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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WEDNESDAY, JANUARY 23, 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,** for Department of Family Services and Labour

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

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

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

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

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

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JANUARY 23, 2013

PROCEEDINGS CONTINUED FROM JANUARY 22, 2013

THE COMMISSIONER: Good morning.

MR. OLSON: Good morning.

THE COMMISSIONER: All right, Mr. Olson?

MR. OLSON: We're ready to proceed with our next witness, who's on the stand. I'll have him sworn in.

THE CLERK: Sir, is it your choice to swear on the Bible or affirm without the Bible?

THE WITNESS: I'll swear on the Bible.

THE CLERK: Okay. Could you stand for a moment? State your full name to the court.

THE WITNESS: Daniel Rodney Berg.

THE CLERK: And spell me your first name.

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

THE CLERK: And your middle name.

THE WITNESS: R-O-D-N-E-Y.

THE CLERK: And your last name.

THE WITNESS: B-E-R-G.

DANIEL RODNEY BERG, sworn,
testified as follows:

THE CLERK: Thank you.

THE WITNESS: Thank you.

DIRECT EXAMINATION BY MR. OLSON:

Q Morning, Mr. Berg.

A Good morning, Derek.

Q You received your Bachelor of Social Work from the University of Manitoba in 1980?

A I did.

Q And then in 1980 you began as a frontline family services worker at the Children's Aid Society of Manitoba?

A Central Manitoba, yeah.

Q Sorry, Central Manitoba.

A Yeah.

Q Then in '82 till August '85, you worked for the Alberta Social Services?

A That's correct.

THE COMMISSIONER: Mr. Olson, just speak into the mic, please.

MR. OLSON: Is that better?

THE COMMISSIONER: Yes.

BY MR. OLSON:

Q So you were -- were you actually in Alberta at that time?

A Yes, for about three -- little over three years.

I worked for the Alberta Social Services out of Peace River, Alberta.

Q Out of Peace River, okay.

A Yeah.

Q And then from August 1985 until January '89, you worked for the City of Winnipeg Social Services.

A That's correct.

Q And then from there you went to the Children's Aid Society of Eastern Manitoba?

A Um-hum.

Q And that was in a shared school position?

A That's correct.

Q Can you just explain what that, what that was?

A It was a shared school position with the Lord Selkirk School Division and the Children's Aid of Eastern, and we had a social work position that was based out of two schools, one in the East Selkirk area and one up at Walter Whyte School, working with children and families in the school system.

Q So you were a school social worker then?

A Officially, I was actually a child welfare worker, but the position was created between the school division and, and the agency at that time.

Q Okay. That was to deal with child welfare issues that arose with students in the school division?

A That's correct, but it was very much a preventative role.

Q Okay.

A Yeah.

Q Then from November 1992 you accepted a family services supervisory position at Children's Aid Society of Eastern Manitoba.

A That's correct.

Q Now, that's a predecessor of Winnipeg Child and Family Services?

A That's correct.

Q You held that position until 1999, at which time you were with Winnipeg Child and Family Services in the east area?

A That's correct.

Q Was that basically a continuation of the previous position, just a different agency?

A No, I was a permanent ward supervisor at that time.

Q In 1992.

A In 1992, I was the family service supervisor.

Q Okay.

A 1999, I was a permanent ward supervisor, and I was there from '99 until I went to the intake, 835 Portage, as assistant program manager in 2003.

Q 2003, and you remained in that position until May 16, 2005.

A That's correct.

Q It was during that time that you would have had -- you would have overseen some of the supervisors that were involved in this particular matter.

A That's correct.

Q From May 16, 2005 until April 2006, I understand you were -- now, were you seconded to the Animikii ...

A Yeah. Yes, I was seconded to a small agency, Animikii Child and Family. We had to develop and, and create and put the mandate together for that agency.

Q Okay. Just for the period of time you were the assistant program manager, who was your employer?

A When I was assistant program manager, it was Winnipeg Child and Family Services, yeah.

Q Was that the case when you were seconded to Animikii?

A Yes.

Q Okay. So you stayed at Winnipeg.

A That's correct.

Q Okay. Some point you became a service manager for Winnipeg Child and Family Services?

A Right.

Q Can you explain for the Commissioner what a

service manager does?

A I was actually an assistant program manager. Currently I'm a service manager, but at 835 Portage I was an assistant program manager, reporting to Pat Harrison, who was my program manager, and my responsibilities were to oversee half of the program functioning at 835 Portage. So I had one of the CRU teams, crisis response unit teams under me, I had two tier two intake teams under me, I had one abuse unit and two community program units where the respective supervisors reported directly to me.

Q Okay.

THE COMMISSIONER: And all of that was what years?

THE WITNESS: That would have been April -- I think I went the 28th of April in 2003, and I left there -- May 16th, 2005, I started at Animikii and that was a Monday, so it was the Friday before that.

BY MR. OLSON:

Q Just so -- and just so it's clear, you were assistant program manager between 2003 and 2005.

A That's correct.

Q You went to Animikii.

A Yes.

Q And then after Animikii became a service

manager --

A When I went to Animikii, I was, I was over there on secondment but it was more in a supervisory kind of a role --

Q Okay.

A -- at Animikii. And then I came back to Winnipeg Child and Family as a service manager.

Q When you came back as a -- for a service manager, was that a similar position to being assistant program manager?

A It's one, one level higher.

Q Okay, I see.

A Yeah.

Q Who did you report to as a service manager?

A I reported to Darlene MacDonald at Winnipeg Child and Family.

Q Is that the position you currently hold?

A Yes.

Q I also understand that you're the Winnipeg Child and Family Services representative on the ANCR steering committee?

A Yes, I am.

Q First of all, what is the ANCR steering committee?

A The ANCR steering committee was set up resultant

of the devolution process. All Nations Coordinated Response reports directly to the Southern Authority and there was a belief by standing committee and the four CEOs at standing committee that ANCR needed to have a steering committee made up of representatives of the 16, 17 agencies in the City of Winnipeg, and they meet quarterly to talk about the programs and functions at 835 Portage. We are the receivers of their work, so their work gets sent on to the various agencies and so we're there to give them feedback, you know, in regards to the, to the work that they're doing, the quality of the work, to troubleshoot areas that are problematic, and to see if we can continue to have a good process going forward with the designated intake agency, which ANCR is for the City of Winnipeg.

Q Okay. Is -- and is that more of a high level position in terms of you don't get down to what's happening on individual files, it's more policy and procedure?

A It's, it's kind of a bit of both. You know, there, there certainly is lots of folks representing different agencies that go there, so some of the individuals that go will raise scenarios, case scenarios that they feel are problematic or practices at ANCR that they feel don't, don't mesh with the practice in the receiving agency. So it's a bit of both.

Q Okay. Now, I want to ask you -- the next

questions I'm going to ask you are going to focus on your position as assistant program manager from 2003 to 2005.

A Okay.

Q First, did you receive any training for that position?

A Before I went into the ...

Q Before you went into the position.

A No.

Q How about after you went into the position?

A Just let me think. I certainly attended training, but not specific to that particular position.

Q Okay. So no specific training focused on being an assistant program manager.

A That's correct.

Q Was that sort of training available to, to you if you wanted it?

A Not specifically for assistant program managers, no.

Q Okay. Can you give the Commissioner an overview of what you did as a, as an assistant program manager?

A Sure. One of the things, I think, that, that happened, Rob and myself tried to do fairly early, is we tried to --

Q Just, just before you go on --

A Sorry.

Q -- you said Rob. We don't know who Rob is yet.

A Oh, I'm sorry. Rob Wilson was the other assistant program manager, and Patrick Harrison was the program manager.

Q Okay.

A So we made up the senior management group that was in existence at 835 Portage.

Q Just, just to give -- before you go on, and I'm sorry to interrupt you --

A Okay.

Q -- but just to give the Commissioner idea of, of how the setup worked, if we could pull up Exhibit 15 on the monitor, please?

THE COMMISSIONER: What was the name of the manager you said?

THE WITNESS: Patrick Harrison.

MR. OLSON: Now, Mr. Commissioner, this is a document we've looked at previously. You'll see that the headings at the top of the document have the date, the social worker, supervisor, assistant program manager, program manager, et cetera.

THE COMMISSIONER: And what ...

MR. OLSON: So it's basic -- this is Exhibit 15.

THE COMMISSIONER: Exhibit 15.

MR. OLSON: Fifteen.

THE COMMISSIONER: All right.

MR. OLSON: So this is basically the chain of command at the relevant times according to openings on, on Phoenix's file.

BY MR. OLSON:

Q You appear first February 28, 2003.

MR. OLSON: Sorry, go to the next page, please. And if you could just show the whole page on the screen?

Okay, that's good.

BY MR. OLSON:

Q Do you see where I'm referring to?

A Yes.

Q So you appear, it's --

THE COMMISSIONER: Where, where, where -- I don't.

MR. OLSON: It's this -- if you look at the first column, Mr. Commissioner, the date would be February 28, 2003.

THE COMMISSIONER: Yes.

MR. OLSON: Sorry, 28.

THE COMMISSIONER: I see.

MR. OLSON: Okay.

THE COMMISSIONER: Yes.

MR. OLSON: And you see next to that there's Laura Forrest. She would have been the worker involved at that --

THE COMMISSIONER: Yes.

MR. OLSON: -- that time, and then there's Andrew Orobko --

THE COMMISSIONER: Yes.

MR. OLSON: -- who would have been her supervisor.

THE COMMISSIONER: Yes.

MR. OLSON: And then the next column, it's split between Rhonda Warren and Dan Berg.

THE COMMISSIONER: Yes.

MR. OLSON: And it says Dan Berg after March 22nd, 2003.

THE WITNESS: Yeah, that, that's when it was announced in the agency that we were the successful candidates, but we didn't go there till, till April.

BY MR. OLSON:

Q Till April, okay.

A Yeah.

Q So you -- as of April 2003, you would have been the assistant program manager, and then in terms of organizational structure, this is where you would have fit

in, between the supervisors of CRU and intake, and the program manager --

A That's --

Q -- who was Patrick Harrison.

A That's correct. That's correct.

Q Okay. And then -- so you would have reported to Patrick Harrison?

A That's correct.

Q And he would have reported to Elaine Gelmon, and so on.

A I think Pat reported to Linda Trigg.

Q Okay.

A If I remember correctly.

Q And she was the CEO at that time?

A That's correct, yes.

Q Okay. So that should give an indication of where you fit in.

A Yes.

Q So if you want to just continue on, based, based on that understanding.

A Okay. Derek, could you ask me that question one more time?

Q I was just asking you to give us a -- the Commissioner an overview of what you did as assistant program manager.

A Okay. When we, when we first went to 835 Portage, early on we, we set aside a team day to meet with the supervisors. We had kind of three or four agenda items, so I'd like to start there if I could, Derek.

One of the things that we wanted to do was to make sure that all of the supervisors, you know, first of all, knew who Pat was and Rob was and I was. You know, joining their team at 835 Portage, we were, were wanting to be clear with them in our respective roles. Rob and I were responsible -- Rob Wilson and I were responsible for overseeing the service that was provided at 835 Portage so we wanted the supervisors to know that we had expectations from them to ensure that we were kept abreast of any of the high risk cases that we were managing at 835 Portage. So that could have been child deaths, both past and present; could have been high risk, politically sensitive cases that were in the media; would have been involvement with cases that were high profile that were in the General Authority or there were ministerial inquiries about; and, and serious complaints. So we were trying to establish, you know, a connection with the supervisors but at the same time letting them know that we needed to be, you know, in the loop of the know of information and we wanted to have a very, you know, hands-on management style, you know, with the supervisors and with the staff.

THE COMMISSIONER: Did you and Wilson each have so many supervisors reporting to you?

THE WITNESS: That's correct. Rob had exactly the same programs, Mr. Commissioner, that I did. I just had one more community unit supervisor that reported to me than Rob did.

THE COMMISSIONER: How many did you have in all?

THE WITNESS: I had one CRU, two intake, one abuse, four; two community, six.

BY MR. OLSON:

Q So one CRU, two intake -- two intake and one abuse --

A And two community.

Q -- and then two community.

A That's correct.

Q And Mr. Wilson would have had a similar -- or sorry, Mr. Harrison would have had a similar -- he would have overseen a similar number of people?

A Rob Wilson --

Q Sorry.

A Yeah, Rob Wilson would have had five supervisors that would have reported directly to him, and then Patrick as the -- Patrick Harrison as the CEO, he was our CEO but he also would oversee the after-hours program. So that was

Pat's additional responsibilities.

Q Okay. And just before you go on, was, was the introduction of yourself and Mr. Wilson a significant change from what the structure was prior to that?

A I'm, I'm not sure that we, we really knew entirely what the structure was prior to that. There was actually only one assistant program manager that had been working over at 835 Portage before the three of us went there. It was a huge, huge responsibility, a very, very big job, and I think we were really short-staffed in terms of senior management and the view was that, you know, we needed to change that. There were a lot of morale related challenges. So we were going there, the three of us, and trying to do a lot more hands-on work than was even possible for the one previous individual who was there. I mean, my hat is off to her for the work that she did and the job that she did, but it was, it was a very big responsibility and it was clearly enough work for three people, if not for more.

Q So, so prior to your coming on --

A Yes.

Q -- and -- you, Wilson, and Harrison, it was -- Rhonda Warren would have been the assistant program manager.

A That's correct.

Q And you're saying under her there were a lot of morality -- sorry, there were a lot of morale --

A I, I want to be careful how I choose my words. Under her responsibility, I think she was, she was understaffed at the senior management level. I believe she did the best she could. I think she did, you know, a remarkable job given there was only one person there that was doing a job that it took three of us to do. And at the end of the day, she did a very nice handoff of the information for us in regards to, you know, who are our managers, how was the place functioning, troubleshooting the issues that we needed to pay attention to. So I think it was a really nice bridge that she was able to do for us.

Q I see. When you came on, what was the morale in the units you were supervising like?

A It was a struggle. It was a struggle when we first came on. The morale was, was, was down. I think the supervisors were -- in some senses, they had, they had kind of come together, but perhaps they'd come together not in a way to work hand in hand with senior management. So our, our walk initially over there was -- it was kind of a delicate walk, you know, when we first were all together there.

Q Do you -- was it your impression that the morale at the time affected the services being provided?

A Well, I think morale always affects the service. Did it place children at risk? No. But was there areas certainly where we, when there was three of us there, could potentially do some things differently in terms of having a different ability to be able to support the supervisors in the respective units and, and, and make, you know, an effort to ensure that we could try to change that from more of a negative morale base to more of a positive morale base. It was certainly high on Pat's priority list, and that was sort of the direction that he provided to Rob and I, that he wanted us to run the service, he expected us to be out there, he expected us to be down with the teams, with the supervisors, and be available to them independent of what their needs are, whether they were case related or personnel related.

Q In terms of your, your role there, what did you see your position being in terms of your relationship with the supervisors of the intake and abuse units and the other units you were overseeing?

A Yeah. Probably, probably different for each one, Derek, to be honest with you. For the crisis response unit, it was, you know, a 24-hour immediate response of all the high-risk related cases that were coming into the branch and the new cases, so my involvement there with the CRU supervisor was much more of a crisis kind of

consultation basis. Every day, at least two or three times a day, I'm probably talking to the CRU supervisor because the volume that they were dealing with and the crisis nature of the calls that they were dealing with, supervisor wanted to have an extra head to bounce things off. And if we had to make some branch related, you know, decisions at that point in time that would have been my, my role and my area of responsibility.

Q Okay. That CRU supervisor, by the way, that was Diva Faria.

A It was Diva Faria for both Rob and I when we both started, and then we were fortunate enough to be able to expand the CRU program and hire a second CRU supervisor.

Q Okay. And that --

A But initially that was --

Q -- would have been Ms. Verrier.

A That was, yeah, Diana Verrier.

Q And he would have been -- sorry, she would have been on Rob Wilson's --

A Yes, she reported directly to Rob.

Q Okay.

A And then for --

THE COMMISSIONER: Who, who did?

THE WITNESS: Diana Verrier.

THE COMMISSIONER: But Faria, Faria to you.

THE WITNESS: Yes, Diva Faria reported directly to me.

THE COMMISSIONER: Yes.

THE WITNESS: And then tier two intake would have been less crisis driven because they're generally managing cases for a four- to eight-week period of time, but they, they, too, would be receiving the cases from CRU so the challenge of their cases were there as well.

So I would be there in my role there to do consultations with the supervisors. I would be there to meet with them on a supervisory related capacity for some sit-down supervision. And beyond that, we would -- if they were at training, if they had double duties, they had court, if they had different experiences, both Rob and I would take turns, you know, with our respective teams going in and covering the units, so meeting with the staff, discussing cases, signing off closures and transfers, that kind of thing.

BY MR. OLSON:

Q So you would do some of that work?

A Yes, for sure.

Q Would you -- would it be accurate to describe your position as a supervisor of those supervisors?

A That's correct.

Q So as their supervisor, would you be responsible, then, for ensuring that they, for example, were applying best practices in the way they handled cases and their workers, and followed policies and --

A As best as possible, Derek. I mean, they were a very, very skilled, experienced group of supervisors that we had --

THE COMMISSIONER: Are you talking about the intake supervisors?

THE WITNESS: I'm referring actually to all the supervisors.

MR. OLSON: All, right.

THE WITNESS: All of them.

MR. OLSON: Right.

THE WITNESS: They have lots of experience. They were very experienced. They were very skilled in their respective areas --

THE COMMISSIONER: But let me just interrupt you.

THE WITNESS: Sorry, sir.

THE COMMISSIONER: After you detailed your relationship with the CRU supervisor --

THE WITNESS: Right.

THE COMMISSIONER: -- you then went on and --

THE WITNESS: Yes.

THE COMMISSIONER: -- talked abut the others.

And were those the --

THE WITNESS: Yes.

THE COMMISSIONER: -- intake supervisors you --

THE WITNESS: Yes.

THE COMMISSIONER: -- were talking about?

THE WITNESS: Yes, sir.

THE COMMISSIONER: All right. That's fine.

THE WITNESS: Intake supervisors.

THE COMMISSIONER: Right.

THE WITNESS: Yes. And then abuse supervisors would be next and, you know, abuse supervisors, it's a real speciality, the area that they work in. I, myself, going there had a fairly steep learning curve, to be very honest with you. I had --

BY MR. OLSON:

Q You had no experience in abuse prior to that?

A I had experience in abuse, but not in the volume of abuse that they were dealing with at 835 Portage. And so the front end intake -- I'd run intake units before, but more as a family service supervisor rurally. The magnitude of the intake program at 835 Portage compared to anything that I had experienced was, was definitely an opportunity for me to grow and expand, you know, in a number of areas. And you certainly had enough cases there to get experience

fairly quickly.

Q As, as the type of supervisor your -- you were, you had the -- you could see what was happening at CRU at the CRU level.

A Yes.

Q You could also see what was happening at the intake level --

A Yes.

Q -- and abuse intake, right?

A Yes.

Q So if there were issues or problems in, in any of those or how they're working together, that's -- you would, you would be the person who would know that.

A Both Rob and I would be the people that would know that. On my area of responsibility, we both had established a consistent approach. We expected the supervisors, that if there were challenges on case transfers, that at the end of the day if they were not able to resolve the professionally, respectfully, then they were to call a halt. If they had differences of opinion, they were to involve either of us as the respective assistant program managers, and then we would become involved.

Q Okay. And I don't want to get too far ahead of myself --

A Okay.

Q -- and that's something we will talk about.
A Okay, for sure.
Q Just, just in terms of your role, I'm just trying to get an idea of, of --
A You bet.
Q -- what it is you would do.
A Yeah, yeah.
Q So the supervisors of the units that you oversaw would come to you when they had issues or problems --
A Right.
Q -- or whatever.
A Right.
Q And you would provide supervision and direction to them.
A That's correct.
Q Okay.
A I would also perhaps get some of those calls or complaints or concerns from the minister's office directly to me, Derek, and then I would go looking for them and do the same thing.
Q And address it with them --
A Exactly.
Q -- and that's part of your role and responsibility.
A That's correct, yes.

Q Now, if you saw a supervisor of yours or a worker that they were supervising, someone on the front lines -- a CRU worker, whatever -- that wasn't meeting standards or meeting best practice, would you address that with the supervisor?

A I think my, my, my general style and my general practice would be to put that responsibility back directly on the supervisor. That would have been the super's -- supervisor's responsibility. They had program descriptions. They were very clear on what the roles and functions and the expectations were around the day-to-day delivery of service in the respective units. Certainly, if something came to my attention that they weren't aware of, it wouldn't be my, my style to go back directly to their staff. I would always go back and work through them and, and provide the information to them, and then leave that with them to deal directly with their staff about -- unless it was a situation of such magnitude that I felt I needed to be part of that.

Q Okay. But you would take those kinds of issues to the supervisor involved --

A Definitely.

Q -- and ask them to address it.

A Definitely, yes.

Q And if, if the supervisor proves deficient in

what they know or how they're responding, is it your job then to educate them and steer the in the right direction?

A For sure.

Q Okay.

A Or to join, or to join with them with their staff, if, if they were comfortable with that and accepting of that.

Q Would you do any sort of performance reviews of the supervisors?

A I wasn't really at 835 Portage for that long, so when I did the performance reviews was after my second year there, just before I left. There were many changes happening for all the staff with the devolution process. Many staff were, were going other places to different jobs, and Pat Harrison, Rob Wilson, and myself decided that one of the things that would make some sense was for us to meet with the management group and for us to develop performance appraisals for each of the respective positions at 835 Portage. And so we actually did performance appraisals on all our supervisors, and our supervisors did on all their staff, before many of us left to go on to other different positions. That was something that was important to the three of us to do.

Q So that would have been, then, just around mid-May 2005?

A Yes, it would have been around March, April, May --

Q Okay.

A -- of 2005.

Q So between when you came in on March 2003 and March or May 2005, there would have been no formal appraisals of the supervisors.

A I did not do a formal appraisal of the supervisors. Certainly would have had sit-down dialogues with them, but nothing formally where pen touched paper and it was become part of a permanent HR record.

Q Just in terms of evaluating how the supervisors were doing, I mean, because you, you would want to gauge their competence as well, right?

A Absolutely, yeah.

Q How would you do that?

A Well, I would do that a number of ways. I mean, first of all, I'm probably dealing with -- other than the community program, Derek, I'm probably dealing with all of the other supervisors at least on a daily or every second day basis, and it was just part of who I am by nature. And as a manager, I go around each morning, say hello to people, ask them how they're doing, make a connection, see if they've got anything on that day that they need to touch base with me about, make sure they know what my schedule is

about, I get a sense of what their schedule is about.

