The Legacy of Phoenix Sinclair

Achieving the Best for All Our Children

The Hon. Ted Hughes, O.C., Q.C., LL.D. (Hon), Commissioner

Volume 2

December 2013

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PHASE ONE - THE STORY OF PHOENIX SINCLAIR

These chapters tell the story of Phoenix's life and death from the many perspectives that were presented in this phase of my inquiry.

In keeping with my mandate, I focus in this phase on the circumstances surrounding Phoenix's death, and in particular:[146]

- the child welfare services provided—or not provided—to Phoenix Sinclair and her family under *The Child and Family Services Act*;
- any other circumstances directly related to Phoenix's death ; and
- why her death remained undiscovered for nine months.

Beginning with Phoenix's birth and ending with the discovery of her death, her story is told through the evidence of the 82 witnesses who testified in Phase I. Where relevant, I have reproduced records made by Child and Family Service workers, Employment and Income Assistance workers, and health care professionals. It is a long narrative, spanning five years of her life and many weeks of testimony before the Inquiry.

In her opening statement on the first day of hearings, Commission Counsel said that one of the questions this Inquiry needed to answer was this:

> *"How was it that Phoenix could become so invisible to a community that included social service agencies, schools, hospitals, family, and friends, as to literally disappear?"*

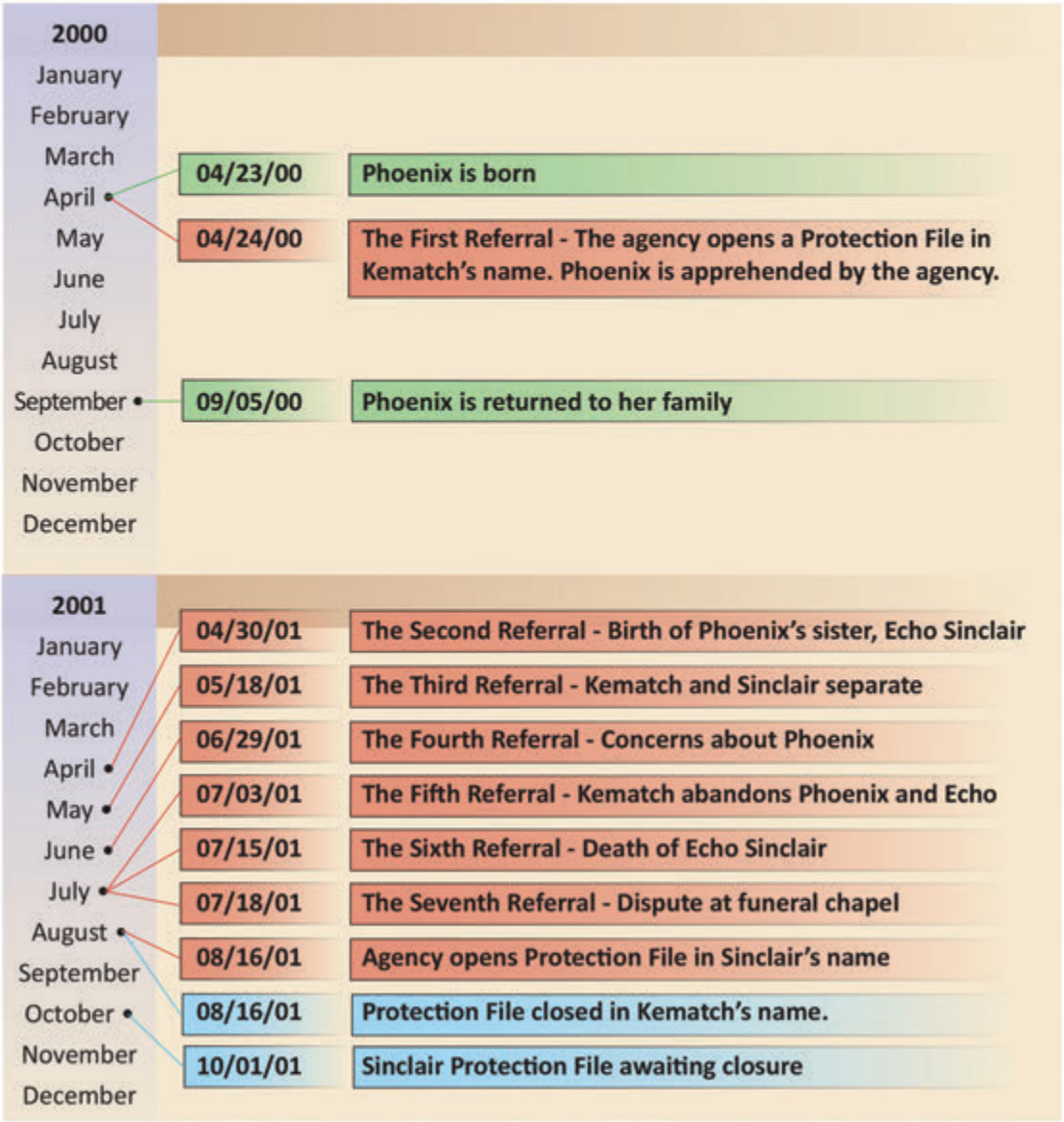
The answer to that question begins to emerge in this chapter. The evidence I heard in Phases Two and Three highlights the vulnerabilities that lead so many members of our community to need help from the child welfare system and other government and community supports: poverty, substance abuse, and lack of education, to name a few. These systemic issues, so often rooted in the long-standing effects of racism and colonialism, are considered more fully in Phase Three of this report.

In the analysis that follows, I comment on actions that were commendable, and on those that failed to protect Phoenix or to support her family.

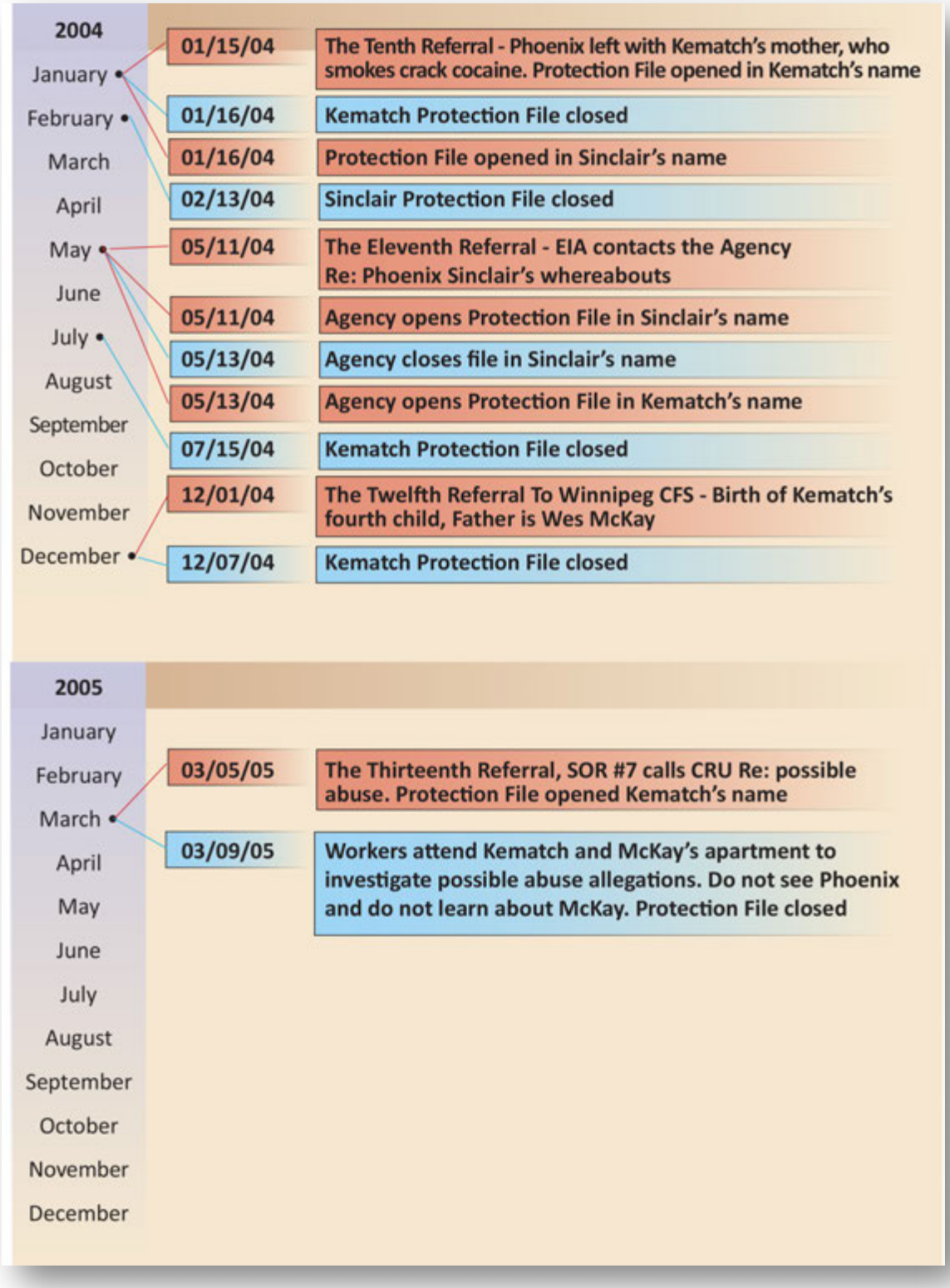
Phoenix was born healthy and had a life of possibilities and potential ahead of her. But to fulfill that potential, the signs were clear that she and her parents would need support, as many families do to varying degrees. Phoenix and her family came to the attention of the child welfare system from the moment of her birth. That is where this narrative begins.

