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 Winnipeg Convention Centre,
375 York Avenue, Winnipeg, Manitoba

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MONDAY, JULY 22, 2013

APPEARANCES

MS. S. WALSH, Commission Counsel

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

G. SMORANG, Q.C. and **MR. T. RAY,** for Manitoba Government and General Employees Union

MS. L. HARRIS, for General Child and Family Services Authority

MR. H. COCHRANE, for Child and Family All Nation Coordinated Response Network

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

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

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

MS. M. VERSACE, for University of Manitoba, Faculty of Social Work

MS. K. BJORNSON, for Manitoba Métis Federation and Métis Child and Family Services Authority Inc.

MR. G. TRAMLEY, for Aboriginal Council of Winnipeg Inc.

MS. C. DUNN, for Ka Ni Kanichihk Inc.

MS. B. BOWLEY, for witness Diva Faria

MR. R. ROLSTON, for witnesses Diana Verrier and Dan Berg

MR. R. ZAPARNIUK, for witness Roberta Dick

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EXHIBITS:

JULY 22, 2013

THE COMMISSIONER: Good morning.

MS. WALSH: Good morning, Mr. Commissioner.

THE COMMISSIONER: All right, Ms. Walsh.

MS. WALSH: Thank you, Mr. Commissioner. Before we begin, we have five exhibits to enter. They have all been circulated to counsel so counsel has seen them all. The first --

THE COMMISSIONER: And is there, is there concurrence with their admission as far as you know?

MS. WALSH: Yes, no one has indicated that they require anything further to be called as a result.

THE COMMISSIONER: All right.

MS. WALSH: The first is an admission of facts by Shelly Willox and Christopher Zalevich respecting the evidence of Jim Chabai and that will be Exhibit 157.

THE COMMISSIONER: Right.

EXHIBIT 157: ADMISSION OF FACTS BY SHELLY WILLOX AND CHRISTOPHER ZALEVICH, RE EVIDENCE OF JIM CHABAI

MS. WALSH: The second is a document that was

provided in response to a question you posed to Jason Whitford from the Eagle Urban Transition Centre. It's entitled "Management Summary". It was with respect to funding and that will be Exhibit 158.

THE COMMISSIONER: Yes.

EXHIBIT 158: MANAGEMENT SUMMARY - EAGLE URBAN TRANSITION CENTRE

MS. WALSH: The next three documents are in response to information provided during the testimony of Lisa Donner. The first one is entitled "All Aboard Public Consultation Process 2013 - List of Organizations Invited to Participate" and that will be Exhibit 159.

THE COMMISSIONER: Right.

EXHIBIT 159: DOCUMENT ENTITLED "ALL ABOARD PUBLIC CONSULTATION PROCESS 2013"

MS. WALSH: Next is a document "Provincial Funding for Prevention Services to Child and Family Services Agencies 2012-2013". That will be Exhibit 160.

EXHIBIT 160: DOCUMENT ENTITLED

"PROVINCIAL FUNDING FOR PREVENTION SERVICES TO CHILD AND FAMILY SERVICE AGENCIES 2012-2013"

MS. WALSH: And finally, a document entitled "Increases in Income for Employment and Income Assistance Participants", Exhibit 161.

THE COMMISSIONER: One sixty-one.

EXHIBIT 161: DOCUMENT ENTITLED "INCREASES IN INCOME FOR EMPLOYMENT AND INCOME ASSISTANCE PARTICIPANTS"

THE COMMISSIONER: Thank you. And that completes the exhibit list?

MS. WALSH: It does, Mr. Commissioner. And so unless there's anything further, we're ready to proceed with the first of the submissions which will be a personal impact statement from Kim Edwards and then following, her counsel and counsel for Steve Sinclair.

I am not going to be making a submission. I will, however, be making some remarks at the end of the hearings and I would ask all counsel to attend for those. Thank you.

THE COMMISSIONER: And we've set aside 10 days, if need be, I take it?

MS. WALSH: We have and what I'm hearing from counsel is that we probably will not need the full 10 days, but they're there if we do.

THE COMMISSIONER: And we'll follow the order that was set out on the schedule agreed to some time ago.

MS. WALSH: Yes, and that's on our website as well as are all of the final submissions.

THE COMMISSIONER: Oh, they're there now?

MS. WALSH: They are.

THE COMMISSIONER: All right. Well I certainly received them a week ago Friday and I've had the opportunity of looking at them, reading them. I can't say I've studied them because of their length and all the detail, but I'm familiar with them and look forward to the presentation as I'm sure everybody does and including the public, as we come to a close of this extended hearing.

Ms. Edwards, I think you're on first this morning and we're pleased to have you here. I know it's perhaps unusual but you have a great interest in this. You showed much kindness to Phoenix during her life, were close to her, and we're pleased that you want to participate in, in making your remarks to this commission as we draw to a close.

MS. EDWARDS: Good morning, Mr. Commissioner. Thank you.

We have lost our daughter and no words can bring her back. No words can express the pain we have felt when we learned of her death. No parent should ever have to grieve for the loss of a child. It has been eight years since Phoenix was murdered and the pain of losing her remains, it always will, and we will never see her smile again.

Some people may want to hear holidays and birthdays were once a time for celebration. Now that's all gone. They are no longer special because they bring into sharp focus that Phoenix is not there. Things such as she'll never graduate from school, marry and have children, I am sure these are the things that this Commission and the family services minister, everybody wants to hear, all the things that keep people down in sorrow, however these are not the things that I want to say or feel. I think it's more important for me to say Phoenix is dead, just dead.

I have a belief and that belief is rooted strong in my Wicca faith and my Christian belief that it is far better to be with Christ and the mother. To me, death is an extension of life, a new phase entered, a phase to be celebrated, not mourned.

Quoting from Steve Sinclair's victim impact

statement of 2008:

> "My heart aches and never stops ... I want the record to show she was loved by me. I always wanted Phoenix and she was never a burden of any kind to me ever."

Are we saddened by her death? Of course we are. We are saddened beyond belief and no words will ever describe our sadness which we care not to share publically. However, we refuse to live in that sadness. Again, I quote from Steve Sinclair's victim impact statement:

> "I want to stay strong so that I can make a change for other potential victims and that's the way I feel. I will not be broken by this, I hope anyways ..."

Truth is she may not have ever graduated from school. She may never have gotten married or had children, but we'll never know that because she was taken from us. The truth is I see her smile when I close my eyes and I believe she is still with me in spirit. She is here in

this room with me today.

Holidays are no different to me as they were yesterday, as they were 10 years ago, their significance nothing more than Hallmark holidays for greeting card companies and corporations that are raking billions. And the tragic reality of CFS and the children in their care is that many parents suffer the loss of their children who have been murdered in care, children's deaths veiled by confidentiality.

Truth is Phoenix's mother and stepfather murdered her. Nine people knew of the abuse, watched while the abuse unfolded. Many people knew of the murder, yet they said and did nothing. Those who did nothing to help this child and some who actually played part in her torture have already been absolved of their role they played in the demise of this innocent five-year-old child. Why? Because they're aboriginal and they don't know better or they're scared. They don't know to call to police instead of CFS regarding a murdered child.

We ask this Commission not to be a part of this. Everybody has been too concerned with offending the guilty or being unfair to them. Everyone always afraid to speak up for children in fear of offending the aboriginals. I am not. The truth is not offensive. It may hurt because of guilt and shame but it does not offend.

Are we angry over our murder? You bet, yes. Yes, we are, but is that not righteously so? Are we violent? No. You can take that to the bank. I ask facetiously what sense is there in a senseless death? No sense at all. It's only almighty dollars.

I believe in hope and I'll live by the mantra there's always a silver lining in every dark cloud. I believe there is a purpose for everything under God's sun. Phoenix, I intend to make sure a legacy of hope is left, one of dignity, not showing a disgrace. Her legacy will be a legacy of hope and renewal.

My mission in life now is to see that abused children of today and future generations are given the care and protection they are entitled to, protection from this abuse within the Manitoba child welfare system and for the public of this province and nation.

We all, as members of a civil society, are obligated to protect the child and place the interests of the child first and foremost. There is no such obligation to protect social workers, making excuses for their actions. Heavy workloads have been used in this inquiry to mask inefficiencies, inequities and poor decision making. We have heard about how rural agencies cannot connect to CFSIS in an age where every campsite in this province is equipped with Wi-Fi.

Mr. Commissioner, the time for excuses must end with your report. Should we not honour the duty to the murdered children, the murdered child, Phoenix Victor Hope Sinclair and all those who died before her and after her to ensure that her death and their deaths were not in vain? We owe it to the children of Manitoba as a civil society to come together as a village, not only to raise but to protect our children as a collective bond. I ask in your wisdom to honour the child here, the child, not the province, not the workers or their unions. With all due respect, sir, I say this on behalf of the child, Phoenix Sinclair.

Phoenix, certainly Phoenix was not the child that has been described by this province's welfare system and their workers. And she was certainly not the child the media and so many had continually lied about, tragically speaking about the details of her life with shallow and little understanding of who she was, falsely portraying her, her name and legacy going down in the history books as the forgotten, tragic child. She wasn't forgotten.

In my knowledgeable opinion, she is a child who has been a victim not only of a horrendous murder but the victim of the incompetency of a system and a province. Phoenix was not the child I hear being described at all. I would know, I raised her alongside Steve, her father, a

good and decent person who loved his daughter tremendously, alongside a true grit kind of guy, that is Ron Stephenson, my ex-husband. And for the record, she was not like one of my children, she was one of my children.

Phoenix Victoria Hope was born April 23rd, Easter Day on the Millennium. The legend of the phoenix, the red bird of grace, born in the first rose under the tree of knowledge. Its sole purpose for sacrifice, for renewal for the many. This is who Phoenix is to us now. This is our condolence. This is the silver lining change for the other children, a renewal, a rebirth of Manitoba child protection system, a system that all children are equal under one law. That is the tissue that dries our eyes, the blanket that comforts. Our Phoenix will create a safer and better life for many other vulnerable children in Manitoba. Her legacy will renew the child welfare system. All children must be equal under the law.

Those who truly knew Phoenix know she was a special child. She had the ability to mesmerize you with her big, brown eyes and infectious laughter. That kid was just cute. But there was something about her that just couldn't be explained. She knew too much for her age. I always said that when you looked in her eyes you saw an old soul and I would go as far as to say is that she was an indigo child.

Phoenix was a vibrant child. She lived a happy, very happy existence. She loved to laugh and play, sing, play with my guitars and drums. She would just head bang to Metallic One, it was her favourite song. And if one knows One, one knows the song One, then that will tell you it could have been premonition, Phoenix's premonition of her own life.

Her horrific abuse and death came at the end of life, of happiness and loads of love. No different than one of your children, if one of your children would have been kidnapped by two strangers and locked away, shot at and strangled. Things like -- and things I cannot mention here, repeatedly assaulted over and over to the extent that the medical examiner stated at trial that every bone in her body was broken.

We believe Phoenix has a road created by the Creator, God, whoever, whatever you want to call him or her for that matter. It is our belief that Phoenix had to take this road. Was it tragic what happened to her? Yes. Sorry.

THE COMMISSIONER: Just take your time, Ms. Edwards.

MS. EDWARDS: Was it tragic what happened to her? Yes. Was it a horrible crime? Yes, it is beyond that. But did she die before her time? I personally do not

believe, for there's a purpose for everything in life, whether we feel it's senseless or not, just because we don't, do not know why or the purpose something bad happens. We believe the purpose of Phoenix's death was to change the system in a fundamental and positive way for all children in Manitoba and across this great nation.

I'm not anything anyone in this Commission perceived me to be -- I'm sorry -- or could ever really understand. I was not her foster mom. I was not her Godmother. I wasn't her place of safety. I was her nana mom. I was love to her, comfort to her, (inaudible) to her, a blessing, as she was to me, my daughter. No degree in the world will help you understand that bond unless you have experienced raising another child from the heart. Yes, I was much more than that. I was her mother in all sense of the word. That is why I fight so hard for justice for this child, for every child in memory of that little girl.

Everyone seems to feel that they have an obligation to thank me for bringing the bright light of Phoenix's life. To them I say they have no business or right thanking me when they truly do not know her life as no one ever asked us about her life and documented it. What do they know if they think that she only had me in her life as a light? She had many lights to brighten her life.

I would also like, like to thank them for looking after and loving their child. And with that I hope they see how it is ludicrous to me that people who knew nothing of who this beautiful child was would take this approach, shallow, narrow-minded thinking and understanding of our Phoenix Sinclair, not the Province's and the Sinclair -- and not the Province's, but the Sinclair and Edwards' family dynamics.

I had no shame for being righteously angry. I was taught it was not bad to get mad, letting justice or freedom ring out. It is something I will continue to do without shame. I am not a violent person, nor is Nelson Draper Steve, just Steve, not Steven, Sinclair. I am a peaceful person. In working with families, however, I have seen disrespect. I have seen CFS disrespect and (inaudible) parents. The entire culture of CFS must change.

We were granted the funding for three lawyers, although we were entitled to two a piece. We compromised with three to represent my position and recommend witnesses. I am absolutely sure that they represented me in the best way this Commission has allowed them to. However, I feel our voice as her family, the people who raised her, the people who knew her best in this world, has been reduced to a whisper.

I do not have a degree in child care or social work, but does that mean I do not know the needs of a child or children? I do not believe so. I raised three children in the heart of the north end Winnipeg, the same slum that so many parents, organizations and government agencies give excuse after excuse to children who run wild and commit crime. In the same slum known for its gang activity and the crime children -- sorry -- for its gang activity and crime, children approached my children, tempted by the perils of poverty. They were approached with bullying and peer pressure, they never caved to it. They always accepted responsibility because that's what they were taught to. I raised my children to make wise decisions and to be fine, upstanding citizens. They have made their own mistakes but they have always lived up to those mistakes without blaming others for their deeds.

My children lived by the motto truth is always better than a lie. It is more a solid position, Mr. Commissioner, that the social workers who have testified before you and this province, this great village, could take a lesson from this mantra by what my children lived and set a good example for the youth.

I stand before you and everyone else in this room today in judgment of myself more than anyone else in this room. And I take full responsibility for my part that

began the chain of events that of the circumstances that surround the death of Ms. Phoenix Sinclair. Should I have taken her into my house in the manner in which I did? In hindsight, which is always 20-20, I do not believe so, or at least I should have gone about it in a better fashion. But I forgive all because I forgive myself and so does my soul brother, just Steve Sinclair. Thank you.

THE COMMISSIONER: Ms. Edwards, I want to thank you sincerely for your presentation. I think everyone in the room has heard you this morning, has to be moved and touched by the sincerity with which you've made that presentation and the way you have spoken from the heart.

There are just two passages from what you said that I would just like to comment upon. When you speak of Phoenix's legacy will be a legacy of hope and renewal. I sincerely hope that when my report comes out you will see the emphasis placed on what I say so that that will be a realized fact in your life.

The other point in your statement that, "We believe the purpose of the Phoenix's senseless death was to change the system in a fundamental and positive way for all children in Manitoba and across this great nation," I can tell you that that is the prime and driving force, if you like, behind this inquiry is to bring in recommendations that will make some fundamental changes and bring a

positive lifestyle for children of Manitoba over and above what it has been up until this point of time and unquestionably you have made a significant contribution in placing facts and evidence and, and documents before this Commission that will be of sincere help to me.

I also want to say that, as I think you appreciated and have alluded to yourself, that you and Steve have been well represented at this hearing through Mr. Gindin and his team, Mr. Ireland, Mr. Derwin, and I'm looking forward now to hearing what Mr. Gindin additionally has to say because his team, being funded as you pointed out, have played a very significant role in balancing the scales of this inquiry and I thank you for retaining the firm, hanging in there, being with us all the way through this inquiry. As you know, my report is due out by December the 15th. I have every reason to believe that that deadline will be met and I hope you will find there something that will give you strength to carry on in the good work you're doing on behalf of the children of this province. Thank you sincerely.

MS. EDWARDS: Thank you, Mr. Commissioner.

THE COMMISSIONER: Mr. Gindin?

MR. GINDIN: Good morning, Mr. Commissioner. It's now my honour and privilege to address you on behalf of Kim Edwards and Steve Sinclair.

Ms. Edwards, in her opening remarks, talked about there always being a silver lining in every dark cloud and the silver lining in this dark cloud, I submit, must be a recognition of what went wrong and recommendations and action that improve the system and make it better. That would be the silver lining in this dark cloud.

Steve Sinclair and Kim Edwards clearly, as you've heard, want fundamental changes to be made. You have heard over the many, many months about a system in chaos, a system that isn't trusted by the public where many mistakes and omissions and unacceptable judgments was clear and the first thing I submit that should be done is to identify these mistakes and omissions and that's a good way to start on the road to assist and that will improve.

There have been some changes that have been made along the way and the inquiry has served some purposes already just by the fact that it was held and we've seen some things happen. It's probably too soon to see how successful those things are but there have been certainly some changes that have begun.

I want to begin by telling you what I won't deal with and what I don't intend to deal with. I will not be repeating my brief or going through it in detail. You've read it and there's all sorts of references in it in some detail, so I hope not to go through that again. I will be

dealing mainly with questions one and two of your mandate, the child welfare services provided or not provided to Phoenix Sinclair and her family and any other circumstances that may have related to her death. That's what I intend to deal with mainly in my submission. I won't repeat the references that I made in my brief. If I have additional ones I'll certainly point those out.

THE COMMISSIONER: I have that available to me.

MR. GINDIN: And as you can see I've formulated the brief in terms of issues rather than a chronology from beginning to the end and there are seven or eight main issues, some of which overlap one with the other. I don't intend to go into all of the reports that were prepared by report writers and their recommendations. I don't intend to deal with funding particularly. I know the other counsel may. But I do intend to talk about what went wrong and what needs to be done and I had to be selective because I could spend a week going through every single witness we've heard from and point out certain discrepancies or inconsistencies but one has to be selective in this process obviously, so I hope to deal with some of the more important ones.

In this case there were many potential turning points, points at which if things were handled a little bit differently maybe we wouldn't be here and Phoenix Sinclair

would. There are many people who could have done some things better and you've heard Kim Edwards herself say perhaps they could have done a couple of things better upon reflection and that would apply even to Rohan Stephenson and Steve Sinclair. I submit that applies certainly to the social workers who were involved along the way. It applies to the supervisors, clearly could have done some things better. It applies to the program managers, the CEOs, politicians and even members of the public who made certainly observations and certainly could have acted differently.

When this inquiry began we heard from social workers who were somewhat reluctant to admit an error or that there might have been a better way. That seemed to change as time went on, maybe because of the media reporting some things or maybe it was because of some prodding that needed to be done and that kind of things but eventually you had people taking a bit of a different approach as we came along.

One of the witnesses that was particularly impressive in that regard was Heather Edinborough, who I recall in particular as being a very emotional witness, who had retired by the time she testified and I can guess from her character she would have testified the same way before that too. But she very emotionally acknowledged errors

that were made, things that she wished were done differently and there were some like her but there were many who, for some reason, just wouldn't admit the obvious and had to be cajoled and prodded before the obvious would be admitted and that speaks to perhaps a certain attitude that needs to change.

In some cases the attitude was rather casual. In fact, most witnesses came here and described this case as a routine file. It may have been routine to them but to the family it wasn't routine and it wasn't just a file. That's a word that we've heard so often, this was just a routine file, nothing unusual about it and that's rather sad that something like this, this horrific story we heard with all the red flags that came up along the way, which I intend to deal with, is just routine.

