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

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

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

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THURSDAY, JANUARY 24, 2013

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MR. K. SAXBERG, 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 and Family All Nation Coordinated Response Network and Mr. D. Berg

MR. H. KHAN and **MR. J. BENSON,** Intertribal Child and Family Services

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MR. KHAN: Mr. Commissioner, I just wanted to advise that I, I don't have any questions for the witness.

THE COURT: Thank you, Mr. Khan. Time well spent.

DANIEL RODNEY BERG, previously sworn, testified as follows:

MR. RAY: Good morning, Mr. Commissioner, Trevor Ray for the record. Mr. Berg, my name is Trevor Ray, I act for the Manitoba Government Employees Union and I also act for, for several social workers, including Mr. Zalevich and Ms. Wiebe, who I believe you are familiar with through their involvement in this file.

THE WITNESS: Yes. Yes, sir.

CROSS-EXAMINATION BY MR. RAY:

Q Now, we heard your evidence, Mr. Berg, that essentially workload was always very high and, in your view, workload still is very high. Is that correct?

A That, that's correct.

Q And you stated that there's a high volume of

cases and a very high complexity to those cases and you're including your comments as it relates to the, the workload and cases at CRU; correct?

A Absolutely. Yes, sir.

Q Social workers have testified, Mr. Berg, and I expect or we expect Mr. Harrison to testify and Mr. Harrison was your supervisor?

A That's correct.

Q That services to clients were impacted by high case loads. Would you agree with that, generally?

A Yes.

Q And would you agree with me, generally, that social workers being very busy and the complexity of the cases would have impacted the ability of social workers to meet best practice, at times, as well?

A Absolutely.

Q And would -- it would have impacted the ability of social workers to meet standards, at times, as well?

A That's correct.

Q And it's not that social workers are not striving for best practise or to meet standards but that was just the reality of the system at the time.

A Yeah.

Q Correct?

A That's correct.

Q And would you agree with me, sir, that it also would impact a social worker's professional judgment in how to deal with a specific case, those factors?

A It could.

THE COMMISSIONER: Explain that to me how that could, could happen.

THE WITNESS: Sir, I, I think that if, if I recall from the discussion the other day, in regards to the July 2004 incident involving one of our social workers, Tracy Forbes, and there was questions raised about whether or not she erred in terms of getting the, the birth date of the boyfriend and part of her, her report to Andy Koster was that they were three social workers down at that time in her unit. She had a very difficult time to track the mom down, probably feels horrible about the fact that that's generally a step that we would want to take to ensure that we have the boyfriend's name and to check his respective files and to check his criminal history if we knew that he would have been actively involved with that mom in a boyfriend capacity and living in that, in that placement.

And when those kinds of situations happen, sir, people sometimes are just, knowing they've got five or six other things in behind them that they need to get done and sometimes it's, it's taxing on the mind and they forget

those things and sometimes, with no ill intent, they may cut corners where, if they had a reasonable workload and reasonable timelines they may have taken those additional steps and it, and it may have yielded a different decision at the end of the day.

THE COMMISSIONER: Thank you.

THE WITNESS: Thank you, sir.

BY MR. RAY:

Q Now, we know, today, since Phoenix Sinclair's death, the government has put significant amounts of money into various initiatives to relieve workload. Are you aware of, of that?

A That's true.

Q And we're talking in the millions of dollars that have been sunk into that initiative and that's primarily as a result of a number of the reports that came out subsequent to Phoenix Sinclair's death; is that correct?

A That's correct.

Q Now, I'm not going to read to you the recommendations about workload, there are many other recommendations, but you're familiar with the concept that the reviewers felt workload was too high and they suggested correcting that.

A Yes, sir. And when I spoke to Andy Koster, for

my own personal interview with him, I raised that to his attention and his comments to me were that in all the reviews that he had ever done, at the various places where he had done reviews, that Winnipeg Child and Family's numbers were --

MR. MCKINNON: Well, well --

THE WITNESS: -- extremely high.

MR. MCKINNON: -- may I object? May I object? This is, this is clear hearsay. He's now talking about what someone else told him about other reviews. Mr. Koster is going to be called, I, I just think if that is going to come out it should come from Mr. Koster.

THE COMMISSIONER: Yeah, I think you should limit it to the, to the Koster report.

MR. RAY: Okay. Thank you.

BY MR. RAY:

Q Sir, you, you had -- you gave evidence about supervision and you gave evidence that at CRU, in particular, supervision was often on an ad hoc basis and would you agree with me that because of the nature of CRU and the, the need to often drop what you're doing and go out on an emergency at that moment, that that would be one of the reasons that supervision is more ad hoc as opposed to planned?

A Yes, sir.

Q And that would make supervision more difficult to schedule?

A That's true. And the supervision policy was generally intended for the family service program and we tried to adopt it to fit all our programs as best as possible at 835 Portage. It was a particular challenge at CRU.

Q And I just want to clarify one, one piece of your evidence. You mentioned that this particular case was, I believe you described it as an average case.

A Average to slightly above average, I believe I said. And, and when the -- Karl Wesley McKay became involved, I would say that it probably was, was, was somewhat a little bit higher than that, risk-wise.

Q And that's what I wanted to clarify. When you, when you say average, you're talking about risk. And, and my, my point is that many, many cases that social workers deal with involve people who have a history, a dated history or current history of domestic violence; correct?

A That's correct.

Q And so the fact that we had an individual here with a history of domestic violence was not -- that was not, in and of itself, unique but you're, you're saying that that did elevate the risk slightly?

A I believe that would be a significant red flag for us that would elevate the risk.

Q Okay. But it, it wouldn't make it an atypical case?

A No, sir.

MR. RAY: Okay. That's what I wanted to clarify. Thank you.

Thank you, Mr. Commissioner, those are my only questions.

THE COMMISSIONER: Thank you, Mr. Ray.

MR. RAY: Thank you, Mr. Berg.

THE WITNESS: Thank you.

THE COMMISSIONER: Mr. Gindin, please.

MR. GINDIN: Mr. Berg, my name is Jeff Gindin, I appear for Kim Edwards and Steve Sinclair.

THE WITNESS: Good morning, sir.

CROSS-EXAMINATION BY MR. GINDIN:

Q Yesterday when you were testifying you were talking about the low morale that you came into, I guess, when you started your position in, I think it was April of '03? Correct?

A That's correct, sir.

Q And you said that low morale always affects services. What did you mean by that? In what way?

A Well, if we're, if we're struggling as a staff member, that our workload is too high, if we're not able to have the time to be able to go out with families, develop relationships, connect with the families and spend the kind of quality time that we need to spend with families because we're kind of going from crisis to crisis, that does impact social workers' ability to feel good about the work that they're doing, feel productive about the work that they're doing. That certainly can, you know, impact the morale of how they feel about the job and also if the workload is too high, climbing levels, at the supervisory level or at the assistant program manager level, and we get spread too thin at those levels then we're not there, supporting the staff in terms of being available to assist them with client related challenges that they need support around.

Q That low morale affecting social workers and the services they provide, could well trickle down to the children that you're interested in?

A Yes, sir, it could.

Q Now, with respect to your role as it was called supervisor of a supervisor, I understand you tried not to interfere with respect to some of the work that was going on by going past the supervisor under you to -- straight to the workers that were involved. Correct?

A Generally speaking my practise would be to go

through the supervisor, as its their team, and do that kind of work together, if necessary.

Q So you would work with the supervisor that's under you?

A The supervisor and the supervisor and the staff but always through the supervisor.

Q And I think you said that you would expect the supervisor to come to you for advice if they had some problems?

A Both. I would go to them if I had concerns and they would come to me if they had concerns or wanted to consult on various matters.

Q There's no record here of any supervisor involved in Phoenix Sinclair's case, having come to you for some advice and you have no recollection of that happening?

A I, I could not ever find a record of that, sir.

Q You told us that in May of 2005 that you did some performance reviews of the supervisors?

A That's correct, sir.

Q And that would be about two years after you got the position and started there?

A That's correct.

Q So for that first two year period there were no real performance reviews done?

A There were no written formal performance reviews,

that's correct.

Q Okay. In May of 2005 you then did written performance reviews; is that ...

A That's correct, sir.

Q And where would, where would those be?

A Those written performance reviews would be on the personnel files of each of the individual supervisors.

Q Okay. And as a result of your performance reviews, can you tell us, today, whether anyone was chastised, criticized, improvement suggested, or anything of that nature?

A In my --

MR. MCKINNON: Mr. Commissioner, just as, as counsel for Winnipeg, my -- I don't have problems with the question if he's limiting it to the parties that would be relevant to -- of Phoenix, if he's getting into his whole staff, many of them had nothing to do with Phoenix.

THE COMMISSIONER: I assume he's limiting it to those involved here.

MR. GINDIN: Yes, absolutely.

THE WITNESS: Thank you. Yes.

BY MR. GINDIN:

Q With respect to workers, supervisors, I'm talking about the ones involved in the Phoenix Sinclair matter.

Can you tell us whether your performance reviews resulted in anyone being spoken to, criticized, chastised, whatever, along those lines?

A My performance reviews would, would again not have been in regards to the, to the line staff. The line staff performance reviews are done by their supervisors. My performance reviews would have been only in regards to the six supervisors that I was responsible for. There were, in this particular case, there were three of my supervisors that would have been involved in this particular case. In performance appraisals there are always learning goals, professional development but in terms of direct complaints or direct criticisms related to their work involving this case, I would have had no comment in regards to that because this case was never discussed by any of my supervisors, directly with me, so would not have been reflected in any way in the performance appraisal.

Q All right. You also told us, yesterday, that it was -- and these are your words -- unrealistic for one supervisor to supervise a staff of 10. And I think you were referring to Diva Faria, because that's the position she was in, I think, when you got there?

A That's correct, sir.

Q Is that right? And because it's unrealistic I presume that her decision making would be affected to some

degree by that, that type of workload?

A Well, the nature of the business at CRU is, is very intense and it's high risk cases, lots of times, and there is always the potential for human error. When you are overloaded with the kinds of load that having 10 CRU workers reporting to you could potentially create that situation.

Q You don't have as much time as you would like to spend on a particular matter?

A That's right.

Q For example.

A And, and workers might get a little tired of lining up at your door and waiting.

Q In fact, you used the word it could be dangerous to --

A It's, it's, it's possible.

Q Yeah. And I think you said that one of the reasons it could be dangerous, because a person could easily miss something, due to the volume of work?

A That's correct.

Q And, of course, the volume of work does not just include receiving phone calls, but I think it's become clear here that there's a lot of reading that, that in many cases ought to be done at least.

A That's correct.

Q Previous histories, that kind of thing?
A That's correct.
Q All right. You were talking about CRU, generally, as a place that would keep a file for a shorter period of time, 24 hours, sometimes 48 hours; right?
A That's correct.
Q With respect to the involvement regarding Ms. Wiebe, for example, she had the matter from December the 1st to December the 7th, so that was a six day period.
A That's correct.
Q So obviously that's an example of where someone might decide it's worthwhile to keep a file a little longer and pursue it further?
A I believe, I believe the rationale around that was that they attempted to send the case up to tier 2 intake --
Q Right.
A -- and the case was returned from intake to CRU, if I'm correct on that, sir.
Q Right, it was. But that -- whatever the reason was, the point was that they did keep the case?
A That's correct.
Q As long as six or seven days in that particular involvement?
A I don't know if it would have been a total of

that much but, but from that timeframe it, it ended up being serviced by CRU --

Q Yeah.

A -- during that timeframe.

Q The evidence is that it was opened December 1st, closed December 7th. That's longer than CRU would usually have a file?

A That's correct.

Q But obviously the discretion was exercised in favour of keeping it longer, maybe making some further checks and then being satisfied, I presume?

A Yes, I believe so and in consistency with the same worker receiving the case back after the decision at tier 2 intake not to accept the case.

Q Right. And because of the way the notes or lack of them, we don't really know why it wasn't accepted or what the discussions were about that, do we?

A I have no knowledge of that, sir.

Q What would you expect CRU to do, if you were in a position where you couldn't really know if a child was safe or not, based on the information that you had.

A Are you referring to the December 1st, 2004 matter, sir?

Q No, just generally for now. You have a few days with a matter and you can't really decide, based on what

you know, whether a child is safe or not. In fairness to you, I'm referring more to the March '05 matter --

A Right.

Q -- where the child wasn't actually seen. All right? So if you have a situation where you don't really know if the child is safe or not because you haven't seen a child, how do you think that should be handled?

A Well, I, I believe in the, in the March two "O" five incident there was challenges in terms of first and foremost locating the family, they didn't have a physical address.

Q Let's see we agree they did a good job in locating the family?

A Excellent job, they did. I think --

Q All right. Let's move on to what happens when they actually go out there now.

A Well, they, they, went out there smartly, I think they went out there in, in a pair. They were out there with Chris Zalevich, who was somewhat new to CRU, he had seven months experience in the abuse program --

Q Well, before you repeat the entire reasons you've already given us, often, I'm asking you now, you're faced with a situation where you don't know whether a child is safe or not because you haven't seen the child, you can't tell whether there's bruises on the child's face, you don't

know whether the child is actually in a bedroom crying, or injured, you just haven't seen the child.

A So you're not interested in, in how this got framed because it's --

Q Well, we all know, we've heard it many times --

A All right.

Q -- how it came to that particular conclusion.

A All right.

Q But I'm suggesting to you that when you don't know if the child is safe or not, wouldn't it be a good idea to maybe try and wait a little longer, keep it open perhaps another day like it was in December of '04?

A I think I've already testified that our, our practises and procedures were that, wherever possible, if a child was the subject of a protection concern it was the practise at CRU that the child and the home should be seen and, in this particular situation, the child wasn't seen and in best practise at CRU, that's a step that, that, that should have happened.

Q Right. So a reasonable option would have been keep it open for another day, at least try again to see the child?

A There, there were three options, sir, I think that were open. That was one option.

Q Right.

A The second option that was available is that we had created, in early February, a partnership between the CRU program and community program that was under my responsibility and we set aside four CRU workers to be able to take five day response cases directly from CRU. So that was a possibility, at the end of the day, that it could have gone there and they could have gone out and saw the child.

Q All right.

A The third possibility is it could have been returned to tier 2 intake and tier 2 intake then could have made the decision to go out and see the child.

Q All right.

A But that was not what the assessment that was done by the worker and by the supervisor.

Q But those are reasonable options, obviously?

A Those are options.

Q Yeah. And you did tell us that perhaps it could have been more complete than it was?

A That's correct.

Q Correct? Now, let's get to the, the actual scenario that's taking place on March the 9th and you've read that over and you know what took place with the workers, Zalevich and Leskiw; right?

A Yes.

Q We know that Samantha didn't let -- wouldn't let them into their suite, met them in the hallway, we know that; right?

A That's correct.

Q And we know, as well, that at least the reason given was that she had a visitor?

A That's correct.

Q And I believe Zalevich testified that there's a confidentiality issue when someone else is in the house so they remained out in the hallway; right? One thing I suppose they could have done is ask Samantha, can we come back when you don't have a visitor?

A That's a possibility.

Q Yeah. We know that Samantha went into her suite and actually brought one child out.

A That's correct.

Q I presume whoever was in the suite would know that she's taking a child out in the hallway, we'd think. They could have said well how about bringing the other child out now.

A What other child are you referring to, sir?

Q Phoenix.

A Do you know that Phoenix was in the apartment?

Q Well --

A I don't have that information.