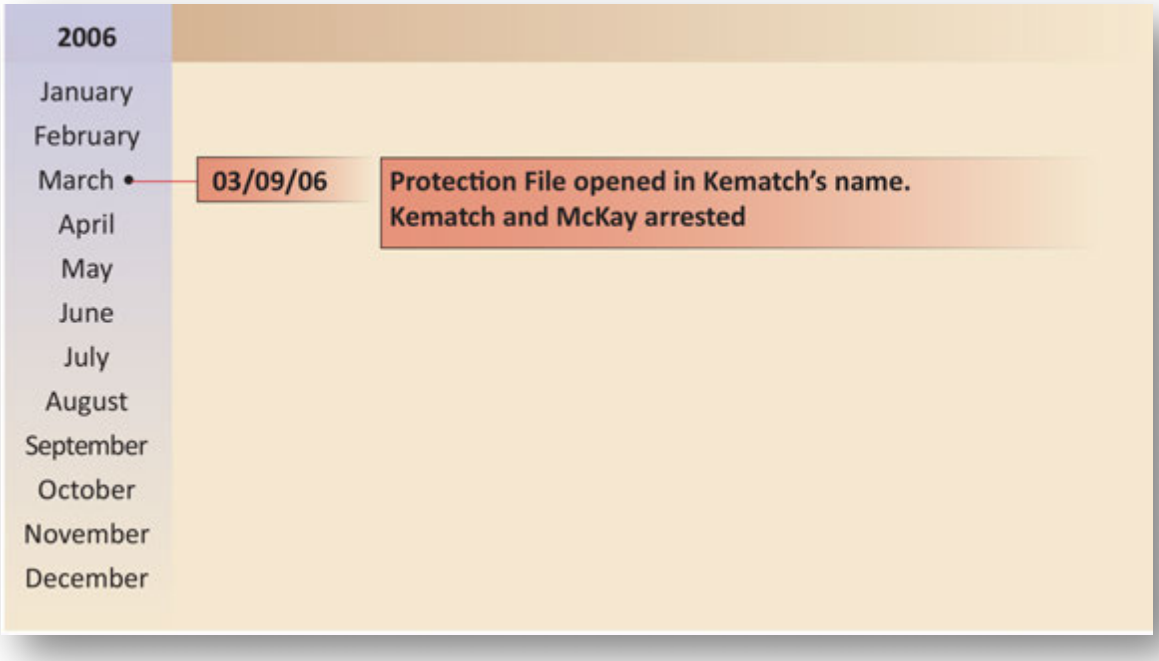
TIMELINE OF DOCUMENTED WINNIPEG CFS INVOLVEMENT WITH PHOENIX AND HER FAMILY

The following timeline shows in red each time the agency opened a file in response to a referral relating to Phoenix's safety and well-being. It also shows a number of additional referrals, also in red, that were made to the agency while the file was kept open. In green it shows significant events relating to Phoenix. Finally, in blue, it shows each time a file was closed by the agency.




2002
January
February
March
April
May
June
July
August
September
October
November
December
03/27/02
Sinclair Protection File closed
2003
January
February
March
April
May
June
July
August
September
October
November
December
02/26/03
The Eighth Referral - Call from the Children's Emergency Hospital. Protection File opened in Sinclair's name
06/21/03
The Ninth Referral - Phoenix is apprehended by the agency a second time
07/29/03
Edwards and Stephenson home becomes a "Place of Safety"
10/03/03
Phoenix is returned to Sinclair
11/03/03
The Sinclair Protection File is closed


2004
January
February
March
April
May
June
July
August
September
October
November
December
01/15/04
The Tenth Referral - Phoenix left with Kematch's mother, who smokes crack cocaine. Protection File opened in Kematch's name
01/16/04
Kematch Protection File closed
01/16/04
Protection File opened in Sinclair's name
02/13/04
Sinclair Protection File closed
05/11/04
The Eleventh Referral - EIA contacts the Agency Re: Phoenix Sinclair's whereabouts
05/11/04
Agency opens Protection File in Sinclair's name
05/13/04
Agency closes file in Sinclair's name
05/13/04
Agency opens Protection File in Kematch's name
07/15/04
Kematch Protection File closed
12/01/04
The Twelfth Referral To Winnipeg CFS - Birth of Kematch's fourth child, Father is Wes McKay
12/07/04
Kematch Protection File closed
2005
January
February
March
April
May
June
July
August
September
October
November
December
03/05/05
The Thirteenth Referral, SOR #7 calls CRU Re: possible abuse. Protection File opened Kematch's name
03/09/05
Workers attend Kematch and McKay's apartment to investigate possible abuse allegations. Do not see Phoenix and do not learn about McKay. Protection File closed



5 THE STORY OF PHOENIX'S LIFE

5.1 PHOENIX IS BORN, APRIL 23, 2000

Phoenix Victoria Hope Sinclair was born on April 23, 2000 at the Health Sciences Centre Women's Hospital, in Winnipeg. She was born a healthy child. Her parents were Nelson Draper Steve Sinclair, age 19; and Samantha Dawn Kematch, 18. It was her father who chose her name. He testified that although he and Kematch had been uncertain about their plans for her, "After she was born I just fell in love with her, so I couldn't let her go."[147]

Both Sinclair and Kematch had, as children, been significantly involved with the child welfare system and as parents, they both strongly mistrusted it.

Child welfare records indicate that Sinclair was taken into care when he was eight years old, in 1989, because of a family history of violence and alcohol abuse. He was made a permanent ward of Winnipeg Child and Family Services (CFS) on December 3, 1991. His file was closed effective May 15, 1998, when he reached the age of majority.[148]

That file indicates that he had been placed with three foster families during his time in care, the last placement beginning in October 1991 and lasting for more than six years. Sinclair's relationship with his foster family reportedly broke down in 1998 as he approached the age of majority. One document in his child in care file, dated April 15, 1998, stated that Sinclair had been the victim of childhood physical and emotional abuse and was addicted to alcohol.[149]

Sinclair had four sisters and two brothers. His mother was a residential school survivor. He testified that she didn't talk to him about her experience in residential school, adding, "I can understand why." Sinclair also recalled that as a child, moving to a new foster home meant moving to a new school as well, making it difficult to make friends and to stay in school. When asked who his parenting role models were when he was growing up, Sinclair said that he looked to the parents he saw on television.[150]

At the time that his Winnipeg CFS child in care file was closed, he had completed Grade 10 and was relying on social assistance to support himself.

Kematch's Winnipeg CFS child in care file indicates that she was apprehended at age 11, in 1993, after a report that her mother drank heavily, had drinking parties, and was physically and emotionally abusing her. Ultimately, Kematch was made a permanent ward of Cree Nation Child and Family Caring Agency (CFCA), and her Winnipeg CFS child in care file was closed in February 1996.[151] In 1998, at age 16 and while still a ward of the Cree Nation agency, Kematch gave birth to her first child. The child was apprehended at birth and was made a permanent ward of that agency.

Sinclair testified that he met Kematch through her brother. They began dating in late 1998 and eventually moved in together. Around that same time, they began to attend the Boys and Girls Club in Winnipeg on a regular basis.[152] This is a community-based organization that provides employment programs, healthy living programs, and after-school programs to young people.

I heard evidence from Nikki Humenchuk (then Taylor) who was a supervisor at the Boys and Girls Club on Aberdeen Avenue from 1999 to 2003. She managed the facilities and staff and worked with the young people who dropped in. Humenchuk testified that although it was not part of her job, if a club member approached her, she would try to help by acting as an advocate.

Humenchuk recalled that Sinclair and Kematch came to the club as a couple, three to five days a week from the time she started working there in 1999 until Phoenix was born in 2000. She remembered Sinclair as an excellent guitar player who taught younger children to play. Kematch was more interested in the kitchen and socializing. Both would make snacks and watch movies.

Humenchuk learned from Kematch, during the time they spent together at the club, that she had been in the care of child welfare, and her mother was an alcoholic. Humenchuk described Kematch as immature and having trouble expressing emotions and feelings. She specifically recalled that Kematch struggled with language, with understanding jokes, and with building relationships.

Humenchuk described Sinclair as nice, and "quiet, shy and surprisingly quite sweet."[153] She was aware that he had been in care and that he had siblings. She recalled that he had let her know that his time in the care of child welfare was not good.

It was clear from Humenchuk's testimony that through her involvement with the Boys and Girls Club, she had developed a relationship with Kematch and Sinclair such that they were comfortable sharing personal information with her, and relying on her for support.

5.2 KEMATCH'S PREGNANCY

Kematch became pregnant with Phoenix in 1999. Sinclair testified that although he and Kematch had initially planned on keeping Phoenix, they had not prepared for her arrival.[154]

Humenchuk testified that in the months before the birth, she and the club's staff noticed that Kematch had gained weight, had an increased appetite, and would always wear her coat indoors. They suspected that she was trying to conceal a pregnancy, but the couple never spoke of it. Humenchuk did not have confirmation of the pregnancy until the day Phoenix was born.[155]

Note: In this Phase of my report I have chosen to reproduce some original documents that were disclosed to the Commission. In other cases, especially where there were legibility issues, I have included transcriptions of their contents instead. Often, these were handwritten or hastily composed notes, for the purpose of file recordings only, and they contained spelling and other errors. The transcriptions are as faithful as possible to the originals and I have not attempted to correct or draw attention to any such errors.

5.3 PHOENIX IS APPREHENDED AT THE HOSPITAL

5.3.1 1ST REFERRAL TO CHILD AND FAMILY SERVICES, APRIL 24, 2000

The day after Phoenix's birth, a hospital social worker received a referral slip from a nurse at Women's Hospital. It was written on a Health Sciences Centre Department of Social Work Form. It gave Kematch's name and under "Consult/Referral Reason:" the handwritten words say:

> *Please assess: Pt 19 y.o. pt is having her 2nd baby. Pt's 1st child is a permanent ward of C+FS. Pt had no prenatal care with this pregnancy. Pt on welfare; lives common-law [with] baby's father.*[156]

Upon receiving this referral, the social worker met with Kematch for about 15 minutes that same day, to ask her about the concerns the nurse had raised.