Other counsel have conceded in their briefs the various problems that existed. For example, Mr. Ray, on behalf of the union, talked about workloads throughout his brief and the impact that would have had on the system or on the case. Ms. Brownlee (sic), in her brief, talked about systemic problems, standards and confusion and training and those kinds of things. Mr. McKinnon, in his brief, in particular at paragraph 47, talked about training but indicated that he didn't feel that the lack of training was a causative factor in what occurred. In paragraph 91

he talked about standards and gave the view that he didn't think the confusion over standards was fundamental with respect to what occurred. And at paragraph 70 he indicated that his view of the workloads and how it wasn't quite as stated and questioned whether it really had an impact. And it's my submission that if it wasn't training, it wasn't standards and it wasn't workloads, what does that leave? Incompetence perhaps? Poor judgment? A profound lack of common sense, a lack of a strong commitment to ensure the safety of children. All of the issues that are dealt with in my brief, at least most of them, could be reduced in a way to one common theme, a lack, a profound lack of common sense.

Now even though no one could predict this horrific end to Phoenix's life at the hands of her own biological mother, that doesn't change the fact that much more could have been done to make that much more unlikely. A few examples of that in a general sense, more contact. That was clearly a theme throughout the chronology of events that we've heard about. In many cases very little contact and while some say well we tried, we went out there and had a look, that's not contact. That's robot-like action just to say you did something. Nobody went out on weekends, nobody went out in the evenings when they weren't able to connect. Workers weren't contacting collaterals

who are listed on the file with their phone numbers. Those things weren't being done. We'll talk in more detail about the time that Tracy Forbes went to see Samantha and Wes came to the door, Wes McKay came to the door and no questions were asked. We'll talk about when Wes's name came up at the hospital when a child was born in December of '04 and nothing much happened in terms of finding out who he was. We'll talk about evidence that came forward that Samantha's mother was smoking crack in front of Phoenix and that seemed to have been taken casually.

If a few things could have been done better or even done at all, once again, we might not be here and Phoenix might be.

There were many errors along the way which I'll go through shortly, omissions, red flags ignored, but then after all of that, there was one final chance in March of 2005 to make a huge difference and I submit that was bungled. And the answer is not which standards applied, which policies applied and whether there was confusion about them because if that's the case that's an error right there. We don't know what standards apply and there's confusion, that should not happen. But there comes a situation sometimes when it doesn't matter. It doesn't matter what's written down somewhere in a book that people may or may not have read. What matters is what are you

doing? What services are being provided at a particular crucial turning point in this case? And I'll deal with that.

We know that that incident in March of '05, March the 9th when the file was closed, three months later Phoenix was tortured to death and we know that the abuse had gone on before that. It was clear from all of the evidence. A few weeks later in April we heard the evidence of Jeremy Roulette who saw a big gash on her forehead. We heard evidence from members of the public that the things they witnessed along the way between that March closing and the torturous murder that followed. So that was a very important part of this case which, if other things were handled differently along the way, might not have been as important, but it ended up that it was.

Who was at fault? I submit almost everyone. Some counsel blame the system and confusion about standards, workload, lack of training. Those are all significant but whose fault is that? Whose fault is it that there was no, there's not sufficient training or the standards are confusing?

Ms. Bowley in her brief, at paragraph 53, says don't blame Diva Faria for not meeting best practice because of some of the systemic issues. And I say why not? Why shouldn't you blame someone for not meeting best

practice? Best practice is simply based on judgment and sense. She points out in her brief that, paragraph 88, that no policies were in place regarding a new partner and what to do with a new partner who shows up. Why do you need something written down for it to occur to you that here's a new person living in the house or connected to the family? We have to know who they are.

Regarding the issue of notes which I will soon move to, counsel have commented on the notes in their briefs and both Mr. Ray and Ms. Bowley have commented on the notes and at paragraph 126 of Ms. Bowley's brief she says we must speculate why Chris Zalevich recommended closure because there weren't sufficient notes. Well whose fault is that? Whose fault is it that there aren't sufficient notes about why someone decides to close the file, particularly when we have heard that they're having a discussion with their supervisor and there's some issue about what that discussion was in terms of going back or not or whatever and so they blame, well there's no notes of these sessions. Well there should be notes of these sessions and if someone did something important, that should be recorded and it if isn't recorded, that's pretty bad. It's almost as bad as not doing anything because we all depend on history in this system.

At page 130 of Mr. Bowley's brief on behalf of

Ms. Faria, she mentions that they didn't try intake again. You may recall that in December they tried to send a file to intake, it came back. Again in March same thing happened. But no one seems to have a note as to why it came back or what the reasons were. I'm going to be suggesting they should have tried again in March and it sure would be nice to know what the reasons were if you're going to try again. And in Ms. Bowley's brief and others, they say, well, it's unfair to assume the worse when people don't have their notes.

I can tell you that you know that throughout my cross-examinations of many witnesses I focused on the notes and I'm sure you'll agree with me, I didn't say show me some notes that tell us what Phoenix was wearing that day or what time it was that you left. I focused on important issues with respect to those notes. There's no notes about the discussion with supervisors and very crucial points in this case, like in the March 9th closing. No notes about went on. People are kind of guessing. Why shouldn't we assume the worst? You'd expect that if something important happened it would be written down, but it's not. So most of the areas in which we would require better notes are not picky little points, they're significant, important things, like questions that were asked, conversations that were held, recommendations that were discussed, all very, very

important, and if there's no notes that's the problem, that's one of the problems.

At paragraph 132 Ms. Bowley says she can't say if Chris Zalevich read the previous reports because he may have been unaware of them. So whose fault is that? Shouldn't he be aware of all of the details before you go out on a field? And in paragraphs 149 to 153, there's a number of paragraphs there, where the argument is that it's unfair to blame when there's no notes, or don't fault them for having no notes. That's the reason we're left to speculate in some areas.

Mr. Ray, in his brief, with respect to notes, in paragraph 720, in talking about Shelly Wiebe, he uses the phrase her notes were, certain issues were precisely recorded. So when the notes are helpful of course counsel points out well look at the notes, they seem to help us. And in paragraph 735 he says well since we don't have any notes why should we assume the worst? You can't have it both ways.

Mr. Ray concedes in his brief that supervision was lacking, there's many paragraphs with that point and I agree. He talks about the complaints that were made by the members of the union in paragraphs 17 to 26, and those were all valid complaints. Didn't do much but at least they complained which demonstrates that there were problems.

Talks about a workload and standards and what those problems are.

I'm going to go into some of these major issues now that I've touched on a little bit and the first one is the issue of notes. That's very important because almost every witness that came here said I have no independent recollection of what happened. I can't criticize that because it is a long time that has passed and it would be hard for anyone to remember the details of their involvement that long ago when they have many, many files, which is precisely the reason why notes have to be made. There can't be any excuse for vague notes or insufficient notes. Anybody in this child welfare system knows all the reasons why you have to make notes. They've all confirmed that in their evidence. They could end up in family court at any time having to give evidence with respect to a file. There could be a child abuse registry hearing that comes up that they have to be prepared to testify about. There's a whole list of things, inquests, inquiries, all of these things are possible. That's why you take detailed notes. You never know what may be important along the way. In fact, one of the social workers that was asked why she had no notes on a certain subject said I didn't know that this tragedy would have happened so I didn't take notes. Again, that's why you take notes, because you don't know what's

going to happen, you don't know what's going to be important, so you have to take notes.

So what do we have here? Andy Orobko was the one who told us that he had destroyed his supervisory notes or at least notes that he made about things to do with supervision. He tried to downplay the significance of those notes but of course in his mind they may have been irrelevant. They may have been relevant to you, we don't know. So he took that option away from us by shredding his notes. What's curious about all of this is that he says that in 2010 he decided to get rid of them and his usual practice was that after five years he would get rid of his notes. Well in 2010 he knew that an inquiry had been called, he knew that murder charges were laid, he knew that a trial was going on and he knew those notes might be important, but he says he got rid of them. And what's very curious is that Alana Brownlee, when she did a search of all of her notes, goes back to 1999 and finds notes of Orobko which should have been destroyed and gone, according to his own evidence, because five years would have gone by obviously. And yet those notes were found but, suspiciously and oddly enough, none with respect to Phoenix Sinclair. That's an odd thing.

Angie Balan was another supervisor. She supervised Delores Chief-Abigosis. Her notes can't be

found, they've gone missing.

Lorna Hanson said that certain parts of the file also went missing.

Carolyn Parsons, no idea where her supervision notes are. She decided to destroy some of her case notes.

There were gaps in the notes of Kathy Peterson in terms of why she didn't close the file sooner and why it remained open for some seven months.

Evidence is clear that Stan Williams didn't take proper notes. Heather Edinborough testified for him, of course, and had to basically tell us that based on what she read there are gaps all over the place.

Doug Ingram destroyed his notes as well. He was the supervisor for Lisa Conlin (Lisa Mirochnik). He started shredding his notes in 2004 and for a number of years after that.

Tracy Forbes had no notes of a conversation between her and Samantha Kematch that took place in July of 2004. She ends up closing the file based on this conversation but yet there are no notes as to exactly what went on.

So those things are very, very important and they reach a certain peak when there are no notes, in particular, about the December '04 incident where the new child is being born and the file was sent to intake and

returned without any explanation as to why that occurred, and then again in March of '09 where there's a similar scenario and again no notes of why it was rejected and why it wasn't tried again. We just don't know.

In March of '04 there was a supervision policy which could be found at 29004 in the disclosures which clearly talks about supervisors must take notes of these sessions. That's March of '04. That's a year before the March of '05 incident. So either there's policies that are not being read or there's policies that are being breached or there isn't enough policies. Either way you look at it, there's certainly not enough common sense.

Now you've heard from Dr. Linda Trigg, who was the CEO of Winnipeg CFS of July '01 to July '04 and she was asked by Ms. Walsh about the notes and the lack of the note, what was her impression of that. And at page 129 of Linda Trigg's evidence, Ms. Walsh asks:

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

your view?
A Absolutely not."
"Q Were you ever made aware of supervisor's notes being shredded or otherwise not retained?
A No."

And after another question, her answer on page 130 is:

"Never in my wildest dreams did I think somebody was shredded (shredding) their notes."

That's pretty straightforward and emphatic and I don't think anyone could even attempt to argue that there was nothing wrong with keeping improper notes, destroying them or losing them.

I'll move on to the second issue. And that first issue was fundamental because it affects all of the other issues. It affects your ability to know every detail.

The next issue, which begins at page 6 of my brief, talks about the issue of parental capacity and the assessment that we've heard about that really wasn't done.

Kerri-Lynn Greeley, in June of 2000, took over the file from Marnie Saunderson, who quite properly

referred this immediately when the child was born. Kerri-Lynn Greeley consulted with Dr. Choptiany who advised her to get a psychiatric evaluation of Kematch and possibly a parental capacity assessment.

A few months later, and this is set out at page 6, Ms. Greeley and her supervisor, Angie Balan, had a discussion in which they were hesitant to return Phoenix without this evaluation being completed. Inexplicably, two weeks later they agreed to return Phoenix in any event even though we know the parental capacity assessment was not completed. So Phoenix was returned on September the 5th. There was no psychiatric evaluation done by that date. Now it was done on September the 13th, 2000, not a long time later, but the whole idea was of this agreement that was in place, that this is something that should be checked out before the child is returned. So why it couldn't wait a little longer to check that out is something I can't answer, especially when we're only talking about a week or so.

THE COMMISSIONER: Was it a parental capacity assessment that was ultimately done?

MR. GINDIN: No.

THE COMMISSIONER: No.

MR. GINDIN: No, and I'll deal with that. Dr. Altman, of course, testifies about what he did on

September the 13th. The point is if it's only a week or so later why not just wait and see what the result is before you place the child back again.

So Dr. Altman meets with Steve and Samantha September 13th, 2000 and after the meeting he says nothing further is required. There's no report put on the file about what his findings are. He performed his evaluation of Kematch, Samantha, with Steve present and Phoenix present and later Dr. Trigg says well I wouldn't do it that say, you have to talk to each person separately, together and separately. There may be certain things that Steve might not be in a position to say in front of Samantha, the mother of his child that was just born. So Dr. Trigg certainly tells us later that that wasn't particularly wise or not the way she would do it anyway.

Now Dr. Altman tells us that what he was looking for was whether this ambivalence that Samantha showed, the emotional flat effect, was due to depression and I can see why that would be important, because if it was, then that's treatable. Depression is something you can deal with. There's medications. So that was his task. Is that why she was so ambivalent and so emotionally flat to her own child? Well he concluded it wasn't depression. I pointed out to him at page 113 to 114 that there were many things he didn't know that perhaps he should have known that were

in Samantha's child-in-care file and I pointed out several things in there where depression is actually listed, inappropriate socialization is listed, eating disorders, being withdrawn. All of these things are in that report which I submit should have been, he should have been made aware of those things when he's making that type of an evaluation but he wasn't. In any event, he concludes it's not depression.

Now to me that's a red flag. If it isn't depression, which is treatable, then what is it? Just plain ambivalence and not caring and having no attachment to the child? Doesn't that become more significant than if it was just depression that you could treat? Yet a report isn't filed, nothing further is required and the child is returned and no parental capacity assessment is followed up or ever done.

We've heard from Nikki Forrest (sic) who worked at the Boys and Girls Club, sometime later noticed clear cognitive issues when she spoke to Samantha in her brief time speaking with her, but yet this is not followed up on. A few years later the matter ends up in court and that's July 2nd of '03 and it comes up in court, it's mentioned in court, this is something we need to do. Now it's a few years later and it's still something we need to do. Nothing further is done.

And all of this is discussed with, again, Dr. Trigg when she's on the stand and she tells us about the experience she has as a psychologist with parental capacity assessments and you may recall how long it took to get the appointment with Dr. Altman, months and months went by to set that up. So that's an issue there. You think that is something we could do a little bit quicker, but yet it took months and months to get that set up. Yet Dr. Trigg, and even a few other social workers, gave the opinion that social workers should have that ability to do a parental capacity assessment and some of them do have that and perhaps there should be special training in performing those things that should be recommended as well. But the point is you're going to spend months and months trying to set it up with a psychologist and then testify that the social workers themselves could have done it. And that's the reason why it wasn't done before the child was returned because you couldn't get an appointment with a psychologist who apparently isn't even necessary, according to some of these social workers and even according to Dr. Trigg, she says that in her testimony, I think a social worker could probably do it the right way and she talks about how it should be done. You need to spend time with the mother alone, lots of questions. And in her evidence of February the 4th, 2013, for a number of pages, she would

go into how she would do it and how it could be done in effect by social workers and she even comments on the fact that it's a rather expensive process to have a psychologist come in and she's not sure that it was necessary. The point being in the end is that it wasn't done and it should have been done and if it was too expensive to get done then it should have been done by social workers with some experience who could have done that themselves.

So that, I submit, is a red flag. Here's a mother who is completely ambivalent. I'm not sure what could be worse than ambivalence and being emotionally flat to your newborn. If that isn't a red flag that there's some serious problems here I don't know what would be. And I urge you to read Dr. Trigg's evidence of February the 4th, particularly the first 20 pages or so where she talks about the way a parental capacity assessment could be done and should be done. So that's a major red flag.

At page 8 of my brief I go into a number of other facts that came up along the way, all of which are really red flags that there are some problems here. We know that Phoenix Sinclair had her first son apprehended in 1998. That's a red flag. She, herself, of course being a ward of CFS would cause some concern.

April of 2000, Phoenix is apprehended, we know that and at the time of that apprehension she's telling the

social worker that there's concerns she may hurt the baby. That's her understanding of why there's an apprehension. That obviously would cause some concern.

At one point along the way she tells people that there's no need for parenting programs for her. She did not need to complete parenting programs. She tells that to Laura Forrest.

We've heard that a call came in along the way that Kematch's mother or Samantha herself was smoking crack cocaine in front of Phoenix. Everyone seems to have taken that quite casually. The answer is well it's just an allegation, it hasn't been substantiated. Do we need to be presented with a video, a surveillance video before anybody does anything about that type of very significant concern?

In '04, we heard from Debbie DeGale who spoke to Kematch and was very skeptical about what she was being told. She thought this was a very high risk situation. She talked about getting a call from an aunt who was concerned about what was going on with Phoenix and this is back in mid, mid 2004. There was evidence of her using drugs, clearly, and what is being done? It's just sort of looked at casually in my opinion. We have evidence of her not being truthful. She was lying to DeGale, according to her, clearly, she was very suspicious of this and made a referral. She was using drugs, lying. We know that when

she told Mr. Zalevich that there was a visitor in her apartment we find out later that she just said that. That's not shocking. It's shocking to know nothing of the rest of the file perhaps, but when you hear the whole story it's not really surprising that maybe she didn't have a visitor there, maybe that was just a story, maybe that's why she came running out to the hallway to make sure no one came in.

So we have a number of concerning things about Samantha along the way, and there were some concerning things about Steve as well, we know that. In fact, one of the things that was described with respect to Steve was odd, in my view. There was some evidence that Steve at one point said, you know, maybe I'm not able to handle the return of Phoenix, this is with respect to Stan Williams becoming involved, and he said he wasn't ready. That comment by him, which I submit was completely unselfish, completely showing a concern for what's best for Phoenix, not just give me the child back regardless, was described by some social workers as abandonment. That was their take on it. The fact that he was wise enough and candid enough to say you know, I'm not ready, maybe someone else should help. Only a real parent would say that.

The next issue that I want to deal with is the issue of Wes McKay and the notion of information sharing

which is a huge issue and was a huge issue at this inquiry and must change. Wes McKay had a horrific background. We've heard a lot about that. His file was read out in court at some length. He had a history of involvement with CFS, a criminal record. It was so bad really that there was a probation officer who wrote a letter early on because she was intimidated by him, didn't want to be alone with him. It was a warning to the CFS system, this is a dangerous person. About 14 months before the death of Phoenix, in April of 2004, a notation is made for the first time on Steve's file where McKay is mentioned and that's referred to in my brief at page 11. Kematch was identified as common law to McKay as of January 2004, according to the evidence of DeGale, and on May the 28th, 2004, Phoenix was placed on McKay's budget. May 28th, 2004, she's placed on his budget at EIA. Just over a year later she's murdered. Surely that should have been somehow known by CFS.

There's evidence that Tracy Forbes went out to Kematch's house on May the 13th, 2004. McKay answers the door, identifies himself. He was not asked any questions, what's he doing there? Who is he? When asked why she didn't ask any questions of this stranger who came to the door, I didn't have any reason to have concerns about him. That's the reason you ask questions, so you'll know. You don't assume the best all the time. Unless I'm told

something bad, I guess everything's good. That's not a good approach if the safety of children is your main concern.

In July of '04, Forbes then goes and has a discussion with Samantha herself, she goes out to see her, and she's told that Wes is her main support, Wes McKay, the eventual killer of Phoenix Sinclair. He's her main support, he's her boyfriend and that he often stayed with them. Not asked his name, not asked how often he stays there, what he does for a living. It's pretty clear. My main support, my boyfriend who stays here when he's in town. How about how long is he in town? How often does he stay here? Who is he? Or maybe just check EIA afterwards. We know it was already on the system by that visit and you'd know a little bit more, you might have a birth date. These things weren't done.

Miriam Browne was the one who was the probation officer who told us that chilling evidence and in her letter she says, "We have serious concerns for the safety of (DOE #3) and her children and believe that they are at risk due to Mr. McKay's presence in the home." And she writes a letter to Kim Shier early on, I believe it was in 1999 as a matter of fact, some five years earlier, a letter is written to CFS about Wes McKay and how dangerous he is. Describes his behaviour as belligerent and non-compliant,

physically intimidating. Described him as an extremely high risk. That, that could be enough right there for some of those things that occurred.

December of '04 there's another child born and he is listed as the putative father, Wes is, and that's where Shelly Willox becomes involved and we had all of that evidence about her and Mary Wu and what they said to each other and what they didn't say to each other and those discussions about privacy. But however you look at it, here's another child being born to someone who's had two previous children apprehended by the system and all those red flags I've mentioned already and no one finds out who the putative father is and what are his details. He's now the father of a newborn and clearly is involved with this family that Phoenix is a part of. It seems previous obvious we've got to find out who he is. And in my brief at page 13 I go through some emails that are sent back and forth and some things that might have been done.

