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

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

****

Transcript of Proceedings
Public Inquiry Hearing,
held at the Winnipeg Convention Centre,
375 York Avenue, Winnipeg, Manitoba

****

TUESDAY, JULY 23, 2013

APPEARANCES

MS. S. WALSH, Commission Counsel

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

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

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

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

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

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

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

MR. M. ZURBUCHEN, The Assembly of Manitoba Chiefs Secretariat Inc. and The Southern Chiefs Organization

MS. K. BJORNSON, for the Manitoba Métis Federation

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

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

MS. B. BOWLEY, for Witness, Ms. Diva Faria

MR. R. ROLSTON, for Witnesses, Ms. Dianna Verrier and Mr. Dan Berg

MR. R. ZAPARNIUK, for Witness, Ms. Roberta Dick

INDEX

	Page
SUBMISSION BY MS. BOWLEY	1
SUBMISSION BY MR. ZAPARNIUK	40
SUBMISSION BY MR. ROLSTON	46
SUBMISSION BY MR. COCHRANE	58

1 JULY 23, 2013
2 PROCEEDINGS CONTINUED FROM JULY 22, 1013
3
4 THE COMMISSIONER: Good morning.
5 MS. WALSH: Good morning, Mr. Commissioner.
6 THE COMMISSIONER: Ms. Bowley, are you on this
7 morning?
8 MS. BOWLEY: Yes, sir, I am. For the record, my
9 name is Bernice Bowley. I'm representing a witness at this
10 inquiry, Diva Faria.
11 Just by way of brief introduction, I expect to be
12 less than the allotted time and I defer to the written
13 submission, which you already have, sir.
14 THE COMMISSIONER: Yes, I have.
15 MS. BOWLEY: Thank you. Today, where references
16 are made to evidence, the pages and cites are included in
17 the written final submission so I don't intend to repeat
18 them; however, I do have them available, most of them
19 anyway, and can provide them if you ask.
20 The fundamentals of Diva Faria's position are as
21 follows:
22 First, she met the provincial standards in place
23 for the crisis response unit, which I will usually call the
24 CRU.
25 The state of the child protection system during

1 the times of her involvement were such that best practices
2 were not always achievable. The CRU was systemically
3 problematic, which I will review in detail today.
4 There is no evidence, no indication, no
5 suggestion that Diva Faria did willfully poor work or
6 deliberately made a bad decision. Her supervisor, the
7 assistant program manager, Dan Berg, described her as
8 highly skilled. She functioned to the best of her
9 abilities in an area of the child protection system that
10 was under-resourced in multiple ways and overworked.
11 Fourth, since she complied with the standards
12 imposed on her by her employer, she ought not to be faulted
13 because she did not exceed those standards, because she was
14 not able to achieve best practices on all occasions or in
15 the circumstances of file openings related to Phoenix
16 Sinclair.
17 It is important to understand the overall context
18 of the decisions of Diva Faria. She was a front line
19 supervisor, an employee of a large organization with senior
20 managers and high level management above her. She did not
21 control her environment.
22 And I want to talk now about what was the CRU
23 environment.
24 It was created in January 2001. It was a
25 relatively unique unit for Manitoba, operating as the front

1 door to the child protection system.
2 Evidence was given from a variety of witnesses,
3 including assistant program managers, program managers and
4 CEOs of Winnipeg CFS to the effect that CRU was not
5 structurally or operationally designed to conduct full
6 long-term investigations. It was not structurally or
7 operationally designed to hold cases and do extensive
8 investigations like those conducted at tier two intake and
9 abuse levels.
10 CRU was, literally, a crisis response unit,
11 specifically designed to deal with high risk emergency
12 matters acting like a triage unit.
13 And I'll pause at this point to respond to a
14 comment made by Mr. Gindin regarding the so-called
15 suspicious timing of the December 2004 CRU file opening.
16 Those documents are at pages 36943 to 36948, the CRU report
17 for that file opening. Those pages show that the referral
18 was returned to CRU from intake on the afternoon of
19 December 2nd. Activities took place that afternoon and
20 throughout the day on December 3rd, which was a Friday.
21 The 4th and 5th were Saturday and Sunday when CRU was not
22 on duty, and the report was typed Tuesday, December 7th and
23 signed off then. There's nothing suspicious about that
24 timing.
25 CRU's limited structure and the nature of the

1 work it did along with its workload resulted in a number of
2 organizational practices and expectations. CRU workers did
3 not always have time and their upper manages recognized
4 that they did not always delve through entire histories or
5 large files, some of which were stored off site.
6 Similarly, due to the structure and function imposed on it,
7 a CRU supervisor was able to spend, at most, 15 minutes to
8 half an hour throughout the course of a work day reviewing
9 CRU reports and having discussions with workers about a
10 particular file.
11 Depending on the caseload, a CRU supervisor might
12 have to sign, sign off on 10 to 15 to 30 to 40 files per
13 day plus have consultations with staff and fulfill
14 administrative functions.
15 In making decisions on a file as to closure or
16 otherwise, a CRU supervisor was expected and only had time
17 to read the materials that were presented to her by the
18 worker, they being the CRU report, the face sheet and the
19 safety assessment form.
20 CRU -- sorry, supervisors were not expected to do
21 a CFSIS review themselves; they were also not expected to
22 double-check their workers' work.
23 THE COMMISSIONER: But they're expected to have
24 consultation with their worker before signing off, I think,
25 were they not?

1 MS. BOWLEY: Yes, they were. And as I said,
2 throughout the course of their day they might have 15
3 minutes to half an hour to review the documents and have
4 those consultations with a worker about a particular file.
5 And this point brings up another response to Mr.
6 Gindin's submission yesterday on the issue of notes. Yes,
7 more detail or comprehensive notes as to why Phoenix's
8 files came back from intake or as to other matters would
9 have been helpful at this inquiry. However and with
10 respect, Mr. Gindin may be transposing his desire for
11 comprehensive notes of every step or every question from
12 his legal practice area. These workers were not police
13 officers expecting, on every occasion, that they would have
14 to go to court to defend and prove every act, every step
15 and investigation. They did not have the auto-numbered
16 notebooks that police officers have and, instead, the CRU
17 environment used a cumbersome word document creation
18 process whereby a worker typed into a word document and
19 then it was up to an administrative assistant to then scan
20 that document into CFSIS.
21 And as part of the expected process for a CRU,
22 CRU supervisor, they did not make notes on the file unless
23 they were directly involved in active work on the file,
24 which was not usually the case. They were not expected to
25 record their discussions with workers.

1 To the extent that a supervisor gave a specific
2 direction or task, a worker may have recorded that in the
3 report.
4 It's also important to note that the supervision
5 policy of March 2004 and its requirements as to note-taking
6 did not apply to CRU supervisors. That is nearly universal
7 from the witnesses who testified here, including Alana
8 Brownlee.
9 And as to Mr. Gindin's expectation that
10 discussions about why a file was closed should have been
11 noted, again, that was not the system in place in CRU. The
12 structure was that the worker brought his or her written
13 report to the supervisor for review and possible sign off.
14 The system did not require the workers to go away and type
15 the discussion which confirmed the worker's recommendation
16 being approved and then return that revised document for
17 signature and then have that revised document go to an
18 admin support staff for scanning into the system.
19 Leaving aside the note issue and returning back
20 to the CRU structure, a CRU supervisor was expected to
21 review the work contained in the worker's CRU documents
22 which, depending on workload and other factors, may or may
23 not contain all relevant information. The supervisor's
24 ability to reliably judge safety or other considerations
25 was dependent on their worker's materials and verbal

1 advice. So as a first obstacle to meeting best practices,
2 the structure of CRU did not provide supervisors with
3 consistently sufficient material or knowledge in order to
4 meaningfully and critically analyze important factors when
5 signing off on a CRU report. The supervisor had a short
6 period of time to read and process the limited materials
7 submitted by the worker and was expected to make decisions
8 based on that information and discussion, and this
9 structure placed onerous responsibility of CRU supervisors
10 without providing them with the resources to consistently
11 meet that responsibility.
12 I turn now to the standards:
13 The applicable standards were still the subject
14 of some confusion at the end of phase two of this inquiry.
15 It seems to be mostly accepted that despite some draft
16 standards, some partially piloted standards and even the
17 online standards, that the governing standards at CRU from
18 2001 to after March 2005 were the 1988 provincial
19 standards. These 1988 standards were in force log before
20 CRU was created in January of 2001 and they did not
21 specifically address CRU's limited intake role.
22 As an aside, the 1988 provincial standards
23 mandated a number of agency responsibilities which included
24 the workers required specialized training and ongoing
25 organizational support which recognized the demands of

1 child protection work. Note the use of the word "required"
2 in 1988. It didn't say should have or it might have been
3 good if specialized training and ongoing organizational
4 support were required -- or were provided, excuse me, it
5 said "required". Because even back then, in 1988, it was
6 known that social work was complex and nuanced and the
7 training was necessary in order to deliver good consistent
8 service.
9 These 1988 provincial standards went on to
10 mandate the agency to create a structure and an
11 organizational climate that was conducive to effective
12 communication, manageable workloads, clear lines of
13 accountability and sound decision-making.
14 Significantly, the 1988 provincial standards did
15 not contain a requirement, when terminating a child
16 protection case at intake, to see the child who was the
17 subject of the referral. Instead, prior to termination,
18 the worker was obliged to discuss the decision to terminate
19 services with the family and were appropriate -- bless you
20 -- the child.
21 The case management standards dated September 16,
22 1999 also predate the creation of CRU. They were not
23 formally or universally implemented, and to the extent that
24 these standards were available to some, it is noteworthy
25 that in closing a file at the intake level they dictated

1 that the process of closure involves consultation with the
2 family or child and notification of all relevant
3 collaterals.
4 Under the section for child protection intake,
5 these standards also stated that where the rating for
6 response time was in the high or medium range, within 48
7 hours or less, the worker could ensure the safety of the
8 child either through direct contact or through confirmation
9 of the child's safety by a reliable source.
10 In July 2001 a document was created which
11 specifically addressed the particular role and function of
12 the CRU. The intake program, description and procedures
13 document, which I will refer to as the intake program
14 manual, is the only global policy or standards document
15 created for CRU from July 2001 until after March 2005.
16 According to the department and Winnipeg CFS in their final
17 submission at page 24, paragraph 81, this document embedded
18 the provincial standards.
19 There was an orientation manual which came out on
20 May 10, 2004 with respect to CRU. A review and comparison
21 shows that that orientation manual mainly contained a cut
22 and paste of the intake program manual with the correction
23 of a few typographical errors. It was not an updated or
24 improved document for CRU operations.
25 With respect to file closings at CRU, the 2001

1 intake program manual and the 2004 orientation manual did
2 not require the child who was the subject of a referral to
3 be seen. To the contrary, they indicated that if a matter
4 may be resolved and the case closed with limited further
5 intervention, such as a few phone calls or a field, the
6 case may be kept by CRU beyond 48 hours to facilitate the
7 case disposable -- disposal. And notably, there were no
8 concrete or practical definitions provided in the manual
9 and no training was provided on the use and applicability
10 of this standard.
11 The intake program manual also contained a
12 criteria for file closing at the tier two intake services,
13 the level above CRU. It stated that closure of a
14 protection case occurs when a child's care and safety
15 concerns can be adequately met by a parent or guardian
16 without branch involvement, the family is refusing
17 voluntary services or there is insufficient evidence to
18 proceed under part three of the Act, that is, the
19 involuntary section.
20 The so-called on-line standards for January 1,
21 2005 were distributed in November of 2004. There is still
22 debate as to whether they came into effect on January 1 of
23 2005. It seems to be mostly accepted that the 1988 case
24 management standards remain the official standards in
25 effect until training on the 2005 standards could occur.

1 Nonetheless, the January 1, 2005 on-line standards were
2 available to CRU workers and supervisors. Those standards
3 also allowed for the use of collaterals to close an intake
4 file and stated that when necessary due to distance or
5 circumstances, the intake worker may confirm the immediate
6 safety of any children through contact with and assistance
7 from police, hospital, school and individuals in the local
8 community.
9 Further, the online standards dictated that where
10 there are protection concerns the intake worker or the
11 assigned worker is to have direct contact with the person
12 or family within 10 working days of receiving the referral
13 for service. Sandie Stoker wrote her policy document for
14 tier two intake, not CRU, with respect to seeing all
15 children in November 2006. It was not until 2008/07/02,
16 which is either July 2nd or February 7th of 2008 that there
17 was a mandatory standard to see a child via face-to-face
18 contact for all intake workers.
19 THE COMMISSIONER: What about that set of minutes
20 of, of the staff meeting. Wasn't that around this time?
21 MS. BOWLEY: Those minutes were in February of
22 2004. They were joint minutes at the CRU level and what
23 those minutes said was, is that where possible you should
24 try and see a child. I'm talking -- and that's an internal
25 meeting minute to that unit. I'm talking about the

1 provision of minimum standards by the employer.
2 THE COMMISSIONER: Yes, I understand you're on
3 standards.
4 MS. BOWLEY: Yes.
5 And I just want to make the point, sir, that it's
6 those above the CRU front line workers and supervisors who
7 controlled and implemented the standards and the policies
8 and the expectations. They wrote the standards and did not
9 include the requirement to see children in all child
10 protection investigations. Instead they drafted and
11 implemented standards which specifically allowed for file
12 closings without children being seen. From 1988 until
13 2008, for 20 years, there were no provincial foundational
14 standards which required face-to-face contact with children
15 who were the subject of a child protection concern before a
16 file was closed.
17 I'm turning now to the issue of lack of tools. I
18 don’t intend to spend a lot of time on what I call the
19 inadequacy of the CRU materials and the safety assessment
20 form except to say that they were inadequate when mandated
21 for use in complication emergency and crisis situations.
22 The safety assessment form, which was part of the
23 intake program manual and used by CRU did not address
24 important and relevant criteria and did not identify
25 appropriate issues on a consistent basis. Its other

1 inadequacies are outlined in the final written submission.
2 And I will just note that then, as opposed to now, the
3 safety assessment tool did not have any accompanying policy
4 and procedures manual to provide descriptive definitions to
5 guide decision-making and to provide practical training as
6 to how the tool should be used.
7 One needs only to look at the structured
8 decision-makings -- structured decision-making tool in
9 place now to see that the two sets of tools are night and
10 day. SDM structured tools focus on critical decision
11 points, require objective decision-making and increased
12 worker consistency in assessment. If there are harm and
13 danger factors present, the SDM tools do not allow a file
14 to be closed and timely and practical training has been
15 provided on the SDM tools.
16 No clear evidence was led from Winnipeg CFS as to
17 why more helpful tools could not have been implemented
18 years earlier. There was no evidence led on what high
19 level management in the department were doing to add
20 helpful tools to the system.
21 I turn now to lack of training.
22 It was conceded by senior management and the
23 report writers that training is of critical importance to
24 good consistent service delivery. Training is of critical
25 importance to workers and supervisors meeting standards.

1 Training is of critical importance to workers achieving
2 best practices. Training of supervisors is of critical
3 importance to the quality of supervision that they can
4 deliver.
5 Senior management knew that the lack of training
6 of workers on standards, policies and procedures and work
7 tools was a major concern from 2001 to 2005. Despite that
8 knowledge and concern, CRU workers and supervisors were not
9 trained on standards, the intake manual, the forms, the
10 safety assessment, and they received no clinical training
11 on note-taking and evidence gathering.
12 Evidence was not led as to why workers were not
13 trained until years after they started in their positions
14 beyond management telling them, in answer to their pleas,
15 that there was no money in the budget. We do not have an
16 answer as to why there was no substantive training in that
17 time period.
18 Quality assurance is the next item.
19 Dr. Alexander Wright testified here that it is
20 very difficult for front line workers and supervisors to
21 meet best practices when they do not have organizational
22 support. She further stated that it is not only the front
23 line people who must strive for best practices. Senior
24 management must also be personally committed to striving
25 for best practices. The organization itself must also be

1 striving for best practices, and part of fulfilling
2 organizational best practices includes providing training,
3 evaluation, service monitoring, quality improvement and
4 resources to workers and supervisors.
5 While considerable evidence was led at this
6 inquiry as to quality assurance initiatives now in place in
7 the child welfare system, there was little or no evidence
8 led as to what high level management or Winnipeg CFS was
9 doing to see that quality assurance steps were taken for
10 CRU from 2001 to 2005. Other than some pulling of some
11 random files by Darlene MacDonald prior to her departure as
12 program manager in early 2003, these quality assurance
13 steps were missing.
14 CRU workers had no way of knowing whether their
15 work was appropriate, met expectations or provided good
16 outcomes for children and families.
17 I'm turning next to workload.
18 Separate and apart from the crisis nature of most
19 of CRU cases, it was conceded by its program manager,
20 Patrick Harrison, that it was a very busy place. Workloads
21 and caseloads were often high. Workers repeatedly reported
22 being unable to meet standards and being unable to achieve
23 best practices in all cases because of workload.
24 Linda Trigg, former CEO, gave evidence that best
25 practice was often impeded by high workload and excessive

1 work.
2 Andrew Koster made a number of findings and
3 conclusions about workload in his Section 4 report dated
4 September 2006, including that CRU had caseload
5 expectations that far exceeded reasonable limits and was an
6 additional pressure. He also wrote that at various points
7 the case managers and, and team supervisors were dealing
8 with far too many cases than would have been possible to
9 manage appropriately. He recommended examination of the
10 role of CRU and consideration to moving to Child Welfare
11 League of America staffing levels.
12 And Mr. Commissioner, I ask you to consider the
13 totality of the evidence on workload, a good summary of
14 which was included in Mr. Ray's submission yesterday from
15 the transcripts of evidence given at this inquiry.
16 Considering the totality of the evidence, the
17 inference must be that workload in combination with all of
18 the other systemic difficulties contributed to the
19 organizational culture and the organizational practices
20 that we've heard described at this inquiry and negatively
21 impacted service delivery at CRU in the years at issue.
22 THE COMMISSIONER: So, so what you're saying in
23 paragraph 62 is while it cannot be said that workload was a
24 specific and direct contributing factor on any service
25 delivery to Phoenix in '02, '03, '04, it, in combination

1 with the other system difficulties, contributed to an
2 organizational culture and impacted service delivery
3 generally. That's your point, I take it?
4 MS. BOWLEY: Yes.
5 THE COMMISSIONER: Yes. Yeah. I understand
6 that.
7 MS. BOWLEY: And I want to also speak to how
8 these systemic factors also negatively impacted supervision
9 at CRU. During the time of CRU, when services were
10 delivered to Phoenix and her family, there was no
11 supervision policy developed specifically for CRU. Having
12 -- and having regard to the excessive workloads and
13 difficulty in conducting regular planned supervision of
14 case files due to turnaround at CRU, that supervisors there
15 did not have sufficient resources and opportunity to
16 provide the meaningful supervision that they would like to
17 have provided.
18 And I note that ANCR now has a supervision and
19 performance management policy specific to its crisis
20 response program. That's at tab "T" to Exhibit 51.
21 The department in Winnipeg CFS say in their
22 written final submission that Winnipeg CFS relied on
23 supervisors to make themselves aware of standards and to
24 ensure that their staff complied with provincial standards.
25 Mr. Ray commented on this and I'm not going to belabour it

1 in response but I feel obliged to submit that making
2 themselves aware of is not a sufficient basis for service
3 delivery in accordance with standards. It does not meet
4 organization best practice.
5 Jay Rodgers admitted that someone merely reading
6 the standards is not a sufficient basis for training.
7 It was conceded during evidence at this inquiry
8 by most senior management, and it was confirmed by Dr.
9 Wright, that in order for supervision to be meaningful
10 there must be adequate time allowed and the supervisor must
11 be trained on standards, manuals and best practices. Jay
12 Rodgers gave evidence that because CRU supervisors were not
13 trained on the standards, policies and procedures, their
14 ability to provide meaningful supervision to their workers
15 was compromised.
16 It was not reasonable of Winnipeg CFS to rely on
17 its untrained supervisors to supervise and ensure their
18 untrained workers met standards or provided excellent
19 service delivery on a consistent basis. This lack of
20 training provided is highlighted by the massive changes to
21 the system such that it now provides helpful resources,
22 comprehensive work tools, adequate training, more time and
23 cultivates expertise in its supervisors.
24 I turn now to the topic of not seeing children.
25 When asked by you, Mr. Commissioner, whether CRU

1 should have known that Phoenix Sinclair should have been
2 seen in March 2005, Sandie Stoker, former program manager
3 of JIRU for tier two intake and abuse in 2005 and now
4 executive director of ANCR, included in her answer, no, not
5 in that environment. She confirmed that it had become an
6 accepted practice in dealing with broad non-specific child
7 protection allocations, that going out and speaking with
8 the parents was sufficient.
9 In addition to the standards allowing file
10 closures without seeing the child, it was an accepted
11 practice. There were many occasions where the practice was
12 not to see the children. It is not a one-time event that
13 occurred with Phoenix Sinclair, it was a practice supported
14 by management.
15 In Rob Wilson's experience as assistant program
16 manager at CRU, not all children were seen during
17 investigations. He said that there was no rule or
18 procedure that mandated seeing the children during a CRU
19 investigation.
20 As a result of management's acceptance of that
21 practice, CRU workers and supervisors believed it was
22 acceptable practice not to see every child who was the
23 subject of a referral where they were broad and unspecified
24 allegations.
25 THE COMMISSIONER: Even though the unspecified

1 part was attached to an allegation of abuse or abuse
2 unspecified.
3 MS. BOWLEY: Yes.
4 THE COMMISSIONER: And your view is that that
5 doesn't dictate, trigger a need to see the child?
6 MS. BOWLEY: In those circumstances, in that
7 environment where someone merely says that she thinks there
8 is abuse, no, it was not unreasonable to act and decide as
9 they did.
10 And Mr. Gindin criticizes Diva Faria for an awful
11 absence of common sense in closing Phoenix Sinclair's file
12 in March of 2005, and I will return to that theme, but
13 first I want to briefly recap the systemic difficulties
14 I've reviewed which constituted the CRU environment and its
15 practices. They were a restricted role and function
16 consisting of short-term non-intensive file involvement;
17 heavy workload with little time for workers and supervisors
18 to spend on files other than serious emergency ones;
19 unclear standards; no training on standards and standards
20 which allowed CRU protection files to be closed without
21 seeing children; inadequate and unimproved work tools, the
22 safety assessment form in particular; no training policies,
23 procedures and work tools; no quality assurance, no file
24 audits in 2004 and 2005, no oversight as to clinical
25 practice, and a practice accepted by management which

1 resulted in protection files being closed without children
2 being seen. That was the environment in which Diva Faria
3 supervised --
4 THE COMMISSIONER: You're saying that was an
5 accepted practice?
6 MS. BOWLEY: Yes. Based on the evidence of
7 Sandie Stoker and Rob Wilson.
8 THE COMMISSIONER: Thank you.
9 MS. BOWLEY: Within that environment, those
10 systemic problems and those practices, Diva Faria did not
11 require her workers to see Phoenix Sinclair in December
12 2004 and March 2005.
13 Mr. Commissioner, you have the written final
14 submission which contains a detailed review of the
15 evidentiary basis for her having made the decisions that
16 she did and I only want to make a few more general points
17 in conclusion today.
18 In those days, in that environment, the fact that
19 Phoenix was not seen in those circumstances was, while not
20 ideal and while not best practice, it was also not
21 unreasonable. It was not misconduct.
22 Mr. Gindin posited that with respect to the March
23 2005 closing, the benefit of hindsight is not required to
24 conclude that this work was dangerously substandard. It
25 must be said in reply that the work was not substandard in

1 the true meaning of that word. The file closure met the
2 standards of the day. If anything was substandard, it was
3 the standards themselves and the environment. What the
4 March 2005 closing did not meet was best practices.
5 To use Mr. Gindin's opening words, yes, things
6 could have been handled differently at CRU, things could
7 have been done better. However, based on the limited
8 information available to Diva Faria, she had no idea that
9 the March 2005 referral was significant or high risk. It
10 was a soft referral and she could not have known that this
11 was a crucial turning point because she did not have
12 sufficient information to see all of the red flags that we
13 know now were present. She had only what was on the CRU
14 report that day.
15 THE COMMISSIONER: Well, who were those red flags
16 available to in CRU?
17 MS. BOWLEY: I don't know that those, that all of
18 those red flags were available to anyone because of the way
19 the system was structure. Some information was available
20 in CFSIS, some wasn't. Some was in seal child-in-care
21 files. Wes McKay's information was not available in CFSIS
22 based on a search of just the phrase Wes McKay. So it was
23 not readily ascertainable to CRU, and that's part of the
24 problems with the CFSIS system and the record-keeping as it
25 was back in those days.

