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

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

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

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MONDAY, JANUARY 21, 2013

APPEARANCES

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

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

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

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

MR. H. KHAN, Intertribal Child and Family Services

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

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

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JANUARY 21, 2013

PROCEEDINGS CONTINUED FROM JANUARY 17, 2013

THE COMMISSIONER: Good morning.

MS. WALSH: Morning, Mr. Commissioner.

THE COMMISSIONER: All right, Ms. Walsh?

MS. WALSH: Thank you, Mr. Commissioner. My apologies for the delay. We had some technical difficulties with our e-mail at the Commission and --

THE COMMISSIONER: I think that's --

MS. WALSH: -- other difficulties and --

THE COMMISSIONER: -- understandable on a major move like this. That's ...

MS. WALSH: Thank you. But we are, we are now ready to proceed.

THE COMMISSIONER: Right.

MS. WALSH: Ms. Faria, are you ready?

THE WITNESS: Yes, I am.

DIVA MARIA FARIA, previously sworn, testified as follows:

DIRECT EXAMINATION CONTINUED BY MS. WALSH:

Q Okay. So we're going to go through the reports that were written, after the death of Phoenix was

discovered. But just before we do that, I just have one, one area of questions that I wanted to ask you about. When you testified last week, you used the term "best practice" and I want to make sure that we understand what you meant when you used that term.

A Okay.

Q So, in terms of defining best practice, does it include following or complying with existing standards?

A No, it does not.

Q Okay. What -- how do you define best practice?

A Best practice, for me, is, is really looking at what we know about, about trying to achieve optimal outcomes for the children and, and families that we serve. And it's also looking at what we know, in terms of, of, of best practice in other jurisdictions and what we know about the work that's being done elsewhere, so leading practice. And ultimately, it is the achievement of standards. The, the question then, the issue then is, do we know that standards ultimately result in the optimal outcomes that we're wanting to achieve for children? So with a, with a standard, that is a, a, a requirement, a measurable requirement of the work that we do. Best practices is something that we try to achieve, based on what we know about leading practice and based on what we know about optimal outcomes for children.

Q So in the absence of an existing standard then, for instance, is best practice something that ought to be done to carry out the mandate under the Child and Family Services Act?

A Best practices is something that you try to achieve. So much like we know that -- like, there are four optimal outcomes that we try to achieve for children involved with Child and Family Services, one of them being child safety. We strive to achieve that outcome. Do we achieve that outcome successfully 100 percent of the time? No. And best practices really looks at, you know, looking at doing quality assurance, looking at our policies and procedures and the practice that we do, in order to be able to improve on those outcomes and in order to be able to institute leading practice. Standards are the requirement, the measurable requirement. I think the issue becomes that in order -- part of, part of the problem is that I would say, right now, we don't know that the standards that exist actually result in optimal outcomes for those kids, based on, on what we're looking at, because there's never really been a measure of that. And, and in terms of what we know about quality assurance, very little work has been done to measure outcomes for, for our children and, and the families being served.

Q And I think that research, or lack of research is

something that we will discuss in other phases of this inquiry.

A Yes.

Q In terms of -- last week you said that seeing the child who's the subject of a child protection investigation was best practice --

A Yes.

Q -- in 2004/2005?

A Yes.

Q So did you mean in the sense of being an optimal, achieving an optimal outcome?

A That is correct.

Q And in 2005, you authorized closing Phoenix's file, knowing that best practice had not been followed?

A That's correct.

Q So let's go to the reports and before we start with the Section 4 report, I want to review with you the notes that were taken by Mr. Koster, which then were used for preparing his report.

A Okay.

Q So you did tell us, last time, that you were interviewed by Mr. Koster?

A That is correct.

Q And his notes of your interview start at page 36873.

If we can pull that up on the screen?

Now, you've had an opportunity to review --

THE COMMISSIONER: Just, just one moment --

MS. WALSH: Oh, sorry, Mr. Commissioner.

THE COMMISSIONER: -- until I get the -- I don't have that by that number.

MS. WALSH: You don't have pages that are separately -- it would be, I think, three pages stapled together, that would have been with the documents, not with the reports.

THE COMMISSIONER: This is the Section 4 report?

MS. WALSH: Yes, but when, when the Commission office gave you a package of documents for this witness --

THE COMMISSIONER: Oh, I, oh, it's in the package? All right.

MS. WALSH: -- I think the notes would be in there, yeah.

THE COMMISSIONER: I have the full, I have the full report here, but if it's in the package, I'll have it.

MS. WALSH: Before we get to the full report, yes. So it's page 36873.

MR. SAXBERG: Which CD number is that?

MS. WALSH: Think it's 1174. Is it, or (inaudible)? Seventeen ninety-four.

THE COMMISSIONER: Yes, all right, 36873, I have

it.

MS. WALSH: You have that, Mr. Commissioner?

THE COMMISSIONER: Yes.

BY MS. WALSH:

Q And Ms. Faria, you've got that on the screen? You know what we're referring to?

A Yes.

Q Now, you've reviewed these notes that Mr. Koster took of, of your interview?

A Yes, I did.

Q Did Mr. Koster send them to you after your interview at any point?

A Not that I remember.

Q Did anyone?

A No.

Q So was your first opportunity to review these notes when you were preparing for participating in the inquiry?

A That is correct.

Q Are the notes accurate? Do they -- are they an accurate reflection of what you said to Mr. Koster?

A I believe so. I mean, the language, the wording may not necessarily have been the exact wording that I used, but I believe they're an accurate reflection.

Q Okay. And maybe we'll just go through them, so that we understand what it is that you said to Mr. Koster.

A Okay.

Q So it starts with the heading:

> "Diva Faria,
> Now a program specialist for the general Authority and for 5 years previously crisis response unit supervisor, and an abuse co-ordinator for a year and a half. Intake and family services worker for another 8 years."

That's fairly straightforward. And of course, since then, you've taken on another position?

A That's correct.

Q All right. Okay.

> "Case was not accepted in intake, and so CRU handled it yourself. No clear standard or policy regarding hospital referral regarding clients with past history of child protection

involvement yet are not identifying any present concerns."

Now, what is this talking about?

A I believe that would be with respect to the December '04 referral that Ms. Shelley Wiebe took.

Q And you, and you told Mr. Koster that the case was not accepted in intake?

A Yes, the case was not accepted as, at intake and it was based on the fact, based on the information being present, there was no new concerning information being presented at that time. What I meant by no clear standard of policy regarding hospital referrals for clients with past history, that this was a, a regular type of referral that we would get where the individual may have identified to the hospital that there was, that they might have had some previous history. But there, where there was no new presenting information of concerns, there really was no policy or standard that spoke to how to address that. So it really had to be dealt with on a case-by-case basis.

Q

"Mckay has no birthdate (sic) and if there were more significant concerns related by the referral perhaps the worker would have

done a record check. Shelley contacts ..."

So what, what were you telling Mr. Koster there?

A At this point in time, he -- I, I can only speculate that he's asking me about the identified father of the newborn infant, Wes McKay. And what I've, what I'm indicating to him is that without a birth date and also the fact that there was absolutely no concerning information being presented to us at, at the time, with respect to Mr. Wes McKay, the worker would have had to have done a, a records check to, to determine which Wes McKay, and which would have been difficult to do without a birth date.

Q So are -- did you tell Mr. Koster that you knew that Shelley Wiebe had not done a, a record check?

A No, I did not.

Q Did you tell him whether she had done one? That she had done one?

A As I testified to last week, when I look at the recording, it says worker looked at the -- completed the records, did -- looked at the information on CFSIS. I'd have to go back to the exact record to look at the exact wording. My assumption was that she did complete a CFSIS check.

Q

"Shelley contacts Employment and Income assistance to get more demographic information on [McKay] ..."

Please turn the page.

"... and [they are aware] they are not aware of any common law partner and so she was not able to have more information. Once again Diva said the referral was not a bad."

Now, I'm not asking you to speak for Mr. Koster, but, but are you able to identify what you would've told, what you told Mr. Koster, based on that recording?

A Can you -- could they please put up -- so I could see the full -- yeah, thank you.

So that, so based -- Shelley does a CFSIS check, because she doesn't have a birth date, she's not able to identify if this is the correct Wes McKay. She then contacts Employment and Income Assistance to get greater demographic information, which would have been a normal procedure at the time. Employment and Income Assistance

identifies to Shelley that they are not aware of any common-law partner in the home by the name of Wes McKay. And again, I'd have to look at the exact wording in the report to verify that.

And in terms of saying this referral was not bad, that this was, this referral was not exceptional. It did not stand out in any way and again, as I indicated previously in my testimony on Thursday, this would have actually been considered a grey referral, because there was no new concerning information being presented at the time.

Q Grey, in the sense of whether you would even do an investigation, open a file?

A Grey in the sense of whether or not I even, you know, if, if -- whether there was any protection concerns that would mandate services by the agency.

Q Okay. So that would be determined, based on the investigation?

A Yes.

Q And you just said Shelley does a CFSIS check; that, that's an assumption on your part?

A That was an assumption, based on the information in the recording, that she had done a review of the information on CFSIS.

Q So then going on:

> "CRU still pursued it and a crucial part of their decision was that Phoenix had been seen in July of 04, was graded as low risk and Samantha seemed to be doing well. Sometimes this was so heated that program managers had to be involved. Diva believes that CRU manager should make the call. It was a huge problem mainly on a workload issue. When she left in November of 2005 it was still an issue. Dan used to call it the 'Walk of Shame' when a supervisor had to return with the file to CRU."

So what --

A Again, as I had --

Q Sorry.

A -- testified on Thursday, in, in the absence of clear standards at the time, largely the programmers, was referring to the orientation manual that we used and the policies and procedures in that. As I identified in the criteria for referral for abuse, based on the information

that we had, this was not a case that met the criteria for referral to the abuse intake program. The case was set to intake. It was declined and therefore came back to CRU. This was something that occurred on, on a regular, ongoing basis. And there were times when program, a program manager had to become involved in the decision making, because there was disagreements between supervisors. And there were also times when there was, you know, open dialogue and agreement, or some, we would come to some consensus around how the case should be managed.

In terms of referring to the walk of shame, that was a term that was used and I think the relevance of that is that it was -- the relevance of that is the term being used is significant, in that it was something that everyone was aware of as being aware of as being an issue at the time, within the program.

Q What did it mean?

A I, I don't, I don't really know what it meant. I think you'd need to speak to Mr. Berg about that. I think the relevance of that, for me, is that that term, the, that that term even exists, because it really indicates the prevalence of the issue, that, that that terminology was created in order to review that and we, and it was discussed at management teams. At one point, I know that there was meetings that happened with the abuse supervisors

to try and resolve the process of referring cases to abuse intake. But I think what's relevant about that is the fact that that term existed and it was well known, within the organization and it really, it really points to the prevalence of the issue at the time.

Q Did, did the walk of shame pertain to cases you attempted to send to abuse intake only, or abuse intake and general intake?

A Abuse intake and general intake.

Q In this case, in December of 2004, you didn't take this file, this intake to your program manager, to discuss?

A I have no recollection of that. I don't know if I did or did not.

Q If you had, would you have taken notes?

A No.

Q Why not?

A It just, it wasn't regular procedure for us to record those types of discussions in our case recording.

Q You said, in the absence of clear standards, clear standards about what were you referring to, with this paragraph?

A Well, at the time, the standards were in transition. There were a multitude of, of standards that were in place between that period of '03 to '05. There was

absolutely no training that, that happened for social workers or supervisors, with, with respect to standards. And I think, you know, there was a lot of confusion about which standards were in place when and which standards should be, should have been followed.

Again, as I had testified to on Thursday, in November of -- I'm sorry, I can't remember now, in, I think it was March of '04, we, my manager, Dan Berg, did provide me with a binder that had all the legislation and all the standards in it and that was when we started to follow that. But I think, generally, you know, was there the degree of, of training and accessibility of standards that exist today? Absolutely not.

Q So in, with respect to the December '04 intake, how, if at all, did that confusion about standards affect how you handled the matter?

A I think with the December '04, it was clear to us that the standard was that we were not required to have face-to-face contact, that we could use a reliable resource in the community. Especially with respect to a referral where we're not getting any new protection concerns being presented to us. What -- I think where some of the issues, standards-wise lie, in the '04, was around the, the understanding of expectations around prior contact checks for other partners in the home. Certainly the criteria

today for that is very differently, is very different and I don't think that there was, there was the same emphasis, at the time, in the standards around prior contact checks, with respect to secondary caregivers in the home.

Q And just before we leave this paragraph, I just want to confirm, after Shelley Wiebe made some attempts to find Mr. McKay's birth date and, and didn't, before you signed off on closing the file, on December 7th, '04, did you refer it back to intake, or make any attempts to have it referred back to intake?

A This is the December '04 contact?

Q Yes.

A No, the case had, there had been a determination that the, that the case was, was not going to be sent to intake initially. Based on the reasons outlined in my testimony on Thursday, and based on confirmation by a public health nurse that she, that she had nothing to report and she understood her obligation, we made the decision to close.

Q Okay.

> "Maybe Carolyn Parsons who did the July 14th assessments and close off in 2004 would have been the Central area manager who turned it

down."

That's fairly straightforward.

A Yeah.

Q You don't have a specific recollection --

A I do not.

Q Okay.

"Supervisor recommended public health since the phn would be going out within the first week after discharge from hospital after birth. Worker contacts public health and they say I cannot have discussion with you because of Fiffa unless there are protection concerns. Declares to Phn and confirms this and then says I have nothing to say to you on this. Mary Wu ... supervisor Nettie Strople ... Shelley Wiebe closes the case but supervisor asks whether phn got back to her. No record and the assumption was that if there had been concerns.

"This was not the norm for public health since most of the cases there is co-operation."

A And that's consistent with what I testified to on Thursday.

Q "The supervisor had spent time with staff on Employment and income Assistance, Mental Health, Fiffa ..."

Should that be PHIA?

A Yes.

Q "... Staff are supplied with 861 of the CFSA which shows that this supersedes. See notes made by Diva."

Now, what's 861 of the Child and Family Services Act? What was that referring to? Do you know?

A Off the top of my head, I do not know. I'd have to look at the Act.

Q And notes made by Diva?

A I don't know what he's referring to there.
Q Okay. Did you give Mr. Koster some notes?
A I gave Mr. Koster the CRU program statistics.
Q Um-hum.
A I don't remember giving him any notes. I don't have any recollection of that.
Q Okay. Maybe while we're -- well, we'll, we'll come back to the, to your dealings with employment and income assistance.

> "Diva never had training on Standards and left because she could not get the needs that were required. People in silos and the higher up people got the more detached from the front line experienced."

What were you saying there?
A I left CRU for a number of reasons, some personal. I certainly was very frustrated with the administrative processes there, with the volume of work, with the level of risk associated with the cases and you know, I just -- and, and really not seeing any movement, in terms of, of change, which was part of the reason why I

left. I mean, I left for other reasons as well. I had other interests and but one of the primary reasons was just the, the, you know, the level of responsibility and the stress associated with the job was, was incredibly high and it's, it's work that you could only do for an, for a period of time before it starts to impact you personally.

Q And the reference to:

> "... higher up people got the more detached from the front line experienced."

A I can only speculate what I was speaking to, but you know, I'm not really certain, but it could be that, you know, there really was an awareness of what was happening, for people that were doing the direct service. And that largely speaks to the fact that there was minimal quality assurance happening, you know, at the time. There was, there wasn't a lot being reported back to staff about how we were, how we were doing, in terms of achieving optimal outcomes for kids and families and I think, you know, because part of my job now is to do program reviews and workload assessments, there really wasn't that type of, of quality assurance happening at the time, so that you could understand the needs and the challenges that people at that

front line level were facing.

Q You mean so that management could understand?

A Management, administrators, senior administrators, whoever.

Q

"Supervisor Diva had 16 staff and on average 1300 a month. Xxxx"

I don't know what that is.

A Well, I had eight staff. But when I was covering for Diana and for a, a lengthy period of time, prior to Diana coming, that would have been correct, I would have had 16 staff. And caseload, not workload, caseload, I did provide statistical data to Mr. Koster at the time and for that, for the month of December '05, we received 1300 requests for service. Of those 1300 requests for service, we opened 411 and we closed 192. So that would have been an average -- well, that would have been 603 cases that we opened and closed for the month of December '05. So when we look at that and we take --

Q December '05?

A December '05, yes. So when we look at that, if we divide 603 by 20 workdays, that's 30 cases a day that were coming in and we divide that by 12 staff, that's 2.5 cases a day, per staff. And then when you look at the

Child Welfare League of America standard is, for excellence in child welfare, to achieve best practice, it's 12 cases, per one social worker, per month. Our staff were dealing with 50 cases per one social worker, per month.

Q You know, do those standards refer to intake workers, or family service workers?

A Those standards are specific to intake, so the -- for intake, it's 12 cases, per one worker, per month.

Q And we'll come back, after we've reviewed the reports, we'll come back to discuss workload some more.

A Again, that speaks only to caseload. That does not speak to workload, which would include the gravity of the cases that CRU was managing at the time, which were all within immediate to 48 hours. When you look at the, the safety assessment, those are all high risk complicated extremely difficult cases to manage.

Q So then we go on to the notes relating to the March '05:

> "Next referral-abuse allegation and locked in room, second hand information, not provided with original source, no details on allegations. Worker pursues foster parent telling but she will

not. This is problem number 1."

A Well, I, I, as I testified to last week, when we cannot speak to the original source, we really miss an opportunity to get information about what the exact detail is that's being discussed and again, often the word "abuse" is used, when people are contacting the agency. It does not always mean abuse. And so when we have an opportunity to speak to the original source, we have an opportunity to get detailed information, greater information, that could, could potentially have, have changed the outcome of this. And, because what's important to realize is that we were making decisions, based on the information we had available to us.

Q And when you say problem, a problem with respect to what?

A With, with respect to not being able to get more detailed or specific information about the exact nature of what abuse meant in this matter, because we have no, no identified incident. We, you know, we don't have any details and that's critical, because we, you know, we need to make the determination as to whether or not this would be something that would be eligible for referral to our abuse team.

Q So that's -- or to intake?

A Or, or to intake, yes.

Q So that's all the more reason to go out and do an investigation; right?

A Yes, there, you do need to do an investigation, but you need to, you need to look at what the function of CRU was and what the context of an investigation means. And CRU was designed to be a crisis response unit, immediate to 48 hour response. We were not structurally, operationally designed to conduct full investigation, either at an intake level or at an abuse level. So when you -- a good example of that would be the referral that was closed in, in May of '04. That was open for three months at intake.

Q Sure.

A That, that is not something that was manageable at a CRU level.

Q And, and I think that we discussed that at some length last week, that CRU was not set up for long term, ongoing investigations?

A That is correct.

Q But you did say that if you were not able to determine whether there were child protection concerns, then you would refer the matter to intake, because they were set up for doing those investigations?

A If -- that is correct.

Q

> "Supervisor attests that abuse never would have taken this and there had been general meetings to resolve. The abuse criteria for referral to them at the time would be abuse as defined under the act ... which would be injury or sexual abuse and or discipline with an implement. No pre occurance (sic), no identified incident, no description of what occurred and so abuse intake would not necessarily receive this and go from there."

A And that speaks to what I testified to on Thursday and I, and I further reinforced that with the criteria for referral to abuse, as outlined in the orientation manual.

Q And I think you confirmed though that abuse was not the only intake option? You could have referred to general intake?

A Yes, I could have, but the case had been declined by general intake.

Q Not once Mr. Zalevich had it, that was before Mr. Zalevich got it; right?

A We had, after Mr. Zalevich had it, we had no new additional information that would have supported the case going back up to intake and the case had already been declined by intake.

Q But once it came under your supervision, you never made any attempts to send it to general intake?

A After Mr. Zalevich's involvement?

Q Yes.

A No.

THE COMMISSIONER: But before his involvement, you did?

THE WITNESS: Yes, that's correct.