(For reasons that are explained in Chapter 2 this social worker and some other witnesses are not referred to by name. They may be referred to as a numbered "source of referral" or "SOR." This is SOR#1.)

After the meeting she made this handwritten recording in Kematch's chart:[157]

> *Writer met with Samantha to review above concerns. Samantha advised that her son (2 years) was made a p.w. of CFS "because they thought I would hurt him." Samantha advised that the Agency felt this b/c Samantha herself was an abused child. Samantha advised that this pregnancy was unplanned. Samantha and her boyfriend Steve have been together for 1 year. Samantha had 0 prenatal care "b/c she doesn't like Drs." Samantha advised that she and Steve are unprepared for baby i.e., no crib, clothes, formula, etc. . . Samantha is unsure if they are emotionally ready. When questioned what her plans were for the baby-- "I don't know," . . .*

SOR #1 was a social worker with BSW and MSW degrees. She testified that there were a number of indications that Kematch's case needed to be explored further by CFS, including Kematch's own history of childhood abuse; her lack of prenatal care for Phoenix; her reported dislike of doctors; her ambivalence towards parenting; and the lack of practical readiness for Phoenix's arrival.

For all these reasons, SOR #1 called Winnipeg CFS at 11:15 am on April 24, 2000, the day after Phoenix's birth, to refer the case to the agency. She recorded in her notes that Kematch had agreed to meet with child welfare to discuss a plan for parenting Phoenix.

5.3.2 A PROTECTION FILE IS OPENED

In 2000 the process was as it is today: a protection file would be opened when the agency determined that a child was in need of protection as defined by section 17 of *The Child and Family Services Act:* that is, where " . . . the life, health or emotional well-being of the child is endangered by the act or omission of a person." CFS policy was to open a protection file in the name of the parent that the agency determined to be the primary caregiver. In this case the file was opened in the name of Kematch. (The agency would open a child in care file in the name of a child when a child was apprehended, and that file would stay open as long as the child was in care.)

A referral from SOR#1, the hospital social worker, dated Monday, April 24, 2000, at 11:00 a.m., was recorded in the Kematch protection file. Under "Presenting problem" the After Hours Unit employee typed the following:[158]

> *[Redacted] was calling with concerns about the above-named couple's motivation and ability to parent. Samantha is eighteen and gave birth to a baby girl yesterday after having no prenatal care. In talking with her [Redacted] was made aware that Samantha has another child that was removed from her care. When [Redacted] asked her why she said that people thought she may hurt the baby, just as her mother had hurt her. [Redacted] questioned her preparation for this baby and found out that the couple had not purchased any clothes, diapers, crib, etc. [Redacted] asked her if she was "emotionally ready" for the baby and Samantha responded by saying, "I don't know." Samantha and the worker talked more about this and it*

> *became quite clear that this couple is not sure if they want to parent. Given Samantha's lack of preparation for the baby, the past concerns and the ambivalence over parenting, [Redacted] is requesting workers attend sometime today to talk with mom. [Redacted] discussed the need to do so with Samantha and after some hesitation agreed to meet with workers. Consulting Supervisor, Arthur Gwynn, agreed that the evening shift should attend to the hospital today as Samantha may be able to leave tomorrow.*

Following the name and signature of the After Hours worker, the following appears:

> *At 1745 Hrs, workers Diana Verrier and Dan Cianflone attended the hospital and met with Samantha and Steve. Samantha stated that her delivery of the baby went well and Steve was with her. She was not aware of any concerns with the babe at the time of birth. Both Steve and Samantha stated that they were unsure about whether they wanted to parent. Sam stated that she was not sure that she was ready to be a mother and felt she should have waited longer to become a parent. The birth of Phoenix was not a planned occurrence.*

As stated in the report, at 5:45 p.m., social workers Diana Verrier and Dan Cianflone met with Kematch and Sinclair at the hospital. Verrier noted in Kematch's protection file that both Kematch and Sinclair were unsure about whether they wanted to parent; Phoenix's birth was not planned; they did not have family members who would be able to care for her; and they had asked that Phoenix be taken into care until they could prepare for her and decide whether they wanted to parent her.

The workers reviewed possible options with Kematch and Sinclair, according to the file. Sinclair testified that afterwards, he and Kematch were left alone to make a decision: he had hoped that Kematch would want to parent Phoenix, but initially they were unsure.[159] Ultimately the workers decided to apprehend Phoenix and place her in care.[160]

After Phoenix's birth, Sinclair called Humenchuk at the Boys and Girls Club to ask her for help because Phoenix was being apprehended.[161] Humenchuk testified that she was shocked to learn the news, and headed to the hospital immediately. She testified that she understood that Phoenix was being apprehended because of the concealment of the pregnancy and the lack of prenatal care. Sinclair confirmed that he called Humenchuk because "she was already in our lives and . . . she was a good person."[162]

After the Kematch protection file was opened by the After Hours Unit (AHU) of Winnipeg CFS, it was transferred to the agency's Northwest Intake Unit. The supervisor of that unit was Andrew Orobko. He had a BA degree; he had been working in child welfare since 1989 and in a supervisory capacity since 1992. As was the case with the majority of social workers and supervisors from the agency

who testified at the inquiry, Orobko had little independent recollection of his involvement with the Kematch protection file.

He testified that in 2000, a file would make its way to his intake unit either through a phone screener in his unit, or via the After Hours Unit. (The Crisis Response Unit was established in 2003.) As supervisor, Orobko's practice was to review a file when it arrived in his unit to get a sense of the family's social history and any history of agency involvement. He would then decide how it should be dealt with.

He assigned the matter to intake worker Marnie Saunderson. Saunderson had a BSW degree and began working for Winnipeg CFS in 1992. She had conduct of the file only from April 25 to April 28, 2000, because she soon learned that she had a conflict of interest. Humenchuk, who was acting as the couple's advocate, was Saunderson's first cousin.

Saunderson's intake transfer summary, dated April 28, 2000 outlines the services she provided during the few days she had the file. On April 25, 2000, she met with Kematch and Sinclair at Women's Hospital. Phoenix was in the room with her parents. Kematch told Saunderson that she had changed her mind, and that she no longer wanted Saunderson to take Phoenix. Saunderson testified that it was "fairly natural" and quite common for parents to attempt to bargain with the agency when it came to the moment that their baby would actually be apprehended.[163] Saunderson then moved Phoenix from the hospital to a Winnipeg CFS shelter, and then to a foster family. Saunderson's file recording was as follows:[164]

> *This writer invited the parents to help this writer to dress Phoenix and only Steve did so. Samantha seemed only vaguely interested in the process, and when we were walking downstairs, she seemed more interested in chatting and giggling with a friend. The girl that the couple met up with, appeared extremely shocked that they had just had a baby. She made it sound as though the couple had kept this a secret on purpose.*

Sinclair remembered this meeting with Saunderson. He testified that he told her they had changed their minds about parenting Phoenix and that he asked for a visit with Phoenix "right away" before Saunderson left the hospital with the baby.[165]

Saunderson's transfer summary further states that on April 26, 2000, she initiated the process to set up visits between Phoenix and her parents. Sinclair telephoned Saunderson twice that day, inquiring about a visit. During the second conversation he told Saunderson that he and Kematch would like their advocate from the Winnipeg Boys and Girls Club, Humenchuk, to attend with them. He testified that he asked Humenchuk to attend the visits with Phoenix because she had acted as an advocate for them and helped them with things they did not fully understand.[166] This was the point at which Saunderson discovered that Kematch and Sinclair's advocate was her cousin.[167]

Saunderson testified that she arranged with Sinclair for visits to begin the Friday after Phoenix's birth and to continue every Friday. The visits were to last two hours and 15 minutes, and were to be loosely supervised.[168]

I note that Saunderson was readily prepared to include Humenchuk's participation in Phoenix's life. This is consistent with the intent of *The Child and Family Services Act.* As the facts will reveal, however, Humenchuk's further involvement was not pursued by the agency.

Saunderson and Orobko discussed the conflict of interest that had arisen for Saunderson, on April 27, 2000, and decided that Orobko would assume conduct of the file from Saunderson.[169]

Before transferring the file to Orobko, Saunderson contacted Cree Nation CFCA for more information about Kematch's child welfare history. Cree Nation CFCA disclosed that Kematch had been a permanent ward of that agency; that her first-born child was also a permanent ward; and that Kematch had not been involved with, or tried to visit that first child. When Saunderson transferred the file she was still waiting for more details from Cree Nation CFCA. She wrote in her intake transfer summary:[170]

> *At this point, the parents remain somewhat ambivalent around their motivation to parent Phoenix. There is some indication that, despite their initial reaction, they are eventually wanting to parent Phoenix. This writer has yet to receive written documentation around the reasons that Samantha's son, [Redacted] became a Permanent Ward of Cree Nation CFS. Once this information is received, it will need to be incorporated in to the final assessment of the family and the Recommended Plan.*

On April 28, 2000, Cree Nation CFCA faxed to Saunderson's attention documents from its files relating to Kematch.[171] The documents provided an outline of Kematch's history, but no information about her first child. Saunderson testified that she had requested the protection file for that child, but instead received Kematch's own child in care file.[172] By the time a second set of documents arrived, containing the information she had been seeking, Orobko had taken over the file and Saunderson was no longer involved.