1 THE COMMISSIONER: Well, what did the, the chap
2 that preceded, Zalevich, going out there the day before --
3 MS. BOWLEY: Buchkowski.
4 THE COMMISSIONER: Buchkowski; what was available
5 to him by way of background of, of, of the, what had gone
6 on in the history of this family?
7 MS. BOWLEY: I don't know what was available to
8 him. I only know what is in the CRU report for March of
9 2005.
10 THE COMMISSIONER: But should they have known the
11 history of, of going right back to Phoenix's birth and the
12 inability of the parents to, to, to be parents at that
13 stage and all of the other events that occurred in this
14 family's history up till 2005?
15 MS. BOWLEY: I don't know for sure that that
16 information was available to CRU people because I believe
17 that gets back to Mr. Gindin's recommendation that
18 histories should be carried under the name of the child so
19 that, for example, if you call up a child's name, you then
20 return and get the results of the parent's history without
21 having to do a search on a fellow named Wes McKay and not
22 getting any of his history.
23 THE COMMISSIONER: And do you agree there's merit
24 in that suggestion of Mr. Gindin's to open a file under the
25 name of the child?

1 MS. BOWLEY: Yes. On behalf of Diva Faria, we
2 do.
3 THE COMMISSIONER: Right. Thank you.
4 MS. BOWLEY: And as part of what we've just had
5 an exchange on, Mr. Commissioner, the decision to close
6 this file in March of 2005 was not more drastic and was not
7 more deserving of criticism than other previous decisions
8 on Phoenix's files; it was just the very unfortunate timing
9 that makes this decision the subject of such harsh
10 scrutiny.
11 THE COMMISSIONER: The, the final event?
12 MS. BOWLEY: Yes.
13 THE COMMISSIONER: I understand you.
14 MS. BOWLEY: And in the face of the terrible
15 results of Phoenix, there is a natural human tendency to
16 feel anger and outrage and a desire to place blame. It may
17 assist a bit in coming to terms with the awful event. And
18 some may not accept that hindsight is overly sharpening
19 some judgments and perceptions in this matter, but with
20 respect, however, it is. Yes, now, it can be said that
21 other, better decisions ought to have been made. At the
22 time, however, and while the department in Winnipeg CFS may
23 say that the various lack of resources, lack of up-to-date
24 standards, lack of tools, lack of training, workload, were
25 not, each one in and of themselves, specific contributing

1 factors in the handling of Phoenix's files, I return to my
2 earlier point and ask that you consider the cumulative
3 effect on those files and on those people in that
4 environment. Because on a general basis, what these lax
5 and inadequacies created was an organization or a system or
6 a program that was not adequately equipped to deal with
7 situations of low to medium risk and low to moderate cases
8 of neglect.
9 As you heard Mr. Ray say yesterday, focus and
10 resources were directed to situations where there were
11 immediate presentations of significant high risk and, in
12 those cases where abuse was occurring, apprehensions took
13 place promptly and effectively. And perhaps it was due to
14 lack of resources of devolution or some effort to balance
15 the priority of keeping children within their families,
16 whatever the reason, the systemic treatment of low to
17 medium risk in neglect cases did not result in intensive
18 investigations or aggressive responses from Winnipeg CFS
19 workers.
20 THE COMMISSIONER: I guess the point is,
21 accumulatively this might well have been high risk.
22 MS. BOWLEY: Yes, it may well have been.
23 THE COMMISSIONER: Yeah.
24 MS. BOWLEY: But the point is, is that that was
25 not known to Diva Faria in March of 2005.

1 THE COMMISSIONER: And maybe therein lies one of
2 the major weaknesses of the whole system.
3 MS. BOWLEY: Yes.
4 THE COMMISSIONER: That there wasn't, you're
5 saying, the ability to make that known to the CRU people at
6 that time.
7 MS. BOWLEY: Yes. And I have a recommendation on
8 that at the end of my submission.
9 THE COMMISSIONER: You'll come to
10 recommendations.
11 MS. BOWLEY: Yes.
12 THE COMMISSIONER: Good.
13 MS. BOWLEY: On a regular basis and including
14 throughout the course of Phoenix's life, these low to
15 medium risk and low to moderate neglect cases did not have
16 the same specific well-ordered niche within the system.
17 Cases were prioritized on a daily basis on a minute-by-
18 minute basis at CRU, and the ones which presented as
19 immediate high risk were dealt with first, and it was a
20 fact that these so-called soft referrals were regularly
21 closed and dealt with in a less involved manner than
22 situations requiring apprehensions and management knew it
23 and condoned it.
24 The new crisis response program offers --
25 operates very differently, as we've heard during this

1 inquiry. It has clear standards, clear expectations,
2 policies, good tools, increased training and less workload.
3 I'm not going to spend a lot of time on it but I refer,
4 refer you, Mr. Commissioner, to Exhibit 51 and all of its
5 tabs. The wealth of resources that are set out there is
6 instructive.
7 THE COMMISSIONER: What is Exhibit 51?
8 MS. BOWLEY: Exhibit 51 is the ANCR tools,
9 policies and procedures documents.
10 THE COMMISSIONER: Oh, oh yes. Okay. I know
11 what you mean. As it is today?
12 MS. BOWLEY: Yes. Now, as I said, there may have
13 been a variety of reasons for that prior state of affairs
14 and I don't intend to try and deal with all of the
15 potential reasons today, but it may be important to note
16 that while Patrick Harrison was program manager from 2003
17 to July 2005, he reviewed the intake manual and was of the
18 view that no further edits were needed. He said he was
19 mindful that the intake program, including CRU, would
20 change with devolution. It was made clear to him that
21 there would be a revision of the program because a
22 different authority would be assuming responsibility for
23 intake and they would want to review it in its entirety.
24 As a result of these factors, he gave evidence at this
25 inquiry that changes to the intake program did not seem to

1 be a worthy effort at that time because it was going to be
2 changing.
3 Linda Trigg was the chief executive officer of
4 Winnipeg CFS from July 2, 2001 to July 5, 2004. She gave
5 evidence here that her number one concern or among her top
6 concerns was training. She brainstormed ideas at the
7 management table about training but said these ideas could
8 not be implemented because of all of the other changes
9 taking place and because it didn't make sense to re-arrange
10 things only to have it unravel six months later.
11 Jay Rodgers admitted the changes to CRU and
12 intake were not high on his list of priorities while CEO.
13 While it was challenging to bring about the
14 massive changes inherent in the necessary devolution
15 process and system failures may have been likely to occur
16 during that process, front line workers and supervisors
17 ought not to shoulder the blame for any system failures in
18 circumstances where their work was so compromised by so
19 many problems.
20 And this now brings me back to common sense.
21 Things at CRU in those years were not as simple and as
22 obvious as Mr. Gindin suggests. The wealth of detail and
23 analysis that has brought us here today was not known to
24 the people in CRU in 2004 and 2005. And as I said, the CRU
25 was not a simple place to work, and Mr. Commissioner, I was

1 heartened to hear your comments yesterday when you said
2 that you understand social work to be a difficult and
3 complex profession. It is and it was, and the events in
4 2004 and 2005 are not as susceptible to easy answers as has
5 been suggested to you.
6 It is my submission that as Dan Berg and Sandie
7 Stoker and others have said, common sense is not the
8 appropriate term by which to review these situations.
9 Professional judgment is a more appropriate term. Common
10 sense is subjective. Many people said that. It is also,
11 in my submission, very much based on its context.
12 As an obvious example, members of the public
13 often think that a judge's acquittal or sentencing decision
14 is utterly devoid of common sense, but in that context, in
15 that environment, the decision is appropriate. And
16 similarly, in the context of standards going back to 1988
17 which did not require a child to be seen, in the context of
18 a practice of not seeing a child occurring and being
19 accepted by management, it should become more difficult to
20 say that it is obvious common sense to do or not do
21 something in that environment, in that context at that
22 time. If everything was so simple and common sense, there
23 wouldn't be a need for standards and policies and training.
24 But this work is not simple and those things are and were
25 needed.

1 The desire for common sense or professional
2 judgment must be balanced against Jay Rodgers' evidence.
3 He said that if there is any doubt about what a worker
4 should do with respect to closing a file or seeing a child,
5 it would have been extraordinarily helpful to have it
6 clearly stated in a manual.
7 And again, I invite comparison to the old intake
8 program manual drafted in July 2001 to Exhibit 51, tab 3,
9 the new crisis response program manual. Actually, I think
10 that's tabs "T".
11 UNIDENTIFIED PERSON: Yeah.
12 MS. BOWLEY: They are, to repeat a phrase, night
13 and day in difference, and that night and day difference
14 speaks to the deficiencies which existed before. The night
15 and day scenario exists for virtually all of the systemic
16 defects which prevented CRU workers and supervisors from
17 meeting best practices in those days.
18 A lot of questions were asked during this inquiry
19 about whether workers and supervisors exercised what was
20 called common sense. Implicit in some of those questions
21 was criticism of those workers for not having gone above
22 the standards or failing to achieve best practices or
23 failing to exercise the idea of common sense based on all
24 that we know now.
25 And I return again to the environment in that

1 context. And Phoenix's situation should not be isolated
2 out of that environment and out of the practice of not
3 seeing children when those in the chain of command above
4 CRU knew that children were not being seen. It should be,
5 I submit, Mr. Commissioner, difficult to criticize and
6 judge the front line people existing in that state of
7 affairs, in that environment, when they were powerless to
8 change it. Jay Rodgers understood that. He gave evidence
9 on February 4 of 2013 and said:
10
11 "... there's no question, from the
12 findings in those external
13 reviews, that we had to really pay
14 attention to clarity about
15 standards. But it's one thing to
16 make standards available. We
17 can't hold our staff accountable
18 until we've had the opportunity to
19 train them in exactly what those
20 expectations mean and what our
21 expectations are, in day-to-day
22 practice to meet them."
23
24 And on that accountability issue, I didn't hear
25 the "wouldn't it have been common sense" question being

1 asked very much or at all about the conduct of management.
2 I didn't hear it being asked about the organization which
3 controlled the CRU environment, who had the power to change
4 and improve that environment. Senior management and
5 Winnipeg CFS, as a whole, had a clear statutory obligation
6 to provide a functioning system, including to train their
7 front line workers and supervisors. There was an
8 organizational obligation to achieve best practices and to
9 provide a system whereby the front line personnel could be
10 more successful in their work.
11 The common-sense questions for management in the
12 organization include: Wouldn't it have been common sense
13 to implement standards which required children who were the
14 subject of child protection concerns to be seen?
15 As Dr. Wright said, seeing the child was not a
16 new concept. If that was the case, why wasn't it included
17 in the so-called minimum standards? We still don't know
18 the answer to that question.
19 And I urge you to ignore Mr. Gindin's suggestion
20 that the standards would have been disregarded by Diva
21 Faria. There's no evidence to support that assertion.
22 Diva Faria worked hard and strived to meet best practices
23 and would have strived to fulfill that standard.
24 Wouldn't it have been common sense to train
25 workers and supervisors? Wouldn’t it have been common

1 sense to provide workers and supervisors with good quality
2 practical tools and manuals? Wouldn't it have been common
3 sense to provide them with enough time to do thorough work
4 so that they were able to achieve best practices, so that
5 they were able to make good professional judgments on a
6 consistent basis?
7 THE COMMISSIONER: But based upon their training,
8 in most instances towards the, the BSW degree and some time
9 on the job, i.e., doing the job for a period of months or a
10 short number of years, at that point they must have had
11 some proficiency to allow them to, to apply professional
12 judgment in a, in a sound manner vis-à-vis someone who was
13 without that training and without that experience that had
14 -- they had accumulated.
15 MS. BOWLEY: Yes. They had more ability than
16 someone without that training and their experience, but --
17 THE COMMISSIONER: So -- yeah, go ahead.
18 MS. BOWLEY: But they existed in an environment
19 where those kinds of cases were not dealt with aggressively
20 and intensively and they were not trained to do otherwise,
21 they were not told to meet standards that said otherwise.
22 That environment had a practice which was condoned by
23 management to not see children when there were broader
24 unspecified child protection concerns. The standards
25 allowed it, the practice allowed it and management condoned

1 it. So to now look at Phoenix's case in isolation, knowing
2 all that we know now is a bit unfair because those kinds of
3 cases were dealt with in that way regularly.
4 THE COMMISSIONER: So, so the workers were
5 operating, you say, within the context of a deficient
6 system?
7 MS. BOWLEY: Yes.
8 THE COMMISSIONER: I hear what you're saying.
9 MS. BOWLEY: And, and a lot of focus has been on
10 these workers and supervisors and there hasn't, with
11 respect, been the same kind of focus on what the people
12 above them were doing or not doing when it was those people
13 above them that had the control. Those people were
14 powerless within their environment to change the standards,
15 to force training on standards, to require different
16 minimal standards.
17 THE COMMISSIONER: But they had to apply their
18 judgment, such as it was, to the factual situations they
19 faced day by day.
20 MS. BOWLEY: Yes. But when their judgment, as
21 they apply it on a regular basis, is being condoned and
22 accepted and there are no file audits and no quality
23 assurance and no clinical training that tells them
24 otherwise, that's why they behave as they do and make the
25 decisions that they do.

1 Now, after having made the point about common
2 sense and unanswered questions about the system, I am not,
3 I want to make clear, suggesting that any person above the
4 front line supervisor of CRU needs to be blamed either.
5 I'm also not suggesting that it would be at all productive
6 to blame Winnipeg CFS or the department. The facts are
7 that the system was undergoing an unprecedented change.
8 Devolution was an important process and an absolutely
9 necessary one. The department in Winnipeg CFS could only
10 do so much in the face of this massive undertaking. And
11 blame against senior management or Winnipeg CFS does not
12 serve a substantive productive purpose for Manitoba's child
13 welfare system. The horrible lesson has been learned by
14 everyone in this system and by many people outside the
15 system. And to the credit of CFS and the department, they
16 have implemented profound and helpful changes in response
17 to this lesson and we can expect that they will do more
18 following this inquiry.
19 In my respectful submission, instead of blame,
20 the better, more helpful course, is to continue to explore
21 more ways to improve this system, something that we all
22 expect will result from this inquiry and its
23 recommendations.
24 And I turn now to the subject of recommendations.
25 THE COMMISSIONER: Okay. And that's on what page

1 of your brief?
2 MS. BOWLEY: It's not.
3 THE COMMISSIONER: Okay.
4 MS. BOWLEY: As a preliminary matter, Mr.
5 Commissioner, I don't have the expertise to speak
6 specifically to the recommendations you inquired about
7 yesterday other than the one about having files be opened
8 in the child's name, and I haven't had the opportunity to
9 consult so I'll leave it to others who have the appropriate
10 expertise.
11 THE COMMISSIONER: If they wish, yes.
12 MS. BOWLEY: Yes, if they wish. Not to put
13 pressure on them.
14 The primary recommendation coming from Diva
15 Faria, and this gets back to the point we exchanged earlier
16 this morning, is an automatic abuse alert on CFSIS when
17 there is an individual who is high risk to children, and
18 that could include being listed on the abuse registry,
19 scoring high on the criminal risk assessment, with a
20 history of violence to children or domestic violence, an
21 automatic abuse alert should be generated on CFSIS and the
22 intake module so there would be an automatic abuse alert
23 for that person's name and the name of any person that he
24 or she has been associated with within CFSIS. So the
25 workers having to deal with emergency situations don't have

1 to sift through volumes of files and hundreds of pages or
2 request files from off site in order to obtain important
3 high risk information. The alert should include all
4 possible aliases, birth dates or approximate ages and there
5 should be a detailed policy document accompanying that
6 automatic abuse alert as to what workers should do when
7 alerts appear.
8 Second, and this is essentially a variation on
9 recommendation number 18 --
10 THE COMMISSIONER: Just before you leave your
11 point number one --
12 MS. BOWLEY: Yes.
13 THE COMMISSIONER: -- do you know anywhere where
14 a system like that is actually in place?
15 MS. BOWLEY: I'm sorry, I don't.
16 THE COMMISSIONER: Okay. I mean, it sounds to me
17 as though it makes sense and I just wondered where, where
18 it might be found.
19 MS. BOWLEY: That recommendation came directly
20 from Diva Faria based on her personal review and searching
21 for something to assist in this process.
22 THE COMMISSIONER: Thank you.
23 MS. BOWLEY: The second is, as I said, a
24 variation on number 18 of the northern and southern
25 authorities' recommendation. The provincial standards

1 should be revised to ensure that they reflect current
2 Manitoba practices and that they are achievable based on
3 quality assurance measurements. Quality assurance
4 measurement should take place on the standards to ensure
5 not only that they are achievable but whether best
6 practices are achievable and that they are resulting in
7 optimal outcomes for children and families. Resource
8 allocation may need to be adjusted accordingly.
9 And if you like, Mr. Commissioner, I can provide
10 these to you or to Commission counsel in writing to save
11 you trying to take them down.
12 THE COMMISSIONER: I would think Commission
13 counsel would find that quite useful, who will be assisting
14 me throughout the remaining weeks to get this report out.
15 MS. BOWLEY: Thank you. With that then being
16 said and looking at the time, I do have the other
17 recommendations in writing and they are, in large part,
18 either endorsements of or variations on recommendations
19 that have already been made, and so with your permission
20 I'll merely submit those in writing and, and we can shorten
21 up this process.
22 THE COMMISSIONER: Providing there is nothing new
23 that your, your -- the other participants should hear to
24 have a chance to respond to.
25 MS. BOWLEY: The, the only one that may be

1 somewhat new is recommendation 28 from the northern and
2 southern authorities. And it is a recommendation that
3 higher qualification requirements and higher compensation
4 schemes should be put in place and funded for child welfare
5 staff occupying intake positions and, further, that child
6 protection workers should receive higher pay than workers
7 in other lower risk lower stress areas of the system,
8 something akin to danger pay or stress pay.
9 THE COMMISSIONER: And that would include
10 supervisors operating in that arena, too, I assume?
11 MS. BOWLEY: Yes. And Mr. Commissioner, that
12 concludes my submission. I want to thank you for your
13 attentive listening and your engagement throughout and also
14 for generously allowing me to appear and participate as you
15 have.
16 I want to thank Commission counsel for their hard
17 work, professionalism and their great assistance to me in
18 getting up to speed on this matter, and that goes for
19 Commission staff as well, for effective and prompt response
20 to my incessant e-mails.
21 And I want to conclude by saying that this
22 inquiry serves an honourable purpose in trying to prevent
23 such cruelty and misery from ever befalling another
24 Manitoba child and for the writer's part and on behalf of
25 Diva Faria, we commend the purpose and confirm the utmost

1 inquiry -- utmost importance of this inquiry and look
2 forward to your final report.
3 THE COMMISSIONER: Well I thank you very much,
4 Ms. Bowley, and I'm mindful of the stage that you were
5 brought into this, and I think you've done a remarkable job
6 of getting up to speed without being here at the time that
7 some of the significant witnesses gave their evidence that
8 bear on what you've had to say this morning.
9 MS. BOWLEY: Thank you.
10 THE COMMISSIONER: All right. I guess we'll take
11 our mid-morning break now and then we'll move on.
12 MS. WALSH: That sounds appropriate, thank you.
13 THE COMMISSIONER: Fifteen minutes.
14
15 (BRIEF RECESS)
16
17 THE COMMISSIONER: So we're ready to proceed.
18 Now the presentation on behalf of Ms. Dick.
19 MR. ZAPARNIUK: That's correct. For the record,
20 my name is Rob Zaparniuk. I represent Ms. Roberta Dick in
21 connection with these proceedings.
22 Mr. Commissioner, I intend to be very brief with
23 respect to my submission. Ms. Dick played a very brief
24 role with respect to this matter, as you're probably well
25 aware. It is not my intention to recite the facts I've set

1 out in my written submission nor go into any great detail.
2 I only simply wanted to highlight a couple of points at the
3 request of Ms. Dick so it would be before the Commission by
4 way of a brief oral presentation.
5 THE COMMISSIONER: Yes.
6 MR. ZAPARNIUK: The only suggestion, Mr.
7 Commissioner, which has come forward in these proceedings
8 indicating that Ms. Dick did anything wrong or in
9 appropriate arises out of the Koster report where Mr.
10 Koster makes a finding that Ms. Dick should have
11 recommended a 48-hour response time as opposed to the
12 within five days response time which she did recommend.
13 And in conjunction with that, it appears that there's a
14 concern that Ms. Dick had taken into account workloads at
15 the intake level in making her recommendation.
16 Ms. Dick testified that it was a judgment call
17 that was made by her and she says these judgment calls are
18 required frequently. She testified that she took all
19 relevant matters into account and ultimately felt that the
20 within five days response was an appropriate response time.
21 She did consider what was before her in terms of the facts,
22 and one must consider the response times in, in -- based on
23 the facts as presented and based upon all surrounding
24 circumstances.
25 I'd submit that one must also take into account

1 the various categories and how they're to be applied.
2 We've got the high, moderate and low risk categories and
3 there are grey areas that one has to consider which
4 requires a professional judgment, which I'm submitting was
5 made by Ms. Dick. I've outlined those definitions in my
6 written submission at paragraphs 9 through 16 inclusive.
7 I'm not going to repeat them now. But I am going to submit
8 that when you look at the facts as presented to Ms. Dick in
9 terms of Phoenix's situation at that time and considering
10 the context of each of those categories, it was a
11 reasonable and appropriate decision on the part of Ms. Dick
12 to select the low risk within five days category.
13 And just to clarify that, the categories have to
14 be read, I submit, in context with each of the sub-
15 categories to get some feel for how severe or how not
16 severe the situation is that's presenting itself, and I'm
17 submitting Ms. Dick did exactly that.
18 Although she did testify that she took into
19 account workloads, she very clearly testified that she
20 would to deliberately misdiagnose or miscategorize an
21 assessment or response time when it was clear that an
22 earlier response time was required. So that's an important
23 point to note because it -- her decision-making wasn't
24 dictated by workloads, it was dictated by all of the
25 circumstances.