Q Well, we don't know.
A Oh.
Q There's no -- there's nothing on the file, as you might know now. All we know is that she's not at school and she's not in child care, according to the report. The question was asked and the child was not in the those two places.
A She was too young for school, I believe, sir.
Q Pardon?
A I believe she was too young for school.
Q Yeah. But the question was, is she in school, or is she in child care? The answer was no, she's not in child care, and she's not being registered until September, I think was the evidence. So nothing in the file about whether -- so where is she, for example? There's no question like that asked; right?
A There's nothing in the file that I saw, sir --
Q Yeah.
A -- on that.
Q And it doesn't appear to be a question like who else might live here because we know from the previous reports that we know of Wesley, with respect to Ms. Forbes, having answered the door many months earlier; right? So there doesn't appear to be a question about who else lives here. Right?

A Not that I'm aware of, sir.
Q And you've told us that's one point that if there was some information about this fellow, that would change the risk dramatically. Right?
A In regards to?
Q Wes McKay.
A Karl Wesley McKay.
Q Yeah. So there is certainly a number of questions or concerns that could have been raised at that time and you've admitted, already, that the file might have been kept open longer, an appointment could have been made to come back when there was no visitor, for example, and if those things were done we might have a more complete report?
A That's correct, sir.
Q You were talking about the Phoenix Sinclair file generally, and I think you said it was kind of an average risk routine kind of case?
A In comparison --
Q Yeah.
A -- to my experience there are -- yes, I agree with that.
Q In comparison to other cases?
A Yes.
Q And the fact that there are other cases that are

very serious doesn't really make this one less serious?

A That's correct.

Q It's just different; right?

A It's just different.

Q Yeah. You indicated that one of the things that would clearly make it a higher risk was information about McKay, Wes McKay?

A That's correct.

Q Yeah. And I think you said, and maybe I have this wrong, but you said that it would make it a little bit higher?

A Well, I think --

Q In terms of risk?

A Pardon me?

Q In terms of risk, I think you used the phrase it would make it a little bit higher?

A Yes. Yes, I did say it would make it higher.

Q I'm suggesting to you it would make it a lot higher, based on what we know about Wes McKay and his background? You're not prepared to concede that?

A No, no. No, I, no, I think I want to be careful with that. My file reviews, when I looked at Karl Wesley McKay's four files and I think I've repeated that here, yesterday, is there were two outstanding abuse investigations regarding children across four files that I

reviewed and both of those were unsubstantiated, children were not injured, children did not have injuries, as was reported by the original callers and the issues in regards to Karl Wesley McKay were to do with substance misuse, which is always a concern --

Q Right.

A -- and serious domestic violence related to one of his partners. So it would have increased the risk, I don't know if it would have, you know, now put it extremely high risk but it certainly would have increased the risk.

Q And serious domestic abuse.

A Serious domestic abuse.

Q Is a serious problem, particularly when there's children in the house.

A Can be, sir.

Q Bad enough on its own but if there's little children around it's even worse. Correct?

A It can be concerning.

Q Were you aware that one of his probation officers had written a report saying she was afraid to be alone with him?

A No, sir, I wasn't aware of that.

Q And she --

A No record on our file of that.

Q And suggested that he should, he shouldn't be

taking care of children?

A No, sir, I have no information of that.

Q But surely if you had known those things it would have even increased the risk higher?

A That would have caused us to consult more with the probation officer, sir.

Q You were talking yesterday about the -- an involvement that included Tracy Forbes' work. Do you recall that?

A Yes, sir.

Q And it sounds like that was the first time that Wes, Wes' name comes up. He answers the door, in fact. Do you remember that?

A That's correct, sir.

Q And we talked about the fact that perhaps more information should have been gleaned about him and from him, if possible, at that time. Do you recall that?

A I recall that, sir.

Q Now, according to the report filed by Forbes, she indicated that, according to Samantha, Wes was her main support and stayed there whenever he was in town. So that's significant; correct?

A Yes, sir, if that was the information provided, significant.

Q And we know that in December of 2004 his

involvement becomes even more so because he's now the father of the next child that's born?

A That's correct, sir.

Q So the knowledge about him seems to be kind of increasing; right?

A That's correct, sir.

Q And, of course, by the time we get to the March '05 incident, we now know that he's the father of one of her children and the record doesn't seem to reflect any questions about who else lives here or what can you tell us about Wes McKay or who he is. That would have been important information to inquire into?

A I think that's a fair comment and I did notice when I had reviewed the file that there was information that was taken by the after hours worker related to the after hours report where there was a document cut and pasted and, and sent forward to the CRU that did not include Karl Wesley McKay's name and information on that record.

Q Um-hum. It should have?

A It would have been helpful.

Q Yes. Now, we were talking yesterday about notes and I think you were asked whether you knew that people were, were shredding their notes and I think you said you didn't know. Am I right?

A That's correct.
Q Now, as program manager or assistant program manager, you should know that, shouldn't you?
A Well, I would only know that, sir, if it was brought to my attention or I learned of it.
Q Yeah. You would expect that something like that might be brought to your attention, someone might ask is it okay to shred our notes or not, or what do you think about it?
A Generally I think they would ask their supervisor that first, sir.
Q Yeah. And it might not make its way to you?
A Might not.
Q But certainly if you knew that was going on you wouldn't have been in favour?
A Certainly want to ask some questions, sir.
Q As you put it, I hope the notes would be preserved was just a polite way of saying they should be taking those notes?
A That's correct.
Q And keeping them?
A Absolutely. Especially if they were pertaining to file information.
Q And especially if there might be something else in those notes that might not have found their way into the

pile?

A That's correct, sir.

Q And the worker who puts things into a file obviously uses their own judgment to decide what they think is relevant and should go in, clearly?

A That's correct.

Q Which might be different than what I might think is relevant or the Commissioner might think is relevant. Right?

A That's correct.

Q We were talking about standards and we've heard lots of evidence about how standards were problematic and I think even Ms. Faria told us that it was confusing, there were drafts and manuals and, and redrafts and all of this going on and, of course, you've also got policies and other manuals, as well; right? The -- and there was no training, really, with respect to whatever the standards were at any given time? Or --

A Not at, not at that time, sir.

Q Yeah. Did you ever feel that there were too many manuals, and guidelines and policies and all of that?

A I did, sir.

Q Yeah. And perhaps not enough common sense which is a word I, I know you don't like to talk about but I do.

A No, sir, standards don't have anything to do with

common sense, they're --

Q Okay.

A -- guiding principles for us to follow.

Q Yeah. There's a lot of things that can't fit into a category?

A That's true.

Q Which means that people have to use their discretion and their judgment?

A Professional judgment, yes, sir.

Q Yeah. And sometimes different workers might disagree on the right way to do something?

A Yes, that happens.

Q Yeah. You said that with respect to a March '05 incident you may have made the same decision but, on the other hand, who knows, you may have made a different decision; correct?

A That's correct.

Q But when it comes to whether a child ought to be seen, if you're trying to see how they are, common sense is clear there, best thing would be to see the kid?

A Best practise would be to see the child.

Q Now, we've heard several social workers talk about pressures, workload issues, case load issues, things perhaps they wish they knew, all of those kinds of things. Would you agree that it's a part of being a good social

worker, or a good anything, really, to realize upon reflection that maybe you could have done something different or something better?

A That's how we learn, sir.

Q Yeah. I think, in talking about Ms. Faria, you said at one point you used the phrase I have to trust her judgment; right? I don't know if you remember saying that but my notes reflect that.

A I have to trust the judgment of my supervisor, is that what you said, sir?

Q Yeah. I think you used the word I have to trust her judgment. Well, in fact, you don't have to trust her judgment, do you?

A I --

Q You can disagree?

A I certainly have to trust her judgment, if it wasn't brought to my attention, sir.

Q No. But if it was and you were aware of a certain situation you're perfectly free to question it and re-evaluate it and perhaps disagree.

A That's a different question, sir, but yes --

Q But that's correct.

A -- you're right.

Q And you would expect that Ms. Faria, herself, also has that power and authority to have a look at what's

written, what's recommended, consider it, analyze it and maybe disagree.

A Yes, sir.

Q Right? Now, I want to talk to you about closing files for awhile.

A Okay.

Q And you've already said, I think, certainly yesterday, I'm not sure if you said it this morning but with respect to closing files, and I think it was yesterday, circumstances may warrant keeping a file open longer than 24 to 48 hours by CRU?

A That's correct, sir.

Q Once a file is closed there's no more monitoring of that matter, it's --

A That's correct.

Q -- closed?

A That's correct, sir.

Q So closing a file is very serious, and could be very critical, as far as decisions go?

A It's important that you're careful when you make the decision to close a file, sir.

Q Because of the fact that there's no monitoring afterwards, in particular?

A That's true.

Q And I think you told us that you would expect the

closing supervisor to read the reports before approving the recommendation brought to them by the workers.

A That was our practise at the time and was in our, in our intake policy manual for CRU and tier 2 intake.

Q So there -- they weren't just a rubber stamp, they were someone who would have a look, read materials, and make their own decision.

A Well, the, the worker and the supervisor I believe I, I testified, generally speaking, on closure there is to be a review. I believe I testified yesterday that closure recommendations that came in from after hours would come to CRU and the supervisor at CRU would review those files, in particular.

Q Now, specifically with respect to the March '05 involvement, you would agree, would you not, that any worker who is going to become involved in a matter, even at CRU, would be, would be wise to read the history, get a feel for what's going on prior?

A It's, it's general practise to, to look at the information on CFSIS where workload allows you to do that.

Q In this case we're told that they received the report from Ms. Davidson, who had took the original referral, and other than that, that was pretty well the information they had and then they went out to the -- they knew of Richard Buchkowski's effort a day or two before but

other than that, that's basically the information that they had.

A That information then would have been about the history, sir.

Q What's that?

A From the after hours worker.

Q Yes. But I'm talking about the previous history of the, the file in general. It would have been wise to have that information, as well.

A Sometimes there isn't time, sir, to go through the entire files.

Q Whether or not there was time, it would have been better to have it.

A It's always better to have it but time is a factor and, and workload is a factor in those kinds of discussions and decisions.

Q Yeah. For example, with respect to the conversation that took place with Samantha it sounds from what we read that the worker is in a position where you're basically stuck with whatever she has to tell you. You tell her that there's an allegation that's come in and she attributes it to maybe someone heard her yelling, for example. That seems to be accepted on its face. Correct?

A From what the documentation indicates, I would have to agree with that.

Q If there was a history that that worker had of all -- of previous involvements in the history of several years of contact with her, in terms of how she responded and things of that nature, that might have been nice to know?

A I think so.

Q Yeah. As a matter of fact, if we can have a look at page 43, if we can bring that up. If you look in the top paragraph of that page, that goes back to the report you were discussing, Mr. Koster's report, and there was a discussion there about Tracy Forbes' involvement some time prior to the March incident that we're talking about and right at the beginning it says:

> "The worker indicated that if she had known ... Wes' last name she would have contacted the police to get past history and done internal record check."

You saw that? And you would agree with that?

A Yes, sir.

Q So far? Then it says:

> "She said that it was difficult to

elicit information from Samantha and said there was a question of how far she could push for information."

Now, that's a good example of knowing the way a person has responded in the past in terms of how you would judge what they're telling you now; correct?

A Is your point, sir, that Samantha, information at times needed to be checked?

Q Yes.

A If you had read this paragraph that would have been helpful to have had that information.

Q So if Chris Zalevich or even Diva Faria later were to have this kind of history before them, they might take a second look at what Samantha had to say about the abuse allegation.

A Sir, I have no idea what kind of information they had before either one of them and, and what they checked.

Q Well, she told them, she told them she may have yelled at the child, that was basically her response, and it was accepted. You've just said that a few minutes ago.

This is information going back earlier in time, that might have given them a little idea here about the way Samantha has responded in the fact, in the past, it might

be difficult getting info from her. It would have been a nice piece of additional information to have.

A It would have been good information to have had.

Q And that's just one point I'm raising, the file was there for years, you know that?

A That's correct.

Q All right. With respect to closing files, you -- we were talking about some policy, some guidelines and you were giving an example of when you might want to kind of hang on to files, you said a little longer, and you said, like, for example, follow up with school. Do you, do you remember that example you gave?

A Yes, sir.

Q Yeah. Another example would be like in the March '05 incident, follow up with the mother, herself? As in can we come back and see you tomorrow?

A Oh, it was an option --

Q Yeah.

A -- that was available to them.

Q And I think you said when closing a file the overriding concern is the safety of the child. That's clear?

A Yes, sir.

Q And you would look at whatever information is available; correct?

A That's correct.
Q And in this case, in March '09 or March '05, no one could say with any clarity that they knew whether or what condition Phoenix was in because she wasn't seen?
A I believe that's accurate, sir.
Q And so if you're looking at whatever information is available, I take it if you needed more information you ought to go get it, if you can; right?
A To make it a more full and complete investigation that's -- that would have been a practical --
Q Yes.
A -- best practise step to have taken.
Q Now, intake, I think you said, generally has a little more time to do things?
A Yes, sir, they keep cases open for 45, 60 days, probably tops about 90 days.
Q Correct me if I'm wrong, but my notes indicate that you said if intake couldn't meet the response time recommended by CRU they might send it back?
A That's correct, sir.
Q So intake, who has more time, is sending it back to CRU, who has less time to look into things, is that the way it works?
A I, I think it's a tough one to answer that question. Intake that's short of staff or has workload

expectations where they can't respond to this matter in the response time recommended would be doing the responsible thing by bringing that back to CRU's attention and asking them to follow up on that.

CRU has it for a shorter period but CRU had more staff.

Q All right. Now, just with respect to the walk of shame that we were talking about, and I'm not suggesting you coined the phrase or anything like that, but does it refer, essentially, to intake being ashamed to go back to CRU and telling we're not accepting your file. Is that essentially what it refers to?

A No, I don't think anybody at intake would be shy about walking down to CRU and, and saying we can't manage this due to workload, at the end of the day bringing it back and saying can you do certain pieces on the case or take the case back.

Q We don't know exactly how it happened here though.

A No, sir, we don't know, it's not documented.

Q And that -- I take it that people at intake and the people at CRU know each other?

A Very well.

Q And they work together?

A Very well, yeah.

Q Right? There is a collegial atmosphere that you helped create?

A I believe it took us about a year, sir, and I think it was a very collegial working relationship. Our numbers of concern in that area became minimal.

Q So the idea that these people that you worked for or with, pardon me, and you have a collegial relationship with, that would make it easier, for example, to try again if they had rejected something and you thought they still needed some work to be done, would be such a big deal to say well, let's try this again and go over there and see if they'll take it this time.

A Are you referencing the March '05 incident, sir?

Q In particular.

A It was definitely an option.

Q Yeah. Because one of the things we know after it was rejected was we simply knew more.

A Yes. And we went out on the call.

Q And --

A At CRU.

Q -- and got to speak to the mother and knew that she wouldn't let them in the house, and various things; correct?

A Yes.

Q So --

A And when we reviewed it for closure we also knew, at the end of the day, the child hadn't been seen, so that was an option.

Q So that was an option. Now, this collegiality that you tried to instill, did that have any effect on, on you doing performance reviews with all of these people that you've become buddy-buddy with?

A I'm not sure I know what the question is, sir.

Q Is there a conflict, maybe, there that you're, you're doing performance reviews of, of this group of people that you have a very collegial relationship with and does that make it a little harder to, to --

A Not really, sir. I make it my own professional practise to keep my personal and professional life separate so no, not an issue.

Q And that's always easy for you to do?

A Never easy, sir.