Orobko testified that there was nothing particularly unique or remarkable about the Kematch protection file; all files in his unit came with serious parental capacity and motivation concerns and many files involved young parents with traumatic childhoods and potential developmental issues. This was consistent with the evidence of many workers involved with Phoenix and her family who described Phoenix's family's files as "routine" or "typical." But, as testimony at the Inquiry showed, as typical as this situation may have been, it demanded serious and consistent attention to protect Phoenix's life, her health, and her emotional well-being.

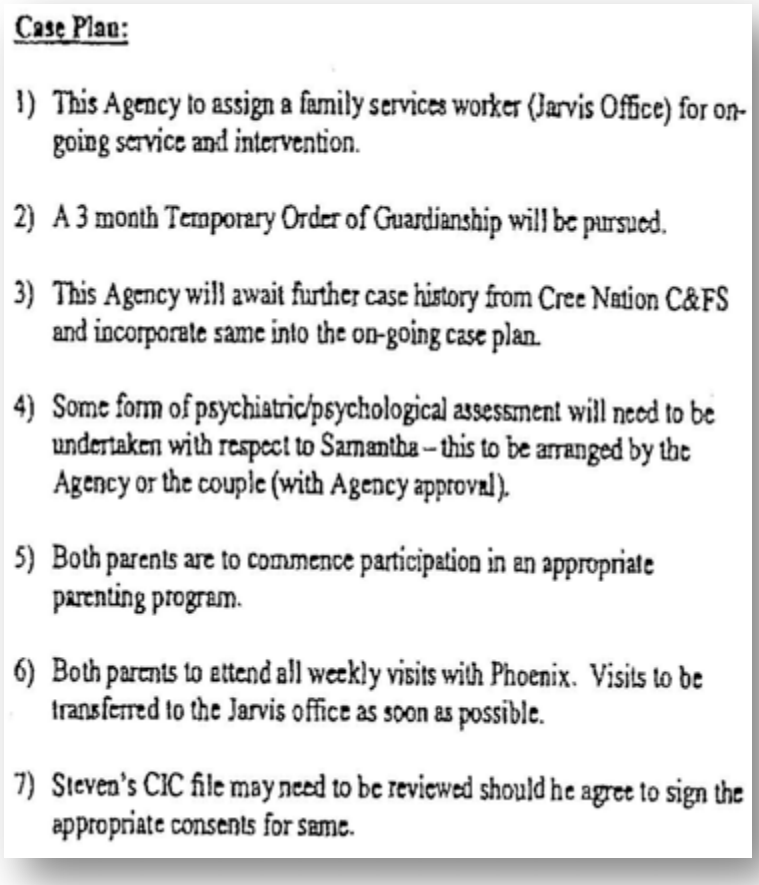
Orobko produced a report entitled, "Continued Summary of Service & Intervention." It referenced a meeting with Kematch and Sinclair at the Northwest Winnipeg Intake Unit office at 831 Portage Avenue on April 28, 2000:[173]

> *As of this writer's meeting with Samantha & Steven on Apr. 28/00, the parents are indicating a desire to continue their common-law relationship with Phoenix being in the family fold. They advise that they came to this position after much deliberation and discussion.*
>
> *The writer aggressively challenged the couple on their ambivalence toward parenting this child and the lack of prenatal care, the "hiding" of the pregnancy, and Samantha's seeming disinterest with respect to [Redacted] were raised as well.*
>
> *Throughout our conversation Samantha remained flat and stoic. She responded to questions in a simple and cautious manner, often pondering her response for a moment or two before uttering same. Complex questions often received simplistic responses, which failed to shed any meaningful light on issues, especially around why she hid this pregnancy and why she has failed to maintain any contact with [Redacted]. Her responses heavily consisted of shrugs and "I don't know." Her presentation is suggestive of some developmental or psychological difficulties, however same will need to be determined. Samantha had great difficulty expressing why [Redacted] came permanently into Cree Nation's care, nor could she account for why she had expressed no desire in maintaining any contact with the child.*
>
> *Steve presented as a relatively articulate and thoughtful young man. He indicated that he permanently came into Winnipeg Child and Family Services care when he was 13 and he remained in the care of this Agency until attaining the age of majority. At this point Steven's biological mother's file [Redacted], File #935858) remains closed and his CIC file is sealed. He advised that his experiences in Agency care have prompted him to parent his child so that Phoenix might escape similar experiences.*
>
> *Steve chose not to share many details of his time in Agency care and he will consider this writer's request for a consent to be signed so that the CIC file might be opened and reviewed.*

Orobko's observations of Kematch's presentation were consistent with the evidence of Humenchuk, who described Kematch as "Immature, cognitively delayed, [having] trouble with showing emotions and expressing her feelings."[174] These were important observations for the agency to consider in assessing Kematch's ability to parent Phoenix. Unfortunately, they were never fully explored.

5.3.3 A CASE PLAN IS CREATED

Orobko's report concluded with the following case plan, to be carried out once the file was transferred to a Family Services Unit: [175]



Case Plan:

1) This Agency to assign a family services worker (Jarvis Office) for on-going service and intervention.

2) A 3 month Temporary Order of Guardianship will be pursued.

3) This Agency will await further case history from Cree Nation C&FS and incorporate same into the on-going case plan.

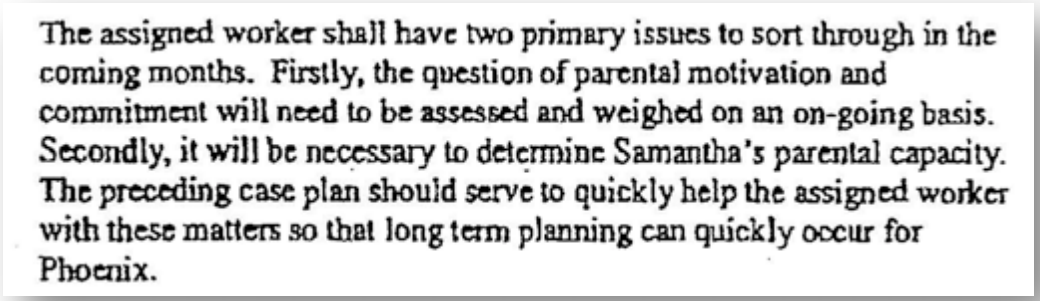
4) Some form of psychiatric/psychological assessment will need to be undertaken with respect to Samantha – this to be arranged by the Agency or the couple (with Agency approval).

5) Both parents are to commence participation in an appropriate parenting program.

6) Both parents to attend all weekly visits with Phoenix. Visits to be transferred to the Jarvis office as soon as possible.

7) Steven's CIC file may need to be reviewed should he agree to sign the appropriate consents for same.

On the last page of his case plan summary, Orobko noted that in the coming months, the assigned family services worker would have to address two primary issues: the young couple's parental motivation and commitment; and Kematch's parental capacity. This was his record:[176]



The assigned worker shall have two primary issues to sort through in the coming months. Firstly, the question of parental motivation and commitment will need to be assessed and weighed on an on-going basis. Secondly, it will be necessary to determine Samantha's parental capacity. The preceding case plan should serve to quickly help the assigned worker with these matters so that long term planning can quickly occur for Phoenix.

Orobko's summary was an astute assessment of the primary issues that would need to be addressed for Phoenix's protection, and it should have guided the agency in its delivery of services to her and her family.

Orobko testified that he believed his case plan gave the family the best chance to be united, while protecting Phoenix from risk. The three-month timeframe would bring to the parents a sense of urgency and yet allow enough time for the agency to assess behavioural indicators that the parents were on the right track in terms of motivation and capacity. [177] The psychiatric assessment was needed to determine Kematch's parental capacity, given the concern with her mental health and developmental issues. Motivation was to be assessed at meetings and visitation sessions with Phoenix.

During cross-examination Orobko testified about the return of a child to a family at the end of temporary order of guardianship. This was not automatic, but if the family had met the case plan and achieved the recommendations, there was a good chance the child would be returned.[178]

After preparing the case plan, on May 2, 2000, Orobko recorded his receipt of the information Saunderson had requested from Cree Nation CFCA. Having reviewed those documents, Orobko remained convinced that his case plan was the most prudent course of action. In another document in the file, he wrote:[179]

> *Further Assessment:*
>
> *At this point in time the previously stated case plan, when reviewed against the just received information from Cree Nation, would still appear to be the most prudent course of action. The major concern expressed throughout the Cree Nation data revolves around Samantha's seeming disinterest in parenting [Redacted] and there appearing to be no concerted effort by Samantha to work towards reunification.*
>
> *Interestingly enough (and to Samantha's surprise), [first child] is not yet a Permanent Ward of Cree Nation and the next court date in this matter is May 17, 2000. Samantha was strongly advised to contact Cree Nation (Germaine Brass) and consult with legal counsel should she wish to "fight for [Redacted]." Her intentions remain unknown at this point. In summary then, Steven and Samantha consented to the 3 month Order and Agency plan (as indicated previously). Nikki Taylor is helping Samantha locate a psychologist for the assessment and Steven will be approaching the Andrews St. Family Centre around the parenting program. Both parents have been advised of the imminent case transfer to the Jarvis Office.*
>
> *A. Orobko/as/03.05.00*

The Cree Nation CFCA documents painted a picture of Kematch as a teenager unready to become a mother at the time she gave birth to her first child:[180]

FAMILY BACKGROUND INFORMATION:

[Redacted]'s biological mother, Samantha Kematch was a permanent ward of Cree Nation Child and Family Caring Agency up until she turned age of majority. His biological father resides at Wasagamach First Nation and has not had any contact with him since [Redacted]'s birthday, July 23, 1999.