1 I would submit that in terms of her comments
2 relating to workload, it was simply a factor that would
3 have been considered but not a factor that changed her
4 assessment. It is my respectful submission that she looked
5 at what risk level was appropriate for Phoenix. She
6 determined that there were no safety issues as it related
7 to Phoenix and, given those criteria, the low risk category
8 made sense in her evaluation.
9 The concept of overwork is simply her making a
10 decision that this wasn't a low risk category, there's no
11 point making it moderate or anything else because that's
12 only going to put undue pressure at the intake level, for
13 which there would be no purpose. So she assessed the risk
14 for what it was before she took into account anything in
15 terms of workload. If anything, workload would only have
16 been taken into account not to force something to arrive
17 sooner than it needs to arrive.
18 I would respectfully submit that what Ms. Dick
19 did is she exercised appropriate professional judgment or
20 common sense, depending on which phrase you'd like to use.
21 Simply put, she didn't make a decision based on workload,
22 she made it based on all of the factors that presented.
23 The problem I would submit with Mr. Koster's
24 opinion is that it's merely his opinion and is entirely
25 subjective to him. He did not interview Ms. Dick, he did

1 not interview her supervisor, Ms. Faria, he did not
2 interview the intake worker, Laura Forrest, who ultimately
3 took charge of this referral, and he didn't interview Mr.
4 Orobko, being Ms. Forrest's supervisor.
5 There's nothing in his report that suggests that
6 he took into account the context of each of the categories
7 by looking at the other subcategories. He simply expresses
8 his opinion and he is effectively substituting his opinion
9 for that of Ms. Dick. I'm going to suggest and ask
10 yourself, Mr. Commissioner, to consider the decision made
11 by Ms. Dick more along the line of what an appellate judge
12 might do. It's common that an appellate judge, and it's
13 stated in many cases that they might disagree with a
14 decision the trial judge came to but they go on to say
15 there was plenty of evidence on which the trial judge could
16 have come to the decision that he did come to and therefore
17 the appellate court is not just simply substituting their
18 opinion. With respect, I think that's what Mr. Koster did
19 and I'm asking you, Mr. Commissioner, not to do that, to
20 consider what was, in fact, before Ms. Dick and whether or
21 not her decision was a reasonable one at the time rather
22 than, in hindsight, trying to substitute something
23 different.
24 It's important to note that all of the experts,
25 meaning Ms. Faria, Ms. Forrest and Mr. Orobko, all agreed

1 with the response time selected by Ms. Dick. These are all
2 experienced people and they all agreed.
3 THE COMMISSIONER: Is Faria, Andy Orobko and who
4 else?
5 MR. ZAPARNIUK: And Ms. Forrest.
6 THE COMMISSIONER: Forrest. Yeah.
7 MR. ZAPARNIUK: And I also note, Mr.
8 Commissioner, that with respect to the written submissions
9 which have been filed, there's not a single statement
10 suggesting that what Ms. Dick did was inappropriate or
11 wrong in any way whatsoever, and I'm submitting that that's
12 something ought to be considered by yourself as well in, in
13 the context of the experts and what has now been submitted
14 in terms of Ms. Dick. I respectfully submit that she did
15 act appropriately based upon her brief involvement with
16 respect to this matter.
17 And that basically concludes my brief submission,
18 Mr. Commissioner, subject to any questions you might have.
19 THE COMMISSIONER: No. I, I made the point on my
20 own sheet that when I went, read your brief and make, made
21 this note, the only issue here is her five-day call re the
22 nose incident following the hospital call, whether Phoenix
23 would be given the medication as prescribed, hence the
24 referral. And that's the issue you've addressed and I
25 follow what you said and I thank you for your contribution.

1 MR. ZAPARNIUK: Thank you, Mr. Commissioner.
2 THE COMMISSIONER: All right. Now I guess we
3 hear counsel on behalf of Ms. Verrier.
4 MR. ROLSTON: Yes. Good morning, Mr.
5 Commissioner. My name is Ryan Rolston and I'm appearing on
6 behalf of Ms. Verrier this morning, and I want to start out
7 by thanking you on behalf of Ms. Verrier for giving her the
8 opportunity, through me, to address you here this morning.
9 As counsel for a witness, in my view my role is
10 perhaps different from many of the parties who have
11 standings and as such I don't plan on making specific
12 recommendations to you. We've provided you with written
13 material which have addressed our position with respect to
14 some very specific factual issues that have arisen and I
15 don't intend on re-arguing those positions but I'm happy to
16 answer any questions you have with respect to those.
17 For the most part, my purpose here today, Mr.
18 Commissioner, is to adopt the comments that were so well
19 spoken by Mr. Ray and Ms. Bowley in, in their submissions
20 with respect to some of the issues that Ms. Verrier dealt
21 with in her time dealing with this file and her time as
22 supervisor in the CRU. But I, I wanted to spend our time
23 here illustrating how Ms. Verrier's involvement fits in
24 with some of the various parties' perspectives on how the
25 system fails, failed here, in an attempt to assist you

1 perhaps in, in your mandate to inquire into the child
2 welfare services provided or not provided to Phoenix
3 Sinclair and her family under the CFS Act.
4 And really effectively, if I can briefly
5 summarize what I've heard as three viewpoints that have
6 been put forward by the various parties:
7 From Mr. Gindin on behalf of his clients, there
8 seems to be a suggestion that workers, which would include
9 Ms. Verrier, were either incompetent and/or ambivalent as
10 to their role in the system. When I have reviewed the
11 department's materials I see that an acknowledgement has
12 been made that a lack of training was a problem and
13 although workload and standards were a problem they don't
14 seem to be the problem that led to the colossal failure
15 that was occasioned to Phoenix Sinclair and her family.
16 And then on behalf of the workers, through the union, the
17 message that seems to be sent to you is, social workers
18 need time and they need training and the fact that these
19 were lacking contributed on a daily basis that effectively
20 led down to -- led to the let-down in services to Phoenix
21 Sinclair.
22 So what I wanted to do for you, then, was look at
23 Ms. Verrier's involvement as supervisor in the brief time
24 that she touched the Phoenix Sinclair file. And I, I will
25 say at the outset that clearly there was a disconnect that

1 occurred when Ms. Verrier had the file. At that time, and
2 perhaps in, in hindsight that let-down or disconnect didn't
3 necessarily result in any major colossal failure at the
4 time but it certainly illustrates, I think, Mr. Ray's
5 position that there was a real stress that was an ongoing
6 cumulative aspect that really let down this family.
7 THE COMMISSIONER: Are you saying a disconnect
8 between she and De Gale or ...
9 MR. ROLSTON: Yes. And I think really it's a
10 disconnect that, that is a systemic disconnect. So while
11 it -- while those two parties were the parties that, that
12 really were disconnected at the time, it really is a good
13 example of, of a disconnect that was a systemic problem,
14 and that's why I wanted to go through it and use it as an
15 illustration --
16 THE COMMISSIONER: Yes.
17 MR. ROLSTON: -- for you.
18 So if we take Ms. De Gale at face value, and you
19 certainly have my comments in our written materials about
20 areas where she may not be taken at face value, but if you
21 take her at face value, Ms. De Gale got some information
22 that Phoenix Sinclair was now under the care of Samantha
23 Kematch and that's why her involvement began in May of 2004
24 once again. And as a result of that she did an, a safety
25 assessment. And I want to start with her review of that

1 which really is, is something that has become a theme, at
2 least in the last three people who are, two people before
3 me who have spoken to you about response time.
4 And it's interesting, because what we have here
5 is an assessment on face value of what you've been told by
6 Debbie De Gale was a 24-hour response time. That's what
7 she's told you and, and, and so we'll, we'll take that at
8 face value for, for these purposes.
9 The interesting thing here from a systemic point
10 of view is, if you look at what others were asked about the
11 specific assessment, you really have a number of different
12 opinions on what the appropriate response time was. So Ms.
13 De Gale says 24 hours, Diana Verrier says 48 hours; Karen
14 Parsons was asked about it, she said five days; Roberta
15 Dick was asked, she said five days. And interesting, the,
16 the sort of the last opinion or authority on it is really
17 the form itself because the form requires the person using
18 the form to tick certain boxes that lead to an inevitable
19 answer. And in this case the form, based upon the answers
20 given, said 48 hours. And so what does that say? What,
21 what does all of that mean in terms of, of your assessment
22 of where things are beginning to fall down? And I say that
23 really this is a training issue.
24 This is a situation where either in the way that
25 the answers are, are given or the way that the assessments

1 are made or, as Ms. Bowley, I think, illustrated quite
2 competently, in tool itself there's a disconnect that is
3 there that is due to lack of training.
4 And of course, we know that ANCR has, has stepped
5 in and adjustments have been made with respect to that, and
6 that's why I say that there's really no recommendation that
7 I can make to you that can't be made by others who will
8 speak to that.
9 Now, after the form gets filled out, we -- let's,
10 let's analyze that, that form. Ms. De Gale checks off 24
11 hours on the form but she fills in sections that speak to a
12 48-hour response time. There's no note made to the reader
13 to indicate that she has other intentions. So if we again
14 accept her at face value that she intends a 24-hour
15 response time, she hasn't made that note anywhere on the
16 form to indicate that this is an unusual case, that even
17 though I'm checking off the boxes that mandate a 48-hour
18 response time, I really think it should be 24 and this is
19 why. There's nothing like that here. So what does that
20 say to us, what does that tell us as, in the position that
21 we're in and, frankly, the position that you're in now,
22 what does that tell you? Again, this is a training issue
23 and really goes to the inadequacy of note-taking that Mr.
24 Gindin mentioned in his opening remarks yesterday.
25 Because ultimately, if, if parties aren't clear

1 on how -- and state their intentions for others, when we're
2 going to have a difficulty, particularly in a system that
3 is so reliant on other people's hands being on a file at
4 any given time. So, is it a training issue? Yes, it's a
5 training issue and perhaps maybe it's a workload issue as
6 well, because we've heard some commentary about the fact
7 that one of the first things to fall down in these
8 circumstances where workload becomes overburdened is, is
9 with respect to note-taking and perhaps maybe that is part
10 of, of the disconnect.
11 The file then moves to my client, Diana Verrier,
12 and the form is corrected. That is to say that the 24-hour
13 box is now changed to 48 hours.
14 Now, I want to pause here and note that comments
15 of Mr. Gindin yesterday, because he was very critical of
16 another supervisor for simply rubber stamping the worker's
17 work and not giving any critical thought as to whether or
18 not that was an appropriate assessment and just saying, no,
19 I accept my workers, whatever they say; even if I disagree,
20 I'm going to leave their work. And now we have the
21 complete opposite. We have a situation here where a
22 supervisor has, has looked at a form, said, I don't agree
23 with this assessment and then made a change. So I'm not
24 sure how we can be critical of both parties, and certainly
25 my respectful view and my respectful submission to you is

1 that the supervisor's job is to do what Diana Verrier did.
2 She saw no reason, based upon the face of the form, to make
3 this a higher priority and accordingly she endorsed the 24-
4 hour, corrected the mistake and moved on.
5 Again, the interesting thing and the important
6 thing from our perspective here, though, is to analyze what
7 has fallen down here. Because this is, in my view, really
8 where the disconnect occurs because we have two parties
9 who, if you accept Debbie De Gale on face value, have two
10 separate intentions and when those two separate attentions
11 -- intentions are, are not rectified, then we have a system
12 that's broken and, and something has really fallen down
13 here.
14 And so why is it that the form wasn't -- or why
15 wasn't there communication between those two parties? When
16 you look at what Ms. De Gale said about it, she said, well,
17 she should have come to me if she thought that there was
18 confusion. And again, that sort of goes back to, well, you
19 didn't put anything on the form itself, where you could
20 have, in that section "C", to, to indicate that there was
21 some other intention. So how is the reader supposed to
22 know it was a mistake? And on the flipside of it, from Mr.
23 -- Ms. Verrier's position, you heard her evidence and, of
24 course, again, not remembering specifically when she would
25 have done it but her evidence was, well, a lot of the times

1 I didn't have time during the day when the workers were
2 there working, to be able to go back and consult with them
3 on the issues. A lot of times, the workers were gone when
4 I was reviewing those works.
5 So what have we got here in terms of the
6 disconnect? What is causing the disconnect? And again, we
7 come back to really what Mr. Ray talked to you about
8 yesterday, Mr. Commissioner, where we have a significant
9 work overload such that supervisors are, are doing the
10 paperwork after people have gone home and ultimately from
11 Ms. De Gale's perspective, a situation where she's not,
12 either not able or not trained to properly fill the form
13 out. And I --
14 THE COMMISSIONER: Just, just to recall, besides
15 the, the form on which the time selection was made, there
16 was a form that was signed that went in for the closing by
17 Verrier, was there not, where the signature of De Gale was
18 absent?
19 MR. ROLSTON: Yes. That was all part of the same
20 form.
21 THE COMMISSIONER: Yeah.
22 MR. ROLSTON: And the evidence on that from Ms.
23 Verrier again was that sometimes the forms were signed and
24 sometimes they weren't, and she didn't take that as a
25 significant factor. I say again that, that's probably a

1 workload issue.
2 THE COMMISSIONER: But, but did not, did not De
3 Gale say that she did not turn in an unsigned document?
4 MR. ROLSTON: I don't know if she could say that
5 she, she's -- I think that her evidence was she wouldn't
6 have put in an unsigned document. That's where you're
7 going to have to, in my respectful view, you're going to
8 have to assess Ms. De Gale's credibility on that and how
9 she could possibly remember that fact so many times, unless
10 she never ever submitted a report unsigned. And perhaps
11 that's some difficulty, but again, we have to be careful
12 not to get confused between the safety assessment and her
13 actual report. And I think it was the report that wasn't
14 signed. The safety assessment was a situation where the
15 wrong box was ticked off from Ms. De Gale's perspective,
16 and you'll recall that Ms. De Gale's perspective on the
17 other document was that things had been taken out. And,
18 and, and I think the signature more relates to the, that
19 fact. And --
20 THE COMMISSIONER: Yes.
21 MR. ROLSTON: -- ultimately, I provided you some
22 documentation that analyzes that, and I don't want to go
23 through that necessarily all again, but at the end of the
24 day we would respectfully submit that Ms. Verrier ought to
25 be accepted in terms of her evidence on that over Ms., Ms.

1 De Gale, for a large number of reasons.
2 At the end of the day, I say that when you look
3 at the, the -- in respect of the altering of the safety
4 assessment and the change in response time, we have a
5 situation where, when you look at the actions of Ms.
6 Verrier, the evidence shows that she was a dedicated
7 supervisor but was overburdened with work. And I say that
8 because, again, her evidence was that oftentimes she stayed
9 after everybody had gone home to complete the work that she
10 was doing. So again, is this a situation where, in Mr.
11 Gindin's words, we have ambivalence of workers? I say no.
12 But really, what we're dealing with here is a, a good
13 example how workload and lack of training cumulates to a
14 point where services are being affected, in fact, even
15 services with respect to this very file, quite to the
16 contrary of what the department's submission was to you.
17 There's another overarching concern here, and
18 that is that there was no clear standards, and there's been
19 a lot of evidence about that. And I just make the
20 observation that without clear standards people within the
21 system are then left to make it up as they go. Everybody
22 in life does things a little bit differently and certainly
23 no matter how collegial your team environment is, when
24 people do things a little bit differently on a team without
25 a plan, you're going to run into problems. I say to you,

1 Mr. Commissioner, that really all of those social workers
2 that have come before this Commission had the same goal,
3 and that was to provide child welfare services to children
4 in Manitoba. These were not ambivalent people. You take
5 any team, for example a football team, may all have the
6 same goal such as the workers did. That same -- in the, in
7 the scenario of a football team, they -- everybody may want
8 to score a touchdown and you may even agree that the play
9 should be a hand-off but that's not the end of the day.
10 Which player will block? Who will get the ball? Which
11 direction will the play go? All of these things are
12 reduced to practice and all of these things are reduced to
13 a play book. And without a play book, a football team on
14 the field is really effectively reduced to a huddle where
15 one person in the huddle is required to call it on the fly.
16 And that effectively was the supervisor here in this
17 scenario that you have before you. With no provincial
18 standards that were clear, that were -- that dictated the
19 actions of all the players on, on the field, as I say,
20 without -- no matter how collegial you are, you're never
21 going to be able to advance the ball or to advance the, the
22 needs of, of children in Manitoba.
23 And so ultimately, at the end of the day, we
24 agree with Mr. Ray's submission. Timing, training,
25 guidance, all of those things were an issue and all of

1 those things came into play with respect to Ms. Verrier.
2 Her involvement, as I say, was, was brief. Many of the
3 circumstances that I've dealt with in my written materials
4 I think are certainly open for any question that you have.
5 We say that she was a supervisor and, in her words, was
6 managing a system that was unmanageable, and we say that
7 she should not be faulted for that.
8 So subject to any questions you have, Mr.
9 Commissioner.
10 THE COMMISSIONER: No, Mr. Rolston, I think
11 you've answered everything. I, I am concerned about that
12 unsigned document. I, I -- and Ms. De Gale's insistence
13 that she never signed in an unsigned document, but we'll
14 have to work through that.
15 MR. ROLSTON: All right. And certainly I believe
16 I've dealt with that in my material, so --
17 THE COMMISSIONER: Yes, I think you have.
18 MR. ROLSTON: Okay.
19 THE COMMISSIONER: And I've read it and I'll
20 re-read it.
21 MR. ROLSTON: Thank you. I'd like to also thank
22 you for, again, the opportunity to address you. As a
23 witness in this proceeding, it was very important to Ms.
24 Verrier to be heard and I thank you for that. I also would
25 like to thank Commission counsel and the staff. It was a

1 little bit difficult at times coming up to speed and they
2 were of great assistance to us, so thank you very much.
3 THE COMMISSIONER: Well, as I've said to Ms.
4 Bowley and the last speaker as well, having come into it
5 late, you were at quite a disadvantage but you picked up
6 the ball and to take your analogy, and ran with it very
7 well.
8 MR. ROLSTON: Thank you.
9 THE COMMISSIONER: Thank you.
10 All right. That takes us to, I guess, ANCR and
11 the two authorities. Mr. Cochrane and Mr. Saxberg.
12 All right. Just let me get to your brief here.
13 All right, Mr. Cochrane.
14 MR. COCHRANE: Good morning, Mr. Commissioner.
15 For the record, my name is Harold Cochrane and, as you
16 know, I'm counsel to ANCR, southern authority and northern
17 authority. At the table here, of course, is Mr. Saxberg
18 who is also counsel, and we also have Sandie Stoker, who is
19 the executive director of ANCR. The reason Ms. Stoker is
20 here at the table is you'll note that a number of our
21 recommendations are what I would call highly technical in
22 nature, so if you do have specific questions that I am not
23 able to respond to properly, I thought it would be quicker
24 to have Ms. Stoker here and I can quickly consult with her
25 and hopefully get you the answer.