Q All right. You were talking about Mr. Buchkowski, in particular, the other day, yesterday, and we know that he went there a couple of times and didn't really see anyone; correct?

A There was a lock on the outside --

Q Yeah.

A -- of the door, he couldn't get in, sir.

Q And you were saying that some of the things you

would need to know, for example, is -- I think the question had to do with the lack of specificity with respect to the abuse allegation, it wasn't too specific, it was kind of vague. You were talking about that; right?

A Yes.

Q Yes.

A I think Richard tried to get that information.

Q Yeah. And you said that you need to know things like when was the child injured, how was the child injured; right?

A It would be very valuable to have that information, sir.

Q Most important part would be if the child is injured.

A Yes.

Q Correct?

A Absolutely.

Q That's where seeing the child comes in; right? Again.

A Yes, sir, best practise.

Q I think you said if you felt a child was unsafe, at least -- and correct me if I'm wrong, maybe this is a new policy, you -- there should be a safety plan developed?

A That, that was part of the safety assessment at CRU.

Q At that time?

A At that time. If a worker's assessment was that a child or children were unsafe the expectation was that they would put a safety plan in place and that would then be reviewed by the supervisor.

Q And if you didn't really know, I guess the most logical step would be, as we've said many times already, would be nice to find out?

A Yes, sir.

Q And when you were talking about best practise, yesterday, in additional to telling us that seeing the child is indeed the best practise, you also mentioned that you should see the residence; right?

A That was an expectation.

Q Yeah.

A Wherever possible.

Q Particularly if the complaint that comes in has to do with someone being locked in a bedroom in that residence?

A Best practise would have been --

Q Yeah.

A -- to see the child and see the residence.

Q And I think you told us that standards and policies don't always take context into consideration. Correct?

A I don't believe those were my words, sir, but I --

Q But you agree with that? I think words to that effect were said. Would you agree with that?

A That standards and policies don't take the context --

Q Of a particular situation.

A Of a particular situation.

Q Into consideration.

A I think that's a fair comment.

Q Because -- and you've mentioned this earlier, not everything fits into a category or a rule. It's not as though you can open a book and say here's what we should do. Right?

A You still, you still need to exercise your professional judgment.

Q Yeah. And the idea of checking out a new partner, who comes on the scene, that's a good practise, clearly, you would agree?

A It is but it's a little more complicated than you're presenting. Some of our, some of our families, some of our moms, will have multiple partners, they'll have partners for a day or two. It's, it's a challenging discretionary call for the worker, you know, to make that decision, when is the appropriate time to figure that out.

Q I'm not suggesting it's easy, necessarily, to get what you want.

A Yes.

Q But when a new partner enters a home, it's always good practise to find out what you can about that person.

A In particular if that partner is someone who is staying around, sir.

Q Yeah. And that's a good idea, whether it's written down in some manual or book, or anywhere else, is it? Isn't it?

A That's right.

MR. GINDIN: Those are my questions. Thank you.

THE WITNESS: Thank you, sir.

THE COMMISSIONER: Thank you, Mr. Gindin. Mr. Saxberg?

MR. SAXBERG: Thank you, Mr. Commissioner. Good morning, Mr. Berg.

THE WITNESS: Good morning, Chris.

RE-EXAMINATION BY MR. SAXBERG:

Q The evidence seems to -- that the Commission has heard, seems to indicate that the -- that intake didn't accept the recommendation from CRU in December of '04 or in March of '05 and -- to take the file and Ms. Faria testified that that was a factor that she considered in her

decision to close the file at CR, RU. Was that a relevant factor for Ms. Faria to consider in making that decision?

A I believe it was, sir.

Q You were asked by Mr. McKinnon about whether you felt that your position, your position that you took up in April of 2003, as an assistant program manager at intake, was a comfortable fit for you or words to that effect.

My question is, had your supervisor, Mr. Harrison, ever raised any issues to you with respect to your capacity and ability to do that job?

A Well, sir, he asked if I would be interested in applying for the position

Q So he was the one that recruited you, as it were?

A I can't necessarily say he recruited me, sir, because I had to compete but at the end of the day there, there was an outreach made based on the positive past working relationship.

Q And what were your performance reviews like, the performance reviews of your work?

A Of my supervisor, sir?

Q By your supervisor, of your work, what were those reviews -- what was the outcome of those reviews?

A Before we left, some of us went on secondment to different places. Part of what we asked the supervisors to do and we, we did as senior managers, we did performance

reviews on all our respective supervisors and we developed the performance appraisal packages for each of the individual positions within the various programs and the supervisors, as well, did performance reviews on their staff.

Q Maybe we might have just been at slightly different altitudes on that --

A Oh, sorry.

Q -- question and that answer. I was asking if your supervisor, Mr. Harrison, did a performance appraisal of you and what the outcome was?

A Oh, I'm sorry. Yes, he did and it was a positive favourable performance review.

Q Okay, thank you. And then did you, in fact, do a performance appraisal of your supervisors, such as Ms. Faria?

A Yes, I did.

Q And what was -- do you recall what the outcome of that appraisal was for Ms. Faria?

A Vividly, sir, I read it the other day. I, I think Diva Faria, quite frankly, is one of the best supervisors that I have ever supervised in all the years that I've been in child welfare. Tremendously good supervisor as a child welfare specialist in the province at this point, and recognized by the province for her skills

in that area and her specialization in child welfare, sir.

Q What year would that appraisal have been?

A That appraisal would have been done April of 2005.

THE COMMISSIONER: That means you gave her a positive appraisal, I take it?

THE WITNESS: Absolutely, sir. A huge endorsement.

BY MR. SAXBERG:

Q Now, you were being asked whether you, personally, upon reviewing some of the file material, had the view as to whether discipline of workers was necessary. Do you recall that?

A That's correct, sir.

Q Are you aware of any discipline, of any nature, being meted out at any, at any location within CFS as a result of the recommendations or conclusions made in the three case specific reports?

A No, sir, I'm not.

Q And you were asked about the topic of the shredding of notes and whether you were aware, with it being done, about it being done. Do you recall that?

A Yes, sir.

Q Is there a difference -- and you had indicated, I

believe, that, that you weren't aware of it, and you would have been concerned; correct?

A Yes, for sure.

Q Is there a difference in terms of the level of your concern as to whether the shredding is occurring at after hours, for instance, or CRU versus intake?

A Provided the pertinent case related information is somehow a part of the record it -- the, the notes always need to be part of the record. So if, if we're going to be destroying notes, we had a supervision policy that was in place but not in place until 2004, that guided us around what we were to do with our notes.

Q The evidence that this Commission has heard with respect to CRU and what information it recorded and provided to intake, was all uniform in that there would be no handwritten notes that were to be provided from CRU to intake, it was a -- three pieces of information, the CRU report, the safety assessment and the, and the face sheet.

A That's correct, sir.

Q And there was no -- and, and no -- was there an expectation that handwritten notes would be kept and passed from CRU to intake then?

A Not that I'm aware of, sir. It might have been in the file if a worker chose to or, or you know had completed their report and got additional information, it

may have found its way into the file but generally, no, you're accurate.

Q And you'll agree that those provisions in the supervision policy relating to the maintenance of notes, were directed at family services more so than intake?

A Primarily at family service, for sure. Doesn't mean there wasn't good things out of it that we tried to adopt.

Q Now, the Commission also heard some, some evidence that the amount of files that a CRU worker would be dealing with, her day could be anywhere between two and a half and three files per day. Is that -- was that your experience?

A Yes, sir, and I believe that Diva Faria told Andy Koster and it's, it's recorded in the record that at any given time her CRU staff may carry between three and four files, at any given time, on a given day.

Q Now how, how then would it have been possible for those workers to do comprehensive CFSIS history reviews if they are dealing with two or three files per day?

A Well, sir, the -- if it's possible that -- I would like to refer to the best practise document in child welfare that was provided to us by Alex Wright, I think there is some very relevant and pertinent information to your question. If that's possible.

Q If you, if you want to refer to something I don't have a problem with it.

THE COMMISSIONER: Are you --

MR. OLSON: Ms. --

THE COMMISSIONER: -- aware of this document, Mr. --

MR. OLSON: That, that document is not in evidence at this point, Mr. Commissioner.

THE WITNESS: Okay. Okay. Sorry, Chris, could you give me that one more time? Your question.

BY MR. SAXBERG:

Q You had indicated that there was a -- in response to one of the questions put to you.

THE COMMISSIONER: Well, do you know about the document?

MR. SAXBERG: Yes, the best practises document.

THE COMMISSIONER: Well, did you make it available to Commission counsel?

MR. SAXBERG: Yeah, it's one of the documents Commission counsel disclosed to all the parties.

MR. OLSON: Maybe I can have a word with my friend.

BY MR. SAXBERG:

Q Okay, Mr. Berg, you've -- you have a copy of that best practises document in front of you?

A Yes, I do, sir.

Q And what's the page number on the bottom?

A The page number at the bottom is 363 and it's under CD number three.

MR. OLSON: That's fine, it's a different document than we were (inaudible).

THE COMMISSIONER: This is one that --

MR. OLSON: This has been disclosed.

THE COMMISSIONER: It's in the book.

MR. OLSON: Yes.

THE COMMISSIONER: He's -- in his book.

MR. OLSON: Yeah.

THE COMMISSIONER: What number is it, page number?

THE WITNESS: It's page number 363 under CD number three, sir.

THE COMMISSIONER: Is this -- what is this document, Mr. Saxberg?

MR. SAXBERG: Well, perhaps we could scroll to the top of the document. It's a document that was attached as part of one of the six reports that the Commission has been referred to in the order-in-council.

THE WITNESS: It's under the --

MR. SAXBERG: Yeah, there we --

MR. OLSON: It's from --

THE WITNESS: -- strength and commitment document.

MR. OLSON: That's right, the strength and the commitment report that's referred to in the order of council (sic), this is part of that document.

THE WITNESS: Yes.

THE COMMISSIONER: This is the Wright report, is it?

THE WITNESS: That's correct, sir.

THE COMMISSIONER: I don't have -- Mr. Olson, I don't have it here, do I?

MR. OLSON: No, you don't.

BY MR. SAXBERG:

Q And if we back up, I -- just to put this all in context, in case we've forgotten what the question was, I was asking you essentially about the expectation of CRU workers to do comprehensive CFSIS history reviews when the evidence is that they're dealing with up to three files per day and that would give them a limited amount of time to do that work.

A That's, that's for sure. Investigative workers

are generally, if you looked at that document, to be carrying, investigative social workers, recommended standard is 12 active cases per month per social worker. And let's take the low side, that if they were carrying three per day, per worker, it would not take very many days to get to what a recommended expert's view is in regards to numbers of cases that they should be managing. So, so it would be very, very difficult to expect them to follow through all those steps, sir.

Q And that intake --

THE COMMISSIONER: Well, now, just a minute. We, we know the shortcomings, if, if that's a fair word, you've referred to various incidents here where --

THE WITNESS: Yes, sir.

THE COMMISSIONER: -- perhaps best practise was not followed.

THE WITNESS: Yes, sir.

THE COMMISSIONER: Are, are you saying that there's something in this document that would say that the right thing was done?

THE WITNESS: No, sir, what I, what I am saying is that this document has one of the University of Manitoba's lead experts saying that here is around the average of case numbers an investigating social worker at CRU or intake should be carrying. Just simply that, sir.

THE COMMISSIONER: Or relate to that to the Phoenix Sinclair matter.

THE WITNESS: Okay. I think Mr. Saxberg's question to me is would it have impacted Chris Zalevich to be able to have read that file thoroughly on that March 7th incident, prior to him going out on that call, if he had workload to the degree that was described by the supervisor, Diva Faria, in her dialogue with the reviewer, Andy Koster. That was, that was I believe the reference. And it could have seriously impacted his ability to have taken the time to have looked at the entire history before he went out on that call.

THE COMMISSIONER: It would have been ideal for him to look at it?

THE WITNESS: Yes, sir, it would have been ideal but it, it, it may have, with that kind of volume, it may have caused him to take shortcuts and simply take the information he received from after hours, simply read that and then go out with that. And we've already disclosed here today that pertinent information related to even Karl Wesley McKay was not included on that information from after hours.

THE COMMISSIONER: And you're attributing that to workload?

THE WITNESS: I'm, I'm attributing just my

response back to Mr. Saxberg's question, sir, and he's asking me could this possibly impact workload for workers at the end of the day, not to read all these files before they go out and I think the answer to that is, yes, it could.

I don't know, sir, whether it did in this exact situation, I don't know that, sir.

BY MR. SAXBERG:

Q Let me try to -- I think I can simplify it. Best practise would be for every social worker, wherever they are, in family services, intake, CRU, after hours, to read all of the material on CFSIS, in every case; correct?

A It is, it is --

Q And that --

A -- really our wish to get to that point, sir.

Q And that's going to produce the best outcomes?

A Absolutely.

Q Correct? Is there a difference in the capacity of CRU workers, who only deal with the file for a very short period and have three files per day, is there a difference between their capacity to achieve that best practise in the capacity of an intake worker?

A Absolutely, absolutely, for sure.

Q And, and just what's the difference in capacity,

who has more?

A The difference in capacity is that, that they're -- they've got three or four things that they're dealing with at one time and they generally only keep the files for one to two days so they've got always a lot of competing priorities and to take, you know, potentially two, three hours to read one individual file as this one might be, because there's two files and they're fairly thick, at the end of the day I don't know that they would physically have that ability, time-wise, to do that.

Q And, similarly, best practise is to see every child on every occasion in every investigation and that's certainly the practise today; correct?

A Yes, it is the practise today and, and that is the best practise, to see the children in particular when they're the subject of a protection investigation.

Q Does --

THE COMMISSIONER: Always, always was I take it?

THE WITNESS: Always was, sir. Always was.

BY MR. SAXBERG:

Q Does -- did intake, in 2005 and -- in 2005, have more capacity to achieve that best practise and ensure that every child is seen on every investigation than CRU?

A Absolutely, yes. They had more time.

THE COMMISSIONER: They have no time?

THE WITNESS: They had more time, sir. They would have that case for at least 60 to 90 days if they wanted to keep that case that long where as CRU would be keeping it generally for a maximum of 24 to 48 hours.

BY MR. SAXBERG:

Q And they have only within that period of time to ensure that all of the children have been seen?

A Yes, sir.

Q And was it your experience that, at the time, that, that you were the assistant program manager, that the, the goal of -- CRU strived for was that the home be seen on every occasion and all the children be seen, but that it wasn't possible on every occasion to achieve that because of workload?

A The -- it would be impossible to have done that on every case, sir.

Q And so I just want to, to call up page 36926. This is the -- you probably have this before you, Mr. Commissioner, this is the first page of the Davidson, slash, Zalevich report, dealing with the March '05 involvement.

And I just -- I really just bring it up so that the witness will, will be aware of the document and report

and everyone will be aware of what -- which document I'm speaking of. This next question relates to this report that was ultimately signed off by Ms. Faria. And you've read the report before and I think you commented in, in response to a question from Mr. Gindin, that the report includes absolutely no mention of Mr. McKay.

A I would like to, to verify seeing the report, if I could.

Q Yeah.

A I can only see a part of it here.

Q Okay. And you have that in, in your binder --

A I, I'm going to --

Q -- at 1795?

A -- look at it on the screen, sir.

Q Sure.

A Yes, this is the document I was referring to earlier that came from after hours to see CRU and I don't see any reference to Karl Wesley McKay on that document.

Q Okay. And, and you had indicated that with Mr. McKay in the picture the, the risk associated with this file is elevated?

A Absolutely.