Prior to giving birth to [Redacted] Samantha had concealed her pregnancy and did not receive any prenatal care. St. Boniface Hospital made a referral to Cree Nation Child & Family Caring Agency when Samantha gave birth she appeared very distant with hospital staff and from her newborn. She appeared emotionally flat when discussing future plans for her newborn. She had informed the nursing staff that she did not know she was pregnant with [Redacted] until she was approximately 8 months pregnant.

Since July 23, 1999 [Redacted] was placed under apprehension and upon discharged from the hospital, 2 days later was placed with foster mother [Redacted].

On September 14, 1998 –[Redacted] was removed from [Redacted] and placed with his mother Samantha at Oskki-Ikwe, a facility for young mothers at WaWayseecapow. Prior to moving to the facility, Samantha was in an Independent Living Program at McDonald Youth Services. Just after 11 weeks at the facility, both Sam and [Redacted] were discharged from Oskki-Ikwe because of safety concerns for [Redacted]. Again, [Redacted] was placed with [Redacted], where he has been since.

Samantha returned to the Independent Living Program under McDonald Youth Services until age of majority September 9, 1999. Activities of mother is unknown at this time.

The Cree Nation CFCA file also included a plan for Kematch's firstborn child:[181]

Cree Nation Child & Family plans are to transfer [Redacted]'s case to the appropriate Native Agency when permanent order of guardianship is granted. The agency recommends the child not be removed until long term placement (in the form of adoption or other) is found.

Orobko testified that he understood that the reason for obtaining the documents from Cree Nation CFCA was to learn about the circumstances that led to Kematch's first child being made a permanent ward of that agency. Information about Kematch's behavior towards her first child would be vital to assessing risk to Phoenix because it would be a strong predictor of her future behavior. He said the Cree Nation CFCA file revealed a concern for Kematch's parental motivation and capacity with respect to her first child.[182]

Orobko's early identification of these two issues—Kematch's parental motivation and capacity—was appropriate and necessary. As the story of Phoenix's life unfolds, it will become apparent that these issues remained constant, and unresolved.

5.3.4 TEMPORARY GUARDIANSHIP FOR PHOENIX, MAY 3, 2000

At child protection court on May 3, 2000 Orobko presented Phoenix's case plan and requested a three-month temporary order of guardianship on behalf of Winnipeg CFS. Kematch and Sinclair were in the courtroom and gave their consent and the order was granted.[183]

Orobko then transferred Kematch's file to the Northwest Winnipeg CFS Family Service Unit, referred to as the "Jarvis office." This unit was supervised by Lorna Hanson. Hanson had a BA, obtained in 1989, and had been a supervisor at the Jarvis office since 1999.

On receiving a file, it was Hanson's practice to review the transfer summary, any court documents, and any medical information. In her testimony, she identified the following issues of concern in this file: Kematch's lack of prenatal care; the parents' lack of preparation for their baby; Kematch's reported immaturity; and the apprehension of Kematch's first child two years earlier. Though this last issue was seen as significant, she acknowledged the potential for change in the intervening two years, because Kematch had been a child herself when she had her first baby. Hanson described the Kematch file as a significant case because it involved a newborn child in care, but still, it was "a very standard kind of file that we would have received."[184]

She assigned it to Kerri-Lynn Greeley, a social worker in her unit, because she was one of the more seasoned workers and had the skills to deal with court matters.[185] Greeley obtained a BSW in 1995 and had been working as a family services worker with Winnipeg CFS since 1998.

Greeley received Kematch's file on May 8, 2000 and worked with the family until she left the Jarvis office about five months later on October 2. In her transfer summary, which she prepared when she left her position at the Jarvis office, Greeley listed these five problems relating to Phoenix's family, which had been identified when the file was originally transferred to her, and which required ongoing services from her unit:[186]

1. *Samantha appeared to have hidden her second pregnancy as she had her first one, with [Redacted].*
2. *Samantha's lack of motivation and/or interest in caring for her first child. It appeared she has not played a role in his life since he was a few months old, over 18 months ago.*
3. *The couple's ambivalence regarding the long term plans for the child. They had not received any prenatal care and had not done anything in preparation for the birth of the baby. Also the parents initial reaction was they were unsure if they wanted to parent the child, there was an ambivalence regarding the commitment to the baby.*
4. *Samantha's reported flat affect and the reason for it. There was some concern that she may have been suffering from depression. Some form of psychiatric/psychological assessment with respect to Samantha was suggested.*
5. *Due to the couple's young age and Samantha's history, it was suspected they had limited parenting experience and skills.*

Greeley saw only the information from Kematch's child in care file that was already in the Kematch protection file that she had received from Intake. She did not review Sinclair's child in care file because it was sealed: she noted in her summary that Sinclair was considering allowing her access to that file, but she testified that this never actually happened. She said that the history she recorded was taken directly from the file and included information from Saunderson's transfer summary and information from Cree Nation CFCA about the apprehension of Kematch's first child.

Greeley said that it was clear to her from her review of the file that Kematch had no interest in having contact with her first child. To her, such a lack of attachment and interest would raise a concern about parenting ability.[187]

I commend Greeley for her work to this point. Kematch's lack of interest in her first child was a red flag that was identified at the outset by several workers. It was critical that the agency follow through on addressing Kematch's parental motivation and capacity, and providing the necessary services to Phoenix and her family, to protect her safety and well-being.

Greeley recorded that on May 11, 2000, Humenchuk told her she was still helping Kematch and Sinclair to access resources, to meet the expectations laid out in the case plan. Greeley also noted that Humenchuk and Kematch had tried several times, unsuccessfully during May, June, and July 2000, to have a psychological assessment completed.

Greeley had supervision meetings with Hanson on May 11 and May 17, 2000.[188] At the second meeting they talked about a psychiatric assessment for Kematch and discussed the possibility of a consult from Dr. Gary Altman. Altman, a specialist in child psychiatry, worked as a consultant with Winnipeg CFS from 1987 until the early 2000s. His services were provided through an agreement with the Child and Adolescent Mental Health Program and were funded by the Winnipeg Regional Health Authority. He was contracted to provide one three-hour consult at a CFS office per week. Greeley's file indicates that she tried to arrange a consultation but Altman was unavailable until late summer or early fall.

Meanwhile, Kematch and Sinclair visited with Phoenix every Tuesday morning from May through August of 2000 at the Jarvis office according to Greeley's records. She could remember them missing only one visit. Her records also indicate that the couple completed a parenting support group at the Andrews Street Centre, which they attended weekly for eight weeks; and participated in a Boys and Girls Club program focused on job training. She noted that Humenchuk told her, "the couple seems to be committed to parenting their child."[189]

Greeley did note in her file concerns about Kematch's demeanour: she believed that Humenchuk's difficulty in arranging for Kematch's assessment may have been partly because Kematch "did not believe she needs to have the assessment and therefore was likely not helpful when asked questions regarding its purpose." Greeley also noted that while the parents were cooperative with her, "Samantha often appeared angry when she was required to discuss any of the relevant issues."[190]

The involvement of the Boys and Girls Club, and Humenchuk in particular, with these young parents is commendable. Their services likely contributed to protecting Phoenix's life, health, and emotional well-being for a time. *The Child and Family Services Act* recognizes that the protection of children by an agency includes the promotion of the family's capacity to care for its children. The services offered by community-based organizations, such as the Boys and Girls Club and Andrews Street Centre, which Kematch and Sinclair to this point clearly accepted, were and are critically important to the achievement of these goals. More will be said about the role of community-based organizations later in this report.

On June 1, 2000 Hanson began a maternity leave and Angela Balan assumed the role of supervisor of the Jarvis office in her absence. Balan had BSW and MSW degrees; she had been a family services worker with Winnipeg CFS since 1996 and was promoted to the role of supervisor to cover Hanson's maternity leave.

Greeley had not yet obtained a psychiatric assessment of Kematch. She recorded that she had supervisory meetings with Balan on July 10, August 15, and August 29, 2000. Greeley's handwritten notes of the July 10 supervision session indicate that they discussed referring Kematch to the Women's Health Clinic to talk to a doctor about whether she was suffering from post partum depression. The clinic offers counseling and can make referrals, she noted. Her note continues:[191]

→ *appear motivated now (both parents)*

-- get some sense if depressed (post partum) – try see a Dr. at U.H.C.

→ *will put in home support services to assist [with] parenting + assess parenting*

→ *do risk ass.*

→ *sign VPA on Aug. 3rd—transition plan*

Greeley testified that her assessment that Kematch and Sinclair seemed motivated to parent would have been based on their attendance at visits with Phoenix, their cooperation with the agency, and their desire to have Phoenix returned to them.[192] She explained that the reference to a risk assessment would not have meant a formal written assessment, but rather an overall assessment of possible risks to a child in the home—both immediate and long-term.[193]

I find that Greeley's identification of the need to assess both immediate *and* long-term safety risks was appropriate, and was something the agency ought to have pursued consistently throughout the time it provided services.

While there was no written risk assessment on file, Greeley testified that a future worker would have seen her assessment of the risk to Phoenix by reading her transfer summary. She said that a risk assessment would include looking at whether parents were attending to a child's needs or were engaging in risky behavior such as substance abuse or domestic violence.

5.3.5 PARENTS AGREE TO TRANSITION PLAN

With the temporary guardianship order set to expire on August 3, 2000 and with Kematch's inability to find someone to conduct a psychological assessment, Greeley requested that Phoenix remain in the agency's care under a voluntary placement agreement. This would allow enough time for Kematch to have her psychological assessment, and for a proper transition of Phoenix to the family home. Greeley said she and Balan agreed that Phoenix could be returned to her parents' care, but there needed to be a transition plan that would allow time for Phoenix to have some visits in her parents' home while she was still in the care of the agency. More time would also allow the agency to connect with a family support worker who could prepare the parents for Phoenix's return and assess their parenting afterwards.[194] On July 25, 2000, Kematch and Sinclair consented to the agency's plan for a one-month voluntary placement agreement. After that, the plan was for Phoenix to come home to live with Kematch and Sinclair.[195] Greeley assigned a family support worker to help with the transition by assessing Kematch and Sinclair's parenting abilities, and teaching when needed.

