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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TUESDAY, JANUARY 29, 2013

APPEARANCES

MS. S. WALSH, Commission Counsel
MR. D. OLSON, Senior Associate Commission Counsel
MR. R. MASCARENHAS, Associate Commission Counsel

MR. G. MCKINNON and **MR. S. PAUL,** for Department of Family Services and Labour, and for witnesses Mr. Patrick Harrison and Mr. Lance Barber

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

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

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

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

MR. N. SAUNDERS, for Assembly of Manitoba Chiefs and Southern Chiefs Organization Inc.

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JANUARY 29, 2013

PROCEEDINGS CONTINUED FROM JANUARY 28, 2013

MR. OLSON: We're ready to proceed?

THE COMMISSIONER: Yes, please.

THE CLERK: Would you stand for a moment, sir. Is it your choice to swear on the Bible or affirm without the Bible?

THE WITNESS: I'll swear on the Bible.

THE CLERK: All right. State your full name for the court.

THE WITNESS: Patrick William Harrison.

THE CLERK: Spell me your first name.

THE WITNESS: P-A-T-R-I-C-K.

THE CLERK: And your middle name, please.

THE WITNESS: W-I-L-L-I-A-M.

THE CLERK: And your last name?

THE WITNESS: Harrison, H-A-R-R-I-S-O-N.

THE CLERK: Thank you.

PATRICK WILLIAM HARRISON, sworn,
testified as follows:

THE CLERK: Thank you. You may be seated.

DIRECT EXAMINATION BY MR. OLSON:

Q Good morning, Mr. Harrison.

A Good morning.

Q Just want to start off going through your background a bit starting with your education. I understand you obtained a bachelor of social work in, was it 1980?

A No, I obtained a master of social work in 1980.

Q Okay. When did you get your bachelor?

A I don't have a bachelor of social work.

Q You don't, okay. And was, was your masters from the University of Manitoba?

A Yes, it was.

Q And aside from that you've received a certificate in non-profit organization management from the continuing education division of the management studies section of the University of Manitoba?

A Yes, I did.

Q That was in 1990?

A I believe so, yes.

Q Was there any other educational related to -- education related to child welfare work?

A No. I have an honours degree in history from the University of Winnipeg and that may have some relevance but --

Q Okay.
A -- the ones you cited are most important.
Q When did you start your career in the child welfare field?
A I began in -- I appreciate you've allowed me to refer to my résumé. In 1980.
Q Where was that?
A That was at the former Children's Aid Society of Winnipeg.
Q And what was your position there?
A I was an intake social worker there.
Q For how long did you stay in that position?
A I was there for approximately two years, two or three years.
Q And where did you go after that?
A I'm sorry?
Q What was your -- what, what did you do after that?
A Then I assumed responsibility as a family service supervisor, again, at the Children's Aid Society of Winnipeg.
Q And for how long did you do that?
A I did that for less than two years, and then the Children's Aid Society of Winnipeg was dissolved, so the, that position ended.

Q And then did you transfer into a new position at --

A I --

Q -- was it Northwest Child and Family Services?

A I assumed a, an equivalent position at northwest, family service supervisor, yes.

Q Is that basically a continuation of what you were doing previously?

A Same general job description, different agency, different area of the city, but essentially the same work.

Q Which area of the city were you servicing?

A I was in the northwest. Northwest Child and Family Services. Our office was on Keewatin, which is in the western part of the North End.

Q Okay. For how long did you stay in that position?

A I was there for 13 years, as I reflect on my résumé.

Q Was it the same position for the full 13 years?

A Yes, it was.

Q And that would have taken you up to, what, 1999?

A '98, if my reference is correct here. Then I changed positions at that time.

Q What position did you take in 1998?

A I became a director of services and supervised,

supervisor at the Salter office. That was a, a very busy office in the heart of the North End. There were four supervisors there that were responsible to me.

Q Was that part of Winnipeg Child and Family Services?

A That was, at that point was Winnipeg Child and Family Services, northwest area, after the result of another reorganization.

Q Would that have been a management position?

A Yes.

Q How many workers were you supervising?

A Well, I supervised four supervisors and they, in turn, had, I would have to check, six or eight workers each. So it was an office of about 40 when you count all the staff.

Q Right. Then I understand in 2003, think it was March 2003, you became a program manager?

A No. In January of '99 I became a program manager with responsibility for permanency planning in Winnipeg Child and Family Services.

Q For permanency planning?

A Yes.

Q And what's permanency planning?

A That program was responsible for the children that we had in permanent care as well as adoption services,

with a hope that some of those children would be adopted and move out of agency care.

Q Okay. When you say -- and you said you were a program manager at that unit or service?

A I'm sorry?

Q You said you said you're the program manager --

A Yes.

Q -- at that time?

A Yes.

Q What did that work involve?

A Well, again, I was supervising supervisors. The, the team had seven social worker -- seven supervisors, I should say, each managing a team of about seven or eight workers, so my responsibilities increased to approximately perhaps about 70 staff that I was responsible for, but I directly supervised the seven supervisors; was responsible for the program, the services and their work.

Q Was that, would that program be throughout the City of Winnipeg?

A That's right, yes.

Q For how long did you hold that position?

A Held that position for about four years.

Q Following that, is that when you became the program manager at CFS for, where you're supervising Mr. Wilson and Berg?

A That's correct. I was the program manager responsible for intake and early intervention.

Q For how long did you hold the, the position as a program manager?

A That particular designation, I was there for about two years but I was at the intake service for a total of about four; as it changed, my title changed, the reporting responsibility changed, the governance changed within that period, as well.

Q Okay. So just so you can nail it down, when did you start that position exactly?

A Started that in March of 2003.

THE COMMISSIONER: And that was just with intake?

THE WITNESS: That was -- yes, that's right.

BY MR. OLSON:

Q Intake and early intervention?

A Right. That would include some community programs, as well, which was part of the intake team at Portage Avenue.

Q So from March 2003, and then you said you did that for two years?

A Right. As I, I note here again, to July of 2005, so a little more than two years.

Q July 2005. And then July 2005 something changed?

A Correct. The devolution process was under way and I was hired as the first executive director of what was initially called the joint intake response unit.

Q That's what we've heard be described as JIRU?

A Correct.

Q And, sorry, what was your position with JIRU?

A I was the executive director.

Q The executive director position is something different than a program manager, or was it, or was it a similar job?

A Well, it was a similar, similar job. The reporting -- the governance, as I said, the reporting responsibilities were different but I was still responsible for intake function and related services.

Q As program manager -- and that's the period I'm going to be mostly concerned with is that --

A Right.

Q -- you understand that, from March 2003 until July 2005.

A Right.

Q Who were you reporting to at that time?

A Initially, I was reporting to Linda Trigg.

Q That -- we heard that Dr. Trigg was replaced at some point by Mr. Rodgers, Jay Rodgers?

A That's correct, yes. Within that -- it was

within that timeframe, the 2003/2005 period.

Q So at some point you started reporting to Mr. Rodgers?

A Yes, that's correct.

Q Can you describe what the position as program manager was like during that period, again, starting in 2003?

A Well, intake was and still is a very busy place. I would liken it to a emergency room of a hospital. There's much activity, many cases, many situations being reviewed. When I came into that position, I was asked to assume that position because there was concern that the intake function of the intake program was not well supported by senior management, there was not enough attention being paid to that. Our predecessor, Rhonda Warren, was there by herself and they felt that, that more support to that team was needed.

Q Just with respect to that, so before you came on it was Rhonda Warren who was doing your job?

A She was the program manager for intake just before me, yes.

Q Okay. And the structure when you came on, we heard it was you and then there were two assistant program managers underneath you?

A Right.

Q That was a different structure than what existed previously?

A Yes.

Q And you're saying previously Ms. Warren would have been doing the job of the three of you; is that ...

A Yes. Quite an unreasonable load for her, and the decision was to increase that support.

Q Okay. That's why you were brought in?

A Yes. As well as my colleagues.

Q So, and I interrupted you. You were explaining what the position was like at that time.

A Well, as I say, it was very busy. We were going through a series of changes. For Winnipeg Child and Family Services that first event, a shift from a private agency to a branch of government, so that was a significant change for staff. There was anticipation of the devolution process where responsibility for intake would shift to one of the authorities and staff would be shifting as well. So it was a period of transition.

Q We've heard evidence that the morale in the agency and in intake was fairly low at that time, it was problematic because of all these changes. Is that, was that your experience?

A Well, there were a number of factors. The changes were certainly significant. That uncertainty I

think affected staff. I think staff were also feeling the effects of the fact that Rhonda had more responsibilities than could reasonable handle by one person. I don't think they felt that there was a strong connection to the management team because how thinly she was spread. So think the hope was that the three of us could, could improve that relationship.

Q Do you, do you think that the new structure improved that, the way the units functioned and, and the workload in terms of ...

A I think we had a better relationship with our supervisory group and with our line staff but the increasing pressure that people were experiencing as they anticipated devolution continued to impact staff.

Q In terms of the quality of work in intake, was that affected, in your view, by all these changes occurring, changeover to government, change devolution process, change in structure?

A I think that, I think that uncertainty affected staff, yes.

Q How so?

A Well, I think, if you're -- a well-running organization has stability at the top with consistent governance, consistent policies, predictability in terms of your job responsibilities, who you report to. I think

that's how a strong organization is built. And at that point all of those things were changing for staff and that, that would have an effect.

Q Would that -- did that create some confusion, in your view, in, in the agency and in, in intake?

A I think that would be fair to say.

Q What impact would that have on the services being delivered to children?

A Well, I think, again, as people are uncertain about their future, that, that has some impact. They're not sure where they're going to be, whether they're going to continue with that function, whether they will be asked to change, change responsibilities. They also anticipated, in the latter part of that period that you refer to, that, that cases were going to be, were transferred, were going to be transferred to different organizations. There was a -- Winnipeg was less and less able to absorb those cases because they were transferring cases themselves to the new agencies so that all had an impact, I think, on staff as they were aware that, that these cases were moving.

Q So wouldn't be clear where cases necessarily would end up in the future once they're open, is that ...

A Sorry?

Q So are you saying it wouldn't be clear to the workers where the cases were going to end up after they

were opened?

A Well, first of all, Winnipeg was, was trying to manage a process where they were moving cases out to the other agencies. Again, this is in the latter part of this period, in 2005 period, and try to move cases from intake to Winnipeg. But Winnipeg had a reduced capacity to take those cases at that point in time because they were, in turn, transferring their cases to the new agencies.

Q What was involved in transferring cases?

A Well, there's a -- all the cases had to be summarized, recording brought up to date and put in a reasonable package for, for reception at the new agencies.

Q It was anticipated that some cases would stay with Winnipeg, though?

A Absolutely.

Q Did you -- was it necessary to prepare the transfer for those cases as well or to do a review of those cases?

A That was, that was the intention because within Winnipeg there would be a staff shuffle within Winnipeg, some staff would be leaving to go to these new agencies, some staff would be remaining behind. Their duties within Winnipeg would change, possibly.

Q So every case open at, at the family service level would have to be reviewed for this, this transfer, is

that ...

A That's correct, yes.

Q What about cases that were in intake, would they have to be reviewed?

A Well, it's the same process at intake. I mean, intake carried on. The demand for service doesn't cease so the cases continued to come in. But I think staff were aware that they had to -- as they always are, that they have to move the process along, the demand continues.

Q How did that need to review these cases impact services at the time?

A Now you're talking about intake or ...

Q I'm talking about at intake. How did, how did that, the fact that the authority determination process was occurring, how did that impact the workload at intake?

A Well, the workload continues. The demand for intake services is pretty constant. We were receiving, I think through this period, about 15 or 16,000 requests for service per year. That continued unabated. What we had to manage was trying to assess them in a timely way, come to some conclusions and transfer as many cases as we possibly could, could be absorbed by Winnipeg and the other agencies who were beginning to receive cases as well.

Q I take it that would impact the amount of time workers had to work on new intakes coming in?

A I expect it had some impact, yes.
Q As program manager, what was your role within the organization?
A My responsibilities were to hire the, hire the staff. I had responsibilities to make --
Q When, when you say "hire the staff", would that include all staff, including the workers or ...
A Well, I, I was -- first of all, I should make very clear that I, I was responsible for the entire service.
Q Okay.
A So I was responsible for the appropriate delivery of the intake service and early intervention services that we're able to provide.
THE COMMISSIONER: Are you talking about two o-three/two o-five period now?
THE WITNESS: Yes. Yes.

BY MR. OLSON:
Q So if we're looking at the quality of services over that time, you're ultimately responsible for the quality of those services?
A I am, yes. So I was responsible for, make sure that we had the proper policies and programs in place, that we had the right personnel in place, that we had -- I

spent, certainly, time looking at the significant cases that came to our attention. I had reporting responsibilities in that 2003/2005 period to senior management at Winnipeg Child and Family Services. Again, that was Linda Trigg and then latterly Jay Rodgers. And I would suggest, and maybe this has been understated through this inquiry process, that one of my significant responsibilities was to maintain a strong relationship with our community. So I spent a good deal of time speaking with community groups and organizations, particularly organizations that partner with us to address the, the social problems and issues that came to our attention.

Q Can, can you give us some examples of which groups you're talking about and how that worked?

A Sure. Examples would be the education system. We depend strongly on a partnership with the, with the schools. They are the ones who see kids. They often have better relationships, more significant relationships with children. That's an important partner organization.

Q Just before you go on from that.

A Sure.

Q What would the, what would the interfacing with the educational system look like?

A Well, it was --

Q What would you do?

A Sure. I mean, it was, it was an exchange of information. It was important that they understood what our mandate was, what the services that we could provide. It was important that we understood what the various school divisions and schools could provide to their students and, in turn, to us. And it was most important to have that kind of dialogue, and we had a familiarity with one another's programs and services and that we could dialogue that and hopefully provide better outcomes for the families and children that we had in common.

Q How, how, how was that done? How was the dialogue created or --

A Well --

Q -- was it created?

A I, I often spoke to school divisions, to, to large groups of principals, guidance counsellors, social workers in the child guidance clinic, often would speak to them. Sometimes that was a large group, a group of two or three hundred people. Sometimes would be a small group at a school. I also encouraged our intakes supervisors, as they had the opportunity, and their opportunities were very limited, to establish those same kind of relations in the area that they were responsible for, the geographic area that they were responsible for. As you recall, the second tier intake was geographically, the work was geographically

designated, so if you were responsible for the North End hopefully you would have some contact with schools in that area.

Q Is that something you expected of the assistant program managers and the intake supervisors?

A As, as best they could. Again, I'm, I can't understate how busy they were with day-to-day cases but as they had opportunities to form those relationships, that was very important.

Q You mentioned the education system. What about other community resources (inaudible)?

A Sure. I mean there's, there's, there's literally hundreds so it's hard to, impossible to list them all. Public Health, another key partner that we worked with. Employment and Income Assistance, Probation Services, many of the individual agencies that are out there to support families, whether it's the Ma Mawi centre, Native Women's Transition Centre. There were many organizations, like sort of more stand-alone organizations that work with families.

Q Was this interfacing with community services essential to your role as program manager?

A Absolutely. Absolutely.

Q Why was that?

A Well, we -- this job is very big. Our

responsibilities to families and children are, are very broad, very onerous. We can't possibly do this job unless we have those partnerships, it's impossible.

Q You said you were reporting to Ms. Trigg and then Mr. Rodgers. What, what was the reporting process?

A I met regularly with them. I participated -- so they would, they would meet with me individually to review issues and processes and progress at intake. I remember Jay in particular would come over to 835 Portage Avenue to meet with me individually on a regular basis. I also participated in the senior management meetings at Winnipeg Child and Family Services which would include Jay or Linda as the chair, and then other program managers with other responsibilities.

Q What was the purpose of these senior management meetings?

A Well, purpose was, again, to -- very similar to mine, is to look at our policies, our programs, whether they were delivering the services they were intended to; to look at, again, personnel issues; to look at human resource issues; to consider case themes rather than -- more so than individual cases, because that would be very difficult given the numbers that we were dealing with, but to look at, examine those, consider those and see if we had the proper programs in place.

Q Is it -- am I correct that you wouldn't have looked at individual cases in your role, or rarely would, rarely would you look at individual cases?

A Well, I don't know about rarely, but not to the same degree as the other folks on the, on the organizational chart. Certainly, cases came to my attention by staff, by Rob and by Dan and by other supervisors. I was involved in case discussions. And then, of course, we'd receive calls from, from the community asking to speak to the director or somebody in a more senior position to express concern about action or lack of action on a case.

Q You were describing your, the functions that you had as program manager and you talked about interfacing with the community.

A Right.

Q What, what were the other functions that you had?

A Well, I, I think I listed them as best as I can recollect. Again, it was to, to look at the policies and programs that we had.

Q Okay.

A To make sure that they were delivering the service that we intended them to serve.

Q Okay. I'll stop you there. How --

A Sure.

Q -- how did you do that?

A Well, we had -- one thing that we were fortunate to have is that Rhonda left a, an intake manual that she developed that I believe you have a copy of there. That is a very helpful -- that was our, I think our foundation document for our purposes as we were operating the intake service. That was developed, and so we used that as our reference.

Q Okay. Maybe what I can do is, just so we have the reference --

A Sure.

Q -- I'll just have that pulled up onto the monitor.

THE COMMISSIONER: Did you say who developed that manual?

THE WITNESS: Did I say who did?

THE COMMISSIONER: Yes.

THE WITNESS: Yes, it was Rhonda Warren.

THE COMMISSIONER: Rhonda Warren.

THE WITNESS: I believe that document is from 2001.

MR. OLSON: That would be, it's Commission disclosure 992, starting at page 19625.

BY MR. OLSON:

Q Is, is this document you're referring to?

A Yes, that's the document.

Q So this document pre-dates your, your role as program manager?

A That's correct, yes. We inherited it.

Q Okay. Was there -- did you do any updating of the document while you were in that position?

A No. We -- first of all, I thought it was -- I reviewed it, obviously, recently and thought it was a very reasonable document for the time. It was like a good description, over 60 pages with appendices of what we needed to do so we didn't update it, I guess particularly, that I can recall. There were no further edits. Also, we were very mindful that the intake program would change with devolution and that was, that was made clear to us, that there would be a revision, a review and perhaps a revision as a different authority assumed responsibility for intake, that they would want to review the whole thing. So it didn't seem to be a worthy effort at that time because it was going to be changing.

Q Aside from this document, the intake program manual, were there any other policies or guides that, that govern practice at intake?

A That's the one that's the most significant one

for us. Through this process, the intake module, of course, emerged and helped, and that was, that was put into play, as was the authority determination protocol as a, as a second or third document and policy that was put into place. Those were the, the ones that I remember particularly.

Q But in terms of day-to-day practice in intake, whether it's CRU or tier two or after-hours unit, workers would, could look to this program manual to --

A That would --

Q -- determine how to react to situations and what they should be doing?

A That would be their principal reference to.

Q Did -- we heard a lot of workers say they didn't have a great deal of training, particularly on standards. Is -- was there any training on, on what's contained in this manual, any formal training for workers?

A Well, I would think that all workers, certainly their supervisors and, and hopefully it was disbursed widely and available, that they would have had a copy of that or easy access to that, and that would have been their reference document. The standards I think were available to each supervisor but I think we felt that that document provided more detail and more direct -- more direction, appropriate direction to staff than the, the standards

which were, which were in some disarray.

Q Okay. Aside from having reference to this document, what, what else would you expect to govern social workers' individual practice?

A Well, I think -- well, Linda made reference the other day to a very large manual, which I believe was there, but the size made it a bit daunting for day-to-day reference. Certainly most of the staff there were degreed social workers with bachelors and masters of social work, and their best practices as they would have been trained at the faculty of social work would have applied as well.

Q We, we heard, and I think it was Dr. Trigg, talk about clinical judgment.

A Right.

Q Is that something that you would expect the workers to come to the intake unit with?