And then if they have activity related to cases that they want to search me out about, or personnel related issues, or anything involving the day-to-day running of their respective unit, we had -- initially when we went, the entire system was structured on an ad hoc supervision basis where you basically had an open door policy and they initiated and they came to you when they felt that there was a need. I personally wasn't comfortable with that, to be honest with you. It's a necessary function of all the programs at 835.

But as a new person and a new manager and a new senior manager coming to 835 Portage, I really didn't know a lot of the staff at 835 Portage so it wasn't conducive to really getting to know staff the way setting a supervision time where you have an hour and a half, two hour sit-down every three weeks, or once a month, where you sit down, you get to know each other, you get to know a little bit about someone's, you know, professional outlook on the business, their personal lives and what's going on, and at the same time it's, it's uninterrupted protected time. So --

Q So you're saying you weren't comfortable when you first came on with the fact that there was no formal supervision.

A Exactly. Exactly. It was all ad hoc, and so

Pat, Rob, and myself sat down, we talked about that, and then Rob and I instituted the, the need for formal sit-down supervision with our supervisors, and then we put that as an expectation on the supervisors that we expected them to do that with their staff.

Q You told the supervisors that.

A Absolutely.

Q Because they weren't doing that previously?

A No. It was, it was all on an ad hoc crisis basis that they were doing their supervision.

Q I see. So when a -- only when a problem arose, a crisis arose, would a --

A Yes.

Q -- worker get the supervision.

A Generally speaking, yes.

Q Okay. That, you're saying, was not best practices.

A I don't think that's, that's necessarily what we needed to do. We just needed to remind people that, yes, we're busy and, yes, there's a huge volume that we're managing, but this is an equal priority, to make sure that we make time for each other so that when -- we're building relationships with each other by doing that.

Q Okay.

A And sometimes, sometimes when you have to make a

decision that a case is going to go from CRU, CRU up to tier two intake, and you're telling the tier two intake supervisor you have to take this case, you want to make sure you have a bit of a relationship with them because you just, you just lost some things at that moment.

Q When you came on as the assistant program manager and oversaw these units, did you know any of these workers previously, any of the supervisors or their staff?

A I have to be honest with you, not that many.

Q Okay.

A I was shocked at how many I didn't know. A lot more that I didn't know than I did know.

Q Okay. So in terms of their practice or what they did or their experience, you wouldn't have that knowledge coming in.

A That's correct.

Q And you wouldn't also have any performance reviews or anything to look at to, to see how they were or what their -- what issues there might be.

A None were produced for me when I arrived at 835 Portage.

Q Okay. You said you, you and Rob Wilson and Patrick Harrison met to talk about some sort of a formalized, sit-down, protected supervision time.

A Yes.

Q When was that?

A I, I would, I would be speculating, Derek, but I would say probably within the first couple months that I joined Pat and Rob at 835 Portage.

Q Okay.

A So I would probably say summer, fall, probably, of, of 2003.

Q Was there a formalized decision that this would be implemented?

A It would have been communicated directly to the supervisors in one of our regular CRU, intake, abuse, and community meetings that we held on a monthly basis.

Q Okay. Would -- did that actually -- did that protected supervision, as you call it, did that actually ever come into being?

A Yes.

Q When was that?

A Well, I'd like to believe it came into being shortly after we discussed it and, and agreed on it, but certain places are harder to implement that. It's harder to implement at CRU that practice than it is -- because of the volume and the immediacy of everything that they're dealing with, so it was a little bit more of a struggle at CRU. And CRU at the time, when Rob, Pat, and I were there initially, was only a single supervisor and she was

covering ten CRU staff.

Q Who was that?

A That was Diva Faria.

Q Okay.

A And so we didn't have the same expectation of her being able to do these additional tasks until such time as we expanded the program to 12 CRU staff and two CRU supervisors, and then that expectation was there for her equal to what it was to the other supervisors.

Q So when you came on as the program manager, was there a staff shortage, then, in CRU?

A There, there wasn't a staff shortage. They, they had -- over the years, the CRU had grown to being ten CRU staff and an EA liaison worker for children transitioning from Child and Family Services into the welfare system. Part of the meeting that I described earlier that we had where we talked about the importance of the nature of cases we wanted the supervisors to be clear with us about, we also talked about CRU, the crisis response unit, and some thoughts that Pat, Rob, and I had, as well as Diva had, and the changes that we wanted to incorporate at CRU by expanding it to 12 CRU staff and breaking that into two teams, one team of six that would be answering the phones and a backup team of six that would be dealing with the callouts.

Q Is that something you implemented as a --

A Yes, we did.

Q Okay.

A But we implemented that only when we had a second CRU supervisor in place.

Q And what was the impetus for that change?

A Well, I think it -- there was probably a number of reasons for it. First and foremost, I think it was very unrealistic for us to believe that one supervisor could actually -- as competent and skilled as Diva was, it was unfair to have one supervisor supervising ten staff on such a high risk and high volume area of our business, so we knew we needed to change that.

We were confident that we can move some staff around. We had to take some inventory a little bit on all the programs first, but we actually moved two staff out of two of the abuse units and put two additional staff at CRU so we could have a comparable six staff for each of the CRU units, and we asked Diva to take the lead.

It was actually my responsibility for that meeting. I was presenting on CRU with Diva and Rob Wilson was presenting, you know, our -- on our best spots in regards to proposed changes at tier two intake around managing workload. So Diva and I put a presentation together, we presented to the management group, and at the

end of the day our recommendations were adopted and the agreement was that we would have two CRU units, two supervisors. They would be on -- three days they would be on phones, one unit, and then they would flip over and they would become the backup unit and the backup unit would then go on phones. And that's a program that has remained consistent to the way they operate today at ANCR.

Q It's still in place.

A Yes. It's, it's a little bigger today, like everything's a little bigger than we were there, but it's, it's the same model.

Q When you say it was unrealistic to have one supervisor handling that many workers and that volume of calls --

A Yes.

Q -- there were a lot of calls coming in, there were always a lot of calls coming in.

A Oh, yes.

Q And one supervisor couldn't possibly be familiar with everything going on. Is that --

A Well, I don't know if I'd want to say that. This was a pretty remarkable supervisor that we had in place there, very, very skilled, very experienced. But any best practice approach around staffing of staff members to supervisory ratio is usually around one to six. So one to

ten, you're really stretching that envelope for that particular supervisor and there is a danger that you are going to not be able to deal with the volume because you're only one person and therefore you could be missing some things in terms of cases because you simply can't get to everybody.

Q In terms of the business of intake, which you said was a little less busy, it sounds like you were saying --

A Yes.

Q -- than CRU --

A Yes.

Q -- was -- do I have that right, intake was less busy than CRU typically?

A Definitely, yes.

Q And did that remain the case even when you made the change to having two CRU supervisors and two teams?

A Yeah. It, it, it wouldn't change the volume of what's coming through the door in terms of business. The fact that there was two supervisors, you're, you're, you're much better able to deal with the ad hoc crisis related consults that ten staff -- and now 12 staff, as we had increased it to -- are going to need. So this way you're responsible for six staff, it's a reasonable workload, and at the end of the day the staff can get what they need in

terms of the immediacy of availability of the supervisor to do crisis consultation with them on, on immediate case responses.

Q In terms of the time required to do some preliminary investigation on a new referral, would, would typically a CRU worker have more time to do that than an intake worker, or would an intake worker have more time?

A Well, clearly, an intake worker would have more time. A CRU worker was generally dealing with emergent and up to 24-hour responses. On occasion we would keep cases 48 hours. Sometimes we would keep cases even a short period of time longer than that, but those were scenarios only where we believed that we could close the case off by end -- you know, a certain piece of work that we could still do so the case wouldn't have to go up to intake. But our timeline was -- generally it was, you know, zero hours to 24 hours, 48 tops, whereas tier two intake, on receiving a case they could keep a case open from six weeks to eight weeks. Sometimes they would keep cases even longer than that.

Q Okay. So the intention was if a case could be dealt with within 48 hours, the max, it would be dealt with at CRU. Right?

A Absolutely, but generally it would be up to 24 hours, generally.

Q Generally up to 24.

A Yes.

Q And beyond that it should go to intake.

A Yes. And anything 48 hours and beyond would be going to tier two intake or abuse.

Q And so it's not the case that CRU was really an investigation unit, whereas intake was more of an in-depth unit. That would be wrong.

A No, no, it's a fair, it's a fair comparison. There's, there's no question it was an investigative unit. I mean, they were, they were doing safety assessments, you know, on cases that met the bar to be open to the branch where there were protection concerns related to children. So they were investigators.

Their job was different than intake. They didn't have the time to form relationships with families. They had to be extremely skilled at going out and assessing where the family was at, assessing where the children were at, you know, determining, you know, priority responses and their assessments, determining whether kids were safe or not safe. And, and if they were unsafe, they were to do safety plans they needed to put in place, come back, then, with a recommendation the very next day to the supervisor on, on closure or on going to the backup unit at CRU.

Q So you reported to Patrick Harrison.

A That's correct.

Q And what type of -- how would you report to him? What would you be reporting to him?

A My reporting structure to Pat was more around -- from a case perspective, it was more around making sure that Pat was in the loop of, of politically and media sensitive related cases. Pat travelled in some circles that, you know, in the, in the, in the higher up level, government-wise, that Rob and I did not go to some of the meetings that Pat did. So Pat at times would be asked about certain things so we wanted to make sure that he was in the loop of information.

He knew what some of the higher risk matters that we were managing were all about. Sometimes we would go to Pat to say, Look, you know, I'm not quite sure, I think we'd better put all our heads together on that, and sometimes Pat, Rob, and myself would all sit together because the risk was so great. We wanted to have, you know, a final line position that all three of us were involved with. So that's how I'd report to Pat on a, on a case perspective.

Q So in terms of cases, neither yourself nor Pat would be aware of what I'll call the routine or typical types of cases dealt with by your unit.

A No, certainly not.

Q Okay. We've heard a number of workers in this particular matter call this, for lack of a better term, a routine or a typical type of a case.

A Referring to the --

Q The Phoenix Sinclair matter.

A -- the Phoenix Sinclair case? If you ask my opinion, 32 years in child welfare, I would say it's probably -- it was average.

Q Okay.

A Slightly above average in terms of risk possibly in some areas at certain points in the case, certainly up until the point where Karl Wesley McKay became involved, and I think that might have tipped the balance at that point in terms of it being a higher risk.

Q Higher risk case.

THE COMMISSIONER: Mr. Olson, I didn't hear your question. I wish you could speak better into that mic. What were you speaking about, what you just said?

THE WITNESS: Mr. Olson asked me in regards to this particular case that we're speaking to today --

THE COMMISSIONER: Yes.

THE WITNESS: -- whether in comparison to the cases that came in as new intakes into our program, whether it would have been at the high risk end or average risk, sort of medium risk type case.

THE COMMISSIONER: And what was your answer?

THE WITNESS: And my answer was that generally it would have been, it would have been different at different points but, generally speaking, it would have been an average case in terms of the degree of severity and vulnerability of the children that we were dealing with. And I said that it would have been an increased risk when Karl Wesley McKay entered the picture.

THE COMMISSIONER: Thank you.

BY MR. OLSON:

Q Now, even if it was an increased risk at the point McKay entered the picture, still not the type of case that you would have had knowledge about, is it?

A That would have been the call of the supervisor, to determine whether or not she felt there was a need for a consultation. That particular case has been managed at, at several of our programs. Some of the programs were under my responsibility. You know, CRU, Central intake, Northwest intake, had managed that particular case; they were under my area of responsibility. And then there was involvement from, from Central intake and there was involvement from the other CRU unit, and those were under Rob Wilson's area of responsibility.

Q Okay. Were you ever -- prior to the discovery of

the death of Phoenix Sinclair, did -- were you ever aware of this case, made aware of this case?

A No. No, I was not.

Q When you talk about your responsibility, am I right that as a -- as the assistant program manager you would have been responsible ultimately for the work done by the units you supervised?

A Absolutely.

Q When we were talking about your meetings with Mr. Harrison, were these meetings you would make notes of? Would you have notes taken during the meetings?

A Yeah, I probably would have taken notes if they were -- certainly, if they were direction related meetings where I was getting direction from my immediate superior in regards to what we needed to do planning-wise on the case, I certainly would have taken notes of that and I would have followed up with the respective supervisor to ensure that the supervisor would have known that, you know, this is the best thoughts of Rob, Pat, and myself, and we think we need to go in this direction, what do you think, and then try to see if I could get the supervisor on board with that direction.

Q Why is it you would keep notes of those types of meetings?

A Well, I think it's -- well, certainly, from my

perspective, it's, it's for consistency of information exchange, first and foremost --

Q Right.

A -- from myself back to the supervisor. But also, then, it becomes -- once, once you involve a higher up level -- like Patrick was our final line of responsibility as the program manager, then that's a decision on behalf of the entire 835 Portage office and all our programs. So ultimately, that's, that's not just direction, that's a directive. So at the end of the day I would want to make sure I captured that accurately, make sure I relayed that accurately to the supervisor, make sure there was an agreement with the supervisor that we were all on the same page, and then let the supervisor do what they needed to do in terms of implementing that with their staff.

Q So if I'm, if I'm hearing what you're saying correctly, you want to capture what you discuss with Mr. Harrison and then relay that accurately to the supervisor, make sure the supervisor captures what you're telling --

A Absolutely.

Q -- the supervisor.

A Absolutely. And then my practice on that would have been to expect the supervisor to do the same thing that I did, so --

Q To also take notes.

A So they would take notes and then they would have the same information I had, and then those notes would be come part of, you know, of our record between themselves and the worker.

Q So there'd be a record of what was discussed.

A Yes.

Q Those notes, I take it, would be preserved, then?

A I'd hope they would be preserved. We had a -- well, I'm sure you're going to speak to me about our supervision policy and that, but there, there was a supervision policy that, that did come in at, at some point in our tenure there.

Q So we were talking first about the notes that you would take when you had meetings with Mr. Harrison.

A Right.

Q Now, you would have -- you said you would have had meetings then with the supervisors of the various units.

A Yes.

Q And during those meetings you would expect them to take notes as well?

A Absolutely.

Q And as you would take notes as well.

A Yeah, well, I would -- in that particular scenario I'd be bringing the notes. But I would expect

them -- when we're having a conversation, I would be reminding them, you need to take notes if this is a directive because we need to ensure that this is followed. I wouldn't generally go to Pat or to Rob, you know, if -- unless I was, you know, really stuck on a case. I would go to Pat to let him know what would be happening, but if I went to Pat because I was stuck on a case and asked for Rob to be a part of that, it's because it's something that's really complicated and I want an extra set of heads in there from the most experienced people that I was working with.

Q When the supervisors had meetings with their workers, was the expectation that they would keep notes of those meetings as well?

A That's, that's a, that's a really hard question for me to, to answer. I almost have to answer it by program. In the CRU, most of your discussion related to cases is on an ad hoc crisis related basis. So they are -- you know, they're, they're doing a CFSIS opening, they're doing a CRU after-hours report where their information and their direction in regards to what they're doing on the case is captured, and, and they're doing a safety assessment. And then individual workers were expected, as well, to do, to do contact notes. So, yeah, there, there would be an expectation there, but it would be different

than when they sat down for that monthly supervision where they might, you know, talk about a lot of different things beyond just the cases. So at CRU, that, that would be my thought for the CRU, and it'd be different for intake.

Q Okay. Well, just for CRU. I'm not --

A Sure.

Q -- sure if I, if I understood what your answer was.

A Right. Okay.

Q The question was whether there'd be an expectation that both the supervisor and the worker would keep notes of those discussions.

A If it was pertinent related cases where they were sitting down, having a discussion, yes. If it was a hallway conversation, I can guarantee you, in the system today and back then, not all those conversations would get recorded and find their way into the record.

Q Okay. And that being the case, that, that's what was happening, you're saying?

A No, some of that did happen, but some of the ad hoc that I'm referring to would be a worker coming with their information outside the supervisor's office, coming in for five minutes, doing a consult. That would be, you know, something that there, there may, indeed, be a record kept of that.

Q We've heard a fair amount of evidence from different workers and supervisors that there were notes kept but they were often shredded either when they left the agency or when a file was closed. Is that something you're aware of?

A You know, it was a bit of a, it was a bit of a struggle. We didn't have a very -- I want to say this respectfully, but we didn't have a very good supervision policy around note taking and record keeping and my hat's off to the people that, that were on the committee that brought in the supervision policy, because it was, it was a lot of work. They, they did a lot of, of, of excellent work and there was direction that was supplied in regards to the supervision policy and what you should be doing with your notes. I'm not sure that it was uniformly agreed with across all the supervisors and senior managers within the branch. And a year later a survey --

THE COMMISSIONER: When was it brought in?

THE WITNESS: In 2004, I believe.

BY MR. OLSON:

Q Maybe what I can do is -- and I was going to take you to there, now.

A Okay.

Q There's a supervision policy at Commission

disclosure 1634. I think you have it in -- on your desk.

A Okay.

Q Beginning at page 29040.

MR. OLSON: You should have that as well, Mr. Commissioner.

THE COMMISSIONER: Yes, I have it.

THE WITNESS: Sorry, Derek, could you say that number one more time?

BY MR. OLSON:

Q The Commission disclosure is 1634.

A Okay.

Q And then the page is 29040.

A I have 1635. I don't have four.

Q If you look on the screen in front of you --

A Okay.

Q -- you should see it.

A I'll -- I can do it on the screen, that's fine.

Q Is this -- take a look at it and tell me, is that the supervision policy you're talking about? You'll see implementation date on the top there of March 1st, 2004.

A Could you do me a favour, Derek, and just run through it all for me, just scroll down?

Q Scroll through it?

THE COMMISSIONER: Why don't you -- do you want

to borrow my copy?

THE WITNESS: No, sir, this is fine. I just wanted to see it all before I commented.

Yes, that's, that's --

BY MR. OLSON:

Q That's the one.

A -- supervision policy, yeah.

Q So this came in in 2004, then?

A That's correct.

Q Would you have been made aware of it?

A Certainly, I was made aware of it, the supervision policy, and it, and it did follow training that a number of the supervisors and managers went to by a reputable child welfare person by the name of Tony Morrison.

Q Um-hum.

A And that was sort of the, the precursor to us realizing that we were behind and we needed to put a supervision policy in place.

Q Did you attend that training as well?

A Unfortunately, I didn't. I covered at 835 Portage. I believe we let Rob go, and Pat and I stayed behind to cover.

Q Okay. Did the supervisors of the units you were

supervising go to that training?

A As many as we could send there went to the training. There were a couple of opportunities for the training. Some had gone earlier to the Tony Morrison training, and then we brought him back. And then -- so a number of them had gone. But if I was asked did all the supervisors or all the senior managers get to attend, the answer would be no. Certainly, the majority did.

Q So this supervision policy was brought into place because of that.

A Yes.

Q That training.

A Yes.

Q And it was intended to apply to whom?

A I'm sorry?

Q Who, who did you -- who does the supervision policy apply to, or who did it apply to?

A I mean, it applied -- the supervision policy in my read of it applied to supervisors that were directly, directly supervising line staff across all our programs at Winnipeg Child and Family Services.

Q So CRU supervisors like Ms. Faria.

A Yes.

Q And, and intake supervisors like Carolyn Parsons.

A Yes. Andy Orobko. All, all of them, and then

all of the family service supervisors across Winnipeg Child and Family and, you know, permanent ward supervisors and foster care. Everybody that was supervising, you know, was expected to follow this policy.

I should be careful with that. Probably shouldn't have said foster care because they didn't -- foster care probably would not have had the same degree of expectation. It was still a model that they could follow and they could use, but because they -- they're not case carrying. It was, it was more aimed at, at case carrying, is my understanding, the supervision policy.

Q Did you follow this policy?

A You know, without sounding arrogant, we had already decided -- Pat, Rob, and I -- before this policy came in and before there was any discussions around this, we had instituted at 835 Portage our own kind of supervision policy around meeting with the supervisors on a regular basis, having the supervisors meet with their staff on a regular basis, so a good portion of this work we, we had started. But this was just, this was just a much more thorough process. So we did take the supervision policy, review it with our respective supervisors and, you know, and, you know, implemented this to the best of our abilities. It was a really good piece of work.

Q So you would have met with your -- the

supervisors that you supervised --

A Yes.

Q -- and reviewed this policy with them.

A Yes.

Q That would have been some time around March 1st, 2004?

A It certainly would have been after March 1st, 2004, but give or take two or three months following, for sure.

Q Then would you expect your supervisors to comply with the policy?

A That was the expectation, is that people would be in compliance with the supervision policy. The only, the only piece of business on the supervision policy that was a challenge to implement was the, the supervisory contracts that were done at the end. They were very, very prescriptive and found a lot of the experienced supervisors would prefer to just negotiate, you know, your meeting times, you know, with yourself and your respective supervisors, as opposed to having such a detailed kind of supervisor-supervisee contract. So that part was a struggle to be implemented.

And, and it's recently even to this day been a struggle and currently my, my supervisors in my, you know, working relationship today, we don't have that particular

piece of the supervision policy in place. And there, there isn't really an agreement across our senior supervisors to do that, but the majority of the rest of it was, was able to be implemented.

Q So on the page in front of you, if we could scroll down under the heading Components, where it says Nature of Supervision. It says:

> "While supervision or consultation occasionally needs to occur on an ad-hoc basis, quality supervision occurs when supervisor and supervisee meet regularly, for an interrupted period of time, to facilitate the development of a strong supervisory relationship."

That's something that you thought -- you said you thought was a good idea that should be implemented.

A Yes, and is an excellent idea, for sure, and really necessary.

Q It says:

> "The frequency of regular supervision varies around the

supervision needs of both the staff and Supervisor. At a minimum, scheduled supervision should occur on a monthly basis."

A That's, that's what was recommended.

Q Was that --

A That we --

Q And was that, that being followed after the implementation of this policy?

A I can't speak to all the units, but I can speak to the units under my responsibility. And as, as much as possible, we were trying to adhere to the supervisory meeting with staff on a monthly basis. It was a struggle at CRU to do that.

Q Okay. As the supervisor of a -- supervisor of CRU --

A Yes.

Q -- what steps did you take to ensure it was being done, if any?

A Well, I certainly would have talked to my supervisor about, you know, whether or not she was able to, you know, meet with each of the staff on a monthly basis and still handle the volume of business that she was doing. And we might, we might aim for her doing that every five

weeks. We might have compromised on that, as opposed to, you know, forcing her to do this monthly and then overwhelming her workload more than it already was.