Q Now, when Ms. Faria received this report --

THE COMMISSIONER: Mr. -- you're not ploughing old ground that we've all been through --

MR. SAXBERG: No.

THE COMMISSIONER: -- in that Commission counsel had the responsibility of, of laying the case out which they've done. Are you, are you -- are these something that came up in cross-examination?

MR. SAXBERG: Yes, I believe so. I, I -- the issue was about whether the workers should have been aware of Mr., Mr. McKay in March of 2005 and should have done something about it, and I'm, I'm now going to ask a question in relation to Ms. Faria who -- he was Ms. Faria's supervisor.

MR. GINDIN: If I can just make one comment. When -- if, if my learned friend is referring to my cross-examination, the issue that I was raising was that the issue of West McKay is something that should have been inquired about when they were there at the scene, talking to Samantha. I don't think I suggested it was nowhere to be found in the, in the report.

MR. SAXBERG: That's a very good clarification.

THE COMMISSIONER: I think that's right.

MR. SAXBERG: Right, that's, that's a good clarification.

BY MR. SAXBERG:

Q My question was about whether Ms. Faria, in

reviewing the report as a supervisor, would have been aware of, of Mr. McKay and his involvement. And or -- and the question is ought she have somehow been aware of that.

A I'm not sure that I, I know the answer to that, if what she reviewed --

THE COMMISSIONER: Well, she got, she got the file before she ever sent one of her workers out there, did she not?

THE WITNESS: The file that includes the report that doesn't say anything about Mr. McKay, yes.

THE COMMISSIONER: No, no, the, the -- she got the -- did that report initially come from Davidson?

MR. SAXBERG: Yes.

THE COMMISSIONER: Well, then Faria had an obligation, as I understand it, to look into this matter before she made an assignment.

MR. SAXBERG: Well, that -- this is precisely what my questioning is of him, is what her obligations were beyond the report. That's what I'm --

THE COMMISSIONER: Well, I, I thought she told us what her obligations were but I'll allow you to ask the question.

MR. SAXBERG: I'm asking the question from her supervisor's perspective.

THE COMMISSIONER: I see.

MR. SAXBERG: He's, he's her boss and I want to know if she's being appropriate in only looking at the report and not doing more. That's the question.

THE WITNESS: Okay. She would have received the report from after hours, the after hours report is a little short on information in that it doesn't mention anything about Karl Wesley McKay, who is a principally important person to have known about with this particular report, so she would have made probably her decisions based on this report in terms of who to assign the case to and -- you know, and the response time, you know, in regards to when they would have, you know, been expected to go out on this report.

THE COMMISSIONER: But isn't the question should she have looked beyond just that report with respect to this file before she made the assignment?

THE WITNESS: I, I don't -- I personally don't think she would have time to do that. She just would not have time with the volume of cases --

MR. SAXBERG: That's --

THE WITNESS: -- that she would be dealing with.

BY MR. SAXBERG:

Q Thank you. And that was the question. Were supervisors that you were supervising, were they obligated

to do CFSIS checks before they signed files?

A No.

Q And just --

THE COMMISSIONER: Well, there's a difference between obligated and, and best practises and also the opportunity, isn't there?

THE WITNESS: There is, sir, but there, there simply would not have been time for there -- the -- for the supervisors to do this, just too many cases, too many calls. They would have to trust that the after hours person put the pertinent information in the record and unfortunately that didn't happen and ...

BY MR. SAXBERG:

Q And just quickly on -- with respect with to the walk of shame issue. You testified about a couple of different scenarios where that -- where a file would be returned from intake to CRU. One of the scenarios you indicated that might involve some informal discussion that leads to a negotiation between the supervisors as to where the file should reside; correct?

A Yes, sir.

Q In other situation there's -- there is a conflict between the supervisors and your -- part of your job was to resolve that conflict?

A Absolutely.

Q Can you just give us an order of magnitude percentages, which -- what amount was in category "A", the negotiation, and what amount of, of, of occasions would you have had to have gotten involved to resolve a dispute between supervisors as to where a file should reside?

A So the first one, sir, was the percentage of what they could resolve or resolve themselves and where I needed to be involved or the --

Q Yes.

A -- assistant program manager?

Q Yes.

A Oh, I would, I would venture to guess that when we first started to where we believed we got to would be a bit different but I would say probably 90 percent resolution probably would have been happening when we first began, 90 percent of probably their involvement they resolved themselves. I, I believe we got to a point that it was hirer than that, sir, until December of 2004, till April of 2005, where there were some real workload related challenges and, and, and I think at various times there we, we maybe slipped back to where we, where we were initially due to the excess workload that was going on.

Q Okay. And just finally, I just want to make sure that, that your evidence is clear on this point. You --

Mr. Gindin had, had raised with you that, I think he put to you, that reasonable workers can disagree from time to time on, on the course of action in a case?

A That's correct.

Q And you had indicated that there were three options with respect to that March 2005 intake?

A For, for Ms. Faria?

Q Yes.

A Yes, there were three options that I, that I am aware of.

Q Okay. Were you talking about options beyond what was ultimately decided?

A I was speaking in terms of just clarifying the point that there are three areas where they could have sent the file but it is my belief that in her review of the file and in her discussion with the respective workers, at least from what I can read on file, she was comfortable in her supervisory capacity to support the recommendation of there being no protection concerns and of therefore supporting the recommendation of Chris Zalevich to close the file.

Q So closing was another option that they had?

A It was her option and that's what she exercised.

MR. SAXBERG: Okay, thank you, those are my questions.

THE WITNESS: Thank you, sir.

THE COMMISSIONER: Thank you, Mr. Saxberg.

Mr. Olson? Did -- Mr. Gindin, do you want, want to --

MR. GINDIN: Can I just have a moment (inaudible)?

RE-EXAMINATION BY MR. OLSON:

Q Mr. Berg, I just want to see if you can clarify something from you -- for me. Mr. Saxberg asked you, I think it was one his first questions about the file, the fact that intake didn't take the file was relevant -- a relevant factor for Diva Faria to take into consideration when she agreed to close it. Is that -- was that -- is that right?

A I'm sorry, could you clarify which incident you're referring to, the March incident?

Q I don't know that it would be -- make a difference to this question which incident it was. The fact is that her evidence was that she thought maybe intake refused to take the file or didn't take the file, there wasn't clear evidence as to whether or not that occurred; right?

A This is on Richard Buchkowski's; right? Yeah. Okay.

MR. OLSON: Sure.

THE WITNESS: Yes. Yes, I can appreciate that that that would have --

MR. OLSON: Okay.

THE WITNESS: -- crossed her mind that if they refused to take the case on the first occasion would they refuse to take it the second time. Yes, sir.

BY MR. OLSON:

Q No, that's -- but that's not my question, though, the question is -- I may have misunderstood what Mr. Saxberg was saying to you.

A Okay.

Q Ms. Faria gave evidence that she thought one of the reasons why the file came back down to CRU was because intake didn't accept it. That's why it went to Mr. Zalevich. And then Mr. Saxberg asked you whether that was a relevant factor for Ms. Faria to take into consideration in her decision to close that file and what I have written down and what I understood was that you said that that was a relevant factor in making that decision to close the file. Is that what you, is that what you meant?

A I, I think I would probably be more comfortable with it could have been as opposed to it absolutely was. I don't, I don't know whether it absolutely was, I, I wasn't there and, and I'm not her, but it could have, it could

have been.

Q It could have been a relevant factor --

A Could --

Q -- in the decision to close the file.

A Could have been a relevant factor in her -- just stop and think about that. I believe, I believe her information suggests that she supported the recommendation based on accepting the worker's recommendation that there weren't protection concerns so I really should stop short of commenting whether or not it was in her mindset as to whether or not she wanted to send it up to intake again or not. I, I wouldn't know the answer to that, quite frankly.

Q Okay. And just so we're clear, if -- that would -- should never really play the role in deciding on whether or not to close a file, the fact that another unit is not agreeing to accept it?

A Well, there's were -- these were also two different times and some interventions had taken place in between so if she believed that that was something that she wanted to reconsider she would have every right, if she decided it was necessary, to send that back up to tier 2 intake.

Q She had the right to do that?

A She had the right to do that.

Q And if she thought there were child protection

concerns she should have done that?

A If she wasn't satisfied with the recommendations around closure related to safety and child protection concerns that was an option for her.

Q Right. So in other words if, if she had child protection concerns she should not have closed that file?

A I believe that's a fair statement.

Q You were also asked about best practise and the ability of CRU workers not to meet best practise and you said, I think, because they were very busy it, it was hard?

A Yes, true.

Q Are you saying that -- were, were you aware, at the time, that you were the -- you were assistant program manager, that CRU workers weren't able to meet best practise?

A You know, probably have to answer that two ways. Initially, the first six months, trying to figure it all out, to be honest with you, the first six months I wasn't quite sure what a reasonable workload was for CRU initially. I think over time, as I got to know the program better and, you know, could see the volume a little clearer, you know, in terms of our stats and what we were dealing with, it, it appeared to me that -- it appeared to me -- sorry. It appeared to me that, that their volume was, at times -- and, and probably throughout my time

there, was excessive.

Q So that -- and you're saying that caused them not to be able to meet best practise; right?

A It can impact, you know, anyone working there, their ability to meet best practise.

Q And are you saying you were aware of the fact that they weren't meeting best practise at the time?

A No, I'm not making that leap.

Q Well, did you believe they were meeting best practise at the time?

A Best practise with -- you know, their, their best work that they could do under the circumstances. I think we were trying to meet best practise, you know, and I think you saw that in the, you know in the February minutes from the supervisor where she's telling the staff, you know, that we need to see the children, we need to see the home, you know, and, and where she's, you know, offering direction to her staff in that regard. We're trying to meet best practise.

Q I, I guess I just want to clarify, you're not, you're not suggesting that time constraints or how busy the unit is would be a reason for not being able to meet best practise, are you?

A I think time constraints and workload related challenges always have an impact, potentially, on your

ability to deliver best practise.

Q Okay. And as assistant program manager that's something that you should have been aware of?

A And I, I think I've suggested to you that, that I am aware of that, that was a very, very, very busy program and you know, and probably had expectations around the volume that we were dealing with that, that challenged our staff to meet best practise. I think that's been established here.

Q That that -- that must have caused you quite a bit of concern at the time?

A Well, it caused all three of us, as managers, concern and, you know, and the respective supervisors. It wasn't just at CRU, it was, it was across a number of our program areas.

Q When Mr. Saxberg asked you some questions about the decision to close the file and whether or not Mr. -- the presence of Mr. McKay should have been known to the supervisor, to Ms. Faria, you said well, she, she would rely on the after hours unit worker to provide a history. Is -- do I have that right?

A Well, close but I don't think quite accurate. I mean, she's reviewing many, many reports so she would be looking at the identifying information that's directly in front of her and if there is something pertinent like Karl

Wesley McKay's name from the report that's provided to her, unless she remembered and made the connection from the December 1st, 2004 incident involving Shelly Wiebe, she might, she might not have made that connection because the information wasn't there directly in front of her and made available to her.

Q Even though she was involved in the other incident, because of the volume of work she may not have put two and two together?

A It's very possible.

Q But when, when she's making the decision to close a file and particularly in a case where a child isn't seen, wouldn't it be important to do a bit of a file review? I mean with -- she knows there's a history in this case.

A I believe I've testified before that at the point of closure our, our procedure manual stated that we should review the file. Whether Diva referred -- was to review the file or, or Chris Zalevich reviewed the file, that would have been our general practise but I can't comment as to whether they did review the file because I don't know that information and it's not documented, as far as I can tell, anywhere.

Q So you say you have no idea?

A I have no idea whether they did or didn't, to be honest with you.

Q But as -- but the expectation on your part would be that one of them would have reviewed the file in, in some detail?

A The expectation, according to the service model that we were following was that, as a general rule, when we were closing we were to review the file.

Q I think you said that CRU would -- wouldn't really have the time that intake would have to do any significant investigation in, in terms of, you know, who Wes McKay is or what's happening with the family and that sort of thing. Is that right, CRU doesn't really do that or can't do that?

A CRU can't do a follow up --

Q Because of the time --

A -- with Karl Wesley McKay?

Q Because of the time they had the file, the short period of time, they weren't able to do that level of follow up that intake could do?

A Had they had the information in regards to Karl Wesley McKay provided to them, they may have chosen to follow up with Karl Wesley McKay as well. They -- would they have had the time to, to do that compared to intake, their contact, if they were to outreach to him, would be more limited in terms of time than what intake would simply because they had a 24, 48 hour window and intake had a 60

to 90 day window. So there was more capacity at intake for that kind of in-depth follow up. It doesn't mean CRU couldn't have seen Karl Wesley McKay.

Q Right. And CRU wouldn't -- would -- wouldn't be, shouldn't be closing a file because they don't have time to properly investigate it? You're not suggesting that?

A On that particular incident in March, I only have the information that's been provided to me, it never was consulted with me and at the end of the day my read was that the worker, at the end of the day, viewed this situation as there being no protection concerns and the supervisor reviewed that with the respective staff and supported that decision. That's all of the information I know.

Q All right. You, you were asked a question about letters in the file from probation officers. Do you recall that within the files connected to Mr. McKay?

A I believe I was asked by Mr. Gindin and I said that I was not aware of that information.

Q Okay. And just, just so it is, it is clear in the admission as to facts of the department, Volume 2, which is Exhibit 19, there is -- there are, in Exhibit "A", three letters from probation officers. We've, we've heard that evidence before. These, these, the department has acknowledged were on the file. That's something you

weren't aware of?

A I would have to see the reports and to know what the dates were of the reports, sir.

Q Maybe we can take -- if you want to take a look at it, it's on the screen. This is the admission of facts from the Department of Family Services and Labour. If we go to item number three on page three.

It says:

> "Ms. X's file contained additional documents which were not available in CFSIS during the period from May 2004 to April 2005. The paper file of Ms. X originates from Winnipeg CFS and consists of 832 pages. Excerpts from Mrs. X's paper file are contained in Appendix B. In the period for May 2004 to April 2005, a worker would have had access to Ms. X's paper file in an unredacted form."

And as I mentioned the, the documents in Appendix A. Sorry, Appendix B are the letters from the, from the Probation Services dated -- one is dated February 18, 1999.

That would be on page 59 of the exhibit.

A I think I could save you time, sir, I have never seen these reports. I, I would not have been aware of this case, it wasn't consulted with me so I wouldn't have been aware that these reports existed because I never had a dialogue related to this case with any of the staff, social workers or supervisors.

Q Okay. So you don't take issue with what's contained in, in the admitted facts, though, you're not saying documents weren't here, you just weren't aware of it?

A I certainly have no issue with it and I can't comment because I didn't know that they were in existence.

Q Okay. Just one last question. When you mentioned -- you were asked a question about Ms. Forbes' involvement in the file and you said she was -- she reported being down to about three workers in CRU. Do you remember that?

A Three workers down in -- she worked at central intake, tier 2 intake.

Q I'm sorry, intake.

A Yes.

Q I apologize.

A And she was a -- in, in her report she said that they were three staff down at that time. It's a fairly

small unit there were only seven staff in that unit, social work staff, so if they were down three staff they were pretty close to half staff. So that was -- Central and Northwest were our two busiest intake units.

Q Yeah. And we -- there has been some evidence from the department suggesting that it was actually five or six workers at a time. Do you have any personal knowledge, one way or the other, as to whether there were three, or five, or six?

A I can't recall, to be honest with you, sir.

MR. OLSON: Okay. Thank you. Those are my only questions.

THE COMMISSIONER: Thank you, Mr. Olson.