BY MS. WALSH:

Q Well, not you, you weren't involved with that?

A My colleague, Diana Verrier did.

Q That was before anyone had gone out to the house?

A That's correct.

Q

> "It is treated as a case that they have to go out on and a determination as to whether it would then be treated as an abuse

> case. Without specifics the worker felt that they were limited. They felt that they had to talk outside [if] she had company and they were trying to respect her confidentiality."

A Could you flip this?

Q Can you turn the page, please? Good, thank you.

A I think that just speaks to the nature of information that was present at the time and again, I could only speculate because when I met with Mr. Koster, and even today, I had no recollection of the case. I was just going based, strictly on what was documented.

Q

> "This would not have been normal supervisory sign off. The supervisor indicated that normally they would wanted children to be seen. The referral is not alleging the common law partner and even on the visit. There was no expectation on the unit by the supervisor's managers that in every case that a child be seen

... no."

A Yeah, and as I -- I guess that's consistent with what I testified on Thursday, that it would have been best practices for us to have seen Phoenix and normally this would not have been something that I would have signed off. Again, I can only speculate, because I have no, you know -- what's in that recording is only a measure of what's been recorded. It's not a measure of any discussions I would have had with staff at the time, which neither myself or staff remember. And that information would have also been taken into consideration when I made the decision.

Q So are you able to say why it is that you signed off on closing the file without best practice having been followed?

A Again, I can only speculate as to -- I -- looking at the information, you have a allegation of abuse that's non-specified and you have an allegation of a child being locked in their room. When I look at the report, you know, I see that this has gone up to intake. It's been refused by intake. In the report, it indicates that mom identifies that there's a lock on the door. It never really says that there, that she admits to locking the child. There's information that the workers speak to the mom about this, because this is not an acceptable parenting practice. And

based on the recommendations of the two staff that attended to the home, one of which had seven months of abuse experience and one of which was a 17 year veteran to the agency, based on their recommendations that there were no protection concerns, I made the decision to conclude the case and close it.

Q Was there anything that prevented you from asking Mr. Zalevich to go back and try to see Phoenix?

A I can only speculate, because I do not know what the other work we would have been managing that particular day. So given the case numbers that we were dealing with on that particular day, given the gravity of the nature of our work, which was crisis response, that may have impacted whatever decisions I made that day, in terms of feeling satisfied and in terms of prioritizing the work that we needed to do for that particular day. I can only speculate to that, I don't know.

Q And is your answer the same if I ask you whether there was anything that prevented you from going back and insisting that intake open it to do, to go see Phoenix?

A Can you repeat the question? I'm not sure I --

Q Sure.

A -- understand it.

Q Is there anything that prevented you from insisting that intake accept the file, take the file, so

that someone could go see Phoenix?

A At this point, I have -- intake has already refused this case and I have two social workers that have gone out to the home and are identifying that there are no protection concerns and are recommending the case be closed.

Q So you didn't think you needed to ask intake to take the file, to go see Phoenix?

A No.

Q Okay. Then you go on to say:

> "This was pre intake module, and just in terms of making the reporting more accessible to the supervisor. It makes information more accessible."

A I think what was happening, I mean, there's been improvements made to CFSIS since this time. So there definitely were some challenges with CFSIS. But I think the other really significant piece was that the intake module was non-operational at this time. And that's a significant for a multitude of reasons. Because intake, the intake module actually has a, an electronic safety assessment built in. So that certainly was very helpful,

not only to myself, as a supervisor, but it was also helpful to the front line protection workers that were doing the work. And as well, for me, as a supervisor, I was only there briefly after the intake module was introduced. So I'm not an intake module expert, but for me, as a supervisor, my recollection was that it made my work as a supervisor easier, because I could access, I could easily access the information on the intake module. I could see what my staff were doing. If I was getting calls from families or collaterals in the community, that information was more accessible to me. And I think, just in terms of, like, in terms of tracking the history of contacts at intake, it was just a much better system. So I think that that was also a significant factor.

Q Was there anything that you were not able to review that you wanted, or attempted to review, with respect to the history or file recordings in this matter, before you signed off on closing in '04 and '05?

A I reviewed everything that would have been the normal, in the normal course for any case, which would have been the CFSIS information sheet, the intake CRU report and the safety assessment.

Q There was no safety assessment for the '05 opening?

A That we're aware of. I don't know that at some

point there might have been a safety assessment and through the course of, you know, multiple reviews of the file, that assessment went missing. I don't know. All I know is that today I -- there's no safety assessment.

Q So but do, do you recall whether, when you were dealing with this '05 intake, did you have a concern that you needed more information and you weren't getting it?

A Are you --

Q I'm trying to --

A -- referring to Mr. Zalevich?

Q -- that, that --

A Who --

Q -- opening, because you said that the intake module would have made a difference, so I'm trying to understand how.

A It would have made a difference in that it would have, there would have been an electronic safety assessment completed which would have provided a, a more -- you know, basically what it did is based on its, and it's based on issue identification, because there were a number of issues of the safety -- like, I look at the, the safety, the safety assessment that we were using at the time and I see a number of concerns with that safety assessment.

Q Very -- are you able to be specific as to how the intake module would have made a difference with respect to

either the '04 or '05 intakes that you supervised?

A There would have been an electronic safety assessment, which would have increased consistency, validity and it would have been less based on clinical judgment. And there was also some, there was also some significant improvements to the safety assessment, the electronic safety assessment on, on the intake module.

Q

> "4 referrals per day per worker. Cannot necessarily resolve them and that assumes that you have a full complement which was not ... sick leave, calling in sick, no replacement at that time. CRU did not have fill in. Other units did on occasion."

A Again, that's, that in light of our caseload numbers, in light of the gravity of the, of the cases that we were managing, there was also the, the issue of staffing. So the, the numbers that I gave you earlier, that's assuming we had a full complement of staff. So when you factor in vacation, sick time and also the fact that we did to have the capacity to call in casual staff, our after hours did. They were also considered an emergency response

team. They had the capacity to call in casual staff, CRU did not.

Q Are you, were you saying to Mr. Koster that workload had an impact on how you handled the '05 intake?

A I think workload did have an impact, yes.

Q Would you ever have compromised a child's safety because of workload?

A No.

Q So when you, when you signed off on closing the file in '05, that was because you were convinced there were no child protection concerns?

A That's correct.

Q And then:

> "Bill was a seasoned worker and the supervisor would trust that judgment when he went out with a less experienced worker who did not do abuse."

A That's consistent with what I testified to on Thursday. The difference is, when I was interviewed by Mr. Koster, my understanding was, I didn't realize that Mr. Zalevich had, actually had abuse experience, so that's, that's an error.

Q And then finally:

"There is an abuse program proposal for Joint Investigation."

A Today, I don't remember specifically what that was about, but there certainly were efforts underway to try and address some of the concerns that were happening with cases being returned to CRU by abuse and intake. I don't remember specifically what that refers to today.

Q Anything else -- I think that's it for the notes of your interview, anything else you want to comment on before we leave those?

A No.

Q So let's turn to Mr. Koster's report, the Section 4 report, starting at page 29. Did you -- before, before we get into the report, how did you find out about Phoenix's death?

A I don't remember specifically, but I believe -- I was, I was already at the General Authority and there was a document prepared, an information document that was prepared for the Child Protection Branch and my name shows up on that document as one of the people that prepared that document. And I suspect that probably would have been how I learned about her passing.

Q Did, did anyone from the agency, Winnipeg Child and Family Services, contact you after Phoenix's death was discovered, to discuss your involvement in the matter?

A Not that I remember.

Q Would that have been useful?

A Yes.

Q And with respect to Mr. Koster's report, or the Section 10 report and Rhonda Warren's report, when did you first see any of those reports?

A Those reports were given to me by my counsel, Mr. Saxberg, in preparation for, for my testimony --

Q Here?

A -- here.

Q Would you have liked to have seen those reports sometime sooner?

A It would have been helpful for me to have seen those reports. Well, not just for me, for everyone involved in this matter, to have seen those reports and to have actually been able to provide feedback as to the, the findings and the recommendations. Eight years after the fact, I was privy to the recommendations because of, of the Changes for Children, you know, initiatives that were happening, to try and implement the recommendations of all the reviews that occurred, but I did not, I was never -- these reports were never made available to me, no.

Q So page 29 of Mr. Koster's report, you met with Mr. Koster in person?

A Yes, I did.

Q Finding 15:

> "The initial contact after the referral was made in two days rather than the five indicated on the safety assessment. This was appropriate since the child was very young.
>
> The safety assessment provided too low a risk. Phoenix was a young child and it was important to establish that she was recovering. It was commendable that the assigned worker went earlier than had been previously assessed."

You want to comment on that? That's with respect to the safety assessment that was done by Roberta Dyck (phonetic) that indicated a response time of five days.

A As I testified to last week, I support my decision to, to give that a five day assessment, based on the safety assessment that existed at the time. Again,

you're looking at a safety assessment where there was absolutely no training, where there was no policy, no procedure manual that accompanied it and that had, that, that was also not accompanied by any clear definitions. So based on the fact, on what I testified to last week, I support my decision for a five day response on that matter. Again, it's up to the discretion of intake to go out earlier.

Q Then page 45 is where the report starts to talk about the sixth protection opening, from December 1, '04 to December 7, '04. Page 45. So that's, that's the involvement where Shelley Wiebe was the CRU worker; right?

A Um-hum.

Q Now --

THE COMMISSIONER: What page is that?

MS. WALSH: Page 45, Mr. Commissioner.

THE COMMISSIONER: Yes, I have it.

BY MS. WALSH:

Q So pages 45 and 46 outline the facts and the results of your interview with Mr. Koster and I, I understand that you've had an opportunity to review this report recently, as in, in preparation for your testimony. Is there anything in this report, including the, the findings that are made at pages 47, 48, related to the

sixth protection opening, is there anything that you want to comment on?

A Just with respect -- no, I don't think I have any, anything to respond to here.

Q Okay. Thank you. Then if we turn to page 49, this entitled the seventh protection opening, from March 5, '05, to March 9, '05. Page 49 has -- and the facts set out in page 50, starting at 51, there's a description of the interviews that Mr. Koster had, including then, on page 52, the interview he had with you. And then on page 53, he sets out a number of findings. Again, is there anything that you want to comment on with respect to this report?

THE COMMISSIONER: Take your time, witness, there's a lot of pages there --

MS. WALSH: Absolutely.

THE COMMISSIONER: -- so just take as much time as you want.

THE WITNESS: Yeah. Just on page 53 --

MS. WALSH: Yes?

THE WITNESS: -- around the findings that a 14 step abuse investigation should have been conducted in this matter, one that this should have been referred to abuse intake and two, that a first 14 step abuse investigation should have been conducted. And I think he is referring to

the '04 referral here?

BY MS. WALSH:

Q No, this is under the '05 referral --

A Okay.

Q -- according to the report.

A I think he correctly indicates here that the case was overturned by intake, we really didn't have a choice, but to close it. As, as outlined, this did not meet the criteria for, for referral to abuse. And I think it's really important to clarify that CRU would not have been in a position to conduct the 14 step abuse investigation, because that wasn't our function. That really would have been something that should have happened by abuse intake. And clearly, based on the criteria for referral to abuse, based under the definition of abuse, under the Act, and the information that we had available to us at the time, this did not meet the criteria for referral to abuse, nor was CRU in a position to complete that 14 step abuse investigation. That's all.

Q That's it?

A Yeah, thank you.

Q Anything else before we leave this report?

A I would support his findings that:

"The Crisis Response Unit had case load expectations that far exceeded reasonable limits."

And that this was a --

Q What page are you looking at?

A This is --

Q We're using the right hand corner --

A -- 54, F42.

Q Okay. So sorry, you support that finding?

A Yes, I do.

Q And that finding is actually on page 57, if you pull that up please.

That's the one you're referring to?

A Yes. That's all I have to say --

Q That's, that's --

A -- yeah.

Q -- all for this report? Okay. Let's go to the Section 10 report. That's the report that was prepared by Jan Christianson-Wood.

A Okay.

Q Think the reference to the intake that you were involved in starts at page 160. You were never interviewed by Ms. Christianson-Wood?

A No, I was not.

Q Her report, starting at 160 and carrying on to, I think, 170 --

THE COMMISSIONER: Did you say 150 or 160?

BY MS. WALSH:

Q It starts at 160, through to 173, covers the, among other things, the intakes from '04 and '05.

A Yeah.

Q Is there anything -- and take your time again, I know that you've had a chance to look at it, but take your time again today, is there anything there that you want to comment on?

A Just page 56.

Q Can you -- okay, so that's --

A I'm sorry --

Q -- that's 172?

A -- page 172.

Q One seventy-two?

A Sorry.

Q Yeah, no problem.

THE COMMISSIONER: What page?

MS. WALSH: One seventy-two.

THE WITNESS: In that she refers to the:

"... the current program standards

> for child protection (2001) specifically require that [a] child who is the subject ... an abuse report be seen by the investigating worker."

And the standards that were in place at the time were the 2005 standards, which required that in a protection investigation, that we have contact with the person or family. It was -- if there was an abuse investigation, then we would have required to have face-to-face contact with the child.

The, the following paragraph, which states:

> "The new online Child Welfare Standards ..."

So now I, I assume she's referring to the 2005 standards.

> "... for Intake services provide direction to workers In situations such as these. Under 'intake Decisions' on p.3 of the intake section, the case management

> decision at [this] point ... [is that] 'Are all children involved safe?' Based on this question, the decision to close the Intake ... without ensuring that Phoenix was safe was a violation of the newest Provincial Standards."

But really, I mean, when you look at are all children safe, that does not specifically outline that there is a requirement that all children be seen in order to ensure that. There were many cases where we didn't see all children, but -- and children were safe. There are, are circumstances where that does happen. Is that best practice? Absolutely.

And again, she says:

> "The report, which [includes] allegations of confinement and physical abuse ..."

The report was abuse, non-specified. There as no information in, in the referral information that we received that there was any concerns with respect to physical abuse. It was a non-specified allegation of

abuse. So looking at it in hindsight, I mean, that's a perspective, a hindsight perspective on that.

Q Are you taking issue with the allegation of confinement too, the reference to that?

A Well, the allegation that we had was that a child was being locked in their room. And when we look at, at the issue of a child being locked in their room, that could mean a number of different things on a spectrum. It is a, a completely unacceptable parenting practice. It is something that we would discuss with a parent. And why I say parenting practice and not an unacceptable form of discipline, is because locking a child in a room is sometimes not even used as a form of discipline; right? So sometimes it's used as a form of time out. Parents use it as a form of time out. Sometimes locking a child in their room is used as a, a, a form of sleep management, you know, if the parent is outside of the door, listening, that doesn't necessarily constitute abuse. And on the other end of the spectrum, you know, if a child is locked in their room for excessive periods of time, or is being unattended, or is being denied the necessities of life, then absolutely, that's abuse. So that could mean greatly different things on a spectrum.

Q But in terms of separating allegations of abuse and confinement, did you understand the source of

referral's reference to suspecting that Phoenix was being locked in the bedroom as meaning confinement?

A I, I think that at the time, we, we weren't sure what that meant.

Q Okay. Anything else in the Section 10 report?

A She -- if you could -- I'm sorry, if you could scroll down please? Here, she, she does comment on the current situation of fragmented standards. And the reviewer, herself, is indicating that, that it's:

> "... [a challenge] to determine precisely which standards are applicable. The existing standards do not provide an easy to access package for workers under pressure to meet deadlines [or] caseloads. [And] further, the provision of the newest standards online may place workers in Agencies without easy access to the Internet at a significant disadvantage."

So even here, she's, she's acknowledging, you know, that the standards were in transition and during that

period of time, there was five or six different sets of standards that were in place.

And I have no further comment. Oh, I'm just looking at the recommendations.

Q Sure, did you want to comment on any of those?

A On page 176 ...

Q Yes?

A I guess here she's basically indicating that she's recommending --

Q Are you looking at number 2 --

A Yes, recommendation --

Q -- towards the bottom of the page?

A -- number 2.

> "... the program standards [are in] for investigation of allegations of mistreatment of children are followed by agencies under its jurisdiction ... to ensure that ... children [you know, are seen]."

I, I think it's also important to note with that that, in terms of regular quality assurance, to ensure that, we also need to have quality, quality assurance to

ensure that, that social workers and supervisors actually have the organizational conditions that exist that will allow them to achieve those standards. Because it's one thing to say this is the requirement, comply with that and then it's another thing to know whether or not, organizationally, you're setting up the conditions in which staff could actually achieve that. And I don't think that's ever happened, to my knowledge. I think that's starting to happen. Today, when we're, where we're looking at, you know, are we able to achieve these standards, because these standards, supposedly, are supposed to result in the best outcomes for children and we really need to understand it's not just about ensuring that there's compliance, but it's also about ensuring that there's operational systems that support that compliance. And then measuring that, measuring whether or not it actually results in the outcomes that we want to produce for children, in particular with respect to child safety.

With respect to 178:

> [This] point should be extended to eliminate the use of household cleanliness and order as a ..."

THE COMMISSIONER: Which, which paragraph is she

reading from?

THE WITNESS: At the top, the very top.

MS. WALSH: So this would be part of recommendation 3 from the previous page.

Let's look at page 177.

THE WITNESS: Yeah, so:

> [The] point should be extended to eliminate the use of household cleanliness and order as a proxy for good parenting and the absence of abuse."

And I think it's important to note that today, in our safety assessment and our risk assessment, the, the physical care of, of the child, the care of the child being consistent with the child's needs, the physical state of the home, are important factors in considering safety and risk, when assessing a home. So --

BY MS. WALSH:

Q So you're saying those factors are still important?

A They're still important and even though it identifies that they shouldn't be considered in isolation,

they can be considered in isolation, because if one of those factors exists, that could have an impact on safety and risk.

Q Let me ask you, when, when you signed off on Mr. Zalevich's recording, did you -- you knew that he had seen the baby, who looked fine --

A Yeah.

Q -- but not Phoenix?

A Yes.

Q So were you using the assessment of the baby as a proxy for Phoenix's safety?

A I think that I was using the information -- all I can -- again, what's in the report is only a reflection of what's been recorded. I don't know what discussions, what other discussions I would have had with Mr. Zalevich and Mr. Leskiw. So ultimately, I can only speculate as to why I, you know, I make the conclusions that I made and what discussions I would have had with them about their sense of the home and why they were reporting that there were no protection concerns. So ...

Q In terms of signing on a recording, would you sign off on the recording if it was missing important information that had been the subject of discussion between you and a worker?

A Given the volume of work that we were dealing

with at the time, I, I think we tried to be as meticulous as we could. Were there, were there instances where, where that occurred? Yes.

Q Do you know whether that happened in this case?

A I do not know.

Q Anything else with respect to the Section 10 report?

A No, nothing further.

Q In terms of, of understanding standards, you've referred to the orientation manual from, it was December of '04 and, and we also looked at the intake procedures manual. If we pull up the, the orientation manual, first, first of all, let's pull up the first page, 29048.

I don't think you have that, Mr. Commissioner, I think you'll just have to, to see it on the screen.

THE COMMISSIONER: Right, right.

BY MS. WALSH:

Q Is this the orientation manual that you've been referring to?

A Yes.

Q Okay. So then if we go to page 29076, the crisis -- this is the detailed program functions, crisis response unit program description. And under:

"The case management decisions at the CRU would include ..."

Could you scroll up please?

"Are the children safe or in need of protection?"

You agreed that was, that was part of, of the --

A Yes.

Q -- matters that CRU had to determine?

A Yes.

Q Okay. And with respect to, to your referring to standards and what standards existed, you're not saying that because there was not a specific standard that said you must see the children, that's why you determined it was safe to close the file?

A No.

Q So let's go to the last report, the internal report prepared by Rhonda Warren. Page 38009 describes the December 1, '04 intake. And again, is there anything in that description of the '04 intake that you want to comment on? It goes over to the top of the next page. Take your time.