Q But in terms of your ensuring it was being followed to some degree, at least, even if it was every five weeks, did you do anything to --

A It was part of my -- part of my review with my supervisors in supervision was to ask them about the supervision policy and how we were doing that. Sometimes our supervisors -- not all of them, but the ones that were very organized, had supervision schedules that we would get a copy, either Rob for some of his folks or me back in -- from my folks in regards to actual schedules that they had set up, which is, which is what we, we really were aiming for, that they had schedules, they were fulfilling that obligation and, you know, and we had some ...

Q Would -- do you recall whether or not Ms. Faria would have had a schedule like you're describing?

A No, I don't believe so.

Q She didn't have one.

A No.

Q Was there a reason why she wouldn't have?

A Hers probably would have been just more on the fact that we, we couldn't even do it once a month given the volume that they were dealing with there, and, and we

needed to kind of move that, you know, to once, once every five weeks or so, but I know that she made every effort to try to do that with her staff. Wasn't always possible.

Q What is it you would have expected a supervisor, like Ms. Faria, for example, to review in these supervision sessions?

A Well, I'm sure in her supervision sessions that she would have a better idea than I do of what she should be doing from a CRU perspective, but I'm assuming part of the, the supervision session would be to see if they've got any current existing cases that they're working on that are challenging or problematic.

Certainly, if there was any activity that came from the General Authority or the Advocate's office or the Ombudsman's office or, or, or many of the other overseeing -- oversight bodies that we have, if the supervisor had those concerns that were brought to her attention, if they weren't immediate and pressing she may just keep those for when they met at supervision where they would have that hour and a half to two hour uninterrupted time, you know, to, to, to chat about in supervision.

Other things would be around performance, you know, how were the workers doing, what was their skill set, what were they good at, what did they have some shortcomings on, what were their training needs in regards

to those shortcomings, did they need to be partnered up sometimes on callouts with a more experienced worker.

And then if there were any HR personnel issues, you know, do we have somebody who's not getting to work, has, you know, got all sorts of personal life problems that are spilling over into the workplace.

It would be that entire range, and I, and I'm sure she could speak to more detail than I can, but, but that would be the, the, the average range of what you'd be looking at.

Q Did you have an expectation that the supervisors would go through standards and best practice with the workers at these supervision sessions?

A It's a very fair question, Derek. This -- I'm trying to think how to answer that. I have to answer that by the fact that the standards that we had in place at the time were -- I'm just going to use the word problematic.

I like to be very, you know, careful with ensuring that I was, you know, up on the standards that were in place at the time. We had '99 case management standards. We used to get new standards practically every year that were given to us. Almost all of them were in draft; we were given mixed messages about whether or not we were to use them or not use them. Some senior managers said we were to use them, the 2001 standards, as an

example. Others said, no, that with the coming on board of a standing committee that training was going to be provided for ourselves as managers, for our supervisors, for our staff. So at the end of the day, those standards -- we didn't even choose to circulate those standards.

So the '99 standards, the late 2004, early 2005 standards, we knew much more solidly going in that those were standards that were going to stay for a period of time so we, we shared that information with our supervisors and, and our supervisors were given -- we received -- from our General Authority I received a very, very large binder. It was probably about yea thick, and it had the Child Welfare Act and it had the child welfare regulations; it had the Authorities Act and the authorities regulations; the Adoption Act, the adoption regulations. It had the child abuse guidelines, the child abuse regulations. It had the '99 standards and it had the beginning of the standards that were going to stick around for a while in 2004.

So I made that -- a copy of that available to Rob Wilson, who was my, my partner at the time, and we made that package of information available to all the supervisors so that they had, you know, a really well put together, organized document of the Act, the regulations, the standards that were in place at the time. Those were made available to all our supervisors.

Q So did you -- would you expect your supervisors, then, to be familiar with those standards, the 1999 standards, the Act, the regulations? Aren't those what would govern practice?

A I have to say yes and no to that. I think everybody would -- in the room would probably agree that, yes, they do govern our practice and the way that we do business, but we had policies and procedures, we had program manuals that were developed and designed with those standards in mind when we put them together. So we were operating -- all your standards talk about minimum standards that you have to deliver on and I think for the majority of all our programs, our policies, our procedures, we had a greater expectation that was built into what we were doing than actually what existed in the standards.

So would I expect my supervisors to know that binder, that thick, cold? No, but I would expect them to know how to be able to find what they needed in those standards at various times. And generally, their day-to-day governance of what they did on a day-to-day basis would have been, would have been provided through our intake program manual and our March 2004 child welfare orientation manual.

Q I see. And --

A That would have guided our practice, I think,

more than anything else.

Q And those manuals, then, they were based on the standards, right?

A They were, they were based on the standards and they were based on best practice within the standards. So at CRU, as an example, the standards would say that -- in a typical protection investigation at CRU and at intake, the standard would say that you had to see the person or the family within a ten day timeline. That was not good enough for us because we were dealing with protection stuff that was way too risky to leave for ten days. So we had set up our own system where at the end of the day we were responding to cases within 24 hours, within 48 hours, within five days, and within ten days. So --

Q So I just want to be sure I'm understanding you correctly. The standards were sort of basic. You went beyond the standards --

A Yes, yes.

Q -- and, and in doing that, sometimes you'd have -- the workers or your supervisors would have to use their professional judgment, making a decision.

A Yes, that's correct.

Q They'd also have to use common sense.

A That last one's a funny word for me. I really don't know what it is. You know, in the first six months

that I was over there people would say that my previous twenty-some years that maybe I was lacking common sense. It's a word I want to steer clear of because the, the, the programs and policies guided our, our folks. The supervisors were trained, very skilled, very knowledgeable, very experienced in those areas, and felt a real comfort zone in guiding people in the area where they had developed an expertise. So I was real confident, you know, in the supervisors I had under my responsibility.

Q Just to go back, though, the standards in place, was there any confusion between 1999 and 2004 as to which standards would have been in effect?

A There was no confusion in my mind that I wasn't going to use the 2001 standards, but there was confusion throughout the system and throughout all the higher ups and through the child protection branch, and mixed messages given in writing to Winnipeg Child and Family after numerous requests over a three-year period. We consistently got different responses in regards to direction of what we should do.

Q But if Ms. Faria came to you, for example, as her supervisor and said, You know, Dan, I'm, I'm not sure which standards I should be applying here, 1999 or 2001, you could -- you would be able to tell her the answer.

A Her and I would both agree that we would be using

the 1999 standards and we would use the 2004 standards, and we wouldn't use the 2001 standards because they were never passed.

Q Okay. And in any case you probably want to make sure you're meeting at least the highest standard and the one the most appropriate for the circumstances.

A Well, again, I want to repeat as much as possible, we hope that we would have had that in our regular day-to-day practice, you know, in terms of our programs and procedures, which, again, were, were, were scripted and developed with the standards in mind when they were developed.

Q Okay. If a particular standard wouldn't be in accordance with what you view as best practice, you, you'd, you'd strive for best practice, then?

A Well, we, we'd certainly highlight that for the staff if we found anything like that, and definitely there would have been a discussion then around what would our practice be if they -- if we were lower on the response time than what was in the standards.

Q You, you expected supervisors, though, to adhere to best practice.

A Absolutely.

Q And you expected their workers to adhere to best practice.

A Yes.

Q Wasn't that you're just trying to do the basic work, the bare minimum. It was, you're trying to do the best, best practice.

A Best practice for each of the programs, which would be somewhat different depending on which program you're in.

Q Okay. Just getting back to the document that's on the screen in front of you, that's the supervision policy. Under Recording and Documentation --

MR. OLSON: At the bottom of the page, Mr. Commissioner.

BY MR. OLSON:

Q -- it says both -- this is 29040 -- says:

> "Both supervisor and staff will maintain notes regarding key decisions and themes that are discussed in supervision. The supervisor will maintain supervision records that will document case discussions and discussions regarding the employee's professional

development and personnel issues."

That was a pretty clear policy.

A Yes.

Q Was, was this policy -- was it your understanding that your supervisors would be following this policy?

A That would have, that would have been my understanding. I mean, that was the expectation, and that's what we were trained on and that's what we followed up with the supervisors on, and that was, you know, a policy that we were, we were asked to, to implement.

Q Do you know if they actually did adhere to the policy?

A Do I know that each of my supervisors adhered to all aspects of the supervision policy or --

Q To --

A -- related to just the note taking?

Q Just to the recording and note taking.

A Just to the recording. I believe that the majority of the supervisors adhered to that.

Q Okay. Some didn't, though?

A I'm not sure. I'm hearing through some of the information exchange that's come out resultant of the proceedings that, that there had been some challenges with that, so I, I can't say for certainty.

Q You've, you've heard about supervisors destroying their notes or shredding notes, or not even keeping notes.

A Yeah, I've heard some of that.

Q That wouldn't have adhered to this policy.

A No.

Q Would you have been aware of that at the time that you were supervisor of any these -- any of the supervisors that you supervised?

A That supervisors were shredding or destroying file related information?

Q Shredding, destroying, or not even keeping notes in the first place.

A I would, I would not have been aware of that.

Q Had you been aware, what would you have done about it?

A Well, shredding or destroying file related information would have been somewhat problematic for us because the file information is fairly important to be keeping as part of the record because we never know if a situation is, is going to result in a court related process, we never know whether a matter is going to escalate and we're going to be in an inquest or we're going to be in an inquiry, so that --

Q This situation today.

A Yeah. So that information becomes part of the

client record.

Q Yeah.

A So it's, it's important, you know, to have that information.

Q Those notes would, would be important to either know what was said or what was done or what wasn't said or what wasn't done.

A Absolutely. Now, in terms of whether or not -- you had asked me as well whether or not people were adhering to all the things that were on the supervision policy in terms of, you know, documenting that full range of responsibilities. I'm not sure if all my supervisors were.

Q In terms of ensuring that supervisors were complying with those policies, though, that would fall on you in terms of being their supervisor.

A Correct.

Q We've, we've heard that the work -- some of the workers -- any of the workers involved in this particular matter would take handwritten notes or other notes that would eventually get transferred into CFSIS or into a report, and then the notes would be discarded or destroyed. Do you know, are you able to say as a supervisor, whether that was in accordance with policy, that practice?

A Are -- which program are you referring to, Derek?

Q Pardon me?

A Which program are you referring to? Are you talking across the board?

Q Either CRU or intake, tier two.

A I'm not, I'm not sure and I'm reticent to give you an answer on that. But as long as there was an accuracy of the record that was available -- I know that, for me, there'd need to be an accuracy of the record that's available. Generally, generally, we kept both. Generally, we kept it on CFSIS and generally we had also put that on the hard copy file. But the, the, the question about there being a record, absolutely.

Q So having a record is key.

A Yeah.

Q An accurate record is key.

A Yes.

Q And so if the notes that workers were taking differed from what they put in the report --

A Yes.

Q -- that could be problematic.

A Well, I'll give you an example. Like, today it's a different world we're all in. The social workers we're hiring today are totally computer savvy so we're having social workers today that instead of doing duplication of recording and duplication of note taking, a lot of them are

doing their note taking directly onto the system, you know, and at the end of the day it saves them time when they're challenged with so many other workload related challenges.

Q Sure.

A So as long as --

Q But, but with reference to what was occurring at that time --

A Yeah.

Q -- when workers were keeping notes --

A Yeah.

Q -- and the question is just simply, if there was more in the notes they were keeping that were eventually getting destroyed or shredded or whatever --

A Yeah.

Q -- if there was more information in those notes than what finds their way into a report or the documentation, that could be problematic.

A Yes. And it should have been kept, then, if there was more information.

Q Okay.

A However it was recorded, it should have been kept.

Q I take it that's not something you would have been aware of.

A I'm not aware that that happened, no.

Q Okay. I've asked you a few questions about performance reviews. We've heard workers, I think, say that they either received no performance reviews or they hadn't received -- you know, maybe one or two in an eight-year period, not, not very regularly or consistently. And I think you, you agreed with me that that was the case.

A Yes.

Q Based on that, were issues with respect to workers' performance ever brought to your attention?

A Certainly, yes. Big part of my, part of my role, you know, having that larger number of units reporting directly to me is that if there were performance concerns, be they case related performance issues or be they personnel related concerns in regards to staff, I would have been the first person in line, then, that my respective supervisors would have spoken to.

Together we would have determined whether it was something that we could resolve at our level through meetings directly with the staff and resolve the issues and get them back on track. If they were not something that I believed that we could resolve at my level, then we would contact human resources, and the human resources department would assign an HR consultant to join the supervisor and myself to plan accordingly in regards to potential progressive discipline steps that we needed to take on a go

forward basis.

Q With respect to the Phoenix Sinclair matter, were any performance concerns brought to your attention with respect to any of the workers?

A Not in the time that I was at 835 Portage. Remember, I was, I was gone from 835 Portage when the case surfaced in regards to the child's death.

Q Okay. Since, since you, you left -- and you've been involved in this process, you've seen all the various reports and documents that related to your workers' involvement in this matter.

A Certainly seen all the documents related to, to my workers' involvement in this matter.

Q Based on what you've reviewed, would you have expected any, anything in those documents, any of the -- any, anything in those documents to have raised performance issues with respect to the work done?

A It's, it's a tough comment. I mean, you're talking -- I had lots of staff that were involved, lots of different scenarios. There's nothing that I read that jumps out at me that would cause me to believe that if I were there and if I was the manager that I would believe that I had a performance issue to discipline a staff over. I, I would say no to that.

MR. OLSON: I notice it's just about eleven

o'clock. Would it be an appropriate time to break?

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

(BRIEF RECESS)

THE COMMISSIONER: All right, Mr. Olson.

BY MR. OLSON:

Q We've heard a number of workers talk about workload, that workload was high, very high, in both intake and CRU. Was that your experience as well?

A Yes. I would have to say that it was, it was high in both CRU and intake, and it was higher at different periods of time when I was there than others.

Q During the period beginning of 2005, was it -- how was the workload?

A It was, it was quite busy in, in 2005. At that time there were, there were a lot of things happening. We were preparing for, for devolution at that time. Winnipeg Child and Family Services had a number of, of their family service units -- in fact, all their 16 family service units, some from the org chart on December of 2004 -- that were closed down to do file recording in preparation for the file transfers to the First Nation agencies. So at

that time we at that time were referring to one preservation unit initially from late December, early January, till around the end of January, and then at that point in time we were referring to two other preservation units from February going forward until the devolution process was over around the 25th of April, so it was, it was really, it was really a busy time.

Q There was a lot going on in the --

A Yeah.

Q -- agency at the time.

A There was a lot going on across the agency at that time.

Q Do you recall Ms. Faria coming to you with workload concerns?

A Well, I, I would have to say yes, definitely coming to me with, with workload concerns. Certainly, when I first started, when she had ten staff, you know, under her responsibility, you know, there were lots of workload related challenges she had managing that.

And, you know, and periodically throughout I think there were workload related challenges, particularly -- you know, I think people managed -- they managed when they had their full staff complement, but you couldn't always guarantee that you were going to have your full staff complement. You know, when staff were sick or staff

were on leave and -- those were particularly problematic or challenging times because you need to as much as possible keep six people at all times on the phones over at CRU to keep it running.

Q So she did come to you, though, with these workload concerns.

A Yes.

Q Did you attempt to address them in any way?

A Well, workload at CRU, as I spoke to earlier, what we did from very early on when we went there was expand the CRU to 12 staff from ten. We --

Q That would have been right at the beginning, right, of your --

A That would have been within first six months, about the first six months. Would have been around October that --

Q But she still --

A -- we did that.

Q -- came to you, though, with workload issues following that?

A Yes. Yes. So there were workload issues there. We expanded, got the second CRU supervisor. We tried wherever possible to take advantage of opportunities that were there. We were approached by the Metis authority and they had a number of students that needed to get years -- a

year of experience under their, their, their belts before they could graduate and be full-fledged social workers, so we, we brought some of that staff on board to assist at tier two intake and at CRU. We took students also from --

THE COMMISSIONER: Was this during the transition?

THE WITNESS: From -- I think Derek's just saying from 2003 going forward, yes, in that period. And we had students that we also took from, from Winnipeg Child and Family to assist us with extra workload. We would bring in casual staff. Pat had -- through his leadership and also through his oversee of the after-hours program, he had access to bringing in after-hours staff on a casual basis.

BY MR. OLSON:

Q Into CRU?

A We could bring casual staff at time into CRU.

Q Did that happen very often?

A Not that often, but we, we did try to do that over, over peak periods. Sometimes they helped out at tier two intake; I believe sometimes they helped out at CRU.

Q Anything else? You mentioned students and ...

A Think for a second ...

I, I think, you know, workload is -- one is about cases, but also is about sort of supervisory kind of

support. You know, when we had the second supervisor, that, that made it easier. We tried to get the supervisory -- the two units to, to meet themselves to take training related activities. When supervisors were at training, we would, we would cover off their units so to assist with coverage and, and workload challenges in that regard.

Q So am I right, though, that the -- it was -- you brought on some students to help out and you also very infrequently had some casual staff, you're saying, would come in to help?

A Sometimes we would bring in casual staff.

Q My understanding was that casual staff weren't brought in until later on. Do you know when that was occurring?

A I'm not, I'm not sure when we did that. I, I know that we had brought in casual staff when we first started. Over the summer and into September we brought three casual staff in to assist, but I believe that was at tier two intake our very first summer there. But we used to try to do that over the, over the summer breaks, but I don't believe we did that the first summer that we were there.

Q Okay. Whose responsibility was it to ensure that the workload was balanced and reasonable for the workers?

A Well, I, I think that was certainly my

responsibility in conjunction with the supervisor. You're looking at workload across, you know, your entire organization. You're not just looking at it one program at a time. So if you've got, if you've got challenges, say, at CRU, we took -- the two staff that we brought in to build the CRU up from ten to 12 staff, we actually took the two staff from the abuse unit. So from the abuse unit, they had less staff, CRU got more staff.

Q So these weren't actually additional hires. They were brought from within another unit.

A That's correct. Those were, those were existing staff that we brought in.

Q So by doing that, you, you decrease somewhat the capacity of abuse, but you increase the capacity of CRU.

A We would, we would sit together and we would look at what the priorities were, and if we had workload challenges in a particular area, then we would put our heads together and come up with the best plan we thought that we could do for the resources that we had.

We were able to hire -- we hired Mark Szewczyk early on in the process, around September of '03. He assisted at CRU for a period of time, but eventually the workload where we wanted him to go to was at Northwest intake. So we, we looked at the workload across the intake program and placed him at Northwest intake.

Q Okay.

A So it was one of those where you're -- if you've got an opportunity to get staff, took advantage of that, we'd prioritize what our priority hot spot areas were where we needed to try to put additional staff in.

Q Okay. The evidence we heard from Ms. Faria was that workload remained an issue right up till she -- right up till when she left and went to Animikii.

A Yes.

Q Why not just hire some new staff from outside of the existing system?

A Well, I wasn't in charge of that decision, to make that decision whether we could hire new staff. Certainly, we would bring those kinds of concerns forward to senior management, have that discussion with Pat. Pat would have those wider discussions at the senior management table at Winnipeg Child and Family. I --

THE COMMISSIONER: Was the situation such that you saw the need for more new staff?

THE WITNESS: It's, it's hard to say. I mean, ANCR today, you know, had an assessment unit besides the two CRU staff that they had working down as part of the, the CRU initiative but they've since moved. That particular unit has now become an additional intake unit.

So it was, it was busy. Was it, was it too busy

beyond what people could manage when they were at full staff? I don't think so. They seemed to be managing okay, and I certainly wasn't hearing a lot that they couldn't manage when they were at full staff complement. I think the problem came in is that if they had a run on people, you know, that had left and gone to another job, and then they had people that were sick, now you start to get down two or three people. That was, that was where CRU started to get into an area where the workload was greater than what they could manage.

BY MR. OLSON:

Q Could that -- that would have an impact, I take it, then, on the services provided to clients.

A It could have an impact because we always wanted to have six people on phones, and so if you had six people on callout, if everybody was there, all 12 of them, and you lost three staff, so that means you leave six, you know, that are still on phones and you actually have only three additional staff, then, you've got to deal with your callouts at that point. So --

Q So some callers might go without the service they need during that period.

A We, we'd prioritize. If at the end of the day there were situations that were significant enough, we

always had the ability at our level, if it was brought to our attention, that we could make some decisions about moving cases around from CRU to tier two intake if -- you know, if we had something was really urgent. But if it, if it wasn't urgent, it's possible that it got a delayed response time.

Q Ms. Faria testified that work -- that she thought workload would have had an impact on the services delivered to Phoenix Sinclair, but she wasn't aware that workload placed Phoenix Sinclair at risk. Are you able to comment on that?

A Can you do that one more time for me, please?

Q She stated that workload had an impact on the services provided to Phoenix Sinclair, but she wasn't aware that workload placed Phoenix Sinclair at risk. Is that something you'd agree with?

A Well, I'd have to look at the case and, and in, in my, in my -- look at the case. Are you referencing any particular time of the case, are you talking about the March incident, or what specifically are you reference --

Q Talking about the services provided to Phoenix Sinclair and her family.

A It's hard for me to answer that question that way.

Q Okay, you --

A I mean, I'd have to trust her judgment, I mean, you know, the life of that case was -- it was over a lengthy period of time, with many, many openings, you know, and closings that happened, family service or at CRU. So it's difficult for me to generalize, and if that's the response she's given, I think she was closer to this case than I would have been, so I --

Q So you're not in a position to disagree with that.

A I'm not in a position probably even to comment because I wasn't involved directly with the case.

Q You said, with respect to workload, you had, you had a meeting with a senior manager.

A Right.

Q Who was that? Who was the manager?

A Who was the senior manager?

Q That you met with?

A About?

Q Workload issues.

A Well, we would have discussed that amongst ourselves. Rob and Pat and I used to -- we had individual supervision. We would have touch base times ourselves to catch up on what's going on across the units, and if there were workload related challenges, those would be discussed amongst the three of us and we would brainstorm what were

possible options that we could do.

Q Did, did any of you bring the, the workload situation to the attention of senior management?

A Well, we were senior management there, but senior management for Winnipeg Child and Family Services, we, we left any of those kinds of decisions to Pat, but tried our best to try to keep him aware of what the challenges were across each of the programs.

Q Okay. But you couldn't bring on new staff yourself.

A I didn't have the authority to bring on new staff. You mean to hire new --

Q To hire new staff.

A -- staff myself? No, no. No, I didn't have that authority.

Q But could you make the request to do that?

A Sure.

Q Did you make that request?

A We certainly did make that request at various times, in particular around those peak periods, you know, where you've got, you know, holiday coverage over the summer holidays, over Christmas, over different places like that, and, and we were -- you know, quite frankly, I think we were quite successful at, at Pat being able to negotiate and get us additional support invariably at different

times.

