protection concerns and, you know, you didn't -- you
14 had children that you deemed to be unsafe, you were to do a
15 safety plan as well, you know, as well as complete your
16 entire safety assessment.

17 Q The safety plan is something different from what
18 we see on the screen.

19 A Yeah. Yeah. It's part of the, it's part of the,
20 the safety assessment form, the checkbox.

21 Q I don't recall coming across any safety
22 assessment forms in this particular matter. Are you aware
23 of whether or not any were, were done in this case?

24 A I, I don't, I don't know, to be honest with you,
25 if I remember that.

1 Q I, I think I may have misspoke. I said it was --
2 I asked about a safety assessment.

3 A Right.

4 Q I think you used the term, safety plan.

5 A Right.

6 Q Was the safety plan part of this document, or was
7 it a separate document?

8 A A safety plan was -- it was a tick mark -- a tick
9 box mark, you know, on this particular form. If you felt
10 at the end of the day that there were children that were
11 unsafe, then the expectation was that you would do a safety
12 plan, you know, as well.

13 Q Okay.

14 A And that was to be reviewed by the supervisor.

15 Q Was that mandatory -- first of all, was this form
16 mandatory to fill out?

17 A There were, there were three forms that you had
18 to fill out. There was the, the CFSIS opening and there
19 was the shared CRU after-hours report, and the safety
20 assessment that you were expected to complete if, if there
21 were protection concerns.

22 Q At what point in time would these forms be
23 required to be filled out? By that, I mean, just so it's
24 clear, when the file comes in to CRU or when it's
25 transferred to intake or ...

1 A The, the safety assessment form was to be, was to
2 be filled out and, and discussed with the supervisor in
3 regards to a verification of the response time. And the
4 other -- the CRU after-hours form was completed on transfer
5 to the next unit.

6 Q What was the purpose of this form that's on the
7 screen?

8 A Well, you, you had various categories of
9 incidents -- of severity of incidents and vulnerability of
10 children, and you would take the complaint that came in and
11 you would look through the various categories to determine
12 your response time, whether it was 24 hours, 48 hours, or,
13 or a five day response.

14 Q Okay. And so, for example, if 24-hour response
15 is selected, would that be the recommendation to intake?

16 A If it was a 24-hour response that was selected,
17 as a general rule that would be managed at the CRU by the,
18 the callout team, the backup team.

19 Q So that wouldn't even go up to intake.

20 A Well, it, it would depend on what the, the first
21 response -- sorry about that. The first response would
22 have been that they would have taken the first look at the
23 24-hour response and they would have, you know, intervened
24 and gone out on the respective call.

25 Q Could happen, though, that CRU has already gone

1 out and they determine more is needed within 24 hours and,
2 and select the 24-hour response time when they send it up
3 to intake?

4 A Well, they would have gone out on their 24-hour
5 response and they, they could have gathered enough
6 information, you know, in that one day to make the
7 determination that it would go up to intake if it looked to
8 them like this was going to be a situation that was going
9 to require a longer term of service. There was room for
10 that to happen.

11 Q And if a 48-hour response time was selected, it
12 would automatically go up to intake?

13 A It's one of those borderline calls, you know,
14 because at 48-hour response you were kind of stretching the
15 limits at, at CRU, but if there was a belief that the
16 matter could be followed up with some -- you know, another,
17 another, say, day of intervention and the possibility that
18 the file could be closed, decisions would be made by the
19 supervisor to determine whether we kept that at CRU and not
20 sent that up to tier two intake. Would have been the
21 supervisor and worker's call.

22 Q The other option would have been five -- a five
23 day response time.

24 A Yes.

25 Q That would certainly go up to intake.

1 A Yes. And most, and most 48 hours would have,
2 too.

3 THE COMMISSIONER: Would have what?

4 THE WITNESS: Most of the 48-hour responses
5 generally would go up to intake unless there was a belief
6 that with a few follow-up pieces of business, that it could
7 be resolved and the matter closed.

8

9 BY MR. OLSON:

10 Q I guess, whatever -- I mean, whatever response
11 time's selected, I guess, at the end of the day the
12 important thing is that somebody responds to the concern.

13 A Absolutely.

14 Q While you were assistant program manager, were
15 you involved in any sort of formal auditing of the agency
16 files?

17 A I certainly was involved if there were client
18 complaints, as an example, that came in, that after talking
19 to the supervisor or the supervisor and the worker if, if I
20 still had some, you know, further concerns, I would
21 instruct the supervisor that I'd want to, you know, take a
22 look at the file myself and review it. Sometimes clients
23 would have appealed whatever decision had been made, you
24 know, from the worker level to the supervisory level and
25 they would want to talk to who's ever next in command and,

1 you know, and ask, you know, for an independent review to
2 be done of a file.

3 So I certainly was involved in some of those
4 situations, and I was also involved in some situations
5 where there was kind of custody related battles and it
6 seemed like we had lots of involvement with particular
7 cases and the system -- you know, the child welfare system
8 was being used by both parents to, you know, put pressure
9 on the other parent and the kids were caught in the middle.
10 Certainly was involved in some of those situations.

11 Q Were you involved, though, in any, any formal
12 auditing of files, where you would select files from a
13 worker and, and review it and see what the work was like?

14 A Not so much at CRU because CRU was such a short-
15 term service that auditing probably didn't make much sense
16 there. But some of the auditing that we would do would be
17 when we did our coverage. When we covered for abuse unit
18 or we covered for the intake unit, we would be reviewing
19 probably 15, 20 files when we did coverage in a day, to
20 review for transfers, for closings, and so that would in
21 itself be sort of an individual audit.

22 I, personally, covered the abuse unit for about a
23 month to two months when my supervisor unfortunately
24 suffered a significant injury, so I, I did my APM job plus
25 carried the supervisory for the abuse program

1 responsibility for that period of time. So I would have
2 directly supervised staff there and would have been
3 responsible for all the transfers, closures, that kind of
4 information, as well.

5 Q So in that case you would have seen the work that
6 was being done --

7 A Yes.

8 Q -- is what you're saying.

9 A Directly would have seen the work being done and
10 we would have directly done all the firsthand consultations
11 directly with the workers. And then we -- Pat, Rob, and I
12 would as well probably -- I believe it was every couple
13 months, we would meet with our counterparts from services
14 to children and families at Winnipeg Child and Family, and
15 that would be individuals at Patrick's level and individual
16 at Rob and my level, and we would hear from them about our
17 cases.

18 We would hear about themes that were working well
19 or problematic with the transfers because they would be
20 receiving our work directly transferred from tier two
21 intake or abuse. So we would get a regular update and
22 there would be times that we would, you know, have four,
23 five complaints. We'd have to come back, take those four,
24 five complaints; we'd review those particular files, you
25 know, with the supervisors and provide either a verbal or

1 written report back to our colleagues, part of the same
2 organization, but in the services to children and families
3 program.

4 Q Okay. Were there any quality assurance programs
5 in place while you were assistant program manager?

6 A We didn't have a quality assurance program that
7 was attached to us at 835 Portage. We did have some
8 additional assistance in a couple of initiatives that were
9 run through people that were connected with quality
10 assurance. So we looked at what some of the themes were,
11 challenges that we were having, you know, at, at CRU and
12 tier two intake in terms of volumes of particular types of
13 cases.

14 And with their advice, assistance, and
15 leadership, we were able to develop two initiatives, a
16 parent team initiative and a substance misuse initiative,
17 that came directly as a result of an examination, you know,
18 of open and closures with particular types of cases. But
19 other than that I, I don't recall us doing any other
20 quality assurance, and we didn't have any other individual
21 that was working alongside us to do quality assurance,
22 other than our compatriots that we were sending cases off
23 to, and they were not too shy about telling us when we
24 didn't hit the mark with some cases. That was kind of an
25 internal to Winnipeg Child and Family quality assurance.

1 Q Going to move on to another area. One of the
2 issues in this particular matter was when Mr. Zalevich and
3 Mr. Leskiw went out and talked to Ms. Kematch at the door.
4 You -- you're familiar with the facts of that, right?

5 A Yes, I am.

6 Q Okay. And you know that according to what was
7 written, they did not see -- they did not actually see
8 Phoenix Sinclair, right?

9 A That's correct. It might be helpful if I could
10 -- if we could pull it up on the screen, just so that I
11 could --

12 Q Sure, let's do that.

13 MR. OLSON: 36926 is the number. Can you scroll
14 -- keep going, please. Next page. Keep going.

15 Stop there for a minute.

16

17 BY MR. OLSON:

18 Q So this is the beginning of Mr. Zalevich's
19 recording, and the page number is 36928. Do you want a
20 minute just to read through this?

21 A Sure, that'd be great.

22 Q Just let us know when you need the page to be
23 moved up.

24 A You can turn the page now. It's okay.

25 Okay, turn the page. Went a bit too far, I

1 think.

2 Okay.

3 Okay.

4 Q I don't think there's any dispute or controversy
5 over the fact that they did not see Phoenix Sinclair at
6 this time.

7 A That's correct.

8 Q Okay. The allegation that they were there to
9 investigate was I think what you may have referred to as an
10 non-specified abuse allegation?

11 A Well, the original caller said that she believed
12 this child to be abused, but couldn't provide any kind of
13 information about the physical address where the family
14 lived or no identifying information about the abuse related
15 allegations themselves.

16 Q I think she said abuse and as well as locking
17 Phoenix in the room.

18 A That's correct.

19 Q So based on that, Mr. Zalevich and Mr. Leskiw are
20 going out to determine if there's anything to this, right,
21 anything to this abuse concern.