I have just one question to ask you.

EXAMINATION BY THE COMMISSIONER:

Q I was going to put it in a different way but Mr. Olson has taken you through the situation with respect to the impact that workload had on the ability of, of the staff to perform their duties. And I think you said to Mr. Olson that once you had been there six months or so you began to appreciate what the situation was and I think you said the three of you, your colleagues conferred about, about the problem. Am I correct?

A That's correct, sir.

Q What did you do about the problem in order to try to have it rectified so that workload didn't interfere in the manner that you believe it was interfering?

A I think I've spoke to some of that, sir, but I'll, I'll try. We found the workload very high at, at CRU, at, at, at tier 2 intake, as well. So what we, what we tried to do -- I'll start first, if I could, sir, with CRU. First it was one supervisor with 10 staff --

Q No, no, my question relates to what did you do to letting your superiors know about the problem so that some decisions above could be made to, to bring relief to what you saw as a problem that I assume required attention?

A Sir, I'd have to answer that, that talking with, with our program manager, assistant program managers were, were an unusual level, sir, we were there for a short period of time as assistant program managers so we weren't regular managers that sat at the senior management table at Winnipeg Child and Family so we would have brought that to our attention -- to the attention of our program manager and then I can't speak to knowing exactly what our program manager did in terms of --

Q That would be, that would be Harrison?

A That's, that's, that's Patrick Harrison, yes, my supervisor. I would have brought --

Q And so if the problem went from where the three

of you saw it --

A Yes.

Q -- it would be his responsibility to carry it forward?

A Yes. And, and, and Pat did a lot of work on that. There's, you know, lots of times we were able to get additional staff over summer breaks, we got additional staff, but to try, at that time, with all the changes that were coming in terms of devolution, it was very difficult for us to get any kind of expansion of any staff because, at that time, Winnipeg was going to be downsized, you know, by 40 or 50 percent of our staffing compliment, due to the devolution process, sir, that was, that was coming our way, you know, effective April of 2005, so -- that's the best I could tell you, sir.

THE COMMISSIONER: You've answered my question to the best of your ability, I'm sure.

THE WITNESS: Thank you, sir.

THE COMMISSIONER: All right. Now, do any counsel want to ask any questions arising out of what I have just put to the witness?

Apparently not, so you're through your tour of duty.

THE WITNESS: Thank you, sir.

THE COMMISSIONER: Thank you.

(WITNESS EXCUSED)

MR. OLSON: Our next witness is scheduled to testify at two o'clock.

THE COMMISSIONER: Yes. I, I notice the hour and, and will it just be one witness this afternoon?

MR. OLSON: Yes.

THE COMMISSIONER: I'm wondering whether we might have -- commence at 2:15. Does, does that sound reasonable?

MR. OLSON: It does.

THE COMMISSIONER: All right, if there's no problem with that, we'll stand adjourned until 2:15.

(LUNCHEON RECESS)

THE COMMISSIONER: Good afternoon.

MS. WALSH: Good afternoon, Mr. Commissioner.

Mr. Commissioner, do you have the documents with respect to Dr. Trigg?

THE COMMISSIONER: I do.

MS. WALSH: Good. If we could have the witness sworn in, please.

THE CLERK: Is it your choice to swear on the Bible or affirm without the Bible?

THE WITNESS: I would like to affirm, please.

THE CLERK: Sure. State your full name for the court.

THE WITNESS: Linda Joyce Trigg.

THE CLERK: And if you could spell me your first name, please.

THE WITNESS: I didn't hear you.

THE CLERK: Would you spell me your first name.

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

THE CLERK: And your middle name.

THE WITNESS: Joyce, J-O-Y-C-E.

THE CLERK: And your last name.

THE WITNESS: Trigg, T-R-I-G-G.

LINDA JOYCE TRIGG, affirmed, testified as follows:

THE CLERK: Thank you.

DIRECT EXAMINATION BY MS. WALSH:

Q Good afternoon.

A Good afternoon.

Q We'll start with your background. You received a Bachelor of Science degree from McGill University?

A Yes.

Q Okay. Then you received both your Masters and your Doctoral degrees in clinical psychology from the University of Manitoba?

A Yes.

Q And when was that?

A 1980 I received my doctorate degree.

Q You've just referred to something, what do you have with you that you're referring to?

A Oh, I'm sorry, it's my CV.

Q Oh. All right. I don't know that we actually, the rest of us in the room have a copy of it, so if you can try to just answer without --

A All right.

Q -- reference to that, that would be preferable, please. Thank you.

Have you received any formal training in social work?

A No.

Q And I'm sorry, when did you say you received your, your --

THE COMMISSIONER: Ms. Walsh, just speak a little more into the mike.

MS. WALSH: How's that?

THE COMMISSIONER: Fine.

MS. WALSH: Is that better?

BY MS. WALSH:

Q When did you say you received your doctorate in psychology?

A 1980

Q 1980. Okay. And after you received your PhD you worked in the St. James School Division for two years as a school psychologist?

A I did.

Q Okay. Then you worked at the St. Boniface Hospital in adolescent psychiatry on adolescent in-patient and out-patient services?

A I did, for four years.

Q For four years? Okay. Then I understand you worked for an organization called New Directions for Children, Youth and Families.

A Correct.

Q What is or was that organization?

A It's a multi-service social service organization that provides residential treatment for children in care of the child welfare system. It also provides family therapy program, family where a child has been sexually assaulted by a third party. It has programs for teenage mothers, for young people, 16 to 18, who are not able to manage in regular school because of behaviour academics. It has a range of services.

Q You worked at that organization in a number of capacities.

A Correct.

Q What were the various positions that you held?

A I began as assistant clinical director. I then held the position of clinical director. In 1991, I was the acting executive director while the executive director, in fact, was the -- seconded to be the CEO of Winnipeg Child and Family Services. And then I -- he, he remained at Winnipeg Child and Family Services and I became the executive director.

Q Then in 2001 you, yourself, went over to Winnipeg Child and Family Services; is that right?

A I did.

Q That was as interim executive --

A Officer.

Q -- officer?

THE COMMISSIONER: As what officer?

MS. WALSH: Interim executive officer.

BY MS. WALSH:

Q And then at some point you became the chief executive officer of Winnipeg Child and Family Services?

A Yes. I was seconded for 16 months from New Directions and when it appeared like some of the

initiatives, such as the Aboriginal Justice Inquiry Child Welfare Initiative were going to take somewhat longer I was appointed the chief executive officer. Still on secondment from New Directions but with the understanding that I would be staying with Winnipeg Child and Family Services.

Q And my understanding is that you remained at Winnipeg Child and Family Services from July of 2001 to July of 2004.

A Yes.

Q Do you recall at what point you became the CEO?

A I believe it was when the announcement was made that Winnipeg Child and Family Services, which was a free standing agency with its own board, would become a branch of government.

Q Was that in '03?

A That was in the fall of '01.

Q Okay. Was there any difference in terms of the job requirements between being the ...

(MONITOR EQUIPMENT MALFUNCTION)

MS. WALSH: Thank you for your patience, Mr. Commissioner.

THE COMMISSIONER: Well, we'll sit till five o'clock and then we'll decide then what time we should

start Monday morning.

MS. WALSH: Okay, thank you. Now, did we record -- did we miss some of the witness' testimony?

THE CLERK: The last note I made is that she became CEO when the announcement was made that Winnipeg CFS would be made a branch of government in the fall of 2001.

MS. WALSH: Okay, so we have missed a little bit, I think.

THE COMMISSIONER: And after that she talked about going into private practise.

MS. WALSH: So we don't have that? Okay.

BY MS. WALSH:

Q So just to confirm the --

MR. MCCKINNON: Just the, the other point that you made and she agreed with was that there was no difference between her position when she was CEO and the prior title, which was interim executive officer.

MS. WALSH: Right. Thank you.

BY MS. WALSH:

Q So from July 2001 to July 2004 you were first the interim executive officer and the chief -- then the chief executive officer of Winnipeg Child and Family Services?

A Yes.

Q Okay. And I think you said there was no difference in your duties, whether as interim or as chief; is that right?

A Yes.

Q Then I think you told us that after you left the agency, you went into private clinical practise as a psychologist and you continue to do that today?

A Yes.

Q Okay. Thank you.

So would you tell us please what your role as CEO of Winnipeg Child and Family Services involved?

A Two-fold. First of all, I was responsible for the operations of its various services, such as adoptions, permanent wards, resources, which included foster care. Family support. I'm sorry, my screen just went -- I know the screen is going off and on. Are we okay?

THE CLERK: It's okay.

MS. WALSH: Okay.

THE WITNESS: Family support. The shelter receiving program. The quality assurance program, aboriginal liaison program. So that was -- part of my job was to keep that running as smoothly as possible while also assisting with the Aboriginal Justice Inquiry Child Welfare Initiative which was the transfer of aboriginal cases to new aboriginal agencies and the downsizing of Winnipeg

Child and Family Services.

To assist in making the agency, with its free standing board, become a branch of government. And also to assist with the development of what was called the integrated service delivery system which was bringing the services of Family Services and Health under one roof. It was intended to be one stop shopping, such as Access River East, where you could see a Child and Family Service worker, but children's special services was also in the building as was public health and so forth.

BY MS. WALSH:

Q So these were -- what you've just described then, these were specific tasks that you understood you were to carry out as CEO?

A Yes. I was charged with keeping Winnipeg Child and Family Services running as smoothly as possible while these other significant changes were occurring and I was part of the planning, of course, for those changes.

Q Okay. What was your understanding of the mandate of the agency during the time that you were the CEO?

A The primary mandate was protection of children.

Q And where did your role fit within that mandate?

A It fit by overseeing the program service to children and families. The other programs, though, were

all in support of service to children and families, such as resources, foster care, family support.

Q Did the fact that you did not have a social work background, per se, have any impact on how you carried out your job?

A I don't think so.

Q And you talked about, about changes within the agency. I understand that your predecessor, and we have not yet heard from him, but Lance Barber, during his tenure as CEO, the agency was restructured from a geographically based organization to a program based organization. Do I have that right?

A That's my understanding.

Q Okay. And did that reorganization have any significance to the agency when you were there?

A I think so.

Q Can you elaborate?

A It had its pros and cons. For example, with the formation of the permanent ward program there were several teams especially devoted to permanent wards. And so, for example, by the time I left some 75 percent of permanent wards had some connection with their family because we know, at age 18, when they are no longer in the system, they go looking for their family.

One very big disadvantage to the program versus

the regional area service was the fact that people with seniority worked in programs that did not have the same level of constant stress that services to children and families.

For example, in adoption, and I know this is in one of the Commission documents, I think, if I remember correctly, some 75 percent of staff had been there, say 20 years, or more, whereas on front line service to children and families there was a constant turn over and I think it was very high, it was over 50 percent, had been there less than two years. So you had, in the program structure, the most junior people filling some of the roles requiring sophisticated judgment.

Turnover was a problem for supervisors because I recall, when I was there, there was more than one team that turned over a hundred percent in one year and supervisors found it difficult to be constantly bringing on new staff and trying to bring them up to speed.

Q And that, that flowed from the restructuring, from being area based --

A Yes.

Q -- to program based?

A When it was area based, each area, each team did some service to children and family's work, worked with some permanent wards, worked with some foster care. There

was variety. You could take a permanent ward out for lunch as an option and spend the rest of your day perhaps on some protection cases. But when it was structured that way it became really clear that as soon as people could get off the front line they would leap to another program.

Also because the collective agreement provided that the most senior person who applies for a job gets the job.

Q So the change in variety of job duties, is that what you're referring to, had, had an impact on, on staffing?

A I think it had an impact on staff stress but it had an impact on the seniority level of those working on the front line.

Q Okay. And I think you said you've seen a document, there is a document that I will refer you to eventually --

A Right.

Q -- where you've set out a chart that shows seniority and various positions?

A Yes. And it's very clear that the most junior people, in fact, the vast majority probably less than two years on the front line, just out of school.

Q Okay. In November of 2001, the government sent a letter to the staff of Winnipeg Child and Family Services

in which it outlined its plans for the changes associated with the implementation of the Aboriginal Justice Inquiry Child Welfare Initiative.

If we can turn to page 39785 please. This is a letter dated November 16, 2001 to staff of Winnipeg Child and Family Services and it's from Tim Sale, who was the minister at the time.

A Excuse me, I --

Q And without --

A -- I can only see portions of it.

Q Okay, well, we'll scroll through it --

A All right. Thank you.

Q -- as, as it goes down. So it's to staff.

> "Today the Government of Manitoba informed Manitobans of its plans for laying the foundation for the General Authority, which will serve non-Aboriginal families and children in the child and family services system after the implementation of the Aboriginal Justice Inquiry - Child Welfare Initiative ...
>
> Significant new features of the

plan include:

• The development and implementation of a transition plan that will see child and family services for non-Aboriginal children and families in Winnipeg delivered by the Department of Family Services and Housing's regional operations on or after April 1, 2003.

• The establishment of an Interim Management Board for Winnipeg Child and Family Services that will be charged with:

> planning and managing the transition to regional operations;

> planning and managing the transition under the AJI-CWI; and

> planning and managing strategies to address the Agency's current fiscal challenges.

The Interim Management Board will be comprised of nine new directors appointed by Government and four directors elected by members who

live or work in each of the four service areas. There will continue to be staff representation on the Board. Mr. Jay Rodgers will chair the Interim Management Board.

Dr. Linda Trigg will continue to manage the agency as the Interim Executive Officer.

During the initial phase of the transition, from November 16, 2001 until March 31, 2003, planning for the transition to the Department of Family Services and Housing's regional operations will take place. Winnipeg Child and Family Services will remain a separate organization and the Interim Management Board and the Interim Executive Officer will direct the operation of the agency. During this period, employees will continue to be covered by their existing collective agreements. Also during this period, the

Government of Manitoba, MGEU and CUPE, will negotiate transition agreements. The transition agreements will spell out the details around the transfer in accordance with the respective collective agreements, The Labour Relations Act, and The Civil Service Act.

On December 22, 2000, we wrote to you about the restructuring of the child and family services system that will take place as part of the AJI-CWI. The following commitment was included in that letter:

'After extensive discussions, we are pleased to announce that the Government of Manitoba has committed to ensuring that no current, permanent employee of the Child and Family Services system, who is in a bargaining unit or comparable position, will be disadvantaged as a result of the

> Aboriginal Justice Inquiry - Child Welfare Initiative.'
> The restructuring that we are writing to you about today, that will see Winnipeg Child and Family Services transition to the Department of Family Services and Housing, does not diminish the commitment made on December 22, 2000.
> The unions representing employees in the system, MGEU and CUPE, and the Government of Manitoba are engaging in discussions to develop a mutually acceptable Workforce Adjustment Strategy for the AJI-CWI."

And the letter was copied to the unions, to the chair of the new interim board and to you, along with the Minister and I think deputy and assistant deputy ministers.

So that, that set out to the staff what was happening in terms of, of transition?

A Yes.

Q So that, that --

A In terms of that -- yes, those two --
Q -- aspect of the transition.
A -- those two transitions.
Q Right. So that gives us some context and, and tells who, who knew what.

In terms of structure, during your time as CEO who did you report to?

A Initially I reported to community board because it was a freestanding agency, albeit funded by government. But there was a community board and the chair of the board was Jean Altemeyer.