1 THE COMMISSIONER: That's just fine.
2 MR. COCHRANE: Thanks. As well, I should also
3 mention that Mr. Saxberg, depending on any issues come up,
4 may stand at the podium to address some certain questions
5 when they arise, and he's certainly here to assist yourself
6 as well.
7 So for our closing, Mr. Commissioner, what I
8 propose to do is as follows:
9 I'll start off with a summary of the evidence
10 provided Ms. -- by Ms. Flett. She's the CEO of the
11 southern authority, as you know. Very short summary. I'll
12 then do the same for Ms. Stoker and give you a brief
13 summary of her evidence.
14 Then what I propose to do is to get into a
15 presentation of our recommendations, the package that you
16 have there in front of you.
17 And lastly, yesterday you asked Mr. Ray to, to
18 respond to, I believe it was four or five recommendations
19 based on Mr. Gindin.
20 THE COMMISSIONER: Yes.
21 MR. COCHRANE: And I certainly hope to do that
22 near the end of the presentation, so that will be the last
23 point that I plan to cover. Okay.
24 THE COMMISSIONER: Thank you.
25 MR. COCHRANE: So to begin, what I wanted to make

1 clear at the outset was ANCR, southern authority and
2 northern authority did not provide any services to Phoenix
3 Sinclair. They had no involvement in the services provided
4 or not provided to her. That was the evidence you've
5 heard. We -- so I wanted to make that clear from the
6 outset.
7 With respect to the evidence of Ms. Stoker, I'll
8 summarize it as follows: As you know, she's the executive
9 director of ANCR. Exhibit 51 is the binder of documents
10 that has been prepared by ANCR and they include a number of
11 key documents in there. You'll find the ANCR program
12 policy manuals, you'll find statistical information, you'll
13 find case recordings and notes -- sorry, policies on notes,
14 note-taking. You'll find in there ANCR's private
15 arrangement policy, ANCR's supervision and performance
16 management policy, ANCR's client contact policy. You'll
17 also find the safety assessment and probability of future
18 harm analysis documents that were prepared with respect to
19 Phoenix Sinclair. That was at the request of Commission
20 counsel, so you'll find those in those documents.
21 Exhibit 52, Mr. Commissioner, is the summary of,
22 or is the witness summary of Ms. Stoker. It provides an
23 excellent outline of the ANCR service model and changes to
24 the service model that have been made since Winnipeg CFS
25 delivered services to Phoenix Sinclair, and I'd strongly

1 recommend that, Mr. Commissioner, you review that witness
2 statement because it does, in my opinion, provide some
3 important information.
4 We've heard already this morning the practices at
5 Winnipeg CFS from 2000 to 2005. Ms. Bowley I think was the
6 one who mentioned those. In that regard, Ms. Stoker
7 testified that when she arrived at Winnipeg CFS intake in
8 September of 2005, she was alarmed at what she described as
9 the accepted practice at a time and she, she used the
10 phrase, phone social work.
11 THE COMMISSIONER: What, what word?
12 MR. COCHRANE: Phone social work.
13 THE COMMISSIONER: Yes.
14 MR. COCHRANE: Phone social work.
15 THE COMMISSIONER: Yes.
16 MR. COCHRANE: The transcript dated May 6, 2013,
17 page 110, there Ms. Stoker testified as follows. Says, to
18 me -- she's talking about this, what, what she was, what
19 she found when she went to Winnipeg CFS. She said:
20
21 "To me it was which is why, why I
22 drafted the policy. But when I
23 arrived there, in September ...
24 2005, it was one of my main
25 concerns that I spoke [to] my

1 colleagues about, spoke with my
2 supervisors about, spoke with my
3 staff about it at program meetings
4 and forwarded to the executive
5 director of JIRU saying that this
6 was a real concern that I have, I
7 had seen phone social work
8 occurring and I had seen people
9 not -- reviewed intakes because
10 I... would cover, as part of [my]
11 learning the organization, I would
12 cover for supervisors when they
13 were absent, as [as] was my way to
14 get to know the staff, get to know
15 the processes, and I spent about
16 six months to a year doing that,
17 and it was not uncommon for people
18 to go out and [to] speak only with
19 the parents and not see the
20 children."
21
22 She was asked:
23
24 'So you actually saw that
25 happening in practice?'

1 She, and she answered:
2
3 "Yes."
4
5 Ms. Stoker then went on to testify at page 111,
6 at line 11 that:
7
8 "... when ... the allegations were
9 broad, ... there were definitely
10 times when children weren't [seen
11 during the course of a child
12 protection investigation]."
13
14 Then at page 112, again I'm referring to the May
15 6th transcript, Mr. Commissioner, you asked Ms. Stoker the
16 following question, and you said:
17
18 "And I had a witness here who said
19 that based upon what the
20 allegations were, that ... the
21 file would not be closed, should,
22 should not have been closed ...
23 and the -- anyone -- a social
24 worker who had experience and
25 applied common sense would know

1 that the child should be seen
2 before that occurred."
3
4 And you asked her:
5
6 "Would ... you agree with that?"
7
8 Ms. Stoker said:
9
10 "I would agree and I would
11 disagree. I would say from my own
12 perspective, yes, ..."
13
14 She agreed with your suggestion:
15
16 "... but knowing that I arrived
17 there four months later there were
18 many circumstances in which the
19 practice was not to see the
20 children, it was not a onetime
21 event."
22
23 And then you questioned her further and, and you said:
24
25 "Yes, but regardless of the

1 practice, if you had an
2 experienced social worker and
3 applied, I take it what you would
4 call professional judgment, he or
5 she would have known that [the]
6 child should have been seen before
7 the file was closed?"
8
9 Ms. Stoker answered:
10
11 "Not in that environment."
12
13 You said:
14
15 "Not so?"
16
17 And Ms. Stoker said no. So -- not at that point and at
18 that place.
19 And then again at page 114, you said to her, or
20 questioned her:
21
22 "So you don't -- do you agree or
23 not agree with the witness who
24 said that, ... a social worker
25 should have known that [a] child

1 should have been seen before ... a
2 social worker with experience
3 should have known that, that a
4 child should have been seen before
5 the file was closed?
6
7 Ms. Stoker said to you, in reply:
8
9 "I do agree but I also think it's
10 important to look at the ...
11 environment in which that work was
12 occurring when you have multiple
13 examples of it not happening. And
14 it's a supported practice by
15 management, then social workers
16 will be -- come to think that
17 that's the accepted practice."
18
19 Then you said to her, Mr. Commissioner:
20
21 "Well, are you saying that that
22 was the accepted practice?"
23
24 And Ms. Stoker said:
25

1 "Yes."
2
3 So that was her evidence with respect to when she
4 arrived at that agency.
5 Ms. Stoker then, in her evidence, talked about
6 changes to policies and procedures that she made from 2005
7 to the present. Talked really about what changes have been
8 made and what, what she did, what changes were made. And
9 she identified six -- I'm trying to categorize it for ease
10 of reference. I would say six, six changes, major changes.
11 There was more but I'll highlight six for you, Mr.
12 Commissioner.
13 One was the introduction of the intake module.
14 Very briefly, you heard evidence that work at the intake
15 level was improved with the introduction of the intake
16 module. You heard evidence about that. You heard that
17 intake module is a new computer system that was -- that
18 improved the delivery of services by --
19 THE COMMISSIONER: Mr. Cochrane, let me interrupt
20 you. These are six changes made over what period of time?
21 MR. COCHRANE: 2005 to the present. First one
22 I've talked about is just the intake module.
23 THE COMMISSIONER: Is the intake module.
24 MR. COCHRANE: Yes.
25 THE COMMISSIONER: Yeah.

1 MR. COCHRANE: And, and evidence was that the
2 improved delivery of services by making prior contact
3 checks mandatory for all new intakes, okay. So every
4 intake now requires a, a prior contact check. A mandatory
5 safety assessment. It makes it easier to cross-reference
6 related parties. It allows information to be entered into
7 the system directly by workers as opposed to administrative
8 staff. She also testified that it makes information
9 entered into the system available in real time rather than
10 it being delayed.
11 And then the last point under intake module she
12 talked about was improvements to, to the determination of a
13 response time by requiring workers to identify issues,
14 which issues come with automatic responses. That's
15 somewhat technical but that was the evidence she provided
16 to you on the intake module.
17 What I would call the second change, the second
18 major change, if I could use that terminology, is the
19 mandatory safety assessments on all allegations of abuse or
20 neglect. And you heard evidence, Mr. Commissioner, of,
21 from Ms. Stoker that she testified that the current
22 protocol at ANCR is to conduct a formal safety assessment
23 and risk assessment on all allegations of abuse or neglect.
24 It's all allegations of abuse or neglect. Formalized
25 assessments of that sort were not conducted when Winnipeg

1 CFS performed the intake function. That is a major change.
2 What I'd call the third --
3 THE COMMISSIONER: And that second point had,
4 with respect to a mandatory assessment, safety assessment?
5 MR. COCHRANE: Yes. Safety assessment and risk
6 assessment.
7 THE COMMISSIONER: And risk assessment.
8 MR. COCHRANE: Yes.
9 THE COMMISSIONER: All right. Three?
10 MR. COCHRANE: Three: structured decision-making
11 assessment tools. You heard a, a lot of evidence with
12 respect to standards of assessment tools, Mr. Commissioner.
13 Ms. Stoker confirmed that all allegations of abuse or
14 neglect, for all allegations of abuse or neglect a risk
15 assessment must be completed. ANCR staff do a probability
16 of future harm assessment and a caregiver, a child strength
17 and needs assessment on all files that are transferred for
18 ongoing services to family service agencies. So those
19 assessment tools are now used, they're now in place.
20 What I'd call number four, Mr. Commissioner, is
21 ANCR's client contact policy. This is at tab "Z", Exhibit
22 51, which is a copy of that policy, ANCR's client contact
23 policy. And this policy, Mr. Commissioner, requires that
24 on every allegation of abuse or neglect or child
25 maltreatment, that the child must be seen; at a minimum,

1 the child must be seen.
2 In addition, if the child is age appropriate and
3 developmentally capable, the child is also interviewed.
4 And if you want a reference to that, Mr. Commissioner,
5 that's transcript of May 2nd, 2013, that's page 22 and 23.
6 The fifth change is ANCR's private arrangement
7 policy. Mr. Commissioner, this you could find at tab "Q"
8 of Exhibit 51, copy of that policy. And at page 139 of the
9 transcript, that's the May 2nd, 2013, Ms. Stoker testified
10 that the creation of this policy was a result of one of the
11 recommendations made in the chief medical examiner's case
12 specific report. And in essence, the gist of it is that
13 private arrangements are not allowed in situations where
14 the probability of future harm assessed the risk to the
15 child to be high. That's important.
16 Sixth changed, Mr. Commissioner, is ANCR's case
17 recording policy. We've heard a lot of comment about this
18 over the last two days.
19 THE COMMISSIONER: Just a minute. Repeat number
20 six again?
21 MR. COCHRANE: Number six, ANCR's case recording
22 policy.
23 THE COMMISSIONER: Right.
24 MR. COCHRANE: And Mr. Commissioner, that's found
25 at tab "P". "P".

1 THE COMMISSIONER: Yes.
2 MR. COCHRANE: It's Exhibit 51. And given the,
3 the comments we've heard the last day and a half, the most
4 important feature of that policy is that no records are
5 ever destroyed and for that you could see Section 4.3 of
6 that policy.
7 With respect to supervision notes, that the
8 supervisor gives case management direction, the worker --
9 THE COMMISSIONER: Are you leaving the six
10 points?
11 MR. COCHRANE: Sorry?
12 THE COMMISSIONER: Are you leaving the six
13 points?
14 MR. COCHRANE: This is, this is within that --
15 I'm still talking about that sixth policy.
16 THE COMMISSIONER: Okay. That's fine. I've got
17 a question for you at the end of them.
18 MR. COCHRANE: Okay. So the policy also provides
19 that regarding supervision notes, if the supervisor gives
20 case management direction, the worker must record that
21 direction in the information module. It has to be
22 recorded, according to policy.
23 Policy also provides that the supervisor is to
24 keep a record of supervision sessions, which are to be kept
25 in the supervision file, and that file cannot be destroyed.

1 If the supervisor receives a direct call from a
2 client, then it's the supervisor's responsibility to record
3 that contact directly into the information module. The
4 point being, Mr. Commissioner, that these files, these
5 records, are no longer destroyed.
6 Did you have a question --
7 THE COMMISSIONER: Well, yes.
8 MR. COCHRANE: -- before I move on?
9 THE COMMISSIONER: My question is this: For --
10 you've indicated, you've pinpointed Ms. Stoker's evidence
11 as supportive of some of these changes. My question is, in
12 that you're here representing ANCR and the two authorities,
13 are you putting forward that those are changes that are
14 made that are applicable not only to the operation of ANCR
15 but also the, the, the policies, the procedures of the two
16 authorities you represent?
17 MR. COCHRANE: Yeah. These, these are ANCR-
18 specific policies.
19 THE COMMISSIONER: All right. That answers my
20 question.
21 MR. COCHRANE: Yes. Those -- there's other
22 changes, of course, that ANCR has made, Mr. Commissioner.
23 I've identified only six. If you look again at Ms.
24 Stoker's witness summary, Exhibit 52, we provide a lot more
25 detail, we provide more examples of changes, major changes

1 that have been made, but for today's purpose I'll leave it
2 at those six that I've identified.
3 Moving on, then, Mr. Commissioner, you heard a
4 lot of evidence from Ms. Stoker about how the Phoenix
5 Sinclair case would have been handled if the same situation
6 presented itself today at ANCR. And she talked about that
7 on May 2nd, and the transcript would be pages 156 to 174,
8 just over 20 pages of evidence was on this topic.
9 And again, in summary form, Ms. Stoker reviewed
10 the, what I'd call the fourth, fifth, sixth and seventh
11 protection openings. And I can give you more -- can give
12 you the dates if you need those. And she applied the new
13 service model to those openings. And her evidence, again
14 in summary form, is that the, the new SDM tools and the
15 existing safety assessment, ANCR would have, ANCR would
16 have shown that both parents, that's Steven Sinclair,
17 Samantha Kematch, were high risk to harm Phoenix Sinclair.
18 With respect to the fourth protection opening,
19 that's the January 2004, Phoenix would have been
20 apprehended and a private arrangement would not have been
21 permitted in these circumstances.
22 With respect to the fifth protection opening, her
23 file would have been opened and transferred for ongoing
24 services so it would have been transferred to another
25 agency for ongoing services.

1 With respect to the sixth protection opening in
2 December 2004 and the seventh protection opening in March
3 2005, it would have also resulted in high probability of
4 future harm risk assessments and would have resulted in the
5 transfer of the file to Family Services for ongoing service
6 delivery. In other words, Mr. Commissioner, the file would
7 not have been closed.
8 Moving on to the next area, Ms. Stoker was asked
9 if she'd reviewed the recommendations from the various
10 reports that have arisen out of the death of Phoenix
11 Sinclair, and at page 174 of her transcript on May 2nd,
12 2013, she stated ANCR had conducted a review of all the
13 recommendations that applied to its intake function for any
14 services provided by ANCR, and she concluded and testified
15 that all recommendations that are applicable have been
16 implemented.
17 THE COMMISSIONER: And that's the recommendation
18 in the reports referred to in the order in council?
19 MR. COCHRANE: Yes. All of those that were
20 applicable to ANCR have been implemented at ANCR. Ms.
21 Stoker was not challenged with respect to that assertion or
22 that evidence, and it does not appear to be an issue in
23 this proceeding. I'll leave my comment there, at that.
24 Ms. Stoker provided evidence that supported her
25 opinion that there was significant improvement to the

1 delivery of services at intake since the Phoenix Sinclair
2 case. She indicated that she could say with confidence
3 that when there are allegations of child protection, ANCR
4 ensures that all children are seen in every instance. ANCR
5 also conducts thorough and formalized safety and risk
6 assessments. No files are closed without the appropriate
7 information being obtained and considered in accordance
8 with the policies and protocols. Ms., Ms. Stoker said that
9 she believes ANCR now does a better job of conducting child
10 protection investigations.
11 So I've very quickly gone through her evidence,
12 Mr. Commissioner, I hope that was helpful. I'll move on to
13 the evidence of Ms. Flette.
14 THE COMMISSIONER: Very much so.
15 MR. COCHRANE: Ms. Flette, as you heard, is the
16 CEO of the southern authority and she held that position
17 for the last 10 years. Prior to being the CEO of the
18 southern authority she was the executive director for west
19 region Child and Family Services for approximately 20
20 years. So all in all, she's had about 38 years of
21 experience, child welfare, in Manitoba, and the focus for
22 the most part on First Nation child welfare.
23 As you may recall, Mr. Commissioner, Ms. Flette
24 explained that the southern authority has mandated 10
25 agencies, the southern part of the province. She

1 explained, broadly speaking, that the southern authority is
2 responsible for developing standards, ensuring the flow of
3 provincial funding to the agencies and for providing
4 quality assurance with respect to the agencies it has
5 mandated.
6 Exhibit 49, Mr. Commissioner, contains a summary
7 of Ms. Flette's evidence along with the relevant documents
8 that were attached to it in the various tabs. Provides a
9 good overview of her evidence, and again, I recommend that
10 you review that summary when you're considering Ms.
11 Flette's evidence.
12 Ms. Flette talked about a number of areas. One
13 was what, what we've called AJI-CWI, which is the
14 Aboriginal Justice Inquiry, Child Welfare Initiative. It's
15 commonly referred to as devolution. She provided the
16 Commission with evidence about her role in that process and
17 how that process resulted in the Authorities Act and in the
18 creation of the four authorities themselves. That's page
19 14 and 15 of her -- of the transcript April 30th, 2013.
20 She explained in very broad terms the objectives
21 of the AJI-CWI process. She said:
22
23 "Well, I think broadly the
24 objectives were to give First
25 Nations and Métis people control

1 over their child welfare services
2 and to have a -- to recognize the
3 over-representation of First
4 Nations and Métis children in the
5 system and to provide for more
6 culturally appropriate and,
7 hopefully, more effective ways of
8 working with ... families and
9 those children."
10
11 Ms. Flette explained that one of the key features
12 of, of the new system was the authority determination
13 protocol. That's what we've, we've heard as referenced to
14 ADP, authority determination protocol. And she said that
15 one of the key features of this new system is what we call
16 the authority determination protocol or ADP. She explained
17 that with the Authorities Act:
18
19 "... it's ... the first time ...
20 we've actually given clients and
21 families a choice of who provides
22 their service. So with the First
23 Nations and the Métis agency
24 having jurisdiction both on and
25 off reserve now ..."

1
2 She's talking about the new system:
3
4 "... a family would complete an
5 ADP and then make a choice as to
6 which authority they would like
7 their services provided."
8
9 Yes. That's a significant change in the system.
10 She then explained the practical effect and
11 benefit of the ADP. She said:
12
13 "Now, most ... families are
14 choosing their culturally
15 appropriate authority, which we
16 had hoped would be the case and
17 which is the case, so I think it
18 does speak to a comfort level and
19 perhaps less of a feeling of
20 coercion. So where before you had
21 services provided based on where
22 you lived, if you lived in
23 Winnipeg, for example, it was
24 Winnipeg Child and Family
25 [services], if you lived in

1 Dauphin it was Parkland Child and
2 Family [services], services are
3 now provided based on who you are
4 and who you've chosen."
5
6 She then talked about quality assurance, which my
7 view is also one of the significant changes that has
8 resulted, in improvements that has resulted, resulting out
9 of the AJI-CWI process.
10 She testified about the southern authority's role
11 in providing a quality assurance function for agencies it
12 has mandated. And this is important, Mr. Commissioner,
13 because it's, it's a formal check, if you will, to ensure
14 or to see that the agencies are fulfilling its mandate,
15 that they're doing their job. That's what quality
16 assurance is all about.
17 At page 26 of her transcript, that's April 30th,
18 2013, Ms., Ms. Flette explained that the southern authority
19 has implemented a schedule of quality assurance reviews
20 that it performs with each agency. And you'll recall she
21 talked about a four-year rotating basis, so the objective
22 is to have each agency reviewed every four years.
23 What are quality assurance reviews and what's
24 reviewed? Well, she talked about that as well. She talked
25 -- that's referenced at tab 3 of Exhibit 49. They

1 generally review, and it's governance, service delivery,
2 practice standards, agency administration, client
3 confidentiality, human resources, communication and
4 infrastructure. Very thorough reviews of the agencies.
5 The result of the quality assurance review is, is
6 a, is a report, a full report is made of the agency with
7 recommendations. The authority then works with that
8 particular agency on work plans to address those
9 recommendations.
10 It's important to note that this type of quality
11 assurance monitoring did, did not exist at the time when
12 services were provided to Phoenix Sinclair and her family
13 and it's a result of the new system arising out of AJI-CWI.
14 So again, Mr. Commissioner, in my opinion that is a
15 significant change and improvement.
16 Very quickly, Ms. Flette also talked about the
17 funding model. She's talked about the new funding model as
18 the place for most child welfare agencies in Manitoba
19 today. And if you wanted to review that, I'd suggest you
20 look at Exhibit 49, tab "E".
21 I won't get into detail about the funding model
22 but that tab is a very succinct --
23 THE COMMISSIONER: Tab "B"?
24 MR. COCHRANE: Tab "E".
25 THE COMMISSIONER: "E" for Edward?