A So it looks like, in these two pages, she's

basically just outlining what the contact was?

Q Yes, and is that accurate? Was there anything that was inaccurate in how she outlined it?

A Not that I could immediately see.

THE COMMISSIONER: You're, you're talking about the May to July '04 opening and closing?

MS. WALSH: No, starting December 1, '04, on page 38009 --

THE COMMISSIONER: Oh, I, I, I had --

MS. WALSH: -- so that would be what had been --

THE COMMISSIONER: -- I have that, but I thought you said you were going to page 11, but it's page 12, is it?

MS. WALSH: Well, if I said page 11, I, I misspoke.

THE COMMISSIONER: Well, maybe I, I misunderstood, but --

MS. WALSH: In any event, Mr. Commissioner, so the --

THE COMMISSIONER: -- I, I --

MS. WALSH: -- it's page 38009 --

THE COMMISSIONER: -- I understand now.

MS. WALSH: -- that, that covers the December 1, '04 intake --

THE COMMISSIONER: Yes.

MS. WALSH: -- and then the following, goes on to the following page and then --

THE COMMISSIONER: And the one -- and it was closed on December 7th?

MS. WALSH: That's right.

THE COMMISSIONER: Yes.

MS. WALSH: And then on page 38010, it discussed the March 5, '05 intake and the, that intake being closed on March 9. So --

THE COMMISSIONER: That's on, that's on page 13?

MS. WALSH: Yes, 13 of the report, 38010 of our disclosure.

THE COMMISSIONER: Yeah.

MS. WALSH: I know it's confusing, having all the different page numbers.

THE WITNESS: So just with respect to the December 1st, '04 --

MS. WALSH: Yes.

THE WITNESS: -- where it says:

> "On [the] date the worker did connect with the Public Health Nurse but the nurse refused to share information based on recent training relating to the Personal

Health Information Act (PHIA)."

BY MS. WALSH:

Q That's on page 38009 that we're looking at; right?

A Yes.

Q Okay. Yes, towards the bottom of that paragraph.

A Okay. I think what should be added to that is that Ms. Wiebe made, made clear to the public health nurse that the Child and Family Services Act supersedes PHIA and FIPPA and advised her of her legal obligation to report if she had any concerns. The public health nurse acknowledges that she fully understood what her legal obligation was. So that would -- I would add that to, to that paragraph.

Q Okay. Thank you. And on the next page, 38010?

A No, nothing further on that.

Q Then, by my reviewing this document, the next reference to the December 1, '04 intake is at page 38036. If you've got something before that, let me know.

Three eight-o-three six, please.

A Okay.

Q And, and this portion of the document, my understanding is that this represents a series of questions that the general authority posed to Ms. Warren that she then filled answers in for. So you see that the bullet

talks about the December 1, '04 intake and then page goes on. Is, is this a page that you've reviewed in preparation for testimony?

A Yes. I'm just looking at --

Q Sure.

A -- I'm just looking at her recommendations --

Q Okay.

A -- which come before this document. And there's on recommendation --

Q What page?

A -- that I think is particularly important and that pertains to risk assessment.

Q What page?

A Three eight zero one eight.

Q Okay. What, specifically?

A Around:

> "Statements of Safety are referred to as Statements of Risk."

And I know that this doesn't necessarily pertain to our outcome, but it's really important, in terms of the recommendations. Because when I -- I think it's really important to note, for this Commission, that when you look at the, at the safety assessment that was being utilized at

the time, it's kind of, it really is a melding of a safety risk assessment. Because the purpose of a safety assessment is to make the determination, are children safe now? And to develop a safety plan; right? That's very different from a risk assessment, which looks at, what is the probability of future harm? And then based on what you determine the probability of future harm, that then determines response times or intake times, or, or contact expectations, which are then defined in the standards. So safety assessment are two completely different things. What we had, during this time period, was a safety assessment that really asks you to define risk. And I think that's hugely problematic. And, and on top of that, you add the fact that there was no training, there was no policy and procedure manual that accompanied it and there was absolutely no clearly defined definitions. And then when you look at response times, those are usually -- or contact guidelines, those are usually outlined in the standards. So then you have complete confusion about what, which standards are in place at which time. So that is significant because it, it, I think it, it impacted some of the decisions that were being made.

Q So in '04 and '05, did you understand the difference between a safety assessment and a risk assessment?

A No, I did not.

Q And in terms of impacting decisions that were made, are you saying that what you've just described to us had an impact on the decisions you made in '04 or '05?

A Absolutely, because if, today, we were using the current safety assessment, or the current risk assessment that exists, CRU would have -- you know, the, the outcome of that would have been that we would, would have considered the vulnerability of the child, which the safety assessment, at that time, did not take into consideration. And that was demonstrated when you asked me to identify a risk level for our contact, for, for our '03 contact. When we went through that safety assessment, it did not identify vulnerability of the child.

The other thing that that safety assessment doesn't, did not identify at the time was protective capacities of the child, protective abilities of the child and protective abilities of the caregiver. So it really doesn't take into consideration, you know, cognitive delays, developmental delays for the child, physical disability. It -- and it also doesn't take that into consideration for the parent, as well as the parent, what the parent's perspective is around allowing access to the child. Whether or not the child is protective, what the parent's perception is of the child. That safety

assessment did not take any of those factors into consideration.

Today, if, if a comprehensive safety assessment had been utilized, the risk, the safety assessment would have required us to do a safety plan and then further, it would have required us to do a risk assessment, a comprehensive risk assessment, which would have, which would score both abuse and neglect and based strictly on the history, that risk assessment would come out high.

Q You knew -- in '04 and '05, you did have information about Ms. Kematch's history with CFS?

A We did, but the safety assessment that was in place at the time, the new safety assessments and risk assessments actually identify those as safety harm and danger items. And the safety assessment that existed at the time did not. We were going on clinical judgment.

Q And a review of, of the history?

A That's correct.

Q And when we reviewed, last week, the intake program's description and procedures manual, we reviewed that the safety assessment criteria included, under the 24 hour response, the age of the child and the fact of a young child being vulnerable, that that was an known criterion to take into account, by a CRU worker?

A In the orientation manual, but not in the actual

tool.

Q But it was something that was known to you and your workers?

A Oh, absolutely.

Q Yes.

A Yes.

Q And I think you told us that, that you took that into consideration when you were assessing a matter?

A Yes, absolutely.

Q So if we turn to page 38036 --

THE COMMISSIONER: Now, Ms. Walsh, are you nearly through with this witness, or are, is it time to break?

MS. WALSH: We could take a break.

THE COMMISSIONER: Well --

MS. WALSH: I think it'd be --

THE COMMISSIONER: -- how far are you from being finished?

MS. WALSH: Maybe 10 minutes, at the most, but --

THE COMMISSIONER: Well --

MS. WALSH: -- we could certainly take a break now.

THE COMMISSIONER: -- are you all right to --

THE WITNESS: Yeah.

THE COMMISSIONER: -- go for 10 minutes more --

THE WITNESS: Yes, thank you.

THE COMMISSIONER: -- before we break? All right. We'll, we'll finish your examination then.

MS. WALSH: Okay. Thank you.

So page 38036, 389036, scrolling down towards -- so we can see the whole page. Good, thank you.

BY MS. WALSH:

Q So where it says:

> "In that it was now confirmed that Samantha was living with McKay, was there consideration given to conducting a PCC or criminal records check on McKay?
> In reviewing the file information it is determined that the [CRU] recommended that the file be sent to Intake for further assessment of the home environment. Further notes indicate the file was returned to CRU with the request ... CRU connect with Samantha, offer family supports and close the file ... if mandated service were not required. After

consultation with the CRU Supervisor, the Social Worker in CRU then called Public Health to see if they had been out to the home to see Samantha and the new baby. When the Public Health Nurse refused to share information, based on recent 'Personal Health Information Act' training her supervisor's name was taken and passed to the CRU supervisor for follow-up. There is no information on the file stating this issue was ever followed up on.

Although Wes McKay's birth date was not known his name was in CFSIS and in fact he had a file under his own name as well as being a significant other in various other files. By reading the dictation in these other files it was easy to determine that he was the same person. The information in these files

presents concerning information on Wes McKay's violence to previous partners and possibly children. To be absolutely sure it was the same person the Social Workers should have made direct contact with both Samantha and Wes to do a proper assessment and conclude this Intake."

"Given the previous recorded documentation on CFSIS, the matter was referred to Intake for ongoing follow-up and assessment of the home environment.
The Agency could not obtain the birth date of Mr. McKay from EIA records as Samantha had only one child listed on her budget and there is not expected to be a common-law partner residing in the home."

So do you have any comments on that recording?

A The only comment I have is what I've commented to

already in my testimony, was that there was no new concerning presenting information being given to us for that contact and there was absolutely no new concerning information being given to us with respect to Mr. McKay. Based on that and based on the fact that public health indicated she understood her obligation to report, we made the decision to close the case.

Q And if we go to the next page, 38037, scrolling down please, so that we can see the full bottom of the page. That's good.

Where it says:

> "What assessment was done to change the plan not to conduct an assessment of the home environment and close the Intake given that non-committal response from the PHN?
>
> To this reviewer's knowledge from reviewing the entire file information there was no reason to change the risk assessment."

Anything more you want to say about that?

A I would say I disagree with that because we have

public health confirming that she's been out to the home and that she has not, no concerns to report.

Q And then on the next page,

> "What is the obligation of foster parents to comply with Agency requests for information?
> There would be no 'obligation' for the foster parent to provide the name of the source of information as the Act clearly states that community members do not need to provide their name in order to make a report of a child possibly in need [of] to protection. It certainly would have been beneficial to have [this] name so the Agency could make direct contact with the source of ... information but since the source had asked the foster parent not to provide the information the Agency would need to respect those wishes."

Any comments?

A That's accurate, we took, we took requests for information from anonymous sources all the time.

Q And then you've told us that this was not an -- didn't meet the criteria for an abuse investigation. Then:

> "Did the Agency comply with Agency procedures when conducting this investigation?"

If we can just scroll down please.

> "The Agency's response to this complaint is concerning. Phoenix was not seen. The apartment was not seen. Samantha admitted that there was a lock on the outside of the bedroom door she and Phoenix shared. No reason for this lock was given. If the lock was deemed necessary by Samantha due to acting out by Phoenix, this would indicate that there were problems in Mom's ability to control this little girl. The history of

> this case, whereby so many sporadic caregivers had cared for Phoenix should have resulted in a red flag to the workers that all was not well in this home. No questions were asked about Samantha's present partner and father to [the new baby]. Add the allegation that Samantha (and or Wes) was being abusive to Phoenix should have put this case in a 'high risk' category and a complete investigation and assessment should have occurred."

You have any comment?

A Well, as I indicated to you on, in my testimony last week, when we completed the safety assessment and we looked at the categories that would deem this matter to be immediate to 24 hours or high risk, the, the presenting information we had at the time would not come out as high risk on the safety assessment that existed at the time.

Q So, finally on this -- is there anything more with respect to, to Ms. Warren's report that you wanted to comment on?

A No.

Q Okay. So then the last area that I want to ask you about is workload. You've talked about it a bit and there may not be anything more you want to say, but I did want to ask you specifically, was workload at the crisis response unit that you supervised, in '04 and '05, an impediment to achieving best practice and complying with standards?

A Yes, it was.

Q Can you be specific?

A I've already outlined that the case numbers for our staff far exceeded what the Child Welfare League of America identifies as what is required to achieve best practices, or excellence in, in child welfare. So they're recommending 12 cases for one social worker, per month. Our staff were dealing with 50 cases for one social worker, per month. You add to that the gravity of the cases that we were managing, which were immediate to 48 hours. If you look at that safety assessment, it outlines specifically what we were looking at. We're looking at parent homicide, child suicide, severe physical abuse. You're looking at, you know, drug, alcohol involvements, children in withdrawal, attending to grow operations, you know, those were the types of situations that we were managing that were high risk. And then you factor into that staff, what

was happening with respect to staffing, that's assuming you have a full complement on any given day and not having the capacity to call in casual staff, that, you know, there is, there's a difference between caseload and workload. Collectively, that was our workload.

Q So then -- thank you. So then my question was, when I, when I asked for specifics, it also referred to, can you give a specific example of how workload affected the delivery of services in '04 and '05?

A Well, a, a specific example of that was some of the challenges that we were having with cases being returned from intake and abuse intake to CRU. It was a matter of every program -- I mean, I can speak to workload at CRU. But I know that workload was equally as significant with intake and our abuse intake units. And with abuse intake, you add to that, you know, the severity and the complexity of the cases that they're managing. And I think that what was happening was that, yeah, there was a push and pull, in terms of who's going to manage the work, based on what was happening, with respect to the volume.

Q And so, were children at risk in '04 and '05 because of workload?

A There was, there, there was -- if I felt, at the end of the day, that children were at risk, I would have done what I needed to do to ensure that that wasn't the

case. So I would say no.

Q And when you say you would have done what you needed to have done, or do, that would include going to your assistant program manager and, and insisting that a file go up to intake, for instance?

A Yes, absolutely.

Q And so then, specifically, did workload have an, an impact on the delivery of services to Phoenix Sinclair and her family in '04 and '05?

A I can, I mean, based on the information that I have, I would say yes, that it did.

Q Was Phoenix put at risk because of workload in '04 and '05?

A I have, I would say no, I don't know.

THE COMMISSIONER: You said no?

THE WITNESS: I would -- not that we knowingly were aware of, that we were placing a child at risk, or any child at risk.

BY MS. WALSH:

Q Did you make your concerns, with respect to workload, known to anyone in management, anyone in authority?

A Yes, we had regular discussions, I had regular discussions with my program manager, Dan Berg. We had

regular management meetings where we discussed workload. Our program statistics, with CRU, program statistics were distributed to our senior management and they were also distributed among our supervisory staff. So the, the numbers speak for themselves. So, yes, it was, it was --

Q Was that in --

A -- known.

Q -- '04 and '05?

A Yes.

Q Were you aware of, of any actions that were taken with respect to your concerns?

A I know that there -- I remember that there were meetings with abuse intake, to look at the referral criteria for abuse and to look at the issues that we were having around transferring cases to abuse intake. And I don't remember specifically what other initiatives would have been underway at the time. That would be something that my program manager, Dan Berg, would speak to more eloquently.

Q So is it fair to say that workload was an issue for you throughout the time that you were a supervisor at CRU?

A Yes.

MS. WALSH: Can we pull up 20260?

I have -- this is my very last question, Mr.

Commissioner and then ...

BY MS. WALSH:

Q There was one other area that I wanted to ask you about. This CRU joint meeting that took place in February of '04, if we turn to the next page, 20261, we already talked about item number 13 on the agenda, but item number 12, do you see that?

A Yes.

Q It says:

> "There have been issues with E.I.A. re: Helen and Stella requesting specific information about cases before giving out demographic information. It was determined that they were given direction to do so, and therefore there will be a meeting at management level with their manager, Brian Barton, to work this out. Dan and Diva will be meeting with Brian Feb 17, 2004."

Do you recall what that was about?

A That was about concerns that we had related to information sharing with Employment and Income Assistance. I don't remember all the specifics of the meeting, but it was, the process, at the time, was that our CRU staff would contact the individuals identified here and would request information and the process had become quite cumbersome, in that, you know, they were being selective, in terms of what they shared and they were requesting information, confidential information. So obviously, we needed to clarify what that process was, in order to, you know, facilitate the process at our end and at the Employment and Income Assistance end as well.

Q So was that clarified? Was the issue resolved after February of '04?

A I think that there was improvements. However, I, I think information sharing with Employment and Income Assistance has, has been an ongoing issue. And I know that in other provinces, there is a joint information sharing system with Employment and Income Assistance and Child and Family Services. And given the workload at, with, at Child and Family, the easier it is for us to obtain information, in the most accurate possible, that really facilitates our, our, our ability to do effective assessments. But it also assists us with respect to workload. Because when we encounter these types of challenges, that only adds to the

workload issues that we're experiencing.

MS. WALSH: Thank you. Those are my questions for the witness, Mr. Commissioner.

THE COMMISSIONER: All right. We've been a long while. We ought to break, which is unusual. But I, I think it was consistent to get through evidence of this witness.

So we'll, now we'll take a 15 minute break and then some of the other lawyers will have questions for you.

THE WITNESS: Great, thank you very much.

MS. WALSH: Thank you.

THE COMMISSIONER: Thank you.

(BRIEF RECESS)

THE COMMISSIONER: All right, Mr. Gindin, we'll get adjusted here and see you.

MR. GINDIN: Thank you.

CROSS-EXAMINATION BY MR. GINDIN:

Q Ms. Faria, my name is Jeff Gindin. I represent Kim Edwards and Steve Sinclair. I have some questions for you.

A Okay.

Q You spoke about standards quite a bit in the

last, last week and today and I understand that you, yourself really only received training in standards in, in September of 2010; I think that's what you said?

A That's correct.

Q And many of the social workers that were, that you were supervising, hadn't received training standards, I think you said, in '04 or '05 certainly?

A That's correct.

Q And there was also quite a bit of confusion, you said, about, even though you hadn't received training, in, in fact, which standards applied, because there were many drafts and many versions; right?

A That's correct.

Q But regardless of what the standards may have been, you've also told us about certain things that would be considered best practice?

A Yes.

Q And best practice, as I understand it, is what you try to achieve, based on the literature, I suppose; is that fair?

A Well, based on what we know, in terms of being optimal practice in other jurisdiction, based on the literature, based on outcomes --

Q Um-hum.

A -- and ultimately, based on standards that exist.

Q Right. So best practice, for example, in this case, is something that you tried to ensure, as supervisor, that the social workers tried to achieve? You tried to make sure that they would follow best practice?

A Yes.

Q Now, in terms of best practice, and I think you've already said some of these things, I just want to make it clear, reviewing the history, with respect to the matter that a social worker is faced with, would be considered best practice?

A Yes.

Q In this case, I think you said, both files should be reviewed, that is Samantha Kematch, Steve Sinclair?

A Yes.

Q So best practice would be then to review as much history as you can and where there are several files, to review them as well; correct?

A Well, at CRU, that would have been reviewing the CFSIS information for both the primary caregiver, which would have been Samantha Kematch and the birth father for the, for the, for the children, which would have been Steven Sinclair. So the expectation would that, would have been that the CFSIS information at CRU be reviewed for both of those files.

Q I didn't mean the paper files, I meant the

information that you could glean from looking at CFSIS?

A Yes.

Q Right?

A Yes.

Q And if the, some information came to light that there was another partner involved, as we've heard about here, certainly with respect to the December '04 involvement, best practice would have been to try and find out some information about this partner, regardless of whether it was in any standard or not?

A Yes.

Q It just makes good common sense; right?

A Yes.

Q Best practice would also include, at any time, regardless of when standards might be changed or not, is to see a child that is --

A Yes.

Q -- the subject of a, an allegation or a safety concern?

A Yes.

Q And in fact, some of the documentation you were referred to used the phrase "to establish safety"?

A Yes.

Q Now, toward the end of your testimony, you were asked by Ms. Walsh if workload might have affected the

ability to use best practice methods and you said that it did. I'm not sure you answered the question as how it did in this case. Are there things that would have been done differently if the workload was less in this case?

A I think that in this case workload was one factor that impacted best practice. There are multiple factors that impult (phonetic), impacted best practice.

Q What were the other factors, other than workload and --

A Well, I think --

Q -- busyness?

A -- I think definitely the case, you know, in terms of workload, there was the, the, the case numbers, the gravity of the cases we were dealing with, staffing. Then the other issues that impacted best practice, I think, really, was the lack of the intake module, the CFSIS program that existed at the time. I think also what was happening, in terms of the policies and procedures that existed at abuse and intake, in terms of cases being transferred to those programs from CRU, definitely a clear understanding of risk assessment, safety assessment, confusion about the standards --

Q Um-hum.

A -- those were all factors that contributed.

Q Contributed, contributed to what occurred in

these various openings we've talked about?