Q That's what you referred to earlier, bringing on some students and --

A No. No, that's, that's --

Q Something different?

A That's bringing on someone to help out, say, for a six- to eight-week period over the summer months with a fixed number of hours.

Q Okay. So someone to replace a worker that was maybe --

A Might be on holidays, that kind of thing. And as I said, the first summer were brought -- we were able to get three staff the first summer, which was, which was really huge, and they continued on with us into September.

Q When would that have been, sorry?

A That would have been over the summer months and through into September of 2003.

Q 2003.

A Yes.

Q What about 2004?

A Again, I would have to probably suggest that it was more over those peak periods if we did get assistance in that time. I can't tell you for sure whether we did or didn't, but it would be generally over the summer months or those peak periods, you know, where we were staff down due

to holidays. Lots of times across the system were operated about 50 percent down over the summer months, so when you're 50 percent down somewhere like CRU, you have to plan into that.

Q Right.

A So ...

Q Despite whatever efforts you made, the workload always was a constant issue.

A Yeah, and I think it always will be. It's, it's, it's a very, very busy place.

Q The case specific reports -- and I understand you're familiar with them now -- they talk about the services provided to Phoenix and her family were generally provided on a crisis basis rather than as ongoing family service basis. Is that, is that something you agree with, having reviewed the documents?

A Well, the, the case was managed at both places. I mean, it was, it was managed, you know, at CRU, it was managed at family service, so there was ample opportunity for family service to manage, you know, the case in whatever way they saw fit. But certainly on a family service caseload, which is the bulk of where my experience has been over the years, is we can have families open for, you know, as long as we're working with the family. Some families we're with for two, three years. So they had a

much longer time frame and capacity to be able to work with the family. But the, the last -- I don't know exactly the last period of time that family service was involved, but at least probably 18 months, the last 18 months, the case appeared to me to be managed, you know, at CRU and at tier two intake and didn't go on over to family service.

Q Never got passed over to family service.

A It never got passed over to family service. The interventions and involvement and decisions around closure were made, and it didn't go to family service.

Q So, sorry --

A I don't know exactly where that period of time was.

Q Right. So for at least that period of time, though, it was managed more on a crisis basis rather than ongoing family service basis.

A It would have been managed on a crisis basis at CRU for sure, because that was all crisis driven. It would have been managed at intake on less of a crisis basis than it would have been managed at CRU, and that service is generally, you know, a six- to eight-week period of time. So I'm not sure that one would have been viewed as, as much crisis as you would see in the activity at CRU with the family.

Q Okay. Ask you about another document. This is

Commission disclosure 992, which starts at page 19625.

MR. OLSON: Just put that on the screen. Sorry, 19625.

BY MR. OLSON:

Q This is called the Winnipeg Child and Family Services, Intake Program Description and Procedures.

A You know what, the screen is so clear I'll just go from the screen.

THE COMMISSIONER: Well, I seem to have two copies of this.

THE WITNESS: Maybe you have mine? Just kidding.

THE COMMISSIONER: Do, do you want one? Why don't you take this?

THE WITNESS: You know what, I will take it. It's fairly lengthy, this one.

BY MR. OLSON:

Q Do you recognize this document?

A 0992. Yes.

Q Can you explain to the Commissioner what it is?

A It's the -- it's called the Intake Program Description and Procedures document. And basically, what the document is, is it's, it's kind of a compilation of the services that we had at that time at 835 Portage, with CRU

and tier two intake and abuse related services and abuse coordination related services.

THE COMMISSIONER: You said "at that time." What time?

THE WITNESS: When I was there from 2003 to 2005.

THE COMMISSIONER: Thank you.

BY MR. OLSON:

Q So would this be one of the policy manuals that would have governed sort of the practice at intake and CRU at the time?

A Yes, definitely.

Q When you go -- if you just go to page 19628 ...

A Okay.

Q This is crisis response unit and after-hours unit.

A Yes.

Q And it has a program description. I won't read it out for you, but you're familiar with that.

A Yes.

Q And does that basically describe the program at the time?

A Yes, it does.

Q Okay. And under Service Provision and Assessment, it says:

"With respect to the day-to-day provision of services the CRU and AHU will" ...

Talks about interfacing with intake and abuse units, responding to any crisis involving assessing and intervention in situations where a child may be at acute risk of abuse or neglect.

A Right.

Q "The CRU will respond to all situations where a response is required within 24 hours or within 48 hours (on cases not open to other agency units)."

You, you confirmed that for us before, that's how CRU operated.

A And I, I think I confirmed for you as well, though, that, generally speaking, we would have handled 24-hour related emergencies, not so much going to the 48 but we could go up to the 48.

Q Same document, if you go, please, to page 19634, under the heading -- it's the third heading there,

Recording Outline: Closings - CRU.

A What number are you under?

Q 19634.

A Okay. Okay.

Q Do you see where I'm referring to?

A Yes.

Q So this is talking about closing files at CRU.

A Right.

Q And this would be the, the procedure to follow then when a file is being considered for closing.

THE COMMISSIONER: Yes.

THE WITNESS: Yes.

A SHERIFF'S OFFICER: Is it possible for the witness to turn the microphone closer to his mouth? It's difficult to hear in the back.

THE WITNESS: Is that better?

MR. OLSON: Maybe just pull it up a little.

THE WITNESS: How's that?

A SHERIFF'S OFFICER: Better.

THE WITNESS: Okay.

A SHERIFF'S OFFICER: Thank you.

THE WITNESS: Thank you.

THE COMMISSIONER: Thank you. You keep us informed, Sheriff, if --

THE WITNESS: Yes.

THE COMMISSIONER: -- there's any more problems.
A SHERIFF'S OFFICER: Of course.
THE COMMISSIONER: Thank you.
THE WITNESS: Yes, Derek, thank you.

BY MR. OLSON:

Q Okay. So that -- your --
A Yes. It says that, that:

> "Cases warranting no response or no further response after AHU or CRU intervention may be closed. If there is a previous case history, a file review shall be conducted prior to closing."

Q That's something you were familiar with at the time as the program -- assistant, assistant program manager --
A Yes.
Q -- that period --
A Yes.
Q -- 2003 to 2005?
A Right.
Q Can you explain for the Commissioner, please,

what the last sentence means?

> "If there is a previous case history, a file review shall be conducted prior to closing."

First of all, when it talks about a previous case history, what's that referring to?

A That's referring to whether there was a previous involvement with this family prior to this most recent incident where we're making a decision to close.

Q I see. So in this particular case, we know that Ms. Kematch had long history with CFS, as did Mr. Sinclair. That would tell you that, that -- I mean, that would be an example of a previous history.

A Exactly.

Q And then it goes on to say, "a file review shall be conducted prior to closing"?

A Yes.

Q What does that mean?

A It means that you're expected before you close that case -- if you're dealing with Samantha's file, as an example, it's expected that you will go back and, and have a perusal of the information that was on that file prior to making the decision to close, and that could be part of the

CFSIS record, that could be part of the file records that we had in storage in the basement over at 835 Portage.

Q So partly CFSIS, partly copies of any hard copy file, right?

A Yeah.

Q How about related files?

A Well, it doesn't, it doesn't speak to all related files, so --

Q Okay.

A -- I, I would be more comfortable suggesting that it would be on the file you're currently working on that you would be closing.

Q So if you're looking at closing, for example, Samantha Kematch's case, you look at her file.

A Yes.

Q And does this mean you look at the entire history of the case?

A It, it's, it's, it's a look-see to see if there's anything there that still might be current in the way of concerns that would cause you to perhaps reconsider your decision --

Q That's the --

A -- to close.

Q -- purpose of doing this.

A That's, that's the purpose, yeah.

Q It's before you close, you want to make sure --
A Yeah.
Q -- that it's the right decision to make.
A Yeah.
Q That's why you look at the history.
A Yeah. I, I think that's a fair way to say it.
Q Based on that, you want to look at enough history to know if there are concerns still existing.
A It's, it's to, it's to ensure you know if there were risk concerns in the past, whether they were addressed, whether or not the current issues that have resurfaced that you've done the work on that you've made a decision to close, would be altered in any way by looking at past history.
Q Okay. And who, who is expected to do this review of the, the case history?
A I believe the workers -- we're talking CRU. I believe the workers would be doing that unless it was a case that came in for closure from after-hours. I believe the cases that came in from after-hours with a recommendation to close, which would have been reviewed by the CRU supervisor, I believe those files would have been pulled by the admin and the supervisor would review those closures.
Q Okay. All other cases, though, it's the worker

assigned the file.

A It's the worker, it's the worker and it's the supervisor, and I'm not sure if one of them owned that more than the other did.

Q Okay.

A But the information from after-hours generally would not have been assigned to anybody at that point because their recommendation would be closure, so the supervisor of CRU would look at those ones.

Q In terms of the timing of the -- this review, it says, it says, "a file review shall be conducted prior to closing." Is your understanding that that's when the review is to occur, just before the file's closed?

A I'm sure as, as quickly as the CRU supervisor could get to it.

Q Do you know whether or not this was being done?

A Well, it, it certainly, it certainly was being done, you know, on the information that came from after-hours, and I believe that that was a fairly regular occurrence that we did. Was it being done in, in every and all situations? I can't say that for absolute certainty, but that was the policy that was in place and that was the expectation.

THE COMMISSIONER: But was it the responsibility of the CRU worker or the supervisor of that worker, or

both?

THE WITNESS: I, I believe it was both unless it came as a closure from the after-hours unit --

THE COMMISSIONER: Yeah, I, I, I --

THE WITNESS: -- and then it --

THE COMMISSIONER: I understand that.

THE WITNESS: -- was the supervisor.

THE COMMISSIONER: You made that clear.

THE WITNESS: Yeah.

THE COMMISSIONER: But I'm talking about a case that --

THE WITNESS: Yeah.

THE COMMISSIONER: -- that didn't, didn't come with a recommendation for closure but was --

THE WITNESS: Yeah.

THE COMMISSIONER: -- taken up --

THE WITNESS: Yeah.

THE COMMISSIONER: -- for, for consideration by the CRU supervisor in assigning it to a worker.

THE WITNESS: Right.

THE COMMISSIONER: Then when it came time to close, in that short period of time --

THE WITNESS: Yes.

THE COMMISSIONER: -- whose responsibility --

THE WITNESS: Yes.

THE COMMISSIONER: -- was it under that provision?

THE WITNESS: Under your example, it would be the worker's responsibility to recommend closure on that existing case, and they would need to do that from one day of completing their report, and within two days the supervisor would have to do the closing on that case. But where I'm a little stuck is whether the worker -- I know the admins often used to go downstairs, pull the record, but I'm not sure if the worker reviewed it first or the supervisor. It's been seven years, I've kind of --

THE COMMISSIONER: That was my question --

THE WITNESS: I'm not sure.

THE COMMISSIONER: -- where that responsibility lay --

THE WITNESS: Yeah.

THE COMMISSIONER: -- with respect to --

THE WITNESS: Yeah.

THE COMMISSIONER: -- compliance with that sentence.

THE WITNESS: Yes, it's either, either worker or supervisor. Sorry, I'm not quite sure.

THE COMMISSIONER: Thank you.

BY MR. OLSON:

Q One of them had the responsibility to do that, though.

A Yes.

Q Just to ground it in the facts of this particular matter, we know that, for example, Mr. Zalevich recommended the closing of the, the file at CRU. You're aware -- and you're aware about the facts surrounding that from what you've read.

A In March of 2005?

Q In -- right, March 9, 2005.

A Yes, I'm aware of that.

Q In that case, would it be your expectation that a file review of this nature would have been conducted before the file was closed?

A Well, he certainly could have completed his report, put his recommendation in for closure, and the supervisor would then decide whether she supported that recommendation for closure. But in that window of time there, there should have been a review of that file to see if there was anything, past history-wise, that would have caused them both to reconsider whatever decision they made at that time.

Q And so I guess the corollary to that is that if this file review isn't conducted, it's not complying with the policy.

A That's correct.

Q Would you agree that this type of a file review is pretty important before closing a file?

A I think it's important.

Q Okay. And another example is where Ms. Wiebe -- Willox, now -- closed the file after speaking with the public health nurse, Mary Wu. You're familiar with that as well, right?

A I am, yes.

Q Would you expect the same sort of review to have been undertaken in that case?

A If I remember the case correctly, I believe that she had, had done a review with that file, if I remember it correctly, when she made the decision for that case to go up to tier two intake initially.

Q Okay. So the -- her decision, then, was to go up to tier two intake.

A It was -- I believe it was a 48-hour response, and the plan was for that case to go up to tier two intake.

Q Just to, just to keep looking at the -- this -- the document, the policy here, under (b) in that same section, says:

> "Generally speaking, if a matter may be resolved and the case

> closed with limited further intervention [you know] (a few phone calls or a field) the case may be kept by the CRU beyond 48 hours to facilitate the case disposal."

What, what -- in what circumstances would that be appropriate, rather than going to intake?

A That, that could be an example where the individuals have taken the call, for instance, at CRU on the phones, they have assessed the situation to be a matter that could be resolved in short order, and they make a decision to pass it to the callout unit. And the backup unit is then able to say: Look, I've got one more piece of business that I need to do on this case. I need to talk to the school. I'm satisfied with everything else that I've seen vis-à-vis the family, but I want to do a follow-up call with the school. It's five o'clock at night. Nobody's around the school. I've passed my 48 hours. I'm going to keep that till the next day. I'm going to follow up with the principal or the guidance counsellor at the school, and at the end of the day, now I'm satisfied that I have all the information I need and I'm going to make a decision to recommend to the supervisor closure.

That, that'd be the kind of example.

Q Right. So, logically, doesn't make any sense --

A Yeah.

Q -- sending it up to intake --

A No.

Q -- in that case because --

A No.

Q -- it can be closed pretty quickly.

A Yeah. And the same thing could be about demographic information that they need from various government offices that could be closed, that could be examples.

Q But whenever you close a case, you, you do want to make sure the children are safe.

A Well, when --

Q That would be the overriding concern.

A Yeah. I mean, whenever you close a case where there were protection concerns initially that were identified, yes, you want to, you want to make sure that you take a look at whatever information is available to you.

Q Okay. Look at the next one here, (c), says:

> "All cases opened to Intake, Abuse or any other unit shall remain

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

Was this, was this policy followed in practice?

A I, I believe we tried as much as possible to follow this policy. You know, an example of that would be that we assigned -- intake cases from CRU went to the respective four units based on geography. So you might have, say, the Central unit, which was under my responsibility at intake, and they might be three staff down. You might have put a response time on a family's situation, a client's situation that's referred that requires, you know, a 48-hour response. And so what could happen at that point is the intake supervisor could

approach the CRU supervisor, let them know about the staffing challenge that they have, and together make a decision whether or not that case could return back to CRU, whether there is one or two pieces that could be done in terms of the Central intake unit following up on and the CRU doing the rest. So sometimes it was negotiated, then, between the two supervisors, and that was strictly because every unit sort of took its turn staffing-wise where they were in staffing related challenges and were not up to full staff, staffing complement. And that's when they had difficulties meeting the expectations around workloads for the respective program.

Q That last sentence in this policy seems pretty clear. It comes after the section where it talks about returning and negotiating cases between the, the supervisors.

A Yes.

Q And it says:

> "Once cases are opened to an Intake or Abuse Unit they shall not be returned for the sole purpose of further information gathering."

Was that -- that part of this provision or policy, was that being followed?

A Yes, and no, because there were times if, if tier two intake, you know, one particular unit was getting more cases than they felt that they could manage, if, if you're sending me cases from CRU and I can negotiate with you around some things that are not complete in terms of the work that you've done, and you agree that you're at a full workload complement and you can handle the case coming back to CRU or remaining with CRU, then at the end of the day, you know, an intake supervisor might agree that, that that'd be okay with them if CRU took the case back. But you weren't supposed to do that strictly for information gathering.

Q Okay.

A And generally, as a rule, that, that wasn't allowed unless the CRU supervisor decided that for whatever reason -- you know, might be a slow, slow week for them, they might have all their staff there, they might feel sorry for the tier two unit that the case has gone to, and they might agree to take it back. And so sometimes they would make their own arrangement, and as long as they worked it out between the two of them, we were satisfied with that.

THE COMMISSIONER: Mr. Olson, I want to just get

something clarified.

THE WITNESS: Yes, sir.

THE COMMISSIONER: That, that speaks to cases being opened at intake.

THE WITNESS: Yeah.

THE COMMISSIONER: Is there such a situation of a case going to intake but it not being open but rather coming back to CRU?

THE WITNESS: Yes, there's -- and there certainly were in some of the examples, you know, in this case where --

THE COMMISSIONER: And what, what would prompt that to occur?

THE WITNESS: I think what would prompt that to occur sometimes would be that -- some of the examples that I gave would prompt that if they were staffing down and if they couldn't complete the callout in the response time that was recommended by CRU. If they said it's a 48-hour response or a five day response, and, and the tier two intake unit who has already received the case because it's been transferred up to them by the admin at CRU -- they just go on the computer system and transfer it to them -- and they might not be able to deploy the staff to be able to meet those needs in that time frame.

And they, they had instruction from us to, to be

careful not to change, at tier two intake, that response time, because they could change that response time and maybe in ten days they could do that, but the response time was based on the protection needs and the concerns that were assessed at CRU so we didn't, we didn't want them to change that time.

THE COMMISSIONER: Was there a requirement that if it was coming back unopened in intake, that the reason for it coming back unopen to CRU was taking place?

THE WITNESS: Yes. The, the rationale, you mean, being provided?

THE COMMISSIONER: Yes.

THE WITNESS: Yes, sir. They --

THE COMMISSIONER: Was there a form to be filled out?

THE WITNESS: Yeah, they had, they had to bring the file back down and talk with the CRU supervisor about the fact that they were not going to keep the file, and they had to work that out between the two of them.

THE COMMISSIONER: It would be a verbal communication.

THE WITNESS: It would be a verbal communication. Sometimes they brought the file with them just to have the information or in the hope that if you were the CRU supervisor you would take the case back.

THE COMMISSIONER: But the reason would be made known.

THE WITNESS: Yes, the reason would be made known to them.

THE COMMISSIONER: Thank you.

MR. OLSON: Thank you.

BY MR. OLSON:

Q I just want to, I want to explore that a little bit more.

A Yeah.

Q It says -- and we're looking at (c) here. It says, "Once cases are opened to an Intake or Abuse unit." Now, my understanding -- I, I could be wrong about this, but the file gets opened at CRU. Comes in, CRU deals with it, they open a file, they do their investigation, determine, okay, this is not a case for us, this is a case for intake, requires more than 48 hours, 24 hours.

A Yeah.

Q We're going to send it up.

A Yeah.

Q So the report's written up by CRU.

A Yes.

Q Have I got that right so far?

A Absolutely, yeah.

Q That case is already open.
A Well, it, it will go to the, the secretary to open it on CFSIS to the tier two intake unit.
Q Okay. So the worker who worked on the CRU case does a report. We've seen many examples of those CRU reports. They make a recommendation that the case be opened.
A Right.
Q Do they come up with a time -- a response time for the case?
A They, they will in their case disposition give their response time, and if it's, like you said, 48 hours or more, it would go up to tier two intake. There were two processes, though, that were happening.
Q Okay.
A That is one process, the one I'm describing to you, and, and usually we would use the two admin that were there at CRU at the time to assist with that.
Q Okay, let me just -- before you --
A Sorry.
Q -- explain both processes --
A Okay.
Q -- let me just finish where I was going with that.
A Sure.

Q Once a CRU report's handed in and the supervisor of CRU -- for example, Ms. Faria or Ms. Verrier -- signs off on the report, gets handed in to administrator --

A Yeah.

Q -- okay, that administrator opens a case on CFSIS --

A Yes.

Q -- the computer system.

A To tier two.

Q To tier two.

A Yeah.

Q Once that's, once that's entered into the system, it's opened to intake, right?

A That's right. It's, it's intake's case at that point.

Q That point.

A Yes.

Q And so when we look at the standard, the intake supervisor only becomes aware of that intake opening when it appears on their desk or however they access it, right?

A Yeah, the file will go up to them.

Q The file goes up, physically --

A Yes.

Q -- goes up to them.

A Yes.

Q That's when they become aware of it?

A Yes.

Q And once they become aware of that, they look at it -- and what this standard seems to be saying is they can't go: You know, I think there should be some more work done on this. I, I want you to gather some more demographic information. I want, you know, CRU to do additional work. I'm going to, I'm going to reject it and send it back down.

According to this policy, it seems to me that that shouldn't happen.

A Well, it says:

> "[It] shall not be returned for the sole purpose of further information gathering,"

but it does say in the above paragraph:

> "... except when the receiving unit cannot reasonably respond in the time frame required to ensure safety."

And that's where the second process comes in.

Diva and Diana always had to know, you know, what was going on in each of the four intake units staffing-wise, how backed up were they, you know, case-wise, what was happening for the two intake units the same, and then they would know at times that, Look, I'm going to send this to Andy Orobko's unit and they'd say, Oh, geez, Andy's two staff down. Rather than just do the regular process, they might -- she might take that case and she might go and -- go up to see Andy, have a discussion with him, and the two of them figure out how that's going to get managed. Is it going to stay, you know, at tier two intake? Is Andy able to do any pieces at all? Could CRU do -- CRU keep the case for another day or two and do a couple more pieces, and then send it to Andy? Some of those were negotiated related processes.

Q Now, would that occur before the case is ever opened in CFSIS?

A That --

Q The process that I explained about the administrator opening the case to intake.

A Yes. Your process, it would be opened by the admin on CFSIS and the hard copy file would go up to Andy. My second example to you, Diva would not take the file to Trudy Carpenter, her admin, and Trudy wouldn't even know about that. She would take that -- she would go up to Andy

so it's not on the CFSIS system open to tier two intake because --

Q So the --

A -- Trudy was our person that -- you know, Trudy or Jolene were the people that put the information on CFSIS for us at CRU.

Q Right. And just so we're perfectly clear -- and we probably are, but --

A Yeah.

Q -- just want to be sure.

A That's fair.

Q In, in an -- this example, Diva Faria -- for example, in, in the -- well, in the Buchkowski, it was -- Ms. Verrier was the supervisor.

A Right.

Q Ms. Verrier looks at it and she knows that it says open to intake.

A Yes.

Q Recommendation's open intake.

A Yes.

Q She can then make the decision, I, I know that intake is particularly busy right now --

A Yes.

Q -- so I'm going to walk this up to the, to the intake supervisor, Ms. Parsons or whoever it was --

A Yeah.

Q -- and see if they can take it or if they want us to do more work on it. Is that sort of how the -- how it would work?