1 MR. COCHRANE: Yes. That is about a four or
2 five-page summary of the new funding model.
3 In general terms, she explained that the new
4 funding model had resulted in an increase of funding to
5 agencies under the southern authority. She did say,
6 though, there are some problems. She explained that the
7 federal government provides funding for child welfare
8 services on reserves using an assumption model. You
9 recall, she talked about the assumptions of seven percent
10 of the reserve child population is in care. That's the
11 basis on which the funding the federal government is
12 providing. That is, if you were to look at page 3 of tab
13 "E", Exhibit 49, that's where we talk about that assumption
14 model. And Ms. Flette explained the problem with this
15 assumption is page 56, line 24 of the transcript, April
16 30th, 2013. She said:
17
18 "We have, in the south right now,
19 three agencies that are above the
20 seven percent. One in particular
21 ... is at 14 percent. And so what
22 ... this model does for them is
23 half their cases are unfunded."
24
25 And the agency she was talking about, when she

1 referred to 14 percent of the children are actually in
2 care, were Southeast Child and Family Services Agency. And
3 that's been a problem for the last two years.
4 She talked about the federal government, though,
5 providing what they call anomaly, anomaly funding, an
6 adjustment to cover that shortfall.
7 THE COMMISSIONER: And you're talking about that
8 shortfall with respect to agencies providing services on
9 reserve?
10 MR. COCHRANE: Yes. With respect to federal
11 funding for prevention services, so now I'm talking
12 prevention services, the federal model assumes that 20
13 percent of families on a reserve require such prevention
14 services. So for protection, seven percent, child in care;
15 prevention, 20 percent of families require services.
16 Similar problems with that assumption again is
17 that Southeast Child and Family Services Agency actually
18 has 40 percent of their families seeking out these type of
19 services, so again there's a funding shortfall.
20 Ms. Flette then explained, at page 60, lines 1
21 through 10:
22
23 "So what that means to [an] agency
24 as well is that any money that
25 they might be getting under the

1 enhanced provision for family
2 enhancement workers or prevention
3 programs, they have to use that
4 money for protection services
5 because these children are in care
6 and these families are at risk and
7 they have to serve them, so ... --
8 it limits their ability which, you
9 know, very unfortunate, because
10 one could argue that [it's] an
11 agency that could really benefit
12 from [prevention] services and
13 they're restricted because of that
14 assumption model."
15
16 Ms. Flett then provided evidence of the west
17 region block funding project, and I won't get into that in
18 detail, but very quickly, you recall that this is a pilot
19 project on block funding.
20 THE COMMISSIONER: Yeah.
21 MR. COCHRANE: Of maintenance, and it was
22 initiated by West Region CFS while she was there as the
23 executive director. She talks about that at length on page
24 92 of her transcript, April 30th, 2013.
25 Ms. Flette then talked, at the end of her

1 testimony, about implementation of the 295 recommendations
2 from the various reports, and this is found on page 125,
3 126 of her transcript. She testified that a significant
4 number of those recommendations have been implemented by
5 the southern authority and that work continues with respect
6 to some of those.
7 So very quickly -- very briefly, Mr.
8 Commissioner, those, that's a summary of the evidence from
9 ANCR and the southern authority.
10 I'm noticing from the clock, Mr. Commissioner,
11 it's 12 noon. Do you wish for me to proceed or --
12 THE COMMISSIONER: Whatever's, whatever you would
13 like. We -- we usually take an hour and a half for lunch.
14 If you want to adjourn now till 1:30, or carry on till
15 12:30 and adjourn till 2:00, whichever you choose.
16 MR. COCHRANE: The next area I want to get into
17 is the recommendations, and I think rather than breaking it
18 up I'd prefer to break now till 1:30 and then I could come
19 back and would finish. I don't anticipate being longer
20 than an hour.
21 THE COMMISSIONER: Well, maybe, maybe we'll
22 adjourn till 1:45 to give people a chance to do whatever
23 they do at their offices over lunch, so --
24 MR. COCHRANE: Sure.
25 THE COMMISSIONER: -- we'll adjourn to 1:45 and

1 then we'll go into your recommendations. And you think
2 you'll be, did you say, about an hour?
3 MR. COCHRANE: I would say, yes, within -- inside
4 an hour, yes.
5 THE COMMISSIONER: Well, you, you've got plenty
6 of time.
7 MR. COCHRANE: Yes.
8 THE COMMISSIONER: You're not taking up your full
9 allotment so that's fair enough.
10 MR. COCHRANE: Thank you.
11 THE COMMISSIONER: But I just, looking at the
12 list, then, that would mean that we would be ready for the
13 Assembly of Chiefs and the Southern Chiefs Organization
14 later this afternoon.
15 MS. WALSH: Mr. Commissioner, I'm advised that
16 Mr. Funke, counsel for the Assembly of Manitoba Chiefs is
17 unwell today. You'll see he's not here.
18 THE COMMISSIONER: Oh.
19 MS. WALSH: And I'm just confirming that he would
20 be able to start tomorrow morning. So he's not available
21 to begin today and counsel for ICFS also advises that his
22 client is not available to provide final instructions
23 today, and so he's not available to, or prepared to proceed
24 today. So it would appear that we'll have the afternoon
25 for the authorities and, and that would be all for today,

1 but we are still ahead of schedule.
2 THE COMMISSIONER: All right. Well, we'll, we'll
3 adjourn now until 1:45.
4 MS. WALSH: Thank you.
5
6 (LUNCHEON RECESS)
7
8 THE COMMISSIONER: All right, Mr. Cochrane.
9 MR. COCHRANE: Good afternoon, Mr. Commissioner.
10 When I, when I left off this morning I had finished a
11 summary of evidence from Ms. Flette and Ms. Stoker and I
12 was about to move into the joint written submissions of the
13 ANCR, northern authority and southern authority.
14 THE COMMISSIONER: Right.
15 MR. COCHRANE: So you have those in written form
16 and you'll see that we've broken them into themes. We have
17 11 themes with a total of 44 recommendations. And like
18 other counsel who have come before me --
19 THE COMMISSIONER: Forty-three or forty-four?
20 Oh, yes. There's a forty-fourth one on the back page.
21 Yes.
22 MR. COCHRANE: Yes.
23 THE COMMISSIONER: I've got it.
24 MR. COCHRANE: Forty-four.
25 THE COMMISSIONER: Yeah.

1 MR. COCHRANE: And like other counsel who have
2 come before me, I don't intend to, to read each
3 recommendation to you. Rather, what I've done is I've
4 selected a number that I'll address today. If you do, of
5 course, have any questions of any others I don't address,
6 please do ask me about those. Also, just so it's clear, my
7 reference to a recommendation this afternoon or my non-
8 reference to a recommendation is not any indication of
9 priority, these recommendations. You should know that a
10 lot of work has gone into these, these have -- these are
11 joint recommendations of three key players in the CFS
12 system, so a lot of time and energy has gone into these and
13 they're all of equal importance to us.
14 So I'll start, Mr. Commissioner, with page 1,
15 which is our first recommendation.
16 THE COMMISSIONER: Yes.
17 MR. COCHRANE: And we recommend the establishment
18 of child wellbeing units made up of child welfare employees
19 and the federal, provincial and First Nation government
20 organizations, partners that are responsible for the
21 largest number of child protection reports, give some
22 examples such as provincial health, law enforcement,
23 education and family services departments, family services
24 departments in Manitoba. These will be modeled after
25 similar offices in New South Wales, Australia.

1 CWUs would be an additional resource for family
2 -- sorry, for child welfare and not simply a re-alignment
3 of existing staff resources.
4 Commission has heard evidence, received evidence
5 that the child, child welfare workers need to ask -- need
6 to be able to ask the right questions of collaterals in
7 order to receive information they are seeking. It's our
8 view that embedding the child welfare workers within key
9 collateral organizations will ensure that the right
10 questions are asked and this, in our view, will improve the
11 flow of information that is required in order to better
12 protect children.
13 I should have mentioned that for each
14 recommendation you have seen that we've included a
15 rationale for each recommendation.
16 THE COMMISSIONER: Yes.
17 MR. COCHRANE: Again, I don't plan to read each
18 of those but the rationale is there. We've tried, where
19 possible, as well, to include a, a reference to the
20 transcript or to, to a particular document I've made
21 reference or that would be supportive of that
22 recommendation. So that's recommendation number one, Mr.
23 Commissioner.
24 THE COMMISSIONER: Well, I -- recommendation
25 number one is a very novel proposal. I'd like to hear a

1 little more from you as to what, what these units would,
2 what their purpose and use would be. I'm sure it's a good
3 one but I would like to have you expand on it.
4 MR. COCHRANE: Sure. The purpose, which is one
5 point you just made, the purpose, frankly, is to, is to
6 have a system that more easily facilitates sharing of
7 information and more readily and efficiently allows a
8 system to deal with child protection concerns. What we are
9 seeing now is a lot of, an awful lot of resources, child
10 welfare resources, are used inefficiently. For example,
11 ANCR, my client, would get calls on matters that, quite
12 frankly, aren't child protection matters. An awful lot of
13 time is devoted to dealing with those type of issues. It's
14 our opinion that embedding these units in these other
15 departments would help to facilitate and streamline the
16 system. We get into that a little bit on page --
17 THE COMMISSIONER: Well, a unit would be like a
18 committee, would it, or ...
19 MR. COCHRANE: No. It would be, it would be
20 child welfare workers right in that department. I can
21 point to one example where something similar is being done
22 here in Manitoba. At the, at the Children's Hospital here
23 in Winnipeg, we have a, a social worker who is at that
24 hospital, and the role of that social worker is to work
25 with the health system there, to engage CFS when

1 appropriate. They know who to call at ANCR or any other
2 agency when a problem arises, and it just helps to
3 streamline the system, helps to streamline the responses
4 and the resources. It's that type of a system we see
5 embedded in other organizations.
6 THE COMMISSIONER: All right. And that, that
7 social worker at the hospital is an employee of the
8 hospital's?
9 MR. COCHRANE: That --
10 THE COMMISSIONER: Or the, or the health unit, or
11 whatever the ...
12 MR. COCHRANE: That, that person is an employee
13 of the child -- of the agency. They're employees of the
14 agency situated in those departments.
15 THE COMMISSIONER: No, no, but, but at -- the
16 parallel you've drawn about the Children's Hospital, that
17 social worker who is performing that function is employed
18 by the hospital?
19 MR. COCHRANE: That employee -- that person is
20 employee of, of ANCR, of the agency.
21 THE COMMISSIONER: Oh, ANCR's --
22 MR. COCHRANE: Yeah.
23 THE COMMISSIONER: -- got a person at the
24 hospital?
25 MR. COCHRANE: That's right. And there's

1 benefits to that because you've got, you've got children
2 coming into the hospital for a variety of reasons that may
3 involve or may not involve child welfare, may, may trigger
4 child welfare services. And we find that that's an awful
5 useful resource because what it does is it allows the
6 streaming, if you will, or the, the assessment to happen
7 right there at the hospital.
8 THE COMMISSIONER: Does, does this person have an
9 office at the hospital?
10 MR. COCHRANE: Yes.
11 THE COMMISSIONER: I see.
12 MR. COCHRANE: Has an office, is there working
13 front line with those families, direct contact into ANCR
14 and to the CFS system. And it's, it's --
15 THE COMMISSIONER: That's, that's because there's
16 an anticipation that families that are coming to the
17 hospital with -- as illness is their reason for coming,
18 also have problems that would benefit being associated with
19 the child welfare system?
20 MR. COCHRANE: That, that's correct. And say a
21 child comes into the hospital, they are injured, physical
22 injuries. Doctor has some suspicions, doctor has a
23 concern, there's a resource right there at the hospital
24 that they can engage. They don't have to pick up the
25 phone, they don't have to wait to call a CFS agency. The

1 resource is there.
2 THE COMMISSIONER: Is that a 24-hour service?
3 MR. COCHRANE: No. Hours are 8:30 to 4:30 that
4 social worker is, is on call.
5 THE COMMISSIONER: Five days a week, I suppose?
6 MR. COCHRANE: Yes.
7 THE COMMISSIONER: Yeah. I see. All right.
8 Now, how -- I understand that. Extend that, now, how
9 that's going to work with what you're proposing here.
10 MR. COCHRANE: So we would -- put it in simple
11 terms, we would say the similar model being used for other
12 government departments, for example, we've heard evidence
13 of E.I., right?
14 THE COMMISSIONER: Yes.
15 MR. COCHRANE: You've heard some evidence of
16 that?
17 THE COMMISSIONER: Yes, yes.
18 MR. COCHRANE: We would see -- if we use that
19 example, we would see, if we use that example, we would see
20 -- and the details, of course, have to be worked out, but
21 in broad, the broad (inaudible) would be that we would see,
22 then, a social worker placed within that department, so
23 that if a CFS agency is calling for information or if a CFS
24 agency -- or, or if that department has child protection
25 concerns, they have the resource right there at the front

1 end which will, in our view, increase efficiencies, and
2 that's what we're proposing.
3 THE COMMISSIONER: All right. Who, who, whose
4 employees would these people be that are placed out in
5 these satellites?
6 MR. COCHRANE: They would be employees of, of the
7 agency, child welfare agency. We're not looking -- we're
8 not proposing that they be employees of those particular
9 government departments. They will be employees of the
10 agency, stationed there in that department to improve
11 efficiencies.
12 THE COMMISSIONER: So you -- it's possible that
13 every agency delivering services would utilize this
14 program?
15 MR. COCHRANE: Yes. Just --
16 THE COMMISSIONER: So that --
17 MR. COCHRANE: -- just as they would the program
18 at the Health Science Centre.
19 THE COMMISSIONER: And, and where all would you
20 put these people? Would you -- you talk about the
21 unemployment --
22 MR. COCHRANE: We would see provincial health.
23 THE COMMISSIONER: Yes.
24 MR. COCHRANE: We would see in law enforcement.
25 We would see --

1 THE COMMISSIONER: Where does that mean, in the
2 police department?
3 MR. COCHRANE: Could, could be in the police
4 department. We have -- police department is one of our
5 main collaterals that we deal with. It could be there.
6 When we're -- I'll give you an example: When
7 we're dealing with an abuse situation, say we have a
8 situation of physical abuse, physical injuries, ANCR does
9 their abuse investigation. Often the offender is also
10 charged criminally. Right now there is some, some issue on
11 whether or not -- if, if the police should share that
12 information with, with the agencies. Our view is they
13 should because it aids in our investigation. But there are
14 problems. There are inefficiencies with that system. So
15 part of the -- so this would be to embed CFS in that system
16 so we can more efficiently deal with the information and
17 the sharing, the sharing of information, quite frankly. So
18 we --
19 THE COMMISSIONER: Well, it wouldn't mean, for
20 instance, the placement of a, of a person in, in the, in
21 every police detachment across the province.
22 MR. COCHRANE: No.
23 THE COMMISSIONER: Where, where would you put
24 this person insofar as law enforcement is concerned?
25 MR. COCHRANE: Well, with respect to law

1 enforcement, and those are discussions we would have to
2 have. It's just like in every hospital, we don't, we don't
3 have a social worker in every hospital, it's the Health
4 Science Centre. But we would obviously want to ensure that
5 the efficiencies are there. But the point in all of this
6 would be this: simply to make, to make the system more
7 efficient, to make it more responsive and to allow the
8 sharing of information in a more effective manner. And we
9 believe all of those three things would improve the
10 services to children and families.
11 THE COMMISSIONER: Well, have you got the, the --
12 something in writing the way the New South Wales program
13 works? Because what I'm concerned about is, is getting
14 into a recommendation that's going to be very costly and,
15 and involving the employment of a lot of people. I've got
16 to know that that's a good use of public funds.
17 MR. COCHRANE: Yes. What I can do is -- I just
18 asked if that's something Ms. Stoker had testified. She
19 did mention it, but I can, I can definitely get you, if you
20 want, the information on the New South Wales project or it
21 is available, of course, online. I can obtain that and
22 provide a copy to Commission counsel.
23 THE COMMISSIONER: But I think, I think you'll
24 have -- you're going to have to flesh this out for me more
25 about, really, what's involved. What, what are you asking

1 me to recommend insofar as, as the expenditure of public
2 money is concerned?
3 MR. COCHRANE: We're asking you to, to -- that
4 there be, first off, new funding for this recommendation.
5 We don't believe that there should be a, a use of existing
6 money because the system, as we've heard, is already under
7 strain. So first point, it should be new money coming in
8 for this purpose.
9 New money, of course, now we don't know the
10 details of, of the number of social workers but all of that
11 would be part of the discussion.
12 THE COMMISSIONER: Who had the discussion?
13 MR. COCHRANE: Well, it would be the province, it
14 would be the authorities.
15 THE COMMISSIONER: The province and the
16 authorities?
17 MR. COCHRANE: And, I would guess, also the, the,
18 the departments, the responsible departments we're talking
19 about. We, we've had an awful lot of dialogue with the
20 department of education, for example, on this very issue,
21 sharing of information. We've had a lot of discussion with
22 the WPS, Winnipeg Police Service. So it's not a new area
23 that we've been dealing with; it's, it's something that's
24 reoccurring, it's something our clients have identified as
25 a need. It's new. And, it exists in another jurisdiction.

1 THE COMMISSIONER: Well, I'm not afraid of
2 something new if it's, if it's sensible and is the right
3 step to take.
4 MR. COCHRANE: Well, the, the three parties I
5 represent, which are key parties in the child welfare
6 system, have jointly recommended this, jointly agreed to it
7 and they believe it is a good recommendation for, for you
8 to consider. We believe -- they believe very strongly that
9 it will increase efficiencies.
10 THE COMMISSIONER: Well, I'll certainly be
11 conferring with Commission counsel to get some further
12 expansion on this, and if there's anything further
13 information needed, they may be in touch with you.
14 MR. COCHRANE: Sure. Just one second.
15 Mr. Commissioner, just one last point on that
16 recommendation
17 THE COMMISSIONER: Yes.
18 MR. COCHRANE: In terms of the size and the
19 resources, we actually don't envision there being a hundred
20 new social workers. Not that big of an enterprise. We
21 would see five or six additional social workers funded for
22 these positions. At the end of the day, when, when it's up
23 and running, if it is up and running, the efficiencies, it
24 may be, itself, cost neutral at the end of the day. Those
25 are discussions we'll have, but that is the recommendation.

1 THE COMMISSIONER: All right. Well that -- you,
2 you get my attention more when you tell me you're talking
3 about five or six social workers and, and --
4 MR. COCHRANE: Yeah. Again, we're not talking a
5 hundred social workers, it's --
6 THE COMMISSIONER: Well, with the number of
7 agencies there are I didn't know what you were talking, so
8 there'd be some sharing --
9 MR. COCHRANE: Absolutely.
10 THE COMMISSIONER: -- obviously?
11 MR. COCHRANE: Yes, absolutely. There'd be one
12 -- there'd be the social worker there in that department,
13 at each agency would have a resource to call or that social
14 worker would know which agency to call if they require CFS
15 services.
16 THE COMMISSIONER: All right. I'll, I'll -- with
17 that background, I'll delve into it and look at it --
18 MR. COCHRANE: Thank you.
19 THE COMMISSIONER: -- with, on the basis that you
20 put before me.
21 MR. COCHRANE: I'll jump forward to
22 recommendation number three, then, Mr. Commissioner, and
23 that's on page 4. This recommendation is that upon request
24 of a CFS agency, peace officers shall provide all
25 documentation and records such as police occurrence

1 reports --
2 THE COMMISSIONER: Just a minute. This is
3 recommendation number four?
4 MR. COCHRANE: It's our recommendation number
5 three.
6 THE COMMISSIONER: Oh, three. Sorry.
7 MR. COCHRANE: Yeah. On page 4. Think that was
8 the confusion.
9 THE COMMISSIONER: All right. Just let -- read
10 that.
11 MR. COCHRANE: Yeah. So it's that peace officers
12 shall provide all documentation and records such as police
13 occurrence reports in their possession or control that may
14 assist a CFS agency in determining the safety and wellbeing
15 of a child. This is all with a theme of sharing
16 information within the system.
17 And the rationale is there but let me just
18 summarize it this way. We have many, many cases where, for
19 example, an agency is dealing with an abuse investigation,
20 the alleged offender is also charged criminally so there's
21 a process that happens there in the criminal area. Police
22 are involved, police do their own interviews. They may
23 interview the offender, they may interview the victim, they
24 may interview other third parties. We don't know. The
25 point is, they often have information that is critical to

1 the services being provided by CFS and there, there's an
2 impediment, I would call it, within the Act itself or
3 perhaps with how it's interpreted by the police service to
4 share that information. So we think that is an important
5 enough recommendation to make and to bring to your
6 attention. The rationale is there. I won't ...
7 THE COMMISSIONER: Well, I just want to suggest
8 to Ms. Walsh she just make a note of that because we'll
9 have to look into what's involved insofar as it getting,
10 mandating the turning over police documents. There's more
11 to it than -- I mean, I, I get the, the reason for it
12 without question and I can see the benefit for it, but I
13 think there's ramifications insofar as police documentation
14 and privacy matters are concerned, so just note that as
15 something we'll have to look at as we look at that
16 recommendation. Okay.
17 MR. COCHRANE: And maybe the last point, and I
18 should note, it is there in the rationale but I'll
19 reference it because Ms. Walsh will be looking into that,
20 Section 18.4(1.1), and it's there for your reference, but
21 it requires a peace officer to provide any information in
22 the peace officer's possession or control that an agency
23 believes is relevant to a child protection investigation.
24 So that section is already there in the Act. The problem
25 is, there's a difference of interpretation of how that

1 provision is -- or when that provision is triggered. So we
2 think that the system would benefit greatly if that is
3 cleared up, that interpretation is cleared up, and this
4 recommendation is intended to do just that.
5 THE COMMISSIONER: Oh, I see. Okay. Well, I
6 mean, if, if the statute now mandates it, then I have no
7 problem endorsing that as something that should be done.
8 MR. COCHRANE: Yeah. Okay, Mr. Commissioner,
9 I'll move on, then.
10 Under our theme two, which is proposed changes to
11 the funding model for child welfare in Manitoba.
12 THE COMMISSIONER: Yes.
13 MR. COCHRANE: You'll notice that we make, under
14 this theme, a total of nine recommendations. And I'll just
15 start with recommendation number four, which is on page 6.
16 THE COMMISSIONER: Yes.
17 MR. COCHRANE: And our recommendation is this:
18 That the province should complete a review of each
19 designated intake agency, and that's been called a DIA,
20 that is operating in Manitoba. Thereafter, in conjunction
21 with each DIA, the province should promptly establish an
22 appropriate funding model for each DIA which takes into
23 consideration their unique roles, functions and appropriate
24 staffing ratios.
25 Again, the rationale explains that but let me try

1 and summarize it this way: You, you've heard evidence from
2 Ms. Stoker that ANCR is a -- ANCR is unique in a sense that
3 it is an intake agency, it's not embedded within other
4 service agencies; it's its own standalone agency. It has
5 no funding under the funding model, no, no -- sorry,
6 there's no funding model for ANCR, and this, this, as Ms.
7 Stoker testified, is a major problem. So we, we're
8 recommending that the province then look at DIAs, including
9 ANCR, and come up with a funding model for that agency.
10 THE COMMISSIONER: Where does ANCR get its
11 funding from now?
12 MR. COCHRANE: It, it flows through the southern
13 authority just as all of the other southern agencies get
14 their funding through. But if I can -- give me one second,
15 I just want to make sure I've got one point clear.
16 THE COMMISSIONER: Yeah. And listen, if you want
17 any of your colleagues to speak to any point --
18 MR. COCHRANE: Yeah.
19 THE COMMISSIONER: -- I have no problem with
20 that.
21 MR. COCHRANE: Thank you.
22 Thank you, Mr. Commissioner. I just wanted to
23 clarify one thing, and that is that ANCR's funding model is
24 based on the 2007 model. Now, there's been some
25 adjustments to that with respect to the abuse unit and

1 differential response, but the, the point is that it is not
2 -- there is no funding model for ANCR and that is a
3 problem.
4 THE COMMISSIONER: And when you're talking about
5 funding model, you're talking about a funding agreement
6 between the government, or the Province of Manitoba and
7 the, the intake agency, in this case ANCR? Or are, or are
8 you -- is the, is the -- we've heard much here about the
9 new funding agreement that involves the federal government.
10 Is it involved in this funding?
11 MR. COCHRANE: No.
12 THE COMMISSIONER: No. So this is strictly
13 between the Province --
14 MR. COCHRANE: Strictly --
15 THE COMMISSIONER: -- of Manitoba and the intake
16 agency?
17 MR. COCHRANE: That's correct.
18 THE COMMISSIONER: I understand.
19 MR. COCHRANE: Yeah. Yeah, ANCR is not federally
20 funded.
21 THE COMMISSIONER: I understand.
22 MR. COCHRANE: The next recommendation I'll
23 highlight, Mr. Commissioner, is recommendation number six
24 on page 9. This one is related to our recommendation
25 number 10. I'll just highlight this one:

1 Province to provide additional family support
2 resources and allow for more creativity and flexibility in
3 the utilization of these resources to facilitate intensive
4 family support services to be provided by child welfare
5 agencies in order to reduce the need to apprehend children
6 and remove them from their homes.
7 So the gist of this is that we're asking for
8 family support services funding and we, the rationale is
9 there that these are not only more cost-effective than
10 bringing children to care, these types of services are also
11 less traumatic to children and they allow for more
12 culturally-appropriate supportive strategies and adhere to
13 the principle that families and children are entitled to
14 the least amount of interference to the extent compatible
15 with the best interest of the children. There's more
16 family support funding.
17 Recommendation number nine, page 13:
18 That adequate funding be allocated to all child
19 welfare agencies for the development of partnerships with
20 community organizations focused on providing services to
21 family so that involvement by the CFS system can be reduced
22 or eliminated.
23 Right now, Mr. Commissioner, the agencies don't
24 have resources to make the linkages with, with the other
25 resources that exist and this, these type of linkages,

1 should assist in reducing the number of families and
2 children that come into contact with child welfare
3 agencies. And, and the development of partnerships between
4 the agencies and these collaterals we believe is important
5 in the development of solutions
6 Next one I'll recommend is recommendation number
7 11, which is on page 15:
8 The funding formula should be modified to take
9 into account the additional resources that are required to
10 provide child welfare services in remote communities.
11 We heard evidence from Felix Walker and one other
12 worker from that agency, I can't recall the name. But the
13 reality is that things are different, things are more
14 difficult in remote communities. Services are more
15 expensive, and this, in our view, should be accounted for
16 in the funding formula. It's not right now. Has to be
17 adjustments to take that remoteness into account.
18 The point there and the rationale we make is if,
19 if that is not adjust -- if it's not accounted for and it
20 creates inequities between those living in the northern
21 remote communities, for example, with those -- compared
22 with those families living in the more southern
23 communities.
24 THE COMMISSIONER: And does this, does this
25 involve federal funding, when you speak of the funding

1 formula?
2 MR. COCHRANE: It would involve provincial
3 funding, definitely provincial funding. We also believe
4 that it should apply to federal funding, bearing in mind,
5 of course, the jurisdiction issues and ...
6 THE COMMISSIONER: That's what I had in mind when
7 I asked the question.
8 MR. COCHRANE: Yes. Yeah. But we believe it
9 should be a full, full adjustment, both funders. Of
10 course, we recognize the limitations.
11 I want to jump right forward to theme number
12 three, which is workload.
13 You'll notice there's one recommendation there,
14 that's recommendation number 14.
15 Heard a little bit about this yesterday but it's
16 consistent, then, with number 14 of the MGEU
17 recommendation. That is, that we amend the funding model
18 to establish and maintain caseload thresholds for workers
19 and supervisors that is keeping with the Child Welfare
20 League of America's recommended ratios. Staff ratio
21 calculation should be based on agency workload with
22 agencies and the authorities tasked performing regular
23 monitoring of caseloads.
24 You've heard an awful lot of evidence, Mr.
25 Commissioner, of the difficulties that child welfare

1 workers are having with being able to meet the standards
2 required of them regarding type and frequency of contact
3 they have with children and families that they serve. It's
4 directly related to high caseloads. So that's the reason
5 for the recommendation.
6 Going forward to theme number four, Mr.
7 Commissioner, which is changes to legislation --
8 THE COMMISSIONER: Number what?
9 MR. COCHRANE: -- standards and policies. Theme
10 four.
11 THE COMMISSIONER: Oh, theme four. Yes.
12 MR. COCHRANE: Theme four. Yes.
13 THE COMMISSIONER: Yeah.
14 MR. COCHRANE: Recommendation number 15.
15 THE COMMISSIONER: Yes.
16 MR. COCHRANE: This is similar to our
17 recommendation number 17. Of course, they're all related
18 but the CFS Act should be amended to provide a clear
19 delineation between prevention and protection services
20 providing clear direction as to when agencies can stream
21 families into prevention services. The threshold for
22 children -- sorry, the threshold for child protection
23 referrals should be when children are reasonably suspected
24 to be at risk of serious harm. All other matters should be
25 referred to the appropriate prevention service program.

1 This is a, this is a rather somewhat of a
2 technical amendment in that what we're suggesting is, in
3 essence, a review of that section of the Act where the
4 threshold was set. We believe that changing the threshold
5 to risk of serious harm would allow more matters to be
6 streamed into the family enhancement stream.
7 THE COMMISSIONER: Would -- does, does your
8 definition of harm include neglect?
9 MR. COCHRANE: Risk of serious harm would -- we
10 address that one later in the abuse but I would, I would
11 say it would depend, obviously, on the circumstances. The
12 -- bear with me one sec. Let me find that other
13 recommendation.
14 Recommendation 16 actually I think would more,
15 would address your question there.
16 But the point of recommendation 15, let -- before
17 I move on, is that --
18 THE COMMISSIONER: Oh, yes. Okay.
19 MR. COCHRANE: -- it would allow more matters to
20 stream into the family enhancement. And it's, it's
21 somewhat at, at odds with Mr. Gindin's recommendation,
22 which I'm going to comment on later, because this
23 recommendation 15, of course, contemplates having CFS
24 agencies performing two functions: prevention and the
25 protection streams. We're just saying that the threshold

1 should be adjusted to allow more use of the prevention
2 streams.
3 THE COMMISSIONER: And, and each agency still
4 have responsibility for both streams?
5 MR. COCHRANE: Yes.
6 THE COMMISSIONER: And would you have designated
7 workers for, for one stream and designated workers for the
8 other?
9 MR. COCHRANE: Yes, that will continue. If I use
10 ANCR as an example, right, we have, we have a unit
11 dedicated to family enhancement, workers that are tasked
12 with that responsibility. That would continue.
13 We make the point there in the rationale, Mr.
14 Commissioner, that under the current legislative framework
15 there is very little that is not initially screened into
16 the child protection stream for investigation, and our
17 experience is that this is extremely taxing on the system
18 as too many resources are funneled towards matters that are
19 not related to serving children who are at risk of serious
20 harm. So recommendation 15 again is somewhat technical,
21 but we believe that changing the threshold would be
22 important for the system.
23 Recommendation 16, I think addresses the question
24 perhaps that you had. But we are recommending that the
25 definition of abuse should be amended to --

1 THE COMMISSIONER: Just a minute. Before you
2 leave 15.
3 MR. COCHRANE: Yes.
4 THE COMMISSIONER: Have you got here what the,
5 what, what -- your, your requested insertion of risk of
6 serious harm, what does that replace? How does it read
7 now?
8 MR. COCHRANE: Right now it reads ...
9 THE COMMISSIONER: The threshold.
10 MR. COCHRANE: Yeah. The threshold is, is in
11 need of protection. The threshold is in need of
12 protection. So we're suggesting "in need or protection" be
13 replaced with "risk of serious harm".
14 And then if you look at the Act -- I didn't
15 intend to get into this detail, but if you look at the Act,
16 Section 17 of the Act provides illustrations of when a
17 child is in need of protection.
18 THE COMMISSIONER: Yes.
19 MR. COCHRANE: And the result of those
20 illustrations, in our view, is that it results in most of
21 the matters being screened into protection stream when
22 we're finding that a lot of those matters could, under the
23 appropriate circumstances, be referred instead to the
24 family enhancement stream.
25 THE COMMISSIONER: Okay. We'll look at that.

1 MR. COCHRANE: Recommendation number 16:
2 Definition of abuse in the CFS Act should be
3 amended to reflect current best practice in child welfare
4 such that it specifically includes abuse that are not
5 accompanied by physical injury and recognizes the
6 significant harm resulting from emotional maltreatment on a
7 child's wellbeing.
8 This recommendation, Commission -- Mr.
9 Commissioner, results from evidence we've heard at this
10 inquiry. The referral of March '05 that Mom was abusing
11 Phoenix and locking her in her room would not have fit the
12 definition of abuse under the Act as the definition now
13 stands. Abuse under the Act is defined to include physical
14 injury. It includes sexual exploitation. And a third
15 heading is it includes mental disability of a permanent
16 nature or of such a nature to, to result in such, such
17 permanency. Or, sorry, or likely to result in such
18 permanency. So it's a, it's a definition that has, has not
19 been updated for several decades and it needs revisiting.
20 It rules out substantiating physical abuse on any matter
21 that does not result in injury to the child, including
22 forcible confinement and any other degrading or inhumane
23 treatment. It requires physical injury. So we are
24 recommending change to that definition.
25 The next recommendation, Mr. Commissioner, I'll

1 mention to you this afternoon is recommendation 18, which
2 is on our page 24.
3 THE COMMISSIONER: Just a minute now.
4 MR. COCHRANE: Oh, sorry. Let me back up.
5 Recommendation 17.
6 THE COMMISSIONER: Yeah, I was hoping you were
7 going to talk about that.
8 MR. COCHRANE: Yes. Page 22.
9 I could tell you, we've had a lot, an awful lot
10 of discussion about how to word this and how to put it
11 forward to you. It is a big issue, as you can imagine,
12 for, for our clients, the southern and northern authorities
13 in particular. But we recommend that CFS legislation be
14 reviewed and revised through a cultural lens to ensure that
15 aboriginal children and families receive culturally
16 competent services that are respectful, effective and
17 reflective of the diverse rules, customs and traditions of
18 First Nations peoples.
19 Revisions to the legislation should include or
20 could include making it compliant with the differential
21 response model and the use of structured decision-making
22 tools. We have other recommendations similar that would
23 also address that issue.
24 Allowing for voluntary mediation processes to
25 take place, such as an alternative to an adversarial court

1 process that takes place when children are apprehended from
2 families. As you know right now, once a child is
3 apprehended, the only recourse then at that point is court.
4 THE COMMISSIONER: Yeah.
5 MR. COCHRANE: Formal process. If you look at a,
6 other systems, say to foster parent appeals under the Act,
7 there's a process there that allows foster parents to
8 appeal to an agency, to the authority and ultimately to an
9 independent adjudicator, point being it allows for that
10 process to happen whereas with apprehension you're
11 automatically to court unless the agency is convinced to
12 change its mind on the apprehension.
13 The third one is to allow for use of customary,
14 customary care model as an option for service delivery by
15 child welfare agencies in order to assist in both
16 maintaining the placement of children in homes with family
17 members and, and in maintaining the child's cultural and
18 community connections.
19 In our rationale, Mr. Commissioner, we say that
20 the CFS Act no longer fully reflects the current child
21 welfare service delivery model. The principles of the CFS
22 Act state that all families and children have a right to
23 services that respect their cultural and linguistic
24 heritage; however, the sections of the Act have not been
25 reviewed to ensure strict compliance with this principle.

1 As well, principles of the AJI-CWI process reinforce the
2 fact that aboriginal peoples have a right to culturally
3 representative and respective services.
4 THE COMMISSIONER: Have you got a list of the
5 sections of the Act you think that depart from compliance
6 with the overall principle that's there now? You say the
7 principles in the Act state that all families and children
8 have a right to services with respect to their cultural and
9 linguistic, linguistic heritage; however, the sections of
10 the Act have not been reviewed to ensure strict compliance.
11 Have you reviewed the sections? Can you be of any help as
12 to which ones you think are offensive?
13 MR. COCHRANE: Yes. What, what I can do, Mr.
14 Commissioner, is I, I don't have it in writing.
15 THE COMMISSIONER: All right.
16 MR. COCHRANE: But I will certainly undertake to
17 get that to Commission counsel.
18 THE COMMISSIONER: That's satisfactory.
19 MR. COCHRANE: Thanks.
20 THE COMMISSIONER: But I am, I'm interested in,
21 in your last paragraph:
22
23 Aboriginal children and families
24 have historically been and
25 continue to be over-represented in

1 child welfare system in Manitoba.
2
3 No argument there. Next sentence:
4
5 The implementation of this
6 recommendation which remains
7 outstanding from the AJI-CWI would
8 help address this issue.
9
10 MR. COCHRANE: Yes.
11 THE COMMISSIONER: My questions is, how will it
12 help? And maybe, now that I read that a second time, maybe
13 it's to be found in the AJI-CWI report.
14 MR. COCHRANE: And I could add this as well, Mr.
15 Commissioner. When, when AJI-CWI, when that process was,
16 was undertaken -- and I'm trying to choose my words
17 carefully because I don't want to misstate anything, and
18 I'm going back in memory about 10 years now because I was
19 involved in that process.
20 THE COMMISSIONER: Yes.
21 MR. COCHRANE: But I can tell you that then there
22 was a commitment by the provincial government to review the
23 entire CFS Act, which is what we're recommending here.
24 When the Authorities Act was enacted, the
25 amendments that happened to the CFS Act, and (inaudible)

1 look at the regulations that run -- that, that resulted,
2 focused strictly on those amendments needed to bring the
3 authority system into place. So those were the legislative
4 amendments. The, the commitment to review the CFS Act
5 through a cultural lens was sort of put off to happen at a
6 future date. That hasn't happened yet. We're recommending
7 that it does for a number of reasons. We have a new system
8 now to begin with, obviously. We believe that the
9 provision of culturally appropriate services, which is what
10 the intention of the AJI-CWI was, will help to address the
11 issue of over-representation, because the services, I would
12 hope, then would be more responsive. It would be more
13 appropriate. And they would be, they would be based on the
14 needs, the customs, the practices and the traditions of
15 First Nations people. That's, that's the objective.
16 THE COMMISSIONER: Thank you, Mr. Cochrane.
17 MR. COCHRANE: Right now, Mr. Commissioner, I'll
18 make this comment later again, but providing, at least from
19 a legal point of view, providing child welfare services on
20 the reserves in a remote community is a lot time -- lot of
21 times like trying to fit a square peg into a round hole,
22 okay. We have a difference of values, different way of
23 doing things, and that's reflected time and time again that
24 I see in the communities. So that, that's one of the major
25 purpose of this recommendation, to do that review.

1 Recommendation number 18, page 24:
2 We recommend that the CFS system revise the
3 provincial standards to ensure that they are current and
4 general enough to allow authorities to develop culturally
5 specific standards. You heard a lot of evidence about
6 that, authority, culturally specific standards.
7 The foundational standards should also be revised
8 to reflect current Manitoba practices be achievable based
9 on current service data and resource allegation be non-
10 contradictory and address jurisdictional inconsistencies.
11 We've heard some evidence about that as well.
12 The process of updating and rewriting the
13 standards should be developed in accordance with the
14 existing develop -- sorry, the existing standards
15 development protocol. And Mr. Commissioner, that is a, a
16 protocol where all authorities have agreed to work together
17 to create standards. And should be -- incorporate current
18 social work practices and the use of SDM tools as well as
19 examine and develop specific intake standards for ANCR and
20 other designated intake agencies.
21 THE COMMISSIONER: Is that protocol in writing?
22 MR. COCHRANE: Yes.
23 THE COMMISSIONER: Do we have it?
24 MR. COCHRANE: If -- is that ... I'm told, Mr.
25 Commissioner, that you do not have that protocol. I can --

1 THE COMMISSIONER: You can make it, you can make
2 it available?
3 MR. COCHRANE: Absolutely, I will do that.
4 THE COMMISSIONER: To Commission counsel, thank
5 you.
6 MR. COCHRANE: Yes.
7 Moving on to theme number five, recommendation
8 number 19, page 26.
9 Recommend that the province, in conjunction with
10 all stakeholders, should develop a new information system
11 for CFS that is consistently used by all mandated CFS
12 agencies.
13 This next sentence, if you recall, Mr.
14 Commissioner, from the evidence of Felix Walker is an
15 important one and it's --
16 THE COMMISSIONER: Well, listen, before you get
17 to the next sentence, when I read this getting ready for
18 today, the note I made in my copy was, are you saying that
19 CFSIS should be scrapped?
20 MR. COCHRANE: I'm saying that CFSIS should be
21 reviewed, at minimum, and the more important part is that
22 all agencies should use whatever is, whether it's the
23 existing system or a new improved system or a new one
24 altogether, should, should use it.
25 THE COMMISSIONER: Yeah. But your sentence calls

1 for the development of a new information system. I guess
2 I'm saying, are you modifying that to say an updated system
3 or -- could work rather than having to go for a new one?
4 MR. COCHRANE: Yeah. We -- I could confirm that
5 just to be sure, with, with my client, but my understanding
6 is that we would, we would be interested in looking at
7 updating and if updating is not possible, then certainly a
8 new system.
9 THE COMMISSIONER: And make, making it available
10 province-wide?
11 MR. COCHRANE: Making it available province-wide
12 and ensuring that all agencies use it.
13 THE COMMISSIONER: Sorry to interrupt you. Go
14 ahead.
15 MR. COCHRANE: That second sentence: Protocols
16 would also have to be developed with respect to access and
17 control of information that is on the system. The reason
18 we recommend that is you've heard evidence from, from Mr.
19 Walker, Nelson House CFS, that they have issues with using
20 CFSIS, and he talked about protocols that he suggested. So
21 we've, we've added that sentence in there.
22 The first step in implementing this
23 recommendation would require the immediate removal of any
24 connectivity, training, IT support and data entry issues
25 that currently exist as obstacles for remote communities.

1 The reason for this recommendation, Mr.
2 Commissioner, of course, is that access to information by
3 child welfare agencies is imperative to accurately assess
4 safety and risk and for servicing the needs of children and
5 families.
6 Without the consistent use of a single
7 information system for child welfare in Manitoba it is
8 difficult to track outcomes or to access relevant
9 information in a timely manner. There have been occasions
10 when multiple agencies have been involved in the same
11 family due to lack of shared information. This obviously
12 is a problem and it's not effective.
13 You'll recall one example we used was ANCR, as an
14 intake agency for 19 agencies in the City of Winnipeg. If
15 we have a, a child coming in from a remote community into
16 Winnipeg requiring services from ANCR, ANCR needs to know,
17 needs to have a place to go to look for information about
18 that child or her family otherwise you're doing social work
19 in the dark, and that doesn't serve the needs of children.
20 That's why we feel recommendation number 19 is, is
21 important.
22 THE COMMISSIONER: But you do agree that an
23 updating could be done with the existing system without
24 having to develop a brand new one? Or I don't want to put
25 words in your mouth but do I, do we leave it on -- with

1 that understanding?
2 MR. COCHRANE: Yeah. Updating existing system
3 would, would be, would be a good thing. Yeah. We would,
4 we would not be opposed to updating the new system, but I
5 think, frankly, that that question and that answer should
6 be left to the experts that would be engaged in that
7 process. Let them look at the system, let them evaluate
8 it, let them determine if the current CFSIS system works
9 for the child welfare system in Manitoba. If it does with
10 upgrades, we would support that. If it doesn't, then we
11 would also support the development of a new information
12 system.
13 THE COMMISSIONER: Right. I follow.
14 MR. COCHRANE: Mr. Commissioner, if I could just
15 back up. I undertook, a moment ago, to provide you with a
16 copy of the standards development protocol.
17 THE COMMISSIONER: Yes.
18 MR. COCHRANE: I've just been advised, for your
19 information and for Commission counsel, that is contained
20 on CD 1047.
21 THE COMMISSIONER: All right. You've got a note
22 of that, Ms. Walsh, have you?
23 MS. WALSH: Yes.
24 MR. COCHRANE: Under theme number six, which is
25 service delivery, you'll notice we make five

1 recommendations under that theme. Recommendation number
2 20:
3 The province, in conjunction with the authorities
4 and designated intake agencies should immediately develop
5 and implement a structured decision-making screening tool
6 with response times tied to safety rather than the
7 selective issues in the intake module.
8 Right now, Mr. Commissioner, we don't have a tool
9 that balances the variables. Right now we select an issue
10 and it gives you a response time. In the rationale we talk
11 about it a bit more.
12 The existing method at ANCR to determine response
13 times for new referrals has response times tied to selected
14 issues in the intake module rather than based on fact-
15 specific assessment of safety. This can result in response
16 times that are sometimes incongruent with one another, and
17 we give an example.
18 Under the current existing model, an immediate
19 response is required where there is a -- there is family
20 violence with no physical interaction; however, where
21 there's a family -- where there's family violence with
22 physical interactions present, only a 48-hour response is
23 required.
24 Current methology (phonetic) also fails to take
25 into account factors that may mitigate or escalate safety

1 concerns for a child, such as vulnerability, access by the
2 alleged offender and the seriousness of the incident. A
3 tool such as we're recommending will address these issues
4 and increase consistency in decision-making pertaining to
5 response times.
6 Recommendation number 21 on page 29:
7 The province, in consultation with the
8 authorities, should improve the capacity of child welfare
9 agencies to provide non-emergent child welfare services
10 after regular business hours.
11 Mr. Gindin, as you recall, yesterday talked about
12 this weekends and evenings, attempts that should have been
13 made. This recommendation is consistent with, with his
14 comments.
15 We state there in the rationale that many regular
16 case management services cannot be performed during regular
17 working hours due to general availability of families being
18 serviced during work/school hours. For these reasons, much
19 of the non-emergent work is passed on to ANCR's after-hours
20 unit for service. However, the after-hours unit can only
21 -- is only resourced to perform emergency functions and
22 this additional workload creates a strain on the system.
23 In our view, adequately resourcing child welfare
24 agencies to perform these functions would improve the
25 ability of child welfare system to make meaningful and

1 effective face-to-face contact with children and families
2 after work and school hours are completed.
3 THE COMMISSIONER: Being that addresses a need
4 for non-emergent child welfare services, it, it may well be
5 that almost exclusively that will fall into family
6 enhancement services. Would that be a fair comment?
7 MR. COCHRANE: Yes. And, and keep in mind that
8 ANCR has a unit dedicated to emergency issues.
9 I just should clarify my last comment, Mr.
10 Commissioner, that --
11 THE COMMISSIONER: That's fine.
12 MR. COCHRANE: -- it's not --
13 THE COMMISSIONER: Take your time. Did you want
14 to take a break? It's up to you.
15 MR. COCHRANE: No, I'm good to go.
16 THE COMMISSIONER: Okay.
17 MR. COCHRANE: It's, it's not necessarily tied to
18 only family enhancement programs. I misstated that. We
19 heard in this, in this inquiry efforts to reach Steven
20 Sinclair after hours. We think it would be beneficial for
21 those other agencies to have those resources to undertake
22 that responsibility as opposed to coming to, say today, to
23 ANCR, because it's taxing on, on ANCR's system is
24 (inaudible).
25 THE COMMISSIONER: (Inaudible).