A Yeah.

Q Right? But despite all of that, best practice remained the same, that is, reviewing as much information as you can get, seeing the child. Those kinds of things were clearly still best practice back then?

A Yes, if it's, if it's achievable, based on the organizational and systemic challenges.

Q Are you saying that those organizational issues and systemic challenges actually had an effect here, as to whether Phoenix might have been seen or not --

A I can only --

Q -- in March of 2005, when the workers went out?

A -- I can only speculate, based on the information that's in the written report --

Q Um-hum.

A -- and what I knew to be best -- what, what I knew to be regular practice at the time --

Q Um-hum.

A -- and what I understood to be best practice at the time.

Q Okay. I'm not sure you're answering the question. If it wasn't for the caseload, or workload, or what, whatever pressures were taking place at that time, are you suggesting that Phoenix Sinclair might have been

seen in March, before that file was closed?

A I can only speculate based on the information from the reporting that I would, that, based on my experiences there and what I can see in the recording, yes.

Q Now, you spoke about your responsibilities, as a supervisor and went through a list of things that you have to do and then you talked about your approval being required for certain matters to take place. Certainly your approval is required when a file is going to be closed?

A Yes.

Q So with respect to the March matter, March of '05, I think it's clear that you would have to approve the recommendation that was put to you by Chris Zalevich and Bill Leskiw; right?

A Yes.

Q That doesn't mean that it's something that you must accept; you have some discretion, obviously?

A Yes.

Q And I presume that, in your experience, there are times when you don't agree --

A Yes.

Q -- with the recommendation? And when you don't, I take it, from your evidence, that you'd probably discuss it with the workers who you didn't agree with?

A Yes.

Q And I think the way you put it was that if that happened, you would meet with the workers and try to arrive at a mutual understanding, is -- to quote your words?

A Yes.

Q Now, I was troubled by that, because I would think that if you're reviewing your work, you would simply make your decision, based on what you thought was right, rather than getting them to try to agree with you?

A We would try to -- what I would do is I would meet with my staff, because keeping in mind, they're the ones that are going out. They're the ones that are doing the assessment. They're the ones that are in the home. They're the ones that are seeing, seeing the children. So I don't remember specifically what discussions I would have had with my staff with respect to this matter.

Q Okay.

A The course was that I would be sitting down with my staff, reviewing the information and then attempting to come to some mutual decision. If, for whatever reason, I felt that, that there were concerns that remained, then I would have directed my staff accordingly.

Q But when you say you try to arrive at a mutual decision, does that mean that you try to arrive at something that, in this case, all three of you would be happy with?

A No, I would be taking whatever assessment information they had into consideration. If I felt that there were any concerns, I would be providing direction accordingly.

Q And if, if Chris Zalevich said anything about well, maybe I should go back and see Phoenix, which you said something like that. It wasn't clear how it came up, but something like that, I think your evidence was that you would never say to him, no, no, don't do that?

A No, I would never direct a social worker not to see a child.

Q Okay. Especially when it's raised by them as something that maybe should be done; right? If it was raised by them?

A If it was raised that --

Q I'm questioning the --

A -- it should be done, then I would be saying yes, go see the child.

Q Or even questioning whether he should have or not, you would likely say, well, maybe we should go see it?

A If he was questioning it?

Q Yeah.

A It would be based on -- I would be taking all the information into consideration.

Q But you wouldn't say no, no, no?

A I would never -- I wouldn't tell a, a social worker not to go out --

Q Um-hum.

A -- and see a child.

Q You were also asked about what notes, if any, that you made about these types of discussions we're talking about now, where you might meet with the workers, review the recommendation and have some discussions. And I think you were saying that you really didn't have notes of that, or keep notes of that?

A No, the expectation was that the CRU worker would document any consultation.

Q Okay.

A And that was simply because of the volume of the work.

Q And you were, you were referred, several times, I think, to the supervision policy, at page 2940, if we -- if you need to look at it again, we can get that up. But it was simply the, the recording that, and documentation of these kinds of notes and it, it's clearly suggesting that should be done; you recall that?

A That supervision policy applies to family service. At crisis response unit, with the volume of cases that we would have been managing, as supervisors, coming across our desks, I'm not really certain that that would

have been feasible.

Q Okay. At page 2944 and we may or may not have to get this up, but there's a section on supervisor notes and it states there that -- and this was quoted to you earlier, it's recommended that supervisors recording the following case material discussed in supervision and some other things.

Now, and you were -- that was pointed out to you earlier and I think you indicated that it was just something that was hard to do, or wasn't done by yourself?

A That is an expectation for family service. For crisis response unit, where the turnaround was within 48 hours, that just would not be feasible to do.

Q Was it the expectation that the worker might record some of the conversations they had with the supervisor?

A Yes.

Q We know that wasn't done here, because we've seen the notes and there's nothing at all about that?

A That is correct.

Q And you would agree with me that that, it would be nice if we had that?

A Yes.

Q Particularly because you have, on very many occasions, when asked about what your decision was,

referred to the fact that you can't see what you guys spoke about and so you have to go on the notes that are there; right?

A That's correct.

Q So it certainly would be nice to have had notes of those discussions; right?

A Yes.

Q But whatever those notes might say about that, about any discussions you may have had, the fact remains that Phoenix wasn't seen. Nothing would change that; correct?

A Correct.

Q Certainly if, if there was some important information about Phoenix, you would expect it to be in the report they prepared?

A Yes.

Q So essentially, whatever discussion you might have had with Chris Zalevich and Bill Leskiw, when they returned, whatever that might have been, it certainly didn't mean that Phoenix was seen; correct?

A Correct.

Q And it certainly couldn't have told you, for example, that they actually had a look at the bedroom, to see what was going on in there? That's clearly contrary to what is in their notes as to what happened; right? So that

you could have had no discussion that would have given you more information about whether a child was locked in that bedroom or not?

A I don't think that the notes indicate either way --

Q Right.

A -- so we really don't know.

Q Yeah. But had they gone in and looked in the bedroom, certainly they would have made a note of that?

A I don't know, I can only speculate.

Q And your speculation would have to be that they would have made a note; isn't that the most logical conclusion?

A I, I don't know what they, they potentially -- all I could say, all I could speak to is what's in the recording and that is not in the recording. That doesn't mean that that didn't happen.

Q You're telling --

A We will --

Q -- you're telling --

A -- we will --

Q -- you're telling --

A -- never know.

Q -- now, under oath, that your workers might have actually gone into a house and saw things and left it out

of a recording? Is that, is that even conceivable?

A It's possible, yes.

Q Is it likely?

A Is it likely?

Q You really have to think about that?

A It's possible.

Q Highly unlikely though?

A It's unlikely.

Q If a social worker that was working under you went to a house and didn't record whether they saw a child or went into the house, that would be a pretty serious problem, wouldn't it?

A Yes.

Q And remember, you were asked about when you got involved in the March '05 involvement that we talked about, that you didn't recall if you were actually involved about three months earlier in the December '04 involvement; correct?

A That's correct.

Q Yeah. And so, after only three months or so, you had difficulty recalling your previous involvement; right?

A That is correct.

Q All of which, I submit to you, points out the necessity of taking good notes, because here we are so much, so many years later and we're kind of left without

any knowledge of what you may have spoken about with Chris or Bill; right?

A I, I agree with that.

Q You talked about CRU being the kind of unit that was involved for a, a very short period of time usually; correct?

A Yes, that's correct.

Q Sometimes perhaps a day or perhaps two?

A Yes, that's correct.

Q So with respect to December, we know it was from December 1st to December 7th, which is six days; right?

A Yes, that's correct.

Q So sometimes, for various reasons, you might have a file for a little bit longer?

A Yes.

Q And with respect to the December '04 involvement, one of the reasons you had it a bit longer was because there was some things you wanted to have checked out; right? You wanted to know more --

A Yes.

Q -- right? So with respect to the March '05 involvement, after you became aware that Phoenix wasn't seen, one option certainly would have been, let's see if we can know more, can always keep this file for an extra day and see if we can find out more. That, that was obviously

an option. I realize you decided against it, but certainly it was an option, to keep that file a little bit longer open before it was closed?

A It would have been an option to keep the file longer, open longer, if we felt that, you know, there was, there was a need to keep it open longer. And again, I don't remember what discussions I had with the worker that would have made the, that ultimate determination.

Q But the child wasn't seen yet?

A That's correct.

Q The child was not seen?

A Yes.

Q So one obvious reason to keep it open longer is to see if the child could be seen, perhaps the next day, perhaps that evening; isn't that an option of, upon reflection, at least, it sounds pretty reasonable?

A At the time, we made the decision to close the case without the child being seen. I can only speculate as to why that was.

Q Okay. Well, we know that's the decision you made, there's no need to repeat it. The question is, wasn't it a reasonable option to have kept the file open a little bit longer, as happened in December of '04, which was six days, a little bit longer, just to see if perhaps there was a way of coming back and seeing Phoenix before

closing it?

A Well, at that time, we had two social workers that went out to the home. There was no protection concerns identified. The case was not eligible for referral to abuse intake.

Q Well, you're, you're again going into why you made that decision.

THE COMMISSIONER: Yeah, the, the question is whether the option was available to you?

THE WITNESS: Yes, the option was available to me.

BY MR. GINDIN:

Q Now, when we look at what occurred on March the 7th, '09, the information is that Samantha met the workers out in the hallway and essentially wouldn't let them into her apartment; correct? You know that, from what you've read?

A That's correct.

Q And apparently the reason given was that there was some adult, I think, in the apartment, a visitor of some kind and the workers didn't insist, because of confidentiality?

A That's correct.

Q Now, I don't see anywhere in the notes, nor did

they testify that they said to her, well, perhaps we can come back sometime when you don't have a visitor, like this evening, or tomorrow, let's make an appointment. Certainly that is an option?

A Yes.

Q But we know that that wasn't done?

A Yes.

Q Now, Mr. Zalevich testified that he noticed that there wasn't any real noise, it was pretty quiet in the suite and I think he -- and he told us that had there been evidence of a party going on, with some noise, et cetera, he would have gone in. That was his evidence.

A Okay.

Q What do you think about that?

A Well, that would have made sense to me, that if he had concerns about what was happening in the home --

Q Okay. So --

A -- at the time, that would have compromised the safety of the children, then he could, he could have insisted on entering the home.

Q So if there was a party going on, confidentiality issues take a back seat; is that it?

A Well, if there's concerns about immediate safety of children, yes.

Q Okay. His evidence was simply that if it was

noisy and it appeared as though a party was going on, he certainly would have done in then. But the same confidentiality concerns would still exist and perhaps even more so, because there's more people there. I'm just wondering how that makes sense.

A Well, then he would be going in to assess new information, not necessarily the information that we would have received on the initial referral. Because now he's gone to the home --

Q Um-hum.

A -- and he's gotten new information. So it would be the same as I initially get a referral that there might be neglect and I go to the home and all of the caregivers in the home are, are completely inebriated and unable to provide care and there's young children in the home. So my -- the initial call, which could potentially be neglect, say, children not having adequate food or clothing for school and winter conditions. When I attend to the home, I now encounter an emergency situation, I'm, you know, in terms of insisting to enter the home, to ensure the safety of the children, that now changes because there's new information.

Q Okay. So another thing that Mr. Leskiw said, that if Samantha didn't admit to having a lock on the door, then he would think that would be a good reason to go in

now. Now, what do you think about that piece of evidence?

A If she didn't admit?

Q Yes.

A I think whether or not she admitted to it or, or didn't admit to it, you would still be having a conversation with the mother about the concern that's being presented. Now, the decision around insisting to enter, you know, again, that would have been based on a number of factors. I don't know that her not admitting would have necessarily been one of those factors.

Q Okay. So what was different when Zalevich and Leskiw went out there, that no one knew before, was that, first of all, Samantha wasn't allowing them to come in. We know that; right?

We know that her explanation for the abuse allegation was, well, she may have yelled at Phoenix. We knew that; right?

We also knew, of course, that they never got to see Phoenix, or go inside the apartment; right?

And the original reason for going there as to find out things; right?

A Right.

Q So wouldn't you agree, there were still more things to find out?

A Again, I could only, I mean, in hindsight, or

based on the information I --

Q Well, even in --

A -- knew at the time?

Q -- even in hindsight.

A In hindsight? Absolutely.

Q Okay.

A Based on the information we have available to us today.

Q But even based on what you had at that time. You had Mr. Buchkowski having gone out on two occasions, but couldn't get in. We had the evidence that he felt it was important enough to go twice on the same day. His evidence was that he felt it was a high priority situation. Then you have Mr. Zalevich going out with Mr. Leskiw, getting in, but not seeing Phoenix and not getting into the apartment. Even based on that, as you've said earlier, certainly there's good reason here to note close it immediately, but look a little further; don't you think?

A Today, based on the information we have today, absolutely. This case should have been closed to intake and Phoenix should have been seen.

Q And I'm suggesting even further, that based on what you had at that time, that would have been a wise decision also?

A Yes, and we made, we made a test to refer this to

intake and it was not accepted at intake.

Q Okay. So an example of how different social workers might have different judgment calls and view things differently? You thought it should go to intake, they didn't agree; right?

A Yes.

Q And you say that happens from time to time?

A Yes.

Q In fact, it happened on these very two involvements you're talking about here?

A Yes.

Q Anything stopping you from trying again, sending it back there again? After all, here, you had a little bit more information, didn't you? You had the information from Chris Zalevich and Bill Leskiw, as to what they observed, what they were told, what they didn't see, what you still didn't know and you had that new information and you could have tried intake again?

A Based on the fact that the case had been closed by intake and based on the fact that we had two workers attend and identify no protection concerns, the case would not have been accepted by intake.

Q Well, that's your, your view, but the point is that you didn't try again?

A No.

Q Going back to the December '04 involvement for a moment, and correct me if I'm wrong, but you were talking about, you know, the grey type of file?

A Um-hum.

Q And I think you said that that December '04 would, would be one of those grey type of situations?

A Yes.

Q And do I take it that that means it's not an obvious situation one way or the other; is that basically what you're saying?

A I'm sorry, could you repeat the question?

Q It's not an obvious situation, one way or the other, but it's kind of in between and debatable; is that what you mean by a grey file?

A Yeah, that it didn't necessarily -- that we were struggling to determine whether or not it meant the mandate under the Act, because there was no new presenting concerning information.

Q Now, when you say there's no known child protection concerns, that's a phrase we've heard quite a bit here, no known child protection concerns. That's a little different than saying that you know there are no child protection concerns; isn't it? Those are different things?

A What I meant by that is that there was no

reported concerns being made to the agency.

Q So no known concerns --

A Yes --

Q -- essentially?

A -- by anyone, by, by the source of referral, or anyone else, at that point.

Q And with respect to the March '05 matter, similar phase was used, there was no known protection concerns and I think you answered a question from Ms. Walsh this morning, you were convinced you said, based on the information you had, you were convinced that there was no safety concerns? That's the phrase you used, you were convinced that there were no safety concerns. And I'm wondering how you could possibly be convinced of that, when Phoenix hadn't been seen?

A Again, I can only speculate, based on the recording, as to why I closed the case.

Q Um-hum.

A If I felt that there were any protection concerns, I would have never closed the case.

Q But --

A So yes, I was --

Q -- you didn't, you didn't know --

A -- I was convinced.

Q -- but you didn't know; isn't that a fair

statement? You simply didn't know?

A In hindsight, that is correct.

Q Yeah. There was no way you could know at the time, because the child hadn't been seen?

A I'm, basically, I'm looking at the information that's available to me at the time, which is an allegation of unspecified abuse and an allegation of a child being locked in their room. Would it have been best practice for us to have seen Phoenix? Absolutely.

Q Um-hum.

A With the information available to us today, should have been, should she have been seen? Absolutely. At the time, we were responding, based on the information we had and it would have -- I don't know what other information would have been available, based on my discussion with staff, but I had two social worker staff that were identifying that there were no protection concerns. And based on their assessment and whatever other discussions we may have had, we, we concluded the case.

Q You said a few times, well, Phoenix (sic) didn't admit to locking the child in the room?

A The mother --

Q Yes.

A -- didn't admit?

Q Well, she didn't say she did, or she didn't say

she didn't.

A All I can say is that the report indicated that -- just trying to remember that specifically --

Q It's --

A -- that there --

Q -- it's --

A -- was a lock.

Q There was a lock on the door.

A Yeah.

Q That's as far as she went --

A Yes.

Q -- right? So there was nothing in the report at all as to whether or not she admitted locking the child in the room or not?

A That's correct.

Q And there was a question asked, during that visit, whether Phoenix was in school or in childcare; right? You recall that?

A Yes.

Q And I think you told us before that when you have a child of that age, if they're not in, in school, or childcare, they're even in a more vulnerable position, because there wouldn't be any corroboration, in essence --

A Yes.

Q -- of anything that would have gone on?

A Yes, that's correct.

Q So when the answer is no, Phoenix is not in childcare or school, doesn't that make Phoenix more vulnerable?

A Yes, it makes both children in the home more, more vulnerable.

Q And when a child is more vulnerable, it become more important to, to see the child?

A Yes.

Q So, I think you also said, that a factor, particularly with respect to the March '05 involvement, was, as you put it, this was a soft referral. I think the, the word you used. Now, we know that that referral was from a foster parent who was employed by CFS. So you certainly weren't referring, I take it, to the person who called in --

A No.

Q -- when you said that? All right. And you did tell us that part of your job is to rely on community involvement --

A Yes.

Q -- for referrals? That's pretty much where they come from?

A Yes.

Q And here we have one, who is a foster parent, who

worked for CFS, took the time and trouble to make this call --

A Right.

Q -- correct? But what you were referring to was, it was perhaps vague, in terms of what they, what was meant by abuse; correct?

A Yes.

Q So did you consider that maybe we should call, we know her as SOR number 7, that we should call SOR number 7 back again and just give it another try and see if we can get more details as to what she was told, or perhaps she could get more details from her source. Anything along that line?

A Not that I can see in the recording.

Q It would have been a good idea, wouldn't it?

A Yes.

Q Just as it might have been a good idea to make another appointment with Samantha when she had nobody home?

A Yes.

Q Just like it would have been a good idea to, for the workers who went, to have gotten as much information on Samantha and Steve and the whole history of the file before they went there; right?

A Yes.

Q With respect to the December '04 referral, that's

where it became known that Wes McKay was the putative father?

A Yes.

Q Now, would you expect that a hospital, for example, would certainly record the birth date or at least some more information about the putative father?

A I believe that in the report Shelley does identify no birth date.

Q No, but, I understand that, that was the evidence.

A Right.

Q She wasn't aware of a birth date, but is that something that would surprise you as a, as a social worker, that someone comes in to the hospital to have a father, putative father's name is given and the hospital doesn't record or request, or find out the birth date of the father? Because the information has her birth date, Samantha's birth date --

A Right.

Q -- so is that surprising?

A When -- the, the normal -- the regular practice would have been for the CRU social worker to get as much information as possible. So that would have included the full name and birth date for the primary caregiver and, and the biological, or any other fathers for these children and

their birthdates.

From looking at the report, it indicates on there that, that the hospital identified that the birth father to this new baby was Wes McKay and in brackets following that, date of birth unknown.

Q Right. You would expect the hospital to at least inquire of that information, try to find out that information, would you not? You've dealt with hospital referrals before?

A We would inquire as to whether or not the hospital would have that information.

Q Um-hum.

A Whether or not the hospital -- I mean, what their procedures are, I can't speak to.

Q But you've had previous experience with hospital referrals?

A Yes.

Q And is it normal that, is it the norm that they often have this type of information, the putative father's birth date?

A They, they might have the putative father's name, but not necessarily the birth date.

Q Have you seen that before, where they do have the birth date?

A Yes.

Q Okay. Think you said that the December '04 file, you actually walked it over to intake. You seemed to recall that; right?

A I have no recollection of that, but --

UNIDENTIFIED PERSON: No, no, it's not.