When the announcement was made about the roll into government and the interim management board formed I reported to Jay Rodgers, and then later on --
Q So that would be, like, November of '01?
A Yes.
Q Okay.
A And then when the agency became a branch of government at the end of -- or at March 2003 I reported to Martin Billinkoff, who was the Assistant Deputy Minister of Community Services.
Q So in terms of your first entity to whom you reported, the board, let's pull up the annual report. If you turn to page 35978 of our disclosure, this will show us the composition of the board at that time.

So what we have on the screen is the 2001/2002 annual report from Winnipeg Child and Family Services and then if we go to page 35981, that shows the board of directors appointed by government during various periods. And then if you scroll down you can see there are members appointed or elected by community area councils. There's ex-officio area council representatives, ex-officio staff representatives.

If you can just scroll down a bit, please.

Then onto the next page, area council members.

So that, that shows us what the board, when you said you reported originally, initially to a community board, that shows us what, what that board looked like?

A Yes.

Q Okay. During the time that you reported to the board, how often did you meet with the board or the executive in some form?

A I can't recall exactly because I don't think the board met each month in the summer. The board would meet monthly.

Q Okay. How much direction did you receive from the board?

A Not a great deal because the other change happened very soon after I arrived.

Q The other change being?

A Meaning the appointment of the interim management board.

Q Okay. Were there any community members on the interim management board?

A Not to my recollection even though it says in, in some documents. But I recall -- wait, let me just think. Most of them were civil servants.

MR. MCKINNON: Just if it would be helpful to scroll back a page to that list of board members --

THE WITNESS: Okay.

MR. MCKINNON: -- if it would assist in jogging your memory.

THE WITNESS: Thank you.

BY MS. WALSH:

Q Now, this is from the community board --

A Yes.

Q -- in '01, '02.

A Most of them were civil servants. I think that Dave Waters was not. He was working -- he was the executive director at Knowles at the time so he might be considered a community person. And I do not remember who Carolyn Blaine was but the rest are all civil servants.

Q And you're looking at the column that's under November 16, 2001?

A Jay Rodgers, under that column.
Q That, that represents the interim --
A Yes.
Q -- board.
Okay, thank you. What kind of direction did you receive from that interim management board? First of all, how often did you meet with the interim management board?
A The interim management board met monthly and I would receive direction regarding all aspects of the organization, whether it was the deficit, the shelter system, questions, concerns about service quality.
They were focused, to a large extent, on all the tasks that had to take place to make the agency a branch of government. For example, Fred Besant was from Finance, Bob Pruden was from Labour. There were various departments of government that were involved in making the transition.
Q Then once the agency was rolled into government, in March of '03, you said you reported to the assistant deputy minister?
A Correct.
Q How often did you meet with him?
A Weekly.
Q Did you meet with anyone else in government after '03?
A Yes. Periodically I met with Joy Cramer, who was

director of the Child Protection Branch and periodically the assistant deputy minister for Child and Family Policies and Procedures would join our meetings.

Q You reported, though, to the assistant deputy minister?

A Martin Billinkoff.

Q And was that the --

A There were several assistant deputy ministers in the department. There were about five.

Q And did the assistant deputy minister of the day, was that who provided you with direction?

A Yes. I would say it was more discussion. It was more often me bringing items forward. Now, as a, as a new branch of government, learning about policies and procedures, bringing things to attention that I thought he should know.

Q Okay. I'm sorry, how often did you say you met with the assistant deputy?

A Weekly.

Q Weekly? Okay. Now, in terms of the community board, which was only there, I appreciate, for a short period of time while you were there, can you comment on the significance of having a community board as compared to not having a community board?

A Yes. A community board has greater variety, I

think in the people who are serving on it. It has people who are, of course, knowledgeable about finance but it might have people from the university, who know about child protection or the latest initiatives, the latest research. A community board is more likely to advocate for more funds than a board that's a group of civil servants working for government.

There were slight -- there were differences in emphasis, perhaps. The community board was invested in having community prevention, early intervention, perhaps to a greater extent than government. I don't think that service existed to the same extent at that time.

Q I want to talk about the structure now within the agency in terms of, of reporting from you down. So if we can pull up on the screen Exhibit 15 please.

Good, thank you. This is a document that the department has prepared for us. You can see, I mean going I guess from, from left to right, which would be from the front line up to the top, through the chain of command, the categories of staff are social worker, supervisor, assistant program manager, program manager, director of program services, later chief operating officer, and then the CEO. Then if we -- and you can see that this is done chronologically, it's been divided according to services delivered specifically to Phoenix.

If we can go to the next page, please, you see you come on in the second level box, Linda Trigg, and after July 2nd, 2001?

A Yes.

Q Then if you go down to the, the bottom line, under the heading that was director of program services, later COO, it says "not applicable," and from then on, from July '03 on, there is no one in that role. Do you know what happened to that position?

A Yes, I do.

Q From March? All right, thank you. From March, March '03 on.

A Ms. Gelmon became part of what I think was called the change management team, gearing up for the transfer of cases to aboriginal organizations. Cases had to be transferred but also staff were sent on secondment so there was a considerable amount of planning for that, 2500 cases were, were transferred and probably two or three hundred staff.

Q Out of Winnipeg CFS?

A Yes.

Q Then her role never -- her position doesn't seem to ever have been filled, if you go to the next page, for instance, which shows the period '04 to '05.

A Which, under the circumstances was not

surprising.

Q While we're on this page you'll see that your role in the agency ends July 5, 2004?

A Yes.

Q So while we're on this page we look, for instance, at the, at the top line, you can see people who were below you, in terms of the, of the chain of command, the worker, supervisor, assistant program manager, program manager. In terms of this chain of command, can you explain to the Commissioner your understanding of the role and responsibility of each staff person in terms of delivery of services to children and families?

A In services to children and families the -- Barbara Klos would have been, at that time, the case manager, the social worker, working with families, directly. Diva Faria would have been her unit supervisor, providing supervision to her team of six to eight people, I can't remember the exact number.

There were a sufficient number of teams in service to children and families and intake that we had assistant program managers. There were some 16 or 17 teams so there were assistant program managers that supervised maybe six or seven supervisors and then there was a program manager who was responsible for overseeing the work of the assistant program managers.

Q What kind of contact did you have with these various levels of staff?

A My contact was primarily with the chief operating officer, Elaine Gelmon. I might also add Steve Toddlerhouse (phonetic), Director of Finance and Judy Morris (phonetic), Director of HR, Human Resources, because there were a lot of issues in those areas to address, too. And I would have contact with the program managers.

I wouldn't necessarily have one-on-one contact with the assistant program managers but we had a management meeting, at that time, every Wednesday morning that the --

Q Who attended that?

A The program managers and the assistant program managers. And then one week of the month it was just the program managers in case of any issues they wanted to discuss about their assistant program managers.

Q So you had regular meetings --

A Had a regular management meeting each week.

Q And those management meetings included the assistant program managers, except for one meeting a month or ...

A Yes. And it didn't start like that and I don't remember, I think -- I'd have to think. I, I was permitted by government to, to hire two or three more assistant program managers and then they started joining the

management meetings and I can't recall when they started attending the management meetings.

Q What kind of issues would you discuss at management meetings?

A A lot of the change taking place. There was a lot of information being distributed, there were a lot of questions coming from staff who were very nervous about what a secondment would mean, what the roll into government would mean because the collective agreements were different. There are labour issues, HR issues, and there were also service issues talked about.

Q Did you ever discuss specific cases?

A No.

Q Would there be other occasions when specific cases relating to, to a given child and family would come to your attention to discuss?

A Yes.

Q What would be an example? How would that happen?

A The minister's office gets an inquiry from the -- from someone in the public. School has a concern. An accident happened in foster care. So it would be unusual circumstances where a case would be brought to my attention.

Q What about from within?

A The work-a-day, the work-a-day cases were not

brought to my attention.

Q Did you have any meetings or contact with supervisors and/or social workers, workers?

A I had contact with supervisors, at the beginning we had an all management meeting and that included supervisors and that was the talk about the changes coming up ahead. I used to make a point, when I could, of going to team meetings to answer questions and just --

Q Who would -- team meetings were attended by whom?

A Supervisors and their staff. I made it to quite a number of the teams, wanting to get to know people, wanting to hear the discussion, wanting to get an idea of the climate, the atmosphere on the team. I wanted to be approachable so people would know me, and when I walked through the building they knew who I was and they would stop and chat and so forth, and I, I often found that just by asking questions of staff who were being at team meetings I have learned things or I would flag things for myself to ask the supervisor about or the program manager.

Q So where the actual front line workers, that is the level below the supervisors, were they at these team meetings?

A These were their team meetings with their supervisor that I would -- I wouldn't drop in on, I would ask in advance if I could come to the next meeting or the

meeting on such and such a date.

Q So how much contact did you have with workers for the period that you were there?

A Not a great deal other than informal.

Q Were you accessible if a worker did want to speak with you?

A Yes. But I would likely, if they had a problem, ask if they would talk to their supervisor or their assistant program manager because that would be the level of -- that would be the first level of problem solving.

And I also was located in a different building, there were no service teams in my building. There was HR and Finance.

Q So if a worker had a problem with, say, some aspect of their job, you would expect that they would take that problem to their supervisor?

A Correct.

Q And if the matter couldn't be resolved, at that point, that the supervisor would take it to their assistant program manager?

A Program manager, correct.

Q And if the matter still couldn't be resolved then it would go to the program manager?

A Correct.

Q And from there to you?

A Rarely. I think the program managers were competent, very competent, and managed their programs well.

Q But if, if necessary, that's how it would work.

A It would come to me, yes. For final resolution.

Q So during the time that you were CEO or interim CEO, did any workers ever contact you, directly, about issues relating to their position?

A I honestly can't recall.

Q And we'll come back to some of that.

A The other route, the other route, I would hear from the bargaining units, if there were staff issues.

Q How often did you --

A They would be more likely to come --

Q -- meet with them?

A -- that -- you know, I can't recall how often we met. We did meet and we met more towards the end as the -- for example, the employee transition agreement was being developed, that was the agreement whereby Winnipeg and government dealt with the fact that there were two collective -- two different collective agreements in operation, there's Winnipeg's with MGEU and government and there were different provisions in them.

Q There's different collective agreements?

A Yes. Because Winnipeg had been its own agency so had its, it's own collective agreement with MGEU and by the

way, had one with CUPE for family support workers.

Q Right. In terms of meeting with the bargaining agents, what kinds of issues would you discuss with them?

A The issues that they would bring to my attention were often workload issues, advocating for themselves, advocating for more staff, advocating for more money. When the actual negotiation was taking place, that was done by labour relations in government.

THE COMMISSIONER: This would be the government negotiating team you would meet with; is that -- was that correct?

THE WITNESS: No, I'm talking about meeting with our own bargaining unit.

THE COMMISSIONER: Your own bargaining unit.

THE WITNESS: Yes.

THE COMMISSIONER: The, the -- but, but with the government representatives?

THE WITNESS: At the latter stages, when the employee transition agreement was taking place, labour relations did the negotiations.

THE COMMISSIONER: Oh, I, I follow you.

BY MS. WALSH:

Q So the bargaining unit would be members of the unions, the relevant unions?

A Yes.

Q They would meet with you and they would bring to your attention concerns about, for instance, workload?

A Yes.

Q Or salaries?

A Yes, those sorts of things, what, what was going to happen when they rolled into government because there was some significant differences in the collective agreement.

Q Okay. And we'll come back to some of those issues.

A All right.

Q During your tenure, what guided how services were supposed to be delivered and by that I mean were workers and supervisors to be guided by standards, manuals, best practise?

A Winnipeg Child and Family Services had a program manual, a very thick one, from "A" to "Z". So, for example, the new supervision policy would have gone in there, the recording policy was in there. All the significant policies and all the mundane such as how to get a taxi slip.

Q Now, you're talking about policies. What about standards?

A We were using program manual because there was

some confusion about standards at that time. There were standards in development that had been piloted and then government suggested that they wanted to finish them, I think they would have been called -- it wasn't finished in my time -- foundational standards for all the authorities and agencies.

So my conversations with the program manager of services to children and families, Darlene McDonald, would bring to my attention that it did not seem clear and so we would discuss, okay, what do we need to ask, what do we need to write and say in terms of asking for clarity as to what we're supposed to use?

Q So in terms of what the workers and supervisors were to be guided by you're saying that was contained within?

A The program manual.

Q The program manual. And did that address all aspects of service delivery?

A I believe so. To be honest, I don't remember the entire table of contents. It was a thick manual. And alphabetized so if you wanted to know something specific you would go to that section.

Q Would you -- is it fair to describe what was dictated by that manual as best practise?

A Yes.

Q And who within the agency was responsible for ensuring compliance with best practise?

A The supervisors, primarily. And I think, to some extent, also the assistant program managers, who met with their supervisors. I don't know how often they did but I'm -- I would think that issues would come up there around best practises so workload issues or such.

Q If best practise couldn't be followed what, if any, expectation did you have as to what should happen?

A If it could not be followed, I assume that I would have been alerted. And certainly I was told that workload sometimes made it very difficult to do perhaps all of the steps involved in doing a completely thorough assessment or spending as much time with a family as a worker might like.

Q So are you talking about -- do you recall were specific instances brought to your attention of where workload made matters difficult or are you just talking that you were aware of it as a general issue?

A I was very aware of it as a general issue.

Q Was there ever a specific instance that was brought to your attention where you were told we could not do "X" because our workload did not permit it?

A I do not recall. I, I don't recall specific instances, there may have one, I do not recall.

Q In terms of being made aware that workload was a factor in delivery of services and following best practise, what timeframe are you referring to?

A Oh, the entire time I was there.

Q In terms of the impact of workload, was it that it made following best practise more difficult or not possible?

A I would think more difficult.

Q So far as you're aware, were children ever put at risk because of workload issues?

A I would probably have to say yes.

Q Can you --

A And I'm --

Q -- elaborate on that.

A -- I'm thinking, for example, about the Phoenix Sinclair case.

THE COMMISSIONER: Pardon?

MS. WALSH: Well, what, the witness said --

THE COMMISSIONER: I didn't get your last answer.

MS. WALSH: -- she's thinking about the Phoenix Sinclair case.

BY MS. WALSH:

Q So what about workload had an impact in -- on the Phoenix Sinclair case?

A Mr. McKinnon gave me copies of the Chief Medical Examiners report, the one done by Andrew Koster for the Office of the Children Advocate and the one done by the internal -- by Rhonda Warren and I would agree with -- assuming the facts are correct in those documents, I would agree with the findings and conclusions.

Q I -- so insofar as those relate to workload, you mean?

A Yes.

Q Okay. And we'll come back to that, as well.

What about at the time that you were actually overseeing the agency? Were you aware, for instance, during the time that services were actually being delivered to Phoenix, did anyone make you aware that workload was interfering with their ability to deliver services to Phoenix Sinclair?

A The bargaining unit made that aware. The bargaining unit also wrote to the minister at the time, Drew Caldwell, expressing concerns about workload.

Q And those are letters that I will take you to. Those letters are not specifically in relation to Phoenix Sinclair though?

A No, no.

Q So my question was, during the time that you were at the agency, were you ever made aware of instances where

workload was specifically interfering with or affecting services delivered to Phoenix Sinclair and her family?

A I thought I answered that so I'm missing something. I was made aware in a general sense.

Q Right, but specifically did anyone say we couldn't do something with respect to --

A No.

Q -- this file --

A No.

Q -- because of workload?

A No.

Q Okay. So you're only aware of a general --

A Staff would talk --

Q -- experience in the agency?

A Yes. Case loads higher than they would like, more complicated cases.

Q But you're not aware of a specific instance relating to services delivered to Phoenix and her family?