In early August of 2000, family support worker Marie Belanger began to work with Kematch and Sinclair. Belanger testified that she had taken child care level one and two training and at the time that she testified she had 24 years of experience in this position.

Belanger described her role. It involved attending at clients' homes and teaching parenting and household skills including cooking, and feeding. She testified that she was expected to see children in their home and make observations about them. If she witnessed something that gave rise to a child protection concern, she would contact the responsible CFS worker.

By mid-August, Kematch and Sinclair were having their access visits with Phoenix in their home, and the duration of the visits was increased. Greeley noted Belanger's observations that the parents "were attentive to and appropriate with Phoenix" and had begun to accumulate the necessary attire for their child.[196]

Phoenix was to be returned home in early September of 2000 but by late August, Kematch had still not had a psychiatric assessment as per the case plan prepared by Orobko in May. The issue of completing this assessment before Phoenix was returned home was a central topic at supervision sessions between Greeley and Balan on August 15 and August 29, 2000. Greeley testified that she had the option of extending the voluntary placement agreement past September since the conditions of the case plan had not been met. She could not recall why she chose not to do so but she believed that by that time she had personally arranged an assessment with Altman.[197]

5.4 PHOENIX RETURNS TO HER FAMILY, SEPTEMBER 5, 2000

5.4.1 PARENTS AGREE TO TERMS FOR RETURN OF PHOENIX

Winnipeg CFS returned Phoenix to her parents on September 5, 2000, on terms that were set out in a "service agreement" signed that day by Kematch and Sinclair, and Greeley. Greeley testified that she and Balan formulated the terms; she could not recall whether Kematch and Sinclair had any input.[198] The agreement imposed obligations to be fulfilled by both the parents and the agency over the next six months, from September 5. The conditions read as follows:[199]

1. *Samantha will meet with Dr. Altman to assess her emotional stability. Samantha will follow recommendations made by Dr. Altman.*
2. *Samantha and Steve will work cooperatively with the Agency in home support worker and will meet with her at least two times a week.*
3. *Samantha and Steve will work cooperatively with the Agency Family Services Worker, this includes meeting with the worker on a regular basis and allow the worker access to the family home. Samantha and Steve will also cooperate with the Agency worker regarding further exploration of issues related to substance use and family violence.*
4. *Samantha and Steve will attend and participate in a parenting class that focuses on issues related to child development.*
5. *Samantha and Steve will work cooperatively with the public health nurse as a method of gaining information regarding general health issues of small children.*
6. *The Agency worker will assist Samantha and Steve with identifying a pediatrician to use for Phoenix's routine medical issues.*

All parties understand that failure to meet the conditions of this service agreement could result in the child being removed from the family home and placed in the care of Winnipeg Child and Family services. This agreement will be reviewed after six months.

The next time Greeley saw Phoenix after she was returned to her parents was September 13, 2000 when her parents brought her with them to the agency for the consultation with Altman. Greeley speculated that she had another meeting with the family after Phoenix's return, but she had no distinct recollection or any recording of this in her notes.[200]

5.4.2 PSYCHIATRIST ASSESSES KEMATCH

Altman testified that his services to child welfare agencies involved meeting at agency offices with social workers, and occasionally with clients. This was typically done weekly, in a two- to three-hour session scheduled by the agency. He was not given advance notice of which clients he would be meeting, nor any information about them. Typically, when he arrived at the office the agency social worker would tell him about the client's background and the agency's concerns or issues. He did not have access to the agency's client files. After meeting with a client, his practice was to discuss the session with the agency social worker, answer questions, and give direction.

Altman testified that he did not provide written reports nor did CFS ever ask for any. He kept his own notes at his office, and did not provide them to agency social workers. His services consisted of interviews with the agency's clients, and discussions with social workers. He did not have a doctor-patient relationship with the clients he interviewed. The purpose of his services was to assist the child welfare agency with its assessments; they were not for the therapeutic benefit of the client.

Altman's notes indicate that Greeley asked him to assess whether Kematch was suffering from depression. That was the sole request made of him. The meeting on September 13, 2000 was the psychiatrist's first and only interaction with Kematch and Sinclair.

According to Altman's notes, he met with Greeley before interviewing Kematch, to get background information and hear Greeley's concerns. His notes indicate that he was asked to do a mental health assessment of Kematch, and specifically, to assess whether her flat affect and ambivalence towards parenting might be the result of depression. He was emphatic that he was not asked to perform a parental capacity assessment of Kematch and that such an assessment would not typically be performed by a psychiatrist.[201]

It is to be remembered that Orobko had identified in his May 1, 2000 report, two primary issues requiring the attention of the assigned family services worker: first, parental motivation and commitment; and second, Kematch's parental capacity.

Greeley did not make a note in her file, nor could she recall what information she shared with the psychiatrist about Kematch and the family. She testified that she would not have given him any part of Kematch's protection file because it was confidential. She said her typical practice was to share with the psychiatrist the agency's concerns, which in this case would have included Kematch's history and functioning, and her flat affect. She would have asked Altman for information that she could use in her assessment of Kematch's functioning as a parent.[202]

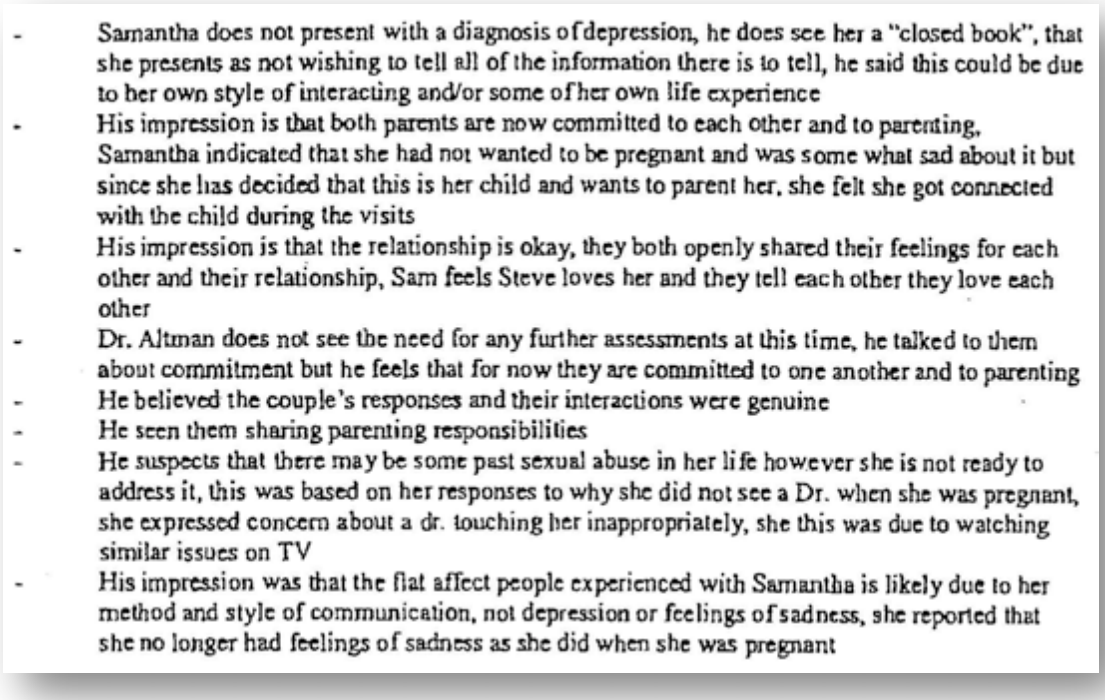
Altman testified that he was not aware of what use Greeley would make of his assessment. His understanding of the reason for his consultation was to address why Kematch was ambivalent about parenting and whether it was the result of depression.[203]

At the time of his meeting with Kematch, Altman recalled having been advised that Phoenix had been apprehended and that the agency queried whether Kematch was suffering from postpartum depression. He did not recall what he discussed with Kematch and Sinclair apart from what he recorded in his notes but he testified that if he had been concerned that Kematch posed a risk to Phoenix, he would have documented it in his notes.[204]

Ultimately his assessment was that Kematch was not suffering from depression. He did note concerns about "sex, marriage, and parenting," which were not attributed to either Kematch or Sinclair specifically.[205] Sinclair was present at the meeting and participated, although Altman had not been asked to assess him.

Altman testified that immediately following his assessment of the couple, he met privately with Greeley. He could not recall exactly what he told her, but said that it would generally be what was reflected in his notes. He said he would have told Greeley that Kematch was not depressed and that her "mental health was okay," but that there were issues regarding the couple's sexual relationship, marriage, and their parenting future.[206] He did not recall Greeley asking him to do any follow up with the couple at this meeting, but that was not typically his practice and in fact he could not recall ever being asked by CFS to follow up with a family.