MR. GINDIN: Do I have that wrong?

UNIDENTIFIED PERSON: No, yeah, she had no memory, that was Carolyn Parsons --

MR. GINDIN: Oh.

UNIDENTIFIED PERSON: -- who said that.

MR. GINDIN: I'll take that back, I might be mistaken there.

BY MR. GINDIN:

Q Now, with respect to that referral, December of '04, according to the information, Phoenix wasn't at the hospital? When --

A That's, that's correct.

Q And we don't seem to know where she might have been?

A Well, that's not uncommon, when you have a baby, that other children are not going to be at the hospital.

Q Okay.

A They --

Q But, but --

A -- it's, it's, it's --
Q -- in terms of --
A -- it would be normal to make other arrangements for other children, if you're having a baby.
Q But the, the point I'm making is there would be no way to observe Phoenix and what she's like, or how she looks, or anything like that, because she wasn't there; right?
A Exactly.
Q Um-hum. And having found out at least who the putative father was, policy or no policy, standard or no standard, best practice would be let's find out what this fellow's all about; right?
A Yes.
Q Now, it appears as though whatever's being said by Samantha on March the 7th to Chris Zalevich and Bill Leskiw -- March 9th, pardon me, not March 7th, her answer to the abuse allegation being that, well, I may have yelled at Phoenix, that's the kind of thing that you, I suppose, just simply accept at face value; is that the way, the way it works?
A Not normally, no.
Q Seems to have been accepted here.
A Pardon me? I'm sorry.
Q It seems to have been accepted here, as a simple

explanation for the, for an abuse allegation.

A In absence of any other information, with respect to a specific incident, you know, any information about, you know, identifiable abuse, you know, the workers, you know, spoke to the mom about what that, what abuse meant.

Q But, essentially, you're simply accepting what she has to say?

A Based on the recording, I don't -- I'm only, I can only speculate. I don't know what the actual discussions would have been at the time.

Q Both the workers, Mr. Zalevich and Mr. Leskiw, told us they had, that they had very little history of this matter, other than the actual intake form; right? You would agree that it would have been wiser for them to have more history at their disposal; correct?

A By that, do you mean a review of the CFSIS history?

Q Well, yes, whatever you can find out --

A Yes.

Q -- right? And for example, you'd like to know how someone like Samantha might have responded over the years to a number of concerns that might have been present in the file? That would be a nice thing to know when you're assessing someone's response to an allegation?

A I guess when you say file --

Q I, I mean information.
A -- like, information that's on CFSIS? Yes.
Q Yeah. All right. And I think you said actually, in your testimony, that it was your expectation, with respect to the March opening, that Chris would review the past history; correct?
A Yes.
Q Because it would be best practice to do that; right?
A Yes, and it was, it was regular practice as well.
Q So your recommendation, or your approval of his recommendation, in the end, was based on this expectation, in part, that he would have read the whole history?
A Yes.
Q And one of the options that I suggested to him is that on that day, March 9th, he indicated it was the end of the day and the AHU unit was coming in, that he simply could have asked one of them to follow-up in some fashion, that particular evening, or even the next day. And he indicated, yes, they were right there. It's -- they were right in the same area. It wouldn't have taken much time or effort to have done that; would you agree?
A If we felt -- well, first of all, it wasn't normal course for us to refer matters to after hours unit, unless they were emergent. So if there was, you know,

something that was immediate to 24 hours, that would go to our after hours unit. And again, I can only speculate, because I don't remember what discussions took place. If, if, at the time, the social workers were indicating that there were no protection concerns and recommending the case be closed, we wouldn't be looking at referring this to after hours unit.

Q But if the whole idea is to see how Phoenix is and to see if she's okay, and she hasn't been seen, I'm suggesting that one of the options would be to simply give it to somebody in the AHU unit, who are coming there 4:00, 4:30 in the afternoon, to begin work. Clearly that would be one way that somebody might see her. I think you've basically agreed with that already?

A Yes, if, if -- in, in -- I don't know if we would have referred it to after hours, we would have likely kept it at CRU for somebody to follow up with.

Q Yes.

A Again, that would not have been an appropriate referral for after hours.

Q Mr. Leskiw was the backup worker and he had much more experience, you said --

A Yes.

Q -- right? Would you consider him to be sort of a mentor?

A It's not that I expected him to be a mentor --
Q Um-hum.
A -- Mr. Leskiw was a 17 year veteran, a respected social worker, one of my stronger staff.
Q Um-hum.
A He attended to the home with Chris. And by virtue of just being there --
Q Um-hum.
A -- if Bill had any questions, concerns, he would, you know, either redirect Chris, or, or consult with Chris, or bring, bring anything to my attention.
Q So one of the, that was one of the factors you used, in deciding to close it, was because Bill Leskiw seemed to acquiesce in whatever was going on without --
A No --
Q -- objecting?
A -- it was, it was because I had two staff that attended to the home and were not identifying any protection concerns and were recommending the case be closed.
Q A decision you could have disagreed with?
A Yes.
Q When you were referred to Mr. Koster's interview with you, you corrected something he said by saying that at the time, I didn't know Chris had abuse experience; do you

recall?

A At the time of my interview --

Q Of your interview.

A -- with Mr. Koster.

Q Yeah. So I take it, are you suggesting that at the time of the actual event, you didn't know he had any abuse experience?

A I did note that he had abuse experience.

Q And then you forgot, is that --

A Yeah, I forgot when I --

Q All right.

A -- when I spoke to Mr. Koster.

Q And just this morning, you were talking about this phrase "locked in the room"; remember that? You were asked some questions about what that could mean --

A Yes.

Q -- and you said it could mean a lot of different things --

A Yes.

Q -- right? One you said was possible -- it had something to do with sleep management?

A Yes.

Q Is there anything in the file that that question was asked and that was given as the response?

A Not in the recorded record, no.

Q You talked about maybe this was a time out and again, there's nothing in there about anyone suggesting that? Or even asking that?

A When I made the comments about that this could mean anything on a spectrum --

Q Um-hum.

A -- I wasn't necessarily referring -- I was referring generally --

Q Okay.

A -- in terms of that information, when that, when that type of information is presented, not necessarily with respect to this, this specific matter.

Q But even specifically, if you're trying to figure out what is meant by that phrase --

A Um-hum.

Q -- which was the phrase in the call --

A Um-hum.

Q -- that came in, there's nothing in the conversation, the material that you saw, that talks about sleep management or a time out; correct?

A Not in the recorded record, no.

Q That phrase could also mean confining somebody in a room and leaving them there alone, possibly, as well?

A Yes.

Q And I take it you don't know, either way, what it

meant in this case?

A Based on the recording, no.

Q And the recording is what you had to work with when you were making you decision whether to approve the closing or not; correct?

A It would have been based on the recording and, and any discussions I would have had with the social workers that attended the home.

Q Which were, which aren't required?

A That's correct.

Q You were talking about safety assessment --

A Yes.

Q -- versus risk assessments; you recall that?

A Yes.

Q So the safety assessment talks about the present safety, right now --

A Yes.

Q -- right? And the risk assessment talks about potential for risk or harm in the future?

A Yes.

Q And those are really connected, are they not? Doesn't a child's safety today have some connection to the potential for risk that might still occur?

A when you're looking at safety, you're looking at current harm --

Q Um-hum.

A -- or imminent danger. When you're looking at risk, you're looking at the potential for future danger.

Q Well, when you're deciding whether to close a file, even back then, shouldn't you be considering both of those issues?

A Yes, absolutely.

Q Okay. Because you were talking about how the forms were different then and the policies were somewhat different, as a reason for why you concluded that would close. But essentially, whatever the polices and forms were, the point is, you're assessing the safety of a child, not only at the present moment, but any potential for risk or harm in the future, whenever you're deciding whether to close a file?

A But the quality of the safety assessment impacts the capacity of front line staff and supervisors to be making those decisions in a more consistent, valid, reliable way. And at the time, I would argue that there was no risk assessment tool in place. What we, what we had was a mutation, without clear policies and procedures and without any training. So that would have had a direct impact on our capacity to do a safety assessment in a, in the reliable, consistent way that exists today.

Q But specifically with respect to this matter,

what you did have at that time was commonsense?

A What we had at that time was clinical experience and our, our judgment and the information that was available in the --

Q Um-hum.

A -- safety assessment that existed at the time, which really did not -- which I am saying is lacking and really did not include any provisions for the, for the establishment of a safety plan. And then factor that with the fact that there was no risk assessment that directly tied risk to response times and contact guidelines and then there was confusion about the standards, what, with respect to those contact guidelines. It certainly impacted the types of decisions that we were making and accuracy, reliability and consistency.

Q But you're not telling us that commonsense doesn't play a role? You'd always --

A At the end of the day, those assessment tools guide your decision.

Q You're not answering my question.

A Clinical -- you're --

Q Does, does commonsense --

A -- clinical judgment and judgment actually is, is, makes, is what results in the final decision.

Q Okay. What about --

THE COMMISSIONER: No, but I think --
MR. GINDIN: -- plain commonsense?
THE COMMISSIONER: -- Mr. Gindin is asking you whether commonsense plays a role, as you put it --
THE WITNESS: Absolutely.
THE COMMISSIONER: -- at the end of the day, in making --
THE WITNESS: Yes.
THE COMMISSIONER: -- your decision? The answer is yes?
THE WITNESS: Yes.
THE COMMISSIONER: Now, Mr. Gindin, are, are you going to be long, or?
MR. GINDIN: No, I just have one possible --
THE COMMISSIONER: I don't want to --
MR. GINDIN: -- further question, if I can --
THE COMMISSIONER: -- I don't want to rush you, but if you were going to be long, we'd adjourn, but --
MR. GINDIN: No, I think I can conclude with one final reference.
If we can just get page 38038 on the screen. Little bit further up please.

BY MR. GINDIN:
Q You were asked to comment on that middle

paragraph that we see on the page there; right? Do you recall that particular paragraph as read out to you? Starting off with:

"The agency's response ... is concerning ..."

You see that first sentence?

A Um-hum.

Q All right. And you were asked about that particular paragraph and just very quickly, the next sentence is:

"Phoenix was not seen."

That's clearly correct; right?

A Yes.

Q

"The apartment was not seen."

That's also correct; right?

A Yes.

Q

"Samantha admitted that there was a lock on the outside of the

bedroom door she and Phoenix shared."

So that's also a fact that you accepted --

A Yes.

Q -- right?

"No reason for this lock was given."

You see no reason in your reports that would have been given; right?

A No, not on the written report.

Q Little bit further down in that paragraph, where it says:

"No questions were asked about Samantha's present partner and father to baby ..."

That appears to be correct, factually?

A Yes.

MR. GINDIN: Those are all my questions.

THE COMMISSIONER: Thank you, Mr. Gindin.

Will other counsel have questions?

Mr., Mr. Paul --

MR. PAUL: Yes.

THE COMMISSIONER: -- yes? All right. Well, I think we, considering we're at one o'clock, I think we're best to adjourn. Do you agree, Ms. Walsh?

MS. WALSH: I do, Mr. Commissioner. We have, excuse me, SOR 10 is scheduled to testify at 2:00. Now, I might be able to move their testimony to 2:30. I don't think I can move them much later. It won't be a long testimony, but I think what I'll do, perhaps, is confer with --

THE COMMISSIONER: Is it from a distance, or in the, in the city?

MS. WALSH: It's in the city, it's an SOR though, so not in, in --

THE COMMISSIONER: Yeah, I understand that.

MS. WALSH: Yes.

THE COMMISSIONER: But the person is in Winnipeg?

MS. WALSH: Yes, but I don't think they can stay past 4:30, for instance.

THE COMMISSIONER: Okay. Well, what, what's your, what's your recommendation for adjourning?

MS. WALSH: Well, let's start at 2:00, but I think what I'd like to -- I mean, if, if -- unless you --

THE COMMISSIONER: Well, does --
MS. WALSH: -- want to take longer.
THE COMMISSIONER: -- does 2:00 give people enough time to have their lunch? I'm not sure --
MS. WALSH: Don't know.
THE COMMISSIONER: -- it does.
MS. WALSH: If it doesn't, what I think I need to do is talk to the other lawyers and see how long they think they're going to be. I'm sure the preference --
THE COMMISSIONER: Well, well --
MS. WALSH: -- is not to split this witness' testimony.
THE COMMISSIONER: -- but, but I thought you were suggesting this one will stand aside until we get the video witness.
MS. WALSH: Well, I'm wondering whether that is a possibility.
THE COMMISSIONER: Well, do you want to meet with your counsel for two to three minutes now?
MS. WALSH: Sure.
THE COMMISSIONER: Well, I'll just sit here, you go ahead.
MS. WALSH: Okay. Thank you. So the consensus appears to be that 45 minutes would be needed by all counsel. What I'm going to try to do is see if SOR 10 can

be delayed in testifying by 45 minutes, so that when we come back at -- now, we didn't talk about having more than hour. That's assuming that we start at 2:00.

THE COMMISSIONER: Well, what --

MS. WALSH: I, I think, I think that we'll have to start at 2:00. I think people will just have to have a, a brief lunch.

THE COMMISSIONER: Well, we'll adjourn until 2:00 and if it's, turns out to be five past, we'll have to accept that. But --

MS. WALSH: Right.

THE COMMISSIONER: -- we'll adjourn until two o'clock.

MS. WALSH: Thank you.

(LUNCHEON RECESS)

THE COMMISSIONER: Mr. Paul?

MS. WALSH: Sorry, I just -- the sun is right in my eyes, Mr. Commissioner, I can't --

THE COMMISSIONER: Oh, right, right.

MS. WALSH: -- see the witness. I'm just going to ... Perfect, thank you.

MR. PAUL: Good afternoon, Mr. Commissioner.

CROSS-EXAMINATION BY MR. PAUL:

Q Good afternoon, Ms. Faria. My name is Sacha Paul, I'm one of the lawyers for Winnipeg CFS and the Department. Couple areas that --

THE CLERK: Mic's not on.

MR. PAUL: Mic's not on? Oh, sorry. I hope you can hear me now. Is there a bit of feedback? Should I step back?

THE CLERK: I'll, I'll (inaudible).

MR. PAUL: Okay. Sorry, my apologies.

Before we begin, witness, is your microphone on?

THE WITNESS: I believe so.

MR. PAUL: Okay. Great. It was just me then.

BY MR. PAUL:

Q Again, for the record, my name is Sacha Paul. I am one of the lawyers for Winnipeg CFS and for the Department and I have just a couple of areas that I'd like to explore. My, I guess my first question deals with the concept of intake generally.

And if I can bring up Exhibit 13, page 5?

And what, Mr. Commissioner, I'm referring the witness to is a summary of, of the program description of Winnipeg CFS that was tendered through the witness, Alana Brownlee. And you can see it on the screen there.

If you could scroll it up so I could see numbers 1 through 8.

Now, again, if we could back up, if we can forget about Winnipeg CFS and forget about the structure, at the very basic level of the child protection scheme, you need, if I can put it this way, the entry door. The referrals have got to come into the system somehow; correct?

A Yes.

Q And that somehow is through the concept of intake?

A Yes.

Q Right. And intake, however it's structured, has to achieve some objectives and I want to see if you agree with these objectives that Ms. Brownlee has put out, which is that one of the things that an intake system must do, of course, is receive referrals; correct?

A Yes, that's correct.

Q Correct. They must also do some information gather, as you see there, to determine the appropriateness and validity of that referral?

A That's correct.

Q They must then also get community referrals for those not requine (phonetic), requiring child welfare involvement. And if I can try and explain that in English, I understand that to be non-emergent calls, sort of like, I

need to know about a daycare, or community resource?

A That is where we receive a request for service that can -- where the request for service does not meet the mandate of the Child and Family Services Act and can be fulfilled by another community resource.

Q So a non-child protection related call?

A Yes.

Q Right. And as we've talked about a bit this morning, again, one of the things that intake has to do is do a safety assessment --

A Yes.

Q -- right? That's to determine also -- the concept of response time must be considered by an intake agency?

A Yes.

Q Right? And again, in point 5, you'd agree that intake is also there to do an emergency intervention, if necessary, in a particular case?

A Yes.

Q And that, as an example, would be apprehension, for example?

A Yes.

Q Right. And then when you go to point 6, there is further assessment and inveshagation (phonetic) (sic) as the file's being worked up, if I can put it that way?

A Yes, and with, with the structure of joint intake response unit at the time.

Q And we'll, we'll get, we'll get to the --

A Okay.

Q -- the structures --

A So yes.

Q -- particularly in Winnipeg. But again, if we look at intake writ large, as one of the --

A Yes.

Q -- one of the functions that you'd agree with Ms. Brownlee on?

A Yes.

Q Another point there, you see brief intervention to reduce risk; you'd agree with that?

A Yes.

Q And again, finally, number 8, you'd agree that one of the functions of intake is to refer to a family service unit for long, longer term work?

A That's correct.

Q Right. And how each individual system organizes it, its intake function can vary from province to province, or from state to state?

A That's correct.

Q And you were aware that before 2000 or so, I don't have the exact date, crisis response unit didn't

exist in Manitoba?

A I'm not sure of the exact date, but yes.

MR. PAUL: Okay.

THE COMMISSIONER: Before what date?

MR. PAUL: I, I thought it was 2000 and I, I'll see if the document speaks to it. I believe that is correct. Mr. Commissioner, if I'm wrong on that point, I'll advise.

THE COMMISSIONER: 2000?

MR. PAUL: Yes.

BY MR. PAUL:

Q So prior to the creation of the crisis response unit, the way that Winnipeg handled referrals was they had a series of general intake teams that handled the phones and then went on to their investigation of those calls. There was no screening function, per se?

A No, there was no screening function, nor was there a specialization. So if you were doing intake, you would do abuse and general intake.

Q And you were doing all eight of those things that you see listed on that screen?

A Yes.

Q Right. And of course, in Winnipeg, in 2000, the scheme changed, it was altered to create the concept of

crisis response?

A Yes.

Q Right. And I think, as you said, that's to try to get some level of specialization for the crisis response unit?

A I don't know. I, I know that there was, abuse units were created to create a, a specialization.

Q In abuse.

A I don't really know what the, what the foundation was for creating a crisis response unit.

Q And, and, and that's fair, but at the very least, in 2000, we took the concept of intake and split it into two parts; you'd agree with that?

A Yes.

Q Okay. And more specifically, it's my understanding of, of Ms. Brownlee's document that points 1 to 5 were to be handled by the crisis response unit; would you agree with that?

THE COMMISSIONER: What was that question?

MR. PAUL: Would the witness agree with Ms. Brownlee, that points 1, 2, 3, 4 and 5 were meant to be handled by the crisis response unit?

THE WITNESS: I would agree, with one exception.

MR. PAUL: Um-hum.

THE WITNESS: If we received referrals on minor

expectant parents, crisis response unit actually did do a direct referral to our perinatal team. So, in those circumstances, number 8 would apply.

BY MR. PAUL:

Q And the peri-natal team being a family service unit, if I can --

A Yes, it's a specialized family service team that works with minor expectant moms --

Q Okay.

A -- and their newborn infants.

Q And correct me if I'm wrong on this point, maybe this is too much of the details, but crisis response unit, their main referral source would be tier 2 intake; correct? If they were to refer a file on, it would go to tier 2, as a general rule?

A Yes, I'm -- would be tier 2 intake, which would be abuse and general intake.

Q Right. But if there was a file already open, CRU could direct it to the family service unit where that file was opened to?

A Yes.

Q Right. And again, I think the point that you've agreed with me is that with the exception of the peri-natal unit, or even with the exception of files that area already

open to family services, CRU's doing points 1 through 5 --

A Yes.

Q -- right?

A Yes.

Q And you'd agree with me that points 6, 7 and 8 are done by tier 2 intake?

A Yes.

Q Right. And again, by tier 2 intake, you understand me to mean what we've called general intake and abuse intake; is that correct?

A Yes.