A Well, or what she could do in that scenario -- they went out on a couple of calls, if I've got it straight in my mind, and they were not able to track down the family, put a response time on, sent it up, and I -- assuming they sent it up the first way we spoke of, through the admin and up to intake, and then intake would have had that case and had the responsibility for the case.

And it was unclear to me in the, in the reading of the record as to how the case ended up back at CRU, whether it was negotiated by, you know, the tier two intake supervisor with Diane Verrier, or whether it was negotiated between the tier two supervisor and Diva Faria, who ultimately had responsibility for the case with Chris Zalevich.

Q Right. And do you agree with me that on the facts that we have and what we know, there's no evidence of the case ever being open to intake on the system. Is that your understanding?

A I, I --

Q Or you don't know.

A -- honestly don't know. I just saw the paper

related --

Q Okay.

A -- record so I, I don't know. I didn't see the stuff related to the CFSIS, whether it was open.

Q But on the --

A I'm not sure.

Q -- paper related records -- and you're referring -- you were referring to the -- Mr. Buchkowski's record, and Mr. Zalevich's CRU report, right?

A Right.

Q And it doesn't say anywhere on there what happened with this case, how it got back down to Mr. Zalevich.

A Right. It just says that they transferred it to tier two intake, is what I recall.

Q Okay.

A If I'm off on that, I, I have to look at the records. I'm just going by memory.

Q That's fine. So if it's not reflected on the computer system -- just assume that for a moment -- what you're saying probably happened is somehow Ms. Faria agreed to do more work on, on the file in CRU, rather than have intake do the work.

A I, I would be, I would be speculating because it could have been, it could have been Diana Verrier with a

tier two intake supervisor, I'm not sure.

Q One of them would have negotiated, though, with the tier two supervisor --

A The --

Q -- as to how to handle the file.

A The tier two intake supervisor did not accept the case and it, and it ended up back at CRU, which means that somebody at CRU, one of the two supervisors, accepted the case back.

Q Okay. Now, when you talk about tier two not accepting the case, that suggests to me that it's -- and I don't want to put words into your mouth, but it sounds like more of a rejection of the case: We're not going to deal with it, you deal with it, CRU.

A Yes.

Q Is that how it worked in some cases?

A Well, it seems to be in this situation, because at the end of the day it appears to, at least on paper, have been referred to them, and then the commentary from CRU is it's not ended up with tier two intake, it's ended up with the callout unit at CRU.

Q Right. So -- but you don't know if that was a negotiation between --

A I really --

Q -- supervisors or not.

A I really wish I could help, but I don't have the answer to that.

Q We have heard -- we've heard some evidence, from Ms. Faria in particular, that there was this phrase, walk of shame.

A Right.

Q And she said that's a phrase that you used. Is that right?

A Well, I think you asked me that when I met with you guys the last time and with Commission counsel, and I think it's important for me to perhaps give, give a context around that, that term, walk of shame. Certainly, isn't a term that was used widely across 835 Portage.

Diva was struggling at times with getting a number of the supervisors to accept cases transferred from CRU and there was pressure always seemingly coming back CRU's direction to take the cases back. And one particular day I believe she'd been involved with the -- one of the abuse supervisors and things had escalated, you know, quite strongly. And her and I -- I met with her in supervision in my office and we talked about that.

And, first of all, I wanted to get a bit of a barometer check on, on how she was doing and what was going on because it was apparent to me that she was, you know, upset about what had transpired, you know, and, and she

felt, she felt strongly that, you know, once CRU made the decision to send a case anywhere, it, it should absolutely, you know, hundred percent of the time should stay there.

I commented to her that, you know, she looked, you know, she looked really beaten down that particular day. She looked like she was embarrassed and, and she was feeling bad about having to go back to her staff and basically say that good work that she believed had been done and she believed at the end of the day that, you know, the case should have gone up to, you know, to the abuse unit, as it turned out at that instance. And, and in my discussion with her, I said, So is it, is it embarrassing for you that you have to kind of walk the case back down, you know, to, to CRU and your staff will be wondering, like, sort of, you know, why as a manager aren't you able to make cases, you know, that we'd done the work on, go to any of the programs? Are the other program supervisors in charge of you or, or, you know, when our work is done shouldn't that speak for itself?

So I, I can't honestly tell you, at the end of the day, who coined the phrase, "walk of shame." It's an irrelevant comment. But at the end of the day, what's important about it is that there's been significant tension, you know, in the time where we were at CRU that the transfer points of cases have been a challenge. So

when CRU is running on, on, on, on all cylinders and has all 12 people there and they know another unit is in trouble, lots of times CRU -- Diva, Diana, their staff -- jump in, help the other people, you know, and take on more responsibility.

But there were -- and I'm going to say that there were a lot more times where both Rob, Rob Wilson and myself had to institute directives to the supervisors -- verbal directives, you know -- when we sat and met with them in our, in our team meetings, and said to them that we need to be careful because these debates about who's taking which case, I mean, these are families we're talking about. So we're, we're debating and we're not taking cases, and time is going on and families aren't being serviced, and that's not okay. So our messaging, you know, is what's really important, and that important messaging is you try to work it out amongst yourself. If you can't work it out amongst yourself, and it's a matter of child safety -- you know, response times not being done within the time frame that has been assessed at CRU, that's child safety.

So if those were the kinds of issues, all the supervisors were very clear that if it was under my area of responsibility, they could approach me. Got trickier when some were in my area of responsibility and some were in Rob's area of responsibility. In those scenarios, wherever

possible Rob and I would both meet with the two supervisors and we would figure it out, we would give a directive, make a decision, and get the case settled.

Q But this term, walk of shame, she said that's a term that you used. Would you have used that term, walk of shame?

A I believe in, in a dialogue with her that day, she said -- I said, You're embarrassed, it looks like you're, you're embarrassed and, and you look like you're shamed to go back to talk to your staff. How that got into the word "walk of shame," and how that got, you know, signifying at the end of the day that that was our pressure point, I can't speak to that. I, I didn't really have any conversations much beyond that other than with Diva in supervision. So whether it, whether it got generated other places ... But it, it was not common knowledge that was used all across 835 Portage. More so perhaps in Diva's unit, I'm not sure.

Q How that -- however you describe that process or that term, what it meant was that either abuse intake or regular tier two intake rejected the file, they weren't going with the recommendation of CRU to open the file, right?

A Right. And remember, there's a difference with abuse than there is with tier two intake.

Q Okay.

A Because abuse is, is -- it's really complicated and complex work. So even in, in the orientation manual and in, in, you know, this intake procedural manual when you look at abuse, there are times where we had extremely serious abuse situations and if abuse, you know, had the staffing component to deal with that, we would take that case -- Diva or Diana -- they would walk upstairs, they would talk to the abuse people, and if the abuse people had the staffing complement to manage that, they would take that case right now, immediately.

Q Okay.

A And --

Q For intake, though, that wasn't happening? There wasn't a walk of shame? Cases would go up and they would get accepted or negotiated back down?

A I mean, both processes happened, but abuse was different. There was many more walks from the supervisor and they just weren't -- the first response we talked about with tier two intake where you would go to Trudy, Trudy would put that automatically on the system and send it to tier two intake, we didn't do that near as much with abuse. Usually --

Q Okay.

A -- the abuse -- maybe if it was a straight-up

real predictable kind of situation in abuse we might have done that. But generally, when you're talking about foster home abuse investigations which might take three or four months to complete, are extremely complicated and need to be managed carefully, a lot of those were walked up by the supervisor.

Q My understanding of the evidence we've heard to date -- of course, I could be wrong, but my understanding is that the, the facts of this particular matter, Phoenix Sinclair's matter, wouldn't have qualified it as an abuse case or abuse referral. It never would have been sent to abuse intake.

A That's correct.

Q Okay. So you agree with me on that.

A Yes. Yes, you're right.

Q So this case would have been what workers described as a fairly typical routine sort of matter, and you agreed with that before, right?

A Yes, average.

Q So this average sort of case is going to go, the recommendation is that it be sent to intake.

A That's correct.

Q Which means tier two intake.

A That's correct.

Q Normally you're saying that would be done through

the process I describe, where it goes through Trudy Carpenter, the administrative person --

A Right.

Q -- to open on the computer, and that's how the intake supervisor learns of it.

A Yes.

Q Here we don't know what happened --

A Right.

Q -- because there's not a record.

A That's right.

Q So for some, some reason the speculation's been that, that intake rejected the file.

A That's, that's what was on Richard Buchkowski's notes, and he appeared in his notes to -- sounded like from reading his notes that he was surprised it ended up back at, at CRU callout.

Q When you're referring to Richard Buchkowksi's notes, are you referring to his, his CRU form?

A I'm referring to the notes that, that we have in, in the records.

Q With -- the notes with meeting with Mr. Koster?

A I mean, I'm going by memory so I'd have to find them. Do you want to find them?

Q Yeah. Let's get -- we'll, we'll pull up Mr. Buchkowksi's CRU summary, 36926.

A Okay.

UNIDENTIFIED PERSON: Oh, that's in the binder.

UNIDENTIFIED PERSON: That's the binder, 1795.

THE WITNESS: Oh, thanks. Okay, (inaudible) I thought I was doing something wrong here. 1795. Okay.

BY MR. OLSON:

Q Okay. Take a minute, look at that.

A Okay.

Q And when I read it, I didn't see any reference to how this file ended up back at CRU. And maybe if, if you have some other information, you can let us know.

A I think it just, it just references Richard saying that it's recommended this file be opened to intake.

Q Okay. And when, when Mr. Buchkowski testified that intake to him -- he always put intake. It could mean CRU, it could mean tier two.

A Yeah.

Q Supervisor said she would have expected that to be tier two but, in any case, we know it ended up back at CRU.

A Right.

Q We just don't know why, right?

A Yeah. I don't, I don't know what he testified to, so ...

Q When, when, when cases would be rejected by tier two intake, and you -- I think you said that did happen.
A That cases were --
Q Rejected by --
A -- rejected?
Q -- tier two.
A Right.
Q Now, I'm not talking about abuse, but tier two. Is that right?
A Yes.
Q Okay. That Ms. Faria or Ms. Verrier, they wouldn't -- they, they would complain about that. They didn't like that happening?
A Rejected means we got the case --
Q Yeah.
A -- we don't believe we can manage the case, we're going to come down and have a discussion with you about it and see if we can agree to work this out in terms of dividing out tasks or in terms of seeing if you at CRU will take it back.
Q So in other words, this is not an outright rejection of the case.
A Right.
Q CRU wouldn't have to not take the case back.
A That's correct.

Q It was an agreement that CRU would do more work. Or --

A I don't know, because if Richard has testified that it didn't even go up to tier two but went across to CRU backup, that's not how I would have interpreted that. But if that's what he's testified to, then I have to respect that.

Q I just mean the situation itself. When, when these cases are -- end up back at CRU after the recommendation was, was that it go to intake, that was -- that would be by agreement, by negotiation.

A Yes.

Q Not by actual refusal by intake.

A Well, not the ones that were through Trudy carpenter, put onto CFSIS. Once it's on CFSIS, that's a tier two intake's case. Now they got to come back and negotiate that with the CRU supervisor to take it back. But if, if Diva or Diana were to walk up a case themselves without giving it to Trudy, without putting it on CFSIS, they could end up having a dialogue with the supervisor. The supervisor at tier two may refuse to take that case. By the fact that they physically took the file up there, they opened a dialogue as opposed to sending it to them.

Q If there was a refusal like you're describing, where intake doesn't want to take the case --

A Right.
Q -- would you -- would it be your expectation that that would be documented by the supervisor?
A Which supervisor? Both supervisors at both ends?
Q Whoever's, whoever's dealing with the rejection.
A I guess I, I wouldn't really have an issue with a supervisor putting a notation on the file that sent this case up to tier two intake, intake refused, and it's back at CRU. I, I wouldn't have a problem with that being on the file. I would have a problem putting something on a client's file where we -- she, she said this and he said this and we got into a lot more information like that. I would have a problem with that.
Q But would you have expected there to be some documentation reflecting that that's what happened here?
A I, I think it's fair if somebody chose to put that on, because it shows the process that was followed, and --
Q But --
A -- if they felt it was important --
Q But what I'm asking about is your expectation. You're the supervisor of the, the supervisor, and she's supervising the worker. What would your expectation have been in terms of documenting what happened?
A Documenting that the file went to tier two

intake, was rejected, and came back.

Q Right.

THE COMMISSIONER: That, that's when it was put in by administration and went up for an open file.

THE WITNESS: Yeah.

THE COMMISSIONER: What about when it went up as a result of a walk up and a dialogue commenced, as you put it, and --

THE WITNESS: Yes.

THE COMMISSIONER: -- and, and the resolution was it should come back down.

THE WITNESS: Yes.

THE COMMISSIONER: Would you expect a recording of that --

THE WITNESS: Right.

THE COMMISSIONER: -- that event?

THE WITNESS: Yes. First thing I would expect, Mr. Commissioner, is if the CRU supervisor felt that this was an important enough issue, safety of children was there, they should have come to one of us as a service manager to resolve that issue, and they shouldn't have conceded taking the case back. But if they did take the case back, they were well within their right to write: I tried to take this up to tier two intake but they refused.

THE COMMISSIONER: But would, would, would it not

be expected they would write and make a notation of that?

THE WITNESS: Yes. Yes. Definitely. And, and, and that's within their right, and they did. They wrote that, you know, in the notes. And that was okay. But if they wrote, This person said that and I said this, we don't need that stuff in there. That, that's, that's irrelevant stuff.

THE COMMISSIONER: I understand.

THE WITNESS: Yeah.

BY MR. OLSON:

Q That -- when you say you don't need that stuff in there, was that a direction to the supervisors, don't record that kind of information?

A It's not a directive that we put in writing, but it certainly is a message that we, we tried to -- we're trying to establish goodwill and good working relationships across programs, and in particular across the supervisors that are the leaders of those respective programs. So what we're trying to do is model for them that they needed to be able to discuss and work through these issues. And work them through when you're calm. And if you can't work them through when you're calm and neither of you are going to concede on your points, then go down the hall, get one of the respective assistant program managers, and we'll help

you, and we'll sort it out, and we'll make a decision. And that's what we would do.

Q And that, that --

A And when that decision would be made, then that would be the final decision.

Q See if you can help us understand what happened in this case. If this was, as you said, a fairly typical OR routine type of case, why, why would the supervisor from CRU walk it up to the supervisor of tier two? There be any reason to do that?

A Are you talking about a specific time frame on this? I can't follow the --

Q No, I'm talking about the specific time frame when Mr. Buchkowski recommended the file go to intake.

A March 7th, would there be a specific reason why Diana Verrier would have walked that up?

Q Yeah, if a typical case, why not --

A Yeah.

Q -- just put it through the system, Trudy Carpenter --

A Yeah.

Q -- opens it, if intake doesn't want it --

A Yeah.

Q -- comes back down.

A Yeah.

Q Your counsel just pointed something out. You -- when you said it was a typical case you meant overall?

A Yeah.

Q Is there something --

A When I said it was an average case, I was talking about the average in regards to the, the risk and response times that we generally would be seeing across the board in terms of new cases that come into our system.

Q Was there anything unique about this particular referral that Mr. Buchkowski was dealing with, that made it somehow not usual or typical?

A Apart from the extensive history on this particular referral -- and it's not uncommon for us at CRU, and, and maybe not that well-known to the general public, but lots of times people will use the word "abuse" for a far, far-ranging amount of things, you know, from shouting at your child. People will send in referrals to us and will call that abuse. So a big part of this referral was our ability to be able to access the direct information from the source of referral, and in this, in this case it was sort of -- it was a second-hand referral. The person did not have any real information to shed some light on whether or not this was, indeed, an abuse situation, and didn't have a physical address. So (a) we didn't know, was the child injured, how was the child injured, when was the

child injured, and we didn't even know the location of where the family lived, so it was a, it was a fairly atypical kind of referral for us, in --

Q We, we've, we've heard workers say that they got even anonymous referrals fairly regularly.

A Yeah, yeah.

Q And also that clients of the system often had extensive histories.

A Yeah.

Q Both fairly typical. So are you saying there's something that was atypical about this particular referral?

A What, what's, what's atypical about this one is the decisions that we made when the word "abuse" was used is -- we have been asked and we've been challenged and we've all talked about that in various, various opportunities to meet with Commission counsel about why we didn't view this as an abuse investigation, why did it go to tier two as opposed to the abuse unit.

Q Yeah, we've, we've been over -- we understand -- I understand --

A Yeah.

Q -- that, and it --

A Yes.

Q -- doesn't meet the criteria, et cetera.

A Yes.

Q But the question I'm just trying to get from you is how is this an -- if you're saying it's atypical, on what basis would it be atypical such that it would -- there'd be a need to walk it up to the supervisor of intake to see if they're going to take it or not.

A I don't think we established that it was -- have we established that it was walked up to the tier two intake supervisor?

Q I've asked you why -- what would be the reason for doing that in a case like this?

A I, I, I mean, if it actually went to intake, it would have been one of those that could have easily gone through the admin.

Q Right.

A Admin opened on CFSIS and shot up.

Q That's my point.

A Absolutely. But I believe I heard you say earlier that Richard had testified here to something different, so I'm, I'm kind of getting a bit confused here. I want to help you, but --

THE COMMISSIONER: I think maybe, I think maybe --

UNIDENTIFIED PERSON: He hadn't said that.

THE COMMISSIONER: I was going to suggest we adjourn for lunch and maybe you can get this clarified.

Did you want to say something, Mr. Saxberg?

MR. SAXBERG: No, I, I, I think that's a good suggestion, to --

THE COMMISSIONER: Yeah.

MR. SAXBERG: -- adjourn for lunch.

THE COMMISSIONER: I, I think this might get clarified in consultation so -- it's time for lunch in any event, so we'll take a break till two o'clock.

MR. OLSON: Very good.

THE WITNESS: Thank you.

(LUNCHEON RECESS)

MR. OLSON: I'm told they're still having some trouble hearing us in the back.

THE WITNESS: Oh, are they?

MR. OLSON: So I'm going to try to speak up, and if you could do the same, maybe pull the microphone close.

THE WITNESS: Thank you.

MR. OLSON: You probably could probably pull it even a little closer than that.

THE WITNESS: Okay. Can you hear in the back? Okay.

BY MR. OLSON:

Q Earlier this morning you mentioned that CRU would -- one of the responsibilities of CRU was to come up with the response time. Right?

A Yes.

Q And you said that the response time they came up with would be the response time that would be expected to be followed at intake.

A Yes.

Q You said that there was a directive from -- it was made very clear from, I guess, yourself and others that that was the expectation on --

THE COMMISSIONER: What was? I missed what you said in your second question.

MR. OLSON: The response time that CRU came up with, whether it's --

THE COMMISSIONER: Yes.

MR. OLSON: -- five days, seven days --

THE COMMISSIONER: Yes.

MR. OLSON: -- that was to be followed at intake.

THE COMMISSIONER: Oh, be followed. That -- the word I missed, was "followed." Okay, thank you.

MR. OLSON: Okay.

BY MR. OLSON:

Q And you said that was made clear to the

supervisors, that intake was expected to follow the response time and CRU was to come up with the response time. Do I have that -- that's right?

A Yes.

Q We heard evidence from Roberta Dick -- and I appreciate this predates your tenure slightly.

A Right.

Q Her evidence was that the response time that she would come up with would sometimes be made to accommodate workload demands at intake. Was that -- had, had you heard of that happening? Were you aware of that?

A I, I heard that it was happening, but wherever it happened, if, if it was a shortened time, that would be fine. If it was an extended period of time then what they had provided as a response time at CRU, it shouldn't simply be for a challenge workload related-wise. It, it needed to be compared against what the, the merits of the need for follow-up with the family should be.

Q Right. Response times should be determined by the case as it presents itself.

A Right.

Q Shouldn't have anything to do with can intake handle it or not. Right?

A Sometimes in that situation, that's where the tier two intake supervisor might be talking to the CRU

supervisor.

Q Right, you get into that --

A Yes.

Q -- who's going to take the file.

A Yes.

Q Because intake doesn't want it if, if it turns out they can't meet the response time.

A Right.

Q And CRU doesn't want it back because they're already swamped.

A Yes.

Q So nobody wants this file. Is, is that sort of -- intake doesn't want it, CRU doesn't want it.

A Well, I don't know if it's nobody wants it, but people are having challenges to deliver on the service within the response time that's been recommended at the CRU level.

Q Was there any concern about the way files would be handled if they were -- if they had come back down to CRU to do further work, in terms of the worker -- CRU workers thought, you know, we send this file up, we want it to go to intake, they reject it and now we got to do more work on it. Did that -- were you aware of that changing approach to the, to the matter?

A No, I'm not aware of that.

Q And the whole issue about response times being tailored to meet intake's ability, that is something you said you had heard about happening?

A Yeah. I'd heard of it happening, but I, I didn't see very many examples of that brought to my attention when I was there.

Q Ms. Dick said that her supervisor, Diva Faria, would give direction as to whether or not they should be deciding on the response time based on workload demand. Said they would often know that there were a lot of files open, and based on that they would try and balance the workload and that Ms. Faria was -- that was something she was aware of happening.

A Are you referring to her commenting about that at CRU in terms of CRU's workload or tier two's workload?

Q No, this is in the context of CRU, they're about to send a file up to intake, they would adjust the response time so that the file wouldn't necessarily go up to intake.

A Well, if, if they were to do that in conjunction with the supervisor, and if at the end of the day the supervisor and worker believed that they could do that safely for the children that were involved in that particular situation, then I guess that would be their call.

Q Was, was the practice of adjusting response times

acceptable --

A I, I --

Q -- in that manner?

A I think you're talking about a difference between -- the first question was about response time adjustment by the tier two supervisor without consultation back with the CRU supervisor. That, that would have been a challenge. This one here would have been a discussion between the CRU worker -- in this case, Roberta Dick -- and, and her supervisor. And between the two of them they could have made a determination whether the family situation that was directly in front of them is something that could be managed within an expanded time frame.

Q So instead of maybe the worker would have assessed the response time as being based on the file, what they've read, what they've seen, as being, you know, a five day response time, knowing that intake can't handle a five day response time they adjusted upwards to be something longer than that. That's what I'm, that's what I'm trying to ...

THE COMMISSIONER: Yes, Mr. Saxberg?

MR. SAXBERG: Thank you for stopping. I just want to rise. I'm objecting to the question on the grounds that that wasn't the evidence that Ms. Dick gave, what she said. There might be one spot where it sounds like she

said that, but she was asked about this issue on several occasions, and what she said was where it could have gone either way between 48 hours and five day response time, she would err on the side of giving intake some leeway if they were busy. She wasn't saying she was picking the response time based on workload, and that's what seems to be being conveyed here. The transcript will be crystal clear on that point.