1 MR. COCHRANE: Next recommendation,
2 recommendation 25. This is linked to our recommendation
3 number 17.
4 We say that the private arrangement policies and
5 standards be developed by authorities with respect to the
6 customary cultural practices that exist and communities
7 that they serve.
8 ANCR's private arrangement policy, of course, is
9 found at tab "Q", Exhibit 51, Mr. Commissioner.
10 In the rationale we state that the Section 10
11 report recommended that the Child Protection Branch develop
12 a province-wide standard with respect to private
13 arrangements; however, in order to be culturally competent,
14 such a policy should be developed at the authority level so
15 each authority can address specific requirements of such a
16 policy in relation to communities they serve. An
17 appropriately drafted private arrangement policy would
18 allow many children to be safely cared for without the
19 necessity of their entering the agency's care. It is least
20 intrusive to families and therefore in the best interest of
21 children.
22 Under theme number seven, which is building and
23 retaining a professional workforce in child welfare,
24 there's a total of four recommendations in there and I'll
25 refer you to recommendation number 28 on page 38.

1 We recommend that higher qualification
2 requirements and higher compensation schemes should be put
3 in place and funded for experienced child welfare staff
4 occupying intake positions.
5 The goal of this recommendation is to recruit and
6 retain experienced child welfare workers occupying intake
7 positions. Currently, many social workers use intake
8 positions in child welfare as a springboard to less complex
9 and are higher paying positions. This, this is a problem.
10 Having more experienced staff occupy intake
11 positions is a desirable outcome given the complexity of
12 intake work generally and the fact that inexperienced child
13 welfare workers have not had the necessary experience to
14 identify the multitude of overlapping resources available
15 to families and children.
16 The point of all of this, Mr. Commissioner, is
17 that, if I could put it this way, is if you want the best
18 and the most experienced staff at intake, then we're
19 learning that you have to pay them, and that's what this
20 recommendation is, is intended to address.
21 THE COMMISSIONER: You spoke to 28. With respect
22 to 27, you talk about the province-wide strategy should be
23 created for the further development and implementation of
24 culturally competent services in the CFS system. Is, is
25 the word "competent" interchangeable with "appropriate",

1 which is a term that's often used, culturally appropriate
2 services? You talk about here culturally competent
3 services; is, is it the same thing or is there a
4 difference? And if so, what it is -- what is it?
5 MR. COCHRANE: Just bear with me and let me read
6 that.
7 THE COMMISSIONER: Just the, the use in, in the
8 second line of recommendation 27.
9 MR. COCHRANE: Okay. I see that.
10 THE COMMISSIONER: Of culturally competent
11 services. Does that embrace or is that what -- the term
12 that's often used, culturally appropriate services?
13 MR. COCHRANE: Yeah. I, I -- yeah, I would say
14 it would embrace appropriate. Be essentially the same,
15 same point.
16 THE COMMISSIONER: They're interchangeable?
17 MR. COCHRANE: Yes.
18 THE COMMISSIONER: Thank you.
19 MR. COCHRANE: Recommendation number 30:
20 Is that there be an independent third party
21 assessment of the structured decision-making tools be
22 completed at an appropriate time so that they can be
23 refined and improved upon and to ensure that there's no
24 inherent cultural bias.
25 You, you've heard some evidence again from the

1 Assembly of Manitoba Chiefs witnesses where they have
2 talked about this issue. And we've heard that evidence, as
3 the authorities. And in the rationale we give an example
4 of an area needing improvement, and that's the current
5 abuse index scoring. This is where a score is assigned
6 where two or more previous abuse allegations have been made
7 against the person, regardless if the allegations were
8 substantiated. This increases the perceived level of risk
9 for the person at issue, even though it may not be
10 appropriate to do so. So we think it's important, then, to
11 be an assessment of that tool for those reasons.
12 Under theme number eight, Mr. Commissioner, which
13 is community engagement, securing ancillary, ancillary
14 services, we have nine recommendations in total.
15 Recommendation number 34:
16 This one I can tell you resulted in an awful lot
17 of dialogue between the two authorities and ANCR, and that
18 is: The restoration of First Nation jurisdiction over
19 child and family matters.
20 I should actually ensure, Mr. Commissioner, that
21 you have the updated version of this recommendation. There
22 was a redraft of this and I want to just make sure you have
23 the updated version.
24 THE COMMISSIONER: The updated version of what?
25 MR. COCHRANE: Of this recommendation --

1 THE COMMISSIONER: Oh.
2 MR. COCHRANE: -- number 34. Is the one you have
3 there ...
4 THE COMMISSIONER: Well, I used one. Let me just
5 look. I have two here. See if they're different.
6 MR. COCHRANE: The updated one should be the
7 restoration, First Nation jurisdiction.
8 THE COMMISSIONER: Over child welfare matters.
9 MR. COCHRANE: Yes.
10 THE COMMISSIONER: Yes, that's what I have.
11 MR. COCHRANE: Okay. So that's the one that,
12 that's the correct version of that recommendation.
13 THE COMMISSIONER: Okay. I want you to explain
14 this to me.
15 MR. COCHRANE: I will try my best, Mr.
16 Commissioner. First off, let me start by saying this:
17 You've heard a lot of evidence about the over-
18 representation of First Nation children and families in
19 child welfare system and you've heard that that's not
20 acceptable, and we agree that should be -- it is a problem
21 that needs addressing.
22 You've also heard that the AJI-CWI process, the
23 new system I've been calling it, you heard about what that
24 is, and you heard that that is a delegation type model of
25 authority. You've heard Norman Bone, when he testified on

1 behalf of AMC and SCO, he talked about the concept of AJI-
2 CWI was, was borrowing provincial laws as an interim
3 measure toward this objective.
4 You've heard evidence about the non-derogation
5 clause contained in the Authorities Act which very clearly
6 contemplates this occurrence.
7 So what we are suggesting, and we're not -- we've
8 been very careful not to use any kind of prescriptive
9 language, which is what the earlier version of this
10 recommendation words we were -- is the reason we revised
11 it.
12 Norman Bone talked about AJI-CWI not being the
13 end game and that it was an interim measure. What he was
14 talking about Mr. Commissioner, was the goal of First
15 Nations to have jurisdiction over child and family matters.
16 He presented a draft law, if you recall. He presented a
17 draft law that was drafted by the northern communities
18 through their organization called MKO. He tendered that in
19 evidence. And you will recall that when I questioned Mr.
20 Bone about this objective, I went through a number of
21 areas. We talked about the scope of jurisdiction, what is
22 it? What will it look like? What will it include?
23 What's, what's the resulting jurisdictional model? Is it
24 treaty-based? Is it territorial-based? Is it linguistic-
25 based, geographical-based? You recall that discussion.

1 We had a discussion, I asked him as well: To
2 whom will the First Nation jurisdiction apply? Would it
3 apply only to First Nation people? Would it apply on
4 reserve or off reserve? Would it apply to non-First Nation
5 people residing on the reserve? These are all issues, of
6 course, that have to be negotiated so --
7 THE COMMISSIONER: Yeah, I remember the witness
8 well, but what was his name?
9 MR. COCHRANE: Norman Bone.
10 THE COMMISSIONER: Bone.
11 MR. COCHRANE: Bone, yes.
12 THE COMMISSIONER: Yes. Yeah.
13 MR. COCHRANE: He was the former chief of
14 Keeseekoowenin First Nation, if you recall.
15 THE COMMISSIONER: Yes.
16 MR. COCHRANE: And he testified that he sat on
17 various committees looking at the --
18 THE COMMISSIONER: And he, he had the draft.
19 MR. COCHRANE: He had a draft.
20 THE COMMISSIONER: Yeah. Um-hum.
21 MR. COCHRANE: Yes. So we would endorse that and
22 we -- our recommendation, then, is the restoration of First
23 Nation jurisdiction.
24 THE COMMISSIONER: Okay. So if I were to
25 recommend that, who would have to then do what to make it

1 become effective?
2 MR. COCHRANE: This is why we were very careful
3 in the language we used, so I don't want my language to be
4 construed as, as speaking on behalf of the Assembly of
5 Manitoba Chiefs because I don't, okay. I'm not speaking on
6 behalf of any First Nations in Manitoba. I don't have that
7 mandate nor do I have that instruction, so bear that in
8 mind. And that may be, actually, a more appropriate
9 question for Mr. Funke, but I can answer and give you my
10 view --
11 THE COMMISSIONER: Yeah.
12 MR. COCHRANE: -- on this.
13 THE COMMISSIONER: That's fair enough.
14 MR. COCHRANE: Okay. We heard evidence that
15 there are 63 First Nations in Manitoba, seven tribal
16 groups, tribal council affiliations, treaty First Nations,
17 non-treaty First Nations. In other words, the landscape of
18 the First Nation reality here in Manitoba is complex.
19 Northern issues, southern issues. And when you throw into
20 that mix treaty perspectives, complicates it even further.
21 My view, only my view, because you've asked for it --
22 THE COMMISSIONER: Yes.
23 MR. COCHRANE: -- is that it ought to be a
24 tripartite process, and what I mean by that is this: You
25 heard again from Norman Bone the jurisdictional challenges,

1 jurisdictional issues that exist. He talked about Section
2 91.24, the constitution, and 92.23 of the constitution, I
3 think. Twenty-three or 13 of the constitution. Point
4 being federal jurisdiction, provincial jurisdiction.
5 When I say tripartite I mean the process should
6 be the First Nations and however they decide to engage in
7 these negotiations. It should be the province, given the
8 Section 92 jurisdiction they have, and it should also be
9 the federal government, given the Section 91.24
10 jurisdiction. Where it becomes very sensitive, Mr.
11 Commissioner, and where I'm trying to be very careful in
12 what I say is you have, again, treaty First Nations, which
13 is a relationship between the First Nations and the Crown
14 that has to be respected in the process, and that just,
15 that simply means that the main agreement, again, if you're
16 asking for my opinion, the main agreement to -- would be
17 respectful of that treaty relationship should be First
18 Nations, federal Crown, with a subsidiary tripartite
19 agreement between the three parties: province, First
20 Nations and federal. To me, that is a way to try balance
21 the treaty perspective with the realities of the
22 jurisdiction distribution of powers that we have in the
23 current system.
24 THE COMMISSIONER: Do you think my terms of
25 reference empower me to move into this area?

1 MR. COCHRANE: That is why, Mr. Commissioner,
2 we're, we're careful not to -- you asked for my opinion.
3 That is my opinion.
4 THE COMMISSIONER: Yes.
5 MR. COCHRANE: I'm not saying that that's the way
6 it goes.
7 THE COMMISSIONER: Yes.
8 MR. COCHRANE: That is why we were careful in how
9 we worded it. It could very well be that, because of the
10 Section 92 jurisdiction, it's a discussion between the
11 province and the First Nations. That would be within your
12 mandate. I was giving you my broader opinion.
13 THE COMMISSIONER: Yes. And I, I knew that.
14 MR. COCHRANE: Yeah.
15 THE COMMISSIONER: And that's fair enough.
16 MR. COCHRANE: Again, I want to be very clear
17 that I'm not speaking for Assembly of Manitoba Chiefs or
18 any First Nation in Manitoba. But we have heard the
19 comments, we know the background, we know that, that there
20 was a process called the Manitoba framework agreement
21 initiative, Norman Bone talked about that. It was a self-
22 government process started in 1994 and it ran for about 10
23 years and then sort of fell off the tracks. So we know
24 the, we know the discussions have occurred.
25 And the bottom line is this: we know that

1 there's over-representation of First Nations people in the
2 system. We know that and we've heard evidence that there
3 may be issues with culturally appropriate standards and
4 services and laws. We know that practising child welfare
5 in First Nation communities is a lot of time trying to fit
6 a square peg into a round hole. We know that the CFS
7 system is a provincial law. We know that that law is not
8 based on First Nation values, First Nation traditions,
9 practices or customs. We've heard that. For all of those
10 reasons, then, we put forward recommendation 34.
11 Recommendation 36, Mr. Commissioner, page 47:
12 Funding should be provided to allow for the
13 creation of a specialized domestic/family violence position
14 in CFS agencies. This would include increased training on
15 impact of family violence on child wellbeing for all CFS
16 workers, increased family support funding allowing the
17 agencies to better support victims of family violence and
18 better coordination between child welfare and other service
19 providers in the area of family violence.
20 You, of course, have heard evidence that this
21 case touches on domestic violence issues with respect to
22 Wes McKay. In the rationale, we note that the zero
23 tolerance approach to family violence by law enforcement
24 has caused an increased number of referrals to the child
25 welfare system.

1 The focus of child welfare is on working with the
2 victim, primarily women, and children. We need the system
3 to look at more effective ways of dealing with family
4 members that are impacted by family violence.
5 The current approach to working with families
6 experience family violence is neither holistic nor
7 culturally appropriate. It alienates families further from
8 the child welfare system and inhibits a family's
9 willingness to engage with formal support systems. We
10 believe that this recommendation will help to address those
11 issues.
12 THE COMMISSIONER: Are you through speaking to
13 36?
14 MR. COCHRANE: Yes.
15 THE COMMISSIONER: I'd like you to go back to 35
16 and I, and I pose the same question about whether, with
17 respect to what's being recommended there, the terms of my
18 -- the terms, my terms of reference allow me to go where
19 you're asking in commendation 35.
20 MR. COCHRANE: This you've heard from Elsie
21 Flette on, you've heard evidence from Felix Walker on. It
22 is an issue that impacts directly the services provided to
23 children and families in the Province of Manitoba. I
24 understand the question, I understand the point. If there
25 is a way to have the issue addressed given -- I hate to use

1 the word "limitations", but given the challenges that
2 you're addressing by your question, that would be extremely
3 helpful.
4 This, of course, what we're getting at are the
5 two funders for, for the agencies, federal funding and
6 provincial funding. And there's a lack of coordination,
7 frankly, between the two funders. In our view, it prevents
8 the establishment of an integrated service delivery model
9 for on-reserve services. It is a challenge, given the
10 number of First Nation people that are in the system and
11 that are impacted by federal funding and the provincial,
12 differences between the two, federal and provincial
13 funding. If there's a way that we can have this matter
14 addressed I think that would be extremely helpful to the
15 system.
16 THE COMMISSIONER: Thank you, Mr. Cochrane.
17 MR. COCHRANE: Recommendation number 39, page 50:
18 Yesterday, Mr. Gindin talked about trust has to
19 be built up in some fashion. I think he said image has to
20 be dealt with in some fashion. I think we're consistent.
21 I think this recommendation number 39 is consistent with
22 what he was getting at.
23 Our recommendation is that efforts should be made
24 to develop a communication and public awareness strategy
25 designed to build and enhance the trust, communication and

1 cooperation levels as between government departments, child
2 welfare agencies, community organizations and the general
3 public, all of whom have a shared responsibility for the
4 wellbeing of children. This recommendation would include
5 the allocation of adequate resources to support the
6 fulfillment of this recommendation.
7 You've, you've heard evidence, Mr. Commissioner,
8 that there, there was information out there in the
9 community that was percolating about Phoenix and her
10 family, and people, various people, decided, for whatever
11 reason, not to contact CFS. An example, one example would
12 be Rohan; he made decision. And I think in large part,
13 they made that decision because of mistrust in the CFS
14 system. You've heard that comment from some witnesses.
15 So this recommendation is meant to try and bridge
16 that gap, try put the CFS system in a different light, to
17 educate the public about what it is we do, why the work of
18 CFS agencies is important and really to try and build up
19 trust in some fashion, again, similar to what Mr. Gindin
20 talked about yesterday.
21 Mr. Commissioner, that -- unless you have any
22 further questions, I, I don't intend to go through any
23 other recommendations. They are there in writing, they
24 each have a rationale, (inaudible) each a linkage made back
25 to a document or to the transcript, and I hope you find

1 that of assistance to you when you're reviewing this
2 document.
3 I can continue. I do note the time, but there is
4 -- the last thing I wanted to address was the questions
5 you, you asked yesterday of Mr. Ray and of other counsel to
6 address --
7 THE COMMISSIONER: Yes.
8 MR. COCHRANE: -- four recommendations.
9 THE COMMISSIONER: Now, do you want to go ahead
10 or do you want a break? It's entirely up to you.
11 MR. COCHRANE: Okay, we'll have a break, Mr.
12 Commissioner.
13 THE COMMISSIONER: Okay. We'll take a 15-minute
14 break. I guess we have been going a while.
15
16 (BRIEF RECESS)
17
18 THE COMMISSIONER: Mr. Cochrane before you
19 continue, I had a few words with Commission counsel over
20 the break and she expressed a concern to me which I share,
21 that with respect to your request for legislative changes
22 to allow the delivery of more culturally appropriate or, or
23 competent services, just what kind of legislative changes
24 are you looking for in light of the enactment of the
25 Authorities Act, which was understood to move everything in

1 that direction arising out of the AJI and the child welfare
2 initiative. And so we think, Commission counsel points out
3 to me we're going to be, have some difficulty in trying to
4 determine what exactly it is you're seeking and if you
5 understand the point, if you could agree to give some
6 additional thought to that and you don't -- you might be
7 able to answer it next week in reply time or whenever we
8 get to your reply or subsequently providing everyone is
9 notified of what your, what else you have to answer that.
10 MR. COCHRANE: Mr., Mr. Commissioner, thanks for
11 that question. I -- what I propose is this. Let me, let
12 me address that next week. But I do want to add some
13 comments today, if I can, just on a very preliminary basis.
14 THE COMMISSIONER: Yes.
15 MR. COCHRANE: That recommendation is not
16 something new. Let me start by saying that. It's
17 something that was previously discussed, previously
18 contemplated and it just hasn't happened yet.
19 THE COMMISSIONER: That as, what, the time of the
20 Aboriginal Justice Inquiry?
21 MR. COCHRANE: Yes. Yes. And the point being
22 this, that the -- and I get your comment that the
23 Authorities Act was put in place and creates the
24 authorities, and so forth. The system, has, as it exists
25 now -- and one example is this, Ms. Walsh did talk to me

1 about the provincial standards and the authorities being
2 able to develop culturally appropriate standards. You've
3 heard evidence about that. And they can, they can develop
4 culturally appropriate standards. The, the caveat to that,
5 though, is that those culturally appropriate standards have
6 to be consistent with the foundational standards, which are
7 provincial standards. And the point being, if I can use
8 that example, is that those provincial standards, I would
9 argue at least, are not drafted with or through that
10 cultural lens that we've talked about in our
11 recommendation. So although we're able to develop
12 culturally-appropriate standards at the authority level,
13 they do have to be consistent or in line with the
14 provincial standard. There is -- the, the authority's
15 ability to, to, to draft culturally appropriate standards
16 is not unfettered, in other words. That's an example with
17 regard to the standards.
18 With regard to the, the legislation itself,
19 again, when the AJI-CWI process happened, the resulting
20 amendments to the CFS Act were those only needed to give
21 effect to the Authorities Act. There's a number of
22 sections that were, if I recall correctly, were, were, were
23 left to come back later. And I've got some -- I have to
24 say, I thought about this further during the break as well,
25 when you asked me to provide a list of those sections, and

1 I did this -- mentioned this to Commission counsel but I, I
2 do have, I realize it is our recommendation but I do have
3 some reservation in coming up with a list for you. The
4 reason for this -- reason for that is this:
5 There are four authorities. I represent one of
6 them -- sorry, two of them, northern authority, southern
7 authority. I don't represent the Métis authority, I don't
8 represent the general authority. And I certainly would not
9 want the list that I come up to be the extent of the review
10 that's to how if, if you endorsed the recommendation,
11 because I think that would be unfair to the other parties.
12 Rather, I would suggest this to you: That if, if
13 you agree with the recommendation that there should be a
14 cultural review, a review of the legislation through a
15 cultural lens, if you endorse that, let that process
16 happen, because what will occur, I would envision, would be
17 an engagement from the province, the four authorities and
18 those experts would sit down and they would review the
19 sections that need to be revised. They will determine the
20 scope of amendments, if any are required, as opposed to,
21 with all due respect, Mr. Commissioner, with, as opposed to
22 any caveat put to that by a list that come up with, that
23 you may subsequently then endorse.
24 So the point being, the recommendations that that
25 process, that process of, of reviewing the legislation

1 simply happen, the parties themselves will work out the
2 scope of the amendments that are required without any pre-
3 determination by the Commission or any predetermined list
4 that I may happen to come up with. And, and it's
5 important, Mr. Commissioner, that all stakeholders
6 participate, not just the southern authority and the
7 northern authority who I represent but all stakeholders.
8 And that's the point to the recommendation.
9 THE COMMISSIONER: All right. And when you use
10 "stakeholders" you, you immediately add the other two
11 authorities. Is there anybody else?
12 MR. COCHRANE: Well, I would, I would see that an
13 organization like the Assembly of Manitoba Chiefs would be
14 engaged. They were engaged in the AJI-CWI process, they
15 had input into the Authorities Act, they had input into the
16 regulations that resulted. I would see them engaged. If
17 that is the appropriate body; I don't know, it's -- again,
18 I don't make that decision, but I would -- stakeholder
19 would definitely be a representative of the, of First
20 Nations, of the Métis community. MMF I know was engaged in
21 the AJI-CWI process. I would see them as a stakeholder. I
22 would again, as you've stated, see the four authorities and
23 the province.
24 THE COMMISSIONER: Okay. One final question and
25 then we can move on. Based upon what you said, are the

1 changes that you contemplate more to the standards than to
2 legislation itself?
3 MR. COCHRANE: I wouldn't agree necessarily with
4 that comment. I would see both the standards and/or the
5 legislation being subject to review. I would see
6 amendments occurring in both streams, legislation and
7 regulations. Certainly don't want to limit the legislative
8 review that I believe has to happen. And when I talk about
9 the CFS legislation, I'm talking about the CFS Act. And we
10 talked about some of the definition of abuse, we talked
11 about, you know, customary care agreements, we talked
12 about, you know, those issues, so it would be both, Mr.
13 Commissioner.
14 THE COMMISSIONER: Okay. All right.
15 MR. COCHRANE: Just, just so I'm clear before I
16 leave that issue, I undertook to provide sections of the
17 Act that need updates. Am I correct, then, based on our
18 discussion we just had, that my suggestion is that I not
19 provide that list?
20 THE COMMISSIONER: Yeah. I, I, I accept what you
21 say.
22 MR. COCHRANE: Thank you. Okay, Mr.
23 Commissioner, the last point, then, for me to address --
24 and again, Mr. Saxberg may, may address you on some points
25 as well that come up -- is a number of recommendations