Q Right. And I think that, again, this structure was new in 2000. It's -- I think the structure, as used today, of breaking up intake into two parts; is that correct?

A Yes.

Q Right. And again, CRU was meant to have very short interactions and then, if necessary, refer it to tier 2 intake to do, as you see in point 6, further assessment?

A Yes.

Q Right. My understanding then, of the Child Welfare League of America's standards, is that when they talk about the unit, the 12 investigations to, to one worker, what they are talking about is a general intake, points 1 through 8 lumped together, as opposed to what we

have here in Manitoba, which is a division of the intake structure between tier 1 and tier 2; would you agree with that?

A No, I would not. Intake, in Manitoba, is considered after hours crisis response unit, intake and abuse intake.

Q But when it comes to the, to the numbers, at the very least, when it's coming to the concept of investigation on the 12 Child Welfare League standards, it's my understanding, and I want to see if, if you agree with this, is that what one of the functions that the Child Welfare League is considering is number 6, further assessment and ongoing. Things that are not done by CRU?

A I wouldn't know that, I'd have to look at the criteria.

Q Okay. Fair enough. If I can then talk, move on to another concept, being referrals to tier 2 intake, my understanding of your evidence that you've given over the past day or two, is that as we sit and breathe here today, you don't have any knowledge as to any discussions on the Phoenix Sinclair file, as between CRU and tier 2 intake; that'd be correct?

A I don't have any recollection, no.

Q Right. And, of course, I think that you told the Commissioner previously and you'll correct me if I'm wrong,

is that when you are making a determination on a file, one of the things, of course, that you're doing is, you are looking at whether or not there's any child protection concerns, to either close a file or refer it on to intake --

A That's correct.

Q -- right? And that, in the process of doing that, you're using your, what I'll call, clinical judgment, in making a determination as to whether or not something should continue on to tier 2, or something should be closed?

A That's correct.

Q Right. And my understanding is that in the event that you wanted to refer something to tier 2 intake and there was some issue at tier 2 intake, what was available to you was that you were able to speak to your program manager to address that particular issue, if you saw fit?

A Yes.

Q Right. And again, if we go straight down to the Phoenix Sinclair file, my understanding is that in December, in March of '04 and '05, where this file would have done is to central intake?

A That's correct.

Q And the reason it would have gone to central intake is because of the location of the mother?

A Because of the residence, yes.

Q Right. I'm sorry, residence is a better term. And at that point in time, the supervisor of central intake was Carolyn Parsons?

A Yes.

Q Right. The evidence of Carolyn Parsons is that she would never outright reject a referral CRU; would you agree with that?

A I think that there were times where cases would have been declined which would have involved involving a program manager.

Q So when --

A But generally, we would have had a discussion and, and tried to come some, to some mutual understanding as to where the, the case should go.

Q So then my understanding of Ms. Parsons' evidence was precisely that, that if there was an issue with a referral from CRU to tier 2 intake, she, as the tier 2 intake supervisor, would attempt to reach a collaborative decision with the CRU supervisor and herself. So you'd agree with that --

A Yes.

Q -- statement? Okay. And Ms. Parsons' evidence that she would never outright reject a referral, but instead would try and reach a negotiated resolution to a

referral, is something that you disagree with? You're saying, your evidence is that Carolyn Parsons would, indeed, reject files?

A I think that there were instances where that did occur and it would have involved -- it wasn't necessarily a rejection, it was that, you know, we, we -- there could be instances where we might disagree on, on the course of a case, at which point then a program manager would have to make the ultimate decision with respect to what would occur.

Q Of course.

A I wouldn't say that 100 percent of the time, that the two of us just, like, with, and I'm not saying Carolyn specifically, with any intake supervisor or with any abuse supervisor, that there was consensus, or that we reached consensus 100 percent of the time.

Q But consensus was reached, on average; would that be fair to say?

A I would say with, with Ms. Parsons, yes.

Q So as a result, I think your evidence was that you couldn't recall this particular case, about the interaction between you as the CRU supervisor and Ms. Parsons as the central intake supervisor?

A No, I can't.

Q Right. And I think what, what you just told the

Commissioner then is that, on average, you and Ms. Parson would, indeed, reach an amicable conclusion to an issue of referral?

A Yes, absolutely.

Q Right.

A She was a knowledgeable and respected colleague.

Q So that in an instance then, when you and Ms. Parsons had an, a discussion, about a, a particular referral, there would be instances in which your dialogue between Ms. Parsons and you would result in a negotiated agreement where you decided to keep the file in CRU?

A Yes.

Q One last area: In terms of the nature of the work at CRU, I believe it was Shelley Wiebe, or Shelley Willox, said that CRU works, in essence, ebbs and flows, goes up and down; would you agree with that statement?

A I'm not exactly sure what that is referring to. Is that referring to --

Q You --

A -- with respect to the number of emergencies that we had to manage in a particular day? Is that in, in respect to the number of requests for, for service that we were receiving in a particular day?

Q I apologize, let, let me try and be clear. In terms of the number of calls coming into CRU, that could

depend on the given day? Some days are heavier than other days --

A Right, but the work --

Q -- right? And that because (sic) is the nature of the fact that CRU, by its existence, is meant to be the front lines and is meant to be responsive to the calls coming in?

A Right. But the receipt of, of telephone calls, or requests for service was only a part of the function of CRU.

Q Right. Of course. There is then, of course, the other -- I think you talked about the fact that CRU is split up between those on phones and those on backup --

A Exactly.

Q -- right?

A So if we receive less requests for service on that particular day, that doesn't mean that we would have not been dealing with more emergent matters, or that we wouldn't be getting referrals, an equal amount of referrals coming in either via fax or you know, written referrals or whatever. So I think I would need to know specifically, you know, what function she is referring to.

Q And I think she was speaking about generally, generally, some days have a lot of calls, some days don't.

A I, I mean --

Q And if you don't agree, if you --
A -- I, all, all I --
Q Yeah.
A -- all I can do is, is speak to the numbers that, that we produced.
Q And, and, and that, and that's fair. If we go specifically to this case then, in terms of what was happening in March of, of 2005, this case comes to CRU from after hours?
A Yes.
Q Jackie Davidson creates a report that goes to your compatriot supervisor, Diana Verrier?
A Yes.
Q Right. And what you know, from the record, is that when it went to Ms. Verrier's CRU unit, what happened was that Richard Buchowski took that file at CRU?
A Yes.
Q Right. And I think the evidence is that he took that file on March 7th --
A Okay.
Q -- and my understanding is that during the course of that day, as a CRU worker, Buchowski called EIA; right?
A Okay.
Q That he called the school; correct?
A Correct.

Q That he attended the house of Ms. Kematch?
A Okay.
Q Would you agree with that?
Then he made another call to EIA; correct?
A Correct.
Q And that he made another attendance out at the Kematch residence during that day on March 7th; would you agree with that?
A Yes.
Q Okay. And that my understanding is that this documented interaction by this CRU worker occurred during the course of, at the very least, 10:45 to 2:30 in the afternoon; you have no reason to dispute that?
A No.
Q Okay. And that, in terms of what was happening at CRU on that day, by Richard Buchowski, what he did then was he created a report --
A Yes.
Q -- right? And he then submitted that report to Ms. Verrier, who's your CRU supervisor --
A Yes.
Q -- right? And they both signed, recommending the file go to intake?
A Yes.
Q But we know that the file was then assigned to

Mr. Zalevich, who was then part of your unit?

A Yes.

Q Right. And that, again, my, my recollection of your evidence here is fuzzy, but in terms of your general practice, at least, I think your evidence was, before you would have given it to your worker, you may have read the after hours and CRU report prior to assigning it to, to Mr. Zalevich?

A It's possible, yes.

Q It's possible. And that you know that on March 9, you sent two of your workers to the residence of Ms. Kematch?

A Yes.

Q Right. And I think your evidence was that was two out of six of your unit?

A Yes.

Q Right. And your expectation then, as a CRU supervisor was that Mr. Zalevich would use his judgment in how to deal with this particular complaint, this particular referral?

A That's correct.

Q Right. And in fact, I think you've mentioned Mr. Leskiw's experience, I think, at the very least, your evidence is that you gained some comfort from the fact that Mr. Leskiw was on that call with Mr. Zalevich at that time?

A Yes.

Q To bring his years of experience to this particular call?

A Yes.

Q So that how he would do it, at least his professional judgment could be brought to bear if necessary?

A Yes.

Q Right. And of course, when they went out on March 9, they would, of course, have to leave the office at 835 Portage and go to Samantha Kematch's house --

A Yes.

Q -- right? So they're driving there; right?

A Yes.

Q And as they're driving there, it's your expectation that if their clinical judgment required that they apprehend a child, your expectation is that they would do that?

A Yes.

Q Right. And my understanding of the apprehension process is that, of course, the very first step is that the workers have to make the information gathering process, they have to assess the situation to say, I need to act now?

A Yes.

Q Right. And that could be done simply by opening a door and seeing an unattended child, or something else?

A Yes.

Q Right. And that through the process of apprehension, they, of course, would have to call back to get your approval to apprehend?

A Yes, unless it was --

Q Really emergent?

A -- it was -- yes, like, there was --

Q Right.

A -- imminent risk to themselves or to the children --

Q Right.

A -- that were involved.

Q But the general practice is that the workers have to make an assessment that apprehension's warranted and then call you for approval?

A That's correct.

Q Right. And then during that period, you have to hear the information on that phone and make that assessment as to whether or not you're going to do the apprehension?

A Yes.

Q Right. And then provided that you believe that there was appropriate information to apprehend, you would then give your authorization?

A That's correct.

Q Right. And that your expectation then would be that the workers would take the steps necessary to do that apprehension?

A Yes.

Q Right. And that would, at the very least, require that they take physical control of that child?

A Yes.

Q And then to transport that child to a shelter, or to a placement?

A Yes.

Q Right. And so that you knew that when Mr. Zalevich and Mr. Leskiw were leaving the office, on March 9th, that that was a possibility, depending on what they saw? There was a conceivable possibility that they may have to apprehend?

A Yes.

Q And that your expectation was that those workers would spend the time necessary to do that apprehension, if they believed it was necessary?

A Yes.

Q In any event, when the workers get to the door, they have their interaction with Ms. Kematch, that's been documented and we've talked about it. And during that interaction at the door, again, you're relying on your

workers' professional judgment to assess how that situation should go; correct?

A Yes.

Q Right. And that when they're at the door, they could pose a whole number of questions that they believe is appropriate, based on their professional judgment?

A Yes.

Q Right. One of the questions that they could ask is where's the child?

A Yes.

Q Right. Another question they could ask is, who are the other caregivers in that house?

A Yes.

Q Right. Another question they could ask is can I come in and, and see the lock on the door?

A Yes.

Q Right. And again, you're relying on your workers to decide whether or not it's appropriate to ask those questions at that time?

A Yes.

Q Right. And of course, you'd agree with me that when Mr. Zalevich and Mr. Leskiw leave the office and attend on McGee Street, the only case they're dealing with at that time is the Phoenix Sinclair case?

A They would have had other cases assigned. The,

the two of them would have had other cases assigned to them.

Q Undoubtedly, but when they're at that door, talking to Ms. Kematch, that's the only case they're dealing with at that time?

A Yes.

Q And that's the only case that they're using their professional judgment on at that time?

A Yes.

Q And based upon the professional judgment of your workers, we know that after they had that interaction with Kematch, they got back into their car and they came back to the office?

A Yes.

Q Right. And when they came back to the office, Mr. Zalevich then wrote a report?

A Yes.

Q Right. And when he wrote that report, part of the effort involved in writing that report was exercising his clinical judgment as to what should happen in this particular case?

A Yes.

Q And he made a recommendation?

A Yes.

Q Right. AND that report is something then that

was submitted to you?

A Yes.

Q And that's something that, of course, you read?

A Yes.

Q And you assessed the situation and you made your decision in this particular case?

A Based on the written report, I can only -- I don't know what conversations or what discussions I would have had with my staff, which also would have been a factor in, in the decision I'm making in this case.

Q And that's fair. But the point is, when Mr. Zalevich came back to the office, he gave you a report to read --

A Yes.

Q -- which you read?

A Yes.

Q And you may have had to spend the time to actually speak to Mr. Zalevich?

A Yes.

Q Right. And that was all stuff that you were prepared to do at that time in order to determine what to do with this particular case?

A Yes.

Q Right. And your decision then on your case was based upon your professional judgment and your workers'

professional judgment as to what should happen with this case?

A Yes.

Q And your determination, based upon the information available to you, was that this file should be closed?

A That was what we concluded, yes.

Q Right. Based upon your assessment, there was no child protection concerns?

A That's correct.

MR. PAUL: Right.

Sorry, Mr. Commissioner, just one moment.

THE COMMISSIONER: That, that's fine.

MR. PAUL: Those are all my questions, Mr. Commissioner --

THE COMMISSIONER: Thank you --

MR. PAUL: -- thank you.

THE COMMISSIONER: -- Mr. Paul.

Anyone else before Mr. Saxberg?

Mr. Ray?

MR. RAY: Good afternoon, Mr. Commissioner.

CROSS-EXAMINATION BY MR. RAY:

Q Ms. Faria, my name's Trevor Ray, I represent a number of social workers and the MGEU, including Mr. Leskiw

and Mr. Zalevich who were working with you on this file. I have a, just a few questions for you. I shouldn't be long.

You had given us some evidence about your rough calculation of the numbers of cases that social workers were dealing with, based on your review of the CRU stats for certain periods of time; correct?

A Yes.

Q And I just would like to review that with you just quickly, if I may.

A Okay.

Q You said December 2005 was the time period you were dealing with?

A Yes.

Q But if I, and I've just reviewed the CRU stats just generally, you picked December 2005 and you mentioned there were roughly 1300 cases that came in in that month?

A Yes.

Q That was fairly common for every month? I mean, it was in the thousands every, every, around that every month, wasn't it?

A Yes, those numbers are consistent. That was not, those numbers were not unusual.

Q So that was my, my point, that was not an unusually high number of cases to receive in that month?

A No.

Q And then you mentioned that of those 1300 cases, roughly 600 were opened to CRU for you to deal with. And by that, I gather you mean you have to determine what to do with the case. You have to assess it. You may have to speak to collaterals. You may have to go out to the home, in this case, as you did on the Phoenix Sinclair matter. And you would do all of those things with 12 social workers; correct?

A Yes.

Q And you, you had --

A That's assuming we had a full complement of staff.

Q Of course, assuming a full complement. And that would result in roughly 50 cases per social worker, per month. And I gather your, your math is based on the assumption that there are 20 working days per month, roughly?

A Yes.

Q Okay. So -- and I think you said that comes out to roughly two and a half cases per day, per social worker, to deal with? Now --

A That's correct.

Q -- the reality is though --

THE COMMISSIONER: Is that new cases coming in, you're talking about?

MR. RAY: That's correct, Mr. Commissioner.

BY MR. RAY:

Q And, and then there was an additional 700 cases that although the calls and cases came into CRU, they were just not opened for further investigation by CRU?

A Right.

Q And the people who -- CRU still had to deal with those cases in some manner, by speaking to the person who's calling on the phone, which could take two minutes, it could take 20 minutes, it would depend on what that person was, was trying to get from you, for CRU; correct?

A Exactly.

Q Okay. So I want to then just ask you, you're basing your math on the fact that there are 20 working days per month, to deal with those cases, but in reality, isn't it the fact that assessing and dealing with these cases, these 600 cases, can be done primarily only on days when a worker is fielding and going out and assessing and having time to deal with the case when they are, when they are acting as backup?

A Yes.

Q So that means, because a worker only does backup one-half of the time, that you only really have, as a social worker, 10 days per month to do those types of

thorough assessments; isn't that right?

A Yes, that's correct.

Q Because while you're on phones, you're dealing with not only taking the information as the social worker, but also in dealing with the other 700 calls that come in, that actually don't go anywhere; right?

A That's correct.

Q So the actual case numbers then, per social worker, per day, to deal with, is actually close to five cases per day, per social worker; isn't that right?

A Yes.

Q And that would be to deal with them in approximately an eight hour day?

A Yes.

Q So that leaves you, per social worker, just a little bit over one hour per case; isn't that right? On average?

A Yes.

Q And we've heard about workload and various people, including yourself, have testified about the things, the types of duties that high workloads impact. And it would impact things like ability to go back and review all openings and closings on CFSIS; correct?

A Yes.

Q And that may simply require, in some cases, that

the worker is only capable -- although best practice would require or want a worker to deal with as much as possible, the reality is, when you have only a little over an hour per case, you have to do what you can with your time; would you agree with that?

A Yes.

Q And the cases that were the most important would be the cases where there's obvious signs of physical abuse, or sexual abuse, or very clear referrals about alleging those types of abuse, or things that are, are very, very serious; would you agree with me?

A Well, the cases that would, we would prioritize, based on risk safety, safety level and risk level, as per the existing safety assessment at the time. So cases, for CRU, obviously, cases that were immediate to 24 hour response were the priority.

Q And, and I think you stated, in this case, in your opinion, this case would not be one which would, you would view as an urgency, or have a particularly high priority, compared to the other cases you dealt with, which were particularly serious; is that correct?

A Yes.

Q So just, if I can summarize workload generally, isn't it simply, and I hope I'm not over generalizing, but isn't it simply that workload impacts the amount of time

that any worker can spend on a particular file, in any given case? And this may impact the ability to make a, a very informed judgment, versus your best judgment that you can, in the circumstances?

A I think it's about the amount of time, but it's, it's more than that. It's also about the organizational context. It's about, you know, the functions that exist. It's about the policies and procedures that are in place. It's about clarity of standards. It's about measuring those standards so that we understand whether or not they're being complied with and then secondly, if they're not being complied with, what are the reasons that they're not being complied with. And then ultimately, if we, if we are achieving those standards, are they resulting in, in the optimum outcomes for children? So it's, it's a combination of case numbers. It's a combination of, of the time requirement. What's happening operationally and, it, it's a question of, of training and clarity of polices, procedures, legislation, regulation, standards.

Q All of those things, combine to impact the judgment of a worker?

A Absolutely.

Q And all of those factors can, unfortunately, while regrettable, impact the best judgment of a worker?

A Yes.

THE COMMISSIONER: And what?

BY MR. RAY:

Q Can, can impact the best judgment of a worker.

A Yes.

Q Even though they're striving for best practice in every case, it's possible that they're not going to need best practice in every case?

A That's correct, that's why it's referred to as best practice. It's something that we strive to achieve, just like optimal outcomes for children, with respect to permanency, safety, community and family support. Those are outcomes that we strive to achieve. Do we achieve optimal outcomes for children 100 percent of the time? No. Do we achieve best practices 100 percent of the time? No.

Q And Mr. Paul asked you, or put to you -- just give me one moment.

I'm sorry, retract that, Mr. Commissioner.

In this case, Mr. Zalevich's evidence was his general practice would be to ask first, when he's at the door, whether the child was home. He noted, of course, but he did not record it in his recording. He believes that he would have asked, based on certain things in his recording.

Assuming, for the moment, he did ask and assuming he was told Phoenix is not here, which is, which is what he

stated in his evidence was possible. He then goes back and the two of you discuss the case and perhaps Mr. Leskiw was there, perhaps he was not. And based on everything that the worker viewed and based on workload, that may or may not have been presenting other problems for you and your workers, and based on the fact there may have been something more serious to be dealing with at that immediate moment, that, those considerations would have impacted your, your decision and the decision of the social workers, ultimately, whether to go back and, and do more assessment; is that correct?

A That's correct.

Q I just have one question with respect to Mr. Leskiw. You stated you relied on the recommendations of your two social workers. When, when you make that reference, with respect to Mr. Leskiw, do I understand --

THE COMMISSIONER: Well, just one, just one moment, just one moment. Was that a recommendation from both the social workers?

THE WITNESS: It would have been a recommendation from Mr., Mr. Zalevich.

MR. RAY: That's what I was seeking to clarify --

THE WITNESS: Yeah.