22 A Yes.

23 Q Generally speaking, it seems fairly basic that in
24 a case like that, the social worker would see the child who
25 is the subject of the abuse allegation. Is that, is that

1 fair?

2 A General practice would be that we would see the
3 child when we go out on a protection investigation.

4 Q And that's -- I mean, that's not -- I won't even
5 use the term "best practice" because it's pretty basic,
6 isn't it?

7 A Well, it, it was in February 3rd, 2004 CRU
8 minutes, I think, where Supervisor Faria outlined it very
9 clearly that when you're conducting assessments you should
10 be conducting assessments by, by wherever possible, seeing
11 the child and seeing the family and seeing the residence,
12 and that was fairly accurately put as to what the
13 expectation of the time was.

14 Q Right. Especially when you're dealing with
15 possible abuse?

16 A I, I think the, the fact that you're out there on
17 a protection investigation would suggest that, that those
18 are things that, that you would normally check out.

19 Q I know you don't like the term -- you don't like
20 to use the word "common sense," but it seems to be fairly
21 common sense that if you're -- you have a report that a
22 child's being abused, you would want to see the child.

23 A Well, you'd want to, you'd want to start with
24 the, with the parent and talk to the parent. And you'd
25 want to do all the steps that they did, you know, to give

1 yourself some kind of assessment whether you believe
2 there's any validity to the, to the report itself. And at
3 the end of the day, it might have been a more full and
4 complete assessment had they seen the child.

5 Q Okay. But my specific question was that it was
6 pretty common sense that you'd want to see the child who's
7 the subject of the abuse allegation.

8 A It would have been advisable to see the child.

9 Q I mean, here you got -- the mother is actually
10 the one who's accused of being the abuser, right, that
11 that's, that's what the concern was?

12 A I'm not -- I really didn't see anything in the
13 record that suggested that it was the mother who was the
14 abuser. I may have missed it, but I don't believe I saw
15 that.

16 Q Maybe just to help you, we can pull that up on
17 the screen at 36927, right under Presenting Problem.

18 A Samantha.

19 Q Yeah, it says that:

20

21 "This person told [the source of
22 referral] that she suspects that
23 Samantha Kematch" --

24

25 A Okay.

1 Q

2 "... is abusing her daughter" --

3

4 A Okay.

5 Q

6 "... Phoenix [Sinclair and] that

7 Samantha may be locking Phoenix in

8 her bedroom."

9

10 A Okay, thank you.

11 Q So that's -- what I said before is correct, it

12 was Samantha Kematch who was --

13 A Yeah.

14 Q -- being accused of abusing her daughter.

15 A Right.

16 Q So in that case, what would you say about relying

17 on Samantha Kematch in terms of determining whether or not

18 there's anything to this allegation?

19 A Well, I think you have to start with Samantha

20 Kematch because they're describing her abusing her

21 daughter, and I think they did start with that. They did

22 talk to her directly about that; she denied that. She was

23 open to them about yelling at her daughter previous to that

24 and recently previous to that. And they did talk to her

25 about the lock on the door. She did confirm there was a

1 bedroom that was shared with her and her daughter, and
2 there was a lock on the door, and, and she appeared to be
3 open and responsive to them in regards to removing the lock
4 as it was definitely a fire hazard and fire danger.

5 In regards to them seeing the child, I think it,
6 it's clear they didn't see the child.

7 Q They didn't see the child, right?

8 A No.

9 Q And that not seeing the child in this, in this
10 case, when you look at it as a supervisor, was that
11 appropriate?

12 A It's, it's hard to say whether it was appropriate
13 or not. Best practice would have been that you would have
14 seen the child. That would have been best practice.

15 Q But wouldn't that just, I mean, just be basic
16 social work practice, that you, you're checking out an
17 abuse allegation about a child? Wouldn't you see the,
18 wouldn't you see the child? That'd be just part of it.

19 A Would have been advisable to see the child.

20 Q And so not seeing the child here, was that, was
21 that appropriate? I mean, you're a supervisor so you know
22 whether or not it's -- you have an opinion, I mean.

23 A Well, if you look under the, the, the standards
24 in regards to protection investigation, the standards state
25 that you're to investigate a protection investigation

1 within ten days and see the person or the family. And I --
2 and, and by our standards, they would have met the standard
3 requirement on there. They were out there before ten days,
4 they did see the parent, so they did see the family. They
5 didn't see the child.

6 Q Are you, are you suggesting now that the
7 standards are actually saying it was unnecessary to see
8 this child or a child when, when they're the subject of an
9 abuse allegation like that?

10 A The --

11 Q I mean, I want, I want your understanding as to
12 what, what's required.

13 A I guess we're having to discern a bit between
14 whether this is a protection investigation or abuse
15 investigation.

16 Q I'm not talking about investigation, just
17 determining whether there's anything to this allegation of
18 abuse. I mean, they substantiated that the door was
19 locked, there was a lock on the door, so that lends -- I
20 would, I would think that would lend some credibility to
21 the caller. You know, going out with the information, the
22 facts that you're aware of, are you suggesting that the
23 standard's that you wouldn't have to see the child?

24 A I'm trying to help to clarify a small but
25 important point that the standards are different if this

1 situation is viewed as a protection investigation verse
2 this is viewed as an abuse investigation. There are
3 different requirements, there are different timelines, and
4 there are different expectations around follow-up and who
5 you need to see. And at the end of the day it is my
6 belief, from reading all the information, that they viewed
7 this not as an abuse investigation but they viewed this as
8 a protection investigation, and based on that
9 determination, they'd actually done what the requirement
10 was under the standard at that time.

11 Q Were they even at the point where they were able
12 to decide whether this was an abuse investigation or, or a
13 protection investigation?

14 A It's a question probably better answered by the
15 worker and supervisor, but it seemed to me when they did
16 their involvement, wrote it up, they believed that they did
17 not have any protection concerns, and as such the worker
18 made a recommendation to the supervisor to close off the
19 case.

20 Q Right. That's without seeing the child.

21 A That's without seeing the child.

22 Q Yeah. So before we get to the recommendation to
23 close and they're closing it based on the fact they don't
24 think there are, there are concerns, but the goal, the goal
25 is ultimately determine whether or not the child is safe.

1 Right?

2 A That's one of the goals.

3 Q And to do that, don't you have to see the child?

4 A As I said, it would have been, it would have been
5 a more complete assessment had they saw the child.

6 Q And when it comes to the standards, you're not
7 saying that there was any question in your mind as to
8 whether or not the standard would require seeing the child.

9 A I'm saying to you that if it's a protection
10 standard, they met their requirement; if it's an abuse
11 standard that you're reviewing based on this being abuse --
12 which I'm not saying that it was, the caller said that it
13 was abuse but was very non-specific in her ability to
14 outline any abuse related concerns -- but the, the
15 expectation in the standards, if it was viewed as abuse, is
16 that you would have had to see the child, you would have
17 had to see the other children that were in the home, you
18 would have had to see the parent or care providers in the
19 home, and you would have had to see the, the offending
20 party if you believe that abuse had happened, with the
21 permission of the and approval of the police, and there was
22 a -- if it was viewed by abuse by our agency and would have
23 gone to the abuse unit, there were 14 other requirements in
24 the abuse program that they --

25 Q Right.

1 A -- would have had to follow.

2 Q But when these workers went out, they didn't know
3 if it was abuse or not. All they had was the allegation
4 that was made, right? Right?

5 A All they had, the allegation that was made and
6 then their involvement in their, their follow-up interview
7 with the mom and the observations with her with the child.

8 Q The mom who was accused of doing the abuse.

9 A Yes, you pointed that out.

10 Q Based on those -- just based on those, those
11 facts -- I mean, whether you characterize it as an abuse
12 allegation or a protection concern, just based on those
13 facts, isn't the first thing to do to find out whether or
14 not there's anything to the concern, the abuse allegation?

15 A That would have been, that would have been
16 valuable and it would have been a more complete
17 investigation had they done that.

18 Q The determination that there were no child
19 protection concerns was something that was made without
20 seeing the child here.

21 A That's correct.

22 Q Is that determination -- is it even possible to
23 make that determination without seeing the child in a case
24 like this? Well, in fact, in this case, I should say.

25 A Is it, is it possible to do that? I think we see

1 an example here, you know, where that's indeed what
2 happened, and that was the recommendation from the worker
3 and it was reviewed and signed off by the supervisor.

4 Q We know what, we know what happened, but you, you
5 as a supervisor -- in fact, the supervisor of the
6 supervisor, would you see this -- or would you be, would
7 you be able to say the child is, is safe, there aren't
8 protection concerns?

9 A No, I have, I have to answer that kind of two
10 ways. The first way would be there were two staff that
11 went out. One of the workers, you know, had seven months'
12 experience in the abuse program. The other worker that
13 went out with the first worker had 15 years of, of
14 experience, most of that at the crisis response unit, was a
15 very seasoned, experienced CRU worker. And at the end of
16 the day, I believe that the supervisor trusted the
17 combination of the information from the two workers at the
18 end of the day and made the decision to close the case off.
19 I -- due to no protection concerns. I do not know what the
20 workload related issues were going on at the time. I don't
21 know --

22 Q But, but you're not suggesting that workload
23 should ever impact a decision as to whether or not an abuse
24 -- whether or not the allegation of abuse is investigated.
25 That wouldn't have a part in it, would it?

1 A Again, back to this being a protection
2 investigation rather than an abuse investigation, in a
3 protection related investigation there have been times when
4 it is really busy and you are having to make choices out
5 there of what you can and can't, what you can and can't
6 follow up on, that some of those difficult choices are made
7 and there are times when children aren't seen. It's not
8 our usual course of action or what we believe that we want
9 to do, and it's certainly not what we, you know, had in our
10 minutes and, and reflected in our expectation.