Greeley's closing summary in Kematch's protection file documents her meeting with the psychiatrist as follows:[207]



- Samantha does not present with a diagnosis of depression, he does see her a "closed book", that she presents as not wishing to tell all of the information there is to tell, he said this could be due to her own style of interacting and/or some of her own life experience
- His impression is that both parents are now committed to each other and to parenting, Samantha indicated that she had not wanted to be pregnant and was some what sad about it but since she has decided that this is her child and wants to parent her, she felt she got connected with the child during the visits
- His impression is that the relationship is okay, they both openly shared their feelings for each other and their relationship, Sam feels Steve loves her and they tell each other they love each other
- Dr. Altman does not see the need for any further assessments at this time, he talked to them about commitment but he feels that for now they are committed to one another and to parenting
- He believed the couple's responses and their interactions were genuine
- He seen them sharing parenting responsibilities
- He suspects that there may be some past sexual abuse in her life however she is not ready to address it, this was based on her responses to why she did not see a Dr. when she was pregnant, she expressed concern about a dr. touching her inappropriately, she this was due to watching similar issues on TV
- His impression was that the flat affect people experienced with Samantha is likely due to her method and style of communication, not depression or feelings of sadness, she reported that she no longer had feelings of sadness as she did when she was pregnant

Altman agreed that this record is consistent with what he believed he told Greeley except for the comment about not seeing a need for further assessment. He said he might have said that he saw no need for further assessment of Kematch for depression, but he did not recall making that comment.[208]

The CFS file makes no mention of the issues identified by Altman: the couple's sexual relationship, their marriage, and their parenting future. Greeley testified that she could not remember if she discussed with Altman whether these were issues requiring exploration.[209]

Altman's notes indicate that Sinclair wanted to further his education and look for employment after arranging daycare for Phoenix.[210] This is not referenced in the CFS records, nor is there evidence that at any time the agency made any attempts to assist Sinclair or Kematch with their education or employment, or to obtain daycare for Phoenix.

Education and employment for her parents, and daycare arrangements for Phoenix were fundamental to ensuring Phoenix's well-being, and these are matters that the agency should have been helping with, under the mandate of *The Child and Family Services Act*.

Having identified the need to determine the reason for Kematch's flat affect, and having consulted a psychiatrist for an opinion as to whether the reason was depression, the agency should have obtained a written report from Altman for Greeley's use, and as part of the history on the file.

5.4.3 AGENCY FAILS TO ASSESS PARENTAL CAPACITY

Greeley testified that she did not recall considering obtaining a formal parental capacity assessment of Kematch. Hanson testified that this file presented typical problems and would not typically warrant a formal assessment. She expressed the view that if this file required a formal parental capacity assessment, nearly every file would require one.[211] Hanson testified that social workers have the capacity and skills to assess parental motivation and commitment.[212]

I note that several supervisors testified that social workers are able to assess parental capacity. Orobko said that workers are always assessing parental capacity: that is what a professional social worker can and should do. He said a formal assessment by a contracted psychologist or psychiatrist is a tool that a social worker could use in an ongoing assessment of capacity.[213] Former CEO of Winnipeg CFS, Dr. Linda Trigg, testified that parental capacity assessments by psychologists were similar to those done by a social worker.[214] Another former CEO of Winnipeg CFS, Darlene MacDonald, testified that social workers could conduct capacity assessments themselves, and formal assessments were required only for court purposes.[215]

I find that while a formal parental capacity assessment might not have been necessary, the agency had identified Kematch's parental capacity and motivation as primary issues it needed to address. Having learned from Altman that the reason for her flat affect and apparent ambivalence toward Phoenix was not depression, it was incumbent on the agency to find out what the reason was, and how to address it. Was there any indication that Kematch's attitude towards parenting had changed significantly since her first child? Would she be able to form a bond with Phoenix? I find that the agency during this period never determined the reason for Kematch's demeanour and never addressed her parental capacity or motivation. In fact, the evidence demonstrates that such an assessment was never done at any time during the five years the agency provided services to Phoenix and her family. Nor did the agency ever explore the three issues identified by Altman: Sinclair and Kematch's sexual relationship, their marriage, and their parenting future.

I find that this failure to conduct an assessment, which had been properly identified as needed, was a serious failing on the part of the agency.

The agency closed Phoenix's child in care file in accordance with its policy. Greeley wrote a closing summary in which she gave the following assessment of Phoenix:[216]

> *Phoenix appears to be a typical five month old little girl. She is developmentally on track and is in good health. She has benefitted from the stability and nurturing she received in her foster placement. It has contributed to her ability to develop secure attachments with her caregivers. It is hoped that she will attach to her parents, there is some evidence that this has started. This will continue to grow and develop as long as Samantha and Steve remain stable and are able to provide for her needs on a daily basis.*

The teaching support worker will continue to monitor the couple's abilities and provide assistance when needed.

According to this assessment, teaching support worker Belanger (described as the family support worker in the service agreement), was to monitor the couple's abilities. But the CFS files contain limited information about her observations and work. Contrary to agency policy, the family support worker's notes were not found in Kematch's protection file and were never located.[217] It appears that this fact did not come to the agency's attention until Commission Counsel sought disclosure of these notes. There is some limited reference to her work in some of Greeley's records.

Greeley's conclusion was appropriate: she recognized that Phoenix's family attachment was contingent upon her parents remaining stable and being able to provide for her daily needs. This, however, seems to have been forgotten in the agency's work with the family. Based on CFS files, over the course of Phoenix's life, Kematch and Sinclair did not remain stable, nor was either of them able to provide for Phoenix's daily needs.

5.4.4 CARING FOR PHOENIX AFTER HER RETURN

Sinclair testified that once Phoenix was returned to them in September 2000, the family was managing on social assistance. He said he soon took Phoenix to the home of his friends, Kim Edwards and Rohan Stephenson. Edwards and Stephenson were living in a common law relationship at the time, on Selkirk Avenue in Winnipeg. Sinclair trusted them, and in the first few months after her return, Phoenix would spend time at their house on the weekends or when he and Kematch had appointments. He also said that he and Kematch continued to "party" at that time and when they did, they would make sure Phoenix was either with one of Sinclair's sisters, or at the Edwards/Stephenson home.

Edwards testified that by October 2000 she was taking Phoenix for weekends, and by November of that year, she was taking her during the week and sending her home to Sinclair and Kematch only on some weekends. Edwards said that Sinclair was not a typical father, but he was very good with Phoenix whenever he was around.[218]

Sinclair testified that being a parent was a new experience for him and he was interested in parenting, though it did not seem to him that Kematch was interested. He said Kematch was inconsistent in her parenting and would get "mad and frustrated."[219] Others made similar observations. For example, the witness identified as SOR #9 visited the family after Phoenix was returned and recalled that Sinclair was more involved than Kematch in parenting. She recalled being "a little bit" concerned about Kematch's parenting;[220] she remarked that Kematch had little patience and would become agitated. Humenchuk also observed that Sinclair was the more attentive parent.

Humenchuk continued to be involved with the family after Phoenix returned home in September 2000. The couple still attended the Boys and Girls Club, though less frequently. Humenchuk testified that, like many young parents, the couple brought their baby to the club. She recalled that the staff took turns taking care of Phoenix and she believed that the club provided the couple with some respite. She testified that the couple told her that they had an in-home family support worker, they had completed a parenting course at the Andrews Street Centre, and they had some attachment to the Ma Mawi Wi Chi Itata Centre (Ma Mawi).

Even though the agency had an open file at this time, there is limited evidence that it made any attempts to communicate or work with the Club, or any of the community-based organizations with which the couple was involved. Communication and collaboration between the agency and these organizations could have led to enrolment in a daycare program for Phoenix, with opportunities for learning and for nurturing by other adults. It also would have enhanced her visibility in the community. At the same time, Sinclair could have been supported in his wish to find employment. Steady work could have helped him towards a more stable lifestyle, so that he could have been the father to Phoenix that he wanted to be. These were missed opportunities to make a substantial difference in Phoenix's life.

5.4.5 WORKER SIGNALS A WARNING

In the fall of 2000, Greeley was wrapping up her involvement with the Kematch file because she was moving to a different unit in the agency.[221] Kematch's protection file remained open, so Greeley prepared a transfer summary for the benefit of the next worker. Her summary includes the following assessment:[222]

> *Samantha and Steve have demonstrated that they are committed to parenting their Phoenix. They have done so by meeting all of the expectations placed on them at the time the 3-month order was granted. As a result Phoenix was discharged from care and is now residing with her parents in the family home.*
>
> *It appears from positive community reports and the in home support worker that Samantha and Steve they are able to meet her basic daily needs. However, now that Phoenix is in their care, ongoing assessment of their abilities to effectively meet her needs and provide her with a safe and nurturing home is necessary.*

I find that this was a significant warning: ongoing assessment of the parents' abilities to meet Phoenix's needs and provide a safe and nurturing home would be essential. But it was a warning that went unheeded by the agency, as the evidence ultimately disclosed.

Kematch became pregnant again in the fall of 2000. Humenchuk and other staff at the Boys and Girls Club were aware of this pregnancy because the couple did not hide it. She said they came to the club less often through the winter, probably because of transportation and weather issues. From time to time the couple arrived without Phoenix, saying that she was with a friend or neighbour, whom Humenchuk later came to believe was Edwards.

5.4.6 WERE THE SERVICE AGREEMENT TERMS BEING MET?

Greeley noted that Kematch and Sinclair were aware that failure to meet the conditions of the service agreement could result in Phoenix being removed from their home and returned to agency care.[223] She also testified about the couple's progress towards fulfilling those conditions at the time she was completing her involvement on the file.

The first term of the agreement was met when Kematch met with Altman.

Kematch and Sinclair met the second term by working with the home support worker for as long as that service was provided. (As will be seen, the home support worker's contract ended about half way through the term of the service agreement and was not renewed.)