MR. RAY: -- Mr. Commissioner.

THE COMMISSIONER: I see.

BY MR. RAY:

Q And, I, I, I trust what you mean by that is Mr. Zalevich made a, the express recommendation to you, in his report, Mr. Leskiw did not participate in that express recommendation?

A That's correct.

Q But you would rely, or -- upon Mr. Leskiw, in the event he observed something of concern to him, perhaps not noted by Mr. Zalevich, that he would bring that to your attention?

A That he would bring that either to Mr. Zalevich's attention, or to my attention, yes.

Q And that's, and that's the way that you relied upon Mr. Leskiw?

A Yes.

Q I just have one question for you. It was a question that Mr. Gindin raised about the alleged conversation that you and Mr. Zalevich may have had the time he came back to see you after the field. I understood your original evidence to be that it would not be your practice to not tell him to not go back, but that, under the circumstances, you could not recall whether you did or did not and that it was possible that you did not tell him

to go back; is that correct?

A It's -- I, I don't remember the conversation. I would have not, I would have not told him, I would have not said don't go out and see her. But it's possible that we could have, based on whatever discussions we had, and whatever assessment he had completed, that we made the determination that we would close the case without seeing her.

Q Right. Essentially that, the two of you agreed that, under the circumstances, it was not necessary to, to, to see Phoenix in these circumstances and the case could be closed, based on all the things you've testified about?

A Yes.

THE COMMISSIONER: If you not having seen the child when he came back, I take it?

THE WITNESS: Yes.

MR. RAY: Thank you, those are my questions.

THE COMMISSIONER: Thank you, Mr. Ray.

MR. RAY: Thank you, Mr. Commissioner.

THE COMMISSIONER: All right. I guess ready for you, Mr. Saxberg.

MR. SAXBERG: Thank you, Mr. Commissioner. Good after to you and good afternoon, Ms. Faria.

If we could -- if the clerk could please turn up

page 44742? And this is from CD2113.

CROSS-EXAMINATION BY MR. SAXBERG:

Q And we're looking at a document entitled CRU Yearly Statistics. You were answering some questions about statistics posed to you by Mr. Ray and, and previous to that as well. And I, I thought you had said that you were speaking of the statistics for the month of December 2005?

A March 2005, sorry.

Q Okay. And is that where, that's then where you get the 1300 figure?

A Yes, 1311, specifically. That's total requests for service.

Q And if we could pan down on this document, scroll down please. Stop there.

So in that month then, how many files would you have opened and closed?

A We opened 411 files and we closed 192 files. So in total, that would be 603 files were opened and closed at CRU.

Q And I understand that this document was provided to Mr. Koster?

A Yes, it was.

Q And who was that that provided it to Mr. Koster?

A I provided it to Mr. Koster during my interview

with him.

Q Now, you've been testifying here for almost two full days, which, by my count, is, makes you one of the, the longest serving witnesses. What I want to ask is, with respect to your involvement in December of 2004 first, how much time, how much of your time was required to make the decisions that you made and that have been under scrutiny here?

A It could have been anywhere from 15 minutes to a half an hour throughout the course of my day.

Q And that would involve -- and that would be for the period between December 1st and December 7th?

A I just, I would need to look back at the report, because I don't remember -- it would have depended on what happened on -- I think I have that in front of me, just ... So this is the -- are you referring to the March 5th --

Q December 1, 2004.

A Sorry.

Q Perhaps you could just describe briefly what you would have had to have done and how long it would have taken you, in this entire involvement through December?

A Well, it would have been the consultations that Shelley Wiebe would have had with me and then it would have been the review of this, of this document, of the CRU after hours intake report. So in total, my whole involvement,

you know, could have been anywhere from 15, 20 minutes, half an hour, at any given time, when I was speaking to Shelley, depending on how long we conversed for.

Q So on the day the file's closed, that's the day you would be reviewing the file?

A I would -- I -- probably take me 15 minutes to review the record.

Q Okay. And on, on any given day, how many of those types of records would you, reports would you have had to have reviewed and sign off on?

A Well, if my social workers were dealing with 50 per day and I had --

Q Sorry, you said 50 per day?

A If they were -- I'm just trying to think. So if they were receiving 50 -- it could have been anywhere from, anywhere, at minimum, 15 to, at a high end, 30, 40, in a day.

Q Reports that you'd have to read and sign off on?

A Yes, plus do consultation with staff on cases.

Q And then with respect to the March 2005 intake, perhaps you can take a quick look at your, at the report and give us an estimate of how much time you would have spent on that matter before making your decision?

A Based solely on what's in the written record and not being completely aware of what my discussions would

have been with staff, again, it could have been anywhere between, you know, 15 minutes to a half an hour. And again, I'm speculating.

Q Now, I, I -- you'd -- in your evidence, you'd commented on the fact of your assumption that intake rejected the file in March of 2005 as playing a role in your decision to close the file?

A Yes.

Q I want to ask if, in, with respect to the December 2004 matter, in that case, it also appears that the file went up to intake and came back down; correct?

A Yes, that's correct.

Q Did the fact of that, would the fact of, of the file having been rejected at intake, in December, have played a role in your decision to close that file?

A Yes.

Q When Mr. Zazelenchuk (sic) and Mr. Leskiw went out to Ms. Kematch's apartment March 9th, 2005, were they conducting an abuse investigation?

A No, they were not.

Q In the entire time you were at CRU, as a supervisor, did any one of your workers ever, as a CRU worker, conduct an abuse investigation?

A If one of my workers was attending to an emergency and was to uncover an abuse matter, they were to

intervene, to ensure the immediate safety of the child and the matter would have been immediately referred to abuse intake, for them to conduct the abuse investigation.

THE COMMISSIONER: Well, well, how do you define an abuse investigation?

THE WITNESS: An abuse investigation, at the time, would have been the 12 steps outlined in Mr. Koster's report.

THE COMMISSIONER: And what your two workers went on, the assignment they went out on that day, in, in, on March the 9th, wouldn't be an abuse investigation, notwithstanding what information they went with?

THE WITNESS: That's correct. Because at the time, it did not meet the criteria for referral to abuse.

THE COMMISSIONER: No, no, I know it didn't meet the criteria to go to abuse --

THE WITNESS: Yes.

THE COMMISSIONER: -- but even though abuse "was involved", that would not be an abuse investigation; is that what I hear you saying?

THE WITNESS: Yes, the word abuse was used, it was non-specified. So based on the information that was available at the time, based on the criteria for referral to abuse and based on, based on the definition of abuse under the Act, they would not have been conducting an abuse

investigation. And it wasn't the function of CRU to conduct an abuse investigation, given the volume of the cases that we were managing and also the gravity of the cases that we were managing.

THE COMMISSIONER: Well, what were they supposed to do about the unspecified abuse that they were cognizant of when they went out on that visit of March the 9th?

THE WITNESS: They were supposed to assess that, to determine if there was any, any further information.

THE COMMISSIONER: Thank you.

MR. SAXBERG: Thank you, Mr. Commissioner.

BY MR. SAXBERG:

Q And I understand that there are special face-to-face client contact rules in conducting an abuse investigation; is that correct?

A Yes, there are requirements with respect to face-to-face contact with, regarding abuse investigations. So it was clearly understood by all staff that if you were conducting an abuse investigation, that you were, you were to have face-to-face contact with the child.

Q And would those face-to-face contact rules have applied to the work that Mr. Zazelenchuk and Mr. Leskiw were doing on March 9th?

A No, the standard at the time required that the,

the family or the person, be -- I can't -- be contacted. Face-to-face was required in abuse investigations.

Q Okay. And just one final area. I took down, in answer to one of Ms. Walsh's questions, that you indicated that if you were not able to determine if there are child protection concerns, you would advance the file to intake. And my question is, is not able to identify a child protection concern similar, or different than not having child protection concerns?

A If you're not able, you don't have any child protection concerns.

Q Okay. And in this case, did you agree with Mr. Zazelenchuk, or Mr. Zalevich's assessment that there were no child protection concerns?

A Yes, I did.

MR. SAXBERG: Those are my questions. Thank you, Mr. Commissioner.

THE COMMISSIONER: Thank you, Mr. Saxberg.

Ms. Walsh?

MS. WALSH: I just have one question.

RE-EXAMINATION BY MS. WALSH:

Q I just wanted to confirm, Ms. Faria, when Mr. Leskiw and Mr. Zalevich went to Samantha Kematch's apartment on March 9th, 2005, they were conducting a child

protection investigation; is that right?

A Yes.

MS. WALSH: Those are my questions, thank you.

EXAMINATION BY THE COMMISSIONER:

Q Witness, I just have one question for you. Your reference to being involved in these two matters and taking, on each occasion, somewhere, you think, in the approximately time zone of 15 minutes to half an hour, I'm not sure what I'm to take out of that. Are you suggesting you didn't have enough time to do an adequate job? Or, or, or just what is, is it I take out of that, that evidence?

A I think the significance of that evidence is that you need to -- is the realities of what a CRU -- like, the length of time that a CRU supervisor is actually involved on a case, especially cases of this nature, which would not be high risk or emergent. Because those were the cases that, you know, I, I likely would have been spending more time on, in terms of doing consultation with staff. But generally, given the volume and the gravity of the cases that we were managing, the CRU worker really, the CRU supervisor had, you know, a limited window upon which to review reports, consult with staff and make decisions.

Q Well, are, are you -- does -- as you reflect on the amount of time you likely hit, does that cause you to

second guess the decision you made on those occasions? I'm just trying to relate the -- your, your reference to the timeframe to the, the decisions you made in each instance.

A I think, you know, with more manageable workload and also given the function of CRU, which really did not allow us the capacity to do that, those longer term assessments, we were having to make a lot of decisions quickly and often based on the information that was available to us and often based on the best judgment, you know, and clinical assessment skills of our staff.

THE COMMISSIONER: Thank you.

Now, does any counsel want to ask anything arising out of the questions I just put to the witness?

If not, then we'll leave it there and, and after, as your counsel has pointed out, nearly two days on the stand, I thank you very much for your attendance and sticking with us and being a cooperative witness.

THE WITNESS: Thank you, Mr. Commissioner.

(WITNESS EXCUSED)

MS. WALSH: Mr. Commissioner, could we just take five minutes and then we'll start with SOR 10?

THE COMMISSIONER: Yeah, I, I --

MS. WALSH: But it really can't be --

THE COMMISSIONER: -- I've had the --

MS. WALSH: -- more than five minutes.

THE COMMISSIONER: -- I've had occasion to see the next witness on the screen and she's waited very patiently, so I don't think we should take too long. But it's time for a mid -- let, let's say 10 minutes and -- or do you think that's too long?

MS. WALSH: Well, it's just, I mean, I don't know what the witness' availability is for tomorrow. I do know the witness has to be out of here by 4:30 for childcare.

THE COMMISSIONER: All right. Well, then we'll just take five minutes then.

MS. WALSH: Thank you.

THE COMMISSIONER: All right. Thank you, witness.

(BRIEF RECESS)

THE COMMISSIONER: ... protocol. I think most people are aware of it. You'll all have to step outside while we have this witness sworn.

MS. WALSH: Thank you.

THE COMMISSIONER: And then we'll take her evidence in the public forum.

THE CLERK: Shall I go off the record now?

THE COMMISSIONER: Yes.

THE CLERK: Off the record.

(PROCEEDINGS OFF THE RECORD)

MS. WALSH: Witness, we're just letting everyone back into the room.

THE COMMISSIONER: We'll start the questions in just a moment.

THE COMMISSIONER: This will be SOR number what, Ms. Walsh?

MS. WALSH: Ten.

THE COMMISSIONER: Ten.

MS. WALSH: Mr. Commissioner, I just, for the record, want to confirm that the witness was duly affirmed in your presence.

I also want to remind the audience, including the media, that our protocol for sources of referral is in effect for this witness' evidence and to pay particular attention to avoid tweeting where a name of either this witness or an individual, a child, in the event that this witness refers to the name of a child, not to identify that information. Witness, can you see me?

THE WITNESS: Yes, I can.

MS. WALSH: Good. And you can hear me without

any problem?

THE WITNESS: Yes, I can.

MS. WALSH: Thank you. And I just want to confirm that the only person in the room who can see you is the Commissioner. We can all hear you. And you are soft-spoken, so I would ask you to speak directly into the microphone. Are you ready?

THE WITNESS: I'm ready.

MS. WALSH: Thank you.

SOR #10, duly affirmed off the record, testified as follows:

DIRECT EXAMINATION BY MS. WALSH:

Q Now, you were related to Phoenix Sinclair; is that right?

A That's correct.

Q When did you first meet Phoenix?

A April 23rd, 2000.

Q The day she was born?

A That's correct.

Q You took care of Phoenix on occasion?

A That's correct.

Q When did you start taking care of her?

A It would have been the beginning of the summer of

2003.

Q And how did it come to be that you took care of her?

A Sam and Karl McKay wanted to travel together as Karl was a truck driver and Sam wanted to journey with him on his job ventures. And she asked if I would be willing to take Phoenix on these occasions.

Q That's in the summer of 2003?

A That's correct.

Q Sam is Samantha Kematch?

A That is correct.

Q And Karl is Karl Wesley McKay?

A That is correct.

Q Did you know Steve Sinclair?

A Yes, I did.

Q What about Rohan Stephenson?

A Yes, I do.

Q And Kim Edwards?

A Yes, I do.

Q Now, you said you took care of Phoenix in the summer of 2003; did you see Phoenix at Christmas in 2003?

A I did not see her on Christmas Day, but we have seen her before and after the Christmas holidays.

Q Did you give Phoenix presents?

A Yes, I did.

Q Did you give them directly to Phoenix?
A I gave them to Samantha and Samantha's mother.
Q So now we're into early 2004, how often did you see Samantha Kematch in that period?
A I would say about a handful of times, give or take a little.
Q When you saw Samantha, was Phoenix with her?
A No.
Q Did you ask where Phoenix was?
A Yes, I did.
Q What did Samantha tell you?
A That she was with Karl's niece.
THE COMMISSIONER: She was -- I didn't hear you.
THE WITNESS: She was with Karl's niece.
THE COMMISSIONER: Thank you.

BY MS. WALSH:
Q In this period, I'm talking about the beginning of 2004, the winter, early 2004, are you able to describe Ms. Kematch's relationship with Phoenix?
A She wasn't a good mother. She was very mentally and emotionally abusive to the little girl. I've never seen any physical abuse, but she wasn't a kind person to be around.
Q Did you ever have an occasion to see Samantha and

Phoenix in your home in 2004?

A Yes, I have.

Q Can you describe what you observed?

A Samantha, Karl and Phoenix had come over one afternoon and it was around suppertime, because I was just getting ready to feed my children and Phoenix was looking at the plates I was putting down on the table and I had asked Phoenix if she was hungry. And Phoenix shook her head yes and I asked her if she wanted to eat and she said yes. And Sam told me that Phoenix will eat when she's ready to feed her. And at this point, I had gotten upset and I said, you're in my fucking house and if this little girl wants to eat, she's going to eat. And at this point, I had made Phoenix a plate and sat her down with my four children.

Q You said you had Phoenix stay with you in 2003 and you had occasion to see her in your house in 2004; what was Phoenix like?

A With or without Samantha?

Q Well, let's start without Samantha.

A She was a loving little girl. She liked to smile. She liked to dance, She liked to play. She played with my children quite a bit. She was just like any other little three year old that wanted just to be around other children and be loved and be played with.

Q And when Phoenix was around Samantha, what was she like?

A She was very timid. She was withdrawn from the other kids, withdrawn from us and she would go into her own little place and stay there.

Q What do you know about the relationship between Mr. Stephenson, Ms. Edwards and Phoenix?

A I know that Mr. Stephenson was the primary caregiver of Phoenix, along with his other children. Ms. Edwards was around, but it was always Mr. Stephenson and the kids that were always (inaudible) on Phoenix and were the ones that were constantly caring for her.

Q Did you know how Ms. Kematch felt about Phoenix's relationship with the Stephensons?

A She didn't like them. She didn't care for it and she had no say, because she wasn't nowhere around.

Q Was there ever a time when you asked Samantha Kematch to leave Phoenix with you more often?

A Yeah, I had asked Samantha if she would permanently give her to me. I told her she could keep her welfare. She could keep her family allowance, just let her, let me have her.

Q What was her response?

A She told me it would never happen.

Q Did you ever have any indication that Phoenix was

being physically abused?

A No, I've never seen any bruises on her, like, when I had cared for her, when I would bathe her, I have checked or signs of physical abuse, but I'd never seen any. There was minor neglect with head lice and just dirtiness, but other than that, there was no evidence of physical abuse at the time.

Q Did you have concerns about any other forms of abuse?

A The emotional and verbal abuse from her. We butted heads a lot on that because I wouldn't tolerate it in my home, when Phoenix was in my presence.

Q And when you say "we butted heads", you mean you and Samantha?

A Yeah.

Q What did you know about Wes McKay, Karl McKay?

A I didn't know him personally. I've met him a handful of times. I did know he was a truck driver, long haul and short haul. I also knew he liked his alcohol and he was physically abusive with Samantha. I've known there's been a few occasions of that, that went on between their relationship.

Q Do you know how much time Phoenix spent with Mr. McKay?

A No, I don't.

Q Do you recall when it was that you last saw Phoenix?
A I would have to say it was the spring of 2004.
Q Now, the Commission has heard evidence that Samantha had a baby who was born at the end of November 2004; did you ever meet that child?
A When the baby was approximately two months, I did.
Q Where did you see this baby?
A In my residence.
Q Was Samantha with her?
A Yes, she was.
Q Was Phoenix with them?
A No, she wasn't.
Q So this would have been in, in early 2005?
A Yes.
Q Did you ask Samantha where Phoenix was?
A Yes, I did.
Q What did she tell you?
A She told me she was with Karl's niece.
Q The same answer she'd given you in the past?
A The same answer she always give me.
Q Going into 2005, then, did you stay in touch with Samantha?
A She visited my residence quite a bit. She was

coming in for checkups on the baby and also pre-natal checkups as well. So I saw her quite frequently, at least once or twice a month.

Q Was Phoenix ever with her?

A No, she wasn't.

Q And again, did you ask where she was?

A Yes, I would.

Q And what did Samantha tell you?

A That she was with Karl's niece.

Q Were you ever in Samantha's apartment on McGee?

A No.

Q Did you know that at some point Samantha moved out of Winnipeg, in 2005?

A No, I did not.

Q Did you ever discover that Samantha had moved out of Winnipeg?

A Yes, I did. Samantha had (inaudible) herself when she had to come into the city for, I believe it was a baby checkup, and that would have been about the end of April, May sometime.

Q Of 2005?

A (Inaudible).

Q Did Samantha tell you where they were living at that point?

A Fisher River, I believe it was.

Q Did she tell you who had moved there, in terms of the family?

A Her and Karl and Phoenix.

Q And the baby?

A And the baby.

Q Now, going into the summer of 2005, did you continue to ask where Phoenix was?

A Every time I saw Samantha, that was the first question out of my mouth.

Q And at some point, you took some steps to try and locate Phoenix, beyond asking Samantha where she was?

A Yes, that's correct.

Q What did you do?

A I contacted CFS. I spent a whole day in approximately mid-August of 2005, contacting every CFS in Manitoba and then I had contacted a mutual acquaintance of mine and Samantha's, to find out which band Steve Sinclair was from, due to that's how they place aboriginal children, is based on their bands. And I was directed to a social worker by the name of Nicole and had a brief conversation with her regarding Phoenix. She had told me she was no longer the present social worker and directed me to Sam Williamson and gave me his number and then I had contacted him. And finally, well, did not find where Phoenix was, but I was able to find someone that knew where she was.

Q Okay. So we'll come back, let's just back, back up to the beginning of what you've told us. You said that sometime in August, you spent a day calling CFS agencies?

A Yes, that's correct.

Q Where did you find the phone numbers? How did you know where to call?

A Phone books, a lot of it was done through phone books and 411, assistance directory and that's how I got a hold of all my numbers.