11 Q The minutes you're referring to are where the,
12 the -- where it's recorded that if there are child
13 protection concerns, workers should get out, if possible,
14 to see the child.

15 A That's correct.

16 Q That --

17 A See the child and, and see the, see the family in
18 the residence.

19 Q Right. Those minutes were recorded February 3,
20 2004.

21 A That's correct.

22 Q That was an issue, and that's something that
23 workers were made aware of.

24 A Absolutely.

25 Q And that's not even specifically talking about

1 abuse concerns, it's just where there's a child protection
2 concern.

3 A That's correct.

4 Q That might be where someone leaves power tools
5 out and the child is at, at, at risk. Right? I mean,
6 it's, it's pretty broad.

7 A It's pretty broad.

8 Q Yeah. And abuse is a little more narrow than
9 that.

10 A Absolutely.

11 Q Okay. So when you're using professional
12 judgment, you have to, you have to look at the
13 circumstances as they present and make your determination
14 based on that.

15 A That's correct.

16 Q And here we had the two workers at the door who
17 had the ability -- I mean, when you say workload, they're
18 at the door at the time.

19 A Yes.

20 Q They could have asked to see Phoenix at the time.

21 A Um-hum.

22 MR. SAXBERG: I, I'm just going to have to object
23 on that point.

24 THE COMMISSIONER: Pardon?

25 MR. SAXBERG: I have to object on that point

1 because Mr. Zalevich gave evidence that he believes he
2 would have asked to see Phoenix and that would have been
3 his usual practice. So that's the evidence before the
4 Commission, not that he didn't care or didn't want to see
5 Phoenix.

6 THE COMMISSIONER: Do you agree with Mr. Saxberg
7 that Mr. Zalevich said he believes he did ask?

8 MR. OLSON: I'm not, I'm not sure about that.

9 THE COMMISSIONER: Well, that's the basis of his
10 objection.

11 MR. OLSON: That's -- I understand the basis of
12 his --

13 THE COMMISSIONER: I, I, I have not reviewed my
14 notes on the point. Mr. Ray?

15 MR. RAY: Mr. Commissioner, I believe Mr.
16 Saxberg's right. I think Mr. Zalevich said it was not
17 reflected in his notes that he asked. It was his practice
18 he would always ask in these types of situations. Based on
19 the way it's documented, he believes he did ask or would
20 have asked. That was, that was what his evidence
21 essentially was.

22 THE COMMISSIONER: Based on the way it's
23 documented?

24 MR. RAY: Based on his recording. He recorded
25 that the children are not in school and were not in

1 daycare. He believed, based on that recording, him asking
2 whether the children are in daycare or in school and, and
3 Samantha Kematch's response that, no, they weren't, he
4 believes he would have asked is Samantha here -- or, excuse
5 me, Is Phoenix here? Answer was no. Is she in school or
6 daycare? No, she's not in school or daycare. So he
7 believed, based on what he recorded, that he would have
8 asked. Also, based on his practice, he would have asked to
9 see Phoenix -- or if she was there, excuse me.

10 THE COMMISSIONER: Well, I think you, you just
11 have to base your question on the basis that it was not
12 recorded.

13 MR. OLSON: Yeah, and that's exactly what I was
14 going to say --

15

16 BY MR. OLSON:

17 Q -- that we don't, we don't know what happened at
18 the door other than what's recorded in the, in the note,
19 right? Mr. Berg?

20 A I just have the record that's in front of me.

21 Q And as, as a supervisor, the supervisor, if you
22 were looking in it, that's what you would have. Right?

23 A Yes.

24 Q If you look -- if -- and if you look at it,
25 knowing what you know today and that's based on what's in

1 the note, would you have expected the worker to do more in
2 terms of asking to see the child, record whether they did?

3 A It's a difficult question, and it could come down
4 to workload. And at the end of the day if I had a
5 seasoned, experienced CRU worker who went out with one of
6 my more junior staff but had seven months' experience in
7 the abuse program, and they met with the mom and they did
8 the steps that they did, and at the end of the day that
9 they were both of the opinion that there were -- that there
10 wasn't validity to the source of referral information that
11 came in, I, I may have made exactly the same decision that
12 the supervisor did.

13 Q When you -- as a supervisor, when you look at the
14 document, documenting here, the recording, there's, there's
15 nothing indicating what questions were asked of Ms.
16 Kematch, right?

17 A Right.

18 Q Wouldn't it be important to have a record of
19 whether or not Ms. Kematch was, was cooperative with the
20 request to see Phoenix, or whether she said Phoenix was at
21 daycare or at school, something setting that out clearly?

22 A You're asking me to respond as if I was the
23 covering supervisor that day?

24 Q Exactly.

25 A And as the covering supervisor that day I might

1 have had those questions. I might have had, you know,
2 questions about what efforts they made to see the child. I
3 do not know what was on their, their plate that day in
4 terms of workload and other things that were happening, and
5 at the end of the day, they, they had options if they
6 wanted to.

7 They could have taken this case, said: We've
8 gone out and done what we need to do; we're going to send
9 this back up to tier two intake. That was an option.

10 The second option that they had is this was a
11 very difficult time for all of us at Winnipeg Child and
12 Family because so many family service units were closed, so
13 we had developed a program at 835 Portage where -- we
14 called it our CRU diversion program which ran out of CRU
15 and we had four dedicated community staff that were
16 available for five day responses.

17 So they had two options that they could have, in
18 the end of the day, chosen to have sent this case to. And
19 they could have said that we want to have this child seen.
20 Those options were open to them. They believed that there
21 were no protection concerns and so, in their professional
22 judgment, they made the decision to close the case. Wasn't
23 that they didn't have options. It's that they believed
24 there were no protection concerns and they were satisfied
25 with the information they'd been provided by the mom.

1 Q And then you as a supervisor --

2 THE COMMISSIONER: Now, Mr. Olson, I think we're
3 just going around in circles now. If you want to ask any
4 questions arising out of that last answer, by all means,
5 but pursuing it much further, I think we're just in --

6 MR. OLSON: And I don't plan on going much --

7 THE COMMISSIONER: -- in a complete circle.

8 MR. OLSON: I don't plan on going much, much
9 further with that.

10

11 BY MR. OLSON:

12 Q But one thing I wanted to ask you about is, when
13 you say they made the judgment -- the workers made the
14 judgment there were no child protection concerns, you're
15 the supervisor looking at it, you'd want to know what the
16 basis of that judgment was, right?

17 A Right.

18 Q And based on what you see here, is there, is
19 there a reasonable basis for the decision to close the file
20 because there's no child protection concern?

21 A What's in the paper record and what the
22 supervisor actually discussed with the respective workers,
23 any information she gleaned as a result of their
24 recommendation to close, I have no information on that, and
25 I would have needed that information beyond what's on the

1 written record to be able to answer that question with any
2 kind of credibility, quite frankly.

3 Q So here there's not enough for you to make that
4 determination.

5 A No, there isn't.

6 Q Okay. Just in terms of abuse allegations before
7 -- I wanted to ask you a little more about the -- what you
8 called the unspecified abuse concern.

9 A Right.

10 Q Were those -- was that unique to this case or
11 were, were those -- did they come in often, or are you able
12 to say?

13 A I, I won't say that they didn't, they didn't come
14 in often, because sometimes they did. But it's very, it's
15 very challenging for us in this particular situation
16 because this -- the caller is familiar to our system,
17 probably familiar with the importance of us getting
18 accurate and timely information, in particular helping us
19 to connect up with the source of referral to be able to get
20 more firsthand information to help us because when you're
21 out there in somebody's home, you're constantly balancing
22 the intrusion to a family's affairs with the protection of
23 the child and the more clarity you can have around the
24 allegations, the better your opportunity to lean on the
25 side of protecting the child.

1 And this entire referral was extremely weak, and
2 I thought the social workers, beyond the fact they didn't
3 see the child, they tried a number of things that I think
4 were, were to their credit. They tried to deal with the
5 locks on the doors. They had some discussions related to
6 Phoenix being abused with the mom, and at the end of the
7 day when they were not getting the information that they
8 needed to validate protection related concerns, then they
9 tried to offer volunteer services to the mom, which would
10 have been another opportunity to keep the branch formally
11 involved in the affairs of the mom, and unfortunately she
12 turned them down. And basically, at that point they're
13 left with two choices: They can see the child or they have
14 the ability to be able to close that case off based on
15 there not being enough grounds to, to proceed under
16 protection concerns.

17 Q I think you went a lot farther than what my
18 question was. It was just simply whether, whether or not
19 you would get unspecified abuse allegations like this. And
20 I think you said that would happen.

21 A Yes.

22 Q And based on that, when you have an allegation
23 like this, is it any less serious than a specified abuse
24 allegation?

25 A I'm not sure that, that anybody can answer that,

1 but I can tell you from 30-plus years in this business and
2 knocking on many peoples' doors as a child protection
3 worker for years, it makes a big difference if I have
4 information that I know to be valid, solid, related
5 concerns, timelines, knowledge of injuries. Knowledge of
6 how those things happened makes it a whole lot easier when
7 you're, when you're intruding on somebody's affairs to
8 ensure that you, you are able to stay involved in their
9 affairs and, and push as far as you can for the protection
10 and safety of children. So that information was crucial,
11 and we tried at after-hours and we tried through Richard
12 Buchkowski and two different opportunities, and we could
13 not get any further information.