THE COMMISSIONER: I'm just wondering whether Mr. Olson has the transcript. I see he has something in his hand.

MR. RAY: Mr. Commissioner, just while counsel is discussing, I'm actually having problems hearing you now.

THE COMMISSIONER: Oh, okay, I'm sorry. I'm glad you brought that to my attention.

MR. RAY: Thank you very much.

THE COMMISSIONER: Thank you.

MR. OLSON: Just so it's clear in terms of what the transcript says, Mr. Commissioner --

THE COMMISSIONER: Well, show it to Mr. Saxberg and see if you can reach some agreement on that if it's down in the transcript.

Is your, your point, Mr. Saxberg, that what Mr. Olson has there, you believe was subsequently modified by the witness later on?

MR. SAXBERG: Yes.

THE COMMISSIONER: All right. Can, can we search for that at some point?

MR. OLSON: I think the, the transcript will, of course, speak for itself in, in due course.

BY MR. OLSON:

Q Maybe the best way to, to deal with this is, on the version that Mr. Saxberg believes is, is accurate -- I don't want to get into that -- would it be appropriate for a worker, if, if it's a judgment call between, you know, this could be a 24-hour, 48-hour response, or it could be a five day response, to err on the side of the five day response to give more time to the intake unit to get out to see, to see the child, or whatever the issue was?

A Well, I, I think at the end of the day that might be one of those where the CRU supervisor would have that discussion with the intake supervisor, and if the intake supervisor is, is not able to provide the staffing to be able to do the follow-through, and if it doesn't pose an increased risk for the children, increasing the response time, that could be something that's negotiated between the two supervisors and in which case the CRU supervisor would inform the worker of that. That, that would be a plausible explanation, I think.

Q That would be the explanation, but would that be an acceptable practice, then?

A Sure. The same practice as it would be going up to tier two intake and nobody goes out on the call, you know, within that time frame because they've already conveyed up front that they're not able to do that.

MR. OLSON: Could we put on the screen, please, page 36934.

THE COMMISSIONER: You, you included in your answer, Witness, providing there, there was no risk to the children, did you not?

THE WITNESS: Exactly.

THE COMMISSIONER: Yes.

THE WITNESS: Yes.

BY MR. OLSON:

Q The response time, though, when you, when you -- when a worker looks at a file, they're basing response time on the risk to the child, right?

A Yes.

Q And what you're saying is there may be some judgment as to whether or not the risk is increased by making the response time longer or not?

A I think what it boils down to is if we transfer the case and we don't give it a reasonable time frame, and

it's sitting there and nobody's providing the service, there are choices. You know, CRU could, you know, continue to do some work, you know, for an extra day or two if they wanted to do that. They can negotiate it between the two supervisors, and if collectively they believe the matter could be managed risk-wise, then they, then they would have that ability to make that decision.

Q Risk-wise within a longer time frame.

A Yes. Or a shorter time frame. I mean, we've seen that, too, with, you know, with some of the situations where CRU has made a recommendation to go out, you know, in five days and, and tier two intake has gone out on, you know, in two days as opposed to the five.

Q Sure. The document that's on the screen in front of you, do you, do you recognize it?

A Yeah, it's the -- it's part of the safety assessment, Shelly Wiebe's --

Q Safety assessment.

A Yeah, from --

Q This --

A -- December 1st.

Q The form itself -- not, not necessarily the content, but the form, was that something that workers were required to fill out?

A If, if it was a protection related matter, then

that was the expectation, that you would fill out the safety assessment. The standards had talked about if it was a 24-hour response that you had to fill out the, the -- a safety assessment, and, and we had a stronger response than that. We said that you needed to fill out a safety assessment if there was protection related concerns and -- you know, and, and we didn't limit that just to the 24-hour response.

Q So are you saying, then, workers were directed to fill these forms out where there was a 24-hour response time or something more than that?

A Yeah. Or 48-hour response. You know, if there were protection concerns and, you know, you didn't -- you had children that you deemed to be unsafe, you were to do a safety plan as well, you know, as well as complete your entire safety assessment.

Q The safety plan is something different from what we see on the screen.

A Yeah. Yeah. It's part of the, it's part of the, the safety assessment form, the checkbox.

Q I don't recall coming across any safety assessment forms in this particular matter. Are you aware of whether or not any were, were done in this case?

A I, I don't, I don't know, to be honest with you, if I remember that.

Q I, I think I may have misspoke. I said it was -- I asked about a safety assessment.

A Right.

Q I think you used the term, safety plan.

A Right.

Q Was the safety plan part of this document, or was it a separate document?

A A safety plan was -- it was a tick mark -- a tick box mark, you know, on this particular form. If you felt at the end of the day that there were children that were unsafe, then the expectation was that you would do a safety plan, you know, as well.

Q Okay.

A And that was to be reviewed by the supervisor.

Q Was that mandatory -- first of all, was this form mandatory to fill out?

A There were, there were three forms that you had to fill out. There was the, the CFSIS opening and there was the shared CRU after-hours report, and the safety assessment that you were expected to complete if, if there were protection concerns.

Q At what point in time would these forms be required to be filled out? By that, I mean, just so it's clear, when the file comes in to CRU or when it's transferred to intake or ...

A The, the safety assessment form was to be, was to be filled out and, and discussed with the supervisor in regards to a verification of the response time. And the other -- the CRU after-hours form was completed on transfer to the next unit.

Q What was the purpose of this form that's on the screen?

A Well, you, you had various categories of incidents -- of severity of incidents and vulnerability of children, and you would take the complaint that came in and you would look through the various categories to determine your response time, whether it was 24 hours, 48 hours, or, or a five day response.

Q Okay. And so, for example, if 24-hour response is selected, would that be the recommendation to intake?

A If it was a 24-hour response that was selected, as a general rule that would be managed at the CRU by the, the callout team, the backup team.

Q So that wouldn't even go up to intake.

A Well, it, it would depend on what the, the first response -- sorry about that. The first response would have been that they would have taken the first look at the 24-hour response and they would have, you know, intervened and gone out on the respective call.

Q Could happen, though, that CRU has already gone

out and they determine more is needed within 24 hours and, and select the 24-hour response time when they send it up to intake?

A Well, they would have gone out on their 24-hour response and they, they could have gathered enough information, you know, in that one day to make the determination that it would go up to intake if it looked to them like this was going to be a situation that was going to require a longer term of service. There was room for that to happen.

Q And if a 48-hour response time was selected, it would automatically go up to intake?

A It's one of those borderline calls, you know, because at 48-hour response you were kind of stretching the limits at, at CRU, but if there was a belief that the matter could be followed up with some -- you know, another, another, say, day of intervention and the possibility that the file could be closed, decisions would be made by the supervisor to determine whether we kept that at CRU and not sent that up to tier two intake. Would have been the supervisor and worker's call.

Q The other option would have been five -- a five day response time.

A Yes.

Q That would certainly go up to intake.

A Yes. And most, and most 48 hours would have, too.

THE COMMISSIONER: Would have what?

THE WITNESS: Most of the 48-hour responses generally would go up to intake unless there was a belief that with a few follow-up pieces of business, that it could be resolved and the matter closed.

BY MR. OLSON:

Q I guess, whatever -- I mean, whatever response time's selected, I guess, at the end of the day the important thing is that somebody responds to the concern.

A Absolutely.

Q While you were assistant program manager, were you involved in any sort of formal auditing of the agency files?

A I certainly was involved if there were client complaints, as an example, that came in, that after talking to the supervisor or the supervisor and the worker if, if I still had some, you know, further concerns, I would instruct the supervisor that I'd want to, you know, take a look at the file myself and review it. Sometimes clients would have appealed whatever decision had been made, you know, from the worker level to the supervisory level and they would want to talk to who's ever next in command and,

you know, and ask, you know, for an independent review to be done of a file.

So I certainly was involved in some of those situations, and I was also involved in some situations where there was kind of custody related battles and it seemed like we had lots of involvement with particular cases and the system -- you know, the child welfare system was being used by both parents to, you know, put pressure on the other parent and the kids were caught in the middle. Certainly was involved in some of those situations.

Q Were you involved, though, in any, any formal auditing of files, where you would select files from a worker and, and review it and see what the work was like?

A Not so much at CRU because CRU was such a short-term service that auditing probably didn't make much sense there. But some of the auditing that we would do would be when we did our coverage. When we covered for abuse unit or we covered for the intake unit, we would be reviewing probably 15, 20 files when we did coverage in a day, to review for transfers, for closings, and so that would in itself be sort of an individual audit.

I, personally, covered the abuse unit for about a month to two months when my supervisor unfortunately suffered a significant injury, so I, I did my APM job plus carried the supervisory for the abuse program

responsibility for that period of time. So I would have directly supervised staff there and would have been responsible for all the transfers, closures, that kind of information, as well.

Q So in that case you would have seen the work that was being done --

A Yes.

Q -- is what you're saying.

A Directly would have seen the work being done and we would have directly done all the firsthand consultations directly with the workers. And then we -- Pat, Rob, and I would as well probably -- I believe it was every couple months, we would meet with our counterparts from services to children and families at Winnipeg Child and Family, and that would be individuals at Patrick's level and individual at Rob and my level, and we would hear from them about our cases.

We would hear about themes that were working well or problematic with the transfers because they would be receiving our work directly transferred from tier two intake or abuse. So we would get a regular update and there would be times that we would, you know, have four, five complaints. We'd have to come back, take those four, five complaints; we'd review those particular files, you know, with the supervisors and provide either a verbal or

written report back to our colleagues, part of the same organization, but in the services to children and families program.

Q Okay. Were there any quality assurance programs in place while you were assistant program manager?

A We didn't have a quality assurance program that was attached to us at 835 Portage. We did have some additional assistance in a couple of initiatives that were run through people that were connected with quality assurance. So we looked at what some of the themes were, challenges that we were having, you know, at, at CRU and tier two intake in terms of volumes of particular types of cases.

And with their advice, assistance, and leadership, we were able to develop two initiatives, a parent team initiative and a substance misuse initiative, that came directly as a result of an examination, you know, of open and closures with particular types of cases. But other than that I, I don't recall us doing any other quality assurance, and we didn't have any other individual that was working alongside us to do quality assurance, other than our compatriots that we were sending cases off to, and they were not too shy about telling us when we didn't hit the mark with some cases. That was kind of an internal to Winnipeg Child and Family quality assurance.

Q Going to move on to another area. One of the issues in this particular matter was when Mr. Zalevich and Mr. Leskiw went out and talked to Ms. Kematch at the door. You -- you're familiar with the facts of that, right?

A Yes, I am.

Q Okay. And you know that according to what was written, they did not see -- they did not actually see Phoenix Sinclair, right?

A That's correct. It might be helpful if I could -- if we could pull it up on the screen, just so that I could --

Q Sure, let's do that.

MR. OLSON: 36926 is the number. Can you scroll -- keep going, please. Next page. Keep going.

Stop there for a minute.

BY MR. OLSON:

Q So this is the beginning of Mr. Zalevich's recording, and the page number is 36928. Do you want a minute just to read through this?

A Sure, that'd be great.

Q Just let us know when you need the page to be moved up.

A You can turn the page now. It's okay.

Okay, turn the page. Went a bit too far, I

think.

Okay.

Okay.

Q I don't think there's any dispute or controversy over the fact that they did not see Phoenix Sinclair at this time.

A That's correct.

Q Okay. The allegation that they were there to investigate was I think what you may have referred to as an non-specified abuse allegation?

A Well, the original caller said that she believed this child to be abused, but couldn't provide any kind of information about the physical address where the family lived or no identifying information about the abuse related allegations themselves.

Q I think she said abuse and as well as locking Phoenix in the room.

A That's correct.

Q So based on that, Mr. Zalevich and Mr. Leskiw are going out to determine if there's anything to this, right, anything to this abuse concern.

A Yes.

Q Generally speaking, it seems fairly basic that in a case like that, the social worker would see the child who is the subject of the abuse allegation. Is that, is that

fair?

A General practice would be that we would see the child when we go out on a protection investigation.

Q And that's -- I mean, that's not -- I won't even use the term "best practice" because it's pretty basic, isn't it?

A Well, it, it was in February 3rd, 2004 CRU minutes, I think, where Supervisor Faria outlined it very clearly that when you're conducting assessments you should be conducting assessments by, by wherever possible, seeing the child and seeing the family and seeing the residence, and that was fairly accurately put as to what the expectation of the time was.

Q Right. Especially when you're dealing with possible abuse?

A I, I think the, the fact that you're out there on a protection investigation would suggest that, that those are things that, that you would normally check out.

Q I know you don't like the term -- you don't like to use the word "common sense," but it seems to be fairly common sense that if you're -- you have a report that a child's being abused, you would want to see the child.

A Well, you'd want to, you'd want to start with the, with the parent and talk to the parent. And you'd want to do all the steps that they did, you know, to give

yourself some kind of assessment whether you believe there's any validity to the, to the report itself. And at the end of the day, it might have been a more full and complete assessment had they seen the child.

Q Okay. But my specific question was that it was pretty common sense that you'd want to see the child who's the subject of the abuse allegation.

A It would have been advisable to see the child.

Q I mean, here you got -- the mother is actually the one who's accused of being the abuser, right, that that's, that's what the concern was?

A I'm not -- I really didn't see anything in the record that suggested that it was the mother who was the abuser. I may have missed it, but I don't believe I saw that.

Q Maybe just to help you, we can pull that up on the screen at 36927, right under Presenting Problem.

A Samantha.

Q Yeah, it says that:

> "This person told [the source of referral] that she suspects that Samantha Kematch" --

A Okay.

Q "... is abusing her daughter" --

A Okay.

Q "... Phoenix [Sinclair and] that Samantha may be locking Phoenix in her bedroom."

A Okay, thank you.

Q So that's -- what I said before is correct, it was Samantha Kematch who was --

A Yeah.

Q -- being accused of abusing her daughter.

A Right.

Q So in that case, what would you say about relying on Samantha Kematch in terms of determining whether or not there's anything to this allegation?

A Well, I think you have to start with Samantha Kematch because they're describing her abusing her daughter, and I think they did start with that. They did talk to her directly about that; she denied that. She was open to them about yelling at her daughter previous to that and recently previous to that. And they did talk to her about the lock on the door. She did confirm there was a

bedroom that was shared with her and her daughter, and there was a lock on the door, and, and she appeared to be open and responsive to them in regards to removing the lock as it was definitely a fire hazard and fire danger.

In regards to them seeing the child, I think it, it's clear they didn't see the child.

Q They didn't see the child, right?

A No.

Q And that not seeing the child in this, in this case, when you look at it as a supervisor, was that appropriate?

A It's, it's hard to say whether it was appropriate or not. Best practice would have been that you would have seen the child. That would have been best practice.

Q But wouldn't that just, I mean, just be basic social work practice, that you, you're checking out an abuse allegation about a child? Wouldn't you see the, wouldn't you see the child? That'd be just part of it.

A Would have been advisable to see the child.

Q And so not seeing the child here, was that, was that appropriate? I mean, you're a supervisor so you know whether or not it's -- you have an opinion, I mean.

A Well, if you look under the, the, the standards in regards to protection investigation, the standards state that you're to investigate a protection investigation

within ten days and see the person or the family. And I -- and, and by our standards, they would have met the standard requirement on there. They were out there before ten days, they did see the parent, so they did see the family. They didn't see the child.

Q Are you, are you suggesting now that the standards are actually saying it was unnecessary to see this child or a child when, when they're the subject of an abuse allegation like that?

A The --

Q I mean, I want, I want your understanding as to what, what's required.

A I guess we're having to discern a bit between whether this is a protection investigation or abuse investigation.

Q I'm not talking about investigation, just determining whether there's anything to this allegation of abuse. I mean, they substantiated that the door was locked, there was a lock on the door, so that lends -- I would, I would think that would lend some credibility to the caller. You know, going out with the information, the facts that you're aware of, are you suggesting that the standard's that you wouldn't have to see the child?

A I'm trying to help to clarify a small but important point that the standards are different if this

situation is viewed as a protection investigation verse this is viewed as an abuse investigation. There are different requirements, there are different timelines, and there are different expectations around follow-up and who you need to see. And at the end of the day it is my belief, from reading all the information, that they viewed this not as an abuse investigation but they viewed this as a protection investigation, and based on that determination, they'd actually done what the requirement was under the standard at that time.

Q Were they even at the point where they were able to decide whether this was an abuse investigation or, or a protection investigation?

A It's a question probably better answered by the worker and supervisor, but it seemed to me when they did their involvement, wrote it up, they believed that they did not have any protection concerns, and as such the worker made a recommendation to the supervisor to close off the case.

Q Right. That's without seeing the child.

A That's without seeing the child.

Q Yeah. So before we get to the recommendation to close and they're closing it based on the fact they don't think there are, there are concerns, but the goal, the goal is ultimately determine whether or not the child is safe.

Right?

A That's one of the goals.

Q And to do that, don't you have to see the child?

A As I said, it would have been, it would have been a more complete assessment had they saw the child.

Q And when it comes to the standards, you're not saying that there was any question in your mind as to whether or not the standard would require seeing the child.

A I'm saying to you that if it's a protection standard, they met their requirement; if it's an abuse standard that you're reviewing based on this being abuse -- which I'm not saying that it was, the caller said that it was abuse but was very non-specific in her ability to outline any abuse related concerns -- but the, the expectation in the standards, if it was viewed as abuse, is that you would have had to see the child, you would have had to see the other children that were in the home, you would have had to see the parent or care providers in the home, and you would have had to see the, the offending party if you believe that abuse had happened, with the permission of the and approval of the police, and there was a -- if it was viewed by abuse by our agency and would have gone to the abuse unit, there were 14 other requirements in the abuse program that they --

Q Right.

A -- would have had to follow.

Q But when these workers went out, they didn't know if it was abuse or not. All they had was the allegation that was made, right? Right?

A All they had, the allegation that was made and then their involvement in their, their follow-up interview with the mom and the observations with her with the child.

Q The mom who was accused of doing the abuse.

A Yes, you pointed that out.

Q Based on those -- just based on those, those facts -- I mean, whether you characterize it as an abuse allegation or a protection concern, just based on those facts, isn't the first thing to do to find out whether or not there's anything to the concern, the abuse allegation?

A That would have been, that would have been valuable and it would have been a more complete investigation had they done that.

Q The determination that there were no child protection concerns was something that was made without seeing the child here.

A That's correct.

Q Is that determination -- is it even possible to make that determination without seeing the child in a case like this? Well, in fact, in this case, I should say.

A Is it, is it possible to do that? I think we see

an example here, you know, where that's indeed what happened, and that was the recommendation from the worker and it was reviewed and signed off by the supervisor.

Q We know what, we know what happened, but you, you as a supervisor -- in fact, the supervisor of the supervisor, would you see this -- or would you be, would you be able to say the child is, is safe, there aren't protection concerns?

A No, I have, I have to answer that kind of two ways. The first way would be there were two staff that went out. One of the workers, you know, had seven months' experience in the abuse program. The other worker that went out with the first worker had 15 years of, of experience, most of that at the crisis response unit, was a very seasoned, experienced CRU worker. And at the end of the day, I believe that the supervisor trusted the combination of the information from the two workers at the end of the day and made the decision to close the case off. I -- due to no protection concerns. I do not know what the workload related issues were going on at the time. I don't know --

Q But, but you're not suggesting that workload should ever impact a decision as to whether or not an abuse -- whether or not the allegation of abuse is investigated. That wouldn't have a part in it, would it?

A Again, back to this being a protection investigation rather than an abuse investigation, in a protection related investigation there have been times when it is really busy and you are having to make choices out there of what you can and can't, what you can and can't follow up on, that some of those difficult choices are made and there are times when children aren't seen. It's not our usual course of action or what we believe that we want to do, and it's certainly not what we, you know, had in our minutes and, and reflected in our expectation.

Q The minutes you're referring to are where the, the -- where it's recorded that if there are child protection concerns, workers should get out, if possible, to see the child.

A That's correct.

Q That --

A See the child and, and see the, see the family in the residence.

Q Right. Those minutes were recorded February 3, 2004.

A That's correct.

Q That was an issue, and that's something that workers were made aware of.

A Absolutely.

Q And that's not even specifically talking about

abuse concerns, it's just where there's a child protection concern.

A That's correct.

Q That might be where someone leaves power tools out and the child is at, at, at risk. Right? I mean, it's, it's pretty broad.

A It's pretty broad.

Q Yeah. And abuse is a little more narrow than that.

A Absolutely.

Q Okay. So when you're using professional judgment, you have to, you have to look at the circumstances as they present and make your determination based on that.

A That's correct.

Q And here we had the two workers at the door who had the ability -- I mean, when you say workload, they're at the door at the time.

A Yes.

Q They could have asked to see Phoenix at the time.

A Um-hum.

MR. SAXBERG: I, I'm just going to have to object on that point.

THE COMMISSIONER: Pardon?

MR. SAXBERG: I have to object on that point

because Mr. Zalevich gave evidence that he believes he would have asked to see Phoenix and that would have been his usual practice. So that's the evidence before the Commission, not that he didn't care or didn't want to see Phoenix.

THE COMMISSIONER: Do you agree with Mr. Saxberg that Mr. Zalevich said he believes he did ask?

MR. OLSON: I'm not, I'm not sure about that.

THE COMMISSIONER: Well, that's the basis of his objection.

MR. OLSON: That's -- I understand the basis of his --

THE COMMISSIONER: I, I, I have not reviewed my notes on the point. Mr. Ray?

MR. RAY: Mr. Commissioner, I believe Mr. Saxberg's right. I think Mr. Zalevich said it was not reflected in his notes that he asked. It was his practice he would always ask in these types of situations. Based on the way it's documented, he believes he did ask or would have asked. That was, that was what his evidence essentially was.

THE COMMISSIONER: Based on the way it's documented?

MR. RAY: Based on his recording. He recorded that the children are not in school and were not in

daycare. He believed, based on that recording, him asking whether the children are in daycare or in school and, and Samantha Kematch's response that, no, they weren't, he believes he would have asked is Samantha here -- or, excuse me, Is Phoenix here? Answer was no. Is she in school or daycare? No, she's not in school or daycare. So he believed, based on what he recorded, that he would have asked. Also, based on his practice, he would have asked to see Phoenix -- or if she was there, excuse me.

THE COMMISSIONER: Well, I think you, you just have to base your question on the basis that it was not recorded.

MR. OLSON: Yeah, and that's exactly what I was going to say --

BY MR. OLSON:

Q -- that we don't, we don't know what happened at the door other than what's recorded in the, in the note, right? Mr. Berg?