A I cannot recall somebody saying I couldn't do this because of workload.

Q In terms of your awareness then of the impact that workload had on delivery of services, what did you do about that, if anything?

A There were a number of initiatives that we undertook, actually. We knew we would not get more

positions at that point in time.

Q Why is that?

A That was made clear by government, the funding levels weren't going to change. So one of the things that I asked quality assurance program to do was look at the intake and crisis response units and try to break down the reasons why children were coming into care. And, for example, there were many, many, many openings and closings on families who had problems with alcohol so we had a team that would attempt to work with those families and essentially say, if you're going to drink and we know you're probably going to drink, fine, but make appropriate arrangements for your children.

Q When did you put that team in place?

A Oh, boy, you're testing my memory. Well, it wouldn't have been the first year I was there. You know, I can't recall. It would be before '03. And then we also had a parent teen initiative because another high percentage of intakes had to do with parent teen squabbles and trying to keep those kids out of care at age 16, 17. Less of a risk, of course, to having them out of care than three or four year olds. So we had a team that specifically tried to work with parents and teens --

Q So --

A -- to resolve their problems, to keep the volume

of cases as low as we could. Great emphasis on the community based program, community kitchens where I should -- perhaps shouldn't say just where the parents would get together, make a meal, take portions of it home. Clothing depot, supports, drop-in time for parents.

Q So an emphasis on prevention and that, that was in an effort to reduce workload by --

A Prevention and early intervention, yes.

Q Okay.

A And also prevent the cases from becoming more serious.

Q Right. Upstream work as it's --

A Yes.

Q -- sometimes called. By the time you left the agency were those initiatives still in effect?

A I understand they were. We also -- I don't know if this is relevant now or if it's relevant at all but we -- I spent a great deal of my time on a project with the shelters which was partly deficit reduction and partly trying to move children through the system faster to help with workload.

Q Those are all initiatives that you took responsibility for. Did, did you make your, your concerns about workload known to the people you reported to?

A Yes.

Q And what, if anything, did they do?

A At that point they felt that the changes had to take place before trying any other significant internal changes which might very well disappear six months later when the cases are sent to the aboriginal organizations.

Q And we know that devolution didn't fully roll out in Winnipeg CFS until the spring of '05?

A It was intended to be earlier and it turned out the planning was much more complicated. The AJI/CWI provided for the document, provided for one aboriginal agency in the city and then all aboriginal agencies wanted to operate in the city and that made for much larger scale planning.

Q Going back to, to compliance, did you personally have any responsibility for ensuring that -- and I mean you in the title -- for ensuring that services were being delivered according to best practise?

A Personally?

Q As the CEO?

A Well, as the CEO the buck stopped with me. I think that's an area of improvement, there was not a formal compliance program. So, for example, there was not somebody -- we asked quality assurance to take on the prevention, early intervention. They also could have started going through files, it was a choice, so we relied

more on supervisors or compliance, to look at files, to look at file recording, to meet with their staff. Have you seen this family, what's the service plan?

Q And was that true during the entire time that you were at the agency?

A Yes.

Q Did you have any requirements or expectations as to whether you would receive reports on compliance from anyone in the agency?

A No. I relied on conversations with the management team.

Q So if you're saying that you relied on supervisors to enforce compliance then issues would come up from the supervisors to the assistant program managers --

A Right.

Q -- with whom you met?

A Right.

Q Did you expect, as CEO, to be advised if best practise was not being followed?

A Yes.

Q And in that case what would you do?

A It would depend, I think, on the issue.

Q Did you receive such reports during your three years at the head of the agency?

A Only in general terms, workload, and not being

able to spend as much time with families, children as the case manager would like.

Q When you talk about hearing reports of families not spending as much time with children as they would like, are you speaking of family service workers then?

A Yes.

Q Did you hear anything about inabilities to comply with best practise at the intake level?

A No. Those teams had options to pass things on to family services.

Q But in terms of hearing --

A So a case didn't stay with them long.

Q But you didn't hear about -- in terms of within their sphere of responsibility you --

A Not to the same degree.

Q -- you didn't receive reports of best practise not being followed?

A Not to the same degree.

Q So the concerns about workload that you were hearing were with respect mostly to family service workers?

A Yes. I would say that intake was very, very busy and CRU was very, very busy.

Q But was it your understanding that they were not able to comply with best practise as a result? Did that issue come to your attention?

A No.

Q Let's talk about the education of workers who were hired by the agency. We've heard that workers doing front line protection sometimes came right out of the Bachelor of Social Work program. Did you have any opinion, as CEO, as to the type of education and training that was necessary for those front line hires?

A Yes. Actually, my -- probably my number one concern or among the top concerns was training. The workers had access to competency based training run by the province but I did not think that they had adequate clinical training. How to do a good assessment, how to assess events occurring on a day-to-day basis, what does that mean, how does it fit with the bigger picture. What questions it might lead you to ask.

Q It was your understanding that that -- those kinds of issues were not covered by the competency based training?

A I don't think much of it was directed towards actual clinical work.

Q How do you define clinical work, what does that mean?

A It means establishing a rapport with a family, and providing therapeutic intervention.

Q And that's something that you felt was necessary

for workers to have?

A Absolutely. And I don't think anybody coming right out of school is 100 percent skilled in doing all that. It takes experience, it takes supervision, it takes a supervisor to say well, but when that happened did you also think that this might be occurring, too?

Q So during your time as CEO did you ever see that kind of training taking place?

A We organized a group from Minneapolis to do training for intake and CRU on what was called motivational interviewing. Different ways of interviewing clients to get them more on side with you because there was sometimes a natural defensiveness with clients. And many of the seasoned workers could wear the child protection hat and still have a good relationship with a family but that requires skill.

Q At what point in, in the worker's tenure did they receive that training.

A I think they would have only received it from the supervisors.

Q So that kind --

A Training and supervision were two of my significant concerns and the supervision policy came into being which addressed that but by the time --

Q And we'll look at that.

A -- I left the training had not been fully addressed. The in -- then, when I left, I don't know about now.

Q Did you think that, that workers, newly hired workers, needed some kind of mentoring program?

A Yes. And for awhile there was one and then staff could no longer maintain it. But I also -- we, we brainstormed many ideas at the management table which we couldn't implement because of all the other changes taking place, it didn't make sense to re-arrange this only to have it unravel six months later, but one of the -- two of the good ideas were ensuring that a new worker did not have a full case load for the first "X" number of months. So maybe a year on the job.

We also talked about having a training team, a supervisor who got all of the new social workers, and was devoted to training them for a certain period of time. And they would gradually pick up cases and then go to service units.

Q Those were ideas that never had an opportunity to be implemented when you were there?

A No, because of the impending changes.

Q What about training for supervisors, was that something that was happening when you were there?

A Yes. The supervisors organized training for

themselves as a group. They often took the initiative. They organized training on supervision, they brought in a fellow named Tony Morrison, I don't remember where he was from, specifically to talk about supervision models and from that arose the supervision policy.

Q And we'll come to that, as I've said. We've heard a great deal of evidence at this inquiry about the relationship between workers and their supervisors, a little less so, so far, about the supervisors of the supervisors. What can you tell us about what was expected of those assistant program managers, for instance, in terms of the nature of oversight that they were supposed to have?

A Well, my understanding is they had a regular meeting with their supervisory group and they would talk about administrative as well as clinical issues and the assistant program managers would also do some one-on-one work with their supervisors, particularly if they were new supervisors.

Q Okay. Were there any specific policies or manuals that governed how those assistant program managers and program managers were to carry out their duties?

A Nothing specific.

Q They would be governed by the, the policy manual, as well?

A Yes. They -- and they would be governed by their

own knowledge of best practises because presumably they had been working for awhile if they had been promoted to that level.

Q Let's turn to the supervision policy --

A So one of my jobs was to make sure there were competent staff.

Q How did you do that?

A At the program manager level.

Q How did you do that?

A Through talking with them, one-on-one, through meeting at the management team. I, for example, made a change in the director of HR when I was there because I thought the person who was there was not doing the best possible job and that was very difficult to do that.

Q So you -- part of your responsibility, you felt, was to ensure that the, the assistant program managers, the program managers, were competent?

A Yes. Yes. And I said in one case, I and the interim management were judged someone not to be, and we regretfully let them go.

Q How would you know whether -- how would you make that assessment, whether a program manager or an assistant program manager was competent?

A By the actions that they undertook.

Q But how would you be aware of, of those actions?

Through your meetings with them?

A I could be aware through the meetings, I could be aware through listening to the conversation at the management table.

Q Did you --

A And sometimes I got feedback from external sources. I got feedback about, for example, about the director of HR, through the AJI process, her performance at the -- I don't know what it was called then but they had begun the meetings about staff transition.

Q Did you have performance reviews carried out of the program managers and assistant program managers?

A Probably should have but I don't remember how often it was done.

Q Let's look at the --

A I should add also, many of these people I had known through the system for 20 years so I had some understanding of their work. When I was at New Directions, as assistant clinical director, I worked with many of the program managers, who were not program managers in the various agencies. So these, these people were known to me.

Q Okay. Thank you. The supervision policy.

A Yes.

Q Let's pull that up, please. It starts at page 29040. You're still in the exhibit.

That was 29040, please. Thank you.

See at the top it says: "Implementation March 1, 2004"?

A Yes.

Q Is this the policy that you were referring to earlier --

A Yes.

Q -- by the way? Okay. Was there a similar or any policy with respect to supervision before March 2004?

A Not in the reorganized Winnipeg Child and Family Services, the reorganization that was done under Lance Barber's tenure. I do understand, from talking to people who ran some of the areas that they had their own policies.

One of the challenges in any reorganization is to make everything consistent across, across the organization and the regions did do things and function differently.

Q So each regional office would have its own, for instance, supervision policy?

A Or not.

Q Or not. Okay. Who did this policy apply to?

A Supervisors.

Q As we saw on that chart, the actual supervisors?

A Supervisors.

Q Okay. Did it apply to program managers --

A No.

Q -- or assistant program managers?

A No.

Q Okay, so specifically to supervisors?

A It was developed -- there is a context to why it was developed.

Q Please go ahead.

A The -- before I went to Winnipeg Child and Family Services the agency had taken the initiative to have Viewpoints Research undertake focus groups with staff about front line retention and turnover, which were big problems. And as a result of that, one of the recommendations of the Viewpoints was examination of a supervision policy. The supervisors picked that up and ran with it by organizing, as I mentioned, the Tony Morrison workshop and from that they put together -- they assembled a supervision policy which eventually came to management for review, suggestions and then for distribution.

Q I gather then this policy that we're looking at is something that the agency expected staff supervisors to comply with?

A As of March 1st, 2004, yes.

Q If we look at page 29044. This is at addendum "B", with the heading "supervisor notes". It says:

"It is recommended that

> Supervisors record the following:
> - Case material discussed in supervision.
> - Supervision activity.
> - Information that belongs in a personnel file."

Then it discusses, under the heading "Record of the Supervision Session" and the items that should be recorded. And then if you scroll down some more please it says:

> "These notes are available to the Supervisor and the supervisee. These notes should be used to inform annual performance reviews. These notes can also be accessed in the event of a grievance, discipline, inquiry or complaint. They should not/cannot be destroyed. Upon completion of performance reviews, as noted above, the supervisor notes should be placed in a sealed envelope and filed in his or her office. When

> a Supervisor leaves the Branchy her or his notes should be summarized into a performance appraisal and then archived as per our Branch's archiving process.
>
> When a supervisor has direct contact or provides an intervention on a case ... this material should be recorded as per our Branch recording policy and provided to the assigned social worker for inclusion on the client file."

Now, I noted that if we you pull up document -- page 29038, this is a memo from you, dated January 20th, 2004 regarding the supervision policy. Can you just tell us about, about this memo?

A This memo was a procedural memo to indicate that this was now part of the agency practise and at the bottom I outline the steps to be taken to, to distribute it and go over it with people rather than just hand it out as a piece of paper.

Q So if we can scroll down please, the steps:

"Step one --"

So you say:

> "To implement the Policy by March 1, 2004, we now need to take the following steps:
> ... one: Assistant Program Managers should review the Supervision Policy with their respective supervisor groups.
> ... two: Supervisors should review the Policy with their staff.
> ... three: All Supervisors and Managers should initiate development Supervision Contracts (attached) for use with the new policy."

And we've heard evidence, during the course of the inquiry, that supervisors shredded their supervision notes at the time that they left the agency, shredded notes after a file was closed. Was that an acceptable practise, in your view?

A Absolutely not.

Q Now, what about if that was done before the policy that we're looking at was in effect?

A That's still inappropriate practise. You need, you need the record, you need the past history in order to go forward with a case.

Q Were you ever made aware of supervisor's notes being shredded or otherwise not retained?

A No.

Q Before this policy was disseminated, before you sent it out, did you ever communicate to -- through the, through the, the hierarchy that supervisor's notes should be retained?

A No. Never in my wildest dreams did I think somebody was shredded their notes.

Q And just generally, how did you communicate directions to the agency as a whole?

A One of two ways. It was either through the chain of command or it would be a memo, such as this.

THE CLERK: (Inaudible) screen is on.

THE WITNESS: Okay, thank you.

BY MS. WALSH:

Q I think you told us that it would not be common for you to have knowledge about the circumstances of an

individual's specific case or family?

A A work a day case, no.

Q And so within the agency, the staff who had responsibility for knowing what was happening on an individual's client file was --

A The case manager.

Q -- or were.

A The social worker, who is also called the case manager. They were managing the case.

Q What about their supervisor?

A And I would assume, through supervision, they would have knowledge of the worker's case load.

Q You did refer to quality assurance. During your time as CEO, were there any quality assurance measures in place at the agency?

A No. That was coming on stream. But we did direct some of their activity towards the early intervention and prevention. The, the base care initiative at intake, that I talked about earlier.

Q Right. That, that was quality assurance associated with that?

A Yes. And they did do a full examination of the permanent ward program. That would have been, for example, why children were permanent wards, did they need to be? I don't know what else was studied but they did do a thorough

review of that program and I imagine would have moved on to others.

Q Also --

A But they were rolled into the change management unit.

Q So what you told us about earlier in terms of looking at the underlying reasons why cases --

A Yes.

Q -- were coming --

A Yes.

Q -- to the agency, that was part of a quality assurance --

A Yes.

Q -- initiative.

A Yes. And they also did a thorough examination of the permanent ward program.

Q Were files, like specific case files, ever audited?

A That was a topic under great discussion because they were not routinely and we were trying to figure out where we could get the staff to do that. And at one point we talked about the administrative assistants at least pulling files to see if there were basic information but they did not have the time. So again, that fell to supervisors and I think that was a weakness in the agency,

that there wasn't a formal file audit process.

Q That's something you think would have been a good idea?

A Yes. And it was something, as I said, was under discussion. It's not that we were unaware of it, we were aware of it.

Q Were there circumstances in which staff are required to fill out incident reports of any nature?

A Yes.

Q Can you give an example?

A Oh, my memory fails me. But if a child fell and broke an arm in a foster home, an incident report. If a neighbour complained about a shelter next door, there would be an incident report. Anything out of the ordinary that I would want to know, we wouldn't want to be caught off guard knowing something significant.

Q Okay, so those reports would come to your attention?

A I don't know if the actual piece of paper did but the program managers and the chief operating officer would certainly keep me apprised, minute by minute, if something like that happened.

Q In terms of ensuring compliance then was the, the --

A Oh, I do remember a specific one but that's okay.

Q Okay. Was the, the main responsibility for ensuring compliance, did that fall on the supervisors of individual case managers?