A Yes, they should -- as I say, they've, they've gone through a social worker process, a three or four-year process. They should have developed those skills, not fully, that, that generally occurs with further work experience, but they would have a beginning understanding of that.

Q Workers, a lot of workers said that they came right out of university with their bachelor of social work --

A Right.

Q -- and started immediately with, you know, caseload of many files, and that would be more for family services, but imagine the same thing with intake; you're given a number of calls to deal with initially?

A Well, first of all, the intake staff was generally a more experienced staff. I think that's how it was structured, that we needed people who had some experience in child welfare, who had seen different situations and were not daunted by them, could, could respond to them appropriately. So we had a more experienced staff.

Q And when you say that, it's because they came out of maybe Family Services or some other area?

A They could have come from that service, they could have been at intake for a very long time. Some of our staff have been here, been there 10, 15 years doing intake. If we had new staff join us, and occasionally there would be a new grad join the intake team, I would have expected the supervisor would have provided a mentoring situation for that, for that new staff and, and some, and some consultation with senior workers to help them adjust to the demands of the job.

Q Who reported to you during this period of time, 2003 to 2005?

A That would be Dan Berg and Rob Wilson.

Q What did the reporting by them look like? Can you describe it for us?

A Well, on a formal basis, Rob, Dan and I met with the, the supervisory group as a large management team. We had regular meetings, and that was, I think, something that we tried to establish to make sure that they understood they were an important part of the management group, the management group wasn't just Rob, Dan and I, it included all the supervisors, so that all of us could participate in discussions about our programs and the challenges. So that was one, one venue. Then Rob, Dan and I met, the three of us, regularly and I also met with them individually on a regular basis. So that, that would have been the formal process. And then again, because this is a busy place with cases and situations developing every day through the day, we would talk often through the day, and our offices weren't separated by much. I'm sure I saw Rob and Dan many times each day.

Q I'd assume there'd be certain issues of concerns and problems that would come up regularly at these meetings?

A Right.

Q What, what were those? Can you give us some of the more significant ones?

A Well, as I said, just the trend, the changing environment was a, was a major issue. Referred to that already. Perhaps I need to go over that again.

Q Right.

A The workload, which was very significant then and continues to be today to my understanding, it's, the demand for services is very high, so the absolute numbers that we were dealing with. In general terms, I think to the challenge of dealing with a high risk population is something that we're always managing. A significant portion of our caseload are high risk families with difficult histories and many other, many other issues that we had to monitor and assess and try to make some plans for.

Q In terms of workload, was it part of your job to address how that workload was being distributed or how it was being handled?

A I would be aware of that. That would probably be something that Dan and Rob had more involvement with because they were the ones directly supervising the supervisors. I believe there were 12 of them. I, I should note that, that I had responsibility for one team, the after-hours team, so I had a small responsibility. They had much larger responsibilities to the supervisors involved in the day-to-day work so they would have been

trying to make those adjustments, depending upon the, where the stress point was at that time.

Q So just want to make sure I understand you. Are you saying that it wouldn’t be your, wouldn't be part of your position to address the workload issues?

A No, I maybe not fairly described it. I mean, I needed to be aware and was very much aware of the, of the workload challenges. I think your question is more about the day-to-day workload stresses and, and they were trying to address that and rebalance that and adjust that within their teams. But I was keenly aware of the, of the workload stressors upon the whole organization.

Q Was there anything particularly unusual about the workload in intake during that period of time?

A Maybe you could --

Q Was it --

A -- describe a little bit of what "unusual" is. It's --

Q Is it higher than -- we've, we've heard that in child welfare the workload is always high.

A Yes.

Q Was it higher than you would have expected?

A No, I, I've, I've said, as you've seen I've had many years of service with Child and Family Services, the workload has always been high and often beyond our

capacity. This was true here. I think what made it more difficult, there was not the raw numbers. It was the Same number coming in perhaps, was still the 15,000 annual referrals. But what was more challenging was the, the work environment, changing dynamics --

Q Changes.

A -- within that environment.

Q Okay. Terms of the problems that families were having that would bring them into contact with the system, was -- had that also changed? Was that also in transition at the time?

A That's a, that's a good question. I think that over the years that we've seen more families in more difficulties, more kids in more challenging situations than when I first began in, many years ago in 1980. I think we've seen a, there's a serious segment of our community that is in very, very deep distress and, and the kids are, too. And so we see that. And I think, I think we should be greatly concerned about, about those families. So that's a gradual process I think that has occurred over these past 30 years. So to try and define it, a period, say '03 to '05 was that worse, I think it was becoming more challenging but it's, it would be hard to describe it more specifically than that.

Q We've seen in this file that there were a number

of intakes and file closings and number of different workers touching the file.

A Right.

Q Which seems to be a function of the intake process.

A Yes.

Q Was that an issue in terms of clients who were using the system being concerned about not having any continuity of service? Is that something that you had to address, deal with?

A That's, that's, that's always been a serious question at intake and an issue we struggled with for many years. We have changed the intake format over the years and had a single point of contact. Then we've gone to a more specialized service where you have, as you've noted, CRU and intake and abuse intake and family enhancement programs and community programs and so on, after-hours programs, so we have a very sort of fractured service. And yes, it's quite true that families may meet four or five workers in the intake process, depending on what happens to them.

On balance, over the years, I think we've decided that that's has, while it has some challenges, particularly for, for families, that that's probably worked better than the single point of having one person carry the whole

process through.

Q We've heard that -- or you said, actually, earlier today that intake service is similar to, you called it, like emergency department in hospital.

A Right.

Q Is -- and report writers have said that services were provided on a sort of a crisis response. Is that, was that your -- when you look at the files, do you agree with that assessment?

A Well, I want to be careful about the words that are used. It's, it's, it is an intake service. It's the point of first contact for families in our communities, whether they're calling about themselves or they're calling about another family that they're concerned about. So we are the first stop. I think that crisis is over-rated in our service because I think you need to be thoughtful about what you do before you start acting. There are certainly situations where a urgent response is required and you need to make that response, but in most situations you have time to reflect upon it, even if it's for a half an hour, and gather more information before you get involved and respond.

I think the, the urgency becomes in the need to keep the process moving because the, the cases come in in such great volume that you, you can't pause too long. You

have to move the case along because there's more coming in. So that's where the process needs to be compressed so that you can assemble all the information in a timely way, move it along and get ready for the next call or client that will walk in.

Q In terms of when a workers get, gets a new referred, for example, in CRU --

A Um-hum.

Q -- we've heard that some workers would just look at the last closing summary and not, not the whole file because there just wouldn't be the time to do that. With that sort of approach, it seems you might miss some of the important things that may otherwise be in the file. Was that -- I mean, is that a problem that was in your mind at the time?

A Well, that's a risk. I mean, certainly the workers, we would expect the workers to review the file record. Some of the file records, unfortunately, a very voluminous and that, that's a challenge, so you're often referencing -- or summaries that are, that are there simply for efficiency: you don't have time to read several hundred pages on each file that comes in so you'd rely on summaries, highlights, whatever, but they surely should look at the past history.

Q Was it your expectation that workers would look

at past history?

A Absolutely.

Q And that's despite time constraints?

A That's right. And as I say, they may have to find some more efficient ways to, to do that, as I say, look at our case summary rather than, than the pages of, of, of dictation that had accumulated over the years.

Q During your tenure, did, did any worker, either directly or indirectly, make known to you that they were having difficulty complying with best practice because of workload or workload pressures?

A That was a constant thing that we would hear.

Q How did you address that?

A Well, we tried to provide support and direction to staff to try to manage it, provide supervisory supports so they didn't feel alone as they had to make those difficult decisions. So we tried to manage it within. It helped staff deal with the demand as best they could. But my responsibility as the, as the program manager and later, as the director, was to make sure that the people that I reported to, whether it was Linda Trigg or Jay Rodgers, or later in the process to other, other governing bodies or persons that -- of this, of this challenge here, and they were well aware of that.

Q So the challenge was well known?

A Absolutely.

Q And you tried to do certain things to address it?

A Right. Internally, we tried to do some things internally, within a very limited scope.

Q Right. In your view, was -- were, were the measures you to took to address it successful?

A We had, we had some success. We tried to, we tried to rebalance caseloads. On the odd time we would have, be able to bring in other staff, but there was no wave of new, new employees coming in so it was -- there were -- we had, were able to make some small adjustments. So were we successful? I think we managed. I think as Mr. Wilson said yesterday, we were able to manage. Was it optimal? Was it best practice all the time? I would say no.

Q We've heard supervisors say, you know, there wasn't always time to have active supervision or to comply with the standards, workers didn't have time to look through the files to do a full history. Why not just have -- bring more workers on?

A Well, first of all, we weren't funded to bring more workers on. I think Linda described yesterday the situation, at least in 2003, and I don't think it had changed significantly when Jay Rodgers joined us later that, in the period. There was a limit to that. And that

was not just at intake, that would have been across Winnipeg Child and Family Services, because I was aware that challenges they were facing. I don't want to suggest that this was an intake problem. This was a systemic problem where the workload for, for all staff was, was, was too high.

Q So you're saying it was essentially a budgetary issue, there just weren't funds to hire new workers?

A I think sometimes the problems that we have in this community overwhelm our ability to respond.

Q Did -- in your view, did the workload pressures put children at risk?

A Well, I should, I should be clear that children are at risk. We are managing risk; that's what we do. That's what the Child and Family Service system, one of the principal responsibilities is to manage, manage and mitigate risk, so there's always children at risk, there always are, there always will be. Your question is did we, did we manage; is that, is that your question?

Q Well, the question was did, did the workload pressures place children at risk?

A They increased the challenge managing the risk.

THE COMMISSIONER: They increased what?

THE WITNESS: The challenge of managing the risk.

BY MR. OLSON:

Q Can you explain that a little bit, what you mean by that?

A Well, again, we are dealing with a, often very high-risk population with many, many challenges. If there are more cases than you can manage, then you're going to perhaps complete assessments that are short of best practice, transfers. Files may be closed instead of opened because family service can't absorb the cases anymore either because they have too many high risk cases. So you're always managing that, and the caseload impacts, the heavy caseload impacts that.

Q In your view during your tenure as a program manager, did CFS do a good job in managing the risk to children?

A I think overall we managed the risk as best it could be expected under those circumstances. Was it perfect? No.

Q Just want to ask you about note-taking and record-keeping.

A Sure.

Q Assume you're aware of the, the policies with respect to supervisors keeping notes and workers keeping notes?

A Right.

Q Those, that policy, we looked at the, the document earlier, the program manual, seems to require notes to be kept and to be preserved. Is, is that your understanding of what the policy required?

A Well, I think, I think we need to look a little more deeply at that. We expected our staff to complete full summaries with full narratives on their involvement with a family.

Q And when you're saying the staff, are you talking about the individual workers?

A Yes. I'm talking --

Q Okay.

A -- about the CRU staff, the intake staff, all of them. We expected them to keep a full record of what they observed, the facts that they had gathered, the, the actions that they had taken, the recommendations that they were making. We expected a full report on that. Did we expect them to keep every scrap of paper that they may have jotted things down, phone number on a, on a napkin, a little notebook that they may have taken out as they visited families? I didn't have that expectation because I think that's, that's redundant. The -- we expected a full report, include all that information there.

It's also not in the worker's best interest to not include that. I can't understand why they would not

include stuff in summary because that was their task, was to complete a full summary with all the relevant data.

Q I take it you've had a chance to review the various documents with respect to this matter, closing summaries, transfer summaries, those, those types of documents?

A I've -- what I've reviewed for this process was the, the reviews, the external reviews, the three, four, five reviews that were done on this matter, and I reviewed those documents.

Q When we've heard, for example, Mr. Zalevich testified that he may has asked certain questions of Ms. Kematch --

A Right.

Q -- but there's no record of them in his, in his notes, is that -- would you expect things like that to be recorded by workers?

A I think that, that would have been very helpful to record the contact, because it sounds like the, the total contact was rather brief, so it wouldn't have been difficult to include all of the, the conversation.

THE COMMISSIONER: I understand you say it would be helpful. The question was whether you would expect the recording to have occurred.

THE WITNESS: It should have, it should have

reflected the totality of the conversation, not necessarily verbatim but the totality of it.

BY MR. OLSON:

Q So it should be comprehensive?

A Yes.

Q And complete?

A Yes.

Q And if someone looks at it down the road at a public inquiry or somewhere else, they should know what actually happened of significance during the involvement of the worker?

A That would be the best practice.

Q How is it that workers would have been aware of that as best practice?

A Well, I think that the intake manual you refer to suggests that that's, that's what required, that a complete report, comprehensive report, including all relevant data, would be included.

Q And that was to be conveyed, I think you said, by supervisors?

A Yes.

Q To the workers?

A Yes.

Q We've heard from some supervisors who said they,

they've shredded their own notes.

A Right.

Q Some that were case specific.

A Right.

Q And that doesn't seem to be in compliance with the policy. Were you --

A Which policy? Which policy?

Q The intake program description and procedures.

A Could you, could you make reference to that?

Q Certainly.

A Specific, or specific references to, I'm, I'm sure clear.

Q Let's go to page 209 -- sorry, 29040.

Sorry, and I made reference to the wrong policy. I should have been referring to the supervision policy. That's Commission disclosure 1634.

A Right.

Q Page 29040. It's in the screen in front of you.

Is this a policy that supervisors at intake were expected to comply with?

A This was a supervision policy written for Winnipeg Child and Family Services as a general guideline to all supervisors within, within the agency. I think that it would be applied differently whether you're a family service supervisor as opposed to an intake supervisor, as

opposed to a foster care supervisor. There would be different ways to apply this. But the, this was designed to establish the principle that supervision, as it says, is critical to the delivery of service.

Q Right. In terms of supervisors keeping their notes, preserving their notes, would that apply to the intake supervisors?

A Well, I guess that's where I'd like to draw the distinction between family services an intake. In family services, because I've supervised both, both programs, in family services you have a stable caseload with a record that accumulates over months and years so it's very reasonable to have a, have a running description of your, of your conversations about the Smith family because you've been dealing with the Smiths for many months and sometimes many years. So the record accumulates in the supervisor's notebook as they continue to talk about that case.

At intake, the cases are changing constantly. It's unreasonable to have notes on all the cases, even on most or even some of the cases, because, for example, at CRU the caseload changes every 24/48 hours so you're not going to be able to record that. What you're probably going to have at intake, at CRU and intake, is a conversation about a case. And if there's a major decision, it would probably be recorded by the worker in

their notes that we did confirm with supervisor that I was going to do this or that or that this would be the plan. But for the supervisor to maintain that up-to-date record on all of the cases that are passing across his or her desk is not reasonable.

Q Wouldn't it be important for a supervisor to at least keep notes of their supervision sessions with workers?

A They would keep some notes, and I think probably at intake those notes would reflect themes, work behaviour issues, case themes, that they would keep those, they would keep notes about that with perhaps a very brief reference to the Smith file, as an example of a case, but without much detail because again it's, that file is moving on very quickly.

Q What about maintaining a record, though, of what a worker, what advice a worker was given and how a worker responded? Wouldn't, wouldn't it be important to do that?

A I would hope that the worker would maintain that as the one keeping the, the, a record of the conversation. Again, the supervisor has a supervision session was, which I think we were trying to encourage would occur monthly is only one of the venues where that kind of conversation would occur. There would be, hopefully, monthly supervision if they could maintain that, but there would be

minute-by-minute conversations as people popped into the office, said, I'm going to do this. There were hallway conversations, there were quick conversations in cubicles. And I guess that's where I liken it to an emergency department; you're having conversations all the time throughout the building. Are all those conversations recorded? No. Is it realistic? No.

Q In your view, what was the role of CRU during that period of time?

A The role of CRU was to take the initial call, assess, gather the demographics, find out who is -- which family we are talking about, understand the, the reason for the call, assess the urgency of it, try to determine what other collateral organizations might have been involved, whether it was the education system or the EIA system, others who might know this family. Determine the validity of the call, whether we feel that the caller has true understanding of the case. And then, make a determination as to whether -- what kind of response is needed, whether an urgent response is needed because the child is in immediate danger or, as we've seen through this inquiry process, whether the, the response can be delayed by 48 hours or five days or whatever the, the timeframe.

Q That was CRU's task, was to determine what the

response time should be on the file?

A That was one of their responsibilities.

Q One of their, one of the responsibilities. When it comes to collecting the demographic information, what, what was the expectation of a CRU worker?

A The CRU worker should have a good understanding of, of all the people who are in the home, the, the adults, all the children, as best they can collect that. That would be the expectation. Whether they were able to achieve that, sometimes the caller is only aware that there was child, because they, they only see the child, they didn't know who the adults were, they didn't know if there were other children; so the worker would have to pay -- make additional efforts to try and figure out who is in that home.

Q Would it be appropriate for a worker to say, you know, I'm just a CRU worker, I would expect intake to get all the more detailed demographic information?

A No, I think at that point it would have been, again, best practice to, to obtain all of the information if you could. Unfortunately some of that, some of that information-gathering may take a very long time because the caller may only know the house, not know who's, who's there, so sometimes it takes a long time to, to gather that information. But ideally, and in most cases, they would

gather it all.

Q Does the fact that it may take a long time to get certain information, you know, some digging would have to be done or CFSIS checks, or whatever, would that negate the need to do that at CRU?

A I'm sorry, would that ...

Q Negate the need to do, do that at CRU because it was going to take some time to get the information? Does it then not still fall on the CRU worker to get that information if they can?

A It still falls, I think, on the CRU worker. But then you have to, you're always juggling caseload. If this, if it is taking several weeks to gather all that information because the information simply isn't easily available, and I think, as you've heard, you may go out to house, nobody is there; you go out repeatedly, the building is locked, there's nobody there, we can't figure out who is there. It may take a longer period. I think probably some CRU workers kept that case to try and figure that out, some send it up. That would maybe vary from worker to worker, and particularly on the environment at the moment. If they're completely overwhelmed they might try and move it faster incomplete because they're, they're running out of time, more cases are coming in the front door.

THE COMMISSIONER: Do you accept anonymous calls?

THE WITNESS: Absolutely, yes.

THE COMMISSIONER: And, and take it from there.

THE WITNESS: No, we, we take all calls and take them all seriously, and the Act guarantees that a caller's anonymity is valued and they -- that's not disclosed. So if somebody calls, we assume it's serious. It's always helpful to find out who it is. You get some perspective as to why they're calling. Maybe it's an aggrieved ex-spouse and you might look at that a little more critically than a school teacher who is a bit more independent. So you -- but you look at it all. But anonymous calls are, are just fine, we take them as --

THE COMMISSIONER: And --

THE WITNESS: -- as equally legitimate.

THE COMMISSIONER: And determine whether they are worthy of following up?

THE WITNESS: Yeah. And I think we would, we would follow up on most of them unless there's some obvious reason why not. We, because we generally don't know whether it's true or not so you probably have to investigate further. But if it's the fifth call about the family that month we might look at it a bit differently (inaudible) so would depend.

THE COMMISSIONER: Thank you.

BY MR. OLSON:

Q When it comes to calls coming in anonymously, we've, we heard the call that came in from the foster parent being concerned about Samantha Kematch potentially abusing Phoenix and locking her in the bedroom.

A Right.

Q That was described, I believe, as a soft abuse referral. Is -- what's your take on that? Is there such a thing as a soft abuse call?

A Well, I don't recall hearing that particular adjective described.

Q Or vague or non-specific?

A Right. That, those would be the terms that I've commonly be familiar with.

Q And what does that mean in terms of how you deal with a call like that, what the expectation would be for dealing with a call like that?

A Well, I think if it's not specific, obviously we're trying to get as much information about who, who is calling, why are they calling, what do they actually know, how do they know that, what's the nature of, of this so-called abuse, do they have any information about that. We would try to pursue all that and try to get more clarity as to what the, what the true allegation is. If it was a call with a confirmed indication of abuse by, for example,

a school teacher who has a child in their office with a black eye, we would respond to that immediately because it's validated by independent party, there's an identifiable injury, and we would respond immediately to that.