14 THE COMMISSIONER: Now did you get an answer to
15 your question, Mr. Olson?

16 MR. OLSON: I'm, I'm not sure. I don't think so,
17 but I think I'm going to leave it.

18

19 BY MR. OLSON:

20 Q I want to, I wanted to ask you about closing
21 files. Was there any pressure in intake or CRU to close
22 files? Do you know what I, I -- I'm not sure if you know
23 what I mean by that, but ... Are you able to answer,
24 answer that question?

25 A Which program? CRU or --

1 Q Go, go with CRU first.

2 A Okay.

3 Q Was there pressure to close files at CRU?

4 A Based on excessive workload that we would close
5 files to close them because there were active protection
6 concerns or no protection concerns?

7 Q Just generally speaking, was there pressure to
8 close files rather than keep them open?

9 A No.

10 Q What about at intake?

11 A I don't, I don't believe that there was pressure
12 to close files and I'm not sure who the pressure would be
13 coming from. From the supervisor or the system? I mean,
14 there's times where there was excessive workload.
15 There's --

16 THE COMMISSIONER: Were you, were you aware of
17 any pressure to get files closed?

18 THE WITNESS: No, sir.

19 MR. OLSON: Thank you.

20 I wonder, Mr. Commissioner, if this is a good
21 time for the afternoon break?

22 THE COMMISSIONER: Yes. Have you much further to
23 go?

24 MR. OLSON: Not a lot.

25 THE COMMISSIONER: All right. Well, I take it

1 you think it might speed things up if you get your break
2 now?

3 MR. OLSON: Yeah.

4 THE COMMISSIONER: We'll adjourn --

5 MR. OLSON: Exactly.

6 THE COMMISSIONER: -- for 15 minutes.

7

8 (BRIEF RECESS)

9

10 MR. OLSON: Before we continue, I just wanted to
11 mention, tomorrow we will need to start a little later than
12 usual, at eleven o'clock, just to accommodate some counsel
13 scheduling.

14 THE COMMISSIONER: I understood that could
15 happen, and that's satisfactory under the circumstances.

16 MR. OLSON: Thank you.

17

18 BY MR. OLSON:

19 Q I want to move now to asking you some questions
20 about comments made in the various reports that were
21 commissioned following Phoenix's -- the discovery of
22 Phoenix's death, okay?

23 A Okay.

24 Q You've, you've reviewed these reports?

25 A Yes.

1 Q Now, the first, first one I wanted to ask you
2 about was with -- it's the Section 4 report and it's with
3 respect to the involvement of Ms. Parsons and, and Ms.
4 Forbes.

5 A Okay.

6 Q You supervised Ms. Parsons.

7 A I did, yes.

8 Q And she supervised Ms. Forbes.

9 A That's correct.

10 Q Now, if you -- if we go to page 41 of the Section
11 4 report, the bottom of the page where the heading's May
12 13, this would begin the background of Ms. Forbes'
13 involvement, and it would continue on till page 43 at the
14 top. Now, if there is -- I, I understand you've read this
15 before. If there is anything you want to comment on with
16 respect to what's recorded in that section, just let me
17 know; otherwise, I'll take you right to page 43.

18 A Page 43.

19 Q Okay.

20 A Yeah.

21 Q Just before I get there, were you interviewed by
22 any of the report writers in connection with this matter?

23 A I was interviewed by Andy Koster.

24 Q Okay. So page 43, under Interview with the
25 Assigned Worker on the case -- that would have been Ms.,

1 Ms. Forbes -- it says:

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19 And then there are a number of bullet points beneath that.

20

21

22

When you reviewed the work that Ms. Forbes did, are you able to say whether it was appropriate to close the, the file?

23

24

25

A I think that the safety assessment called for a 48-hour response and I believe that she was out there in that, that time period. Her assessment of the situation,

1 based on the information she gathered from her meeting with
2 the mom, was that she was not concerned that the mom was
3 doing drugs and she was not concerned at the time of her
4 involvement after seeing Phoenix that the child wasn't
5 doing okay. Her assessment at that time differed from
6 previous workers in that she viewed this as a, as a low
7 risk case at this point and, and made the decision to close
8 the case.

9 THE COMMISSIONER: So the question was, was it
10 appropriate to close it, in your view? If you're able to
11 tell us.

12 THE WITNESS: I can appreciate that it was
13 difficult for -- Tracy's a very, very experienced, very
14 thorough worker, made a lot of efforts to try to find the
15 mom and that took some time. And at the end of the day
16 when she went out, she didn't see any protection concerns
17 that would warrant remaining involved in the case, and
18 it's, it's hard to comment. She didn't have any real
19 information other than past history to make the
20 determination of whether or not she should remain involved
21 or whether this should have gone up to -- from tier two
22 intake gone across to a family service unit.

23 THE COMMISSIONER: So are you saying that, that
24 you're not in a position, then, to say whether it was
25 appropriate that the file be closed when it was?

1 THE WITNESS: Yes, sir, that's what I'm saying.

2

3 BY MR. OLSON:

4 Q Okay. On that same page, if you look under the
5 heading, The Worker's Circumstances beyond the case file,
6 second paragraph says -- after she talks about several
7 colleagues on the unit being sick, says:

8

9 "In addition, she stated that
10 in 2004 as is the case now in
11 2006, Standards were not a
12 priority for workers since the
13 reality is that they cannot
14 necessarily meet them. In
15 particular, high medium or low
16 time frames are not met and
17 workers use their own judgment."

18

19 Is that -- was that your experience, in terms of
20 what she's describing here being accurate?

21 A Well, there's, there's two things in that. The
22 first reference is to the standards themselves, and I think
23 it's, I think it's a view of a lot of child welfare social
24 workers that the standards have a lot of expectations on
25 workers, and there's never, ever been a true look-see at

1 the standards in terms of what an appropriate caseload-
2 workload size for workers would be in terms of needing to
3 meet the standards. So I think a lot of workers at the end
4 of the day try to, as best possible, meet the programs and
5 policies that are put in place in their respective units.
6 I just wanted to comment on that first, if I could.

7 In regards to the response time frames, I don't,
8 I don't believe that it was a general practice -- and
9 shouldn't be a general practice -- that tier two intake or
10 abuse should change the response times at the worker level.
11 I don't, I don't believe that was the, the practice that we
12 had, you know, at that point in time. If at the end of the
13 day the, the two supervisors had chatted about that, as we
14 mentioned earlier, and made a decision due to the fact that
15 they were three staff down and made the decision to move
16 the case to intake and expand the response time, is, you
17 know, is one point, but I don't think it was a matter of
18 course that workers would make the decision to ignore the
19 response times.

20 Q Okay.

21 A I'm not saying it didn't happen, but it, it was
22 not a matter of course.

23 Q She says the -- where it's recorded here that:

24

25 "The assignment of risk and the

1 information comes from CRU and
2 often the right information cannot
3 necessarily be obtained by phone.
4 She said that 'You don't feel that
5 you can help people because you
6 are running on a wheel and it
7 feels like it is getting worse'."

8

9 Do you have any comments with respect to that?

10 A I, I'm not sure what that means, to be honest
11 with you. I can't comment.

12 Q I want to take you to some of the findings in
13 this report. Page 44, please. Finding 28, at the top of
14 the page, says:

15

16 "It would have been good practice
17 to obtain Wes's full name if the
18 worker had thought that he was
19 living in the home."

20

21 And then it goes on to explain that finding.

22 Do you agree with that, that at that point when
23 there was information that, that Wes was providing support
24 to Ms. Kematch, that it would have been good practice to
25 obtain his full name?

1 A It's a tough question because on May 13th, '04,
2 it says the intake worker and a colleague visited
3 Samantha's address, recording identified the home as
4 Sarah's residence. It's unclear to me whether or not the
5 worker learned of where Samantha was at, whether that was a
6 friend of hers, so it's hard to know at that point in time
7 whether or not that was Samantha's home or it was whoever
8 Sarah's home would be, and if it's Sarah's home, I'm not
9 sure that she would have been able to connect the dots as
10 to who Wes was.

11 Q We have heard from Ms. Forbes that it was -- that
12 was simply a typo or misnomer. She was referring to
13 Samantha's home.

14 A Okay. At that time, she would have chosen to ask
15 for that information, probably would have been a good thing
16 to have done, but he certainly was under no obligation to
17 provide any of that information. There was nothing that we
18 would have as any authority to insist that he provide his
19 name, his birth date, or any of that information.

20 Q Question, though, is, should she have asked that,
21 for that information?

22 A If she would have been able to ascertain that he
23 was somehow connected to Samantha --

24 THE COMMISSIONER: Well, I think --

25 THE WITNESS: -- that would have been valuable.

1 THE COMMISSIONER: I think the initial question
2 that got this going was whether you agreed with the comment
3 that it would have been good practice to have obtained
4 Wes's full name.

5 THE WITNESS: Yes.

6

7 BY MR. OLSON:

8 Q If you look at Finding 30, the same page, says:

9

10 "This file should have been
11 transferred to Family Services due
12 to the past history of the case,
13 the mother's possible drug and
14 alcohol problems and the young age
15 of Phoenix...."

16

17 Do you agree with that comment, that -- sorry,
18 that finding?

19 A It may have been -- it's, it's a tough call. I
20 mean, she made a judgment call, a professional judgment
21 call that this was a low risk assessed situation from her
22 perspective and, and her view then, as a low risk case, was
23 that she didn't see it as necessary to be transferred on to
24 family service. Mr. Koster's referencing that with the,
25 the history and the extent of the concerns that he points

1 out, that a referral to family services would have then
2 resulted in more of an ongoing and possible long-term
3 involvement. So probably was a safer position to take to
4 have considered a referral to the family service unit but
5 -- I don't know if they would have accepted it, but it, it
6 could have been something that could have been forwarded to
7 them for their consideration.