1 raised by Mr. Gindin yesterday.
2 THE COMMISSIONER: Yes.
3 MR. COCHRANE: And if my note-taking is correct,
4 you identified, I believe it was four recommendations that
5 you asked for comments on.
6 THE COMMISSIONER: Yes.
7 MR. COCHRANE: I've got them here somewhere.
8 THE COMMISSIONER: Well, the first one was number
9 one.
10 MR. COCHRANE: Number one. And that is he
11 recommended that the CFS Act be changed to reflect child
12 protection as the only purpose of a mandated child
13 protection agency, of mandated child protection agencies,
14 family preservation support services be delivered by
15 separate government agency or non-government organizations.
16 So it's a separation between the two.
17 THE COMMISSIONER: Yeah. Is that, is that, from
18 your perspective, is that a practical recommendation or do
19 you see how the -- should there be the division and, if so,
20 how, how should it be structured?
21 MR. COCHRANE: Our -- from our perspective, Mr.
22 Commissioner, we, we do not endorse that recommendation and
23 offer you the following comments:
24 The gist of his recommendation is that CFS'
25 function should be limited only to child protection. You

1 heard evidence, Mr. Commissioner, that prevention and
2 voluntary services are extremely important. It's just as
3 important as protection work and, in many cases, even more
4 important. Prevention is where focus of social work should
5 be. This, I believe, is consistent with the evidence
6 you're heard. The proposal or recommendation that someone
7 else perform this work, it lists government or non-
8 government agencies or organizations. That's very broad,
9 Mr. Commissioner, and it includes, on my reading, any form
10 of entity. And that recommendation I think raises more
11 questions than it does answers.
12 Will this important prevention function be
13 performed by social workers? Will there be oversight at
14 the work done by these non-government agencies or
15 organizations? Will they be subject to quality assurance
16 reviews? You've heard Elsie Flette testify about that.
17 Will there be standards? Will they be regulated? What
18 does it mean? How will CFS and this new prevention entity,
19 interact? How will they communicate? How will they share
20 information? How will they engage with each other for the
21 protection of children? Will there be protocols in place
22 for sharing of information? These are all questions that,
23 that arise from that recommendation.
24 At its heart, I think this recommendation is
25 about changing structure. It's not about changing

1 substance of social workers, of social work and how they
2 deliver service to families. I think it is the substance -
3 - the delivery of these services that should be the focus
4 of this Commission.
5 So we have -- we don't support the
6 recommendation. We think it makes the system too complex.
7 There already are issues with sharing information, there
8 are restrictions on communicating information between
9 entities already. I think the, the evidence of Andrews
10 Street Family Centre speaks volumes when you're considering
11 this recommendation. And the witness was Dilly, Dilly
12 Knol, K-N-O-L-L (sic). From Saint (sic) Andrews Street
13 Family Centre. She testified on May 31st, 2013 at page
14 168, Commission counsel was asking her some questions,
15 questions I think that were relevant to this
16 recommendation. And Commission counsel says:
17
18 "Okay. So maybe that takes us to
19 the next topic, which is the topic
20 of ... whom should -- well, it ...
21 specifically differ -- money for
22 differential response funding,
23 which is ... what you are all
24 doing, is you're not doing
25 protection work, you're doing ..."

1 And she's interrupted.
2
3 "-- the child welfare system calls
4 family enhancement work."
5
6 That's the type of work you're doing, Ms. Walsh is
7 suggesting to them.
8
9 "So what, what recommendations
10 [do] each of you have regarding
11 funding in terms of ... better
12 supporting your work?"
13
14 And then she says:
15
16 "... we'll start with you, Dilly.
17
18 And Dilly answers on page 166/170 -- sorry, 169 and 170.
19 She said, in a nutshell, where she, she won't open or keep
20 files on families if that is a requirement to do
21 differential response work in a place of CFS. And she, she
22 states this, this is her words:
23
24 "My fear is that if I have to
25 start keeping files on families

1 ... that I work with in order to
2 get money, then keep your money
3 because that's not going to help
4 my families. My families are not
5 going to come to [me at] my centre
6 because they're going to lose
7 trust because they're going to
8 feel that I work for CFS not
9 Andrews Street Family Centre. And
10 ... they do want -- you know, if
11 they -- because I read about it
12 and stuff like that, and ... just
13 saying, if I have to open a file
14 to a family that drops in, in
15 order to get some [extra] money to
16 get extra child care or to get
17 extra bus tickets or to be able to
18 home visit, have more people doing
19 home visits and those supports at
20 home and stuff like that, my
21 families are not going to trust
22 me, they're not going to come to
23 my centre."
24
25 I think that's an illustration of some of the

1 problems that we will have if that recommendation is
2 adopted as worded. So for those reasons we don't, our
3 clients do not support recommendation number one.
4 The next recommendation you asked --
5 THE COMMISSIONER: I guess the reason I've
6 highlighted that, invited any comment, you know, we heard
7 over and over how there's a, the relationships are not good
8 when CFS comes calling on the door because they're viewed
9 as being apprehenders.
10 MR. COCHRANE: Yes.
11 THE COMMISSIONER: And yet we've also heard a lot
12 of evidence at this hearing about the advantages that can
13 accrue as a result of a properly delivered family
14 enhancement program. So my question is, how do we deliver
15 the latter so that their efforts are not jaded by the
16 attitude that's understandably out there with respect to
17 the apprehension --
18 MR. COCHRANE: Yes.
19 THE COMMISSIONER: -- model.
20 MR. COCHRANE: Yeah, and I get that, and we do
21 agree, of course, with Mr. Gindin's comment and we made the
22 similar recommendation, that there be public awareness, you
23 know, to educate people about CFS, and hopefully that will
24 begin to break down some barriers because there is, there
25 is mistrust right now.

1 THE COMMISSIONER: Yes. Okay.
2 MR. COCHRANE: I do, I do appreciate that
3 comment.
4 Mr. Commissioner, we just have one moment.
5 THE COMMISSIONER: Surely.
6 MR. COCHRANE: Thank you, Mr. Commissioner.
7 Second recommendation you asked us to comment on,
8 or you invited comments was recommendation number three, I
9 believe, of Mr. Gindin.
10 THE COMMISSIONER: Yes.
11 MR. COCHRANE: That is that files be opened in
12 the name of a child as opposed to the parent or caregiver.
13 Northern authority, southern authority and ANCR
14 do not support this recommendation. And I'll try my best
15 to explain the reasons why.
16 So right now, files are opened in the name of the
17 child when the child is taken into care. That's clear.
18 I've misplaced my notes. Bear with me, Mr.
19 Commissioner.
20 THE COMMISSIONER: Would you like five minutes?
21 MR. COCHRANE: No. No, I'm just -- I've got it
22 here.
23 Children are attached to all family files so that
24 if you run a check on any child, they're involved in an
25 open case. It will come up, it will come up either through

1 the intake module or CFSIS. Our concern with this
2 recommendation, or that concern of my clients is that this
3 recommendation is administratively unfeasible and it could,
4 for example, result in, you know, up to 10 files per
5 family, per family, for example, if a family has 10
6 children.
7 So right now, on an intake, everyone is attached
8 to that particular intake, the mom, the dad, the boyfriend,
9 the girlfriend, the children, stepchildren, if you have
10 blended families, they're all in that one intake.
11 The result of this recommendation is that if the
12 family has eight children, ten children, which we do see,
13 Mr. Commissioner, does that mean that there are eight
14 separate files rather than one intake? Right now, with the
15 one intake, it, it provides for efficiencies. The risk of
16 having eight files per family, for example, is that you
17 risk the loss of information in, in the transmitting of
18 that information.
19 If you're doing a prior contract -- contact
20 check, for example, the result is you may have to look at
21 eight separate files whereas right now you look into the
22 one intake.
23 What's unclear to me is what, what problem is the
24 recommendation trying to solve? I'd be interested to know
25 that because that's something we should examine and find a

1 different way, because frankly, this recommendation is, is
2 not implementable, it's not, it's not workable and it's
3 going to cause, in our view, significant administrative
4 delays and a substantial risk that information may be lost
5 in transition if you have that number of files being
6 opened.
7 We recognize, of course, that there have been
8 issues or problems in the past where information was lost
9 between the opening and closing of one parent and the other
10 parent, because it is a common occurrence that parents are
11 no -- no longer live together in the same family home. To
12 address this issue, ANCR now opens an intake file and, like
13 I've said, attaches all relevant people, the mom, the dad,
14 the stepdad, stepmom, brothers, sisters, offenders, to that
15 intake so that when workers run a prior contact check, all
16 relevant individuals will come up when they do that check.
17 So for those reasons, Mr. Commissioner, we don't
18 endorse that recommendation. I'm pretty confident that, or
19 at least I'm told that if anyone is asked who knows the CFS
20 system, to look at that recommendation, that it will not,
21 you will not have agreement on that. It's too
22 administratively difficult to implement.
23 THE COMMISSIONER: Thank you.
24 MR. COCHRANE: With respect to the recommendation
25 number 32, I think which is, which is the next

1 recommendation you asked us to comment on, that is,
2 recommendation 32 of Mr. Gindin, that the Office of the
3 Children's Advocate be a truly independent voice for
4 children and youth in Manitoba, and to remove any
5 appearance of bias the Children's Advocate should not be a
6 former child welfare social worker.
7 I believe that's what you've asked us to comment
8 on.
9 We would agree with the concept or the issue of
10 independence. The Children's Advocate, in order to
11 effectively to their job under the legislation has to be
12 independent. We agree with that part of the
13 recommendation.
14 To say that the Children's Advocate should not be
15 a former child welfare worker definitively, we have some
16 issues with that. We believe it would be more appropriate
17 that not only with the Children's Advocate, him or herself,
18 but with the investigators from that office, there should
19 be definitely a cooling off period where that investigator
20 or that person assuming the position of the Children's
21 Advocate, if they were a former employee of a CFS agency,
22 there should be a clear cooling off period so they're not
23 put in the position of having to review an agency at which
24 they were formerly employed. And it becomes particularly
25 troubling if you have that investigator, having left the

1 position at that former agency because of termination
2 reasons. They may have an axe to grind, for example. So a
3 definite cooling off period, clear conflict of interest
4 provisions (inaudible) the office of the Children's
5 Advocate, and we believe that would go a long way to
6 ensuring independence of that office.
7 THE COMMISSIONER: And did you say applicable to
8 not only the advocate but her staff as well?
9 MR. COCHRANE: That's right. The investigators.
10 THE COMMISSIONER: Yes.
11 MR. COCHRANE: I could speak first hand, Mr.
12 Commissioner. It's not in this, not evidence at this
13 inquiry, but I can speak first hand that a child death
14 review report that was done by that office, the
15 investigator who did the review was a former employee of
16 the agency. We did not leave on the best of terms. That
17 person was then put in the position of coming in to review
18 their former employer, and one has to question the
19 independence of that review in those circumstances. So we
20 feel a cooling off period, a reasonable cooling off period,
21 clear conflict of interest, again, not only for the
22 Children's Advocate but for staff and investigators of that
23 office.
24 I believe, Mr. Commissioner, the next
25 recommendation you asked for comment on was number 47 of

1 Mr. Gindin's document. That's the one saying there should
2 be a clear acknowledgment by the Manitoba government that
3 the over-representation of aboriginal people in the child
4 welfare system requires a concerted effort to increase
5 funding and develop programs to deal with poverty for
6 housing and substance abuse in all communities across
7 Manitoba.
8 My clients would endorse that recommendation, Mr.
9 Commissioner, and we, we have no amendments to make.
10 Reference being on all communities across Manitoba, we take
11 that to include First Nation communities in the south and
12 the north.
13 I believe those were the four, Mr. Commissioner,
14 that you asked about?
15 THE COMMISSIONER: Yes. Although I was
16 interested -- have you got any view, views on the, there's
17 a proposal in there about the college, and have you got any
18 views about -- I think that was recommendation 17, that the
19 new registration process be implemented as soon as it is
20 proclaimed, requiring all social workers to be registered
21 with the MIRSW and therefore governed in a similar way to
22 other disciplines. I don't think I pinpointed that
23 yesterday so you may not want to comment on that, but it's
24 one I, I will be dealing with in some form and didn't know
25 whether you had any position.

1 MR. COCHRANE: Yeah. Mr. Commissioner, at this
2 point I haven't canvassed that with my clients. I don't
3 have instructions yet on that particular recommendation.
4 THE COMMISSIONER: That's fine.
5 MR. COCHRANE: So moving on, then, Mr.
6 Commissioner, the recommendations of other parties.
7 We do not have any comments with respect to
8 recommendations made by MMF, Aboriginal Council of
9 Winnipeg, MGEU, the general authority or the University of
10 Manitoba. Of course, the Department of Family Services did
11 not make recommendations.
12 With respect to AMC and SCO, we have no comments
13 other than with respect to their recommendation number
14 eight. And their recommendation number eight reads: That
15 immediate efforts be made to increase the level of First
16 Nations representative -- sorry, representations among ANCR
17 staff to ensure that culturally appropriate services are
18 delivered by staff that better reflect the cultural makeup
19 of their clientele.
20 THE COMMISSIONER: What page is that on? Or
21 maybe it's right at the back.
22 MR. COCHRANE: I don't have the page, I can get
23 it, but it's recommendation number eight, AMC.
24 THE COMMISSIONER: That the province and federal
25 government enter into discussions with First Nations

1 leadership --
2 MR. COCHRANE: No.
3 THE COMMISSIONER: -- is that it?
4 MR. COCHRANE: No. It's that --
5 THE COMMISSIONER: Oh, no. That's, that's,
6 that's 18.
7 MS. WALSH: Page 37.
8 THE COMMISSIONER: I have it.
9 MR. COCHRANE: Page 37?
10 THE COMMISSIONER: I have it, yeah.
11 MR. COCHRANE: Okay. So that's the only
12 recommendation we make the following comments on:
13 With respect to ANCR, approximately 70 percent of
14 the families at ANCR, 70 percent of the families at ANCR
15 provide services to are aboriginal. Approximately 11 to 15
16 percent of those families identify as Métis.
17 You've heard Ms. Stoker testify during her
18 examination that one of the main objectives of ANCR and one
19 of its main goals is to get a workforce that is
20 representative of the people that ANCR provide services to.
21 The comment that immediate efforts be made to
22 increase the level of First Nations representation among
23 ANCR staff implies that such efforts have not already been
24 made. If that's the intent, then it misstates the fact
25 that such efforts are ongoing and Ms. Stoker provided

1 evidence to you in that respect.
2 She indicated that ANCR has an aboriginal
3 recruitment policy and that ANCR has worked with the Human
4 Rights Commission to develop a special measures program to
5 increase the number of aboriginal workers. When it was
6 mandated in 2007, ANCR's objective was a workforce
7 comprised of 53 percent aboriginal employees. That
8 objective has been updated to 70 percent, and she talked
9 about this in more detail during her testimony.
10 Seventy to 80 percent of the staff in ANCR's
11 prevention stream, that's its early intervention program,
12 self-identify as aboriginal social workers. That's 70 to
13 80 percent.
14 With respect to the overall compensation of
15 ANCR's workforce, Ms. Stoker testified that currently 39
16 percent of ANCR's employees self-identify as aboriginal.
17 That's page 58 of the May 26 -- sorry, May 2nd, 2013
18 transcript.
19 Ms., Ms. Stoker testified about difficulties that
20 ANCR is facing in its achieving its 70 percent target for
21 aboriginal workers. And she, she talked about six
22 difficulties. Aboriginal candidates are more attracted to
23 the prevention stream versus the protection stream. It's
24 hard to get candidates in the protection stream.
25 Aboriginal candidates have a strong desire to work in their

1 home community. They go back home and they go back to the
2 reserves; there's good reasons for that: they want to help
3 their people where they grew up, and of course there's
4 incentives, pay incentives to go with respect to the Indian
5 Act and the tax exemption status that is available should
6 they work on the reserve. That's very difficult to compete
7 with.
8 Third thing she talked about is there's a
9 shortage of aboriginal candidates for intake and abuse
10 functions at ANCR. They've identified that.
11 Fourth, she talked about a high turnaround with
12 respect to aboriginal social workers at ANCR due to the
13 number of opportunities that are otherwise available to
14 them elsewhere within the child welfare system. Again,
15 they're going home, working for their communities.
16 Having said all that, of course, ANCR is
17 committed to building and having a representative workforce
18 and ANCR is prepared to work with any party to develop
19 initiatives to increase qualified aboriginal social
20 workers. The recommendations made, that we made, that's in
21 particular recommendation number 29, which relates to
22 building of a qualified workforce, and that is at the
23 University of Manitoba, which is to offer an aboriginal
24 social work type specialization is intended to address that
25 issue.

1 So those are the comments that we wanted to make
2 with respect to that recommendation. I think the evidence
3 is clear, ANCR is committed to that, remains committed to
4 it and will work again with any party who shares that
5 objective. There are challenges, however, to meeting the
6 targets it has set.
7 So in closing, Mr. Commissioner, again, I stated
8 at the outset that ANCR, southern authority and the
9 northern authority provided no services to Phoenix Sinclair
10 or to her family.
11 I've talked about, through the evidence of Elsie
12 Flette and again through the evidence of Sandie Stoker,
13 that the CFS system has changed fundamentally since the
14 death of Phoenix Sinclair. You've heard through evidence
15 that today her file would not be closed as it was back
16 then.
17 You'll recall that I also attended to the inquest
18 with a number of people from Fisher River. I want to take
19 the opportunity to very, very briefly touch on that.
20 Mr. Khan talked about how the death of Phoenix
21 Sinclair greatly impacted the people in Fisher River. The
22 evidence that you heard was, I think demonstrates that the
23 community as a whole and that the individuals who were
24 called did not know of Phoenix Sinclair's death. There's
25 no evidence that anyone tried to hide or assistance in

1 hiding -- assisted in hiding Phoenix Sinclair or her death.
2 No evidence that that happened in Fisher River at all, not
3 one shred of evidence.
4 In fact, you heard evidence from Keith Murdoch.
5 You'll recall he was the gentleman who came to testify and
6 at the time of the death he was an elected council member
7 at Fisher River, one of the councillors. And he's, he's
8 the fellow that lived across the street from the house
9 where Phoenix was murdered. And he talked to you about
10 sitting up one night, looking out his window and seeing
11 some activity at that home. Although he was some distance,
12 he couldn't make out details, but it stuck out to him as
13 odd. And he didn't put anything to it at the time, of
14 course, because who would? No one knew at that point what
15 had happened. But, that when he read about it in the
16 media, which is how most people learned about it, learned
17 about the death, when he read about it in the media he
18 remembered that, that night and what he saw. And his
19 evidence was that he, he immediately or shortly thereafter
20 took it upon himself to contact the RCMP. He provided a
21 statement of what he saw, he assisted with the police, and
22 of course he was in a leadership position in Fisher River.
23 So any suggestion that people in Fisher River
24 knew of the death, covered it up, anything along that line
25 is completely not supported by the evidence and, frankly,

1 would be false.
2 THE COMMISSIONER: I don't think there's any
3 evidence to support that proposition.
4 MR. COCHRANE: So Mr. Commissioner, that -- I was
5 -- bear with me one second.
6 THE COMMISSIONER: Surely.
7 MR. COCHRANE: Okay. Mr. Commissioner, I'll say
8 nothing further, then, in that regard.
9 THE COMMISSIONER: Well, no, I don't want to cut
10 you off, but I --
11 MR. COCHRANE: No.
12 THE COMMISSIONER: -- I mean, I --
13 MR. COCHRANE: No, I want to just consult with
14 my --
15 THE COMMISSIONER: -- I've never, in this
16 hearing, heard anything to suggest that there was any
17 cover-up or anything, or any knowledge in the community
18 about the tragic events that had happened. I --
19 MR. COCHRANE: Oh.
20 THE COMMISSIONER: I just have never heard that
21 in this, in this hearing room, and but if you want to speak
22 to that further, if you want to speak further to it, I
23 wouldn't --
24 MR. COCHRANE: Yeah. Mr. Commissioner, I
25 appreciate that language. What I was getting at were some

1 comments made yesterday, during the victim impact statement
2 by Kim, Kim Edwards, and I wanted to be careful in how I
3 worded this. I did attend to the Commission counsel's
4 office to review and listen to the audio recording of the
5 statement. If there was a suggestion in her statement, she
6 uses the word quite broadly that aboriginal people, if her
7 suggestion was that aboriginal people were at fault, that's
8 the (inaudible) I was getting at, because there's certainly
9 no evidence to suggest that. And again, I want to be
10 careful in how I word it because I don't want to misstate
11 anything that was said. That's the point I was making in
12 those comments, and I'm glad you've clarified that because
13 if there was -- if that was a suggestion, then, frankly I
14 think that would be outrageous and that's certainly not --
15 no evidence to support that.
16 THE COMMISSIONER: That is my view of the
17 evidence, unless someone can show -- point me somewhere
18 else. I, I do not believe there's any evidence --
19 MR. COCHRANE: Thank you.
20 THE COMMISSIONER: -- to support that
21 proposition.
22 MR. COCHRANE: And I'll leave it at that, Mr.
23 Commissioner. So that's the end of my submission. Thank
24 you for listening to me today, and we look forward to your
25 report.

1 THE COMMISSIONER: Thank you, Mr. Cochrane.
2 All right, Ms. Walsh, I guess we're adjourned
3 till 9:30 tomorrow morning?
4 MS. WALSH: That's correct. And so far as I'm
5 aware, we'll be starting with the AMC.
6 THE COMMISSIONER: Yes. And then --
7 MS. WALSH: Hopefully.
8 THE COMMISSIONER: And then follow the schedule.
9 MS. WALSH: Yes. Exactly.
10 THE COMMISSIONER: All right. We'll be here.
11 Thank you.
12
13 (PROCEEDINGS ADJOURNED TO JULY 24, 2013)