And it's not just EIA. On August 30th of 2004, Phoenix was registered for nursery at Wellington School. She never really attended but they could have provided some information if someone checked it out. What's in that form when she applies? Is there a father mentioned? Is there someone else involved with the family that we can check out?

December of '05, when it was clearly too late, Kematch had her fifth baby and of course there was no referral made then because they weren't aware of the previous history for some reason. The file from March had been closed and so there was no kind of connection with well let's check it out. That might have something to do with why the body wasn't discovered or nobody knew for some time.

So clearly there is a problem with this new partner and many, many opportunities to do something about it and it's just a matter of common sense, it doesn't have to be written down anywhere. The fact that it's now written down somewhere emphasizes that it should have always been written down and it doesn't need to be written down. In my submission, anybody, social work degree or not, would say to you if there's a new partner coming into the scene you check him out and as it happens there is information in the system about Wes, at the hospital, EIA, maybe at the school. There has to be a better system of information sharing.

I move on to the issue of supervision which I won't spend a lot of time on because pretty much everybody here agrees that it was lacking. In fact, many social workers wrote letters complaining that there were problems.

Angie Balan, when she testified, basically

explained her role as a supervisor as kind of waiting to see if there's a problem. Page 49 of her evidence, November the 28th. That's basically what she's saying. If I don't have hear otherwise, my expectation was that she was carrying that out, that is with reference to the worker under her and that's the theme that comes up. If I don't hear otherwise, I'll assume everything's okay. That's not sufficient. We've heard that there were no performance reviews conducted. I believe it was Tracy Forbes who said that her own performance was reviewed only twice in over eight years, over eight years. That should be done every month.

On December the 5th, 2002, the issue was brought to the attention of senior managers of Winnipeg CFS, as pointed out in paragraph 59 of my brief and then it goes on to talk about the Viewpoints Research which was conducted by Dr. Trigg, or at least she was involved in that and she comes to certain conclusions. Morale is very low. The devolution issue obviously makes it even worse. And lots of complaints were made and she testified about all of those complaints. People were complaining about a lack of supervision clearly and repeatedly. So not much time has to be spent on convincing you that supervision was a problem.

Lisa Conlin said she had no regular scheduled

supervision with her supervisor, Doug Ingram. The only way they'd ever discuss anything is if she initiated the discussion, it never came from him. And of course we know his notes were destroyed in any event.

On January the 22nd, '04, Conlin consulted with her supervisor Ingram as well as Heather Edinborough and decided that Phoenix should stay with the Stephensons. Then Edinborough tells Conlin to transfer the file to Family Services for further follow up and then she does not do that. I suppose proper supervision would be to make sure that it was done if that's what you think should have happened.

December 2004, that file was closed as opposed to being sent over to intake and it's interesting because that file was, even though it was with CRU, was open for some six or seven days and it was sent to intake and returned and nobody knows why. When asked why the March incident was closed so quickly, the answer was well CRU doesn't keep things more than a few days, yet in December they had it for seven days. So that's inconsistent and doesn't make sense. And the same thing happened in March. It was, they tried to send it over to intake, it was returned, no notes about why, no notes about why you wouldn't try again. It's interesting because Dan Berg was the program manager, talked about the collegial atmosphere that existed between

CRU and intake. They were in the same building, they were close by, they all got along well. Why couldn't you walk up and say, well we've got a problem here, we think we need to do more work on this March incident and discuss it and figure out what you can do.

THE COMMISSIONER: March of '05?

MR. GINDIN: Yes, with respect to March of '05 particularly. He was asked about how it works and how he tried to present a collegial atmosphere so they all got along well, discussed things, were close by to talk, yet apparently no one decides let's go talk to them again, let's make it clear why they wouldn't accept it the first time and maybe we can convince them to accept it now.

So again, I would ask you to look at, when you're looking at the issue of supervision which clearly everyone concedes was lacking, not only in terms of having regular meetings, in terms of having performance reviews, also in terms of not having notes about these meetings. How else do you learn as opposed to marking down what you talked about, seeing if it's followed up on. There was very little of that.

And Dr. Trigg, in her testimony of February the 4th, 2013, between pages 22 and 32, goes through all of the problems with supervision that she tried to address in the Viewpoints Research and she talks about the fact that they

decided to have a program to help supervisors, only one problem, too few people showed up to take advantage of it so they couldn't continue it. I'm not sure what that shows but that's important. And the evidence that she gives and some of the complaints that were received, for example, at page 31 of her evidence, which is page 3 of the letter she writes:

> "It is for the above reasons that we feel we must put this government on notice that children and families who require protection services in Winnipeg are at risk and we as workers feel unable to ensure their safety."

Now that is a pretty significant statement.

THE COMMISSIONER: This is Trigg's letter?

MR. GINDIN: This is Dr. Trigg's evidence.

THE COMMISSIONER: Yes.

MR. GINDIN: On page 31 where she refers to the letter she wrote which is found at 34664 of the disclosure.

THE COMMISSIONER: Yes.

MR. GINDIN: And there's a lot more detail there and I've just quoted a certain portion of the letter where

the workers themselves are concerned that they can't ensure the safety of children.

THE COMMISSIONER: And who did Trigg send that letter to?

MR. GINDIN: Let's see. I don't have that handy but it's all there.

THE COMMISSIONER: I'll find it.

MR. GINDIN: Yes, it's on that page, I'm sorry I don't have it in front of me.

THE COMMISSIONER: I'll find it.

MR. GINDIN: The letter is quite lengthy.

THE COMMISSIONER: Yeah.

MR. GINDIN: And as a result of many meetings.

I'm going to move on now to some of the front line social work.

THE COMMISSIONER: Well I wonder if this is a good time to take --

MR. GINDIN: This might be a good time to take a break.

THE COMMISSIONER: -- our mid-morning break before you move into the new subject.

MR. GINDIN: That's fine, yeah.

MR. COMMISSIONER: So we'll rise for 15 minutes.

(BRIEF RECESS)

MR. COMMISSIONER: All right, Mr. Gindin, you were just about to start the next theme which is front line social workers.

MR. GINDIN: Yes. Before I get there, Mr. Commissioner, you had asked me a question earlier about a letter that I was referring to.

MR. COMMISSIONER: Yes.

MR. GINDIN: And I've looked that up and it was actually a letter written by certain union members to Drew Caldwell, who was the minister at the time, and Dr. Trigg was referring to the letter and was quite familiar with it and that's how it came up.

MR. COMMISSIONER: That's the context?

MR. GINDIN: Yes.

MR. COMMISSIONER: Yeah, that letter was mentioned in some other briefs --

MR. GINDIN: That's correct.

MR. COMMISSIONER: -- that were filed for today.

MR. GINDIN: It's a fairly lengthy letter and it goes through all of the complaints and problems that the union felt were present.

MR. COMMISSIONER: I'm familiar with that letter.

MR. GINDIN: Now just before, I just missed one thing I wanted to refer to when I was talking about supervision earlier and Ms. Parsons, who was a

supervisor --

MR. COMMISSIONER: Yes.

MR. GINDIN: -- at page 120 of her testimony dated December 18th, 2012, I just want to read out a portion of her cross-examination which I submit shows what supervision isn't. Now I ask her:

> "Did you ever on occasion have a look at a safety assessment form like the one you've been shown earlier, and feel that you disagreed with it?
> A Yes.
> Q And if you did do that, and felt that way, what would you then do? Would you, would you bring it to the attention of whoever prepared the form?
> A No, no.
> Q No.
> A Generally what would happen we would go with whatever had been assessed as being the timeline and would go with that, and, and make our attempts to connect.

Q So even though you might not agree you, you would leave it the way it was?
A Yes.
Q Even if you disagreed strongly?
A Yes."

Now I question whether that's proper supervision.

Now with respect to the -- and that's just one example of a number of things that were problematic.

With respect to the front line social workers, it's my submission that the work and services provided was simply not good enough. There was a significant lack of contact with the family, that's clear throughout the chronology of what occurred here. There were instances of poor judgment. There were decisions to close files where there was still significant protection issues that were unresolved. That is quite clear, I submit, and likely won't be disputed. And I'll just mention some of the highlights.

We heard the evidence of Delores Chief-Abigosis who was one of the witnesses who remembered absolutely nothing. And we heard her say I don't know or I don't remember so many times that I couldn't really count. But

one of her jobs was to make sure that the service agreement on September the 5th, 2000, which was the return of the child to Steve and Samantha, her job was to make sure that was carried out and there's no recordings on the file to suggest that she did anything at all to help the family fulfill that agreement.

There was some evidence that Marie Belanger, who may have used Marie Pickering, was the family services worker who was visiting the home on occasion and for some reason that was abruptly stopped at a certain point and there was no explanation that could be given as to why that didn't continue longer than it should have.

This is where we see long periods of time with nothing going on, sometimes five or six months. And her supervisor, that is Delores' supervisor, Angie Balan, agreed in her testimony that it was bad practice to let that many months go by. I think at one point there was five months that went by without any sort of contact. I can't recall whether there might have been an attempt or two along the way but there was no contact.

When Samantha's second child was born April 29th, 2001, no one seemed to know that she was even pregnant. You may recall that. Now it seems to me, based on the history, that a second child being born when your other child is only one and that other child had been apprehended

at birth and your previous child before that was apprehended at birth, that becomes a high risk situation just on the basis of common sense.

We have the evidence that Delores Chief-Abigosis was commuting from quite a distance away. You may recall that. And she was also attending some courses at the University of Manitoba. I don't know whether that was a factor in her doing very little. She says she told her supervisor about those issues. The supervisor doesn't recall if she was made aware of that but admits that it would have concerned her if she knew those things because obviously they would be distractions to doing the work properly. They would certainly be distractions from visiting at night or on the weekends if someone found that to be necessary. So we have Delores Chief-Abigosis who I submit did not do enough clearly. Any way you read her evidence it comes out quite clearly. There wasn't enough contact, she should have done more.

We have Kathy Peterson or Epps, who was Steve's former social worker, and she got involved actually prior to her official involvement as a former social worker where she spoke to Steve and was told about the breakup with Samantha and she had some warnings that she gave about Samantha not being allowed to come near the child. Well there's very nice to warn someone but I think more is

required than that. In fact, she did more, I think, before she took over the file than after she did take over the file because this was the file that remained open for some six or seven months with virtually nothing being done. This was the file that was supposed to be closed, I believe it was August but really officially wasn't until the following March and yet no real record of anything being done.

So there was an awful lot of inactivity in this matter, particularly between November of 2000 and July of 2001, just some nine moths, November 2000 to July of '01, about nine months and similarly other periods, many, many months went by where there was just nothing at all. And it may well be that there was no open file but maybe that's a problem with the system. Maybe once you've been apprehended and you have these kinds of issues they shouldn't just close a file and stop all monitoring.

We know that nobody really checked with Kim about her connection, not that they would have found out anything bad but they certainly should have at least checked things out when you find out that other people are involved with the child.

Kathy Peterson really never saw Steve or Phoenix when she had conduct of the file. She spoke to Steve before and that was very nice that she took the time to do

that, but once she got conduct of the file nothing happens.

Then we have the involvement of Stan Williams who didn't amount to very much. He obviously had a lot of faith in Steve, but still more should have been done.

At paragraph 89 of my brief, I'm going to read that one paragraph out. Stan William's supervisor was Heather Edinborough. She testified that this information, which is referred to in the previous paragraph where Williams finds it not necessary to renew the temporary order of the court, she says this information made her angry because obviously Stan was thinking Phoenix may need to stay in care longer but he closed the file anyway. There was no evidence Stan ever visited Steve and/or Phoenix after her return home. Edinborough and Williams did not discuss or consider leaving a family support worker with Steve or offering him daycare. And she states in paragraph 91, "We had stepped out too soon." And she was one of those that admitted mistakes were made in a very emotional, straightforward way.

We have the evidence of Lisa Conlin, who took over and actually went out to visit Rohan Stephenson. No notes about whether Phoenix was there or talking to Phoenix or playing with Phoenix or telling us anything about Phoenix. She did not explain to Rohan that being a place of safety would have prevented Kematch from being able to

simply come and pick Phoenix up. Rohan told her about how he didn't live there all the time and she didn't seem to know very much about his working hours or his schedule or how difficult things were, no real questions were asked. And I concede he wasn't all that interested in being cooperative because of his own views about CFS.

Conlin never explained to Steve that what a private arrangement means and those kinds of things. She wasn't aware of how had picked up Phoenix in January of 2004. She knew that drugs were involved in some way, both for Steve or Samantha, and she was asked during her testimony, that is Lisa Conlin, if she knew the difference between a risk assessment and a safety assessment and in her evidence of December the 3rd she said she thought they were the same thing. Now there's a lot of evidence that has been presented about what those things are, yet she thought they were the same thing.

Then we have the evidence of Forbes, and I'm just being extremely selective here because there were so many workers that were involved and all of their evidence has to be looked at. She didn't know that Phoenix was on McKay's budget and again that might be because of a type of system we had but that's certainly something she should have known. We know that she had two very important chances to find out about Wes, I mentioned them already, in May of '04

when he comes to the door and in July of '04 when she speaks to Samantha --

MR. COMMISSIONER: That was who are you speaking of?

MR. GINDIN: Tracy Forbes.

MR. COMMISSIONER: Who?

MR. GINDIN: Tracy Forbes.

MR. COMMISSIONER: Oh Forbes.

MR. GINDIN: Forbes, yes. And I'm emphasizing the fact that she herself had some very important chances to find out about Wes McKay, when she first came to the door in May of -- when he came to the door in May of '04 when she made her visit, and I've talked about that already, and then in July, July 13th she meets with Samantha and Phoenix but yet there's notes of any real conversation, didn't speak to Phoenix, but was told some things about Wes that weren't followed up on and then she goes to see Samantha's mother right after that visit. And she was asked in her testimony, well why didn't you ask Samantha's mother about how Samantha's doing and who's she's with or how her drug problem is. Her answer was, well why would I ask her mother? What do you expect the mother to tell me? Yet in other times they rely completely, without question, on what Samantha says about her being clean and not being on drugs, things of that

nature. That's not very consistent. She should have asked the mother. Who knows, maybe the mother would have said oh, there's this guy called Wes, I don't like him. We've heard lots of witnesses come forward and tell us they didn't like Wes. Maybe Samantha's mother might have talked about Wes, maybe she might have talked about drug use. You've got to ask. She thought well why ask the mother, it's the mother, what can you expect her to say?

And with respect to Tracy Forbes, I've mentioned a couple of things that I found quite surprising. Her answer to the issue about Samantha smoking crack in front of Phoenix, well that was just an allegation. Asked about why she didn't check with Kim or Rohan and follow up on that as well, if they had concerns they'd call me. Reluctantly agreed that CFS also has an obligation to make contacts and check things out. When asked why she never went out in the evening, "chose not to", that was her response, page 200 of her testimony, "chose not to". "Why didn't you question Wes at the door?" "I had no specific reason to be concerned." Those answers are all quite curious and they demonstrate, in my view, an attitude of sitting back and just letting things be.

MR. COMMISSIONER: And was it the conversation with the mother that took place that Samantha's source of support then was a trucker?

MR. GINDIN: That's where that -- no, that --

MR. COMMISSIONER: That's when that came up?

MR. GINDIN: That conversation came up in July of '04 when Tracy Forbes actually spoke to Samantha.

MR. COMMISSIONER: That's when that came up?

MR. GINDIN: Yes. In May she went to the house and Wes came to the door and didn't ask, check that out. She goes back in July, on July 13th of '04 and actually talks to Samantha and those, that's where she says my main support was Wes, et cetera, those things come out.

Carolyn Parsons also, as a supervisor, testified December the 18th that, she spoke about the wrong assumptions that she made. She assumed the parental capacity assessment was done. That comes out at page 134 of her evidence. I don't think that's in the brief but her evidence at page 134. She assumed that it had been done and she assumed it had been done on both parents, even though it hadn't been done and was never requested on Steve. Those are some wrong assumptions.

She was asked about whether she, if she knew about Wes McKay's background, whether that would have been a significant factor and might have changed the course of this history. She said yes. Forbes was asked about that and she didn't admit the obvious in my opinion. She said, well, I don't know, it could be perhaps, we'd have to

consider it. Interestingly her program manager, Mr. Berg, was asked the same question about whether if he knew these things about Wes McKay at the time, whether that would have been a significant change in the way this was handled and he said well probably, somewhat, maybe, it might have. Again, those are answers that I can't quite fathom but that's in his evidence.

MR. COMMISSIONER: It was Parsons who acknowledged that it --

MR. GINDIN: Yes.

MR. COMMISSIONER: -- could have made a difference.

MR. GINDIN: That's right.

I'm now going to move on to what I consider to be extremely significant time in this case and that is the last closing and that deals with the March '05 matter. And this is where the profound lack of common sense reaches a high point.

Chris Zalevich recommended that this file be closed, Diva Faria went along with that, when they had absolutely no idea whether Phoenix was safe and left knowing no more than when they got there. In fact, what they discovered from being there was more suspicious circumstances and more causes for concern than when they got there and I think that becomes quite clear.

So first we have on March the 7th, 2005, this is before, a couple of days before Zalevich takes over the file and we have Richard Buchkowski tries to connect with the family and this is on page 29 of my brief.

MR. COMMISSIONER: Yes, I have it.

MR. GINDIN: And so Richard Buchkowski tries to connect with Phoenix. He views the file as a high priority, sounds like he's the only one. He went out there without a partner and he tried a couple of times, two separate occasions, to make a connection and wasn't able to. Now this was a referral that came in after a call came in which was taken by Jackie Davidson about potential abuse. Everyone describes it as a rather vague referral. The referral was made incidentally by someone who worked with CFS, SOR #7. It was actually a foster parent who worked with CFS, was employed by CFS. They called that a soft referral. In any event it was vague and Mr. Buchkowski comes out and tries to find out more and isn't able to so he passes the matter on to Chris Zalevich on March the 9th.

The referral that was typed out by Jackie Davidson, interestingly, it has things missing in terms of a history. One of the things it has missing is any reference to Shelly Wiebe or Willox in terms of the December '04 birth of the child and the putative father

being called Wes and there being another child in the premises and that kind of thing. That seems to be left out of the report for no reason that I can think of. In any event, that's what occurred. It probably wouldn't matter because I don't think that Chris Zalevich read very much of anything. Whatever he read was quite brief. But in any event, he takes over on March the 9th and he goes to this address to check to see whether this allegation of abuse that was made concerning Phoenix has any merit or what can he find out. And what's the first thing that happens? She comes out to the hallway, refuses to let him in the apartment. Now does that make things better? Would that make you more relaxed or would that cause you more concern? Obviously more concern.

He then advises here that they've got this report that came in that there was some abuse. She doesn't deny it immediately but says who made the call? That wouldn't ease my worries, that type of response, but that's what's made. She then admits to yelling at the child. An ordinary sensible person, I submit, would say well what were you yelling about, tell us something about that. No questions are asked and it's not followed up on. At some point during this discussion she leaves, comes back with another child. She tells him there's a visitor in there and that's why he can't come in. Yet she goes in there and

takes another child and brings that child out. Now I would assume that the visitor would now know that that child is being taken out to the hallway. What's wrong with bringing the other child out or being asked to, well it's very nice that this child appears all right, where's the other one? Doesn't appear to be asked. But there was a question asked, where's Phoenix? Or is Phoenix in school? No, she's not. Is she in day care? No, she's not. Well according to all the evidence we heard, that's makes her very vulnerable. We've heard all about why. If she's in school or in day care there's other people around, there might be some --

MR. COMMISSIONER: Do they ask where she was?

MR. GINDIN: That's a little unclear. There's nothing in the notes that they asked where she was. Now I would think if you ask that question and got an answer, that's important enough to make a note of and I can only assume that they didn't ask that, although it stretches the imagination almost beyond belief that they wouldn't, but they don't say so bring out the other child.