8 Q Okay. But do you agree with the statement that
9 the file should have been transferred to family services?

10 A I'm a bit torn. I'm a bit torn because at that
11 point in time her assessment was that the, the mother and,
12 and the child seemed to be doing fine, and part of the
13 issue is that I believe she only had the one contact.
14 Would have been helpful to either have one more contact at
15 least before making that potential decision, probably.

16 Q The next finding, Finding 31:

17

18 "The Statement of Risk for Phoenix
19 was assessed at too low level for
20 the risk factors that were known
21 to exist in the recent past."

22

23 Is that something you agree with?

24 A Probably, because there was, there was a distinct
25 difference in the risk related recommendations of the, of

1 the two workers. One of the workers had suggested that it
2 was from Central -- no, sorry, from the -- I'm trying to
3 remember which unit that was. Northeast intake unit had
4 recommended that this was high risk and, you know, and the
5 worker here determined that it was low risk. And it's,
6 it's, it's a professional judgment at the end of the day
7 and at this time they, they didn't do any kind of a risk
8 assessment on this situation. We didn't have a
9 freestanding risk assessment tool at that point; it was
10 left up to the professional judgment of the worker based by
11 standards on them. Taking competency based training and
12 professional opinion, you know, was that, that this was a
13 low risk case. I think it was probably greater than that,
14 to be honest with you.

15 I'm not sure it was a high risk case, but it, it
16 strikes me that it was higher than a low risk case and at,
17 and at which point would it have been closed when it got
18 vetted through the supervisor or would they have had a
19 different conversation. The worker makes a recommendation,
20 but the supervisor reads, reviews, makes the determination
21 at the end of the day whether they sign off on the closure.
22 And if it's low risk, you might get a different response
23 than you might get if it's a medium risk.

24 Q Would this have been more of a medium risk case,
25 then, in your view?

1 A In my mind, it's more of a medium risk.

2 Q Turn to page 72 of the same report. The, the
3 "C," as you know, stands for conclusion, so this is
4 Conclusion 9 I want you to look at. Says:

5

6 "A Review of previous case files
7 would have found that Kari Wesley
8 McKay had a history of abuse,
9 alcoholism and domestic violence."

10

11 If that, if that history was uncovered -- that
12 is, Mr. McKay's past history was -- became known to the
13 agency through doing some searching -- what influence would
14 you have expected this type of history to have on the file
15 going forward?

16 A I had the opportunity in, in September of 2006 to
17 review all the files, including all the files of Karl
18 Wesley McKay and all the files that he was, he was open
19 with in terms of various partners. And if you would have
20 reviewed three of the files, you would have found nothing
21 on those files. On the fourth file, to do with (REDACTED
22 NAME), you would have found two allegations --

23 Q Just before you go forward, the name you
24 mentioned is a name that will be redacted; that is not a
25 name that --

1 A Oh, sorry.

2 Q -- should be publicized. Just want to make sure
3 the media's aware of that.

4 A Apologize, I didn't know that; thank you for
5 pointing that out.

6 So three of the files, you would have been left
7 with very little in the way of concerns. On the fourth
8 file, you would have had two incidents on Karl's file,
9 shared file, of abuse of small children under the age of
10 one year of age. Both incidents were unsubstantiated, both
11 incidents were abuse related allegations that were checked
12 out by the workers and there was no injuries on the
13 children.

14 The issue around alcoholism and domestic violence
15 -- in particular, the domestic violence on that particular
16 file -- was very serious and it was a very dangerous
17 situation. The domestic violence alone should have -- if
18 -- you know, if that file had have been read, it should
19 have been enough to, to, to tip the balance in terms of
20 wanting, you know, to proceed with, you know, more follow-
21 up family service.

22 Q So in terms of the risk level that the case would
23 have if that information was uncovered, that put it into
24 more of a high risk situation?

25 A Well, it certainly -- from the last experience,

1 would have certainly bumped that from a low risk to a
2 medium risk for sure, because domestic violence is -- was a
3 -- it was a newer area to us, quite frankly, in, in 2003,
4 2005, and we were, we were part of a -- part of a project,
5 the Canadian incident study over at 835 Portage, where
6 they, they used the sampling across child welfare agencies
7 across Canada. And, and one of their major findings of
8 underreporting and follow-through from child welfare
9 agencies across the country was in the area of domestic
10 violence. And the work that they, they had done really
11 highlighted that for us, that domestic violence was
12 something that we needed to really pay particular attention
13 to.

14 Q I just want to make sure I understand what you're
15 saying. In 2004, are you saying that domestic violence in
16 terms of its impact with respect to child welfare was
17 really not known?

18 A It's not that it wasn't know, but I don't think
19 that we had the same appreciation for how to build that in
20 -- you know, into our protection and safety planning. It,
21 it -- but in this particular incident, it was, it was a
22 pretty big red flag.

23 Q Right.

24 A Yeah.

25 Q Because this was pretty extreme.

1 A Pretty extreme. Very extreme.

2 Q Yeah.

3 A Very dangerous situation.

4 Q Certainly wouldn't close the file with this sort
5 of a history out there.

6 A Sure would hope you wouldn't.

7 Q I want to take you now to Rhonda Warren's report
8 which is at Commission disclosure 1802, and specifically
9 page 38008. The bottom of the page, under Samantha Kematch
10 file, says May 11th, 2004. Now, this, this -- what you're
11 seeing here, have -- do you have that?

12 A Yes, I do.

13 Q That, and then the next page after "The case was
14 closed at the Intake level on July 14, 2004."

15 A Yeah.

16 Q That's basically a factual area, but I want to
17 give you the opportunity to comment on it if you do have
18 some comments.

19 A Okay. I'm just going to read it.

20 Q Is there anything you want to comment on?

21 A I think the only thing that I would want to
22 comment on is that whether we made the connection with Wes
23 and the acknowledgement by Mom that she had been travelling
24 with her boyfriend who's a long-distance trucker, and
25 whether or not we used that as an opportunity to determine

1 who exactly the boyfriend was and whether we had the
2 identifying information that we could have then used to
3 crosscheck whether or not he, indeed, was known to the
4 child welfare system.

5 Q And I'm not sure I understand exactly what, what
6 it is -- your, your comment is.

7 A I, I think my comment is I, I can't, I can't
8 determine here, with what's written, as to whether or not
9 we followed up to ask any information related to
10 identification of who the boyfriend was and whether he was,
11 you know, indeed, the same person as Wes and whether he was
12 living in that same residence.

13 Q You're saying it's not recorded, in effect, is
14 that ...

15 A It doesn't, it doesn't say that, that we asked
16 those questions so ...

17 Q Okay.

18 A I've not heard the person's testimony, so I don't
19 know if she asked and just didn't record it.

20 Q All you know is what's in the report.

21 A That's right.

22 Q And the report doesn't show that those questions
23 were asked.

24 A No, it doesn't show it.

25 Q And would you have expected a report like that,

1 if those questions were asked, to be recorded?

2 A I would have hoped that it would have been asked
3 and recorded, and generally the expectation is that you
4 would clarify those questions. And the person's name, if
5 they're living in the residence, they would also then be
6 needed to be added on to the, you know, to the child
7 welfare face sheet, you know, as another party that's
8 living in the home and that, that might have, that might
9 have caused us then to, to ask them further questions about
10 that.

11 Q Just, just on that point -- I'm, I'm curious --
12 if, if the worker had asked Mr. McKay for his name and
13 information -- or Ms. Kematch for Wes McKay's name and
14 information, because that was another option -- if either
15 refused to provide it, would that -- would you expect that
16 would signal to the worker that maybe more needs to be done
17 to look into this person?

18 A Well, it is their right, at the end of the day,
19 to choose whether they share that information with us or
20 not, and part of our responsibility is to try to join with
21 the mom about the fact that we both have a shared
22 obligation to ensure that the children, you know, in the
23 home are safe and that that would be, you know, a
24 reasonable step that we needed to take as a child welfare
25 agency to, to determine that information. If at the end of

1 the day she would have refused, it, it would have caused
2 you some worry. I can't say whether or not it would have
3 tipped the balance for the worker to have raised the risk
4 level or, or made her, you know, arrive at a different
5 conclusion than to recommend closure of the case. I can't
6 say for sure; I really don't know.

7 Q Page 38018. This is the same report, under Risk
8 Assessment.

9 MR. OLSON: And maybe pull the screen up a little
10 bit. Perfect.

11

12 BY MR. OLSON:

13 Q Says:

14

15 "Statements of risk change
16 from low to high without any
17 change in circumstance.
18 Statements of Safety are referred
19 to as Statements of Risk. A
20 family situation may be high risk
21 even if on any given day the child
22 is deemed to be safe.
23 Unfortunately in this case 'low
24 safety assessments' were deemed to
25 be 'low risk assessments' which

1 were not the case. This
2 continuous error resulted in this
3 case being closed numerous times
4 without adequate intervention by
5 the Agency."

6

7 And then there's reference to a recording done by
8 an intake worker in June 2003. It says ... I won't read
9 it out, but it says:

10

11 "Unfortunately this statement
12 was ignored once the case was
13 transferred for ongoing service.
14 Based on this case review it is
15 apparent that Risk Assessment is
16 not universally understood by
17 Agency staff."

18

19 Whose responsibility would it have been to ensure
20 that risk assessment was understood by agency staff?

21 A I'm not sure in this situation. And perhaps I
22 have, you know, some benefit over Mr. Koster, having worked
23 with the staff member that was involved here.