If it's a vague, to use your term, or non-specific allegation, then we would want to try and find out more information before we would just rush out, try and find out who is this about, which family, who is in this family and, and then, with as much information as we can and in as timely way we can, go out and try to confirm that.

Q But it would be important to obtain as much information as you could?

A Yes.

Q Including who was in the family, what was the family's history?

A Right.

Q What kind of contact had the family had with CFS previously?

A Right.

Q Those would all be important factors in determining the response?

A Yes. In either, in either situation. In a more -- in a confirmed view situation, a little more vague

allegation.

Q And, call like that, I understand that there -- that it wasn't unusual to have vague calls coming in concerning abuse, that was something that happened fairly frequently?

A We got all kinds of calls, about abuse, about neglect that were, that were vague and not, not very specific.

Q Would the fact that many calls like that came in or they became a matter of routine, mean that they would be treated any less seriously?

A No, they're still serious because we don't know the detail. It could be very serious, are we just getting a bit of, sort of tip of the iceberg, or it could be something that's not, not true at all. So we, without confirming that, be difficult to proceed.

Q All right. All you know is there's a concern there?

A There's a concern.

Q And whatever the file shows in terms of history, who's in the home ...

A We'd, we'd know that and then we'd have to investigate further.

Q Okay. Just want to go back to the intake program description and procedures, page 19634.

If you got, could you scroll to the bottom of the page, right there, under "Recording Outline: Closings - CRU", would this be the process that workers and their supervisors in CRU would be expected to follow during the time you were program manager?

A And you're, you're referring to the section "Recording Outline: Closings - CRU"?

Q Yeah, Recording Outline --

A (a), (b), (c)?

Q (a), (b), (c).

A Is there, is there, is there more or is that the full section?

Q That's the full section.

A Okay. Can I just take a moment to just read that?

Q Please.

A Okay. Sorry, your question?

Q Was this, was this the policy or procedure that workers were to follow, workers and their supervisors were to following when considering a case closing at CRU?

A Yes.

Q When -- under (a), where it says:

> "Cases warranting no response or no further response after AHU or

CRU intervention may be closed. If there is a previous case history, a file review shall be conducted prior to closing."

A Right.

Q What was that? What, what does that mean? How, how did you interpret that?

A Well, I would understand that if the CRU worker received, excuse me, a referral, that they would have gathered all the information, as much demographics as possible, would have reviewed the history, if there is any, and would have determined that there was no current child welfare/child protection concerns, there's no current child at risk, and they would, with -- having gathered all that information, would, would recommend that the file be closed.

Q So the worker gathers information, recommends the file be closed?

A Right.

Q Where it says if there's a previous case history a file review shall be conducted prior to closing.

A Right.

Q Was it -- who was responsible for doing that case, case -- sorry, file review?

A The, the worker would have been responsible for, for doing that file review.

Q At what point in time was the worker responsible for doing that?

A Well, ideally, as I said earlier, I think if you had an opportunity to take, take the call, gather what you can through the initial referral and then pause to look at any additional information that would have been available on on, on the --

Q On CFSIS?

A On, on CFSIS, on the fire record. You take that information, you look at the history and then you decide how you proceed, which might involve further interview with the family, it might involve a closing at that point, although more commonly it would involve a further investigation directly with the family.

Q When it comes to actually closing a case, what's the ultimate consideration that should be made or determined before the case is actually closed?

A That's the current issues of interest that we are satisfied that there is no child at risk at that point.

THE COMMISSIONER: Satisfied what?

THE WITNESS: That there is no child at risk at that point or in danger. And often if there is no opportunity to engage the family or they are followed by

another system, that would be an element that you would consider.

BY MR. OLSON:

Q Those are the things you would expect a worker and a supervisor to have in mind when they're looking at closing a case?

A Right.

Q (c) here on this page. It says:

> "All cases opened to Intake, Abuse or any other unit shall remain with that unit for assessment, intervention or closing. Cases shall not be returned to the CRU except when the receiving unit cannot reasonably respond in the time frame required to ensure safety. Such a return shall be negotiated between receiving unit supervisor and the CRU supervisor. Once cases are opened to an Intake or Abuse Unit they shall not be returned for the sole purpose of further information gathering."

We've, we've heard that some cases, cases would be sent to intake from CRU and they'd come back down to CRU. Is that what this provision is speaking to? I know this pre-dates your tenure as program manager.

A No, I think that's the intention of the, of the point (c) there, section (c).

Q Was that something you were aware of as, as program manager, that there was issue about cases going up to intake, being sent back down?

A I was aware that that would happen on occasion. I, I had understood that most of the cases pass from CRU to intake without debate but there was some movement back and forth for a variety of reasons. Not back and forth, but there was discussion that occurred.

Q Was it always a case that when cases came back down from intake it was due to a conflict or intake refusing a file?

A Well, I, I think conflict isn't perhaps the right term. There's, there's discussion about whether it's possible to gather more information at CRU. There would be probably discussion about workload, that who, who is in the best position at that moment to respond, to gather more information or to take the next steps. Sometimes I think it might come down because one intake unit might be feeling quite overwhelmed, can you do a little bit more. So

there'd be some useful discussion. The important thing was to resolve it and, and make the inquiry, whether it was CRU or intake, carry on with our process.

Q The file's going up to intake, if it's being referred to intake from CRU --

A Right.

Q -- seems to me that would indicate that CRU has determined that there is some risk and further investigation is required.

A That's a reasonable assumption, yes.

Q In that case, would it -- would there be -- if a case comes, is sent back down from intake to CRU, would it be reasonable to assume the expectation would be to close the file if ...

A No, it would be different for each situation. Would be sent down for -- I mean, there's all kinds of reasons it could be returned: We need more demographic information, please try and make another visit, could you check on this part, is public health involved, I mean just a wide range of reasons it could be returned.

Q In terms of that processing occurring, when you say it did occur, files being sent back down, would it be documented somewhere as to what happened or why it happened?

A I, I wouldn't expect that it would be documented.

It would be a conversation. We have two CRU supervisors at this point, we have four intake supervisors, they are separated by a very short physical distance. They are colleagues, they know one another, I would hope they would simply have a discussion and resolve it. I don't think that would necessarily be documented. The important thing was just resolve it, settle who's going to deal with this and, let's go.

Q In your experience, was, was it typically a contentious issue when that happened or was it more of a negotiated --

A I think --

Q -- agreement?

A -- I, I think most of them were negotiated agreement. There's some give and take. If there was some further discussion needed, I think that's, that point that perhaps Dan Berg or Rob Wilson would have become involved to try and mediate and resolve it and do so in a timely way because the important thing is somebody needs to respond to this call, make some further investigation, and it needs to be done.

Q Just want to ask you about safety assessments. If we -- you go to the next page of this document, 19635. It's (inaudible) "Safety Assessment". Can you explain what this is?

A Believe this is, of course, in the intake manual and provides some direction to CRU workers and to after-hours workers, who are the crisis response folks, that these are issues that they should look at, they should attend to if at all possible.

Q So when a CRU worker is filling one of their roles of determining what the response time is, should they have in, in mind these factors that are listed on, on 19635 and 19636?

A Yes, these would be the, this would be a list of, of things that they should be considering.

Q And (m) on this list is:

"Child(ren) is vulnerable because of age or other factors ..."

What was the significance of that (inaudible) --

A Could you just maybe -- sorry. Could I just ask that to be scrolled down?

Q Oh, sorry. Can ...

A (m)?

Q (m).

A Right.

Q What was the significance of age as a risk factor?

A Age is a factor because children of a younger age, particularly at preschool, are not visible in the community. There are no other eyes on them. They're not in school, they're not in daycare often. Also, as younger children they don't have the same voice as an older child. Adolescents tell us loudly and clearly when they're having difficulty often; two and three-year-olds don't. Their young age, because they're just growing and developing, they are maybe a bit more fragile, depending on the age. Obviously, a baby is more vulnerable than a teenager to an, a physical assault, for example. So age is, is a significant factor.

Q So that's one of the significant factors to consider in the overall context of the concern?

A Yes.

Q In, in this case we know, speaking of the non-specific abuse allegation --

A Right.

Q -- locking in a room, we know that Phoenix, at the time, was at this vulnerable age.

A Yes.

Q And with an abuse allegation like the one made where it wasn't specific, and with the specific of locking a child in the room, what would you expect to be done in that scenario?

A Well, I would expect that they would, again, gather all the demographics, the history of the -- as best they could find it, if that information was available, about who was in the home, any history that they would have, gather that information in advance of going out so you know what you're, you're entering, and then go out and if -- usually meet the parents or the care-giver first because that's the only way you're going to get access to the child is through them.

Sometimes we will, we'll go and see the children first, but if with young children like this at home, you have to start with the parents and that's, that becomes a bit problematic as you're, you have to move through them to see the children.

Q Right. But you're talking about ultimately seeing the children?

A But ultimately, best practice would be to see, to see the children, the child, the children, all the children, actually.

Q Would it be reasonable in a case like that, and I think you know the facts of this particular case --

A Yes.

Q -- was it reasonable not to see Phoenix, in your view?

A It would have been best practice to see Phoenix.

Q But, but was it reasonable not to see her? There's a difference between it would have been best practice and what actually happened.

A No, well, I'm not sure the distinction but, but I'll, I'll certainly agree that, that Phoenix should have been seen.

Q Okay. It's, it's important to see a child, specially a young child, when there's an abuse allegation made to determine whether or not there's anything to it, right?

A That would be, that would be important, yes.

Q When, when a worker does see a child, and I'm talking generally, but when there's an abuse allegation like this, what things should the worker be looking for?

A Well, seeing -- if, if you're just talking about seeing a child, that's a limited assessment because you're, you often have only a few minutes to see the child and you're restricted by what you can see, so the child may appear to be healthy, unmarked, playing with toys, engaged in a, normal activities. That's some reassurance that the child may be safe but that's not a guarantee because you're not, you only have those few minutes and you're not able to look at the child fully, you're not undressing children, you're not looking at the totality of the situation. If you have a conversation with them, if they're an age for

that conversation, that's very limited as, again, because it's under the supervision of the parent who's there present. You don't have an -- it's rare that you have an opportunity to see a child apart from the parent, so that conversation would be limited. So seeing a child is helpful but it's not going to be definitive and you may have difficulty proceeding further.

Q Right. So it doesn't necessarily tell you that there was abuse or not.

A No.

Q You may see physical marks.

A And you may not.

Q You may not. It may be abuse of a sexual nature so you can't tell on looking at the child?

A That's right.

Q But the child may appear withdrawn or, or usually quiet, shy?

A Well, then you have to evaluate that. Some children are withdrawn and shy. You have to be careful that you don’t come to conclusions based on a two-minute visual inspection of the child.

Q Would it help to have a recording of contact the child has had with the agency and, and what the child was like at each contact or what was observed about the child at each contact so that when you go out on a call like this

you can -- you have a base line?

A Sure.

Q Say this is what the child was like before and this is the child now?

A Absolutely. In these kind of cases where there's a lot of serious concerns, elements that suggest risk, that absolutely you would want to have that accumulated record so you can see, yes, this has validity because there had been previous injuries or previous concerns, or no, the child has been seen regularly or intermittently over the years and seems to be in good health. That would be helpful to have.

Q One of the things that's apparent when, when one reviews the various recordings in this file is there is not a lot of information about Phoenix Sinclair herself. Most of --

A Yeah.

Q -- the recordings are centred on what's happening with the parents or --

A Right.

Q -- what's, you know, a drinking problem or alcoholism or whatever. Is -- in your view would it, would it have been better to have more information about the child throughout the file?

A Well, workers are always trying to balance that.

I mean, our point of engagement is usually with the parents because they're the, they're the people responsible. They're the people often who need to make the changes, so the emphasis is on the parents and try, to try to work with them. But yes, it would be helpful to have more comments, more observations about the child. But usually the dialogue is with the parents and discussion is with them to start.

Q I know it's just about time for the break, I just have one or two more questions I wanted to ask in this area.

Just when it comes to risk assessments there was some evidence suggesting that risk assessments by CRU workers, or safety assessments, or whatever you want to call them at --

A Right.

Q -- this point in time, CFS.

A Safety assessments here.

Q Were being tailored in part to respond to the capabilities of intake. So for example, if, if it wasn't felt that intake could get to a file within a certain amount of time, the response time might be adjusted to reflect that. Is that an issue you were familiar with?

A Well, again, the, the teams are trying to juggle workload demands and so on. I think it's just important

that somebody, somebody was able to see the child, whether it was CRU or whether it was intake. Who saw them I don't think was important, let's still take that independent comprehensive as best we can view of what's happening in this family with this child.

Q So the important thing is that someone gets out there to see the child and find out what's happening?

A To see the family and the child, yes.

Q That would be key for any of these types of files?

A Right.

Q But in certain cases it would be important to make sure that, based on the assessment of risk, her safety, someone gets out there fairly quickly?

A Well, again, I don't want the crisis to be over, over-emphasized because there are, there are crisis situations absolutely that we need to respond to, but again, I think you try to be thoughtful about how you're responding: do you have the information? What's the best time and place and way to intervene with the family? You need to think about all that before you just immediately rush out and, and make a quick assessment.

MR. OLSON: Would this be an appropriate time to break?

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

mid-morning break.

(BRIEF RECESS)

THE COMMISSIONER: Mr. Olson, when we adjourn, if you find, if you think you're going to need more than the 15 minutes, let us know.

MR. OLSON: Certainly.

THE COMMISSIONER: We'll certainly allow that but everybody was waiting, and just let us know if you think you need more time.

MR. OLSON: Certainly. I, I apologize.

THE COMMISSIONER: I understand.

MR. OLSON: Though it should shorten my questioning considerably --

THE COMMISSIONER: Well, that --

MR. OLSON: -- so save some time.

THE COMMISSIONER: -- (inaudible). Fair enough.

BY MR. OLSON:

Q Was there any sort of an auditing program at the intake level while you were program manager?

A In the past, Winnipeg Child and Family Services had a, a Q.A. program that did review programs. In the period that you're referring to, though, that, that program

had been -- resources had been redirected so any auditing or Q.A. function rested with myself and Dan Berg and Rob Wilson.

THE CLERK: I'm sorry, I didn't understand what you said. Something (inaudible).

THE WITNESS: Q.A.

THE CLERK: Q.A.

THE WITNESS: Quality assurance.

THE CLERK: Yeah.

THE WITNESS: Sorry.

THE CLERK: No, that's okay (inaudible).

BY MR. OLSON:

Q So that any quality assurance rested with yourself, Mr. Berg and Mr. Wilson?

A Correct.

Q Can you tell us what, if any, quality assurance was being done during that time by any, any of you?

A It wasn't in the formal way that I think it really -- it wasn't, it wasn't being done in the formal way that it probably should have been done. We were, as again, I would suggest, a transition period so we were just looking at our program descriptions and trying to assess them so (inaudible) by themes, by case by case, but really just trying to keep the intake process flowing. There

wasn't really a proper case audit or quality assurance program. It was on a case-by-case basis as they came to our attention.

Q So you would have liked to have had some sort of a formal Q.A. program if possible?

A That would, that would have been ideal. It was very helpful in the past and in the circumstances at that point, in the transition that we were in, that wasn't going to happen.

Q Was it possible for you to monitor, as program manager, the quality of the work being done without any sort of quality assurance program in place?

A It was obviously more difficult. I had, as I described at the outset, many other functions, many other things to attend to. Really, stabilizing and reassuring the staff complement was one of our primary duties. Staff had felt, I think, somewhat alone and unsupported because of the unfair workload on Rhonda Warren, so that was where most of our attention spent. So quality assurance really occurred on, as cases were brought to our attention by, as I said earlier, by outside callers, by high profile cases that may have come to our attention.

Q When you came on as program manager, was your impression that the staff felt like they didn't have support for management at the intake level?

A I think that's, that's fair, but I want to be also fair and say that Rhonda Warren had a, an overwhelming task, she was responsible for what I believe was 12 teams, 12 different supervisors as well as trying to establish policies and programs. She did the latter function quite well, thus the manual we have here, but it was -- one person could not accomplish that. The three of us struggled. I have no idea how she could have functioned in that environment.

Q Just too much for one person to do?

A Correct.

Q Wanted to ask you about some of the evidence we've heard from Ms. De Gale in terms of problems with her report being altered.

A Right.

Q Safety assessment being altered.

A Um-hum.

Q Is that something you had any knowledge of?

A Direct knowledge of that, what she's made reference to? No.

Q Right.

A I have no knowledge of that.

Q So at the time you didn't have any knowledge of it?

A No.

Q Have you had, have you -- do you have any knowledge of it now?

A Well, only from what I've read, what we've previously discussed. But that's from, from third, third party.

Q Was that issue brought to your attention prior to any involvement you had with the inquiry process?

A No, it was not.

Q No. You could put page 36943 on the monitor.

This would be the CRU report of Shelly Wiebe, now Shelly Willox. Are you familiar with this particular involvement?

A I am -- excuse me, I am now. I was not at the time but through this process I've become aware of this report, this intake contact.

Q One of the things that is apparent is that there was contact with the public health nurse.

A Yes.

Q And the public health nurse felt constrained, we've heard, due to privacy legislation, from sharing information with Ms. Wiebe. First of all, that sharing of information, is that, that something you mentioned earlier as, as being important, you know, interfacing with Public health. Was that one of the issues that would come up when you were looking into or dealing with interfacing with the

community?

A The PHIA/FIPPA restrictions that they would be under?

Q Right.

A That was certainly something that would often come up. I think we always tried to make it clear, as one of the purposes of my, my meetings in the community, was to emphasize that child welfare considerations would trump PHIA and FIPPA and that information should be shared.

Q In this case, you saw what happened with the information-sharing process. It doesn't seem like it worked very well.

A Not at that point.

Q Based on the information that Ms. Wiebe had at the time, that is, the public health nurse saying, I can't tell you anything, I do recognize my obligations to report child welfare concerns but I can't tell you anything --

A Right.

Q -- was that information sufficient for, in your view, for Ms. Wiebe to rely on in terms of someone having seen the children?

A I -- well, I, I don't know what Ms. Wiebe understood through that.

MR. MCKINNON: I, I just want to make sure I understand the question because I think that the witness

may need a lot more background information if you're asking him, as a manager, whether the worker's work was sufficient. I think most of his information is either from reading the reports, and I don't know if he's read the case file cover to cover to be able to comment on that narrow question, unless you want to put some more facts to him and ask him to assume them to be true.

BY MR. OLSON:

Q But the facts that, that I would put to you would be about what Ms. Wiebe recorded in her summary. If you want to go and scroll down, please. Keep going. (Inaudible).

You see where, it's about second-last paragraph you see on the page:

On December 3, 2004 at 1:15 ...

If you want to just read from that point.

A Um-hum.

THE WITNESS: Carry -- can move it on.

MR. OLSON: Scroll the page down, please.

THE WITNESS: Can carry on.

MR. OLSON: Can you scroll down further, please.

THE WITNESS: Carry on.

MR. OLSON: Scroll down again.

THE WITNESS: Okay.

BY MR. OLSON:

Q So you've read the background facts of the contact with the public health nurse, and here we have Ms. Wiebe who's attempting --

THE COMMISSIONER: Let's hear your question before I hear Mr. Ray.

BY MR. OLSON:

Q ... who is attempting to determine the safety of the children in the home. That's why she's going out, right --

A Yes.

Q -- or that's why she's making contact?

A Yes.

Q So she speaks with the public health nurse who isn't able to directly provide her with any information, and based on that she determines that there's no known risk. Was that, in your view, appropriate?

THE COMMISSIONER: Now, have you got a problem with that, Mr. Ray?

MR. RAY: I guess the only problem that I have, Mr. Commissioner, is that in addition to what's recorded in

the report of Ms. Wiebe, Ms. Wiebe testified and, and elaborated somewhat on what's contained in her recording, and this witness doesn't, obviously, get that context in simply reviewing what Ms. Wiebe has written in her report. So ...