Now when I spoke earlier about Heather Edinborough being candid, straightforward, admitting her mistakes, I can't say that about Mr. Zalevich. He was very matter of fact and when I said just because you saw the other child, that doesn't really tell you anything about

whether Phoenix was abused or not, his answer was it doesn't say she wasn't. That's the answer.

Do they make another appointment when she says I'm with somebody right now? Wouldn't that be the obvious thing? Buchkowski has been there twice, couldn't a connection. Now they're coming, she won't let them in, she's in the hallway, she's presenting other children not Phoenix, nobody knows where Phoenix is and there's no other appointment made. Can we come back in an hour? Can we come back tomorrow? Why not?

In fact, the standards are so confusing that -- and again, I'm still confused about which standards apply to when, I still don't have a handle on that. But the evidence of Darlene MacDonald, one of the higher ups, on February the 5th, 2013, she testified that the standard of seeing a child was in place already at that time. Now I don't know if that's accurate, if -- we've tried to check it out. There was some evidence about standards of '05 being online. I haven't really seen them, we couldn’t locate them. But her view was that at the time of that March incident the new standard about face to face contact was already in place. She may be wrong, I don't know. The mere fact that she believes that and she's confused about it as well, and what do you expect about the rest of us?

Zalevich did not read the history. He had no

idea, no idea how Samantha had been responding in the past in a way that many people were not pleased with. We've heard about Debbie DeGale, she thought she was being very deceptive. We later hear that of course there was no visitor in the apartment, no shock, but we've heard that she told a friend later who testified, one of the family members, that she told her no one was visiting her, she just said that so they wouldn't come in. That can't shock anybody. But Zalevich never read the history or if he did he read very little, but he knew nothing about her --

MR. COMMISSIONER: You said that there's evidence that there was a discussion subsequently where Samantha acknowledged there had not been a visitor in the apartment?

MR. GINDIN: That's correct.

MR. COMMISSIONER: Whose evidence is that?

MR. GINDIN: It was one of the civilian witnesses, it wasn't a, I don't believe it was a social worker. I'll see if I can find that by the time I'm through. But it became clear later on in the evidence that she had told someone, perhaps it was a friend or family member, that she just told them that so they wouldn't come in.

MR. COMMISSIONER: That's in evidence, is it?

MR. GINDIN: Yeah, it is in the evidence.

MR. COMMISSIONER: All right.

MR. GINDIN: I'll try and locate that along the way.

MR. COMMISSIONER: I hadn't picked up on that point but I will, I'll find it.

MR. GINDIN: Now this whole scenario, which was delved into during cross-examination at great length by myself, in terms of all of the things that could have been done, should have been done, one of the things was well, try sending it back to intake. Well they had rejected us once. Do you know why? No. Why not try again? No real answer. All of this evidence was discussed with Dr. Trigg and in her opinion or requested as to how she thought about the things that happened and she agreed completely, that you don't simply take -- you can't come in for an answer. There are more questions that need to be asked. Her evidence on that is dated March, or January the 28th, 2013 and it starts at page 96 and it goes on for a number of pages where most of these options and suggestions and things that happen are put to her and she's pretty clear on her opinion of what was going on that day and what should have been happening that day.

MR. COMMISSIONER: You say that starts at page 96 of Trigg's evidence?

MR. GINDIN: Yes.

MR. COMMISSIONER: All right.

MR. GINDIN: And again, I won't read it all to you but it's pretty clear.

MR. COMMISSIONER: Yeah, I have it.

MR. GINDIN: Particularly the pages 98 and 99 I think speak for themselves.

Now this particular incident where a file is closed without anything further known than you knew when you went out there, in fact whatever you find out and what you observe should cause you more concerns rather than less, is, I submit, a drastic decision. Probably the most important decision that was made along the way was to close this file. There was some discussion about Faria and Zalevich and Leskiw discussing what should happen or what were the reasons why it was closed or maybe you should go back and all of that is very vague because no one has notes about it but they seem to recall something about bringing up the issue of perhaps I should go back. Zalevich thinks he asked that question. Faria says well if I was asked that question I would say, yeah, you go back for sure. But they didn't go back, they just closed the file.

Now in Ms. Bowley's brief at paragraph 148, in dealing with this issue, and of course I've told you already that her argument with respect to Faria for the most part is the systemic issues and the lack of clear standards and all of that, but then at paragraph 148 she

mentions as though this might be a response and a good answer, that we have evidence in this hearing that on March the 18th, nine days later, there was a photograph taken of Phoenix, and that's Exhibit 7 by the way and it just shows her sitting on the floor and there's a photograph there, and some counsel have suggested that that photograph shows a happy little girl and as if to suggest that it wouldn't have made any difference if she was seen or not because clearly she was fine. Well the evidence about that photograph was given by SOR #9. She talked about how she was over there with her kid and when they went outside Sam walked ahead of Phoenix and SOR #9 was holding Phoenix's hand and she said that Sam didn't want a picture taken. She described Phoenix as being different, reserved, didn't say much, that she wasn't treated as nice as Samantha's other child was and that no one ever saw Phoenix with her hat off or no one ever saw her hair.

Now that photograph shows Phoenix sitting on the floor with a hat covering, a big floppy hat on her head. She's fully clothed, long sleeves, long pants and I would like to ask that photograph, does that mean that she wasn't locked in her bedroom, that photograph? Does it mean there wasn't a gash on her forehead that was similar to the one observed about a month later by Jeremy Roulette when they were going off to Fisher River? Does it tell us anything

about Wes not being violent or about anybody not smoking crack in front of her? Does it tell her whether there are bruises on the head? Bruises on her body? No. It captures a split second in time when she appeared to be smiling.

Now let's say there were no bruises anywhere. Does that mean that she shouldn't have been seen? Even if we saw her without bruises, it doesn't change a thing. In fact, this reliance on a photograph is exactly why she should have been seen so that we're not left to speculate by looking at a photograph taken nine days later of a fully clothed child with a big floppy hat on during a split second.

MR. COMMISSIONER: Well I think what happened on March the 5th stands on its own as to whether --

MR. GINDIN: It does.

MR. COMMISSIONER: -- it was good practice or whether it wasn't and I make no observation at this point whether it wasn't but, was or wasn't, but that seems to me --

MR. GINDIN: Yes.

MR. COMMISSIONER: -- you look at what happened that day.

MR. GINDIN: That's correct. And I only mentioned that because counsel had referred to this

photograph as if it tells us something and whatever it tells us, which is very little, is the very reason why the child needs to be seen, so we don't have to speculate about a photograph taken nine days later over a split second.

Now Zalevich was with Leskiw, his backup worker. Leskiw had much more experience; Zalevich didn't have very much, Leskiw did. There's three people, Zalevich, Leskiw and Faria, who together let that happen and closed the file. That's astounding. That is a profound lack of common sense, to close that file based on what was happening that day. And here again the question was why couldn't you have kept that file open a little longer and have that checked out properly? Well we're at CRU, we don't keep files open more than a day or two. And I remind you again of the December '04 file which was also a CRU matter, which was kept open for seven days to have some things checked out. The December '04 was simply a newborn being born. There was no allegation of anything, yet that file was kept open longer and here we have an allegation with suspicious circumstances when you go out there, people not letting you come in, and that file isn't open for any longer or kept open. There's just no excuse. You can spin it any way you want, the file should not have been closed.

MR. COMMISSIONER: Well do the issues around workload and training and standards, do they have any

impact on the decision made that day?

MR. GINDIN: I say that it wouldn't matter what was written down anywhere, common sense is enough. Best practice is enough. Good sound judgment would be enough. You don't have to write down somewhere that if there's allegation of abuse and you go to the house you try and see that child and if you can't you try again. There's no way around that. That had to be done.

MR. COMMISSIONER: You're saying anyone practicing social work should have known that?

MR. GINDIN: I would say anyone not even practicing social work would know that. I don't even think you have to be a social worker to know that or to feel that.

Faria was asked, Ms. Faria was asked in her testimony, and she kept using the reason for closing the file, there were no known protection concerns. Now there's semantics for you. No known protection concerns. That's not the same as saying we know there were no protection concerns. No known protection concerns, which is exactly why you have to see the child because you don't know. They left not knowing. They came not knowing. And the reason? Well we closed the file. There was no known protection concerns. That is a far cry from knowing there were none. But when I pressed her on whether or not this was simply a

matter for common sense, it took several pages to get around to the point where you had to intervene, Mr. Commissioner, and say look, Mr. Gindin is simply asking you, isn't it a matter of common sense? And then the answer was absolutely. It took five pages to get there but that was the answer in the end.

And you may recall the evidence of Pat Berg (sic) about the role of common sense. He says common sense, that has nothing to do with standards and that's pretty sad.

I don't think anything more needs to be said about that very fateful decision on March the 9th to close that file. We know that within three months she was tortured to death. We know that a few weeks later, perhaps a month, Jeremy Roulette notices a gash on her forehead. We know other people have seen bruises and disturbing behaviour and we had the whole history. So it's not as though suddenly three months something surprising happened, three months later.

Now the last, one of the last issues that is raised in my brief at page 33 is the image and the perception and the public and I put this in because the blame goes further than the actual system. It goes further than the social workers and the supervisors. The public has a role to play as well. The evidence was clear that the image of the child welfare system is not very good.

People don't trust it. People are resistant to it. Steve himself testified one of the reasons he wanted to try and take care of Phoenix because he's familiar with what happens when the system gets involved and he didn't want that to happen to Phoenix. He wanted to do that himself.

So my submission is that something has to be done to improve this image. That's a very important task and I deal with that later on in the recommendations. But there's a number of individuals who could have done something along the way and they're all mentioned in this portion of the brief. Page 33 we have Ashley Roulette, a young --

MR. COMMISSIONER: That part in italics at the start, that's the --

MR. GINDIN: Yes, the --

MR. COMMISSIONER: -- principle you're expounding?

MR. GINDIN: Yes, image, perception and the public.

MR. COMMISSIONER: Yeah.

MR. GINDIN: And I'm suggesting that the public also has a role to play in reporting things that they observe, reporting the concerns that they observe and there were plenty of people here who observed some things, some of whom went far enough to report, some of whom did not.

MR. COMMISSIONER: And what follows starting at

paragraph 119 and thereafter is supportive of that proposition?

MR. GINDIN: That's correct, that's correct.

MR. COMMISSIONER: Okay.

MR. GINDIN: And very briefly I'll just --

MR. COMMISSIONER: Yes.

MR. GINDIN: -- run through that quickly.

MR. COMMISSIONER: No, take your time.

MR. GINDIN: Ashley Roulette, in 2004, she witnessed Phoenix with a bruise on her face and she didn't call because, as she put it, it was none of her business. Now that kind of thinking is not proper. I know she was young and I know she may have been afraid and those issues are all going to come up and sometimes it's a friend of the person that is acting improperly, but it's difficult, but it's not proper to say it's none of your business.

Amanda McKay, another -- actually Ashley Roulette's sister, also young, saw a facial bruise on Phoenix that Samantha explained away as an accident. She found the explanation very fishy, at paragraph 123, but she did not call.

And we have Alison Kakewash, McKay's niece, who visited the house in Fisher River some six to ten times. She saw Phoenix on a couple of occasions. She said that she knew that McKay was wicked and mean and was somewhat

afraid of him, but she didn't go there very often. She observed Phoenix being sent to her room for accidentally knocking over another child, she observed McKay grab her and shove her into the room. She heard him say, "Get into the room, you fucking bitch." Kakewash asked if they would let her out of the room, he said no, McKay said no. And she goes on to describe in the following paragraphs concerning behaviour. She did not call CFS because she was afraid of McKay and while that's understandable, that type of thinking has to change.

She came back later to the same house. She saw blood on the back landing. She saw Kematch on the computer, crying, McKay going up and down the stairs cleaning. When Kakewash asked about Phoenix, Samantha didn't answer. McKay says she was sent back to her dad's because she was being bad. And later she visited again and they were watching a TV show and McKay said to cover up the gravesite with pepper to cover the smell. She should have called. There may be reasons why she didn't but everyone has to be able to cooperate in this type of scenario. She didn't make the call.

We then have the evidence of SOR #5 and 6 and 7 and SOR #5 is one of Samantha's friends. She thought McKay was abusing both Samantha and Phoenix. She recalls Samantha locking the bedroom door as he left the apartment.

I think we can assume that Phoenix was behind that door. She had some discussions with Della Fines and there's some dispute about who told who what and that kind of thing but she claims she made a call. She didn't want to give her name and they, according to her, the call really wasn't accepted.

SOR #5 and #6 were friends and #7, who was the mother of one of them and a foster parent who worked for CFS finally made the call and spoke to Jackie Davidson. And while there may be different evidence with respect to that call, #7 was quite emphatic about the extent of her complaints. She indicated, she said that she was shocked that Phoenix could even be with Samantha.

SOR #6 had concerns about Phoenix being locked up and whimpering behind the door. One of these SORs was told to call back and at paragraph 136 at the top of page 37, SOR #7 testified,

> "I can't remember my exact words, but I indicated that it wasn't shocking that she might be hurting the child, what was shocking was that somebody had placed a child with her."

It wasn't shocking that she might have hurt the child. What was shocking was that somebody had placed a child with her, referring to Samantha.

We have the evidence of Lisa Marie Bruce, 17 years of age. She was in grade 12 at that time. She was living on her own and while she was young, she was certainly old enough to be living on her own. She called CFS because of the way Phoenix was being treated. She described McKay grabbing her roughly. She saw Samantha using crack. She spoke to her mother and she spoke to Amanda about these things. She noticed some bruising on a couple of occasions. And we have other members of the family who observed some things, particularly Jeremy Roulette, I've mentioned him before. He's the one who noticed the gash on her head and he felt that she was being coached just to how to explain it away, that she fell or something. That was his evidence. He went and told his mom, DOE #3 I think it was, the mother. He says he told her and there's evidence about other things that the mother was told eventually by the boys.

DOE #3 went to her son's therapist, Grant Wiebe, told him that she had made some calls to ICSF. Three's no record of these calls but he believed that she made the calls. The police indicated they were told many times that she had these calls, and there were others who made calls.

I know that Mr. McKinnon, in his brief, dealt in some length with all of these various calls and did his best to place some doubts as to whether some of them may have been made because they're aren't any records. All I can say is they can't all be lying, all these people who said they made calls all the time. The simplest explanation is that maybe they weren't recorded, maybe they were missed. Maybe someone didn't recall. When you consider that nobody made proper notes, that isn't surprising either.

Then we have a number of CRU workers who made a number of searches, Jennifer Strobbe, Deanna Shaw, Nicole Lussier, and others. They couldn't really explain why they made these searches. They just told us that their computer shows they made some searches.

Now I would imagine that a reasonable inference to draw is that they were making these searches because people were calling. Why would you suddenly decide to make a search for no apparent reason and do nothing further?

MR. COMMISSIONER: Well the, the records show they were identified in Phoenix's name, I believe.

MR. GINDIN: Yes, yes, there were searches conducted about Phoenix, yet they have no recollection of why they were making the searches or what they learnt about it. One of them remembered Stan Williams' name coming up and some other minor details, but I think the only

inference is that calls were being, were coming in, that's why they were making searches.

So it's clear, I submit, from the evidence that the image is not what it should be and that's a problem if people don't trust the system. Maybe that's one of the reasons they don't call when they see things. That trust has to be built up in some fashion. Rohan Stephenson, for example, he was very clear that he didn't respect the system and the rules and they may not have said as much as they should have but they just wanted to keep her safe, they just wanted to keep her out of CFS. And I mentioned earlier that Steve had attended some programs and done some things, so he wasn't avoiding being helped. He simply wanted as little as possible to do with CFS because of his own experience and that's why for everyone's sake this image and perception has to be dealt with in some way and I later suggest that it's through education and advertising, things of that nature.

Now I just want to deal with some of the higher ups in the system that testified and I'll be as brief as I can here as well. We heard from Jay Rodgers a number of times. He was the CEO of Winnipeg CFS and the CEO of the General Authority after that. We heard from Carol Bellringer who was the Auditor General of the Province of Manitoba since 2006. And very briefly, with respect to

Jay Rodgers, he testified February the 4th, 2013. He talked about how the morale was very low. He talked about accountability. He talked about the fact that notes should have been kept. Almost everybody agreed that notes should have been kept. At page 158 of that testimony, he says that if mistakes were made, holding staff accountable was important, that's part of accountability. He then told us that no one was disciplined, no one was let go. So I would question whether there really was accountability. Accountability, of course, means a number of different things. One is holding people accountable if they've made mistakes. And the other way of looking at accountability is how do you measure whether they have done all right or not, how do you measure outcomes and that's also an issue here because there's a lack of performance reviews and a lack of appropriate methods to measure that.

He came back and testified on May the 14th of 2003, of 2013, and talked about his time as the CEO of the General Authority. He talked about a number of changes that were made. It turns out that many of these changes are unique to the General Authority and he admitted that even if these changes were in place way back at the important times they wouldn't have helped Steve any because he wasn't, didn't choose the General Authority. He talked about this new user friendly manual at page 320 of his

evidence. You may recall it was very colourful and it put everything together in a reasonable way and he admitted that there was confusion about standards and policies for a long, long time, going back to before Phoenix was born. So I asked him, well why couldn't this have been done with this new user friendly manual way back? And he said I can't answer that question. There's a question that we should have an answer to. So even if was important it wasn't available till too late. He talked at page 330 of his evidence that little progress has been made with respect to performance appraisals.

We heard evidence from Carol Bellringer of lots of things that still were in progress and weren't really getting very far, such as foster home licences not being renewed for many years and how dangerous that could be and child abuse registry system being backdated and not up to date and how dangerous that would be. So I asked Mr. Rodgers about that. He said there's no issues with respect to that in the General Authority. According to him, everything was hunky dory for the General Authority. So he was asked of course, well all these things seem to be working so well with the General Authority, what about the rest of the agencies and authorities? Well, some of them have asked for some help, many have not.

So not only do we have a problem with information

sharing between the child welfare system and hospitals and EIA and other establishments, what about within the child welfare system? They're not even communicating within that system. Why should everything be so be well with General Authority, with all these changes and new user manual, no issues with licences being renewed and none of the problems that are still there according to Carol Bellringer in her testimony? What's wrong with sharing all this wealth with everyone and making sure they all have the same new wrinkles?

May the 16th he came back and testified and the question then was well why wouldn't these reports be shared right away with the workers who were involved in the case so they could see what they did wrong? We know that that wasn't done. And letters written back and forth about only certain people could see them. It was all kept very quiet for whatever reason and whatever those reasons are they have to be changed because those workers should know right away. Leskiw testified that he wished he knew right away, he'd like to learn from mistakes. Everyone must agree with that.

One of the reasons given by Mr. Rodgers was it wasn't shared because he wanted to be sensitive to the feelings of other workers. In other words, there might be some criticism and the word might get out about who screwed

up. Well I said to him, well surely they can handle that criticism and they can discuss it and explain and they can learn. And he said it might not be accurate and that's the problem. Well, so if it isn't accurate a worker can say that's not accurate. We've heard other counsel point out that maybe some of the evidence that these recommendations are based on might not have been entirely accurate. So that can be pointed out but that certainly isn't the reason to not share them right away. And we heard evidence about the fact that there wasn't even a meeting that took place when Phoenix Sinclair's death was announced. I would think that everybody involved in that case would be getting together the next day to review their notes, to review the files when their memory might have been fresher seven years ago. That didn't take place, it should have.

I asked Darlene MacDonald when she testified about why workers wouldn't be made aware of these reports. She said well if it was about me I'd want to know.

Carol Bellringer, in her testimony, talked about some progress that was made in a 2006 report that she shared with us. And then she had another report in 2012 where she indicated that there was still a lot of room for progress in other areas, particularly the foster home licences and child abuse registry and that kind of thing. And she said, which is a line that still resonates, if we

can keep track of every dime why can't we keep track of every child?