24 Q This is actually from the internal review done by
25 Ms. Warren.

1 A Oh, okay. Knowing the person that had been
2 involved in this particular case, I don't believe that she
3 has a professional confusion between safety and risk
4 assessment. Your question about risk assessment, you know,
5 whose responsibility is that, we didn't have a uniform
6 agreed-upon risk assessment that was in place at that time.
7 We do today.

8 Q But as assistant program manager, did you have
9 any responsibility to ensure that the supervisors and the
10 workers understood risk assessment?

11 A I believe they did and --

12 Q No, but that --

13 A -- they had --

14 THE COMMISSIONER: No, no, the question --

15

16 BY MR. OLSON:

17 Q I just want --

18 THE COMMISSIONER: -- is whether you had any --
19 you had responsibility for that.

20 THE WITNESS: Well, I mean, first responsibility
21 would be for the supervisor to ensure that their staff, you
22 know, had training and knowledge related to risk
23 assessment. Certainly, I would have responsibility for
24 that, and certainly our staff members that had lots of
25 experience like this particular staff member did, would

1 have taken competency based training where risk assessments
2 would have been covered off as part of the training for
3 competency based training. That was an expectation of our,
4 of our, of our staff.

5

6 BY MR. OLSON:

7 Q That was one of your expectations of the staff?

8 A That was, that was an expectation of our, our
9 branch of Winnipeg Child and Family, that our staff needed
10 to take risk assessment related training as part of
11 competency based training. It was a universal training
12 that all the staff had to go to.

13 MR. OLSON: If we could put up page 38020?

14

15 BY MR. OLSON:

16 Q This is still from Ms. Warren's report, under
17 Assessment of New Partners.

18 A Right.

19 MR. OLSON: Move the page up. Oh, sorry. That's
20 38020.

21

22 BY MR. OLSON:

23 Q Now, this again, we've already touched on the
24 issue of looking up Mr. McKay and I won't go over that
25 again unless you want to. Just under the recommendation,

1 says:

2

3

"That if a new partner becomes
involved with a family and spends
any significant time in the family
home, background information on
the individual be gathered, CFSIS
prior contact checks completed,
Abuse Registry checks completed
and if there is reason to believe
the person has had contact with
the justice system, Police
contacted to provide a criminal
risk assessment."

15

16

17

18

19

20

It's my understanding that that -- the, the prior
contact check was something that was always expected and
required of workers when there was a new person identified
as providing care to the child. Is that right? Is that
your understanding?

21

22

23

24

25

A I'm trying to remember. It is one of the
exhibits that we had that I believe I spoke to when I met
with Commission counsel in regards to the -- we had a
criminal risk policy. I can't remember the specific date
of, of when that policy came into effect but it was

1 intended as a policy for us to be able to do these kinds of
2 checks on other individuals that were new arrivers to a
3 family and, and those --

4 Q Just, just before you go on, because I'm not sure
5 you understood my question. It was with respect to prior
6 contact checks.

7 A Right.

8 Q That has a specific meaning for a social worker,
9 right?

10 A Yes, prior contact check is a check within our
11 CFSIS system to see whether there's any previous
12 involvement with the child welfare system.

13 Q And so the specific question was, was, was it
14 already an expectation that a prior contact check would be
15 done when a new person was providing care for a child in
16 the home?

17 A And I, I need to know what the date of that
18 policy would have been at that time and whether it was
19 before or after this date, because we, we put a policy in
20 place. It was in 2004 but I can't remember the exact date
21 of when the policy was put in place, because at the time of
22 that policy being implemented, then it would have, it would
23 have been an expectation for you to, to check that
24 information out.

25 Q Okay. So prior to that policy being put into

1 place, are you, are you saying that workers weren't
2 expected to do a prior contact check as I described?

3 A I don't believe it was mandated anywhere that
4 workers would have had to have done that. It would have
5 been good practice to have found out more information about
6 who the individual was, but some time -- I kind of think it
7 was in March of 2004, but I, I could be wrong on the date,
8 but at the end of the day, at that point it was, it was
9 policy at the branch that you were supposed to make every
10 reasonable effort to determine who the partner was and to
11 work in conjunction with the, the mom, in this case, to let
12 her know that we would want to do those respective checks
13 -- and, and some of that was criminal risk assessment
14 checks and prior contact checks -- to see whether or not
15 any further information could be gleaned about the
16 individual related to a criminal activity or activity
17 across the child welfare system.

18 Q I want to ask you -- now move, move on to the
19 involvement of Ms. Faria and Shelly Wiebe or Willox.

20 First with respect to the Section 4 report, it's
21 Commission disclosure 1, starting at page 45, under the
22 heading, The Sixth Protection Opening: From December 1,
23 2004 to December 7, 2004. This is basically, again, a
24 factual account of what's recorded in the file. Do you, do
25 you -- I want to give you an opportunity, opportunity to

1 respond to anything recorded here.

2 A Sorry, could you tell me the page again?

3 Q Page?

4 A Yeah.

5 Q Is 45.

6 A Forty-five, okay.

7 Q Do you have any comments?

8 A Can you be more specific, comments about ...

9 Q You don't have to comment, but if, if you have
10 any comments with respect to what's recorded there in terms
11 of your understanding or accuracy.

12 THE COMMISSIONER: From just December 1st or the
13 whole page?

14 MR. OLSON: The whole page.

15 THE WITNESS: Oh.

16

17 BY MR. OLSON:

18 Q In fact, if you read that whole page and the next
19 page as well, that will probably shorten things a bit.

20 A I think I'd better just take a second, here.

21 THE COMMISSIONER: Take your time, Witness.

22 That's --

23 THE WITNESS: Thank you, sir. Thank you.

24 THE COMMISSIONER: -- a lot of paragraphs. I
25 know you've seen it before, but still.

1 THE WITNESS: Yeah, yeah. Thank you.

2 MR. SAXBERG: If I could just interject here, I'm
3 having trouble understanding why this witness would be
4 verifying whether another -- whether Mr. Koster's depiction
5 of events is accurate, when this witness has no direct
6 involvement in this matter. All he can do is say is this
7 the same as -- is what Mr. Koster wrote the same as what
8 workers wrote in another report? I don't understand what's
9 probative about asking this witness about how these facts
10 have been recorded, when he had no involvement.

11 THE COMMISSIONER: Well, I guess he's asking
12 whether this witness agrees with, with Mr. Koster's
13 assessment of the situation related to the various events
14 outlined here.

15 MR. SAXBERG: But he wasn't a participant in
16 those events. He can only -- he only knows about the
17 events from reading someone else's recording of them.

18 THE COMMISSIONER: Yes, I think that's correct,
19 but I think if he wants to comment on what's here in, in --
20 you're asking for a comment if he wants to make one.

21 MR. OLSON: Yeah, because I -- what I'm going to
22 do is put some specific comments or findings made by Mr.
23 Koster to the witness -- he was a supervisor at the time --
24 and if it's based on something that's incorrect, then I
25 want to give this witness an opportunity to clarify it. Or

1 if something needs further explanation, to clarify that.

2 THE COMMISSIONER: But, if, if -- but, but it
3 would have to be something he has knowledge about to know
4 whether it was correct or not.

5 MR. OLSON: Absolutely. I don't -- I'm not
6 asking him to comment on anything he doesn't have knowledge
7 of. So he may very well not have any comments with respect
8 to what's recorded here.

9 THE COMMISSIONER: Well, but that -- what do you
10 take out of that answer if he has no comment?

11 MR. OLSON: If he's -- if he has no comment,
12 that's, that's fine.

13 THE COMMISSIONER: Well, I don't think you can
14 assume from that, unless you go through it line by line,
15 that he's agreeing or disagreeing with it.

16 MR. OLSON: No, what I'm going to do is put some
17 of the specific findings or comments that the report writer
18 made that --

19 THE COMMISSIONER: Well, put, put the, put the
20 first one of those to the witness and then I'll hear Mr.
21 Saxberg on the point.

22

23 BY MR. OLSON:

24 Q Page 47, Finding 32 says:

25

1 "This was the first time that the
2 agency was officially aware that
3 there was a 'Wes McKay' in the
4 home and a partner to Samantha
5 Kematch."

6

7 Finding 33 says:

8

9 "The CRU worker and supervisor
10 made the right decision to open
11 the file to Intake for Assessment
12 and Intervention."

13

14 That was done while you were the supervisor of
15 the supervisor, right?

16 A (Inaudible) timeline here. Do you have a
17 reference of a timeline? Is that July two-o-four?

18 Q Well, that -- if you look back at what I was
19 referring to before, it goes through the, the history of
20 this -- of, of Ms. Wiebe's involvement here.

21 A December of '05, okay. Or of '04, yeah.

22 Yes, I was, (inaudible) the assistant program
23 manager.

24 THE COMMISSIONER: All right. So now I want to
25 know what you're going to ask, because I said I would hear

1 Mr. Saxberg.

2 MR. OLSON: So what I'm, what I'm doing, Mr.
3 Commissioner, is putting the specific comments that the
4 report writer's making to the witness with respect to the
5 period of time over which he was the supervisor of Ms.
6 Faria, and to do that I'm -- he needs some context as to
7 what he's -- what kind of questions he's answering.

8 So, for example, the next one would be Finding 34
9 on the page. Says:

10

11 "The refusal to have the file open
12 to Intake as requested is a major
13 error in the Winnipeg CFS case
14 management of the protection
15 file."