A I just have the record that's in front of me.

Q And as, as a supervisor, the supervisor, if you were looking in it, that's what you would have. Right?

A Yes.

Q If you look -- if -- and if you look at it, knowing what you know today and that's based on what's in

the note, would you have expected the worker to do more in terms of asking to see the child, record whether they did?

A It's a difficult question, and it could come down to workload. And at the end of the day if I had a seasoned, experienced CRU worker who went out with one of my more junior staff but had seven months' experience in the abuse program, and they met with the mom and they did the steps that they did, and at the end of the day that they were both of the opinion that there were -- that there wasn't validity to the source of referral information that came in, I, I may have made exactly the same decision that the supervisor did.

Q When you -- as a supervisor, when you look at the document, documenting here, the recording, there's, there's nothing indicating what questions were asked of Ms. Kematch, right?

A Right.

Q Wouldn't it be important to have a record of whether or not Ms. Kematch was, was cooperative with the request to see Phoenix, or whether she said Phoenix was at daycare or at school, something setting that out clearly?

A You're asking me to respond as if I was the covering supervisor that day?

Q Exactly.

A And as the covering supervisor that day I might

have had those questions. I might have had, you know, questions about what efforts they made to see the child. I do not know what was on their, their plate that day in terms of workload and other things that were happening, and at the end of the day, they, they had options if they wanted to.

They could have taken this case, said: We've gone out and done what we need to do; we're going to send this back up to tier two intake. That was an option.

The second option that they had is this was a very difficult time for all of us at Winnipeg Child and Family because so many family service units were closed, so we had developed a program at 835 Portage where -- we called it our CRU diversion program which ran out of CRU and we had four dedicated community staff that were available for five day responses.

So they had two options that they could have, in the end of the day, chosen to have sent this case to. And they could have said that we want to have this child seen. Those options were open to them. They believed that there were no protection concerns and so, in their professional judgment, they made the decision to close the case. Wasn't that they didn't have options. It's that they believed there were no protection concerns and they were satisfied with the information they'd been provided by the mom.

Q And then you as a supervisor --

THE COMMISSIONER: Now, Mr. Olson, I think we're just going around in circles now. If you want to ask any questions arising out of that last answer, by all means, but pursuing it much further, I think we're just in --

MR. OLSON: And I don't plan on going much --

THE COMMISSIONER: -- in a complete circle.

MR. OLSON: I don't plan on going much, much further with that.

BY MR. OLSON:

Q But one thing I wanted to ask you about is, when you say they made the judgment -- the workers made the judgment there were no child protection concerns, you're the supervisor looking at it, you'd want to know what the basis of that judgment was, right?

A Right.

Q And based on what you see here, is there, is there a reasonable basis for the decision to close the file because there's no child protection concern?

A What's in the paper record and what the supervisor actually discussed with the respective workers, any information she gleaned as a result of their recommendation to close, I have no information on that, and I would have needed that information beyond what's on the

written record to be able to answer that question with any kind of credibility, quite frankly.

Q So here there's not enough for you to make that determination.

A No, there isn't.

Q Okay. Just in terms of abuse allegations before -- I wanted to ask you a little more about the -- what you called the unspecified abuse concern.

A Right.

Q Were those -- was that unique to this case or were, were those -- did they come in often, or are you able to say?

A I, I won't say that they didn't, they didn't come in often, because sometimes they did. But it's very, it's very challenging for us in this particular situation because this -- the caller is familiar to our system, probably familiar with the importance of us getting accurate and timely information, in particular helping us to connect up with the source of referral to be able to get more firsthand information to help us because when you're out there in somebody's home, you're constantly balancing the intrusion to a family's affairs with the protection of the child and the more clarity you can have around the allegations, the better your opportunity to lean on the side of protecting the child.

And this entire referral was extremely weak, and I thought the social workers, beyond the fact they didn't see the child, they tried a number of things that I think were, were to their credit. They tried to deal with the locks on the doors. They had some discussions related to Phoenix being abused with the mom, and at the end of the day when they were not getting the information that they needed to validate protection related concerns, then they tried to offer volunteer services to the mom, which would have been another opportunity to keep the branch formally involved in the affairs of the mom, and unfortunately she turned them down. And basically, at that point they're left with two choices: They can see the child or they have the ability to be able to close that case off based on there not being enough grounds to, to proceed under protection concerns.

Q I think you went a lot farther than what my question was. It was just simply whether, whether or not you would get unspecified abuse allegations like this. And I think you said that would happen.

A Yes.

Q And based on that, when you have an allegation like this, is it any less serious than a specified abuse allegation?

A I'm not sure that, that anybody can answer that,

but I can tell you from 30-plus years in this business and knocking on many peoples' doors as a child protection worker for years, it makes a big difference if I have information that I know to be valid, solid, related concerns, timelines, knowledge of injuries. Knowledge of how those things happened makes it a whole lot easier when you're, when you're intruding on somebody's affairs to ensure that you, you are able to stay involved in their affairs and, and push as far as you can for the protection and safety of children. So that information was crucial, and we tried at after-hours and we tried through Richard Buchkowski and two different opportunities, and we could not get any further information.

THE COMMISSIONER: Now did you get an answer to your question, Mr. Olson?

MR. OLSON: I'm, I'm not sure. I don't think so, but I think I'm going to leave it.

BY MR. OLSON:

Q I want to, I wanted to ask you about closing files. Was there any pressure in intake or CRU to close files? Do you know what I, I -- I'm not sure if you know what I mean by that, but ... Are you able to answer, answer that question?

A Which program? CRU or --

Q Go, go with CRU first.
A Okay.
Q Was there pressure to close files at CRU?
A Based on excessive workload that we would close files to close them because there were active protection concerns or no protection concerns?
Q Just generally speaking, was there pressure to close files rather than keep them open?
A No.
Q What about at intake?
A I don't, I don't believe that there was pressure to close files and I'm not sure who the pressure would be coming from. From the supervisor or the system? I mean, there's times where there was excessive workload. There's --
THE COMMISSIONER: Were you, were you aware of any pressure to get files closed?
THE WITNESS: No, sir.
MR. OLSON: Thank you.
I wonder, Mr. Commissioner, if this is a good time for the afternoon break?
THE COMMISSIONER: Yes. Have you much further to go?
MR. OLSON: Not a lot.
THE COMMISSIONER: All right. Well, I take it

you think it might speed things up if you get your break now?

MR. OLSON: Yeah.

THE COMMISSIONER: We'll adjourn --

MR. OLSON: Exactly.

THE COMMISSIONER: -- for 15 minutes.

(BRIEF RECESS)

MR. OLSON: Before we continue, I just wanted to mention, tomorrow we will need to start a little later than usual, at eleven o'clock, just to accommodate some counsel scheduling.

THE COMMISSIONER: I understood that could happen, and that's satisfactory under the circumstances.

MR. OLSON: Thank you.

BY MR. OLSON:

Q I want to move now to asking you some questions about comments made in the various reports that were commissioned following Phoenix's -- the discovery of Phoenix's death, okay?

A Okay.

Q You've, you've reviewed these reports?

A Yes.

Q Now, the first, first one I wanted to ask you about was with -- it's the Section 4 report and it's with respect to the involvement of Ms. Parsons and, and Ms. Forbes.

A Okay.

Q You supervised Ms. Parsons.

A I did, yes.

Q And she supervised Ms. Forbes.

A That's correct.

Q Now, if you -- if we go to page 41 of the Section 4 report, the bottom of the page where the heading's May 13, this would begin the background of Ms. Forbes' involvement, and it would continue on till page 43 at the top. Now, if there is -- I, I understand you've read this before. If there is anything you want to comment on with respect to what's recorded in that section, just let me know; otherwise, I'll take you right to page 43.

A Page 43.

Q Okay.

A Yeah.

Q Just before I get there, were you interviewed by any of the report writers in connection with this matter?

A I was interviewed by Andy Koster.

Q Okay. So page 43, under Interview with the Assigned Worker on the case -- that would have been Ms.,

Ms. Forbes -- it says:

> "The worker indicated that if she had known the Wes' last name she would have contacted the police to get past history and done internal record check. She said that it was difficult to elicit information from Samantha and said there was a question of how far she could push for information. She indicated that she did check past history on the file. The reasons that she closed the case at this point in spite of the history in this file included the following points."

And then there are a number of bullet points beneath that.

When you reviewed the work that Ms. Forbes did, are you able to say whether it was appropriate to close the, the file?

A I think that the safety assessment called for a 48-hour response and I believe that she was out there in that, that time period. Her assessment of the situation,

based on the information she gathered from her meeting with the mom, was that she was not concerned that the mom was doing drugs and she was not concerned at the time of her involvement after seeing Phoenix that the child wasn't doing okay. Her assessment at that time differed from previous workers in that she viewed this as a, as a low risk case at this point and, and made the decision to close the case.

THE COMMISSIONER: So the question was, was it appropriate to close it, in your view? If you're able to tell us.

THE WITNESS: I can appreciate that it was difficult for -- Tracy's a very, very experienced, very thorough worker, made a lot of efforts to try to find the mom and that took some time. And at the end of the day when she went out, she didn't see any protection concerns that would warrant remaining involved in the case, and it's, it's hard to comment. She didn't have any real information other than past history to make the determination of whether or not she should remain involved or whether this should have gone up to -- from tier two intake gone across to a family service unit.

THE COMMISSIONER: So are you saying that, that you're not in a position, then, to say whether it was appropriate that the file be closed when it was?

THE WITNESS: Yes, sir, that's what I'm saying.

BY MR. OLSON:

Q Okay. On that same page, if you look under the heading, The Worker's Circumstances beyond the case file, second paragraph says -- after she talks about several colleagues on the unit being sick, says:

> "In addition, she stated that in 2004 as is the case now in 2006, Standards were not a priority for workers since the reality is that they cannot necessarily meet them. In particular, high medium or low time frames are not met and workers use their own judgment."

Is that -- was that your experience, in terms of what she's describing here being accurate?

A Well, there's, there's two things in that. The first reference is to the standards themselves, and I think it's, I think it's a view of a lot of child welfare social workers that the standards have a lot of expectations on workers, and there's never, ever been a true look-see at

the standards in terms of what an appropriate caseload-workload size for workers would be in terms of needing to meet the standards. So I think a lot of workers at the end of the day try to, as best possible, meet the programs and policies that are put in place in their respective units. I just wanted to comment on that first, if I could.

In regards to the response time frames, I don't, I don't believe that it was a general practice -- and shouldn't be a general practice -- that tier two intake or abuse should change the response times at the worker level. I don't, I don't believe that was the, the practice that we had, you know, at that point in time. If at the end of the day the, the two supervisors had chatted about that, as we mentioned earlier, and made a decision due to the fact that they were three staff down and made the decision to move the case to intake and expand the response time, is, you know, is one point, but I don't think it was a matter of course that workers would make the decision to ignore the response times.

Q Okay.

A I'm not saying it didn't happen, but it, it was not a matter of course.

Q She says the -- where it's recorded here that:

"The assignment of risk and the

> information comes from CRU and often the right information cannot necessarily be obtained by phone. She said that 'You don't feel that you can help people because you are running on a wheel and it feels like it is getting worse'."

Do you have any comments with respect to that?

A I, I'm not sure what that means, to be honest with you. I can't comment.

Q I want to take you to some of the findings in this report. Page 44, please. Finding 28, at the top of the page, says:

> "It would have been good practice to obtain Wes's full name if the worker had thought that he was living in the home."

And then it goes on to explain that finding.

Do you agree with that, that at that point when there was information that, that Wes was providing support to Ms. Kematch, that it would have been good practice to obtain his full name?

A It's a tough question because on May 13th, '04, it says the intake worker and a colleague visited Samantha's address, recording identified the home as Sarah's residence. It's unclear to me whether or not the worker learned of where Samantha was at, whether that was a friend of hers, so it's hard to know at that point in time whether or not that was Samantha's home or it was whoever Sarah's home would be, and if it's Sarah's home, I'm not sure that she would have been able to connect the dots as to who Wes was.

Q We have heard from Ms. Forbes that it was -- that was simply a typo or misnomer. She was referring to Samantha's home.

A Okay. At that time, she would have chosen to ask for that information, probably would have been a good thing to have done, but he certainly was under no obligation to provide any of that information. There was nothing that we would have as any authority to insist that he provide his name, his birth date, or any of that information.

Q Question, though, is, should she have asked that, for that information?

A If she would have been able to ascertain that he was somehow connected to Samantha --

THE COMMISSIONER: Well, I think --

THE WITNESS: -- that would have been valuable.

THE COMMISSIONER: I think the initial question that got this going was whether you agreed with the comment that it would have been good practice to have obtained Wes's full name.

THE WITNESS: Yes.

BY MR. OLSON:

Q If you look at Finding 30, the same page, says:

> "This file should have been transferred to Family Services due to the past history of the case, the mother's possible drug and alcohol problems and the young age of Phoenix...."

Do you agree with that comment, that -- sorry, that finding?

A It may have been -- it's, it's a tough call. I mean, she made a judgment call, a professional judgment call that this was a low risk assessed situation from her perspective and, and her view then, as a low risk case, was that she didn't see it as necessary to be transferred on to family service. Mr. Koster's referencing that with the, the history and the extent of the concerns that he points

out, that a referral to family services would have then resulted in more of an ongoing and possible long-term involvement. So probably was a safer position to take to have considered a referral to the family service unit but -- I don't know if they would have accepted it, but it, it could have been something that could have been forwarded to them for their consideration.

Q Okay. But do you agree with the statement that the file should have been transferred to family services?

A I'm a bit torn. I'm a bit torn because at that point in time her assessment was that the, the mother and, and the child seemed to be doing fine, and part of the issue is that I believe she only had the one contact. Would have been helpful to either have one more contact at least before making that potential decision, probably.

Q The next finding, Finding 31:

> "The Statement of Risk for Phoenix was assessed at too low level for the risk factors that were known to exist in the recent past."

Is that something you agree with?

A Probably, because there was, there was a distinct difference in the risk related recommendations of the, of

the two workers. One of the workers had suggested that it was from Central -- no, sorry, from the -- I'm trying to remember which unit that was. Northeast intake unit had recommended that this was high risk and, you know, and the worker here determined that it was low risk. And it's, it's, it's a professional judgment at the end of the day and at this time they, they didn't do any kind of a risk assessment on this situation. We didn't have a freestanding risk assessment tool at that point; it was left up to the professional judgment of the worker based by standards on them. Taking competency based training and professional opinion, you know, was that, that this was a low risk case. I think it was probably greater than that, to be honest with you.

I'm not sure it was a high risk case, but it, it strikes me that it was higher than a low risk case and at, and at which point would it have been closed when it got vetted through the supervisor or would they have had a different conversation. The worker makes a recommendation, but the supervisor reads, reviews, makes the determination at the end of the day whether they sign off on the closure. And if it's low risk, you might get a different response than you might get if it's a medium risk.

Q Would this have been more of a medium risk case, then, in your view?

A In my mind, it's more of a medium risk.

Q Turn to page 72 of the same report. The, the "C," as you know, stands for conclusion, so this is Conclusion 9 I want you to look at. Says:

> "A Review of previous case files would have found that Kari Wesley McKay had a history of abuse, alcoholism and domestic violence."

If that, if that history was uncovered -- that is, Mr. McKay's past history was -- became known to the agency through doing some searching -- what influence would you have expected this type of history to have on the file going forward?

A I had the opportunity in, in September of 2006 to review all the files, including all the files of Karl Wesley McKay and all the files that he was, he was open with in terms of various partners. And if you would have reviewed three of the files, you would have found nothing on those files. On the fourth file, to do with (REDACTED NAME), you would have found two allegations --

Q Just before you go forward, the name you mentioned is a name that will be redacted; that is not a name that --

A Oh, sorry.

Q -- should be publicized. Just want to make sure the media's aware of that.

A Apologize, I didn't know that; thank you for pointing that out.

So three of the files, you would have been left with very little in the way of concerns. On the fourth file, you would have had two incidents on Karl's file, shared file, of abuse of small children under the age of one year of age. Both incidents were unsubstantiated, both incidents were abuse related allegations that were checked out by the workers and there was no injuries on the children.

The issue around alcoholism and domestic violence -- in particular, the domestic violence on that particular file -- was very serious and it was a very dangerous situation. The domestic violence alone should have -- if -- you know, if that file had have been read, it should have been enough to, to, to tip the balance in terms of wanting, you know, to proceed with, you know, more follow-up family service.

Q So in terms of the risk level that the case would have if that information was uncovered, that put it into more of a high risk situation?

A Well, it certainly -- from the last experience,

would have certainly bumped that from a low risk to a medium risk for sure, because domestic violence is -- was a -- it was a newer area to us, quite frankly, in, in 2003, 2005, and we were, we were part of a -- part of a project, the Canadian incident study over at 835 Portage, where they, they used the sampling across child welfare agencies across Canada. And, and one of their major findings of underreporting and follow-through from child welfare agencies across the country was in the area of domestic violence. And the work that they, they had done really highlighted that for us, that domestic violence was something that we needed to really pay particular attention to.

Q I just want to make sure I understand what you're saying. In 2004, are you saying that domestic violence in terms of its impact with respect to child welfare was really not known?

A It's not that it wasn't know, but I don't think that we had the same appreciation for how to build that in -- you know, into our protection and safety planning. It, it -- but in this particular incident, it was, it was a pretty big red flag.

Q Right.

A Yeah.

Q Because this was pretty extreme.

A Pretty extreme. Very extreme.
Q Yeah.
A Very dangerous situation.
Q Certainly wouldn't close the file with this sort of a history out there.
A Sure would hope you wouldn't.
Q I want to take you now to Rhonda Warren's report which is at Commission disclosure 1802, and specifically page 38008. The bottom of the page, under Samantha Kematch file, says May 11th, 2004. Now, this, this -- what you're seeing here, have -- do you have that?
A Yes, I do.
Q That, and then the next page after "The case was closed at the Intake level on July 14, 2004."
A Yeah.
Q That's basically a factual area, but I want to give you the opportunity to comment on it if you do have some comments.
A Okay. I'm just going to read it.
Q Is there anything you want to comment on?
A I think the only thing that I would want to comment on is that whether we made the connection with Wes and the acknowledgement by Mom that she had been travelling with her boyfriend who's a long-distance trucker, and whether or not we used that as an opportunity to determine

who exactly the boyfriend was and whether we had the identifying information that we could have then used to crosscheck whether or not he, indeed, was known to the child welfare system.

Q And I'm not sure I understand exactly what, what it is -- your, your comment is.

A I, I think my comment is I, I can't, I can't determine here, with what's written, as to whether or not we followed up to ask any information related to identification of who the boyfriend was and whether he was, you know, indeed, the same person as Wes and whether he was living in that same residence.

Q You're saying it's not recorded, in effect, is that ...

A It doesn't, it doesn't say that, that we asked those questions so ...

Q Okay.

A I've not heard the person's testimony, so I don't know if she asked and just didn't record it.

Q All you know is what's in the report.

A That's right.

Q And the report doesn't show that those questions were asked.

A No, it doesn't show it.

Q And would you have expected a report like that,

if those questions were asked, to be recorded?

A I would have hoped that it would have been asked and recorded, and generally the expectation is that you would clarify those questions. And the person's name, if they're living in the residence, they would also then be needed to be added on to the, you know, to the child welfare face sheet, you know, as another party that's living in the home and that, that might have, that might have caused us then to, to ask them further questions about that.

Q Just, just on that point -- I'm, I'm curious -- if, if the worker had asked Mr. McKay for his name and information -- or Ms. Kematch for Wes McKay's name and information, because that was another option -- if either refused to provide it, would that -- would you expect that would signal to the worker that maybe more needs to be done to look into this person?

A Well, it is their right, at the end of the day, to choose whether they share that information with us or not, and part of our responsibility is to try to join with the mom about the fact that we both have a shared obligation to ensure that the children, you know, in the home are safe and that that would be, you know, a reasonable step that we needed to take as a child welfare agency to, to determine that information. If at the end of

the day she would have refused, it, it would have caused you some worry. I can't say whether or not it would have tipped the balance for the worker to have raised the risk level or, or made her, you know, arrive at a different conclusion than to recommend closure of the case. I can't say for sure; I really don't know.

Q Page 38018. This is the same report, under Risk Assessment.

MR. OLSON: And maybe pull the screen up a little bit. Perfect.

BY MR. OLSON:

Q Says:

> "Statements of risk change from low to high without any change in circumstance. Statements of Safety are referred to as Statements of Risk. A family situation may be high risk even if on any given day the child is deemed to be safe. Unfortunately in this case 'low safety assessments' were deemed to be 'low risk assessments' which

> were not the case. This continuous error resulted in this case being closed numerous times without adequate intervention by the Agency."

And then there's reference to a recording done by an intake worker in June 2003. It says ... I won't read it out, but it says:

> "Unfortunately this statement was ignored once the case was transferred for ongoing service. Based on this case review it is apparent that Risk Assessment is not universally understood by Agency staff."

Whose responsibility would it have been to ensure that risk assessment was understood by agency staff?

A I'm not sure in this situation. And perhaps I have, you know, some benefit over Mr. Koster, having worked with the staff member that was involved here.

Q This is actually from the internal review done by Ms. Warren.

A Oh, okay. Knowing the person that had been involved in this particular case, I don't believe that she has a professional confusion between safety and risk assessment. Your question about risk assessment, you know, whose responsibility is that, we didn't have a uniform agreed-upon risk assessment that was in place at that time. We do today.

Q But as assistant program manager, did you have any responsibility to ensure that the supervisors and the workers understood risk assessment?

A I believe they did and --

Q No, but that --

A -- they had --

THE COMMISSIONER: No, no, the question --

BY MR. OLSON:

Q I just want --

THE COMMISSIONER: -- is whether you had any -- you had responsibility for that.

THE WITNESS: Well, I mean, first responsibility would be for the supervisor to ensure that their staff, you know, had training and knowledge related to risk assessment. Certainly, I would have responsibility for that, and certainly our staff members that had lots of experience like this particular staff member did, would

have taken competency based training where risk assessments would have been covered off as part of the training for competency based training. That was an expectation of our, of our, of our staff.

BY MR. OLSON:

Q That was one of your expectations of the staff?

A That was, that was an expectation of our, our branch of Winnipeg Child and Family, that our staff needed to take risk assessment related training as part of competency based training. It was a universal training that all the staff had to go to.

MR. OLSON: If we could put up page 38020?

BY MR. OLSON:

Q This is still from Ms. Warren's report, under Assessment of New Partners.

A Right.

MR. OLSON: Move the page up. Oh, sorry. That's 38020.