We heard from Ms. Brownlee and Karen McDonald, who went through the whole file with some of the changes that have been made since and told us how it would be dealt with today and clearly lots of changes. What it emphasizes is that what happened before was so wrong, clearly wrong. And, yes, with some of these new tools almost everything would have been done differently. The verdict is still out on these structured decision making tools. Some people like them, some aren't so sure. Some people think they're a little too structured but they're just tools. We've heard that from many people, they're just tools. Are they better than what we had before? Yes. But do you still need common sense to do your work? Absolutely. And do you still need professional sound judgments? Do you still need a commitment to the safety of children? You need that, whatever tools you are given.

So in conclusion, in terms of the factual scenario that you've heard and just before I move on to dealing with some of the recommendations, there are so many things that were not explained. I've mentioned many of them. It hasn't been explained why a new user friendly manual couldn't have been developed many years before, so maybe it would have made a difference. It wouldn't have

made a difference if you're not following common sense anyway. The lack of supervision is hard to understand. Disregarding the ambivalence towards a child is hard to understand. Workers who say that even if they knew about Wes McKay they're not so sure it would have changed anything, that's very hard to understand. No one being disciplined, no one being let go, it's hard to understand.

Performance reviews that happen every eight years is hard to understand. Notes being lost and letters being lost, parts of files being lost, notes deliberately shredded. No meetings taking place after the death is discovered, leaving out important parts of referrals so that workers who come out don't have all the information. EIA knowing all these things about Wes but yet CFS doesn't. Essentially you come down to a colossal absence of common sense, and closing a file in the circumstances in which it was closed in March of '05.

So there were so many people involved in this matter between social workers and supervisors and their supervisors and their supervisors, so many involved and so little done. Confusion about standards is not an excuse, it's a fact. It was so wrong that they were complaining about it regularly. No one listened. Money alone will not solve this issue. You can have all the money in the world, you have to have good judgment and common sense. Too many

instances of the bare minimum being done, just running out to check something out, not coming back again, not going back in the evenings or the weekends, not asking the right questions.

So the question that you have to answer, what did CFS do or not do? Well they did very little and they didn't do an awful lot. That's the simple answer.

We've heard a lot about best practice from academics and that clearly everyone agrees keeping proper notes, making proper notes and then keeping them, reading files, reviewing the history, calling the collaterals that are listed on the file when you can't make contact other ways, accepting all calls regardless of age or area, performance reviews, real supervision, don't close files if issues are unresolved, they all say that. Check out a new partner and finally of course, see the child when there's an allegation, not just the child, everybody in the family, ask the right questions, don't accept things at face value. Not all social workers made mistakes; I submit most did. Many did nothing, which is a mistake in itself.

So I want to move on now and I don't expect to be that much longer, just deal with the recommendations.

MR. COMMISSIONER: Well I think we'll carry on --

MR. GINDIN: Yes.

MR. COMMISSIONER: -- and let you finish,

Mr. Gindin.

MR. GINDIN: Thank you. Thank you, Mr. Commissioner.

Now this is a very difficult thing, dealing with exactly what to recommend and one of the reasons it's difficult is, for example, if you look at the evidence of Ms. Brownell who testified and she talked about all the different approaches that you could take when you're dealing with a child welfare system and you may recall at page 49, and I don't think this is mentioned in my brief, this particular reference, but she testified June the 5th, right near the end of this inquiry, 2013. And she talked about the different approaches, the downstream approach, the midstream approach and the upstream approach and it was very interesting, the analogy that she used in discussing exactly what we should do. So she talked about the downstream approach, if we're going to take a downstream approach you would build a hospital at the bottom of the cliff. When everybody falls over you've got a hospital there to take care of the casualties. That's the downstream approach. That's not the approach I'm suggesting.

Midstream approach might be to put a sign along the way saying watch out, there's a sharp bend coming around the cliff, there's some problems that you might

encounter. Maybe a few people won't go off the cliff. That's another approach.

The upstream approach, why not build a better road, why not put a big fence so people don't go off the cliff? And so it appears as though something more dynamic needs to be done rather than just putting up a few signs or making a few things better and that makes it difficult, a very difficult test.

Dr. Trocmé testified on May the 28th of 2013 and at page 217 he says the following:

> "... for reasons that I fail to fully understand, we, we don't hesitate to cut these types of services in half and think, well, a bit of it is better than none. And there's actually no evidence that a bit of it is better than none. It very well may be that a bit of it is worse than none, as is the case with antibiotics."

And he gave that example of antibiotics and not giving the proper dose. That make it difficult too because it may well be that some of the things that we're doing in a

haphazard fashion are not the answer and maybe they're making it worse.

And his evidence is very important, I submit, in terms of some of the things he talks about in his evidence. He talks about, for example, at page 207, special training for working with high risk families. Before that, at page 202, he talked about when you talk about the safety of children you shouldn't just talk about whether they have a bruise, it should include their wellbeing which is a much more complex thing to deal with and doesn't just come up when you decide whether to apprehend or not. He spoke about a few programs that I've recommended in my brief that you should look at. He talks about them at pages 215 to 218, the nurse family partnership program, where nurses become involved before the child is born and they focus in on the health of the baby as opposed to what mother did wrong and he talks about that program. And he talks about the Early Start program at page 219 in New Zealand which is very specialized and intensive and sustained for periods of time. That comes up at page 219 to 220. So these are very important things that need to be looked at. He talks about the idea of trying to return children, who have been apprehended, too quickly as if that's the impetus when really the issue should be are the parents ready and have they made the improvements they need and are all the issues

resolved before that is done. That should be more of an emphasis.

So he brings up some interesting observations and why it is so difficult to come with the right recommendations. He talks about how the people who need help the most often don't get it. The people who are organized enough to make appointments and seek help sometimes don't need it as much as the others. So maybe a new philosophy entirely is required.

Mr. Santos and Sanderson, who testified in a very compelling way, just tried to make the point very strongly that prevention is paramount, you get more bang for the buck when you worry about prevention. And their testimony is, I submit, excellent and I would urge you just simply to look particularly at pages 150 --

MR. COMMISSIONER: That's whose evidence you're talking about now?

MR. GINDIN: Santos.

MR. COMMISSIONER: Yes, okay.

MR. GINDIN: And Sanderson --

MR. COMMISSIONER: Yes.

MR. GINDIN: -- who testified together. And Mr. Santos, his evidence at page 150 to 152 is very compelling. It talks about all of the important issues and focuses on prevention.

I'm going to review very quickly some of the recommendations that I've put into my brief. I'm certainly not going to read them all out.

I'm not going to repeat all the recommendations that were made by the various report writers. Those recommendations are excellent. Some of them have been put in place already and I'm sure other counsel may deal with those, but the first thing I talk about is that consideration be given to a new philosophy, where there's some separation between the people who apprehend the child and those are the ones of course who aren't trusted and who are feared and who people are resistant to and that they shouldn't be the same group but then recommends other treatments and programs because it may be lost to the people who are dealing with them. So that's a very complicated issue and whether there's some way that maybe these should be separated and a lot of people talked about that, Dr. Trocmé talked about it and a reference is made in my brief here, Alexandra Wright talked about it and that reference is also included. They talked about the advantages of trying to separate the system and the problems with the same people doing both of those jobs, because the trust just isn't there.

After that particular point, which is I think may be made by others as well -- there was a word left out and

just for the record I corrected it, it should have said the word image there because we're dealing --

MR. COMMISSIONER: Where's that left out?

MR. GINDIN: In front of number 2 in terms of a heading.

MR. COMMISSIONER: Oh yes.

MR. GINDIN: We talk about how we have to improve this image and the perception through education, knowledge and advertising and that safety of children is a responsibility of all members of society. People should know they can call anonymously, they can call if they're under 18, they could call and they should call.

Next I deal with a number of issues relating to the openings and closings of files and we've heard a lot of evidence about files being opened and closed and I suggest that files be open in the name of the child as opposed to the parent or caregiver. We've seen files being closed in one person's name and then being opened in another one and then back to the other one and then back to the other one when it's Phoenix that we're concerned with. Maybe there should be a file in the name of the child.

MR. COMMISSIONER: Yeah, I'd be interested to hear whether others comment on that. I'd be interested to hear what is thought universally about the group.

MR. GINDIN: As would I, as would I. It seems

like a lot of energy was put into closing files and opening them and transferring documents to the next one and it just seems to me that if you have a file in the name of the child and that file follows the child, that's a consideration.

A file should never be closed when unresolved issues remain. And even after a child is deemed safe it should remain open for a certain period of time, I suggest three months perhaps, so that it doesn't just end without monitoring suddenly. I even suggest that perhaps in open files there should be an automatic medical checkup at some intervals.

I won't repeat the various recommendations that I make with respect to notes. Koster makes a lot of recommendations with respect to notes, but essentially what we're arguing there is that everything should be recorded.

Number 8 talks about Dictaphones being made available. A lot of people said that they didn't have time to make notes, they had to make them later, they had to try and remember what was being said. So number 8 suggests maybe a little bit of technology might help, maybe there should be Dictaphones so that while you're waiting in front of a house for the police to arrive you can dictate a few notes. It seems reasonable to me. There was problems with connecting from rural spots, maybe there should be iPads

available for some of the workers in these remote areas so they can communicate and be connected. So it should be clear what has to be recorded, what needs to be recorded, where they should be kept, how they should be preserved.

Page 43 talk about hiring, that social workers should be screened to make sure that they have enough time to fulfill all their commitments if there are any other distractions this is obviously designed to, with respect to the Delores Chief-Abigosis matter in particular. I suggest at number 12 that maybe there should be a court worker who attends all of these court appearances because I can tell you from appearing in court a lot, you don't just walk in and get into court. There's many hours spent waiting and is it really necessary especially when you look at these things very little information is given and probably anybody could give it from a file. So maybe there should be a worker who attends to these things so that the other workers can go out and see the family and make more contacts. So that's a possibility, something to look at.

Training and accountability is the next heading and I've mentioned this before. Social workers should have regular performance reviews. You heard about supervisors who received training after a year on the job. Why shouldn't they receive supervision training before they begin? I suggest the University of Manitoba should have

more clinical courses with an emphasis on front line social work, that there be random file audits and regular random file audits. We've heard about this registration process that hasn't been proclaimed yet. I suggest the moment it's proclaimed it proceed into action immediately. There has to be a governing body. Social workers need to be registered. There has to be a way of complaining. All of the things that apply in almost every other profession. It should have been in there long ago.

MR. COMMISSIONER: It seems to me there was a witness who gave evidence that there was an implementation committee at work and they were to report on June 30th, I think.

MR. GINDIN: Yes.

MR. COMMISSIONER: So I don't know --

MR. GINDIN: I don't think we heard about the latest on that.

MR. COMMISSIONER: No.

MR. GINDIN: We know that the law was to be proclaimed for sure soon and I know that you were very concerned that that should have been maybe proclaimed even earlier and it seems to make --

MR. COMMISSIONER: But some reasons came up with respect to disciplining matters and that kind of thing, it had to be resolved.

MR. GINDIN: And there were issues about how to define a social worker.

MR. COMMISSIONER: Yes.

MR. GINDIN: And who should be included and what about people who had worked for a long time and maybe didn't have a degree. So there some issues that had to be --

MR. COMMISSIONER: Yeah.

MR. GINDIN: -- ironed out. That's an important process.

MR. COMMISSIONER: Yeah.

MR. GINDIN: I talk about, in my recommendations under supervision, some system where there's regular contact and supervisors should be reviewing the level of contact on a regular basis, once a month. Six months shouldn't go by, 10 months shouldn't go by without contact.

Number 19 talks about family support workers should report directly to the family services workers that contacted them rather than going through a separate office and supervisor and that pertains particularly to Marie Belanger and I think it was Delores Chief-Abigosis, or for some reason it was suddenly stopped and the report didn't come through to her but went somewhere else.

There's a number of discussions about social workers. One of my recommendations, number 20, is that

regular drug testing should be implemented in all cases of suspected substance abuse. Now how can you leave the safety of a child to someone who may be involved and rely completely on the fact that they say no, I'm okay? I don't know, that may be complicated legally but --

MR. COMMISSIONER: Drug testing of whom?

MR. GINDIN: Of the mother.

MR. COMMISSIONER: Okay.

MR. GINDIN: Let's say, for example, in this case.

MR. COMMISSIONER: Okay, all right. Yeah, I didn't -- that following the heading of social workers, I didn't know whether you were talking about social workers.

MR. GINDIN: Yes. Pardon me. Well this is something they would have to implement.

MR. COMMISSIONER: Yeah.

MR. GINDIN: And especially here we have something about smoking crack in front of the child and just to go there and say so did you smoke crack in front of the child? No. And that's all there is to it? There has to be more.

Number 22, I say if you attempt to contact the family on a couple of occasions you don't have success, then you've got to find a way to have success. Then you move on to the evenings or the weekends and if that doesn't

work you move on to the collaterals. There has to be a set format. You don't just try a couple of times and then forget about it. There has to be something changed with direct policies about what you have to do when you can't make contact initially.

I talk about the child abuse registry being updated, that there be a way of checking criminal records quickly, foster home registry, the licences shouldn't be lagging behind five years. That can be an extremely dangerous situation. A couple of years go by and someone might have a criminal record. They might even be on the child abuse registry list, but no one has checked them out.

I talk about parental capacity assessments. They should be mandatory when you have cognitive issues, things like ambivalence and flat emotional effect, that should be ordered automatically when you have those kinds of issues. There should be special training to identify those issues and deal with them.

I talk about the fact that there was too many social workers switching. Sometimes when you do actually build up a little trust, you find out that someone else is now on the file. It seems to me that that shouldn’t happen unless it's no other choice and if it does happen, shouldn't the old social worker talk with the new social worker and the family to explain that here's the new person

and let's talk about this transition. That doesn't seem to be happening.

I mention father specific programming. Here we have Steve Sinclair, a single father, at one point had two children under 14 months old by himself at the age of 19, having himself been a ward of CFS. There's all sorts of programs out there but several witnesses agree that there could be more programs for single fathers.

An old theme of CFSIS being updated. I won't go through with that.

Information sharing is obviously a major issue and that should be dealt with clearly. Obviously every child must be seen and every member of the family of that child must be seen when there's any allegation. New partners need to be checked out fully. That apparently is the situation now. We have to make sure that that's clear. And even with these new structured decision making tools, there still is room for common sense, flexibility and discretion and hopefully that will be used.

I mention best practices at page 47 and I've mentioned most of these points already but before a social workers attends the family home maybe they should have to read and initial the history to show that they've actually read it. One child should never be viewed as a proxy for the wellbeing other children. I think that's probably the

case now. Then I mention a number of the new programs I've already mentioned that Dr. Trocmé had referred to.

And then I conclude with a number of suggestions such as developing a joint committee, number 42, to review all other Canadian jurisdictions child welfare training programs and initiatives on a regular basis. We should always know what's going on in another province. We've heard some evidence that BC has better training or there's other issues, Saskatchewan had a program of some kind and it seems to me that we should all be aware of what's new everywhere in Canada, and not just in Canada, anywhere.

At the bottom of that page, and I won't repeat all of these recommendations, they're all there, but I say that each and every child in care be credited some additional period of extended care upon their aging out of the CFS system for each year they spent in care. And we've heard a lot of evidence about how when a certain child who was in care ages out and the problems that they can have and there has to be some, something to address that.

And finally, at number 47, of course I ask you to consider all the recommendations in that brief. I don't intend to read through all of them, they're all there, but the last one says that there should be a clear acknowledgment by the Manitoba Government that the overrepresentation of aboriginal people in the child

welfare system requires a concerted effort to increase funding and develop programs to deal with poverty, poor housing and substance abuse in all communities across Canada, and I think that's one of the recommendations that everybody is making essentially, that we really have to address this issue. And Ms. Walsh took great pains to present evidence to you as to why that is such an important issue and not an easy thing to figure out but it has to be acknowledged.

Now before I conclude my submission, I would like to first of all thank you, Mr. Commissioner, for the patience and wisdom you've shown throughout this inquiry. I'd like to thank commission counsel and our whole staff for the professional approach and the way in which they've conducted themselves throughout and I'd like to thank the administrative staff, without whom I don't think we would have been able to complete this as smoothly as we did. I know you have a difficult task ahead of you and I wish you well. Thank you.

MR. COMMISSIONER: Thank you, Mr. Gindin, I appreciate your contribution you've made here. There's many questions you've addressed today, there's two sides to them. Somehow I've got to find the answer. But I'm thankful that someone came to put that side in front of me and I'm sure when we reconvene after lunch we'll start to

hear other points of view on the other side and perspectives and that equally will be helpful to me.

MR. GINDIN: Thank you.

MR. COMMISSIONER: All right. It's, I guess we can adjourn till two o'clock now, Ms. Walsh?

MS. WALSH: That sounds right, Mr. Commissioner. Thank you.

MR. COMMISSIONER: We'll rise till two o'clock.

(LUNCHEON RECESS)

MR. COMMISSIONER: Are we going to use the screen this afternoon?

MR. RAY: I'm sorry, Mr. Commissioner?

MR. COMMISSIONER: Are we going to use the screen this afternoon?

MR. RAY: Not by my account, Mr. Commissioner.

MR. COMMISSIONER: Oh, somehow it's placed differently but where was it this morning?

MS. WALSH: I think staff moved it because it was in the way of the camera.

MR. COMMISSIONER: Oh, okay, okay. Well I'll move over then because I wish to be able to see counsel.

MS. WALSH: Do you want it moved again?

MR. COMMISSIONER: No, that's all right. I'll

move over this way and that's -- I knew it was something different.

MS. WALSH: We can always change it again.

MR. COMMISSIONER: Yeah. No, no, that's fine.

All right, Mr. Ray, please.

MR. RAY: Yes, Mr. Commissioner, good afternoon. Thank you. It's Trevor Ray for the monitor, representing the Manitoba Government Employees Union and a number of social workers that participated in this inquiry.

Mr. Commissioner, I'm not going to be long. Although I've been gratuitously allotted six hours, you'll be pleased to know that I'm not going to use more than about an hour and a half of that. We have provided you, obviously, with a very detailed written submission. With some minor exceptions I intend to limit my submissions to some key themes this afternoon.

Just one housekeeping matter, Mr. Commissioner, you will have recalled that in approximately June you issued notices of alleged misconduct to a number of individuals, many of which participated in the inquiry. We provided you with our written position as it relates to those and I'm assuming you've had an opportunity to read that.

MR. COMMISSIONER: I have.

MR. RAY: That should be read obviously in

conjunction with the submission that I intend to provide to you this afternoon as well as our written submission.

MR. COMMISSIONER: Yes. And that is -- there are those responses and then there's, there is some content in here that overlaps. I think that's --

MR. RAY: That's, that's correct.

MR. COMMISSIONER: Yes.

MR. RAY: And I think you received --

MR. COMMISSIONER: But I -- yeah, I can assure you that as I work through this and with the assistance of commission counsel, all will be taken into consideration.

MR. RAY: And I'm certain that that would have been the case. I just was confirming that you had the opportunity to receive that.

MR. COMMISSIONER: Yes.

MR. RAY: We've obviously provided you with a very detailed written submission, Mr. Commissioner. It's certainly much lengthier than most parties. Although had I maximized my 40 pages per party that we represent, I think you would have got something in the neighbourhood of about 800 pages. So with just over 200 I think we did a fairly concise job.

MR. COMMISSIONER: I'm appreciative of what you provided me.

MR. RAY: Our written submission,

Mr. Commissioner, is really two parts. The first deals with the child welfare system and the second deals with the services that were provided to Phoenix Sinclair during the time her file was open. Today I intend to deal almost exclusively with the first of those two issues and I will just have a few comments as it relate to the second, second issue.