16

17 THE COMMISSIONER: And so what would your
18 question be?

19 MR. OLSON: So I would ask him if he agrees with
20 that comment or not.

21 THE COMMISSIONER: Well, offhand, it seems to me
22 that based upon his supervisory responsibility, it's a
23 reasonable question, but if you want to --

24 MR. SAXBERG: No, no I don't have a problem --

25 THE COMMISSIONER: All right.

1 MR. SAXBERG: -- with that question. All I'm
2 saying is Mr. Berg's only knowledge of this matter comes
3 from reading the reports in the file that have only -- that
4 have been given to him to read in advance of this
5 appearance. So he, he can only know what's in the reports
6 -- the Shelly Wiebe report from December 1st through to
7 December 7, and based on his knowledge of the practices and
8 procedures at the time, he can comment on whether the
9 finding is something that he agrees with.

10 THE COMMISSIONER: That's what's, that's --

11 MR. SAXBERG: Yes.

12 THE COMMISSIONER: -- what's being asked.

13 MR. SAXBERG: And that's completely fine.

14 MR. OLSON: Yeah. And the reason for allowing
15 the witness to review the factual underpinning is he may
16 not agree with the way Mr. Koster's characterized
17 something, he may not agree with the facts as based on this
18 compared to what he's looked at, so I just want to be fair
19 to the witness and give him an opportunity to see what
20 facts Mr. Koster's findings are based on, and then to
21 comment.

22 THE COMMISSIONER: That led him to that
23 conclusion.

24 MR. OLSON: Exactly.

25 THE COMMISSIONER: And the question is whether,

1 witness, you agree with that, F34.

2 THE WITNESS: Yeah. I'm not sure I would agree
3 that it was a major error in the case. I think that, that
4 CRU attempted to move the case up to tier two intake, if I
5 read this correctly, and it was returned to CRU. It was
6 reassigned to the same worker that had involvement prior to
7 the case being sent up to tier two intake, so I think that
8 was, that was very wise on the supervisor's behalf for
9 continuity of the case. It's, it's their right under the
10 standards. They have every ability under the standards to
11 be able to look for a credible source, to be able to
12 ascertain safety related to the newborn baby.

13 We are talking about December '04, right?

14

15 BY MR. OLSON:

16 Q That's right.

17 A Yeah. And the hospital staff report a different
18 experience. You know, for mom, they talk about her having
19 prenatal care. They don't have concerns in regards to her
20 usage at that time, if I've read this correctly, and at the
21 end of the day the CRU social worker made a number of
22 attempts to locate the mom, and at the request of the
23 supervisor she followed up with a credible, reliable
24 collateral in the public health nurse. And at the end of
25 the day the public health nurse and her had an exchange --

1 and Shelly Wiebe had an exchange of information. Public
2 health nurse said that she didn't have any, any child
3 protection concerns or safety concerns about the baby, and
4 the decision at that point in time was to close the case.
5 That'd be congruent with, with the standards, and it'd be
6 congruent with the '99 standards, the November '04
7 standards, the January '05 standards, and the current
8 standards we have today.

9 THE COMMISSIONER: So I take it that what you've
10 just recited are your reasons for not agreeing that this --

11 THE WITNESS: Yes.

12 THE COMMISSIONER: -- was a major error.

13 THE WITNESS: Yes, yes, sir. Yes, sir.

14

15 BY MR. OLSON:

16 Q Thank you. The, the investigation that was being
17 conducted, what was your understanding as to who was being
18 -- what was being investigated in this opening?

19 A What was being investigated was the, the birth of
20 the newborn that returned, returned to live with the --
21 Samantha's family.

22 Q So not, not the safety of Phoenix Sinclair?

23 A This, this incident wasn't about the safety of
24 Phoenix Sinclair. It was about the birth of the, of the
25 newborn child.

1 Q There are some other findings on this page that
2 apply to that same time frame. I want to give you the
3 opportunity to respond to them if you like, but I'm not
4 going to review them with you unless you need that.

5 THE COMMISSIONER: Which numbers?

6 MR. OLSON: Finding -- it's actually the balance
7 of the findings of the page, Finding 36 and Finding 37.

8 THE COMMISSIONER: Those that follow 34, you
9 mean?

10 MR. OLSON: Sorry. Finding 35, 36, and 37.

11 THE COMMISSIONER: Right.

12 UNIDENTIFIED PERSON: If we could just scroll to
13 the next page, please? Thanks.

14 THE WITNESS: I can't, I can't comment about the
15 computer data system at this time. I understand there's
16 been some developments with that and so I would, I would
17 probably stand down on being able to comment on that.

18

19 BY MR. OLSON:

20 Q That's not something you'd have knowledge of
21 what's reported here. That's with respect to Finding
22 number 36?

23 A Thirty-six, yes. I mean, I think, I think he
24 articulates that he made the effort himself to try to be
25 able to determine, you know, that information, and, and his

1 response is there so I think it, it stands on its own.

2

3 "The unwillingness of the public
4 health nurse to provide
5 information was regretful and made
6 the possibility of obtaining a
7 birth date for the father more
8 difficult."

9

10 You know, her legal obligation is to, you know --
11 we -- the Child Welfare Act supersedes PHIPA and PHIA in
12 terms of her ability to be able to share information
13 related to protection concerns that she may or may not have
14 had related to the baby. You know, if, if we, if we
15 decided that the obtaining of the birth date for the father
16 -- I would agree with him that it, it made that more
17 difficult, so I think, I think his comment is fair.

18 Q You, you did say you read these reports
19 previously and you're familiar with them?

20 A Yes.

21 Q Okay. I want to give you an opportunity -- and
22 this is to be fair to you -- to make any comments you, you
23 like with respect to the reports, but I'm not going to go
24 through them with you. Is there anything you would like to
25 comment on?

1 A From, from the three reports? Is that your
2 question?

3 Q And the internal report. So that'd be the --

4 THE COMMISSIONER: Well, I, I -- when you look at
5 the volume of them --

6 THE WITNESS: Yeah.

7 THE COMMISSIONER: -- I don't know what -- where
8 that -- what answer you're looking for but --

9 MR. OLSON: I'm not looking for any answer. I
10 just want to give the witness an opportunity to respond to
11 anything raised that he feels he needs to address.

12 THE COMMISSIONER: Well, I think maybe the way to
13 do that is to, is to -- if, if he does, let his counsel
14 bring it out when his time comes because it's --

15 MR. OLSON: That's fair.

16 THE COMMISSIONER: It's a huge question.

17 MR. SAXBERG: Yeah, and I would, I would just say
18 that there are no findings in any of those reports that
19 relate to this witness.

20 THE COMMISSIONER: Well, the question's been
21 asked and I think if there's anything in particular you
22 want to have him speak to, you'll, you'll have the
23 opportunity to do that.

24

25 BY MR. OLSON:

1 Q Just want to ask you now a few final questions.
2 First, how did you learn of Phoenix Sinclair's death?

3 A I learned of Phoenix's death during my time at
4 Animikii Child and Family Services.

5 Q And can you remind us again when that would have
6 been?

7 A I went to Animikii Child and Family on May the
8 16th, 2005, and I left there -- I'm struggling a little bit
9 -- I think it was April of 2006, if I remember correctly.

10 Q How is it you learned of her death?

11 A I may get the sequencing of this wrong. I, I
12 believe we -- I first learned of her, of her passing -- I
13 can't, I can't remember exactly how, but we had involvement
14 with a file at Animikii that had to do with [REDACTED]
15 [REDACTED].

16 Q And I don't want you to give me the specifics of
17 that file. It was -- but you're saying it was through a
18 file that you had involvement with, that had some
19 connection.

20 A Right. And, and we asked for permission from
21 ANCR to be able to go and review their file, just in the
22 event that it had any related follow-up that we needed to
23 do related to the dad, at our time at Animikii.

24 Q Did you have any discussions on a managerial
25 level with respect to your supervision or the supervision

1 of your -- of the workers involved in providing services to
2 Phoenix Sinclair?

3 A I did. I did just prior to my leaving Animikii.
4 I had first involvement with the, the police come to see
5 one of my, one of my staff who had left Animikii and was
6 working at another location. And the police had come to
7 the Animikii office, and so I agreed to meet with the
8 police and they informed me of the fact that they were
9 looking for a previous staff member of mine. And I asked
10 them what it was about and they shared with me that it was
11 about some allegations of information that had allegedly
12 been shared with my staff member, and they were good enough
13 to provide me with a timeline of when that information was,
14 was allegedly had been able to be told to the staff member,
15 and at that point in time I provided them with the follow-
16 up information in regards to how to contact that staff
17 person.

18 MR. OLSON: Thank you. Those are my questions
19 for this witness.

20 THE COMMISSIONER: Thank you, Mr. Olson.

21 Well, now what's the view of counsel? Do we --
22 Mr. Gindin, have you some questions? I'm sure you have.

23 MR. GINDIN: I expect to be fairly lengthy. My
24 plan was to go last, so I'm not sure about the others,
25 whether they're prepared to ask some now or try to do it

1 tomorrow.

2 THE COMMISSIONER: All right. Well, we'll, we'll
3 leave yours over till tomorrow in any event.

4 Mr. McKinnon, have you some questions?

5 MR. MCKINNON: Yes, Mr. Commissioner, and I don't
6 think I'll be lengthy so I, I would suggest --

7 THE COMMISSIONER: So --

8 MR. MCKINNON: -- I could proceed.

9 THE COMMISSIONER: Yes, please, do.

10 MR. MCKINNON: There's one more piece of paper I
11 need, sir.

12

13 CROSS-EXAMINATION BY MR. MCKINNON:

14 Q Mr. Berg, my name's Gordon McKinnon. As you
15 know, I represent the department and Winnipeg CFS.

16 I just wanted to get a bit of -- put some of your
17 evidence in a bit of context. As I understand it, you
18 started working as an assistant program manager at Winnipeg
19 CFS in 2003.