Q And do you know who answered your calls?

A Most of the people were, that I had talked to were from the front desks of the agencies. It was never any actual social worker that I had spoken to, up until Nicole.

Q And do you remember what information you gave the people you talked to on the phone?

A Yes, I do.

Q What did you tell them?

A I told them that I was an aunt that was looking for my niece by the name of Phoenix Victoria Hope Sinclair, born on April 23rd, 2000. And that I hadn't seen or heard from her and I was concerned and that I wanted to get a hold of the social worker that was, that was caring for her at the time. That way, I could at least try to get some kind of knowledge or clearance that I knew she was okay, or

that I could see her again.

Q Did you say whether you had concerns about Phoenix?

A I told them I was worried about her wellbeing because I knew how Samantha was and I told them that every time Samantha had come into the city, that Phoenix was never with her and that was a bit of a concern for me, because she was always bringing in the other child, but never Phoenix.

Q You said up until the time you spoke to Nicole, you didn't get names of the workers; right?

A No, I did not.

Q But do you recall what the workers said to you, in response to your call?

A Every time I had, had given Phoenix's full name and her date of birth, knew one, no one knew of her, or has heard of her, so they said they couldn't help me because she wasn't in the system.

Q Do you recall whether they asked you any questions?

A No, they did not.

Q Then you said you spoke to someone named Nicole, so just go back to that, please.

A Like I previously stated that, I had contacted the band that Steve was from and to locate the agency that

Lake, Lake St. Martin deals with and it happened, so I was able to get a number from Lake St. Martin and was directed to Nicole from there, from the band office, to that agency. And Nicole was the name that was given to me, along with her number and I contacted her.

Q What did Nicole tell you?

A She told me she was no longer the attending social worker for Phoenix and that she, the case was transferred to Stan Williams and she had given me the number to Stan.

Q Did you call Mr. Williams?

A Yes, I did.

Q Was this all on the same day?

A This was, everything was done the same day.

Q Did you get through to Mr. Williams?

A Yes, I did.

Q And what was the discussion?

A I told Stan who I was and that I was looking for a little girl by the name of Phoenix, (inaudible). He had (inaudible) information. All of her information, excuse me. And then he asked me who I was and I told him I was her aunt through marriage. And he told me, because I am not a blood relative, he cannot disclose any information to me. And his last words to me was she's doing fine and well.

Q This was in August of 2005?
A That's correct.
Q Did you keep in touch with Ms. Kematch after August of 2005?
A Yes, we seen her a few times after that.
Q Did you continue to ask her where Phoenix was?
A All the time.
Q Did you ever tell Samantha Kematch that you had called CFS?
A Yes, I have.
Q What was her response?
A She didn't really say anything to me and I told her that I would continue calling until I saw Phoenix.
Q And how did you first hear about Phoenix's death?
A Through the papers.
Q Is there anything else that you want to tell us about the matters I've discussed with you?
A No.
MS. WALSH: Thank you, those are my questions, Mr. Commissioner.
THE COMMISSIONER: Thank you.
Witness, there'll be some more questions in just a minute, and I think, fairly quickly.
Mr. Gindin?
MR. GINDIN: Good afternoon, ma'am. My name is

Jeff Gindin. I represent Kim Edward and Steve Sinclair; can you hear me all right?

THE WITNESS: Yes, I can.

MR. GINDIN: I just have a few questions for you.

CROSS-EXAMINATION BY MR. GINDIN:

Q You met Phoenix on the very day she was born; is that right?

A That's correct.

Q And you said you took care of her on occasion during the summer of 2003?

A That's correct.

Q And when you say on occasion, I'm just wondering what you mean? Is it on a weekly basis, or a monthly basis, or what did you mean?

A Well, at first it started out every weekend, then the weekend turned into weeks. And, and it just turned out that I had her for the whole summer of 2003. So it had started out that I was taking care of her at the beginning of 2003, during the spring.

Q So when you say the summer, do you mean a period of two or three months or so?

A Yes.

Q Okay. And the reason that Samantha would give you, whenever she asked you to take care of Phoenix was

that she and Karl Wesley McKay wanted to travel together?

A That is correct.

Q And during that time period, in the summer of '03, would you see Steve Sinclair on occasion?

A No.

Q Or Kim or Rohan?

A No, but I was in contact with both Kim and Rohan at the time.

Q Okay. So they would contact you and, and you would discuss Phoenix; right?

A That is correct.

Q Okay. And they expressed their interest and concern about Phoenix; right?

A That is correct.

Q In early '04, I think that you said that you may have seen Samantha perhaps half a dozen times; is that what you said?

A About a handful of times, give or take --

Q Handful of times?

A -- a little.

Q Okay. And again, just to be clear, regularly, or just once in awhile?

A It was once in awhile.

Q But you never saw her with Phoenix?

A Never.

Q And again, whenever you asked about Phoenix, her response was the same, she was with --

A Karl's niece.

Q -- Karl's niece? Were you ever given a name as to who she actually was with?

A No, it was just always Karl's niece.

Q And this handful of times, are you referring to the first two months of 2004, or beyond?

A It would have been the first couple of months.

Q And did you see Phoenix very much in the fall of '03? I know you said summer of '03.

A We had come into contact with Phoenix in the fall of '03 periodically. At this point, it became a time where Samantha would only allow us to see her when Samantha felt the need for us to see her.

Q So you would have liked to see Phoenix more, but Samantha didn't really cooperate?

A That is correct.

Q And when you did see Samantha with Phoenix, you formed the impression pretty clearly, it sounds like, that she was mentally and physically abusive towards Phoenix?

A Yes.

Q And then you say not a kind person to be around? You mean that she was rude and (inaudible), that (inaudible)?

A She was just -- she had a mean persona to her. She was not like a whole person. Like I had said earlier, we had butted heads, due to the way she had treated this little girl.

Q So you're saying that she was mean to Phoenix?

A Yes, physically -- not physically, sorry, emotionally and mentally she was.

Q You described Phoenix as a loving, playful child?

A That is correct.

Q Fun to be around? Easy to get along with; right? When Sam wasn't around?

A When Sam wasn't around.

Q And there was quite a difference when, when Samantha was?

A That is correct.

Q And we've heard that Phoenix spent some time at Kim and Rohan's place, different periods of time; were you ever there as well, at wherever Kim and Rohan, or one of them was? It was on --

A I wouldn't (inaudible).

Q -- Magnus, according to the evidence, if I recall correctly?

A I used to go visit Rohan and Kim on occasion, I would say at least once to twice a month, for a period of four or five months. And ever time I was in the home,

Phoenix was always there and ...

Q So you would have seen -- you would have been there perhaps 10 times, it sounds like?

A Yeah. I've seen her quite a bit there.

Q And you would see her at that home and I take it that her demeanour, as a child, would be quite different than it was when she was with Samantha; correct?

A She was happy when she was at the Stephenson household.

Q Um-hum. And when you asked Samantha if you could see Phoenix more and, and in effect, take care of her, she was not agreeable to that?

A No, she was not.

Q You say you met Wes McKay a few times --

A That is correct.

Q -- what, what year would that be?

A That would have been in the beginning of 2003 sometime, around the spring is when I first met him.

Q This would be before Phoenix was born?

A No, Phoenix was way born, she was already three, going on (inaudible).

Q Oh, we're talking about '03, oh pardon me. You said -- so you met him when Phoenix was around three?

A Yeah.

Q And you saw him a few times?

A That is correct.
Q Enough to know, or feel that he was physically abusive towards Samantha?
A Well, I, I knew he was physically abusive to her, because I've seen the marks on her a few times and she had told me that it had come from him.
Q I see. And when you say you, he liked alcohol, is that something you saw, or were told by Samantha?
A It was something I had seen and heard from not only Samantha, but a lot of people that were in contact with these people at the time.
Q Did you see him drinking alcohol --
A On a few occasions --
Q -- with any --
A -- when I had gone to Samantha's mother's house, there would be alcohol there.
Q And would, would there be any children there as well?
A No, Phoenix wouldn't be around at that time.
Q And in 2005, you say that the, Samantha came to see you quite a bit?
A Yes.
Q Couple of times a month?
A That's correct.
Q And when you say '05, do you really mean from the

beginning of '05?

A Around spring of '05, she was coming in for prenatal checkups or baby checkups for the baby that they had just had.

Q So you're talking about April or May; is that what you mean by spring?

A Yes.

Q Okay. And Phoenix was never with her?

A No.

Q And she used the same excuse each time?

A Every time.

Q Phoenix is with Karl's niece?

A That is correct.

Q When you decided to contact CFS, you made a number of calls and they were all on a particular day in August of '05; correct?

A That is correct.

Q And obviously you did that because you had great concern for Phoenix, you hadn't seen her, or heard about her for some time?

A That is correct.

Q You tried to find out things directly through Samantha and weren't really getting anywhere?

A No.

Q Okay. So you made a number of calls that day;

did you call a number of different agencies or --

A I've called basically every single agency Manitoba has to offer.

Q And would it be fair to say that it was a frustrating experience?

A Indeed, it was.

Q Um-hum. And, and, and how so?

A Because this little girl wasn't in the system, when she should have been. And no one knew who she was, or how to locate her.

Q And that's one of the things you were told on one of your phone calls, that they didn't have her in the system?

A That is correct.

Q And when you made these calls, you would always give the -- Phoenix's name?

A Her full name, along with her birth date.

Q Yeah. And basically, you were quite willing to give them whatever information you had; right?

A That is correct.

Q And you were told that no one knew of her and I think that you said that they didn't really ask you any questions?

A No, they didn't.

Q So when you voiced the fact that you were

concerned and hadn't heard anything about her, no one really asked you for details, did they?

A No, they did not.

Q And that was part of the frustration?

A That is correct.

Q You spoke to two social workers; is that correct? Nicole --

A By the end of that day, I had finally been able to speak to, yes, two social workers.

Q And the first one was Nicole; you, you don't recall her last name?

A No, I don't recall her last name.

Q But she said she was no longer the social worker for Phoenix?

A That is correct.

Q And gave you the name Stan Williams?

A That is correct.

Q And he, at first, didn't want to give you information because you weren't a blood relative?

A That is correct.

Q But he did say, in August of 2005, she's doing fine, she's doing well, or something like that?

A She's fine and she is well.

Q Did he ask you any questions about why you were calling, or whether you had information?

A No. He just asked who I was an I explained to him who I was and that's when he told me, because you are not a blood relative, we cannot disclose any information to you. All I can tell you, she is doing fine and she is well.

Q So that's what you recall him --

A And that was --

Q -- that's --

A -- the end of the conversation.

Q -- that's what you recall him saying in August of '05, she is well?

A Those words ring in my head --

Q I'm sure you'll never --

A -- almost every day.

Q -- I'm sure you'll never forget those words; right? Am I correct, you'll never --

A (Inaudible).

Q -- forget those words? Yes?

He never asked you when you would have seen her last, or when you would have spoken to Samantha last, or anything like that?

A He didn't ask me nothing, just what my relationship to the little girl was.

Q Oh. And even after Stan Williams said that she is well, you saw Samantha after that a few times?

A I believe it was a few weeks after I had made that call that Samantha had come to my residence.

Q And how many times would you say you saw her after that call?

A Once a month, to twice a month. By this time, she was coming in the city for prenatal checkups.

Q And do you recall the last time you saw her, what date that would have been?

A It would have been in December, just a day or two before she went into labour with her last child.

Q December of?

A 2005.

Q Of 2005? And I take it that you heard about Phoenix's death in March of '06?

A That is correct.

Q From the newspapers; right?

A That is correct.

Q So you would have seen Samantha three or four months prior to hearing about Phoenix's death; correct?

A I would say about a month after Phoenix's death (inaudible).

Q Pardon me?

A About a month after Phoenix's death (inaudible). So throughout the whole year of 2005.

Q No, what I'm talking about, when you found out in

March of '06, from reading the paper, what happened to Phoenix --

A Okay.

Q -- how long, prior to finding out, had you last seen Samantha? A few months?

A December of 2004, or 2005, sorry.

Q Okay. So that would be about three months earlier, or so?

A That's correct.

Q And when you saw her then, she continued to say the same thing she'd always been saying, in terms of where she --

A That is correct.

Q -- in terms of where Phoenix is; right?

A That is correct.

Q Do you know how many phone calls you might have made that day in August of 2005, when you were calling various agencies?

A I would say anywhere from 20 to 30 calls in that day.

Q Um-hum. And every one of them left you frustrated; right?

A That is correct.

MR. GINDIN: Those are my questions, thank you.

THE COMMISSIONER: Thank you, Mr. Gindin.

Mr. Paul?

Mr. Ray?

Mr. Saxberg?

Mr. Ray?

MR. RAY: Yes, Mr. Commissioner, I'm wondering if we can just take a quick five minute break? I know the witness needs to -- was it 4:00 or 4:30 that the witness needs to --

MS. WALSH: Yeah, she has to be out by 4:30.

MR. RAY: Out by 4:30? I just wanted to confirm some, a couple facts that the witness spoke to and I --

THE COMMISSIONER: All right.

MR. RAY: -- need a couple minutes to do that.

THE COMMISSIONER: Witness, I understand that you have family responsibilities at 4:30; is that correct?

THE WITNESS: That is correct.

THE COMMISSIONER: Well, it's, it's just five past 4:00, so we're going to stop for five minutes while the lawyer confer, to see what else there is, if anything, to ask you and we'll be back and, and we will let -- you will be away by 4:30, whether -- I think they'll be through with you, but if not, we'll just make some other arrangements. So just stand by for five minutes and then we'll be back to -- with likely a few more questions.

THE WITNESS: All right.

MR. RAY: Thank you, Mr. Commissioner.

(BRIEF RECESS)

THE COMMISSIONER: All right, witness, we're, we're ready, I think, with some more questions.

Mr. Ray, please?

MR. RAY: Yes, good afternoon, witness. My name's Trevor Ray. I act for the MGEU and some social workers. I just have some, some very brief questions.

CROSS-EXAMINATION BY MR. RAY:

Q Firstly, with respect to the dates that you first indicate that you believed you met Mr. McKay, we've heard evidence that during the summer of 2003, now you had indicated that you were caring for her for several months, so that's June, July, August, around that period of time; is that what your, what your recollection is?

A Yeah.

Q Okay. Now we've heard evidence that during July of 2003, Phoenix was actually apprehended and was in the care of Child and Family Services and then she went into the care of Rohan Stephenson and Kim Edwards, under a formal place of safety. So is it possible that you misspoke and you were actually, the dates actually were the

summer of 2004, not the summer of 2003?

A No, it was the summer of 2003, because I remember this partly because I had three three-year-olds in my care at that time and Phoenix being one of the three-year-olds.

Q So are you saying you disagree that Phoenix was in care during the summer of 2003, which has been well established in this hearing?

A She was in my care for part, most of part of that summer, from the spring, right to, I'm pretty sure, until my kids started school in the fall.

Q Okay. So you, you disagree then that she was in care, taken into care by Child and Family Services agency, apprehended in July 2003?

A I disagree on that.

Q Possibly you could be wrong?

A Could be a possibility. It was a long time ago, but I know she was three at that time and like I said, I had three three-year-olds (inaudible).

Q Okay. I would just like to ask you, I, if I understand your evidence, you were in, then again, later in the summer of 2005, you were looking to locate Phoenix; correct?

A That is correct.

Q And you called many agencies, was your evidence, 20, I think you said 20 to 30 different agencies?

A No, I said I placed about 20 --
Q Oh --
A -- to 30 calls --
Q -- 20 to 30 calls.
A -- throughout Manitoba agencies on, in August of 2005.
Q Thank you. And you were seeking information from them?
A I was looking for Phoenix.
Q Okay. But -- and you were seeking information from them, you didn't -- not necessarily giving them information; is that under, my understanding?
A I wasn't seeking any information. I wanted to know where this little girl was and how I could get my hands onto her.
Q Right. So you were asking the agency for information about Phoenix, how to locate her and how you --
A That is correct.
Q -- could get her; correct? Okay. And you were frustrated because the social workers would not give you information about a private file that they had, or maybe, or perhaps didn't have; correct?
A Can you say that again please?
Q And you were frustrated because the social workers that you spoke to, or the agency you spoke to, were

not giving you out personal confidential information about one -- about their clients?

A It's not that they weren't giving me personal information. They had told me she was not in the system, that they could not find her. There's a big difference in that.

Q So they, they didn't, I'm going to suggest to you they didn't confirm, one way or the other, whether they had a file open on her or not?

A That is correct.

Q Correct. And you weren't calling about specific child protection concerns that you necessarily had about Phoenix, because you didn't have any at the time, you just didn't know where she was; correct?

A Well, I was concerned about her safety as well, considering I knew how Samantha was with her.

Q But you didn't convey that to any social worker?

A No, I did not.

MR. RAY: Thank you, those are my questions.

THE COMMISSIONER: Thank you, Mr. Ray.

Anyone else any questions?

Mr. Paul? No.

Mr. Saxberg? No.

All right. Anything further, Ms. Walsh?

MS. WALSH: Sorry, I, I am just a little

confused, so I have just two questions.

RE-EXAMINATION BY MS. WALSH:

Q When you spoke to the various people on the phone at Child and Family Services, were you told that Phoenix was not in the system, or they couldn't tell one way or the other?

A When I had started out the, the phone calls in the morning and was talking to numerous CFS agencies throughout northern and southern Manitoba, they had told me there was no Phoenix Victoria Hope Sinclair, born on April 23rd, 2000 in their systems. They had no recollection of her.

Q And then did, did anyone tell you that they did have her in the system?

A The way I found Phoenix and the social workers that were looking, that I was looking for, was through the band office that had directed me to the proper agency, because of the band she's under knew which agencies that they were dealing with and that's how I had gotten a hold of Nicole.

Q And which band was that?

A That was Lake St. Martin.

Q And you said you gave the, the people who answered the phone Phoenix's full name and her date of

birth?

A That is correct.

Q What did you tell them the reason for your call was?

A I explained to them that I was her aunt and I was looking for her, because every time the mother had come into the city and would come to my house, Phoenix was nowhere in sight and that she was constantly telling me that she was with Karl's niece. And I wanted to see her, to make sure she was okay.

Q Did you say whether or not you had concerns about whether she was okay?

A I can't remember, but I do know that I hadn't spoken to all the social workers, telling -- well, not social workers, but majority of them were the receptionists, that I was looking for a little girl that her mother was never bringing her into the city.

Q Did you say how long it had been since you'd seen Phoenix?

A I believe I told Nicole it was a few months since I had physically, like, visually saw the little girl.

MS. WALSH: Those are my questions. Thank you very much.

THE COMMISSIONER: Thank you, witness. I just

have one question for you.

EXAMINATION BY THE COMMISSIONER:

Q Do you know the phone number from which you made the calls?

A I don't remember my home number, but I believe it was a 474 or a 412 number.

Q Four seven one, or 412?

A Four seven four, or 412, or 478. It's the Osborne number district for that area.

Q And was that a phone that was registered in your name?

A That is correct.

THE COMMISSIONER: All right. Does anyone want to ask any questions arising out of the question I've just asked?

MS. WALSH: Yes.

THE COMMISSIONER: Ms. Walsh?

RE-EXAMINATION BY MS. WALSH:

Q Was that, was that a landline, or a cell phone?

A It was a landline.

MS. WALSH: Thank you.

THE COMMISSIONER: Any other questions?

All right, witness, thank you very much for your

time you have given to us. You have completed your examination and you're out of here in sufficient time, hopefully, to attend to your family.

THE WITNESS: Thank you.

(WITNESS EXCUSED)

THE COMMISSIONER: Well, I guess there's not much point in starting another witness today, is there?

MS. WALSH: No, I don't think so.

THE COMMISSIONER: No, I would think not. So we'll adjourn until 9:30 tomorrow morning.

MS. WALSH: Thank you.

(PROCEEDINGS ADJOURNED TO JANUARY 22, 2013)