That said, Mr. Commissioner, we have heard and reviewed a mountain of evidence here about the child welfare system and the families that are served by the system and while I have no doubt there are many success stories, the picture that was painted was a very sad one and I suppose to some degree that's to be expected. The circumstances that bring a child into care are, and under the watch of the child welfare system, are typically tragic in themselves. Even in situations where a child is kept safe by apprehension, we still have a tragedy in having to remove them from their own families and social workers in that respect, Mr. Commissioner, have a very difficult job. They operate under a legislative scheme that has conflicting objectives and the first is to protect children and the second is to do that but to keep families together and achieving those two conflicting objectives isn't easy. It requires a great amount of skill and experience, but more importantly, achievement of these goals requires

resources, it requires ongoing training, supervision and manageable caseloads. And even when resourced properly, the factors that lie well beyond the control of social workers and leaders of child welfare services will often interfere with achieving good outcomes for families.

I don't envy you, Mr. Commissioner. You have a very difficult task ahead of you in solving some of these problems.

MR. COMMISSIONER: Well, I can tell you, Mr. Ray, I certainly appreciate and agree with you that the social work profession is a very difficult assignment and it's the kind of crises and problems that face those dedicated workers day in, day out. I quite understand.

MR. RAY: And I'm sure the social workers would be appreciative of your comments. Thank you.

Let's talk about history for a minute, Mr. Commissioner. History can repeat itself if we're not careful and I don't think that the child welfare system in Manitoba can afford that. Multiple factors operate to impact the ability of social workers to do their jobs effectively. And by now you'll be well aware of the various socio-systemic issues that have been reviewed before you in varying degrees of evidence in phases two and phases three, but to highlight it, and I don't think any of this is a secret, we've seen stories of poverty, housing

problems, substance abuse, domestic violence, mental health issues, cyclical involvement with child welfare within families and essentially third world conditions that exist on First Nation reserves and these are all issues that for decades have impacted the child welfare system. Those factors make the jobs of social workers even more difficult than they already are, and the reason I'm raising those issues is these are not problems that are going to go away overnight, not in this province and not on a national basis, so what that means is that whatever resources we would hope to put into a system that operates with perfection and without these systemic factors, needs to be greatly enhanced. And the sad reality is that until very recently the system has not done an adequate job of resourcing itself in light of those various factors. Child welfare services are often provided in a far from perfect world and it's fundamental that social workers are given necessary tools and resources to do their jobs.

And you've heard evidence at this inquiry and it's been evidence that's been established essentially without any contention, Mr. Commissioner, that since at least the mid-1990's social workers and the MGEU have identified very serious problems with the child welfare system. Social workers by telling their union that they had far too many cases and that this impacted services to

families and to address those concerns the union tried to negotiate with the department to ensure caseloads and workloads for social workers were reasonable and they did that for two primary purposes. Firstly, to ensure fair working conditions for their members and for social workers. And secondly, and more fundamentally, to improve services to families and to better protect Manitoba children. And you've heard the evidence of Janet Kehler, Mr. Commissioner, and you heard ultimately that the department would not agree to establish reasonable workloads for social workers. And these negotiations started in the mid-1990s and the MGEU continued in their attempts for close to five years and that continued right until the point in time essentially that Phoenix was born and became under the watch of the system. And from 2000 to 2006, the MGEU and social workers continued to identify concerns for the entire period that Phoenix's file was open.

It's critical to note that the opinions of social workers and the MGEU are not theirs alone. Senior representatives of the department acknowledge the problem. They did so in their evidence before you. They know and they knew how those problems can impact services to families. They knew provincial standards were not being met and they knew why they were not being met. And put

simply, Mr. Commissioner, social workers were commonly carrying caseloads that greatly exceeded the levels recommended by professional organizations. They exceeded caseloads that are endorsed by academics and experts who testified at this inquiry.

And studies were conducted to identify common themes that were causing social workers difficulty in providing services to families and the results identified serious problems. They identified high workloads, they identified high caseloads, significant lack of training, inability to meet provincial standards and best practice, inability to provide or receive adequate supervision and the department, through dubbed Winnipeg CFS as it was then, acknowledged all of these problems identified by social workers and the union. And quite frankly there were no surprises in the results of these reports. These were not tightly held secrets and effectively most of the problems relate to the need for adequate resources and ultimately this comes down to money and government didn't have any and the problems continued.

High workload, high caseloads, lack of supervision, lack of training are all conditions that existed throughout the entire period that Phoenix's file was open to the system. And social workers and the MGEU continued to seek improvement but nothing changed. So they

began to write to various ministers of government in charge of Child and Family Services and ultimately the result was the same and there was no significant improvement for families and children.

We've heard, Mr. Commissioner, testimony at this inquiry from academics who are experts in child welfare and what we've heard from them really comes as no surprise. What we heard was that child welfare services, in particular the ability to provide services in accordance with best practice and provincial standards, are greatly impeded by the types of problems that everyone agrees were present for the entire period that Phoenix's file was open to the system.

MR. COMMISSIONER: I just missed a word, you said were greatly what?

MR. RAY: Impeded.

MR. COMMISSIONER: Impeded, right.

MR. RAY: And this isn't new groundbreaking research, Mr. Commissioner. Dr. Wright's papers on best practice referenced many resources in there that were entered as exhibits at the inquiry and they're not new, they are well founded, they're well established, they're conditions and they're factors that everyone has known have existed for a long time.

Ms. Wright, Dr. Wright pointed out that many

child death reviews have been conducted in Manitoba and throughout the world and the common findings in many of those reviews cite lack of resources as playing a major role and Manitoba has had multiple child death inquiries, or excuse me, inquests. You have reference to those in the Commission disclosure material and I don't propose to go into them in any detail, but at Commission disclosure 615 and this is simply for your notes, Mr. Commissioner, it's not necessary to bring it up on the screen.

MR. COMMISSIONER: Have you got a page number per chance?

MR. RAY: I do, yes.

MR. COMMISSIONER: That's, that's what I go by rather than disclosure numbers.

MR. RAY: Certainly. It's an executive summary that's provided to the Strengthen the Commitment report.

MR. COMMISSIONER: Oh yes.

MR. RAY: And it commences approximately page 16287 and continues from there.

MR. COMMISSIONER: And that's the, the report's called Commitment to Children?

MR. RAY: Strengthen the Commitment.

MR. COMMISSIONER: Yes, it's one of those identified in the order of council?

MR. RAY: Correct.

MR. COMMISSIONER: Yeah. And what it makes note of and it's simply noting it, I suppose, in reference to the fact of inquests were conducted and made certain findings and certain recommendations came out of those and those inquests were conducted from the years 1975 to 2003 and they identified many of the same problems that were identified in the section 4 report conducted by Mr. Andy Koster and the section 10 report conducted by Ms. Christianson-Wood and which are before as evidence and they identified the same themes and the same problems and that those problems impact delivery of services to children and families.

We can say with almost 100 percent certainty that Phoenix's file suffered the same fate as many files open to the system and that is that her file was often a file that presented as one without confirmed abuse or serious neglect in terms of the allegations. So what --

MR. COMMISSIONER: You say there was no confirmed abuse?

MR. RAY: Or serious neglect in terms of the allegations. And there are points in time that I'll admit that there are points in time where that was not the case and I'll address those. But for a very long time it received relatively low priority and a low risk assessment from social workers and in that respect it received less

attention among many files that workers had which they felt would have had obvious or imminent child protection concerns in which they had to prioritize and address. And, Mr. Commissioner, that quite frankly, is one of the saddest realities for this system, because what it effectively means is that social workers are reduced to doing what Dr. Alexandra Wright described as defensive social work and what that means is that all they can really do is focus on protection services and not prevention services. And if that's the fate of the system, Mr. Commissioner, then we're not going to be successful in achieving good outcomes for families. We will be reduced, and when I say we I mean the system generally, will be reduced to a policing agency that has no time to work with families and can do nothing but effectively apprehend children who are at obvious risk. The numbers of children in care will continue to grow, social workers caseloads will continue to grow as a result and we will never catch up to what is becoming an unmanageable problem.

MR. COMMISSIONER: Well do you acknowledge that what has been called the new funding agreement has made some difference?

MR. RAY: I think it's better than what we had. I think everyone acknowledges that, but I think that it's also very clear from the evidence, including in particular

I refer to the evidence of senior representatives in the department, Mr. Rodgers, Ms. Stoker, Ms. Brownlee, all of whom said despite the fact that we have more money now than we did before we still have workload and caseloads that are too high for social workers and we still have situations where social workers cannot meet provincial standards and that's concerning for a number of reasons which I'll get into but primarily I think that speaks volumes about what the system must have been like before we injected 330 million dollars additional money, to address these problems. I can't imagine what workloads and caseloads and training must have been like before we more than doubled the budget.

So what's the solution? How do we avoid this problem that I've described for you? Ultimately, I suppose speaking from the obligations and abilities of the system, the solution has to lie in manageable caseloads for social workers and I'm sorry if this sounds over simplistic and I'm sorry if this sounds like the MGEU and social workers saying we told you so because it's not intended to be that, but everything we heard in phases one and two of this inquiry support that conclusion and I'm going to break it down to you, Mr. Commissioner, as it relates to the two primary services that child welfare provides and that's firstly protection services and secondly prevention

services. Phoenix's file received those two types of different streams.

And from a protection aspect, social workers need the time to conduct adequate assessments to make sure they are reaching correct conclusions about the safety of children and potential risk and that means they need the time to review extensive CFSIS file histories, paper file histories, perhaps sealed child-in-care files which you heard some information about early in phase one. They need to be able to meet face to face with families and they need to see every child in a home and conduct an assessment of every child in a home. And they need to thoroughly review all of the various socio-systemic factors that may be present in a family's life such as substance abuse and domestic violence issues and mental illness and these aren't simple issues to diagnose or address, it takes time. And we know today that by 2005 by the time that Phoenix's file had been in the system for approximately five years, that her file and simply the openings and closings that had accumulated within that file, not even taking into account her own child-in-care file or Steve's child-in-care file or Ms. Kematch's child-in-care file. We're talking about hundreds of pages that social workers, in a protection situation, so when a file comes in to CRU or to after-hours, they have to, in a perfect world to provide perfect

services, have a chance to review all of that information to diagnose it and digest it and evaluate it if we're going to give proper protection services to children and families.

And what you heard from Ms. Faria in her evidence when I cross-examined her, was that on average within the CRU a worker has an about an hour to deal with, investigate and dispose of a case. And it's --

MR. COMMISSIONER: An hour to do what?

MR. RAY: To receive a file and to do all those things that I just described for you which would be to review the CFSIS history and paper file and any other historic information that they need in order to conduct a good and thorough assessment --

MR. COMMISSIONER: Prior to going out to see the file.

MR. RAY: Prior to even, prior to even going out to see a child, unless there's, of course, an imminent and obvious reason.

MR. COMMISSIONER: Which will take more time.

MR. RAY: Of course. And social workers had, at the time that this file was open to CRU, roughly an hour to do all that and that's just not possible. And Mr. Berg, in his evidence, confirmed that's not possible for social workers in the system, in the intake system particularly to

handle that in advance of going out on a case.

MR. COMMISSIONER: Getting a handle on the background?

MR. RAY: Correct. And of course all that background information informs us about how we need to respond. So unless there is something done to address the volume of work that social workers have to do in order to do their -- or review in order to do their job competently, we're not going to see much of a difference in terms of protection type services.

The result for Phoenix's file, Mr. Commissioner, and the sad result was that what happened in many situations is the risk was underestimated and people reached wrong conclusions about what they should do with the file and whether it should be open to intake or whether it should be closed or whether it should be passed on to family services. And the bottom line is that protection services can't occur if social workers don't have adequate time to conduct thorough assessments. All of the training and all of the tools in the world won't matter if people don't have time to put them to use.

Second of all, Mr. Commissioner, from a prevention aspect and the types of prevention services that we provide and obviously those are types of services that are typically provided by what's been referred to as the

family services worker, those are the social workers that are supposed to provide long-term care for a family. Examples of social workers in this situation would be Ms. Greeley, Ms. Delores Chief-Abigosis.

We know prevention services are provided with the goal of providing long-term services to families, but we also know, and we've heard and Mr. Gindin has submitted, that for those types of long-term services to be effective, social workers need to develop a relationship with the families they're servicing. They need to gain trust with those families and they need to build relationships. And for me at least, what it comes down to is that clients in the system need to be able to trust their workers. They need to understand why their social worker is telling them you need to take a parenting course or you need to take AFM, addiction foundation counseling, or you need to take anger management and they need to accept what their social worker is telling them and believe them and address the concerns that the social worker is identifying for them. And that's not going to happen unless there is a trust relationship between the social worker and the client and if that doesn't exist then the clients are not going to get the help they need to help themselves.

One of the -- I'm laughing at myself because one of them, I'm about to say one of the most memorable

witnesses that I recall from this inquiry was an SOR that testified in phase one and she was a friend of Samantha Kematch's and she had met Kematch --

MR. COMMISSIONER: What number was she, four?

MR. RAY: And that's why I'm laughing at myself because as memorable as it was, I was unable to find which SOR it was.

MR. COMMISSIONER: It's all right.

MR. RAY: I can try to find that and --

MR. COMMISSIONER: I can -- when I hear your comments I'll be able to figure that out.

MR. RAY: Sure. She was a friend of Samantha Kematch's and she had met Ms. Kematch in a home for young single mothers.

MR. COMMISSIONER: Yes, I know who you're talking about.

MR. RAY: And in many respects she was facing the same type of similar predicable fate that Ms. Kematch and perhaps her children were facing. But she succeeded against the odds and that question was asked of her, how did you manage to succeed? And her answer was I had a great social worker that I trusted and that I connected with. And obviously there's no doubt there are other factors that allowed her to succeed and which caused Ms. Kematch to fail, but for prevention services to be

successful, social workers need the time to make that type of connection with their clients and that's something that really should come as no surprise to any of us. That's what social workers and the MGEU have been telling members of the department for approximately over a decade.

And maybe the jaded observers who are ignorant to the roles played by unions just think that our position is about less work for lazy workers. And that jaded review or that jaded view is impossible to advance when the union's position and the social worker's position is supported by experts in child welfare and those of us, and those who are running the system at a very high level. And ultimately, Mr. Commissioner, what it comes down to is resources and that comes down to money and hundreds of recommendations were made suggesting improvements to the system and to the credit of the department and other authorities those recommendations have been accepted and they've been implemented and as a result the budget, the entire budget for the system has gone from roughly 215 million dollars, that's when Phoenix's file was open, to roughly 547 million dollars now and that's an increase of 332 million dollars to address systemic problems. And those numbers alone tell you all you need to know, Mr. Commissioner, about the status of child welfare when services were being provided to Phoenix and roughly hundreds and thousands of other

families in 2000.

And as I've said, notwithstanding that amount of money we've heard that more social workers are still needed and we didn't just hear that from social workers. We heard that from Jay Rodgers, we heard that from Alana Brownlee, we heard that from Sandi Stoker and these are some of the most senior people in the system who are directly responsible for providing child welfare services.

And the goals of the new funding model are admirable. Caseloads of 20 for prevention workers and caseloads of 25 for protection workers, provided those caseload goals will be achieved, will go a long way to moving in the right direction. But what we also heard is that because of the way the funding model is set up that agencies have to provide other important services using that caseload funding money.

MR. COMMISSIONER: What did you say, 20 to one for protection?

MR. RAY: Yes. For every 20 prevention files you get one social worker. For every 25 protection files, you get one social worker.

MR. COMMISSIONER: Yes.

MR. RAY: So what that equates to is you should have a social workers who does prevention services should be handling 20 files ideally.

MR. COMMISSIONER: Which did you say is the 20 to one?

MR. RAY: Prevention, prevention services.

MR. COMMISSIONER: Yes.

MR. RAY: Which is the long-term types of services.

MR. COMMISSIONER: Yeah, which should be providing more service --

MR. RAY: Correct.

MR. COMMISSIONER: -- than under the protection side.

MR. RAY: Correct. And that is where the prevention services are of a stream where you see, you need the deeper connection with, with -- and relationships between social workers and clients and that in fact, that really was detailed very greatly in Dr. Wright's paper and in her testimony and she really emphasized that that is what's critical to providing good social work and that's what's critical for good outcomes and for reducing the numbers of children in care in the system, because those are services that hopefully will keep children from becoming apprehended.

MR. COMMISSIONER: That's why the emphasis is there.

MR. RAY: Correct. And that's why, my

understanding is that's why those social workers have lower caseloads or ideally have lower caseloads.

MR. COMMISSIONER: Yeah.

MR. RAY: And what I was saying, Mr. Commissioner, is sadly what we also heard is that other agencies and the agencies that are funded at those ratios are having to take dollars that are intended for those cases and spreading them out to cover other services. And the result is that workers are not truly carrying those caseloads that are desired by the model and that's precisely what we heard from Mr. Rodgers.

And Mr. Rodgers, as you know, is the leader of the General Authority. He's one of the major or head of one of the major employers in the system and he's asking you in their submission, their written submission, to recommend a truly case sensitive ratio of one to 20 cases and he's asking you to do that for all types of services, regardless of whether those are prevention or protection, and to ensure that caseloads aren't just a concept but are a reality.

And the other thing that struck me about the General Authority's submission and Mr. Rodgers' testimony was that they supported the MGEU's position which was we need to know with greater certainty whether the provincial standards as written can be met with the current funding

and the current caseloads that are contemplated. As you know, the standards set out what social workers were expected to do, yet inexplicably we don't know what caseloads should be in order to meet those provincial standards and in order to provide services to families and children in the way that we want to. And the standards as drafted today are not evidence based. We do not know whether they take, whether they can be met by a social worker carrying 15 cases or 40 cases and that review needs to be undertaken. The MGEU is encouraging you to do that and other parties are encouraging you to do that or recommend that. And until we know the answer to the question of what is an appropriate caseload, we will never know with any reason whether social workers are capable of delivering best practice service and what's going to happen is we're going to end up repeating history, Mr. Commissioner. Social work --

MR. COMMISSIONER: Unless ...

MR. RAY: Unless and until we know what types of caseloads are needed in order to meet provincial standards, because until we know that we're going to repeat history because social workers will continue to try and do their best and that will end up with them prioritizing files based on rudimentary assessments of safety rather than thorough assessments of a risk. And cases like Phoenix's

presented will often be at risk at falling through the cracks of the system.

And, Mr. Commissioner, that, in a nutshell, summarizes the MGEU's position and what I'm going to discuss are suggested recommendations but I'll do that afterward.

I'm going to move and I'm going to discuss the submissions of some of the other parties and I'm also going to address just some comments that were raised by my learned friend, Mr. Gindin. But I want to start by noting something that I think is very telling. Phoenix was apprehended twice during her life. The first time was at birth and the second time was in 2003. Now the first apprehension was effectively carried out by Marnie Saunderson. She was the very first social worker you heard from back in September. Was it September?

MR. COMMISSIONER: Yes, I think so.

MR. RAY: It was another social worker that had actually placed Phoenix under apprehension at the hospital after she was born but it was Ms. Saunderson that gave evidence in response to a question by Mr. Olson and the question was: How was it you were able to do such a good job on the file? And her answer was effectively that apprehension was really a no-brainer at that point in time and what she further elaborated on is she said but the rest

of my files likely sat without attention while I dealt with this file.

And when she said it was, apprehension at that point was really a no-brainer, it's obvious at the time she was dealing with two young parents both themselves permanent wards, Ms. Kematch had a previous child apprehended. But fundamentally beyond those historical factors, we had a situation where both Steve and Ms. Kematch were telling the hospital staff, look, we're not ready for this, we're not ready to be parents and so the hospital staff called CFS, social workers took immediate steps to ensure Phoenix's safety, they placed her under apprehension and they did that before the parents and Phoenix were discharged from the hospital. So we had a situation where risk was obvious, safety was obvious, social workers responded and other files sat.