20 A That's correct.

21 Q And you had had some prior experience in intake,
22 but this was -- if I can put it in the colloquial, this
23 was, this was a whole different ballgame when you came to
24 be the assistant program manager at intake at Winnipeg CFS.

25 A I think that's a fair comment.

1 Q And our -- by your own words as I recorded them,
2 this was a steep learning curve for you.

3 A The, the intake piece was a steep learning curve,
4 yes.

5 Q To, to become familiar with and get up to speed
6 with that complex program.

7 A That's, that's correct.

8 Q And you viewed one of your ... One of the
9 important initiatives that you undertook was to try and get
10 a more collegial and friendly and familiar atmosphere
11 between you as a junior manager, if I can use that
12 phrase --

13 A For sure.

14 Q -- and your supervisors and your staff.

15 A Absolutely.

16 Q And collegiality is important to you.

17 A It's, it's important to me as an individual, but
18 far more importantly, it's important that we have a good
19 working relationship because just in the nature of our
20 business if we treat each other respectfully,
21 professionally, it filters all the way down to the way we
22 interact with our, our families out there.

23 Q So you think it's important for the program, as
24 well.

25 A It's important to the, the whole service business

1 that we do, for sure.

2 Q And, and it's an important value, your -- as a
3 personal value, and it's an important value to you as a
4 social worker, and, and you believe it's important for the
5 program as a whole that there be that kind of collegiality.

6 A Absolutely.

7 Q Now, we know that you left this position to go to
8 Animikii in around April, was it, of 2005?

9 A May 16.

10 Q May of 2005. So you were actually in this
11 position for only two years.

12 A Just two years, yes.

13 Q So you had limited experience with intake prior
14 to this, and subsequent to 2005, you went to Animikii and
15 then you came back to Winnipeg CFS after about another
16 year, was it?

17 A Can I just back up for a second? I want to give
18 myself a little bit more of a pat on the back. I, I had
19 lots of experience when I went over to the position, just
20 never having worked with the degree of volume with the
21 intake. So I had responsibilities as a supervisor for, for
22 many years before going there and we ran our own intake
23 programs rurally. But you can appreciate running the, the
24 new, the new case intakes at 835 Portage compared to a
25 rural intake system in Steinbach and St. Pierre, there

1 would be differences and the volume intensity would be
2 that, that different. Doesn't take away from I had a
3 learning curve.

4 Q Let me -- and that's what I'm trying to get at in
5 terms of ... Would you agree with this, that, that just in
6 terms of the experience you had in that job when you came
7 back to Winnipeg CFS, Winnipeg CFS didn't have an intake
8 function anymore. That's obvious. You'll agree with that.

9 A Correct, yes.

10 Q So your experience as a assistant program manager
11 at intake is limited to that two-year period that we've
12 been talking about.

13 A My experience at intake at 835 Portage, that
14 office was limited to those two years.

15 Q And would you agree with me that that particular
16 -- the pace of that work and the volume of that work was
17 not a good fit for you?

18 A No, I wouldn't agree with you on that. I would
19 just say that it probably took me six months to wrap my
20 head around the abuse program, CRU, and intake program
21 because they were, they were new programs to me. So it
22 meant a lot more work and a lot more hours to get up to
23 speed, but I don't think I was out of place.

24 Q When Mr. Olson was asking you questions this
25 morning and there was a great deal of discussion about

1 cases being received at CRU, being referred to intake, and
2 then coming back to CRU, you'll recall that discussion.

3 A Yes, I do.

4 Q And I just want to make sure I'm clear and the
5 Commissioner's clear on this. We talk about general
6 intake; sometimes we use the expression tier two.

7 A Yes.

8 Q Tier one is CRU.

9 A That's correct.

10 Q Correct?

11 A Yes.

12 Q So both -- if we talk about the function of
13 intake, that's tier one and tier two collectively is an
14 intake function. Correct?

15 A I think that's a fair comment.

16 Q And you were responsible for both tier one and
17 tier two.

18 A Yes --

19 Q Certain aspects of it. I, I know there were --

20 A Yes.

21 Q It was a shared position, but --

22 A Yes.

23 Q -- in terms of your --

24 A Definitely.

25 Q -- your reports, you had some reporting to you

1 from tier one and some reporting to you from tier two.

2 A Abuse and intake and community.

3 Q Right.

4 A Yeah.

5 Q But just trying to focus for this moment on, on
6 this --

7 A Okay.

8 Q -- this issue of, of, of CRU and tier two and,
9 and the back and forth.

10 A Yes.

11 Q And there was a great deal of discussion between
12 you and Mr. Olson about, you know, what happens when files
13 -- administratively, how they go up and what happens and
14 how they sometimes are referred down for follow-up. My
15 question to you is this: As an assistant program manager,
16 is it particularly important whether it's in tier one or in
17 tier two, or is it, is it the function, is it the job, is
18 it, is it -- do you see where I'm, I'm going to this --
19 with this? Does it matter from the point of view of the
20 program from intake, whether the follow-up is being done at
21 tier one or at tier two, so long as the follow-up is done?

22 A I think it's important that the follow-up is
23 done; I think that that's crucially important. But the
24 function at CRU, with the volume that they were managing,
25 means that it's going to be a short-term service. You're

1 not going to get the level of potential intensity, the
2 opportunity to connect with the family, the opportunity to
3 join with the family, and the opportunity to work with the
4 family for, for two months, that you could potentially have
5 if the referral goes to the intake unit.

6 Q Yes. And I, and I understand that, but when --

7 A Yes.

8 Q -- when a case is being referred back, it's
9 usually in the context of one more thing needing to be
10 done.

11 A Potentially.

12 Q One or two things needing to be done to make a
13 decision on that case. Would that be fair, that that's
14 when these cases can sometimes be referred back?

15 A It's certainly true. Some, some cases were that
16 way.

17 Q And regardless of whether that one thing or that
18 two things, it's usually an investigation, fair?

19 A Um-hum.

20 Q Regardless of whether that one thing or that two
21 -- or those two things are done follow-up by CRU or follow-
22 up by tier two, in both cases the same work has to be done.

23 A That's a fair comment. If it's --

24 Q And --

25 A If it's a short-term service like that --

1 Q Right.

2 A -- yes, for sure.

3 Q And in both cases the instructions would be not
4 to close that file until safety is assured; is that fair?

5 A Yes, I think that's fair.

6 Q Just a third area I wanted to just clarify. You
7 told the Commissioner that when you started there was only
8 one supervisor at CRU, and that was Diva Farrera
9 (phonetic); is that correct?

10 A Faria, yes.

11 Q Faria.

12 A Yeah.

13 Q We've heard evidence here on -- actually, on day
14 one of the Inquiry that in 2000, 2000 -- I think it was
15 2000 when CRU was first established, it had two
16 supervisors. Were you aware of that?

17 A I was aware of that, but my, my information about
18 how CRU functioned prior to that is fairly limited. I know
19 it had two supervisors, but not when I showed up.

20 Q Right.

21 A There was just the one.

22 Q And, and I'm advised that the two supervisors
23 were, were Diva Faria and Jim Richardson?

24 A Yes.

25 Q And that at some point in about 2002 -- in 2002,

1 Jim Richardson left for another position and there was a,
2 an individual named Rick Manteuffel.

3 A Rick Manteuffel, yes.

4 Q Manteuffel.

5 A Um-hum.

6 Q Who was a supervisor in CRU, and then there was a
7 period of about eight months where there was only about one
8 supervisor. And when you joined, you were successful in
9 convincing the administration to return to two; is that
10 fair?

11 A Yes, I think that's very accurate.

12 MR. MCKINNON: I think those are my questions,
13 Mr. Commissioner.

14 THE COMMISSIONER: Thank you, Mr. McKinnon.

15 Mr. Ray, do you have any questions?

16 MR. RAY: I do, Mr. Commissioner, but I don't
17 expect I would finish my ... I do have some questions, Mr.
18 Commissioner, but I don't expect I would finish today if I
19 started now, given it's 25 after four, and given that Mr.
20 Gindin's going to be after me.

21 THE COMMISSIONER: Well, I'd sit to quarter to
22 five, but that likely won't do it, I take it?

23 MR. RAY: Pardon me?

24 THE COMMISSIONER: If we sat to quarter to five,
25 would that give you enough time?

1 MR. RAY: Possibly. I can't say for sure.

2 THE COMMISSIONER: You'd rather not, I gather.

3 MR. RAY: If we're going to be coming back in any
4 event, I, I'd rather just wait. I may be able to be more
5 concise if I take some time to review this witness's
6 evidence and --

7 THE COMMISSIONER: All right.

8 MR. RAY: -- then come back tomorrow and start
9 tomorrow.

10 THE COMMISSIONER: All right. Is there anybody
11 else who's got a few questions? I assume not.

12 Mr. Khan?

13 MR. KHAN: I may have one question, but I
14 wouldn't mind reviewing my notes.

15 THE COMMISSIONER: You may what?

16 MR. KHAN: Wouldn't mind reviewing my notes --

17 THE COMMISSIONER: All right.

18 MR. KHAN: -- overnight, if I could.

19 THE COMMISSIONER: Overnight. Okay.

20 All right. Now we're, we're adjourning till
21 eleven o'clock tomorrow morning or thereabouts, when
22 everybody's gathered. I think we'll try to sit eleven to
23 one and perhaps take a one-hour noon hour. If it extends
24 another five or ten minutes, no one's going to get upset by
25 that. But that would be our objective for tomorrow.

1 Okay. We stand adjourned.

2

3 (PROCEEDINGS ADJOURNED TO JANUARY 24, 2013)