THE COMMISSIONER: You mean on the preceding pages?

MR. RAY: Correct. Ms. Wiebe expanded in her -- when she gave evidence she expanded in terms of this is the discussion that she had with the public health nurse, and I don't think all of her discussion that she had with the public health nurse is, is necessarily entirely recorded in, in the document that's just been put to the witness. So I don't think there's a foundation for the question because the witness has not heard Ms. Wiebe's evidence.

THE COMMISSIONER: Oh, I think this summarizes it in the -- the meat of it. I agree with you she expanded on it more, but I think the import of, of what she understood the exchange to be is recorded here.

MR. RAY: In that case, with your comment, Mr. Commissioner, perhaps the best way for me to deal with it would be to put additional evidence to this witness in, in my opportunity to examine the witness.

THE COMMISSIONER: If you want to, if you want

to, you'll have that opportunity.

MR. RAY: Thank you.

THE COMMISSIONER: Now, would you repeat your question for me.

MR. OLSON: It may be a difficult task.

THE COMMISSIONER: Or, or did you want the reporter, want the reporter to read it back?

MR. OLSON: I think I can, I think I can repeat it.

BY MR. OLSON:

Q Would the reliance on the public health nurse in this circumstance be acceptable and (inaudible)? Was that acceptable in determining that it was safe to close the file; no risk, no known risk at this point?

A Again, I don't know all the information that Shelly had that led her to that decision. However, if I look at some of the information, which I understand is a call from the social worker at the Health Sciences Centre as well as public health nurse, I believe that's what's contained in this, in this report. I believe the worker from the Health Sciences Centre said that there was satisfactory pre -- then continuous pre-natal care and that all seemed well. I don't know if I'm fairly summarizing, I hope I am. And that the public health nurse, by inference,

is not aware of any difficulties. The fact that she did not report anything I assume Shelly may be referring, well, then there's nothing to report. And I know Mary Wu and I know that she's, has been a key partner for us for many years. Personally I know her and was confident that she would report that, so that's how I'm drawing that conclusion.

THE COMMISSIONER: Did you get an answer?

MR. OLSON: No, I'm not sure what the conclusion was. I have (inaudible) --

THE COMMISSIONER: No, I'm not --

THE WITNESS: I'm, I'm saying that I don't -- you asked if, was it sufficient to close the case, and I'm saying I don't know what else she had. I, I can see that the health, health services folks, the public health and the worker at the hospital are saying things seem to be fine or not something that we need to draw to your attention. But I don't know what other material she had that, that led her to close the file.

THE COMMISSIONER: Well, based on what you read there --

THE WITNESS: Right.

THE COMMISSIONER: -- are you able to answer the question?

THE WITNESS: Seems to me that, that you could

come to that conclusion, but that doesn't answer the question is it a full assessment. She hasn't seen anybody, she hasn't -- I don't know how much she's read of the past history, how much information she had there.=, but based on what I've seen here, I could see how you could come to that conclusion at that point, but it's limited information.

BY MR. OLSON:

Q In 1999 standards there's, there's reference to being able to have reference to a reliable source of information, gives couple of examples, rather than seeing a children in -- child in a protection file.

A Right, right.

Q You're aware of that standard?

A Yes.

Q Would this be that kind of circumstance where you don't know what the public health nurse saw in terms of did she see both children, did she see one, what kind of assessment she was doing, what does she know about the children, what does she know about the background. Would this be the sort of circumstance where that standard would be met by talking with the public health nurse?

A Well, surely. Sometimes, particularly with these kind of cases where you have unco-operative clients that this kind of proxy would be helpful, this kind of report,

from a party who, who knows Samantha and had, presumably, some opportunity to engage her might, might lead you to that, that decision to close the case. In hindsight.

Q Okay. Just in terms of the standard, though, when you're looking at the standard itself, and if you're measuring what happened here with what the standard will permit, does it, does it accord with the standard in terms of what was done? And again, this is in your view.

A Well, it accords with the standard. But again, as we've talked about through this, we need as much information as we can to come to that conclusion from that, from -- this doesn't speak to history, this speaks to her experience delivering this, this child and then perhaps a visit from the health nurse. Doesn't talk about the history.

Q Right. And --

A So ...

Q -- we, we know that there was a lengthy history with Ms. Kematch.

A Right.

Q Concerns over --

A What Shelly knew, what the public health department, what the folks at the Health Sciences Centre knew, I don't know.

Q Okay. Workload was, was a significant issue

between 2003 to 2005; that's something you said?

A Yes.

Q Remained an issue up until 2007?

A Well, that was when my time ended but --

Q Right.

A -- it was an issue through my time --

Q So for your whole period of time, it was an issue?

A Yes.

Q Did things improve?

A In ...

Q Up till 2007?

A Into 2006, 2007, did workload improve? No, I would, I would suggest things became more complicated.

Q Yeah. Post-2007 you were still involved with the system but in a different capacity?

A Yes.

Q Were you able to, are you able to comment on workload?

A That's -- no, that's not reasonable. I'm not familiar with --

Q Okay.

A -- ANCR at this time.

Q Fair enough. But you did say it was, it got worse up until 2007 when you left?

A Between 2005 and 2007, the demand for service continued, it's pretty constant, but the, the circumstances at JIRU and ANCR became more complicated and the changes continued and really accelerated, which made, made things more difficult.

Q Are you saying was partly function of the additional changes that were being made that impacted workload negatively?

A Yes.

Q When the change was made from the structure where you were the program manager to assistant program managers to the model that was at JIRU --

A Right.

Q -- what was the reason for that change?

A Well, there was a different governance structure in place. The responsibility for intake, the intake function, shifted to one of the authorities. It was the southern authority that took responsibility for that, and they, they hired myself and I, in turn, hired six other program managers to, to oversee the, the operation.

Q So was, was it just a change in sort of the governance of the, the system itself, intake system?

A It was a change in the governance, as I say, to the southern authority, to the -- a board. Of course, should have mentioned that. There's a board, an interim

board and then a longer-standing board that took responsibility for, for ANCR. But I think the biggest challenge was the constant -- and that was, that was a new relationship that we had to work on, but I think the bigger challenge was the constant turnover of staff. Because I think, as you know, the staff was composed of temporary -- permanent loanees from Winnipeg Child and Family Services and temporary staff, and the temporary staff left at a, at a constant rate as they were called back to Winnipeg and we, we hired new staff. So there was a significant turnover of staff during that period.

Q You're aware of the reports that were commissioned following Phoenix's death?

A Yes, I am.

Q And we've been giving witnesses an opportunity to comment on any of the findings in the reports. I don't intend on putting the reports to you specifically but I do want to make sure you have the opportunity to comment on anything you feel you need to. And you may wish not to, it's just you have an opportunity to do that now, if you wish.

A I don't know if I have, have a lot to say. I would just comment that obviously considerable effort was undertaken to have a number of reports done and then that they were gathered together in summary format, and I

believe we ended up with 300 plus recommendations as how the system could be improved. Personally, that I, for my benefit, I thought that the report by Mr. Koster was the most valuable for me as an independent person from outside our system with a strong background in child welfare. So his independent analysis and the way he completed his report I thought was, from my point of view, the most helpful, but there are plenty of recommendations from his reports and the other reports that were gathered and have helped us move forward over the, the intervening period here that have taken us to today.

Q Were you in any way involved in (inaudible) --

THE COMMISSIONER: We'll stay put till further warning.

Has anyone reason to believe it's a fire alarm? Well, carry on.

THE WITNESS: Sorry.

THE COMMISSIONER: Hope I'm not endangering you all.

BY MR. OLSON:

Q Were you involved in any way in Mr. Koster's report in --

A Yes.

Q You were. Okay. What was your involvement?

A Well, my involvement was that we were, I guess, one of the hosts while he was in town from Ontario and he spent a considerable amount of time with all of us at ANCR, interviewing myself, the other folks there, staff, variety of people.

Q We heard that none of the workers that were interviewed or the supervisors were provided with actual copies of the reports or Mr. Koster's notes, in cases where he took notes. Were you aware of that?

A You mean the final report?

Q Right. Or even any, any report. They, they, they hadn't received any.

A Well, as I understand the process, those reports were not written for ANCR or for myself or for the staff there, they were written for more senior people in government and at the various authorities so they were the recipients of that report. Eventually, I think others were involved. To be honest, I can't remember when I received a copy of the report and I don't know when or if the staff received copies of the report.

Q Okay. So the reports weren't generated for the purpose of sharing them with the workers or supervisors?

A No, or myself.

Q Or yourself. Okay. When it comes to the recommendations and the findings of the various report

writers, do you think it would have had a value to have those reports shared with the workers and the supervisors?

A Yes. Yes, I do. I know our current practice, because of, regrettably children who we have involvement with die and I know the Office of the children's Advocate does review them and their process has now been to involve with the agencies and to review them with senior management and ultimately with staff, and that's been a helpful process for us. If that had been in, in, in effect for this, that would have been helpful, I think.

Q Just finally, were, were any workers or supervisors or anyone in the chain of command made aware of the criticisms, and I'm talking as far as you know, that, that were made with respect to the work they did in the various reports?

A Again, I, I honestly don't recall when these reports became available to management. I believe these reports arrived in the fall of 2006 and I was gone by 2007, so I don't recall whether that was in that period of subsequent, so I don't, I don't know.

MR. OLSON: Okay. Thank you, Mr. Harrison. Those are my questions.

THE COMMISSIONER: Thank you, Mr. Olson.

Mr. Gindin.

CROSS-EXAMINATION BY MR. GINDIN:

Q Mr. Harrison, for the record, Jeff Gindin. I'm appearing for Kim Edwards and Steve Sinclair.

A Good morning.

Q I have some questions for you. You were talking this morning about, you were describing your role.

A Yes.

Q Going through some of your responsibilities. And one of the first ones you mentioned was hiring staff.

A Right.

Q Right. Did that also include firing staff if it became necessary?

A Absolutely.

Q And if -- we've heard, for example, that the nature of the beast really is that important judgment calls have to be made from time to time and that different people might have come to different decisions based on the same circumstances. You'd agree with that?

A Are you referring to social workers making --

Q Yes.

A -- assessments about families?

Q Yeah.

A Yes.

Q And if, if there were some judgment calls that were questionable, would that come to your attention in

your role?

A If there were concerns about the worker's decision-making that were addressed first with the supervisor, because they would be the person who would review that, if there was -- if he or she had concerns they would have been brought to the attention of the assistant program manager, Mr. Berg and Mr. Wilson, and ultimately it could have been brought to me.

Q So there were several --

A But it would go through that process.

Q Yeah. There were several levels it would have to go through --

A Yes.

Q -- to get to you. Okay.

And did that happen on occasion?

A On occasion?

Q Yeah.

A We certainly talked about cases where we were trying to decide what the best approach would be to the family, what the best plan would be, perhaps whether the case needed further investigation or a transfer. I would be involved in, in cases like that.

Q What I was asking was, did it come to your attention on occasion that judgment calls were being questioned by some of the workers, generally speaking? Not

just this case, I'm just asking you a general question. Do you recall that coming to your attention on occasion?

A Whether -- make sure I understand the question. Whether judgment calls by workers ...

Q That were perhaps being called into question ...

A Would they come to my attention?

Q Yeah.

A On occasion, yes. It would more be in the format of what's the right thing to do, is this --

Q You mean about --

A -- the right approach.

Q You mean about the worker --

A About -- no --

Q -- having made a bad judgment call?

A It could be that. More often it would be about the case: what do we do. The, the answers were not always clear as to how to proceed with a case. It's not the nature of the business.

Q And in the course of discussing on occasion the performance of workers or supervisors --

A Sure.

Q -- did you ever have to look at performance reviews to be able to assess how a particular worker was performing? Was that within your scope?

A The performance -- I understand again your

question. The performance reviews would have been undertaken by the supervisor.

Q Um-hum.

A That would have, in turn, been perhaps reviewed by the assistant program manager. I don't recall those performance reviews coming to my attention.

Q Okay. But if there was such an issue, it would, it would first be dealt with by a supervisor?

A Yes.

Q And then the supervisor of the supervisor?

A Yes.

Q And then it might get to you?

A Yes.

Q All right. You also said that part of your function was to see that proper policies were in place, and I'm just using your words.

A Yes.

Q What did you mean when you said "proper"?

A Policy -- be mindful of my responsibilities as running an intake system, that staff had sufficient program descriptions and policies that would allow them to do their work.

Q Okay. But when you say proper policies, are you referring to policies that make sense, policies that are in accordance with standards or policies in accordance with

the best practice? What did you mean?

A In our situation at that point, they were policies that would have allowed us to continue the intake function under the circumstances that we were working in.

Q So you're talking about policies that would make the process easier to follow?

A The process clear to follow and, and better assessments and better conclusions, yes.

Q All the while considering the best interests of the children who may be at risk, right?

A Of course.

Q Yeah. And part of your responsibility would also be to make sure these policies that were deemed to be proper were, in fact, working well or as best as could be expected?

A Yes.

Q In describing workload, you used the phrase, it was often beyond our capacity.

A Yes.

Q And what would be the effect when workload was beyond your capacity? How would that translate into services that were provided or not provided?

A Well, workers would have to make some decisions about families that they could engage, families that they could see, cases that they would have to close believing

that, at this point in time, the child was safe.

Q Um-hum. They would have to prioritize is what you're saying?

A They would have to prioritize, yes.

Q And just casually mention that deciding a file should be closed --

A Right.

Q -- for example, but files should not be closed if they weren't sure the child was safe, right?

A They shouldn't be closed if they were concerned that there was a current risk to the child.

Q Yeah. And if they couldn't tell or didn't know, then some other action other than closing the file should be undertaken, right?

A That would be an option. I do want to emphasize, in this business we are never absolutely sure, we can never guarantee child safety. The families that we deal with are very fluid, the situations change. What's safe today may not be safe tomorrow, so you're running that -- you're having to consider that.

Q And of course, a file being closed is a very serious thing because there's no monitoring of the situation once the file is closed?

A We're not active with the file anymore, no. But other, other organizations may be.

Q Which you may or may not know about?
A That's right. Hopefully we do know about it if there are any.
Q You were discussing the decisions that have to be made, and I think you were talking about CRU and the need to be thoughtful before making decisions. You recall that?
A Yes.
Q And you indicated that there's, there's always time to analyze, consider and to assess and hopefully to arrive at a decision, right?
A I believe, I believe I said there should be time.
Q Okay.
A There's not always time.
Q Ideally, there should be?
A Ideally.
Q And when, when anyone makes a decision to close a file because it's such a dramatic decision, you would hope they would have the time to consider it fully so as to make the best judgment possible?
A I'd hope so.
Q But you did indicate there was some pressure to keep things rolling because there's always something else coming in?
A Correct.
Q And in terms of what should be read in terms of

history, you indicated that you expected workers to read as much as they could; the more they could read, the better?

A Yes.

Q Right. And if they're suffering through some time restraints, they may have to read summaries and, but certainly the more they can read the better?

A Correct.

Q You were also discussing note-taking in general, and you would agree that's a very important thing to do. In this work, you appreciate that a lot of what happens could easily end up in court?

A Not a lot.

Q Not a lot?

A I think that's overstated. The work that we do is mostly accurate and not end up in court. A small, a percentage of it does but it's, it's in the minority.

Q But you never know which one will, which case will end up in the court?

A I guess the potential is there.

Q Yeah. We know that, for example, there, there's Child Abuse Registry applications that end up in court, right?

A Yes.

Q Child protection hearings end up in court?

A Yeah.

Q Custody matters may end up in court?
A Um-hum.
Q Inquests, inquiries like we have here. So that's one of the reasons why things should be recorded properly in case you ever have to recall information and decisions have to be made about what's been done, right?
A That's one of the reasons. That's --
Q Yeah.
A -- not the first reason but that's one of the reasons, yes.
Q Another reason, another reason would be for the next worker who comes into a file --
A Yes.
Q -- so that they know everything that happens so there's a proper history?
A Yes. We have an accumulated record, yes.
Q Yeah. And that's very important, of course?
A Yes.
Q When you were talking about notes you said that sometimes it's a little more difficult to take notes in CRU because they have very limited and short contact sometimes with a matter and there's a lot of things going through?
A Yes.
Q Right. In this case, and I don't want to get too specific, there are two involvements we've heard about

where CRU was involved, one from December 1st to the 7th of 2004 --

A Um-hum.

Q -- which is almost a week, so that in that kind of a case there's more than the usual involvement, correct?

A Not necessarily. They may have had difficulty contacting people. The delay is often because we can't find people, phone calls haven't been returned. Doesn't mean there's been more contact.

Q But there --

A It just means it's been open longer. There's a difference.

Q And therefore, more opportunity to record the things that are going on because it apparently is with them for longer.

A Mean a more accumulation on that particular work road --

Q Yeah.

A -- for that particular worker's workload, yes.

Q And you've heard about the issue that we've been discussing here about a couple of involvements at least where a file was sent over to intake, returned and there's no real notes about what discussions took place, why it was returned, things of that nature. We're left to speculate, obviously. And you'd agree it would be better if we had

some notes or some material to look at that could help us?

A With the benefit of hindsight --

Q Yeah.

A -- that would be better. In most cases that would not be occurring because those conversations occur all the time with people in hallways as cases are exchanged back and forth. Those conversations may not always be recorded. In this case, yes, it would have been helpful.

Q You did say that files being rejected and returned occur only on occasion?

A That's my understanding. Most cases went through.

Q I'm talking about those matters that occur fairly rarely and aren't the norm. In those matters would it not be wise to have some notation as to why they were rejected and returned? We're not talking about every single day, every single call, but we're talking about some fairly rare situations.

A I'm not sure that I think that that record should be maintained in all situations.

Q Even though it is, doesn't happen all the time?

A People are -- the folks at intake are a team, two at CRU, four at intake, as I said. They need to decide who's going to go. You come to a conclusion and you act upon it. I'm not sure that the debate on this, why I could

do this, why you could do that, I think in all organizations these kinds of discussions occur, who's going to handle this situation, whether it's social work or law or whatever, people have the discussions. I don't think they write down those discussions all the time.

Q No --

A I'm not sure that it's necessary.

Q Yeah.

A As long as the end result was that somebody went and saw the child --

Q Um-hum.

A -- and made, made a decision.

Q And of course, if no one saw the child in the end and the issue then becomes, well, why not and why was it returned. That might be useful information to know, as we've been trying to find out?

A If the case, if the case is closed, then that decision is, rests with the supervisor and the worker who made that decision.

Q Right.

A Not with the worker and supervisor who didn't accept the transfer further up the, the chain.

Q So the supervisor who decided to close it you say perhaps should have recorded the question of why it came back?

A Should or should not have?
Q Should have.
A I didn't say that.
Q Well, I'm asking you if you agree. I thought you said right now that the responsibility to record or make notes might, might have been with the supervisor who was closing the file.
A Yes. Supervisor closed the file. Again, I'm talking theoretically, not specifically the case. The supervisor and the worker who close a file take responsibility for that decision to close it. If they continue to feel that this demands more service that could be provided at intake, then that should be brought back to intake again.
Q Right.
A Brought back to assistant program manager and they should review that again.
Q Yeah.
A But they're responsible for the decision to close the case.
Q Right. And they certainly have the authority?
A Yes.
Q And power to send it back again?
A Yes.
Q If they felt that way?

A Yes.

Q They certainly don't have to simply accept any recommendation a worker gives them?

A No.

Q No. All right. So if a referral comes in and it's something that is somewhat vague, as in the phrase we used before, soft referral perhaps, I think you indicated that you'd want to find out more information, obviously?

A About the case before --

Q Yeah.

A -- proceeding or while you're proceeding, yes.

Q And if a decision was actually made to go out to the home in order to get as much information as you could, then I take it that if you are left without adequate information the file should not be closed?

A Sorry, who's not left with accurate information, the supervisor or the worker?

Q All of them.

A Well ...