BY MR. OLSON:

Q Now, this again, we've already touched on the issue of looking up Mr. McKay and I won't go over that again unless you want to. Just under the recommendation,

says:

> "That if a new partner becomes involved with a family and spends any significant time in the family home, background information on the individual be gathered, CFSIS prior contact checks completed, Abuse Registry checks completed and if there is reason to believe the person has had contact with the justice system, Police contacted to provide a criminal risk assessment."

It's my understanding that that -- the, the prior contact check was something that was always expected and required of workers when there was a new person identified as providing care to the child. Is that right? Is that your understanding?

A I'm trying to remember. It is one of the exhibits that we had that I believe I spoke to when I met with Commission counsel in regards to the -- we had a criminal risk policy. I can't remember the specific date of, of when that policy came into effect but it was

intended as a policy for us to be able to do these kinds of checks on other individuals that were new arrivers to a family and, and those --

Q Just, just before you go on, because I'm not sure you understood my question. It was with respect to prior contact checks.

A Right.

Q That has a specific meaning for a social worker, right?

A Yes, prior contact check is a check within our CFSIS system to see whether there's any previous involvement with the child welfare system.

Q And so the specific question was, was, was it already an expectation that a prior contact check would be done when a new person was providing care for a child in the home?

A And I, I need to know what the date of that policy would have been at that time and whether it was before or after this date, because we, we put a policy in place. It was in 2004 but I can't remember the exact date of when the policy was put in place, because at the time of that policy being implemented, then it would have, it would have been an expectation for you to, to check that information out.

Q Okay. So prior to that policy being put into

place, are you, are you saying that workers weren't expected to do a prior contact check as I described?

A I don't believe it was mandated anywhere that workers would have had to have done that. It would have been good practice to have found out more information about who the individual was, but some time -- I kind of think it was in March of 2004, but I, I could be wrong on the date, but at the end of the day, at that point it was, it was policy at the branch that you were supposed to make every reasonable effort to determine who the partner was and to work in conjunction with the, the mom, in this case, to let her know that we would want to do those respective checks -- and, and some of that was criminal risk assessment checks and prior contact checks -- to see whether or not any further information could be gleaned about the individual related to a criminal activity or activity across the child welfare system.

Q I want to ask you -- now move, move on to the involvement of Ms. Faria and Shelly Wiebe or Willox.

First with respect to the Section 4 report, it's Commission disclosure 1, starting at page 45, under the heading, The Sixth Protection Opening: From December 1, 2004 to December 7, 2004. This is basically, again, a factual account of what's recorded in the file. Do you, do you -- I want to give you an opportunity, opportunity to

respond to anything recorded here.

A Sorry, could you tell me the page again?

Q Page?

A Yeah.

Q Is 45.

A Forty-five, okay.

Q Do you have any comments?

A Can you be more specific, comments about ...

Q You don't have to comment, but if, if you have any comments with respect to what's recorded there in terms of your understanding or accuracy.

THE COMMISSIONER: From just December 1st or the whole page?

MR. OLSON: The whole page.

THE WITNESS: Oh.

BY MR. OLSON:

Q In fact, if you read that whole page and the next page as well, that will probably shorten things a bit.

A I think I'd better just take a second, here.

THE COMMISSIONER: Take your time, Witness. That's --

THE WITNESS: Thank you, sir. Thank you.

THE COMMISSIONER: -- a lot of paragraphs. I know you've seen it before, but still.

THE WITNESS: Yeah, yeah. Thank you.

MR. SAXBERG: If I could just interject here, I'm having trouble understanding why this witness would be verifying whether another -- whether Mr. Koster's depiction of events is accurate, when this witness has no direct involvement in this matter. All he can do is say is this the same as -- is what Mr. Koster wrote the same as what workers wrote in another report? I don't understand what's probative about asking this witness about how these facts have been recorded, when he had no involvement.

THE COMMISSIONER: Well, I guess he's asking whether this witness agrees with, with Mr. Koster's assessment of the situation related to the various events outlined here.

MR. SAXBERG: But he wasn't a participant in those events. He can only -- he only knows about the events from reading someone else's recording of them.

THE COMMISSIONER: Yes, I think that's correct, but I think if he wants to comment on what's here in, in -- you're asking for a comment if he wants to make one.

MR. OLSON: Yeah, because I -- what I'm going to do is put some specific comments or findings made by Mr. Koster to the witness -- he was a supervisor at the time -- and if it's based on something that's incorrect, then I want to give this witness an opportunity to clarify it. Or

if something needs further explanation, to clarify that.

THE COMMISSIONER: But, if, if -- but, but it would have to be something he has knowledge about to know whether it was correct or not.

MR. OLSON: Absolutely. I don't -- I'm not asking him to comment on anything he doesn't have knowledge of. So he may very well not have any comments with respect to what's recorded here.

THE COMMISSIONER: Well, but that -- what do you take out of that answer if he has no comment?

MR. OLSON: If he's -- if he has no comment, that's, that's fine.

THE COMMISSIONER: Well, I don't think you can assume from that, unless you go through it line by line, that he's agreeing or disagreeing with it.

MR. OLSON: No, what I'm going to do is put some of the specific findings or comments that the report writer made that --

THE COMMISSIONER: Well, put, put the, put the first one of those to the witness and then I'll hear Mr. Saxberg on the point.

BY MR. OLSON:

Q Page 47, Finding 32 says:

> "This was the first time that the agency was officially aware that there was a 'Wes McKay' in the home and a partner to Samantha Kematch."

Finding 33 says:

> "The CRU worker and supervisor made the right decision to open the file to Intake for Assessment and Intervention."

That was done while you were the supervisor of the supervisor, right?

A (Inaudible) timeline here. Do you have a reference of a timeline? Is that July two-o-four?

Q Well, that -- if you look back at what I was referring to before, it goes through the, the history of this -- of, of Ms. Wiebe's involvement here.

A December of '05, okay. Or of '04, yeah.

Yes, I was, (inaudible) the assistant program manager.

THE COMMISSIONER: All right. So now I want to know what you're going to ask, because I said I would hear

Mr. Saxberg.

MR. OLSON: So what I'm, what I'm doing, Mr. Commissioner, is putting the specific comments that the report writer's making to the witness with respect to the period of time over which he was the supervisor of Ms. Faria, and to do that I'm -- he needs some context as to what he's -- what kind of questions he's answering.

So, for example, the next one would be Finding 34 on the page. Says:

> "The refusal to have the file open to Intake as requested is a major error in the Winnipeg CFS case management of the protection file."

THE COMMISSIONER: And so what would your question be?

MR. OLSON: So I would ask him if he agrees with that comment or not.

THE COMMISSIONER: Well, offhand, it seems to me that based upon his supervisory responsibility, it's a reasonable question, but if you want to --

MR. SAXBERG: No, no I don't have a problem --

THE COMMISSIONER: All right.

MR. SAXBERG: -- with that question. All I'm saying is Mr. Berg's only knowledge of this matter comes from reading the reports in the file that have only -- that have been given to him to read in advance of this appearance. So he, he can only know what's in the reports -- the Shelly Wiebe report from December 1st through to December 7, and based on his knowledge of the practices and procedures at the time, he can comment on whether the finding is something that he agrees with.

THE COMMISSIONER: That's what's, that's --

MR. SAXBERG: Yes.

THE COMMISSIONER: -- what's being asked.

MR. SAXBERG: And that's completely fine.

MR. OLSON: Yeah. And the reason for allowing the witness to review the factual underpinning is he may not agree with the way Mr. Koster's characterized something, he may not agree with the facts as based on this compared to what he's looked at, so I just want to be fair to the witness and give him an opportunity to see what facts Mr. Koster's findings are based on, and then to comment.

THE COMMISSIONER: That led him to that conclusion.

MR. OLSON: Exactly.

THE COMMISSIONER: And the question is whether,

witness, you agree with that, F34.

THE WITNESS: Yeah. I'm not sure I would agree that it was a major error in the case. I think that, that CRU attempted to move the case up to tier two intake, if I read this correctly, and it was returned to CRU. It was reassigned to the same worker that had involvement prior to the case being sent up to tier two intake, so I think that was, that was very wise on the supervisor's behalf for continuity of the case. It's, it's their right under the standards. They have every ability under the standards to be able to look for a credible source, to be able to ascertain safety related to the newborn baby.

We are talking about December '04, right?

BY MR. OLSON:

Q That's right.

A Yeah. And the hospital staff report a different experience. You know, for mom, they talk about her having prenatal care. They don't have concerns in regards to her usage at that time, if I've read this correctly, and at the end of the day the CRU social worker made a number of attempts to locate the mom, and at the request of the supervisor she followed up with a credible, reliable collateral in the public health nurse. And at the end of the day the public health nurse and her had an exchange --

and Shelly Wiebe had an exchange of information. Public health nurse said that she didn't have any, any child protection concerns or safety concerns about the baby, and the decision at that point in time was to close the case. That'd be congruent with, with the standards, and it'd be congruent with the '99 standards, the November '04 standards, the January '05 standards, and the current standards we have today.

THE COMMISSIONER: So I take it that what you've just recited are your reasons for not agreeing that this --

THE WITNESS: Yes.

THE COMMISSIONER: -- was a major error.

THE WITNESS: Yes, yes, sir. Yes, sir.

BY MR. OLSON:

Q Thank you. The, the investigation that was being conducted, what was your understanding as to who was being -- what was being investigated in this opening?

A What was being investigated was the, the birth of the newborn that returned, returned to live with the -- Samantha's family.

Q So not, not the safety of Phoenix Sinclair?

A This, this incident wasn't about the safety of Phoenix Sinclair. It was about the birth of the, of the newborn child.

Q There are some other findings on this page that apply to that same time frame. I want to give you the opportunity to respond to them if you like, but I'm not going to review them with you unless you need that.

THE COMMISSIONER: Which numbers?

MR. OLSON: Finding -- it's actually the balance of the findings of the page, Finding 36 and Finding 37.

THE COMMISSIONER: Those that follow 34, you mean?

MR. OLSON: Sorry. Finding 35, 36, and 37.

THE COMMISSIONER: Right.

UNIDENTIFIED PERSON: If we could just scroll to the next page, please? Thanks.

THE WITNESS: I can't, I can't comment about the computer data system at this time. I understand there's been some developments with that and so I would, I would probably stand down on being able to comment on that.

BY MR. OLSON:

Q That's not something you'd have knowledge of what's reported here. That's with respect to Finding number 36?

A Thirty-six, yes. I mean, I think, I think he articulates that he made the effort himself to try to be able to determine, you know, that information, and, and his

response is there so I think it, it stands on its own.

> "The unwillingness of the public health nurse to provide information was regretful and made the possibility of obtaining a birth date for the father more difficult."

You know, her legal obligation is to, you know -- we -- the Child Welfare Act supersedes PHIPA and PHIA in terms of her ability to be able to share information related to protection concerns that she may or may not have had related to the baby. You know, if, if we, if we decided that the obtaining of the birth date for the father -- I would agree with him that it, it made that more difficult, so I think, I think his comment is fair.

Q You, you did say you read these reports previously and you're familiar with them?

A Yes.

Q Okay. I want to give you an opportunity -- and this is to be fair to you -- to make any comments you, you like with respect to the reports, but I'm not going to go through them with you. Is there anything you would like to comment on?

A From, from the three reports? Is that your question?

Q And the internal report. So that'd be the --

THE COMMISSIONER: Well, I, I -- when you look at the volume of them --

THE WITNESS: Yeah.

THE COMMISSIONER: -- I don't know what -- where that -- what answer you're looking for but --

MR. OLSON: I'm not looking for any answer. I just want to give the witness an opportunity to respond to anything raised that he feels he needs to address.

THE COMMISSIONER: Well, I think maybe the way to do that is to, is to -- if, if he does, let his counsel bring it out when his time comes because it's --

MR. OLSON: That's fair.

THE COMMISSIONER: It's a huge question.

MR. SAXBERG: Yeah, and I would, I would just say that there are no findings in any of those reports that relate to this witness.

THE COMMISSIONER: Well, the question's been asked and I think if there's anything in particular you want to have him speak to, you'll, you'll have the opportunity to do that.

BY MR. OLSON:

Q Just want to ask you now a few final questions. First, how did you learn of Phoenix Sinclair's death?

A I learned of Phoenix's death during my time at Animikii Child and Family Services.

Q And can you remind us again when that would have been?

A I went to Animikii Child and Family on May the 16th, 2005, and I left there -- I'm struggling a little bit -- I think it was April of 2006, if I remember correctly.

Q How is it you learned of her death?

A I may get the sequencing of this wrong. I, I believe we -- I first learned of her, of her passing -- I can't, I can't remember exactly how, but we had involvement with a file at Animikii that had to do with [redacted].

Q And I don't want you to give me the specifics of that file. It was -- but you're saying it was through a file that you had involvement with, that had some connection.

A Right. And, and we asked for permission from ANCR to be able to go and review their file, just in the event that it had any related follow-up that we needed to do related to the dad, at our time at Animikii.

Q Did you have any discussions on a managerial level with respect to your supervision or the supervision

of your -- of the workers involved in providing services to Phoenix Sinclair?

A I did. I did just prior to my leaving Animikii. I had first involvement with the, the police come to see one of my, one of my staff who had left Animikii and was working at another location. And the police had come to the Animikii office, and so I agreed to meet with the police and they informed me of the fact that they were looking for a previous staff member of mine. And I asked them what it was about and they shared with me that it was about some allegations of information that had allegedly been shared with my staff member, and they were good enough to provide me with a timeline of when that information was, was allegedly had been able to be told to the staff member, and at that point in time I provided them with the follow-up information in regards to how to contact that staff person.

MR. OLSON: Thank you. Those are my questions for this witness.

THE COMMISSIONER: Thank you, Mr. Olson.

Well, now what's the view of counsel? Do we -- Mr. Gindin, have you some questions? I'm sure you have.

MR. GINDIN: I expect to be fairly lengthy. My plan was to go last, so I'm not sure about the others, whether they're prepared to ask some now or try to do it

tomorrow.

THE COMMISSIONER: All right. Well, we'll, we'll leave yours over till tomorrow in any event.

Mr. McKinnon, have you some questions?

MR. MCKINNON: Yes, Mr. Commissioner, and I don't think I'll be lengthy so I, I would suggest --

THE COMMISSIONER: So --

MR. MCKINNON: -- I could proceed.

THE COMMISSIONER: Yes, please, do.

MR. MCKINNON: There's one more piece of paper I need, sir.

CROSS-EXAMINATION BY MR. MCKINNON:

Q Mr. Berg, my name's Gordon McKinnon. As you know, I represent the department and Winnipeg CFS.

I just wanted to get a bit of -- put some of your evidence in a bit of context. As I understand it, you started working as an assistant program manager at Winnipeg CFS in 2003.

A That's correct.

Q And you had had some prior experience in intake, but this was -- if I can put it in the colloquial, this was, this was a whole different ballgame when you came to be the assistant program manager at intake at Winnipeg CFS.

A I think that's a fair comment.

Q And our -- by your own words as I recorded them, this was a steep learning curve for you.

A The, the intake piece was a steep learning curve, yes.

Q To, to become familiar with and get up to speed with that complex program.

A That's, that's correct.

Q And you viewed one of your ... One of the important initiatives that you undertook was to try and get a more collegial and friendly and familiar atmosphere between you as a junior manager, if I can use that phrase --

A For sure.

Q -- and your supervisors and your staff.

A Absolutely.

Q And collegiality is important to you.

A It's, it's important to me as an individual, but far more importantly, it's important that we have a good working relationship because just in the nature of our business if we treat each other respectfully, professionally, it filters all the way down to the way we interact with our, our families out there.

Q So you think it's important for the program, as well.

A It's important to the, the whole service business

that we do, for sure.

Q And, and it's an important value, your -- as a personal value, and it's an important value to you as a social worker, and, and you believe it's important for the program as a whole that there be that kind of collegiality.

A Absolutely.

Q Now, we know that you left this position to go to Animikii in around April, was it, of 2005?

A May 16.

Q May of 2005. So you were actually in this position for only two years.

A Just two years, yes.

Q So you had limited experience with intake prior to this, and subsequent to 2005, you went to Animikii and then you came back to Winnipeg CFS after about another year, was it?

A Can I just back up for a second? I want to give myself a little bit more of a pat on the back. I, I had lots of experience when I went over to the position, just never having worked with the degree of volume with the intake. So I had responsibilities as a supervisor for, for many years before going there and we ran our own intake programs rurally. But you can appreciate running the, the new, the new case intakes at 835 Portage compared to a rural intake system in Steinbach and St. Pierre, there

would be differences and the volume intensity would be that, that different. Doesn't take away from I had a learning curve.

Q Let me -- and that's what I'm trying to get at in terms of ... Would you agree with this, that, that just in terms of the experience you had in that job when you came back to Winnipeg CFS, Winnipeg CFS didn't have an intake function anymore. That's obvious. You'll agree with that.

A Correct, yes.

Q So your experience as a assistant program manager at intake is limited to that two-year period that we've been talking about.

A My experience at intake at 835 Portage, that office was limited to those two years.

Q And would you agree with me that that particular -- the pace of that work and the volume of that work was not a good fit for you?

A No, I wouldn't agree with you on that. I would just say that it probably took me six months to wrap my head around the abuse program, CRU, and intake program because they were, they were new programs to me. So it meant a lot more work and a lot more hours to get up to speed, but I don't think I was out of place.

Q When Mr. Olson was asking you questions this morning and there was a great deal of discussion about

cases being received at CRU, being referred to intake, and then coming back to CRU, you'll recall that discussion.

A Yes, I do.

Q And I just want to make sure I'm clear and the Commissioner's clear on this. We talk about general intake; sometimes we use the expression tier two.

A Yes.

Q Tier one is CRU.

A That's correct.

Q Correct?

A Yes.

Q So both -- if we talk about the function of intake, that's tier one and tier two collectively is an intake function. Correct?

A I think that's a fair comment.

Q And you were responsible for both tier one and tier two.

A Yes --

Q Certain aspects of it. I, I know there were --

A Yes.

Q It was a shared position, but --

A Yes.

Q -- in terms of your --

A Definitely.

Q -- your reports, you had some reporting to you

from tier one and some reporting to you from tier two.

A Abuse and intake and community.

Q Right.

A Yeah.

Q But just trying to focus for this moment on, on this --

A Okay.

Q -- this issue of, of, of CRU and tier two and, and the back and forth.

A Yes.

Q And there was a great deal of discussion between you and Mr. Olson about, you know, what happens when files -- administratively, how they go up and what happens and how they sometimes are referred down for follow-up. My question to you is this: As an assistant program manager, is it particularly important whether it's in tier one or in tier two, or is it, is it the function, is it the job, is it, is it -- do you see where I'm, I'm going to this -- with this? Does it matter from the point of view of the program from intake, whether the follow-up is being done at tier one or at tier two, so long as the follow-up is done?

A I think it's important that the follow-up is done; I think that that's crucially important. But the function at CRU, with the volume that they were managing, means that it's going to be a short-term service. You're

not going to get the level of potential intensity, the opportunity to connect with the family, the opportunity to join with the family, and the opportunity to work with the family for, for two months, that you could potentially have if the referral goes to the intake unit.

Q Yes. And I, and I understand that, but when --

A Yes.

Q -- when a case is being referred back, it's usually in the context of one more thing needing to be done.

A Potentially.

Q One or two things needing to be done to make a decision on that case. Would that be fair, that that's when these cases can sometimes be referred back?

A It's certainly true. Some, some cases were that way.

Q And regardless of whether that one thing or that two things, it's usually an investigation, fair?

A Um-hum.

Q Regardless of whether that one thing or that two -- or those two things are done follow-up by CRU or follow-up by tier two, in both cases the same work has to be done.

A That's a fair comment. If it's --

Q And --

A If it's a short-term service like that --

Q Right.
A -- yes, for sure.
Q And in both cases the instructions would be not to close that file until safety is assured; is that fair?
A Yes, I think that's fair.
Q Just a third area I wanted to just clarify. You told the Commissioner that when you started there was only one supervisor at CRU, and that was Diva Farrera (phonetic); is that correct?
A Faria, yes.
Q Faria.
A Yeah.
Q We've heard evidence here on -- actually, on day one of the Inquiry that in 2000, 2000 -- I think it was 2000 when CRU was first established, it had two supervisors. Were you aware of that?
A I was aware of that, but my, my information about how CRU functioned prior to that is fairly limited. I know it had two supervisors, but not when I showed up.
Q Right.
A There was just the one.
Q And, and I'm advised that the two supervisors were, were Diva Faria and Jim Richardson?
A Yes.
Q And that at some point in about 2002 -- in 2002,

Jim Richardson left for another position and there was a, an individual named Rick Manteuffel.

A Rick Manteuffel, yes.

Q Manteuffel.

A Um-hum.

Q Who was a supervisor in CRU, and then there was a period of about eight months where there was only about one supervisor. And when you joined, you were successful in convincing the administration to return to two; is that fair?

A Yes, I think that's very accurate.

MR. MCKINNON: I think those are my questions, Mr. Commissioner.

THE COMMISSIONER: Thank you, Mr. McKinnon.

Mr. Ray, do you have any questions?

MR. RAY: I do, Mr. Commissioner, but I don't expect I would finish my ... I do have some questions, Mr. Commissioner, but I don't expect I would finish today if I started now, given it's 25 after four, and given that Mr. Gindin's going to be after me.

THE COMMISSIONER: Well, I'd sit to quarter to five, but that likely won't do it, I take it?

MR. RAY: Pardon me?

THE COMMISSIONER: If we sat to quarter to five, would that give you enough time?

MR. RAY: Possibly. I can't say for sure.

THE COMMISSIONER: You'd rather not, I gather.

MR. RAY: If we're going to be coming back in any event, I, I'd rather just wait. I may be able to be more concise if I take some time to review this witness's evidence and --

THE COMMISSIONER: All right.

MR. RAY: -- then come back tomorrow and start tomorrow.

THE COMMISSIONER: All right. Is there anybody else who's got a few questions? I assume not.

Mr. Khan?

MR. KHAN: I may have one question, but I wouldn't mind reviewing my notes.

THE COMMISSIONER: You may what?

MR. KHAN: Wouldn't mind reviewing my notes --

THE COMMISSIONER: All right.

MR. KHAN: -- overnight, if I could.

THE COMMISSIONER: Overnight. Okay.

All right. Now we're, we're adjourning till eleven o'clock tomorrow morning or thereabouts, when everybody's gathered. I think we'll try to sit eleven to one and perhaps take a one-hour noon hour. If it extends another five or ten minutes, no one's going to get upset by that. But that would be our objective for tomorrow.

Okay. We stand adjourned.

(PROCEEDINGS ADJOURNED TO JANUARY 24, 2013)