A For the work a day cases, yes.

Q And was there a process that a supervisor was supposed to follow if they found that a worker was not complying with best practise?

A Well, I assume they would ask the worker to take some corrective action and if not I assume it would be reflected in a performance review.

Q What would be an example of corrected action?

A Whether it be changing the way they interact with families. There were sometimes workers would get frustrated, they could get angry and defensive, which was unhelpful. So sometimes it was helping them achieve an equilibrium again because it was not unusual for the case managers to be attacked, verbally attacked.

Q So would corrective active include being sent for some kind of training?

A Corrective action also -- what was the topic? I read a report, a review, that the Child Protection Branch had asked for, and it, it -- in the report it was clear that the worker who wrote it was very angry and I think this was the death of a child in foster care. And the worker had become very punitive, which is unhelpful. You

need to at least have a neutral approach in writing reports so people will read them and pay attention to your recommendations. And a supervisor had to do some work, some talking with the worker about the position she had put herself in.

Q And that --

A And how to get out of it.

Q -- came to your attention?

A Yes, it did.

Q Okay. Performance reviews, was there an --

A It came to my attention because the branch asked for a report on something, from one of the abuse units and I don't remember how it got to my desk. Yes, I do. I heard that it went to the branch and I took issue with the fact that it should have come through my desk first before it went to the branch. Unfortunately, it had already gone to the branch before I saw it, and there was just a very punitive, negative tone.

Q Performance reviews. Was there an expectation that performance reviews would be done of front line workers by their supervisors?

A Yes.

Q How often?

A I don't recall.

Q Did you look for those reviews?

A No.

Q Who was expected to look to see if those reviews had been done?

A I would think that would have been the assistant program managers, working with the supervisors.

Q And your understanding is that that was an expectation within the agency that those performance reviews would be done?

A Yes.

Q How often?

A I don't recall how often, and if you talk about best practises and slippage that might be an area of where there would have been slippage.

Q In not doing performance reviews --

A Yeah.

Q -- you mean?

A In favour of doing case work.

Q In terms of, of standards, you said that there was some discussion about which standards were in effect at various times when you were CEO?

A Yes.

Q Okay. We heard evidence, we have heard evidence, that workers were not trained on the standards. Was that something you were aware of?

A Yes and no because there was confusion about what

we were training them with so we used the program policy manual and I know in the competency based training they covered some standards in that training.

Q Were you aware whether confusion about standards was actually a problem in terms of workers knowing how to do their jobs? Was that an issue that came to your attention?

A I think because the agency did actually have a strong program policy manual the information would have been contained in that manual.

Q So regardless of whether it's --

A But our manual might --

Q -- in standard 1.1 or standard 3.5, the underlying information, you're saying --

A Would be --

Q -- was available to workers?

A -- in that manual but, you know, another agency's manual might be different so you want a common set of standards that everybody is using.

Q Sure. But within your agency you think the information that was --

A Was available.

Q -- otherwise in standards was contained in the policy manual. And how available was that manual to, to staff?

A I think that each unit had a copy of it.

Q Was there training on that manual for either supervisors or workers?

A Probably just by supervisors and that's something, for example, we talked about a training unit. If they're a training unit then they would be fully trained in the manual and everything else they needed to know.

But I can imagine it was hard for supervisors. If you have a hundred percent turnover of staff in a year you're constantly trying to remember how to check list about what do I need to do with my new staff person. Or my yet another new staff person.

Q During your tenure can you remember what, if any, requirements there were for workers to have face-to-face contact with a child in the context of doing a child protection investigation?

A You couldn't do a child protection investigation without having face-to-face contact with a child.

Q Would there have been any doubt about that within the agency when you were there?

A It's impossible to do an abuse investigation if you don't talk to or see the child.

Q Or -- now you've used the term abuse investigation. Does the same apply if you call it a child protection investigation?

A Yes.
Q Okay.
A There were two units dedicated to abuse investigations when cases were referred to the agency by schools, by daycares, so forth.
Q In the course of carrying out a child protection investigation, you're saying there would not have been any doubt within the agency that the child who was the subject of that investigation had to be seen?
A A formal child protection investigation I'm talking about. I'm not talking about reviewing an assessment or reviewing a case plan.
Q What --
A I don't, I don't know --
Q I don't --
A -- I --
Q -- I don't think we've heard about what reviewing a case plan, what that means.
A Oh. I'm just using different terminology. The assessment that pulls all -- together all the information about the parents, partners, children.
Q Is that at the family services level?
A No, that would typically be at intake level.
Q Okay.
A And they would make a determination, based on

their assessment, as to whether to send the file for ongoing family service.

Q So when a call came into CRU, to the crisis response unit, about suspected abuse and it's --

A Right.

Q -- no more specific than that, and the workers go out to investigate that call, is that a child protection investigation?

A Yes.

Q Okay. And so when I said was there any doubt in the agency that when you're doing a child protection investigation you have to have contact with the child who is the subject of the investigation?

A I would think not.

Q No doubt.

A Although my understanding in the Phoenix Sinclair case, in one instance, it did not occur.

Q Yes. But in terms of a requirement to do it there would not have been any doubt that it was necessary. You're nodding but we have to pick up --

A Yes.

Q Sorry.

A I'm sorry.

Q Thank you.

A You would get a call from a school, the child

protection investigator has to go talk to the child at the school.

Q Sure. Now, you have touched on this but, in general, during the time that you were CEO of, of Winnipeg Child and Family Services what was the work environment like?

A It was very difficult, very, very difficult. Staff were extremely apprehensive about the secondment process, they didn't know whether they would be welcome in the aboriginal organizations. As far as rolling into government, nobody knew what would happen with pensions and how that would resolve because the plans were different. It was, it was a tough working environment and we had an anonymous question box to which staff could submit questions and we would write answers for them.

Q What were some of the -- did staff take advantage of that box?

A Yes, they certainly did and there were lots of questions about AJI/CWI, what happens to us? What -- there was the letter from the Minister, reassuring staff about having a position was extremely helpful.

Q The one that we looked at --

A You looked at --

Q -- from November of 2001?

A -- because that was on the minds of a lot of

staff, where am I going to be at the end of this? And they also had to do things such as the authority determination process, with all cases, determine which authority a child was going to be moved to. So there was extra work involved, too.

Q Those anonymous questions, those actually came to your attention?

A I think it was the question box. Yes, I think I wrote most of the answers but Elaine Gelmon, the Chief Operating Officer, wrote some, too. Or if it were a finance question, the chief financial officer might have answered it. Whomever was the appropriate person, who had the most knowledge about the subject, answered it.

And when we rolled into government, I recall there was one question that was best directed to, to one of the assistant deputy ministers and he answered it.

Q And the answers, where were they put? Were those delivered to the, to the agency, as a whole?

A Yes.

Q Okay. If we can pull up, please, page 39788. This is an interoffice memorandum from you to the interim management board, dated November 19, 2001. And it contains a synopsis of key issues that were facing the agency and that were to be addressed through the upcoming transitions. It covers topics such as the structuring function of the

agency, service trends, staffing and human resource issues, deficit reduction, impact of the AJI/CWI. The future of the agency and change, other areas to address in the devolution.

And what prompted you to write this memo?

A My purpose was to give the interim management board some information about the agency. Key issues that I thought they should know about.

Q Okay. So if we look at some of those --

A That was an orientation for them, essentially.

Q For the new --

A Interim management --

Q -- interim management board.

A -- board under Jay Rodgers. Um-hum.

Q All right. And was this something you took the initiative of doing?

A Yes.

Q Okay. Okay, if we look at the memo you talk about the changes that are resulting from reorganization and you said some were positive, some were not. If you look at page 39791. 39791. Here you talk, in the second paragraph about:

> "... programs are under significant stress or still in the

process of clarifying roles and responsibilities. An example of the latter would be Intake, which was not only restructured --"

You say.

"-- during the 1999 reorganization but again in ... 2000."

You described it as having many "internal problems, including 'after-hours'." And you say: "I am not convinced that --" you say that:

"A centralized intake was designed to provide consistent service for the city. I am not convinced this goal has been achieved and furthermore the centralized system has robbed the 'front line' Services to Children and Families teams of community contact."

What were you talking about there?

A Well, prior to having specific intake teams,

before the 1999 reorganization, for example, a team that worked for a long time with the same supervisor in St. James was well known to the schools, to the daycares, to the community resources in that area and they did their own intakes.

Q And --

A So they were better connected with the community, they were -- CRU intake serves children more of a distance.

Q And we've heard that, that the agency relies on to a large extent referrals from the community, including from collaterals, so you're saying that, that connection, direct connection with the community, was of a benefit to intake services?

A I think it was a benefit to the teams and I'm sure some of the teams managed in their area, after re-organization, to develop that in some but they didn't receive, for example, the telephone call from the school so they might not have had the same working relationship with the school or the daycare.

Q Um-hum. And those are important relationships.

A I mean, it's hard to say, really, which one is better.

Q Then you go on to talk about:

"Services to Children and Families

as an example --"

If we scroll down, please.

"-- of a program under enormous stress." These teams have no control over intake; they have no connection to resource centers, daycare, and clothing depots; they no longer have consistency of other supports such as family support workers; they no longer have case aids ... they feel completely disconnected from the foster care department ...

Even more serious --

You say.

"-- is the fact that since the 1999 reorganization there have been many opportunities for staff to transfer from front-line protection work to other programs, a phenomenon that has decimated the workforce --"

Can you scroll up, please.

> "-- in child protection services (see detail below under Staffing Issues)."

And if we scroll down to page 39794, I think this is, this is the chart that evidences what you were talking to us about before in terms of staff turnover and seniority. Can you just walk us through what this chart shows?

A What it shows is the percentage of people who have served a certain number of years in each program once the program system was developed.

As I said before a service team would do a bit of everything and you would have a range of experienced, inexperienced workers. But if you look, for example, at foster care, there are 69, 69 percent of staff had worked over 10 years.

Q Right.

A If you look at service to children and families, 12 percent had worked over 10 years, whereas 45 percent, that's almost half the staff, had worked one to two years. And in adoption, if you look at that, 76 percent of staff

had worked more than 10 years.

Q And what was the explanation for that, in your view?

A As soon as a position became open in a program that might be -- they had all had stress associated but perhaps not having to make the judgments moment to moment that you do in service to children and families, or intake, or deal with families who are defensive and angry at the agency, what would happen was when a vacancy became open in adoption or permanent wards, because of the collective agreement the most senior position who applied got that job.

So anybody -- the most senior person, for example, service to children and families, would get a job opening in another area, although -- I'm trying to think what would be the preference. What it meant was that as soon as a position became open in what you might say -- I hate to use the word happier but maybe less stressful --

Q Yes.

A -- someone would leap from the front line to that program.

Q Was there a difference in salary, too?

A No.

Q So just the nature of the work. And you're saying that other programs, other than services to children

and families attracted senior people?

A Had senior people because it was a seniority driven --

Q I see.

A -- employment situation.

Q Okay.

A So the most senior person who applied to, say, foster care, if there is an opening, got the job.

Q You conclude your memo, on page 39805 -- and the memo does go through a number of concerns, it's fairly lengthy. You conclude it by saying that:

> "In closing, although there are serious challenges within (the agency) ..., in general I have been very impressed with the willingness of staff to talk openly about their concerns. I have also found that among the generally beleaguered crew who often feel defeated and battered, many are genuinely concerned about the well-being of the children and families they serve. Restructuring consumes

> considerable time and energy, sometimes at the expense of service and many staff are weary of perpetual change of structure. As we proceed through the upcoming transitions it will be important to listen to the concerns of staff and management about the organizational climate and culture and about day-to-day business."

Now, did you receive a response to this memo from the interim management board?

A Not a specific response.

Q Did you receive any response then?

A To the memo, itself, no. Some of the topics were discussed over a period of time.

Q Who would you have expected to hear back from after you delivered this memo?

A I would have expected either the board, itself, or the chair of the board. In fairness to them, they -- I was in the Minister's office when they were given their marching orders which is essentially to reduce the deficit.

Q And what's the significance of telling us that?

A They were all civil servants and I think many

felt that they had been charged with doing a job and they needed to do it and that was a priority. Their own performance rested upon some of the, the mandate given to them by government.

Q And just finally before we conclude. Did you continue to raise the issues that are outlined in this memo with the board?

A From time to time.

Q And what kind of a response did you have?

A There was usually some good brainstorming. On the other hand, there was also a lack of understanding fully of the differences between government and the agency, particularly in regard to the collective agreement. For example, they would tell me well, just move people from adoption to front line. You couldn't do that under the terms of the Winnipeg Child and Family Services collective agreement. In government, I gather they move people as they need them moved.

Q Did you see tangible responses to the issues raised in your memo during the time that you were CEO?

A I would have to go back and look at them all, quite frankly. Can you scroll to the first page?

Q Sure.

A I think I did an outline on the first page.

Q Yes.

A Thank you.

Q The first page was --

THE CLERK: (Inaudible) is how far back?

THE WITNESS: The very top of the memo.

MS. WALSH: It's 39788.

THE WITNESS: Could you scroll down a little bit more? Thank you. Certainly there was lots of discussion about deficit reduction. Lots of discussion staffing and human resource issues. Much discussion about the short term placements, shelters, hotels. And there was a fellow, initially, from Labour Relations on the intermanagement board and unfortunately he left, Bob Pruden, who was helping them understand, and explaining the collective agreements.

So over time many of these issues were discussed. They would come up, obviously, the impact of the AJI/CWI.

BY MS. WALSH:

Q Would you have expected or wanted something more than just discussion, though, to address the issues?

A It's hard to say. Sometimes they were directive and sometimes not because there wasn't necessarily a hard and fast solution. So it might have been left with management to come back to the table with some ideas about something.

MR. WALSH: I think, Mr. Commissioner, given that it is after 5:00, this would be an appropriate place to stop.

THE COMMISSIONER: I think that's reasonable. Now, I understand the witness has time constraints on Monday.

MS. WALSH: Yes. How -- we generally start at 9:30 and how long can you stay?

THE WITNESS: Well, unless I rearrange my schedule, my first client of the day is at noon.

MS. WALSH: Okay.

THE COMMISSIONER: Well, I know you're rearranged your schedule to make possible today so I don't want to interfere with your practise. I notice you have a number of documents still to go through, Ms. Walsh.

MS. WALSH: I'm about two-thirds through my examination, I think.

THE COMMISSIONER: Well, why don't we just start again at 9:30 and, and presumably you need to leave by 11:30. If, if we're not done, and we may not be, we'll just have to pick another time when the witness has an hour or two, whatever counsel think they need.

MS. WALSH: Sounds good, thank you.

THE COMMISSIONER: I think that's the only practical way of doing it.

MS. WALSH: All right.

THE COMMISSIONER: So we'll have you back at 9:30.

THE WITNESS: 9:30 on Monday?

THE COMMISSIONER: On Monday morning. And we'll, we'll see you leave at 11:30 and you may -- we may have to find another date to finish you up, if we don't get finished but I don't want to interfere with your practise.

THE WITNESS: Thank you.

THE COMMISSIONER: All right. We'll adjourn now till 9:30 on Monday morning.

MS. WALSH: And we'll still be here in this location on Monday.

THE COMMISSIONER: Yes, Monday and Tuesday and all the following week.

MS. WALSH: Yes. Yes.

THE COMMISSIONER: Yes.

MS. WALSH: Thank you.

THE COMMISSIONER: All right. Thank you.

MS. WALSH: Thank you.

(PROCEEDINGS ADJOURNED TO JANUARY 28, 2013)