Q I'll be more specific --

A Okay.

Q -- you're checking out an allegation that Phoenix was abused or locked in her bedroom.

A Right.

Q We know there's a situation like that.

A Yes.

Q This is a situation where you've agreed that the child should be seen but wasn't, right?

A I agree.

Q And so you're left in a situation that you can't be assured that the child is safe because you haven't seen the child. That might be a situation where perhaps more information is required or more effort being made to actually see the child?

A That was one of the options they could have pursued, yes.

Q You indicated, when talking about closing files in general, and this is a quote: The worker or the supervisor must be satisfied that no child is at risk or is in danger. You stand by that?

A Is at current risk, I believe I said.

Q Yeah.

A Yes, correct.

Q And if one, if someone can't be satisfied of that, of the current risk, then you agree that the file likely shouldn't be closed yet?

A They should, they should pursue more information, yes.

Q And one of the options, you said yourself, is that sometimes another visit is required?

A I'm not sure if I said that but I would agree.
Q Yeah. We were talking about the importance of seeing the child, obviously, when it's an allegation that is made, and I think you said that, and you agreed that Phoenix should have been seen; that would have been the ideal situation --
A Correct.
Q --correct?
A Um-hum.
Q And then you indicated that if you saw the child, if a worker saw the child, even when your child may appear healthy or unmarked, that's generally still not enough; there's more to it than that? Not that simple?
A I said that that would be of some help but that is not as, as much -- that doesn't necessarily assure you that, that the child has not been abused. You only can see what you can see in that two-minute period, you can only see how the child presents in that very small window.
Q So seeing the child is very important. But even when you see the child, there's still sometimes more to be done?
A There's sometimes more questions and they're not -- have not been answered. And then the question for the worker is how much further do you produce it -- do you intrude on that family.

Q Um-hum. So if what the worker sees is another child instead, as in the March '05 incident --

A Right, right.

Q -- where we know that Samantha wouldn't let them in and was out in the hallway --

A Um-hum.

Q -- and brought out another child that appeared healthy. Even simply that other child appearing healthy in a very brief period of time doesn't really tell you even that much about that child necessarily?

A About the child that was presented at the door?

Q Yeah.

A No. It's, it's -- the child looks healthy, (inaudible). But that doesn't, isn't a full evaluation of that child's situation.

Q And certainly it's not evaluation of the child you haven't seen?

A It's -- no, it's not an evaluation of the other child.

Q And the issue of who sees the child, and there was some discussion, should be intake, should be CRU and sometimes --

A Um-hum.

Q -- there's some issue about who should see the, the child, the fact is that the important thing is not who

sees the child but that the child is seen?

A Absolutely.

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

THE COMMISSIONER: All right. We've got 20 minutes or so before lunch break. Who would like to come forward? Mr. Ray.

CROSS-EXAMINATION BY MR. RAY:

Q Morning, Mr. Harrison. My name is Trevor Ray, for the record. I represent the MGEU as well as a number of the social workers that were involved in this file through various points. I have a few questions for you.

One question I'd like to ask you is an area just being put to you or suggested to you by Mr. Gindin, his last area of questioning. And I interpreted what he was suggesting was that if a worker comes to the door on a vague or a soft allegation of, of concerns and that worker actually sees the child about whom the reference is made, that there's no assurance that the child, even though the child appears fine over the course of a two to three-minute investigation, there's no assurance that the child is, in fact, fine. And if something more is to be done in every circumstance, such as the one that was referred related to Phoenix, isn't that going to effectively require a full-blown abuse investigation in every unconfirmed or vague

allegation and isn't that going to require an amazingly huge amount of resources for CFS to conduct those types of thorough investigations?

My, my understanding of an abuse investigation is you take the child out of the home, you take them to the doctor, the doctor investigates; I mean it is, it is a huge, huge process. That's my understanding of what, what Mr. Gindin was suggesting.

A Well, I think I, I think I understand your point and, and I agree that, that a further investigation is a further intrusion into the, into the family's life. First of all, if we were to do that, we would, we sometimes might require police intervention to enter the home because I think in this particular situation, Ms. Kematch said she wouldn't allow us further into the home, so we would have to determine whether we were going to get police to actually assist us to enter the home, then we would have to decide, if we can't visibly see anything, do we have grounds to remove the child and take the child to the hospital to be more fully evaluated. We'd have to make all -- the worker would have to make all those decisions.

And I think we also have to be mindful that as we intrude further into family's lives the, the less likely family is to engage with us or other helping systems as we become more intrusive, more aggressive in our

investigation, and there's consequences to that.

So yes, to answer your question, yes, require much more, much more investigation. Well, it's not just an investigation -- a commitment of time and money and resources and so on. It's -- you have to measure the impact you're having on the family, whether they -- we can legally have the right to take all those steps without any evidence of any abuse.

Q And certainly you would agree with me that that would be far greater a role than is anticipated or mandated by CRU at the time it existed when this case was investigated?

A Well, more than CRU --

Q Or intake.

A -- would, would -- or, but no, intake could take that step. I mean, they have a responsibility. They can handle a case for 30 days, 60 days, 90 days. That could have -- some of that could have been -- some of those steps you suggest could have been accomplished within that period. They decided not to.

Q But for, for those steps to be taken in every single case as presented like Phoenix's case, I'm suggesting to you that you'd need far greater resources than were in existence at the time, correct?

A Yes, that's fair.

Q Mr. Harrison, I believe you were here for the evidence of Mr. Berg and Mr. Wilson and Mr. -- and, excuse me, and Dr. Trigg?

A For some of it, not all of it, but ...

Q And I'm just paraphrasing their evidence, but generally, all three of them agreed that best practice is something that workers strive for but it's not always achievable. Would you agree with that?

A Yes, I would agree.

Q And a number of factors impede best practice, don't they, such as workload constraints? And you'd agree with that?

A I would agree.

Q You'd agree with a lack of supervision or clinical supervision would impact an ability to achieve best practice?

A I'm not sure, I'm not sure I'd agree with that. I believe that was Linda Trigg's observation but I'm, I'm not sure that I fully agree that that, that would be important in these situations or critical need situations.

Q Critical. But it would, would potentially have an impact if a, if a social worker was not receiving the necessary supervision that it could empower their best practice?

A Yes.

Q And you'd agree with me that lack of training and lack of ongoing training would impede best practice?

A Theoretically, yes.

Q And not only appropriate workloads but appropriate caseloads would impede best practice?

A Absolutely.

Q And job training and continued education are things that would impede best practice if not provided, a lack of?

A Those would, those would be of great assistance, and lack of them may impede, may impede that, yes.

Q Would you agree that positive public profiles and the ability to work with collaterals or the clients in certain circumstances would impede best practice if that was not achievable?

A Yeah, particularly, we have good, generally had good relations with our collaterals. I think they understand our mandate. But working with unco-operative resistant clients makes things extremely difficult. That's our most challenging cases.

Q You, your evidence you have mentioned, in, in response to a question about what governed social workers, and one of your answers was that they may be governed by or assisted by the best practices as, as trained in the faculty of social work.

A Right.

Q Are you aware, sir, that not all social workers who graduate from, graduated at that time from the faculty of social work received child welfare or child protection course work?

A I'm aware of that, yes.

Q And you're, you're also aware that not all people that were hired by the agency leading up to that point in time, some of them did not even have a bachelor of social work degree?

A My understanding is that most of the work force did have a masters or a bachelor of social work. Some others had degrees that were designated as equivalent, particularly a human ecology degree was something we found very helpful, and there was some equivalency acknowledged to them.

Q But certainly those people would not receive any bachelor of social work training as provided by the, the program, the University of Manitoba?

A No. If they weren't in the bachelor of social work program, no.

Q And if they, if they didn't receive that training initially upon being hired by the agency, then they would be at somewhat of a disadvantage as compared to other people that had a bachelor of social work degree?

A They would have a different education. I don't know if they'd be at a disadvantage. Again, they were given equivalency, so they might be stronger in other areas, weaker in others.

Q Sir, I -- you recall at one point I had interjected in a question being put to you by Mr. Olson as it related to the conversation that occurred between Ms. Wiebe and the public health nurse.

A Right.

Q And you reviewed the report and I accept your comments in term -- basically was that you don't know, based on the report, what other information Ms. Wiebe had through her conversations with the public health nurse?

A Right.

Q Are you aware, sir, that the public health nurse recorded in her chart notes that Ms. Wiebe was inquiring whether there were concerns and she recorded that there were no child protection concerns in her chart notes?

A Was I aware that those notes were in the public health nurse's record?

Q She --

A Am I aware of that?

Q She recorded that there, that there were no -- she had no concerns --

A Okay.

Q -- in her chart notes.

A I was, I was not aware of that but ...

Q And are you aware of the fact that Ms., Ms. Wu, I'm sorry, testified that she was attempting to convey to Ms. Wiebe in a, in a read-between-the-lines sort of way that she is aware of her obligations as a public health nurse to report child safety concerns and that she was trying to convey that to Ms. Wiebe in a, in a way without coming out and breaching perhaps PHIA or FIPPA requirements. Are you aware of that?

A I'm, I'm not aware of that specifically but that's what I inferred by my reading of the, the record here and my knowledge of Mary Wu personally.

Q And would you agree with me, sir, that it would be a reasonable interpretation, based on the information I've just told you and based on your knowledge of Ms. Wu and Ms. Wiebe, and that it would be a reasonable interpretation of Ms. Wiebe to conclude that the public health nurse was attempting to convey to her that there were, in fact, no concerns as Ms. Wiebe was inquiring about?

A I, I understand that's what she was trying to convey from the perhaps limited perspective that she had, yes.

Q But, but you'd agree with me that it would be

reasonable of Ms. Wiebe to conclude, based on her conversations and based on what Ms. Wu was telling her, that in Ms. Wiebe's view there were no child protection concerns for Ms. Wu to report?

A I think it would be reasonable for her to conclude that that was what the public health nurse was advising her.

Q That was my point, yes.

A Okay.

Q And in particular, we know that this referral did not, was not based on the fact that anyone had any actual child protection concerns, it was, it was a new, birth of a new baby to a woman who had a history of involvement. The presenting problem was not because the, the source of referral had any child protection concerns?

A I do understand that and I agree, yes.

Q And you'd agree with me that that would support Ms. Wiebe's, further support Ms. Wiebe's conclusion in that regard?

A Yes. Yes.

Q Would you agree with me that that involvement with Ms. Wiebe, sir, is, is one of those cases that would, would be fairly low on the priority scale in terms of a, a file that needed to be dealt with in a very unurgent basis; it wouldn't, it would not be an urgent matter to deal with

from a social worker perspective?

THE COMMISSIONER: Yes, Mr. McKinnon.

MR. MCKINNON: Just raise -- rise on that one. I don't know that this witness has the context. I mean, he's been very clear that he's just dealing with that one piece of paper. I don't know if he knows whether it's an urgent or a not-urgent matter, but what inferences he can draw from that one piece of paper or that one report. But I don't know if the witness has enough information to know what went on before that to comment on its urgency.

MR. RAY: That's fair comment, Mr. Commissioner, I can rephrase.

BY MR. RAY:

Q The, the report that you've read, you'd agree with me that -- that was put to you by my friend, you'd agree with me that CRU deals with far greater, deals with matters that have far greater urgency and, and far greater severity than what was conveyed by the source of referral?

A Yes. There are, there are more urgent matters. If I understand, just to make sure I do understand what the referral was about, that, that there was an indication in the hospital that a new baby had arrived to a mother with a, a difficult history and we might be interested in that.

Q Correct.

THE COMMISSIONER: So what would that mean insofar as this case was concerned?

THE WITNESS: Well, I think that would mean that Ms. Wiebe would be wanting to look at the history, which we would have --

THE COMMISSIONER: Ms. Wiebe would what?

THE WITNESS: Would want to consider the history, the record that we had, any other information that might have been accumulated on a record, any other information from other parties, and she would add that to what the hospital was reporting, what the public health nurse was reporting and then decide whether she wanted to investigate further or close the matter at this point until there was a better opportunity to become involved.

BY MR. RAY:

Q And my point, sir, is that based on your knowledge of the types of cases that CRU handled, it's very possible that Ms. Wiebe had -- and I don't want to use the term "important" because I think all -- everyone agrees that all cases are important, but Ms. Wiebe very possibly had more urgent matters to be dealing with than this particular one.

MR. MCKINNON: I really think, Mr. Chair -- or Mr. Commissioner, I don't know how this witness can comment

on what --

THE COMMISSIONER: I don't know how you can speculate --

MR. MCKINNON: -- other cases ...

THE COMMISSIONER: Not unless he knows more about Ms. Wiebe's workload at that particular time. I don't see how he can answer that question.

MR. RAY: Well, he is aware of the types of cases that CRU dealt with. I think he has stated that --

THE COMMISSIONER: Let me ask him this.

MR. RAY: Sure.

THE COMMISSIONER: Are you aware of what else Wiebe had on her plate to deal with at that time?

THE WITNESS: At that time?

THE COMMISSIONER: Yes.

THE WITNESS: No, I don't know that.

THE COMMISSIONER: All right. Based upon that, go ahead and ask your question.

BY MR. RAY:

Q Based on the types of cases CRU dealt with on a regular basis, is it -- and taking those types of cases into consideration, is it conceivable that Ms. Wiebe was dealing with a case that was, was greater urgency than the type of case she was dealing with in this case?

A I think through these proceedings we've tried to make clear that there is a range of cases that CRU receives. There are some that are, demand urgent attention because a child is at immediate risk. This report did not suggest it was a child at immediate risk at that moment, so it would be, it would be lower down on the list. How to rank what happened that day, I have no idea.

MR. RAY: And I appreciate your comments in that regard, sir, thank you.

I'm just double-checking my notes, Mr. Commissioner.

THE COMMISSIONER: That's fair. That's fine.

MR. RAY: I think I'm almost completed, but just give me a moment.

THE COMMISSIONER: That's fine.

MR. RAY: Thank you, Mr. Commissioner, thank you Mr. Harrison, those are my questions.

THE COMMISSIONER: Thank you, Mr. Ray.

All right. Let's get an idea how much longer we'll be with this witness this afternoon. Mr. Saxberg, will you have questions?

MR. SAXBERG: Yes. (Inaudible) 10 minutes.

THE COMMISSIONER: Ten minutes. Fair enough. And Mr. Khan, no?

MR. KHAN: No, sir.

THE COMMISSIONER: All right. Mr. McKinnon?

MR. MCKINNON: I only have one question on re-exam.

THE COMMISSIONER: Well, I guess you'll have another witness available for us, will you?

MR. OLSON: Yes, we will.

THE COMMISSIONER: All right. We'll adjourn now till two o'clock and then Mr. Saxberg will ask his questions.

(LUNCHEON RECESS)

THE COMMISSIONER: Mr. Saxberg, please.

MR. SAXBERG: Thank you, Mr. Commissioner. Just one quick housekeeping matter --

THE COMMISSIONER: Yes.

MR. SAXBERG: -- if I may. Yesterday we referred to a policy manual that was at CD1656. There's also another version of it at CD1657. And I'd just like, for the record, that all of the pages from those two disclosures be deemed to have been referred to in this proceeding so that I can speak to them during closing argument. And those page numbers are 30361 to 32018.

THE COMMISSIONER: Commission counsel, is there any problem there?

MR. OLSON: No, that's fine.

THE COMMISSIONER: All right.

CROSS-EXAMINATION BY MR. SAXBERG:

Q Good afternoon, Mr. Harrison. My name is Kris Saxberg and I act for the general authority, the northern authority, the southern authority, ANCR and Dan Berg, Rob Wilson among other individual witnesses. Good afternoon.

A Afternoon.

Q Just a quick minor clarification. When you became the executive director of JIRU in 2005, JIRU's interim board consisted of the four CEOs from the authorities, correct?

A That's, that's correct.

Q But in terms of your day-to-day reporting of your activities during that transition period, you were reporting to the general authority?

A Yes, that's, that's true. I'm trying to remember. It was a bit of a tangled web because I was reporting to the general authority and switched to the southern authority, there was some uncertainty there.

Q Yeah. My understanding is that the southern authority switch occurred when ANCR came online.

A That's right, in 2007.

Q Right.

A Yes.

Q And, and then at that point you went back to Winnipeg CFS?

A Yes, that's correct.

Q So during that period where you had indicated that workload issues continued and that there was some complication, that was between 2005 and 2007; that was prior to ANCR going online, correct?

A Yes, that's correct.

Q And, and of course, prior to the southern authority then taking over as the, as the authority for that function within CFS, correct?

A Right. Although I was at ANCR and the southern authority for a period of about seven or eight months.

Q Okay. Now, if we could call up page 44741. That's from CD2113. These are CRU yearly statistics. I take it you're familiar with this document and these statistics?

A I am.

Q And, and you yourself had referenced that the total requests for service per year for the intake function, which I'm, when I say the intake function I'm speaking of CRU, after-hours, tier two and abuse along with early intervention, was -- if you could pan back again to the right side of the document -- 16,313. You'd referenced

between 15,000 and 16,000, but that's the source of your information?

A That's correct, yes.

Q And so that is that there were, in 2004, as recorded here, 16,313 requests for service, right?

A That's -- I'm sure that document is accurate, yes.

Q And if we could scroll down to the bottom of this document, please. And then we'll have to scroll over to the left first. Yes, thank you.

There's a heading that says "Subtotal Open File & Transfer to Service Unit", and then there's a heading that says "Open & Close File". Do you see that?

A Yes.

Q And if we scroll back to the final year end tallies, again to the right side of the document.

The numbers that we have for matters that are referred to intake units is 5,235 and the number of files that were opened and then closed for that year, 2004, is 1,875. Do you see that?

A Yes.

Q And so is it fair to say, just using approximate numbers here and, that it looks, if you add those two numbers together it's approximately 7,000 and approximately 2,000 of the 7,000 are matters that CRU has dealt with on a

short-term basis and closed in 2004, correct?

A I believe that's right. Unfortunately, the, the screen only shows half. Maybe if this -- I -- my vision is still okay, I can -- if you shrink it down maybe I can see the whole --

Q Yeah. Is --

A -- form at one time.

Q -- it not possible ...

A Okay. So you're saying CRU, their total there is eighteen, what, eighteen seventy-five?

Q Yeah, for the amount of files that are opened by CRU and then closed --

A Right.

Q -- don't make it on. And then the number of files that are opened and make it to the next level, to intake, is five thousand --

A Yes.

Q -- two hundred and thirty-five?

A Yes, yeah.

Q So, so when I add those two together I'm just indicating that approximately two out of every seven files was opened by CRU, dealt with on a short-term basis and then closed?

A Right, correct.

Q And keeping that in mind, then, if we could turn

to the intake manual and page 19634. That's CD992.

A Did you say 634?

Q I think I said 19634, yes. Now, this was a document that you discussed earlier this morning in your testimony and you indicated, these are the rules that relate to provision of services under you in intake generally, and specifically here at CRU?

A Right.

Q In this section we're looking at, the manual, which you said was the guide --

A Right.

Q -- to the work being done and how it was to be done, this is the section that deals with closings at CRU, and I want to draw your attention to item number (b), which says, quote:

> "Generally speaking, if a matter may be resolved and the case closed with limited further intervention (a few phone calls or a field) the case may be kept by the CRU beyond 48 hours to facilitate the case disposal."

You see that?

A Yes.

Q Now, that's quite clearly contemplating that of those two out of seven files that CRU is dealing with, they can be closed, they can be kept for more than 48 hours first of all; it's contemplating that, correct?

A Yes.

Q Then they can be disposed of or closed, it says here, with a few phone calls, firstly?

A Right.

Q So this specifically does not require that with respect to those two out of seven files that every matter, all of the children have to be seen?

A This statement?

Q Yes, yes, this rule, this policy.

A Well, a guideline. I think you've called it a rule and a guideline. I would suggest it's a guideline.

Q Okay.

A And if you're suggesting that that means -- that suggests that children don't have to be seen, that statement?