In 2003, that was the second time Phoenix was apprehended and that's when Ms. Laura Forrest was involved. Mr. Gindin, in his submission, had described Ms. Forrest's involvement as one of the high water marks of child service delivery on this file and I certainly agree with him, and let's review what happened in that situation. Phoenix had her immediate safety placed at risk. Mr. Sinclair was caring for her at that point in time. A source of referral called CFS, which, by the way, was something that did not

otherwise occur for many instances on this file. Sources of referrals reported there was a drinking party in progress that effectively there was no sober adult to take care of Phoenix. CFS went out, they investigated. Ultimately Mr. Sinclair failed to take appropriate steps to responsibly care for Phoenix. No other appropriate caregiver was available at that time. Phoenix's immediate safety was compromised, she was apprehended to ensure her safety and a thorough assessment was completed by Ms. Forrest. And I'm bringing these two instances to your attention, Mr. Commissioner, because I feel they precisely illustrate our point and that's that high risk files where safety or identified protection concerns existed got the necessary attention and steps were taken immediately to take Phoenix into apprehension and to make sure she remained safe. And when these situations did not otherwise exist, the file received lower attention and it got less priority.

And all files are important, Mr. Commissioner. Certainly when we say it was Mr., Mr. Gindin described it as a typical file, that's not made, those comments by social workers are not made with any disrespect to the importance of any file. It's simply putting it in context and when they say it was a typical file, it was a file that presented with those types of circumstances which were

very, very common and it was those type of situations that did not always receive the highest attention. Those types of files got less priority. And on those types of situations, less thorough assessments were completed and ultimately the types of issues that should have been explored, according to concepts of best practice, were not explored and that's because, as social workers testified, they're always very busy, files were always prioritized and they were done so based on immediate safety.

And ultimately, Mr. Commissioner, if social workers had more time to dedicate to prevention or to conduct thorough assessments on files with medium to low risk, then better outcomes might have resulted. And sadly we know from the weight of the evidence that is not what the system offered, at least from 2000 to 2006 and probably much longer than that.

So just in terms of very broad principles, there was good work done on Phoenix's file at times. That good work occurred when her file reached the top of the priority list and when it didn't, it didn't receive the attention it should have got.

Beyond that observation, Mr. Commissioner, you have our submission as it relates to various individuals that were involved in services to Phoenix. I don't intend to elaborate on those submissions other than to say that

social workers tried their best in very difficult circumstances. They do this work because they're dedicated to child protection and nobody would ever knowingly leave a child at risk. And people deeply regret the errors that were made and that more was not done to protect Phoenix.

I want to take this opportunity now, Mr. Commissioner, to move to the submissions of some of the other parties that have been provided. I know we have a right of reply and I'm trying to address some of those issues now. I think it will help to expedite things.

MR. COMMISSIONER: That's fine.

MR. RAY: It may limit the amount of time that we need to spend at the end, if any. Of course I'll reserve the right to reply but hopefully this will get us through final arguments much quicker.

MR. COMMISSIONER: Well it's quite satisfactory use of the time.

MR. RAY: The first thing I'd like to address is the submission of my friend, Mr. Gindin, that was advanced on behalf of Mr. Sinclair and Ms. Edwards. I'm just going to address a few points that was raised by Mr. Gindin in his submission, his written submission. Before that, I think there is one thing that needs to be acknowledged and you've done it already, Mr. Commissioner, but that is Ms. Edwards' dedication to this process. I don't think

that other parties necessarily agree with everything she's advanced and I suppose that's to be expected and I suppose it's expected that different parties are bound to have different views. But what was lacking so long in Phoenix's file and in so many other files in the system, was for someone in the community to step up and to be a voice from a community perspective and it takes a great deal of courage to do that and we need to do a better job of educating the public about their responsibility to become part of the solution and not part of the problem. In that respect, I think Ms. Edwards has done an admirable job in bringing a number of issues to your attention.

Mr. Gindin's submission, which was well put on behalf of his clients and I understand the frustration that he conveyed about the system, but much of his submission is about accountability and about blame and with respect, that's not the goal of this inquiry. The goal is to solve problems. This isn't about proving whether certain people did or didn't do certain things, we know all that already. We knew most of that before this inquiry started. The question is why did those things happen, how do we fix that so it doesn't happen again? This isn't a trial and I've heard you say that a number of times and I just want to make sure we're not losing sight of why we're here. And as he aptly pointed out, there's more than enough blame to go

around here. We can blame parents, we can blame Ms. Edwards and Mr. Stephenson, we can blame family, friends for not reporting concerns, we can blame social workers for their respective roles, we can blame the department and government for not funding the system, but that doesn't get us anywhere toward improving the system. Two people caused Phoenix's death, not anybody else.

Mr. Gindin raised a point about note taking.

MR. COMMISSIONER: About what?

MR. RAY: Note taking.

MR. COMMISSIONER: Oh yes, yes.

MR. RAY: He raised several points about note taking and I'll be the first to agree and social workers will be the first to agree that accurate and thorough notes are important. But with respect, this issue got quickly and disproportionately blown up into a large issue and, yes, note taking is important but there was no conspiracy here. Can notes be better and more detailed? Yes. But people destroyed notes because they thought they were done with them. That was an accepted practice. Senior representatives of the department knew it occurred and notes were recorded electronically into the electronic recordings and we have those notes.

As it relates to supervisors and note taking, the majority testified they made notes and they kept them.

Some acknowledged destroying them. Unfortunately those notes could not be located and essentially, Mr. Commissioner, that's all there is to that issue.

With respect to the issue of parental capacity and whether parental capacity assessments were conducted or ought to have been conducted or should be conducted in the future, in an ideal world with an abundance of specialized doctors, no wait times, unlimited funding or psychological assessments, it would be great and ideal to explore every sign of mental illness that presents in a parent, but that's not the child welfare system as we know it. Samantha Kematch presented as depressed and ambivalent. Those issues were explored by a doctor. That doctor told social workers there was no need for a further assessment. Samantha Kematch was no different than hundreds of young single mothers with their own child welfare history and who had likely presented as having educational difficulties or depression or what have you, but in 2000 it would have been impossible to predict, doctor or no doctor, that she would deteriorate into a person capable of allowing her own child to be murdered five years later.

And the system simply does not have the capability to accommodate the type of detailed assessments and perhaps therapy that has to be provided to hundreds and hundreds of people with similar conditions.

Social workers would love it if that was the case. They would love to do a direct referral to a doctor and get an immediate result and an immediate diagnosis that provided some secure long-term future prediction about the health of this person. But I can't imagine how much that would cost and I'm not here to defend spending money or not spending money but I think that's a huge reality.

Mr. Commissioner, we heard evidence about CFSIS problems and we heard a great deal of evidence about CFSIS and at paragraph 45 of Mr. Gindin's submission, he has suggested that social workers would have easily located information about Wes McKay if they had conducted a CFSIS search for him. And the reason I am addressing this point, Mr. Commissioner, is because in phase one Exhibit 22 was tendered and that exhibit we now know contained incorrect information about what would have been found on CFSIS if a social worker entered Wes McKay's name using a PCC search method and the exhibit suggested that McKay would have been easily located and somehow connected to Ms. Kematch's file and we now know that that is not correct. That evidence has been corrected to show that entering Wes McKay likely would have produced no results on CFSIS and even if results were obtained for Mr. McKay, his file contained no cross-references to Phoenix or Kematch. So without more information, social workers would not likely have

identified him as being connected to Kematch or to Phoenix. And the evidence in that respect, Mr. Commissioner, can be found in the evidence summary of Jim Chabai and in the new exhibit that was filed this morning by Ms. Walsh respecting the, I think it's the admitted facts of Willox and Zalevich as it relates to Jim Chabai's evidence.

MR. COMMISSIONER: Which of those three exhibits was that?

MR. RAY: I believe it was the first one that was filed.

MR. COMMISSIONER: That would be Exhibit 157, I think.

MR. RAY: Correct. And I do make reference to those points in my written submission, Mr. Commissioner, but I just wanted to identify that issue for the record.

Mr. Gindin's submission has a number of other comments respecting services that were provided by social workers, Mr. Commissioner, and those are addressed in our written material and I don't intend to go further than I've gone.

With respect to the submission that was made on behalf of ANCR, the Southern Authority and the Northern Authority -- actually, Mr. Commissioner, I'm just noticing it's three o'clock. I probably have another 45 minutes perhaps. I'm at your disposal in terms of a break.

MR. COMMISSIONER: All right. Would you like to break at this point?

MR. RAY: I could continue or I can take a break, I'm at your convenience.

MR. COMMISSIONER: Well I doubt we'll go for three-quarters of an hour and --

MR. RAY: No.

MR. COMMISSIONER: I would -- normally about 3:15 but if you want to break now that's -- and then you're going to be through for the day?

MR. RAY: I think we can go to 3:15 and I'll stop at an adequate point then.

MR. COMMISSIONER: All right.

MR. RAY: Okay. So ANCR, Southern Authority, Northern Authority, I just want to note a few of the recommendations that support the MGEU's position, their recommendation 14, and by the way they have many, many valid recommendations.

MR. COMMISSIONER: Fourteen?

MR. RAY: Recommendation 14 recommends caseloads consistent with the CWLA standards, the Child Welfare League of America standards and you heard some evidence about that in the submission of Dr. Wright and of course those were the standards that the MGEU was attempting to bargain with the department back in the mid-1990's and

those, achievement of those standards and containment of those standards and those caseloads in a collective agreement and from what I gather from ANCR's position and Southern Authority, Northern Authority, is they are hoping to see you recommend caseloads that are consistent with those numbers. And again, that's coming from some of the larger employers in the child welfare system.

MR. COMMISSIONER: And that's their recommendation number 14?

MR. RAY: That's correct.

MR. COMMISSIONER: Okay.

MR. RAY: And their position respecting use of the CWLA standards obviously supports what the MGEU has been saying and is contrary to the evidence of Ms. Loeppky, who, without actually knowing what the appropriate caseloads would be to meet provincial standards, suggests that CWLA caseloads are somewhat or somehow not appropriate. With respect, that position is based on a lack of knowledge, it's not evidence based, and that's why we encourage you to recommend that the standards and the caseloads be studied to determine what would be an appropriate caseload.

MR. COMMISSIONER: And what recommendation number in ANCR's and the two authorities' brief is that?

MR. RAY: That's still, that's still

recommendation 14.

MR. COMMISSIONER: Still 14, okay.

MR. RAY: And my point is is that supports the MGEU's position and it supports obviously of lower caseloads for social workers and also the need to study and determine whether the provincial standards can be met by current caseloads or anything, or whatever the caseloads are.

Their other recommendation, recommendation 26, they are seeking funding for trainer positions and better training that is more specific to different types of jobs performed by social workers. And I simply note this, Mr. Commissioner, because we've heard that there is now much more training available but we still have employers telling you there's still room for improvement. There are many excellent recommendations in their submission, I leave that to their counsel to explain to you in greater detail.

With respect to the General Authority, their recommendations start at paragraph 99 of their submission. Similar to ANCR and to the Northern Authority and the Southern Authority, they have identified that more funding is needed to address areas of workloads and caseloads to improve training and to improve training, I'm sorry. So now what we've heard, Mr. Commissioner, from three of the main employers within child welfare is despite millions of

dollars invested in workload and training since roughly 2006 that workload still is too high.

And at paragraph 104 of the GA's submission, they mention that standards are predicated on reasonable workloads and can't be met unless there is adequate funding they need to know whether the funding model allows the standards to be met.

MR. COMMISSIONER: And that's paragraph what?

MR. RAY: One zero four.

MR. COMMISSIONER: Thank you.

MR. RAY: And this comes back to what I was saying earlier, Mr. Commissioner, until we do that, social workers are going to be left to use their own judgment to determine what standards need to be sacrificed in order to meet requirements that demand greater urgency. And ultimately what's going to happen if that's the case is this is going to jeopardize services to families where risk is perceived to be low and safety appears to not be an issue. Having reviewed the recommendations from three of the major employers in the system, I have to ask rhetorically what were workloads and caseloads and training for social workers like before the injection of all this money?

Mr. Commissioner, I'm going to be going into the submission of the department and WCFS. This probably is a

good time for a break because I think I'll be a little longer in dealing with that.

MR. COMMISSIONER: That's fine. We'll adjourn for 15 minutes.

(BRIEF RECESS)

MR. COMMISSIONER: All right, Mr. Ray.

MR. RAY: Yes, Mr. Commissioner. Thank you.

I'm going to move now into the submission of the department and Winnipeg CFS and to address some of the points that were contained in their material. Obviously to the department's credit they have accepted responsibility for the systemic conditions that existed when Phoenix's file was open. They've accepted the recommendations of the external reviews and they've gone to great lengths and expense to improve the child welfare system. And let's face it, they had to because massive change and improvements were required.

The department submits that the deficiencies in service to Phoenix fundamentally related to a failure to appropriately assess safety and risk and that's at paragraph 11 of their submission. And the MGEU and I think the social workers for the most part agree with that, but the bigger question is what led to social workers not

appropriately assessing safety and risk?

And we have submitted and we submit that the answer is clear, it's clear from our submissions, it's clear from the evidence of social workers and supervisors, it's clear from the evidence of management and senior representatives, it's clear from experts and academics and child welfare, it's also clear from the submissions of the other authorities and the answers lie in training and supervision, clear standards, training on standards, appropriate workloads and appropriate caseloads, because all of those things, Mr. Commissioner, will dictate to various degrees how well a social worker will be able to assess circumstances to determine whether there are child protection concerns. And if the system doesn't create an environment to do thorough assessments based on education and training, then safety and risk assessments are not going to be accurate and that's precisely what happened at various points in Phoenix's file. The failure to open a file at intake or closing a file because there was no apparent child protection concerns occurred and because long-term risk and short-term safety were not appreciated, various factors were not taken into consideration and in depth assessments were not conducted and all of these things come right back to one thing, I've said it already, social workers need time to dedicate to a file, they need

training and they didn't have it.

And paragraph 12 of the department's submission refers to the evidence of Heather Edinborough, who the department advances as a prime descriptor of problems. And you'll recall she originally started her testimony by saying that workload didn't impact decisions on this file. When I pursued that with her in cross-examination her answers, after some thought was put into it, were rather illuminating. At page 21 of her transcript what she acknowledged is that they underestimated the risk related to Steve's alcohol issues. They didn't put enough emphasis on that issue and that's why they mistakenly closed the file. And at paragraph 24 of her transcript she agreed that if they had lower caseloads and lower workloads that social workers could have done a more in depth and broader assessment or Stan Williams could have perhaps eliminated barriers and made some grounds with Steve if he had a better opportunity to work with his client. And she clarified her earlier comments about workload by saying that high workload didn't necessarily prevent good work from being done, that good work was done despite high workloads. But lower caseloads and workloads would allow social workers to get to know clients better. They would know just how serious or not serious the problems were. I'm referencing page 25 of her transcript. They could do

more with clients if they had lower workloads. Page 26 of her transcript she said as much when she was interviewed by Andy Koster. When she was interviewed by Mr. Koster she said smaller workloads mean more in depth knowledge of families and ability to see them more and she said that also applies to supervisors.

So broken down to its most basic form, workload impacts the ability of social workers to spend time on a file. They miss things and when they miss things that impacts their assessments. So notwithstanding Ms. Edinborough's original views about workload not impacting the service, when she thought about it and when she was cross-examined, she acknowledged and she agreed in terms of how workload and caseloads probably impacted their assessment of Steve's file and their decision to return Phoenix to Steve at a time that that probably shouldn't have occurred.

Paragraph 17 and 18 of the department's materials, I note again with interest, Mr. Commissioner, the evidence we heard about the increase in the system's budget, and I think that gives you great insight into what the system must have been like before the additional funding, the improvements of the system have resulted in nothing less than massive changes. I expect the department and the various authorities will explain those improvements

to you. I'm not going to go into them in great detail.

One thing I note, Mr. Commissioner, is contained at paragraph 37 of the department's brief and it mentions one supposed improvement and it's an improvement that I find puzzling. WCFS has, Winnipeg Child and Family Services, has implemented a policy now where new hires are eased into actual casework. They cite a cap of 20 cases at any one time during the social worker's first year on the job. So that's their new policy and their new goal is for new social workers you don't have any more than 20 cases. And my concern is that's what the cap is supposed to be for experienced social workers, not new social workers. So while in principle a cap on cases for new social workers is admirable, 20 cases is still too high. And Mr. Rodgers and the General Authority have expressed a need for true caseload caps for all social workers, regardless of whether they're doing protection or prevention type cases and they are advocating for caseloads of 20. So I'm not sure how a cap of caseloads for 20 is good for a new person without experience who is a rookie social worker.

Page 15 commences my friend's submission on workload and at paragraphs 50 to 54 the department acknowledges the need for reasonable caseloads. Paragraph 55 recites some evidence by Ms. Loeppky. She candidly stated that the funding model was introduced to be

equitable within fiscal limits of the province. So we've seen this song and dance before, Mr. Commissioner, and basically what it says is there's only so much money. And I'm not without sympathy to the Province's difficulties. People in politics have to make tough political decisions on how and where to stream their money but when the evidence clearly establishes that funding is inadequate and workloads are too high, don't fault the people that provide frontline services to families and children.

At paragraph 55, continuing with the brief, Ms. Loeppky's answer was to the commission counsel as to why -- sorry, sorry. In her evidence in her testimony she was asked a question as to why not use the CWLA caseloads and her response was it's difficult to compare Manitoba to CWLA. My question is how do we know that when everyone has acknowledged that our own provincial standards and caseloads are not evidenced based? Our own province has no clue whether current caseloads allow social workers to meet best practice because that study has not been performed. So for the department to say that CWLA recommended caseloads are not appropriate is an unknown at this point. They may not be fundable, perhaps the department can't fund to those levels.

And I'd say there's no shame in simply telling us that there's a limited amount of money to throw at this

problem. Manitoba has huge problems to address. Our child in care rates on a per capita basis are way out of line with those of other provinces. And if the Province is telling us for the foreseeable future that this is the best we can do then I suppose we have to accept that and we --

MR. COMMISSIONER: What did you say was out of line with other provinces?

MR. RAY: The child in care ratios. Manitoba has significantly higher child in care ratios on a per capita basis than other provinces with the exception of Saskatchewan which is somewhat close.

MR. COMMISSIONER: Is that one of the exhibits?

MR. RAY: You're testing my memory, Mr. Commissioner.

MR. COMMISSIONER: Well commission counsel will make a note of it and find it.

MR. RAY: Yeah. I don't think, I don't think it's contested or seriously contested that they're extremely high regardless of how they compare to other provinces.

MR. COMMISSIONER: No, but if I say it I want to know --

MR. RAY: And I appreciate your --

MR. COMMISSIONER: -- what my authority is.

MR. RAY: Of course.

MR. COMMISSIONER: Commission counsel will find that.

MR. RAY: And if we have to work within that funding to deliver services on a as best as possible basis, then we're going to recognize best practice and standards are not going to be met and cases will continue to be prioritized. Low risk files won't get the attention they need.

Turning to paragraph 58 and this is where my friend's submission asks the question was workload a factor for Phoenix Sinclair's file? The department has submitted for your consideration that workload was not a factor in key decisions that were made on this file and with respect they seem to have reached that illogical conclusion because nobody made a note about the file and nobody, or excuse me, nobody noted on the file that workload was a problem. So let's consider that response or that explanation for a minute. Firstly, Alana Brownlee testified that when people are too busy one of the first job functions that starts to slide is note taking and that's because that's a relatively low priority item for social workers. People didn't have time to do even the most primary functions so it's unlikely they had time to write down how busy they were.

Secondly, many notes, including supervision notes are missing so we really have no idea what was recorded or

discussed beyond the remnants of a written record that is eight to 13 years old.

Thirdly, discussions about workload often did occur between supervisors and workers and they occurred in ad hoc supervision meetings that weren't recorded and we had evidence of that before you, Mr. Commissioner, when Ms. Forbes had meetings with her supervisor and with Ms. Sandie Stoker and there were expressions about concern about workload and everyone acknowledged that that occurred and those things were discussed from time to time. Regrettably the response that many social workers received was we're sorry, just do your best.