Q It's that there's no rule requiring that they be seen, which is different than saying -- that, that this contemplates files being closed with a few phone calls. Stop there first. Do you agree with that?

A Yes, that's possible.

Q And then it also contemplates files being closed with a field?

A Yes.

Q And, and just making the obvious point, it doesn't say in there that with respect, before any file is closed out of those, that CRU is dealing with, that all of the children have to be seen?

A It doesn't say that, no.

Q And if we could then go to the next document, which is a February 3rd minute from 2004. It's at page 20260.

Now, this is a, a document that the Commission is familiar with that's been put to several witnesses, including the witnesses listed as being present for this CRU joint meeting minute, which included Shelly Wiebe, Diana Verrier, Diva Faria, Chris Zalevich and Bill Leskiw, who latterly are the individuals involved in the two last CRU involvements which have been the subject of this Commission's consideration this past few weeks.

Would you have been aware of, of these, of minutes of meetings such as this at your time?

A I, I could have been. These particular ones I don't recall. They were completed for the benefit of the staff who attended and perhaps the assistant program manager. They may have come to my attention. I, I don't

recall whether they were brought to my attention --

Q Okay. And if we --

A -- as a rule.

Q Sorry.

A No.

Q If we could turn to the next page. Item number 13 says:

> "Assessments - There were concern raised about assessments being made over the phone that should be done by a field to the home. As much as is possible, when there is a concern about a child in the home, the home and the child should be seen by a worker. If the decision is made to complete an assessment via telephone or through a collateral this should be reviewed and approved by the Supervisor."

Do you agree that that was the policy and the practice that, that CRU was striving for in terms of its investigations?

A That they were striving to make sure that the home and the child were seen by the worker, that they were striving for that?

Q Yeah. That as much as is possible --

A Yes. Yes.

Q -- when there is a concern, see the home, see the child?

A Yes. That would be -- that describes what the goal should be as best, as best as can be done.

Q Right. And it's -- and were you aware of the issue that they're talking about here being made that some assessments were being made just over the phone and here they're saying, as much as possible, get out to the home rather than just making a phone call, get out to the home and see the child. Were you aware of that concern?

A Not specifically. It's a pretty general statement. I mean, you might assess situation with a teenager in dispute with a parent over the telephone, which would be quite different than assessing a pre-school child.

Q Right.

A So it's a, a very general statement. It's hard to comment on them; and I don't recall this particular document specifically.

Q My information is that there was concern by the supervisors that there were too many assessments being done

over the phone and they wanted to make sure their workers were going to err on the side of getting out to the home and getting, and seeing the child and that that was the directive supervisors were giving to their workers.

A Okay.

Q Does that sound right?

A That sounds reasonable.

Q And we know, though, that in many cases, out of that two files for every seven files that we've said that were just dealt with at CRU and then closed, we know that, that on many occasions before the files closed, there -- the file would have been closed without all of the children being seen?

A Yes, I'm sure that's true.

Q So if we -- when we were looking at that CRU statistic --

MR. OLSON: I --

THE COMMISSIONER: Yes.

MR. OLSON: -- I just -- I don't believe that has been the evidence so far.

MR. SAXBERG: I'm asking him. He's giving the evidence.

MR. OLSON: Well, the way I understood it, you -- Mr. Saxberg was putting it to the witness.

THE COMMISSIONER: He's giving evidence that he's

never seen -- he's not familiar with this document you're questioning him on.

MR. MCKINNON: Yeah, I think that the way the question was put is, is Mr. Saxberg said, we know that files were being closed without all the children being seen, implying we heard evidence to that effect. I'm not sure we have heard evidence to that effect.

THE COMMISSIONER: Mr. Olson thinks not.

MR. MCKINNON: Yeah. So I --

MR. SAXBERG: But I --

MR. MCKINNON: -- think it would be better if he rephrased that question.

MR. SAXBERG: Sure. I wasn't --

THE COMMISSIONER: All right. You let me know if you have a concern about its appropriateness.

MR. OLSON: I will.

MR. SAXBERG: Let's go at it this way. If we could call back up that CRU statistic that we'd looked at earlier, which was page 44741.

BY MR. SAXBERG:

Q I'm -- the number under number 3, open and close files that we spoke of before, eighteen seventy-five. Those were files that have been opened at CRU and closed by CRU after some short-term service?

A Yes.

Q And I'm not putting to you what anyone else has said in this proceeding, although others have said it, but I'm just asking for your evidence here. Of those 1875 cases in 2004 that are dealt with by CRU and then closed by CRU, many of those cases would have been closed without all of the children being seen, correct?

A I would agree that that has happened. You've used the term "many". I don't know what the number would be, but there, there would have been cases closed. The number, I have no idea.

Q Right. And that would have been in compliance with the policy that we looked at in the intake manual that provided that cases could be closed at CRU with a few phone calls or perhaps a field, correct?

A Yes.

Q So, and you cited one example of parent/teen conflict, which would be one of the more, which would be one of those examples of files where all of the children in the home may not have been seen before the file is closed, correct?

A That could be an example, yes.

Q And there'd be all kinds of other examples. But there's a discretion that the worker and the supervisor have with respect to whether or not all of the children in

the home, they strove for that objective to see all the children in the home before closing a file but they would have a discretion as to whether it was necessary in any particular occasion before closing the file, correct?

A Yes, that's fair, that's correct.

Q And that was completely in line with the policy and practices at CRU at the time?

A Yes.

Q And so you were asked if it was reasonable to close the file in this case without seeing Phoenix.

THE COMMISSIONER: In which case?

BY MR. SAXBERG:

Q In this case, without seeing Phoenix on the March 2005 matter. You're right. Sorry. Thank you for that clarification.

A In the March, the March contact?

Q Yes.

A Okay.

Q You were asked that question. You recall being asked the question?

A Yes.

Q And your answer was, you didn't directly -- this is my opinion --

A Okay.

Q -- you didn't directly answer the question. You said, though, Phoenix should have been seen --

A Yes.

Q -- in your view, and you said that would have been important to see Phoenix --

A Yes.

Q -- correct? We know that today there's a specific provincial foundational standard which would require, if these events occurred today, that Phoenix had been seen. That would have been a minimum requirement if that happened today, correct?

A Okay, yes.

Q You're aware of that?

A I, I, I am aware of that. I'm not doing intake so this is where I'm not as familiar with current practice at intake, but I believe that's to be true.

Q And, but would you agree, though, that back in 2005, in March, given the guidelines from the intake manual that were in place and the practices that were in place at the time, that it was a reasonable option to close the file at that time based on the information, other information that had been gathered without seeing Phoenix?

A Are you talking specifically about this case or are you talking in general?

Q I'm talking -- well, I'm talking in general

firstly, about that it's reasonable to close a file based on the guidelines from the manual, without seeing a child. You've already agreed to that.

A In 2004. Are you talking about the intake manual at that time?

Q Yes.

A Yes, it would have been reasonable to close some files without seeing all of the children.

Q Right. And in this case, I'm not going to ask you about the specific Phoenix Sinclair case on this point because I think you'll agree you'd need to know all of the information that was available to the workers and to the supervisor before they made that decision to close the file without seeing Phoenix on that specific occasion, correct?

A Right.

Q You would need to know everything that they knew at the time they made their decision, correct?

A Right.

Q And you're not going to sit, you wouldn't sit up here and back-seat quarterback or second-guess, in hindsight, a decision that they made because you don't have that information that they had available, correct?

THE COMMISSIONER: Well, he's already --

THE WITNESS: Well --

THE COMMISSIONER: -- he's already expressed an

opinion, hasn't he, based upon what he said this morning, you just repeated to him that Phoenix should have been seen, it was important to have done so?

MR. SAXBERG: And I'm challenging that, I guess --

THE COMMISSIONER: Oh.

MR. SAXBERG: -- by saying that it's not reasonable to reach that opinion without knowing all the facts.

THE COMMISSIONER: Oh, if you want to challenge that, fine, go ahead.

MR. SAXBERG: Yes.

THE WITNESS: Well, in fact, if that's what you're doing, I would refer to my earlier answer that, yes, that Phoenix should have been seen.

BY MR. SAXBERG:

Q And, and what I'm saying is that, that you're only basing that on what you've read in the reports that, that came out after Phoenix's death?

A I've made mention that I've, I've seen all of the reports. I mentioned, too, that Mr. Koster's report was particularly striking, and I believe he made that, drew that conclusion as well.

Q Yeah. And it certainly would have been best

practice to have seen Phoenix. That, that's one thing you're saying?

A Absolutely.

Q What I'm saying is that it was generally permitted to close a file at CRU without seeing all of the children, and you've agreed to that?

A Yes.

Q And what I'm saying is that in this particular case, to know if it was the appropriate decision at the time made by the supervisor and the two workers, you'd really need to know everything that they knew at the time they made that decision, to be fair in deciding whether it was a reasonable decision, not the correct decision but a reasonable decision to make at the time. Would you agree with that?

A You've, you've made statements and linked them and I'm not sure that that's reasonable.

Q Okay.

A You've suggested that can cases be closed without seeing all the children; I said yes. Was it the best practice in this specific case? And the answer is no.

Q Yes. And I think we're -- I think all the witnesses are on the same page --

A Okay.

Q -- on that point. My -- I, I'm asking about the

closing of the file and whether the closing of the file was a reasonable decision, and I'm suggesting that you wouldn't know whether it was a reasonable decision unless you knew all of the surrounding information that was available to the supervisor and the workers. Would you agree with that?

A I don’t think there was a lot of material to consider and I think I have a good working knowledge of the information they can -- that they had at that time that they drew that conclusion, that they decided to close it. I think I understand what the facts were that drew them to that. I would say that they should have seen them. There, as we've discussed here, many other factors, the workload demands, the fact we're working with a high risk population where files are closed with the hope that nothing happens. I mean, there's lots of different elements here. I'm not sure that I'm prepared to agree to what you've said.

Q Let me, let me try one more time.

A Okay.

Q If -- notwithstanding that it may not be best -- that it wasn't best practice to not see Phoenix, given the other information available to the workers and the supervisor, will you concede that it may still have been a reasonable decision that they made at the time, given whatever workloads and matters they're dealing with that day, and other information, to decide to close the file?

A They made an error by closing the case. That error is magnified by the results, the extraordinary results of this case. But if they had seen this case things might have been different, they might have been exactly the same. I don't know.

Q Okay. Now, in terms of the referral that they were dealing with, then, in March of 2005, we've heard it be referred to as, as vague, another description used was soft, and that's because it was a referral in which the word "abuse" was used but there was no indicia or information about the abuse itself. Would you agree with that?

A That's correct. That's what was lacking in the referral.

Q So the word is used but there's no information that would lead a CFS worker to conclude that it's an abuse referral?

A Right. And there's also no information that would conclude it's not abuse, not an abuse referral.

Q That's right. And so subsequent investigation is warranted, correct?

A Yes.

Q And that includes phone calls, correct?

A Well, phone calls, home visits, file -- is a whole --

Q The whole, the whole assortment?
A The whole range of information-gathering.
Q And there's a discretion in how far you go in every case before you, you make your conclusion as to whether or not that unspecified allegation is something that should be further investigated at intake or should be closed, correct?
A Correct.
Q And there's no, specific guideline on how much work you do to flesh out whether that unspecified allegation of abuse is actually an allegation of abuse or something else, or nothing, correct?
A It was not specific, and that was left to the worker's judgment at that time --
Q Right.
A -- it was not a specific.
Q Okay. It's left to the judgment.
And would you agree that in terms of if you need to flesh out, if you need to find out what this allegation is because you just have the word "abuse" being thrown out --
A Right.
Q -- but no examples of, of what is being intended to be communicated, would you agree that the best source to flesh out that referral is going to be the person who made

the referral, the person with the information?

A That would be one source. It would depend on what that person knows, what they have observed, what they've seen. They, they, they would be a source. There might be much better sources than that; we didn't know.

Q But would you not agree that if you want more information on what the concern is, you're going to talk to the person who has the concern?

A That would be helpful to speak to that person, yes.

Q Okay. And you are aware that in this case that person was not prepared to speak to CFS?

A I am aware.

Q And that that was made crystal clear --

A Yes.

Q -- during the after-hours report --

A Yes.

Q -- that they would not speak to CFS?

A Right.

Q So did that not hamper the ability of the workers to find out more about this amorphous referral of abuse?

A That, that absolutely made the case more difficult to handle. We had very limited information from a source that we could not discuss this with further.

Q Right. And so what the investigators are left

with is they have to talk to the parent, is one of the things they have to do --

A Yes.

Q -- they field to the home to talk to the parent. And you've indicated talking to the parent isn't something that you can't give a lot of weight to their answers, it's going to be self-serving information, correct?

A Of course.

Q So, so -- and then you've also indicated that seeing Phoenix obviously would have been best practice but it may not have shed anymore light on the situation, correct?

A Right. But that would have been one more step you could take to add to the, to the store of information that you have, not that it would be definitive --

Q Right.

A -- one way or the other, but that, that could have been helpful.

Q So you've indicated that the ultimate decision, then, in March to close the file, your view, your opinion is that it was an error?

A Yes.

Q Can you put that, in terms of order of magnitude, you've worked, you were, you were the person at the head of this organization in terms of the intake function, you're

at the top --

A Yes.

Q -- of the, of the ladder?

A Yeah.

Q And you surely have, have -- it's come to your attention work that's been done by workers under you and, and errors that they've made, correct?

A Yes.

Q I mean, they've all made errors, right? People make errors.

A Absolutely.

Q And when you're dealing with 16,313 requests for service, there's going to be a few errors in there?

A Um-hum. Yes.

Q Yes?

A Yes.

Q And in terms of magnitude of this error, I had said that it was reasonable to close the file. That was what I was asserting to you and you disagreed, but in terms of the level of error here, how would you describe it?

A Well, that's an evaluation I guess we're making in hindsight, and we -- CRU intake, the entire intake operation would be measuring high risk cases all the time and trying to assess the risk, the current risk, the future risk, our opportunity to involve it with, with families

that really don't want to talk to us and are not willing to engage with us in any transformative behaviour. So those kinds of decisions were made and this case is one of the most serious I've seen because of the result.

Q Right.

A So to rate it on a scale, I'm not sure that that's a reasonable question.

I just -- it has many similarities to other cases. What we're concerned about here is the result of that decision.

Q In this case, the -- would you agree that the error is magnified to an extraordinary degree because of the magnitude of the tragedy that occurred afterwards?

A I would agree.

Q But the error in itself isn't something that, that was unique in terms of errors that workers would make at that period of time, given the --

A Well, I'm -- you're characterizing them as errors. I think workers were making decisions about high risk families. Some families we could engage with, some families we had leverage because their children were in care, and we have some families who we didn't have a current situation to deal with. And decisions were made to close some of those cases. And fortunately most, most of those families carried on, not necessarily with a good

result, but carried on. In this case, that's not what happened.

MR. SAXBERG: Thank you for that answer, and I think that's fair and as far as you can go.

Those are all my questions.

THE COMMISSIONER: Thank you, Mr. Saxberg.

MR. SAXBERG: Thank you.

THE COMMISSIONER: Mr. McKinnon.

MR. MCKINNON: Thank you, Mr. Commissioner. I just have one question for the witness, and it arises out of a question that you asked, Mr. Commissioner. You asked the witness -- take me a minute to find my notes. You asked Mr. Harrison about the extent to which the intake program that you were managing responded to anonymous calls, and I want to just explore that a little bit with you because I think the evidence that we've heard at this inquiry, there's two distinct concepts that I want to try to separate a little bit and I'm going to ask you if you can help us.

RE-EXAMINATION BY MR. MCKINNON:

Q One is what I'll refer to as an anonymous call where someone calls intake, presumably gets through to CRU, and refuses to give up their name and is truly an anonymous caller. And they say, my, my neighbour or someone down the

street or someone I know of, I saw something in the playground, I don't want to give you my name. That's a truly anonymous call and as I understand your evidence, Winnipeg CFS would respond to that?

A Yes, we would acknowledge that call and explore it further.

Q And then we have a situation that arose here where the caller wasn't anonymous, the caller disclosed their name and disclosed their, their identity and indicated they were calling on behalf of a third party. Again, is, is it the practice of Winnipeg CFS to follow up when someone is calling on behalf of a third party?

A Yes.

Q Yes. And in this case, to make it even more confusing, the third party then said, I want to maintain the name of that third party as confidential or anonymous or refused to provide to Winnipeg CFS the name of the third party who had the information. So I'm drawing that distinction again, correct?

A I'm sorry, what -- and what's your question?

Q So the question is this, you would follow up on that, that kind of anonymous phone call as well, where the caller identifies themselves and say they have information from a third party who wishes to remain anonymous, Winnipeg CFS would follow up on that as well?

A Yes. If your, if your point is that all of those calls would be treated with equal seriousness, I would agree.

Q Okay. And that is my point. And then, and then just one more point. Would you expect your worker, your CFS worker, who is receiving information from a source that they know the name of and who is withholding the name of the anonymous person who has the actual information, would you expect your CFS worker to try to get the name and contact information for the individual who has the actual knowledge?

A Yes. I think the more information we have about the referral source the better. Those sources are protected under the Act so we try to re-assure folks. But we treat them all equally because we really have no way, until we explore further, the validity of the thing. But you also try to assess who are these people and what -- do they have any other motives to call.

Q And in this case the anonymous caller, we've heard, perhaps didn't give as fulsome an explanation as to what her suspicions were to the person who phoned, so shouldn't say the anonymous caller. The person who wanted to remain anonymous with the information may not have given a full explanation to the person who phoned Winnipeg CFS so that can create a problem?

A That's possible that would have been, made it more difficult to sort that out, yes.

MR. MCKINNON: Thank you. Those are just the only points I wanted to clarify.

THE COMMISSIONER: Thank you, Mr. McKinnon.

Mr. Olson?

MR. OLSON: I've no additional questions.

THE COMMISSIONER: Thank you. All right, witness. Thank you very much. You've completed your time here.

THE WITNESS: Thank you.

THE COMMISSIONER: You can leave the stand.

(WITNESS EXCUSED)

THE COMMISSIONER: Ms. Walsh.

MS. WALSH: Our next witness will be Mr. Barber. If we could call him to the stand, please.

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

THE WITNESS: I'll swear on the Bible.

THE CLERK: All right. State your full name to the court, please.

THE WITNESS: John Lance David Barber.

THE CLERK: And spell me your first name?

THE WITNESS: L-A-N-C-E.
THE CLERK: John?
THE WITNESS: John.
THE CLERK: Lance?
THE WITNESS: I go by Lance, yeah. David, D-A-V-I-D.
THE CLERK: And your last name?
THE WITNESS: Barber, like in haircut.
THE CLERK: B-A-R-B-E-R?
THE WITNESS: Correct.
THE CLERK: Thank you.

JOHN LANCE DAVID BARBER, sworn,
testified as follows:

THE CLERK: Thank you.

DIRECT EXAMINATION BY MS. WALSH:

Q Mr. Barber, you were the chief executive officer of the agency, Winnipeg Child and Family Services, from 1997 to July of 2001?

A Correct.

Q And in terms of services delivered to Phoenix Sinclair and her family, you were only there for one year of the period in which those services were delivered?

A Correct.

Q You were at the head of the agency, however, during what was a period of transition and so for that reason, it's important for the Commissioner to hear your evidence about your tenure as CEO to put matters -- to give some context to matters.

A Okay.

Q Now, like Dr. Trigg, you do not have a social work background; is that correct?

A That's correct.

Q You have a bachelor of science and you have your masters in business administration?

A Correct.

Q You got your masters in business administration from the University of Manitoba?

A Yes, I did.

Q When was that?

A I graduated in 1985.

Q And where are you currently employed?

A I'm the director of surgery at St. Boniface General Hospital.

Q Now, when you say you're the director of surgery, you're not a physician?

A No, I'm not.

Q What was the mandate of Winnipeg Child and Family

Services from 1997 to 2001?

A We were mandated through legislation to preserve and work with families and within the community to protect children from abuse and neglect.

Q How would you describe your role and responsibilities while you were CEO?

A When I came into Child and Family Services there were a number of issues that I was brought in specifically to, to deal with. I was involved in the implementation of a number of recommendations that came out of a report by Prairie Research. I had the opportunity to work on improving, and I'd say repairing, the, the external image of the, of the agency in, in the public's eye. I had to deal with issues of staff engagement, numbers of children in short term hotel placement, create a different relationship with First Nation mandated agencies and aboriginal and Métis collaterals, to understand the business at a, a level commensurate with, with a CEO and to identify other opportunities to engage the agency in a, in a different fashion with the foster network that we relied on so heavily and with our volunteer network. So that's the world I came into.

Q We'll come back to, to some of those areas.

At the time that you were CEO did you report to a board?

A Correct.

Q And how was that board appointed and comprised?

A The board was comprised of a number of individuals appointed I believe through Order in Council by the government of the day, and there were also four individuals on that board, one for each of the geographic areas, and they were elected to the board by their -- by the community in which they resided.

Q So was a community-based board --

A Correct.

Q -- in that sense?

A Was a non-profit private corporation funded through the province.

Q In your view was there a significance to having a community-based board?

A I believed it was very significant. It connected us to the community in a, in a very different way. It made us more responsive to the needs of the community. We very often took the board on tours of our various offices. I believe we had 40 or more offices across the City of Winnipeg and rural eastern. Many times the board would come to see a particular aspect of, of our work and we very often held board meetings in one of the various offices in one of the, in, in one of the communities.

Q Did the fact that you did not have a social work

background present any challenges for you as a CEO?

A I needed to understand the business from a strategic level but I don't believe it hampered me. I was hired for my leadership and change management skills. I was not hired to be a social worker and manage cases and, and et cetera.

MS. WALSH: Want to take a look at the organizational structure. If we can pull up page 29579. Can you make that more legible?

MS. WALSH: You have that, Mr. Commissioner?

THE COMMISSIONER: Yes.

BY MS. WALSH:

Q Can you just describe for us what this chart shows in terms of, of the organizational structure?

A Yes. That would have been the structure that I came into when I arrived at the agency in '97, and it was the result of the reconsolidation of six separate agencies in 1991 back into one corporate structure. It was divided amongst four different geographies which, each of which had an area director and then it had a central infrastructure of human resources and payroll and et cetera.

Q So that's a geographically-based organizational structure?

A Correct.

Q Then if we go to the next page. You'll have to shrink this, please.

Now, the previous page was dated 1998. This one is dated 1999. Does this show a different organizational structure, the document in front of you?

A Correct. This would show the structure after we had completed the -- or I wouldn't say completed -- after we had initiated the reorganization and it would represent a organization that was based on, on programs or structured around the programs and services that were delivered rather than the geography.

Q So we've got a variety of, of programs: alternative care/permanency planning, quality assurance, research and planning; services to family and children; resources in support of services; community outreach/early intervention; and aboriginal liaison.

A Correct.

Q Now, was this something that you initiated, this change, or was it something you were hired to implement?

A I was hired to implement but how it was going to turn out, the structure, how we were going to organize ourselves, the different functions that we were going to create, that was a component of, of my leadership and the leadership of the team around me. What we did was, using the basis of the Prairie Research report, which was good at

identifying symptoms of a number of problems but required a, a little deeper level of analysis and, and understanding to, to decide how we were going to organize ourselves, we took the first 12 or 18 months to work through that.

We first engaged an external facilitator to take us through a strategic planning exercise around what we wanted to have from, from a new organizational -- what were we trying to accomplish. We weren't restructuring for the sake of restructuring, we were structuring to deal with a number of issues that had been, been raised in, in that report.

Coming out of that, when we had some strategic directions that have been endorsed by the board, we created 13, I believe it was 13 -- time erodes the memory somewhat, but I believe it was 13 different working groups that involved a large number of staff across the agency because this needed to be an organization that was being restricted with input from the people that did the work. Lot of these people had tremendous career content knowledge; they'd been through a number of reorganizations in the child welfare system starting back in 1985. Many of those were, shall we say, top down type of reorganizations with little input from, from the front line.

In order to have an organization that I believed would be more sensitive to, to providing the best

opportunities going forward, we involved the input of staff in helping to work through some of the issues and barriers that had been identified in the Prairie Research report. That helped us to formulate different options. Those options were vetted by a steering team and ultimately approved, the direction would be approved by the board. This culminated in the structure that you see before you.

Q Can you give us some examples of the issues that led to this reorganization?

A Yes. Prairie Research did a fairly good job of identify -- doing an environmental scan, identifying a number of issues that existed in the world in which Winnipeg Child and Family Services needed to provide service. The child poverty rate in Manitoba was above the national average. The number of teenage, the teenage pregnancy rate in Manitoba was above the national average with many of those teens wanting to parent.

I remember, I was always struck, it's, it's funny how certain passages will stick with you, but there was a passage in that Prairie Research report that commented on, after talking with a number of law enforcement, educators, social workers, community outreach workers, et cetera, that they were unanimous in identify that children were coming into the child welfare system at younger and younger ages with greater degrees of, of, of issues and, and, and

damage. And that environmental scan along with some research and analysis that we did to support some of the decisions in, in creating a structure helped us to, you know, get more focused in, in what we wanted to accomplish.

One example would be we provided service across, you know, City of Winnipeg and rural eastern Manitoba. What was important is, was there a way that we could define intense pockets of, of service that we could better engage the agency with that community. Part of the reason, the rationale for the creation of the quality insurance function was so we could better understand information that was available out there that would help to inform us, not just in the service we provided but in the way we would organize Winnipeg CFS.

We looked at census data from 1986, 1991 and 1996 to identify some indicators that were fairly good predictors of whether or not you were going to be involved in the child welfare system.

Q Now, when you say you looked at census data, I just want to interrupt you. Was that separate from the Prairie Research --

A Correct.

Q -- that you did?

A That was separate.

Q Okay. So we'll come back to that.

A Okay.

Q So in terms of the, the Prairie Research report, that report you said identified rates of poverty, high rates of child poverty?

A Correct.

Q And what year was that report?

A I believe that report, its final version was either '96 or '97.

Q So those were some of the issues that led to -- or that prompted the reorganization into a program base rather than a geographic base?

A There were, there were, there were more issues than just that. That --

Q Sure.

A -- that, that's the environmental scan. With, within that report it very clearly identified a number of organization dysfunctions that were the outgrowth of being a geographically-based organization. That was the outgrowth of the reconsolidation of five Winnipeg community-based child welfare agencies and a rural agency.

Q So can you give us an example or two of the organizational issues?

A Yes. There -- it was my opinion upon my arrival in the agency that there could be a greater level of cooperation between the area directors. There was a

significant imbalance in workloads between the areas. There were significant differences in programming, depending upon which area in which you resided, meaning certain services to families may be available in one area but that program may not exist in another area, but those areas were both under the corporate umbrella of Winnipeg Child and Family Services.

Q So part of the reorganization was to effect more consistency in delivery of services across the city or across the agency's jurisdiction?

A Correct.

Q How would you describe the work environment or culture when you arrived at the agency in '97?

A It was, it was a system in which staff engagement would have been low and the competitiveness between the areas would have been, would have been noticeable.

Q Did you see a change in that environment over the four years you were there?

A Correct. I believe there's a significant change in that environment, yes.

Q Meaning?

A Meaning we, by basing our services based on the needs of the families and children that we served, by cooperating with collaterals and First Nation mandated agencies in a, in a manner that hadn't been the habit of

the agency when I arrived, in particularly focusing on certain activities that improved staff engagement.

What I felt would be important upon my arrival, in this type of an environment was ensuring that the, the staff of the agency very quickly felt that we were entering -- reorganization was not something to be feared but, rather, we are going to enter an area of stability where we all had a common vision of where the organization was going; that we had an organization where the CEO had an open door policy. I regularly visited each of the 40 offices, sometimes at least once a year and many times twice. I, at the invitation of, of a unit would attend a staff meeting. We held general staff meetings at different times to communicate to, to the organization. We -- I felt it was important to repair the public image of the organization because at times we were only seen in the newspaper when something was going on around a particular case. We wanted to create a, a different environment where the organization was seen for all of the other work that it did. And we also created different ways of communicating within the organization so that staff knew what was going on and they also had the ability, if they thought something was happening, they could go to their manager or they could come, you know, have a conversation with the CEO at one of the staff meetings. We tried to create an open and

transparent environment, which I believe is very key to improving staff engagement and creating a more calm platform in which, you know, services could be delivered. If --

Q Sorry, you said you, you worked with mandated First Nation agencies. Did you have any involvement with devolution while you were CEO?

A I had very little. The meetings were just starting towards the very end of, of my, of my time at Winnipeg CFS and my involvement would have been restricted to some meetings and conversations with the other non-profit private agencies.

Q You did hire a director of aboriginal services?

A Correct.

Q And was that a first for the agency?

A Yes, it was.

Q What was that individual charged with doing?

A That individual was charged to, as part of the re-organization -- let me, let me just back up, create a bit of a context.

These number -- any numbers I, I'm going to give over the course of my testimony are going to be approximations because ...

Q Understood.

A But let's say there were roughly 2700 children in

care when, you know, on average during my time with the agency. I'm going to say maybe 1300, you know, 40 percent, 45 percent, would have been permanent wards. Of the children in care, I believe 60 to 70 percent of those children were status/non-status or Métis in, in heritage. It was tremendously important as part of the agency's restructuring, that the units that were dealing with, with those children and those families, develop some cultural competency and understanding of, of the people that they were dealing with.

The aboriginal liaison position organized a, a program where each of the units, as a unit, went to Red Willow Lodge out on Brokenhead River and spent, I believe it was five days, learning about the impact of European settlement and residential schools and the child welfare system and its, what its impacts were on, on First Nation people. And the reason a unit went is this wasn't an optional activity. This was a required activity, and the executive of the agency and each of the units, over a period of time that I -- you know, may have been a year or 18 months, attended that. That was a very significant role of, of, of that individual.

The involvement with First Nation mandated agencies I took upon myself, upon arrival in the agency, because for it to have meaning the CEO of the agency needed

to be the one that was developing those relationships, and once those relationships were developed then others in the agency could pick up with their appropriate counterpart and, you know, relationships could develop from there.

Q Now, you say you reported to the board. Did you receive directions from the board?

A Correct.

Q How often did you meet with the board or the executive of the board?

A There were monthly meetings.

Q Who reported to you?

A Directly would -- the people reporting to me would have been the five boxes immediately below me plus some clerical staff, et cetera.

Q How often did you meet with those five boxes, those heads of the, the various programs?

A I would meet with each of those individuals monthly, you know, on -- as individuals. We would have met as a, a management team monthly. And we also would have met as need be if there was something that required our attention, all of us or a sub-set of that group.

Q What about the workers and supervisors who reported to the individuals that you've just identified? Did you have any contact with them?

A I would have contact with them if I went to visit

an office to, you know, provide two-way feedback, you know, between the, this -- you know, the various offices and myself. But I did not, you know, have monthly meetings with each of the --

Q Right.

A -- units that, that, you know, worked for the agency.

Q During your, your tenure as CEO, who in the agency was responsible for ensuring that work was being performed in compliance with the mandate of the agency?

A There would have been an expectation that the supervisor, their manager and the chief operating officer or the, you know, director of program services, Elaine Gelmon would have -- they, those are the people that I would have expected to be responsible for that.

Q Were files ever audited?

A I believe as part of the quality assurance function we did start to have file audits but I wouldn't be able to tell you how frequently and under what circumstances. I don't recall.

Q Did compliance issues come to your attention?

A They would more often come to the attention of the supervisor or the manager and they would be dealt with at that level or through the director of program services.

Q What was the process if it was determined that a

worker or a supervisor was not performing in compliance with fulfilling the mandate of the agency?

A Then their immediate supervisor would have a performance conversation with them as would be expected in any organization.

Q What were the options for dealing with an employee who was not performing adequately?

A I can't recall one so this would, you'd be asking me for a hypothetical response.

Q Fair enough. There were, however, I would assume, consequences of some sort to address issues of performance?

A Correct. One of the things, though, that I wanted to bring from -- I'd come to the agency from St. Boniface Hospital but in a different role than I currently hold. In the health care system we have a, created an environment where we try to learn from, from errors or mistakes and circumstances, and I tried to inculcate that type of culture so that there was a, a learning experience around errors or omissions that might occur. That's about as far as I can go.

Q So for --

A And then there's a human resource structure, obviously, around performance.

Q In order for a, a worker to be able to learn from

their errors, the errors would have to be discussed with them?

A Correct. Or they needed to identify the errors themselves.

Q Right. When you were at the agency, did you formulate an understanding as to the underlying reasons why families came into contact with the child welfare system?

A Yes. Part of -- I, I've come to some conclusions. Some of those are rooted in some of the environment scan information that was provided in the Prairie Research report and some of it was provided through the dialogue we had with the agency staff as part of the strategic planning and then the reorganization, and then some of it came through some of the analysis we did around the census data and some other information that helped us to drill down to better understand our, our constituency.

Q So in terms of -- now, this is what you were telling us earlier -- an analysis of the census data. So what exactly did that involve?

A What that involved was Winnipeg -- I'll explain to you as it was explained to me because it was a bit of a learning experience for me at the time. Winnipeg, as far as the, the census goes, is divided into around a hundred and fifty-five or so, they're called small neighbourhoods, and that allows you then to have a different lens on what

may be occurring in, you know, in a smaller area as opposed to the whole city. The research and planning function identified that, was each for me to recall about some of this is there, some of the percentages were, were, you know, one-quarters or two-thirds, so they were kind of easy to remember. So what we -- at a high level what we identified were that about a quarter of, a quarter of families were living in poverty and about half the families that had a single parent head were living in poverty, and two-thirds of single parent families living in poverty were aboriginal, usually with a female head of household.

What we did was, when we looked at those three indicators, what we did was look for those part -- those small neighbourhoods where each of those three indicates was above the city average, and the exercise identified, I'm going to say, approximately 30 small neighbourhoods. And looking longitudinally between '86 and '96 they identified that about half of those neighbourhoods, let's say, increased in their intensity, meaning if they were above the average in '86 they were even further above the average by '96. We then overlaid our caseload, our open protection cases based on postal code across those small neighbourhoods and identified that about 40 percent of our open protection cases could be identified from those, those, those 30 neighbourhoods.

We then looked at the neighbourhoods where any two of those three indicators were above the city average, and identified in '86, I believe, 18 or 20 additional neighbourhoods. By '96 those 18 or 20 had grown by about 25 percent, so there might be around 25 or 24 of those neighbourhoods.

When we combined the 30 neighbourhoods where all three of those factors were above the average with the rest of the areas that had two of those three, we came up with about 50 or 55 small neighbourhoods that were at extreme risk and represented about 60 percent of our open protection cases.

Rather than taking a shotgun approach, what we were doing was coming down the funnel to try to see where we could concentrate some, some preventive services in a different fashion.

The last level of analysis that we did was to overlay the public housing areas on top of that.

Q Just before we get to that, so in terms of the issues that you identified as being risk factors, those were, if you could just outline those again for us.

A They were living in poverty as a aboriginal single parent.

Q Okay.

A Particularly, usually female-led household.

Q Now, you were coming to, to strategies that you developed to address these risk factors, so --

A Correct.

Q -- carry on.

A What we did, when we overlaid the public housing locations, what we identified was, I believe it was between 40 and 50 percent of our open cases in those 55 small neighbourhoods were concentrated in public housing. What was important about that was there was a large level of population that was in crisis, that was requiring service, and why this was important is it ties back -- I mean, it, it's, it's hard in a synopsis to try to take all the different pieces that were going on over the, over the couple of years that we were developing our strategies of reorganization, how every piece plugged together. But what was important is, and I used a -- I remember using a medical analogy because just was more familiar to me.

If you didn't have the campaigns we've had for the last 40 or 50 years around smoking, if the habits around smoking, access, advertising, et cetera, had not remained -- had remained the same and nothing had changed, we would have been hard-pressed to invest in all of the operating rooms in-patient beds and oncology beds required to service the outcome of, of, of, of smoking.

Q Okay.

A Well, it wasn't different with this. If we could, by identifying where we had concentrations of families requiring service, if we could approach that service in a different fashion and invest in the community through community capacity building -- and I can explain what we did, if you like, later, but not to lose the point, we felt that dollar invested in preventive services in these areas of risk was a way of ameliorating future workload because maybe the families wouldn't come into crisis and maybe the children wouldn't need to come into care. It doesn't mean they may not have still had involvement with the agency or collaterals but it might have been a different level of involvement than what we were facing at this time, and I ...

Q Can you give us an example, then, of prevention initiatives that you developed?

A Yes. Upon my arrival at the agency we had just recently opened a community resource centre in, on Mayfair in a public housing unit near Fort Rouge school, and we were seeing some very good interactions with the community and, and with the local elementary school. What we did was expand that network as part of this exercise into Marlene Street in St. Vital, into Dale Boulevard out in far Charleswood and into Lord Selkirk just off Main Street north of the rail yards.

Q And what did the program involve?

A Program involved putting a community resource worker into a, a vacated housing unit within those developments and working with the community around -- and working with collaterals around issues of, maybe nutrition, parenting, creating a network amongst the individuals. Because a large part of the issues, as we got, got into these communities was people felt isolated from each other. They did not have a network to rely upon. And if the neighbourhoods in which they were living they felt were unsafe, then they would move from project to project. And what that did was it kept moving children from school to school; and if they're not in school, then they're not learning. And one part of breaking the cycle is the ability to have an education, to be literate, to be able to get a job, and we felt that, although we certainly couldn't cure all, all the ills of society, we could have a positive impact because of the kind of programming that we could put into these, these, into these resource centres.

Q Were you able to evaluate the impact that this programming had, in fact?

A Yes. I, I -- once again --

Q Just briefly.

A -- erosion of memory, but I do remember seeing analysis done by our research and planning quality group,

that identified that, I'm going to say, around 2000 or 2001 we had information to show that the number of children in care from the areas where we had our resource centres was less than it had been and the number of calls into those communities from our after-hours service were, were also at a minimum.

And by creating capacity in those, in those communities, we also were able to identify people in each of those communities that were, were, (inaudible) say they were, you know, they were rocks, they were pillars of the community; they were people you could rely on. And many of them we approached to become places of safety, and that contributed towards dealing with one component of our children in hotels issue.

All of these things are, it's like a web and every part of a web touches and is, and is interactive, so you identify, by having a resource centre, people that you could approach to become a place of safety. Why that --

Q Sorry, did you -- were you able to keep those resources in the community? Were they still there by the time you left the agency?

A All of that was fully functioning when I left. I think, I know personally and I, I'm sure many people in the agency felt a great level of satisfaction because of what we'd accomplished in putting this type of a focus. And it

was, it existed when I left in July of 2001.

Q What was it called? Where would it have fallen in the organizational structure?

A It would have fallen under Sue Hudson, under community outreach and early intervention.

Q Okay. Now, was funding an issue while you were with the agency?

A It always was an issue.

Q Were you -- did you feel that you were impeded in the work you did by funding issues?

A No, I didn't let, I didn't let the funding issue hamper us. That doesn't mean I had a blank cheque, but we had a mandate to provide a service. We were like an emergency department. If people came in at that end, we had a level of service we're, we needed to provide. We also had a large number of children for which the state had become the guardian and we had a responsibility for those children and we made investments in those children and we tried to be good financial stewards of the money that the people of Manitoba provided to us through, through the province but we needed also to get business done.

Q So you said you had a mandate to fulfill. Did you run a deficit?

A Correct. I came it, it ran -- the agency had a deficit and we ran a deficit each of the, the years that I

was there. I believe the year I left expenditures for the previous fiscal year had topped ninety million dollars.

Q But that didn't stop you from doing what you felt needed to be done?