And finally, for at least five years prior to Phoenix's file even being opened, likely longer, social workers and the MGEU repeatedly expressed concerns about systemic failings including workloads and caseloads. They repeatedly expressed those concerns the entire period Phoenix's file was open and the response they got was sorry, we don't have any more money, just do the best you can. And given that answer, I can't imagine why a social worker would make a recording as suggested by the department. What would be the point in writing down you're too busy to do stuff on a file? Everyone knows social workers were too busy. It's been entirely acknowledged by every level of this department, it wasn't a secret, and it

wasn't a secret that nothing was being done to address those concerns. I think it's unreasonable to expect social workers to have the foresight to make those types of notations in a very difficult and frustrating situation.

The department also says that nobody testified that workload was a factor in various decisions made on Phoenix's file. I disagree. First of all, the consistent and unchallenged evidence, Mr. Commissioner, was that workload has always been a problem, it continues to be a problem, even after millions of dollars of improvements, it's still impacting the services delivered by social workers to families. It impacts delivery of services, it impacts professional judgment and all of that was acknowledged by senior representatives of the department when they testified. And the department is suggesting that even though workload was always a factor and even though it impacted all sorts of other decisions on many other files, when it came to Phoenix's file, somehow there was a sudden calming of the workload storm. Conditions perfectly and miraculously existed for perfect service and that is such a stretch of the imagination and is so inconsistent with the weight of all of the evidence that you heard, that it's simply a fallacy.

Now to try to support its position the department has offered some specific, what I'll refer to as snippets

of evidence from the inquiry. Those are contained at paragraphs 59 to 69 of the department's brief. And I'm going to go through that evidence to show you what the witnesses said in greater detail and without taking those comments out of context. So let's start with Mr. Orobko who is contained at paragraph 59. He didn't say workload issues didn't place children at risk and he suggested actually the opposite. At page 111 of his transcript he had a question to him, what impediments existed to delivery of services in accordance with standards and best practice? His answer was staffing and resources. The question was were children ever at risk? His answer, he's not aware of anything he ever did to consciously place children at risk, but children were always at risk. And his answer perfectly describes the reality, (a) he didn't really know (b) he never consciously placed children at risk, they were always at risk. In other words, it describes Phoenix's file. Nobody consciously placed her at risk. They didn't appreciate the level of risk and their assessments were not as thorough as they should have been and if they had more time they could have done better.

Paragraph 60, Mr. Commissioner, there's reference to Ms. Chief-Abigosis. What I'll note for you here is that she had 24 cases at the time she had Phoenix's file. That is seven more than the recommended levels. It's 20 percent

more than the current caseload cap for new social workers, which she was.

At page 88 of her transcript, she said her caseload was between medium to heavy and that's consistent with the new policy which is that the maximum number of caseloads for a new social workers should be 20. Specifically pages 88 to 89 of her evidence, her ability to provide services to clients was impacted by her caseload.

Kathy Epps, paragraph 61, she did acknowledge workload didn't impact her decision but I will say that her situation is somewhat unique. You recall Ms. Epps' evidence was that at the time she received Phoenix's file a decision to close the file had already essentially been made. Her role was limited to trying to make some grounds with Steve to have him accept voluntary services and the thought and the hope was is that she could succeed because of her relationship with him as his former social worker when he was a child. But specifically at page 172 of her transcript, in August 2001 was when Ms. Epps had the Phoenix Sinclair file she had 30 cases. That was nearly double the recommended levels and 30 percent more than the current funding goals of 20 files.

Laura Forrest, paragraph 62, for her things were so bad that she actually did record in her report that she couldn't deliver services due to her workload.

Paragraph 63 is the evidence of Ms. Edinborough. She was represented by counsel for the department. As I have stated earlier she originally indicated that she did not believe workload impacted services to Phoenix. Her December 3rd transcript at page 24, on cross-examination by me --

MR. COMMISSIONER: Page what?

MR. RAY: Page 24 --

MR. COMMISSIONER: Thank you.

MR. RAY: -- December 3rd transcript. On cross-examination when that issue was pursued in more depth, she fully acknowledged workload could have impacted the assessment of Steve and with fewer cases and more time they may have identified that his drinking was worse than they thought and if they had that chance, perhaps the assessment would have been more thorough. And she goes on at page 25, if social workers had lower caseloads they would get to know clients better and would know the seriousness of their problems. And we submit, Mr. Commissioner, that would amount to better assessments and better decisions.

Page 64 is the transcript, or excuse me, the submission respecting Lisa Conlin. Again she was somewhat unique. You'll recall Ms. Conlin was the person that ultimately left Phoenix with the Stephensons because she felt it was safe and which we submit in that case was a

reasonable decision under the circumstances, given what everybody knew about Ms. Edwards and Mr. Stephenson at the time. But that doesn't tell us anything about whether her assessment of that situation was impacted by workload.

On the December 4th transcript, page 67, she was asked whether anything prevented her from doing more work in terms of follow up with the Stephensons. Her answer was time and workload. She says she may not have got to that right away because she was always getting more files and that the file would have been less of a priority.

Paragraph 65 is the submission respecting Debbie DeGale. December 10th transcript, page 87, question: What was your workload like? Answer: There were days when it was really busy, it was a busy time. If something serious came in we put the phones on hold and dealt with the serious case. In that regard it could be manageable if you were able to do that.

So in other words, Mr. Commissioner, she managed because she gave priority to urgent cases and ignored others.

Paragraph 66 relates to Shelly Willox, she was Shelly Wiebe at the time she had the file. She closed the file because based on her assessment there was no known risk based on the information she had. But like Heather Edinborough she agreed that more work could have been done

on the case. If more work could have been done then perhaps she could have collected more information to better assess the situation. And she said regarding workload specifically, and I'm speaking from page 226 to 227 of her transcript, she said CRU is always very busy.

And then at pages 19 and 29 of her transcript she says she recalls the ability to refer matters to intake were being impacted by workload at intake and that CRU was having to hold cases longer.

Page 176 to 177 of her transcript, she says excessive caseloads and unit pressures were something that was occurring when she had the file and tried to refer it to intake.

Page 223 of her transcript, specifically, workload was affecting our functioning and ability to provide services to families and she then cited specifically with reference to Phoenix's file as an example and she said if there had been more time than the case should have gone to intake so proper services could be delivered, she says she might have had the time to dig further to field to the home, to make direct contact, to do more follow up. But they were overworked and didn't have the proper resources to provide services that needed to be provided. And that was her unchallenged evidence.

Paragraph 67, the department references

Jackie Davidson, specifically as it relates to Phoenix, her transcript is January 14th pages 50 to 52. She stated she assumed it was a busy night because she was forced to do a cut and paste of a history from a previous file recording instead of reviewing through all of that information. And, Mr. Commissioner, we now know that in doing that cut and paste she made an error and she failed to include certain portions of the previous report and that may have impacted service on the file on a go forward basis.

Paragraph 68 with reference to Mr. Zalevich, page 125 of his transcript, the evidence was the question were there indirect pressures that impacted the work on Phoenix's file? His answer was pressure, time constraints, lack of staff, that makes it more difficult for us to follow through on every file as much as we would like to. Page 126, workload pressures affected the ability to deliver services. Phoenix's file was no different than the other files he handled. It makes it more difficult to do the job. There's pressure to move things on and there's a need to prioritize files.

Also, Mr. Commissioner, I'll remind you that people had very little and in many cases no independent recollection of their involvement in this file. And even when prompted by written record their memories were very challenged and given that people had this file between

seven to 13 years ago that should come as no surprise to anybody. So how then, Mr. Commissioner, they could be expected to specifically recall their personal workload during a small window of time that they each handled Phoenix's file is beyond me. Most people only have this file for two to three days, Mr. Commissioner, and it was anywhere between seven to 13 years prior to their testimony. And for it to be suggested that certain factors weren't present because people can't recall is an entirely unfair assumption, particularly when the department had an opportunity to tell people about their involvement in the file but declined to do so. Many people didn't know about their specific involvement in this file until preparation for this inquiry commenced. And frankly, it mystifies me as to how the department could possibly suggest that workload didn't impact the decision making in light of the evidence is very strongly supportive of a different conclusion.

Now it is accurate to say that workload didn't cause people to close Phoenix's file. A social worker is not going to say to their supervisor I'm closing this file because I'm too busy. That much is obvious. They close files because they believed there were no child protection concerns and that it's safe to close the file. But files get closed because people come to incorrect conclusions and

those decisions are impacted by things like high workloads and that, Mr. Commissioner, we submit is an obvious conclusion to reach.

I'm going to speak briefly about the department's submission respecting standards. They have acknowledged that, starting at paragraph 78 that there was confusion. They acknowledged there was no training on provincial standards. But at paragraph 80 they seem to suggest somehow that they relied on supervisors to ensure social workers complied with standards. First of all, I don't recall any evidence that anyone ever communicated to supervisors that they were expected to train their social workers on standards. And even if that was the expectation of the department, Mr. Commissioner, these are the same supervisors who themselves were not trained on standards or that weren't aware of them when they were social workers. These are the same supervisors with unmanageable caseloads and workloads and at best could complete ad hoc supervision. These are the same supervisors that lacked proper training themselves and didn't get training until after they were in the supervisor position. So the department's position that they expected supervisors to do the training that they should have done themselves is completely unrealistic. And to underscore that point, Mr. Commissioner, today employees of the General Authority

are trained twice yearly on standards and this underscores the importance of this training and just how inadequate the system was until after Phoenix's death was discovered.

I'm going to move, Mr. Commissioner, to the MGEU requested recommendations now.

MR. COMMISSIONER: Thank you.

MR. RAY: I'm nearly complete.

MR. COMMISSIONER: Are they -- they're on one of the pages here?

MR. RAY: Yes, they are, Mr. Commissioner, that's -- if I could have a moment -- page 61.

MR. COMMISSIONER: Sixty-one. Yes, I have them.

MR. RAY: There aren't a lot of recommendations, Mr. Commissioner, and part of the reason is that we leave a lot to the experts in the department to determine the best and the most appropriate way to deliver child welfare services. What we ask for is the resources or to ensure that the proper resources are provided so that social workers and supervisors can carry out what experts feel is the best way to deliver services, whether that be in culturally sensitive manner or through different protection streams or use of the SDM tools or however it's decided.

You'll recall that Janet Kehler gave evidence on our submission and put simply, it's really about two parts and the first thing we'd like to see is a recommendation

that encourages the department and various employers in child welfare and the MGEU to sit down in collectively bargain language to establish reasonable caseloads. And related to that we'd like you to recommend that the department determine whether the current provincial standards are achievable under the current funding model and if not, then what are the caseloads that would allow social workers and supervisors to meet the provincial standards?

And we're asking for that, Mr. Commissioner, because social workers want to do good work. They want successful outcomes for families. They want to meet standards, they want to meet best practice and that's, by doing that, that's how they'll succeed. And the MGEU and social workers also want accountability and so do other people in the system, but we can't have that until we answer the basic question are these standards achievable? And if they're not, then how do we structure the system so that social workers can meet provincial standards? And as I said before, it's interesting the MGEU isn't alone here. The General Authority has encouraged this undertaking. The other authorities have encouraged lower caseloads and lower workloads. So we're just asking that you take it one step further and we say put those caseloads, whatever they are, into the collective agreement, make it something that's

enforceable and there's a reason for that. Firstly it builds accountability into the system. There's accountability for the employer to ensure reasonable caseloads are not exceeded and there's accountability for the social worker, because once they have reasonable caseloads there should be a reasonable expectation to deliver good services. And if that's not occurring despite reasonable caseloads, then we need to look at why.

And it also brings accountability to the social worker to voice concerns to the employer when caseloads become excessive so that steps can be taken to ensure caseloads are adjusted and good service is provided to families. And, Mr. Commissioner, that's what this is about, it's about creating other checks to ensure ways to deliver services in accordance with provincial standards and best practice. This isn't about dumping cases from social workers' case lists so they can go home at 4:00 on a Wednesday.

Now we heard Dr. Wright give evidence about the need for organizational commitment to best practice and frankly I don't see why this should be so problematic for the department or any other employer. This is about organizational commitment to best practice and best outcomes for children. And you'll recall, Mr. Commissioner, my friend, Mr. McKinnon, attempted to cross-examine

Ms. Kehler on this recommendation and he tried to suggest that it would somehow be unfair of you to make a recommendation for the department to make a written commitment to reasonable caseloads so that social workers can do their job properly because that's what that recommendation that we're seeking is about. And my understanding of his client's position is that somehow the sphere of labour relations between the MGEU and the department is untouchable, that you ought not to meddle in that arena. This is going to come as a shock to you, Mr. Commissioner, but it's your job to meddle here. You've been encouraged to meddle with funding formulas, with provincial standards, with registration of social workers, with the Child and Family Services legislation, with relations between First Nations, the Province and the Federal Government. The list is endless and quite frankly it should be. Everything should be on the table here and we're trying to solve a major problem. And if different parties aren't going to come, are going to -- sorry. If different parties are going to come to you and say we don't want you to mess with this area, even if it could mean better outcomes for children, then there's something seriously wrong with this process.

We aren't saying impose language, we're not saying write the collective agreement for he parties, but

you certainly can and you should suggest that the department engage in this process and fulfill its obligations as an organization to help social workers meet best practice. It's an organizational commitment. Social workers need to be able to tell their employer when working conditions do not allow them to meet expectations and then it's up to the employer to improve the situation and that's what Dr. Wright said in her evidence and that's what this is about.

Now we've provided you with a sample collective agreement for your review and your consideration. There really is nothing magical about that particular agreement. It's there for you to see the kinds of things that other parties have agreed to. Just one moment, please.

MR. COMMISSIONER: When you say you provided that, you're referencing Exhibit 59, tab C in Ms. Kehler's evidence I think.

MR. RAY: That's the CUPE collective agreement with --

MR. COMMISSIONER: Yes.

MR. RAY: Yes, that's correct, Mr. Commissioner.

I just want to correct, before I go into my conclusions, I think Mr. Gindin misspoke earlier. I didn't quite catch all of what he said, but with respect to Ms. Chief-Abigosis, there was a reference that he made to

her having been in university at the time that she was working for CFS and that actually was a misstatement which was corrected later on in the evidence. We provided a copy of her university transcript that illustrated that she was not in fact at university at that time, so I just wanted to correct that. I don't know if Mr. Gindin recalls that evidence, but ...

Mr. Commissioner, child welfare and child protection is a very difficult profession. It's difficult for social workers who work in this area and it's much more difficult for clients, families and children who live within the world that is served by the system. We need to give social workers and supervisors and other employees and collaterals an opportunity and a chance to do their best work because if we don't they're not going to succeed and that can't continue to happen for the child welfare system in Manitoba. And with greatest of respect, Mr. Commissioner, inquiries like this can be avoided and government needs fewer inquiries and more listening. They need to listen to writers of past inquest reports and to senior representatives of the system who ask them for more money, for more resources and to social workers and their union. And all of these groups have said there were problems and they've been saying it for many, many years before Phoenix's file came into the system.

MR. COMMISSIONER: But I don't -- are you being critical of the government for calling this inquiry?

MR. RAY: No, I'm not at all, Mr. Commissioner.

MR. COMMISSIONER: Because it seems to me --

MR. RAY: There's no question --

MR. COMMISSIONER: It seems to me there was good reason.

MR. RAY: There's no question that this was needed under the circumstances.

MR. COMMISSIONER: Yes.

MR. RAY: But regrettably these can also be avoided.

MR. COMMISSIONER: Yeah, I hear you.

MR. RAY: And all of those groups have identified concerns and problems and changes that needed to be made in order to protect children and little has changed and little did change until Phoenix's tragic death occurred.

Front line social workers, Mr. Commissioner, are in touch with clients every single day. They see heartache and successes and they know the reasons for the problems and failures. Often social workers are the only voices that clients and families have in order to voice concerns and to voice problems toward government and toward the department. And it's respectfully submitted, Mr. Commissioner, that the system needs to start paying

attention to these individuals and they need to start listening to these individuals and listening to what they're saying. And those are my submissions, subject to any questions you have or comments and any possible reply.

In the event I have nothing further, I'd like to thank you for listening and with your luck in writing a difficult report.

MR. COMMISSIONER: Well I thank you. Now I do have -- arising out of Mr. Gindin having gone through his 48 recommendations this morning --

MR. RAY: Yes.

MR. COMMISSIONER: -- there's three or four here that I'm going to identify and if you, either now or in the morning, want to comment on them, I'd be interested in hearing you --

MR. RAY: Of course.

MR. COMMISSIONER: -- and I won't identify them for other counsel on a subsequent occasion because they're here to hear me identify them today and I may, this may repeat itself from other breaches when the recommendations are reviewed. But these -- and in your case where you've limited your recommendations to really the one area --

MR. RAY: Yes.

MR. COMMISSIONER: -- I can understand you may not want to comment on these and I quite understand that

but I do, they are matters that interest me.

One is Mr. Gindin's first recommendation about there be some separation between, with respect to the preservation on the one hand and the, the protection side on the other and he had a novel way of making the separation which may or may not be acceptable to me or to other people, but it is an issue that's so very much on my mind about the social workers being in a position where they have to try to provide the two sides of the road, so to speak, and the difficulty that causes --

MR. RAY: Yes.

MR. COMMISSIONER: -- for them and we've seen many examples of it here.

Secondly, his suggestion that the files be opened in the name of the child. That's something I've been thinking about all through this Commission and I'd be interested to hear you or anyone else that wants to comment on that.

MR. RAY: As opposed to the parent.

MR. COMMISSIONER: Another one of his suggestions relates to the proposed legislation dealing with a college of social workers and I will be dealing with that in my report in some ways, so I would be interested to know anybody's view on that.

And then likewise I'm interested in,

particularly, in the recommendation -- there was one other. I think maybe that's got them all. Oh yes, there's reference in one of his recommendations to the role of the advocate's office and I'd be interested to know anyone's opinions with respect to that.

And finally, his last recommendation, number 47, that there should be a clear acknowledgment by the Manitoba Government that the overrepresentation of aboriginal people in the child welfare system requires a concerted effort to increase funding and develop programs to deal with poverty, poor housing, and substance abuse in all communities across Manitoba.

So as I say, those -- I will consider all naturally of Mr. Gindin's 48 recommendations. Those four sort of stuck out to me as matters I'd like to hear other people on if they wish to speak to them. Not a, and nothing more for me than just a request that that be done if people are comfortable speaking to those issues. And when I see recommendations from other briefs tomorrow and then subsequent days I may well identify that I'd like to hear more on those recommendations from other people also.

MR. RAY: Certainly, Mr. Commissioner. I'm not in a position to comment on that today. I'll take the evening to review those.

MR. COMMISSIONER: If you wish.

MR. RAY: Certainly.

MR. COMMISSIONER: And my request is no stronger than that.

MR. RAY: Thank you. Again, thank you for allowing us to participate and I think we participated in good faith and in fact without seeking any public funding in terms of our participation in this so ...

MR. COMMISSIONER: Yes, I acknowledge that, that's --

MR. RAY: I hope our participation has been of assistance to you and thank you very much.

MR. COMMISSIONER: It has and while you've responded to a number of things today I think we still have time on the agenda if there are others responses that you want to make before we close the hearings.

MR. RAY: Yeah, I don't anticipate that I have anything further at this point, subject to what may come out in the rest of the parties' submissions and I believe we have some reply period for next week and I would use that period if I have anything further to say.

MR. COMMISSIONER: Yeah, that's what I had in mine.

MR. RAY: Yes, thank you.

MR. COMMISSIONER: All right, Ms. Walsh, I guess we'll adjourn until 9:30 tomorrow morning?

MS. WALSH: That's correct.

MR. COMMISSIONER: All right.

MS. WALSH: Good afternoon.

(PROCEEDINGS ADJOURNED TO JULY 23, 2013)