A We needed to provide our service. A lot of those expenditures came from the mandated component of, of, of our service. We couldn't stop providing that.

Q We've heard a great deal of evidence in this inquiry about workload. Do you recall what the workload was like when you came into the agency in 1997 and what it was like during the time you were there until you left in 2001?

A When I came into the organization there were imbalances in workload between the different, between the four areas. Part of the restructuring was not only to create the, the programs that we've discussed but to also rebalance the front line staff into this new structure and ensure that some of the imbalances that had existed were, were, were dealt with. So there -- I -- some things, as I've wracked my memory over the last, you know, few months, I have been able to have memory epiphanies. One that I'm not able to, to completely pull up is exactly what the number is, but it was a significant number. By significant number I mean I believe it's in excess of 15 or 20 EFTs, it may even be greater than that, of, of staff that we were

able to redistribute from within the existing structure to a front, to a front line function.

Q So that was one way you responded to workload issues?

A That was one way. The second way was putting the emphasis on the early intervention and community programs, because if we could prevent work from coming in that was another way of dealing with workload. It was an -- it was not just an investment in preventing workload, it was an investment in the community and it was an investment in children and families.

MS. WALSH: Mr. Commissioner, would this be a good time to take the afternoon break?

THE COMMISSIONER: Yes. Are we likely to finish this witness today?

MS. WALSH: I hope so. I have probably another 10, 15 minutes.

THE COMMISSIONER: Well, you don't know what your colleagues will be, but we may well -- we'll, we'll target that if it's possible. All right. We'll break for 15 minutes.

MS. WALSH: Thank you.

(BRIEF RECESS)

BY MS. WALSH:

Q Mr. Barber, we were talking about workload just before the break and you told us that you had some initiatives to address workload. Did you see any differences in workload issues between '97 and 2001?

A Yes, I, I did.

Q Can you --

A You want me --

Q -- tell us what those were?

A -- to elaborate?

Q Yes, please.

A As I mentioned, there were imbalances between the four geographic areas and the reorganization directed the various front line resources into the different program structure that we created and ensured that under the -- let me back up a little bit.

Under the geographic structure, a similar type of, of service delivering unit might have one level of caseload in one part of Winnipeg and they might have a very different caseload -- and when I say "very different" I'm not talking about, you know, one or two case different, they -- there could be significant differences. We addressed that through the new structure that we put in place.

Q So are you telling us that your understanding was

that workload issues improved by the time you left?

A I wouldn't, I wouldn't say they'd gone away. They had improved over what they were under the geographic structure but we were still challenged.

One thing that I was remiss in mentioning, remember I talked about the environmental scan, I talked about the census data, one of the other components of our analysis that I should have mentioned, and it was also contained in the Prairie Research report, was the increasing acuity that was occurring in the interaction between the agency and the families and children in, in which they were providing service to. I remember that somewhere in the Prairie Research document it talked about how the school divisions were noticing the, the same intensity of service that they were needing to, to provide.

What compounds that, where it makes it difficult to say that we had, you know, solved or, you know, we had levelled the workload, to say we had solved or improved it might be a bit of a stretch because you had increasing acuity. And the way child, the child welfare -- the way I came to understand how the child welfare system worked at a, at a high level, there's lots of different services that are provided to families and children, if some component of the larger system retracts or stops providing service, the needs don't go away. The needs then search for another

vehicle in which to receive service, and many times the child welfare system becomes the, the default service provider for, for retraction or changes in services by other systems. So when you put all of those pieces together, at that point in time we were able to ensure that we had balanced the workload amongst the service delivering units, we had tried to put something in place to stem the same level of influx at the front, front end. We were not able to control our destiny as we fit into the larger system that was creating children -- as I also referenced Prairie Research had identified children were coming into the system at earlier age in -- with more damage and needs being required. So it's within that mix that we were trying to reorganize our services and, and, and move forward. So it was a tremendously complex problem.

Q When you talk about not being able to control your destiny, you mean in terms of, of systems outside the child welfare system?

A Correct.

Q During your tenure, were you ever made aware that workload was an impediment to services being delivered?

A Yes, I was, and it would have been part of the, you know, certainly it was identified in the Prairie Research report but would also have come out as part of our strategic planning exercise and as part of those 13 working

groups and the dialogue that I would receive from the front line staff as I attended the various staff meetings.

Q Did you take steps to address that?

A We -- well, yes, as part of the reorganization.

Q Were you ever aware of a specific instance where something was not able to be done for a family because of a workload impediment?

A Not that I can recall off the top of my head.

Q And if that were the case on a given file, would you expect that fact to be documented?

A I would expect it to be documented, yes.

Q Couple of documents that I wanted to turn your attention to, and I appreciate that you may not have full recall but perhaps you can explain them to us.

MS. WALSH: If we can go to page 30775. This is -- if we just scroll down, please, so we can see the witness' name.

BY MS. WALSH:

Q This is dated, it's signed April 23, 2001 under your signature.

A Correct.

Q If we go to the top, would we identify this as, as described as a policy?

A Correct.

Q So the heading is, "Case Closures on CFSIS - Policy April 2001". It relates to an issue that we've heard some evidence on.

MS. WALSH: Do you have this document, Mr. Commissioner --

THE COMMISSIONER: Yes.

MS. WALSH: -- 30775?

THE COMMISSIONER: Yes, I have.

MS. WALSH: Good.

BY MS. WALSH:

Q The background is as follows:

> "Since the last Agency reorganization, it has become apparent that the CFSIS terms 'Waiting Closure' and 'Closed', and the application of those terms have been interpreted in a variety of ways. These interpretations vary from cases going directly to 'Closed' status; closed when service is complete whether the paperwork of closing is completed or not; closed once the supervisor

has signed off. Some Admin. Support staff never use the 'Waiting Closure' status while others go back into the CFSIS case and delete this status once the case is 'Closed'.

In an effort to be consistent across all Agency programs, the following Policy has been developed. This Policy is in keeping with the original material received from the CFSIS trainers."

You can scroll up, please.

"Policy Guidelines":

"Waiting Closure: Cases are set at 'Waiting Closure' when a worker's involvement with the client has ended. Specifically related to [children in care] cases, the 'Waiting Closure' date is the date the Agency no longer has a legal status regarding a child. The case status remains as

'Waiting Closure' until the file dictation is completed. This system enables the Supervisor or Program Manager to identify how many cases a worker or unit has where direct Agency involvement has ended, but where file dictation hasn't been completed.

Closed: Cases are set at 'Closed' when the file dictation has been typed, attached to CFSIS and signed off by the supervisor.

[Note]: There is to be no more than a five day turnaround time from typing to the supervisor signing off.

If a case reopens within 30 days of Closed status, it remains the previous worker's case."

Are you able to tell us anything about what led to this policy?

A I wouldn't have prepared the policy. This would have been -- this issue would have been identified by the social workers and, and the leadership structure. They

would have identified a consistency issue. They would have created a draft policy. There would have been discussion, and I would have been, at the time that this document was presented to me, I would have been briefed on the background of the issue, the importance of putting this policy in place, why it was important to put in place and what it was intended to deal with. And as the CEO, policies were signed off by myself and ultimately the buck stopped with me, but I would have been, I would have been briefed on this issue and my interpretation, as you read through it, is this is to ensure that similar situations are dealt with in the same fashion.

And the last bold component is to ensure case continuity if a case re-opens within 30 days.

Q How would the policy have been distributed amongst staff at the agency?

A I, I can't recall exactly but we had a structure within the organization that policies and procedures would be distributed through each, each appropriate program and would make their way into each of the, the appropriate offices where the policy had, you know, was relevant, and it would most likely have been the responsibility of the clerical staff in that area to update the, the policy manual in that office. This is the era before on-line policy manuals, et cetera.

Q Okay.

A Everything was paper.

Q Turn to page 31224.

And I note that this is marked as draft, but this is a memo to agency management from Margaret Paterson dated November 16, 2000 regarding educational equivalency policy. Margaret Paterson was who?

A She was the head of the human resources.

Q The memo indicates:

> "As you are probably aware, since the Agency reorganization in September 1999, we have had difficulty filling our vacant social work positions. As at November 7, 2000 we had a total of 14.5 vacancies in permanent positions and 9.5 vacancies in term positions.
>
> One of the major factors contributing to the problem is that there are an insufficient number of applicants with the required Bachelor of Social Work degree. This has created

particular concern for the Family Service and Intake program functions where workload and continuity of client services are significant issues.

In order to address the acute shortage of B.S.W. applicants, Management has reviewed the educational equivalency policy and decided, as a short term interim strategy, to extend the existing educational equivalency policy to external applicants for an interim period as set out in the policy addendum which is attached.

In addition to expanding the current educational equivalency policy to external applicants, Management is also considering selection criteria and a process to provide opportunity to current employees who wish to pursue social work careers within the Agency but do not have the necessary education or directly

related social work experience. As soon as a draft policy is developed on this subject it will be shared with staff."

Now, what do you recall about this issue in terms of, of hiring and, and expending criteria?

A What I recall, and I can't say that it directly relates to this document and I can't recall the timeline of, of the, of the information I'm going to share, whether -- how it fits in with this 2000, but there was conversation, and the conversation would have been between the directorate of, that resided within family services and ourselves and, and the board in regards to, to the fact that bachelor of social work requirement provided an exclusion for the ability of a number of aboriginal and Métis individuals to be able to work at, in non-First Nation mandated agencies. There had been some discussion about extending the, the equivalency. As you can see from reading the document, and I don't recall, but the wording suggests there was already an educational equivalency policy that existed within the organization because it's being extended to external applicants, the extension of this to external applicants would not have happened in isolation of a conversation with governance and with the

child directorate. And as I recall, it has to do with the issue that I referenced.

Q This policy is in draft. Do you recall what happened -- or the memo is in draft.

A I, I, I do believe it was, it was implemented in some form, to the extent of which I don't recall.

Q Just briefly if we go to page 31225, the next page, this was also in draft but it's "Personnel Policy Social Work Education Equivalency - Addendum" of the same date, and it says:

> "As an interim strategy to address the acute shortage of B.S.W. applicants for vacant front line social work positions, Agency Management has agreed to broaden and extend the current educational equivalency policy to external applicants."

And then it goes on to describe:

> "... applicants without a social work degree will be considered for vacant Band 5 social work

positions provided the applicant has an equivalent combination of education and social work experience as follows:"

And then it sets out:

"i) Grade 12 education plus 10 (10) years experience;
ii) Community College Social Service Certificate/New Careers plus six (6) years experience;
iii) Bachelor of Arts Degree (3 years) plus four (4) years experience; [or a]
iv) Four (4) year University degree in another human service discipline ... plus three (3) years of experience."

A Yes.

Q So that's just to complete what you were telling us about.

Was, was that something that, that you can recall as being a challenge that faced the agency, finding

qualified workers to hire?

A Without having seen this document, I would not have recalled that on my own.

Q Okay. That doesn't stand out in your mind as one of the challenges that you faced?

A No. I had, I had many challenges, so in the hierarchy of challenges I don't recall this one over others. That's not to say it's less important, it's just been crowded out of my memory over time.

Q Fair enough. You left the agency in July of 2001 and Phoenix's death was discovered in March of 2006. When her death was discovered, a number of reports were commissioned to look at the services that were delivered to Phoenix and her family. We've heard evidence from the various social workers and supervisors who provided services to Phoenix and her family that those reports were never shared with them until they participated in this inquiry, the findings and conclusions were not shared with them. Would you have expected, as a CEO, to share if not the reports then the information in the reports with the workers who, about whom the reports are written?

A I can, I can only speak in, in, in parallels to how we shared information under my tenure. If it was not privileged information, if it wasn't strategic information, a cabinet document or something that we weren't able to, to

share, Winnipeg Child and Family Services was a non-profit public organization. Our board meetings, except for, you know, in-camera sessions related to personnel, were open to the public. The minutes of the board meeting were open to the public. Doesn't mean public could wander into any area of the agency and demand information but we tried to inculcate a culture of, of, of openness. I talked about transparency, two-way communication, being visible, and if I had information that was relevant to creating a learning environment -- remember I talked about trying to bring that health care learning-from-our-mistakes environment into Winnipeg CFS, I would, under my tenure, have shared information as a learning experience for the organization and for the staff directly involved.

Q There's just one conclusion from one of the reports that I wanted to draw to your attention. If we can pull up page 71, please, from CD1, from Mr. Koster's report.

Now, this report was produced or delivered in September of 2006 and it looked at services delivered to Phoenix and her family for the period 2000 to 2005. And I appreciate that you were only at the agency in that period from 2000 to 2001. The conclusion C7 --

MS. WALSH: Page 71, Mr. Commissioner.

THE COMMISSIONER: Yes, I have it.

BY MS. WALSH:

Q Says that:

> "Based on the Review Findings, Winnipeg Child and Family Services presently lacks the staffing and resources to adequately protect children under its care."

Now, as I said, this was written in 2006, looking at services delivered over a period of five years. But would that conclusion have been an accurate reflection of what was happening in the agency for the period 2000 to 2001?

A It, it may have been on any given day, depending on the circumstances. One of the, one component of our analysis as we try to determine how we would deploy our resources in the reorganization was also looking at the -- there were cycles, cycles of intake and after-hours intervention. The cycles occurred around the child tax credit and around the provincial social assistance payment. We correlated, I mean this was rather common-sense, but we, we needed -- we put it in, on grass and correlated the impact of those payments and the level of activity that occurred for both the intake function and for the after-

hours service. There were correlations each month around that, so this statement, around one of those peaks of service, would be as relevant in 2000 and 2001 as it would have been then in May. So it's, it's contextual.

Q So is it your evidence that there were periods of time in that period, 2000 to 2001 when the agency was not able to adequately protect children?

A I, I can't affirm that. I --

Q That's not what you're saying?

A -- not to my knowledge, no. I'm saying on any given day this may or may not have been relevant in 2000/2001 but I don't have specific information to validate that.

Q Did you ever have occasion to tell your board that the agency, under your tenure, was not able to fulfill the mandate and, and adequately protect children?

A No, I never told that to my governance.

Q Would you have advised the board of that if you had believed it to be true?

A Yes.

Q And you left in 2001?

A Correct.

Q You went --

A In July.

Q You went on to do other things?

A Correct.

MS. WALSH: Thank you. Those are my questions.

THE COMMISSIONER: Thank you, Ms. Walsh. All right.

Mr. Gindin?

CROSS-EXAMINATION BY MR. GINDIN:

Q My name is Jeff Gindin. I represent Kim Edwards and Steve Sinclair. I just have one area that I wanted to ask you about.

You had said earlier that when you came in you tried to create an environment where we could learn from our mistakes. I think that's what you had said.

A Correct.

Q I take it when you said "we", were you referring to social workers, supervisors, everyone involved?

A I'm talking about the organization, yes.

Q And what was your plan, how, how did you plan to do that?

A By making people aware that there were other systems in the social network that approached misadventures and, and mix-ups in, in a, in a learning fashion. And part of the reason that that was important was I came into the agency shortly after the Sophia Schmidt incident, and the inquest that occurred after that occurred, the evidence was

given during my, my tenure but the results didn't come out till many years after I had left. I -- it was part of my intention was to show that there were ways that we could learn from, from that and from other instances to create a learning environment within the organization where people could --

Q And --

A -- learn from these issues.

Q The idea of learning from one's own mistakes I presume begins with realizing you've made them and admitting that a mistake has been made?

A Correct.

MR. GINDIN: Thank you.

THE COMMISSIONER: Thank you, Mr. Gindin.

Gentlemen at the back? Mr. Ray.

MR. RAY: Yes, thank you, Mr. Commissioner.

CROSS-EXAMINATION BY MR. RAY:

Q Mr. Barber, my name's Trevor Ray. I represent the Manitoba Government Employees Union as well as several social workers that were involved in providing care to Phoenix Sinclair. And I appreciate much of your involvement as CEO predated Phoenix's case and when it started to be taken over by social workers, but I just want to ask you, you -- as CEO, I assume that your primary

function was to oversee the operation of CFS and you were not involved kind of in the day to day oversight of cases that would be discussed between, say, a social worker and a supervisor?

A Correct.

Q And I assume -- we've heard evidence from other senior management and another CEO that says they typically would not become involved in case management other than if it was a very high profile case or something particularly unusual. Would that be the same for your ...

A No. I had a competent staff of social worker supervisors and managers including a director of program services who was a social worker. I would expect extraordinary or difficult cases to be managed by those professionals.

Q Okay. And so your, your evidence is you would not necessarily even become involved in those difficult or extraordinary unusual cases?

A No.

Q I understand. Thank you. You were asked a question about -- by Ms. Walsh: were you ever aware of specific time something was not able to be done on a, on a file. And I think your evidence was it was not ever brought to your attention. And then Ms. Walsh asked you a question, would you expect, if that did occur would you

expect that to be documented, and you said it, if I understood, you would expect that to be documented. But just because it was not documented or -- and just because it was not necessarily brought to your attention does not mean that there were not instances where social workers were not able to do everything on a particular case that they wanted to do, correct?

A Yeah. That would be correct.

Q You wouldn't necessarily have specific knowledge of those types of issues, correct?

A Not necessarily.

MR. RAY: Thank you. Those are my questions, Mr. Barber.

THE WITNESS: Thank you.

THE COMMISSIONER: Thanks, Mr. Ray.

Anyone else before Mr. McKinnon? I guess not.

MR. MCKINNON: I have nothing on re-examination, Mr. Commissioner, thank you.

THE COMMISSIONER: Thank you.

MS. WALSH: Just one area, Mr. Commissioner.

RE-EXAMINATION BY MS. WALSH:

Q Mr. Barber, you referred to the Sophia Schmidt inquest. That's an inquest where the report didn't come out until 2003 but I believe the inquest itself took place

in 1999 related to a death that occurred I think in '96. You testified at that inquest?

A Correct.

Q What was this -- and for the record, that's -- the report from that inquest is at Commission disclosure 225, pages 8584 to 8764. What was the significance of, if any, of that inquest to you in your role as CEO?

A The, the difference in service between different regions within Winnipeg CFS, the lack of consistent case management communication between different geographies in the old structure and the differences in workload between different geographies within the former structure of Winnipeg CFS, and then finally the lack of enough CFSIS work stations to allow workers in that period to document their work in a timely fashion. There was some lengthy discussion with me on the stand by, I believe it was the government lawyer, on that point. And what was important about that is there were certain expectations of going into the system and completing certain work. We did not have enough work stations to allow each worker, at whatever moment in time they were ready to access the system and get information or put information in, so rather than waiting around an office they would be out doing work in the field and they would keep notes and they would catch up. The way I characterized it -- it's funny things that you remember

-- I characterized it as, at that moment, as trying to run a baseball team with one glove in the outfield. You could probably do it but it would be real hard to be successful if the left fielder had to run over and throw the glove to the right fielder so they could make the play.

Q Is it, is it fair to say, then, that although the report did not come out until 2003, you were aware of the issues that were raised during the course of that inquest?

A Correct. In some measure, such as having sufficient CFSIS work stations were remediated long before the report came out in 2003.

Q Based on, on your --

A Based on --

Q -- addressing some of those issues?

A Correct.

MS. WALSH: Thank you.

THE COMMISSIONER: All right. Thank you, Ms. Walsh. Everyone else has had their questions put? Yeah.

Witness, you're finished. Thank you very much for your attendance.

THE WITNESS: Thank you.

(WITNESS EXCUSED)

MS. WALSH: So we're finished for today, Mr.

Commissioner, and for the week.

THE COMMISSIONER: And we start again next Monday morning?

MS. WALSH: Yes, still in this venue.

THE COMMISSIONER: In this location.

MS. WALSH: Yes.

THE COMMISSIONER: And then we move after the end of that, of next week, do we?

MS. WALSH: Yes.

THE COMMISSIONER: All right. We'll stand adjourned, then, now, for, till Monday of next week, 9:30.

MS. WALSH: Thank you.

(PROCEEDINGS ADJOURNED TO FEBRUARY 4, 2013)