With respect to the third condition, that Kematch and Sinclair cooperate with the agency to address substance abuse and family violence issues, Greeley relied in part on a report by Humenchuk that she had not observed any substance abuse or domestic violence in the family.[224] Sinclair testified that he could not remember regular visits by Greeley at their home, nor was there any record in the agency's files that Greeley was ever there. Further, Sinclair testified that the agency did not work with him or Kematch in regards to substance abuse or family violence. He said there might have been some substance abuse issues at the time, but not violence.[225]

Greeley testified that it was her understanding that Kematch and Sinclair had completed an eight-week parenting course. Conditions 5 and 6 of the agreement required the couple to work with a public health nurse, and required the agency to help them find a pediatrician. Greeley testified that these were typical conditions when small children were in the home because medical professionals are another source of information that can be used in monitoring a child's care. Greeley could not recall if these conditions were fulfilled in this case, or if she had any conversation with a public health nurse or pediatrician,[226] but her records do not indicate any such contact. Nor is there any evidence that the agency relied on any public health nurse or pediatrician as a source of information to help monitor Phoenix's care. Sinclair said he believed the agency did help them connect with a nurse at a public health office, but never helped them find a pediatrician, so he found one on his own.[227]

Humenchuk testified that Kematch and Sinclair enrolled in a summer employment program. She said she visited their home after Phoenix's birth, and saw the baby. She recalled later sitting in on a meeting with CFS about the conditions that needed to be met before Phoenix was to be returned to her parents. She also remembered a phone call with Greeley about setting up a psychiatric assessment for Kematch, though she was not told the reasons for it. She said she had tried, unsuccessfully, to find a female psychiatrist because of Kematch's problems with male doctors.

I find it laudable that Humenchuk was so involved in supporting the family to fulfill the conditions of the service agreement. But if a CFS agency is to rely on a community organization for the fulfillment of such agreements, then the agency must articulate its expectations, for the benefit of all parties. A clear understanding of expectations, and coordination between the agency and the community organizations involved with the family, can ensure that the family receives the services and support that CFS has identified as necessary for the child's sake.

Greeley's transfer summary was dated October 2, 2000.[228] She testified that this was the date that she would have completed all of her work and the expected date of transfer of the file.[229] Neither Greeley nor Balan signed the transfer summary that is found in the file. Balan testified that she believed that she reviewed it and signed off on it at some point but she is not sure when.[230] Balan testified that Greeley actually moved to her new position on October 14, 2000.

Balan testified that typically, the case would have gone to her, as supervisor, until a new worker could be assigned, which happened a month later. Balan said she did not make any contact with the family during the month she had responsibility for the file, but the family support worker, Belanger, was visiting the home bi-weekly and she believed this to be sufficient contact at the time, along with others in the community who were involved with the family.[231] The evidence was that the family support worker's contract was renewed for one month from October 30 to November 30, 2000.[232]

5.4.7 NEW WORKER SETS PRIORITIES

On November 14, 2000 Balan assigned conduct of Kematch's protection file to family services worker Delores Chief-Abigosis, who remained responsible for the file for some eight months, until she resigned from the agency in late July 2001. Chief-Abigosis began working in child welfare in 1986, obtained a BSW degree in 1999, and joined Winnipeg CFS in 2000. Balan continued as supervisor until Hanson returned from maternity leave in June 2001.

Chief-Abigosis testified that on receiving the file she reviewed it, including the case plan contained in Greeley's transfer summary. She determined that her priority would be to work with the family to ensure the case plan was being followed and that the family was using any community resources they needed. She also said she would need to monitor the home and Phoenix's progress.[233]

This was an appropriate assessment. Regrettably, neither the worker nor the agency followed through to provide the services this assessment required.

Chief-Abigosis' first recorded attempt at contact with the family was dated February 1, 2001, some 11 weeks after she had assumed responsibility for the file. This attempt was documented in Balan's notes of her supervision session with Chief-Abigosis on February 5, 2001. Chief-Abigosis testified that she did not recall this supervision session, but agreed that Balan's notes would be an account of what they discussed. The notes read as follows:[234]

> *Field to Ms. Kematch home on February 1, 2001, there was no answer at the residence on 740B Magnus Avenue, left card to call. It is not known at this time if Samantha followed-up with Dr. Altman re: emotional stability or if Samantha and Steve completed an appropriate parenting program. It is clear that they did work cooperatively with the in-home support worker and, according to the support worker – the parents did work with the PHN. It remains to be confirmed with PHN re: nature and extent of involvement and if Public Health will continue to be involved, also need to clarify if parents have identified a pediatrician for Phoenix.*

Balan's supervision notes listed the following short-term goals for the file, in addition to the existing case plan from Greeley's transfer summary:[235]

1. *Make contact with the family asap to gather updates on progress to date re: service contract*
2. *Identify child's pediatrician*
3. *Determine need for further in-home support services or identify referral to community resources eg. parenting programs*

Portions of Balan's supervision notes were incorporated directly into Kematch's protection file. But as the evidence disclosed, supervisors' notes of supervision sessions were rarely kept in protection files. They were kept in separate binders in supervisors' offices. Moreover, the agency failed to retain supervisors' notes relating to services delivered to Phoenix and her family. The agency had no definitive explanation for what happened to those notes. This issue will be discussed in Chapter 13 of this report.

On February 7, 2001, Chief-Abigosis visited the home again and did make brief contact with the couple. Her record reads as follows:[236]

> *Field to 740B Magnus about 1:15 – (no scheduled visit) – both Samantha and Steve were leaving the apartment and Samantha stated they had not time to talk to this worker – informed her that it was difficult to connect with them because they have no phone and when we attend the home no one is usually home – this is why we have to come out unannounced – Samantha stated "you could write me a letter" – since we are unable to meet today – this worker scheduled an appointment to meet on February 9th at 2 PM.*

On February 9, Chief-Abigosis met with the family. Her record reads as follows:[237]

02/09/01

Field to 740B Magnus on February 9, 2001 @ 2PM to meet with Samantha – her and Steve were at home with Phoenix – Samantha appeared angry and annoyed that I was visiting – during the homevisit Steve sat in the back room and did not participate in the discussion. Although he did answer some general questions that the worker asked. The home was very clean although sparsely furnished. Samantha sat the entire time in front of the TV – while the worker attempted to have a conversation with her – she would nodded or respond aggressively when asked a question. She did offer some information about the parenting program she did attend along with Steve and that Marion Belanger, FSW was in the home and she felt that she did help – they are connected to the Boys and Girls Club, Nikki Taylor, Andrew Street and Ma Ma WI. Samantha stated that her child Phoenix was doing really well and had no concerns at this time about her health. Samantha stated she doesn't know why CFS is still wanting to be involved and further stated that she has done everything that was asked of her – this worker explained that they are young parents that WCFS is available to offer any support needed.

Samantha stated that her and Steve are doing well at this time. Samantha stated that she did see Dr. Altman for the appointment and that she did have Marion Belanger in her home and felt she worked okay with her. Samantha will be getting a pediatrician to follow Phoenix. When this worker mentioned that Cree Nation was in contact with the Agency about her eldest child – Samantha sharply stated that she doesn't want or need to have her oldest child [redacted] situation involved in this matter because he is permanent ward of Cree Nation.

Overall; it is evident to this worker that Samantha is annoyed and dislikes the involvement of WCFS – the family appears to doing well although Samantha does appear angry and annoyed with agency involvement – the home is clean and well maintained and the child Phoenix appear clean and content – Steve appears to be actively involved into the general care of the child.

Steve appeared very quiet and did offer very little input into today's conversation. Samantha appeared agitated and clearly stated her obvious annoyance of the Agency involvement and stated that if the Agency want to meet with her in the future that we need to send a letter for an appointment and not just drop by. The worker informed her that we do drop by visit especially if a person has no phone and to date that it was very difficult to meet with them.

Plan: Will do drop by visit to monitor the situation or as needed.

5.4.8 AGENCY FAILS TO FOLLOW TERMS OF ITS AGREEMENT

Chief-Abigosis testified that she recalled meeting with the family in February of 2001; that she saw Phoenix sitting on the floor playing with toys; and that she believed Phoenix was safe because the home was clean, Phoenix was clean, and the family was connected with external resources. As to her recorded plan that she would "drop by visit to monitor the situation or as needed," Chief-Abigosis testified that she meant that she would monitor the requirements of the support agreement and "if a collateral had called or there was a concern, then I'll respond to it and I will attend the home." [238] She could not recall how often she planned to make drop-in field visits. There is no evidence that she ever did. This failure to monitor and meet with the family on a regular basis violated the agency's obligations under the service agreement.

Chief-Abigosis explained her lack of documented contact with the family from November 2000 to February 2001, saying that she probably did have activity on the file that she failed to document, although she could not specifically recall any. She said that any face-to-face contact would have been recorded, but she may have recorded it somewhere other than in her file.[239] I find that since Chief-Abigosis had no recollection of any additional contact, and none was recorded, there is no basis to find that there was any contact during this period.

With no record of Balan having provided any services to the family during the month she had the file before she assigned it to Chief-Abigosis on November 14, 2000 the protection file has no record of direct contact with the family during the four months between October 2, 2000 and February 7, 2001.

I find that Balan, who remained the supervisor throughout this time, had an obligation to ensure that the agency met its responsibilities under the service agreement, which required meetings with the family on a regular basis. She and the agency failed to meet this crucial obligation.

As her supervisor, she would have been expected to inquire of Chief-Abigosis to ensure that she was meeting the agency's obligations to its clients. Balan's diary[240] shows that from November 2000 to June 2001 she scheduled more than 20 supervision meetings with Chief-Abigosis, including more than eight before the worker's first contact with the family in February 2001. That Balan was unaware of Chief-Abigosis' limited contact with Phoenix and her family is disconcerting.

This lack of contact was contrary to the terms of the service agreement, which required the agency to monitor the family at least until March 2001 when the agreement was to be reviewed. I am further troubled that there is no evidence that the agency ever conducted that review. This lack of attention is another example of the agency failing to meet its obligation to protect Phoenix and support her family pursuant to *The Child and Family Services Act*.

5.4.9 SUPPORT WORKER COULD HAVE BEEN USED TO ADVANTAGE

Balan's supervision notes from February 2001 also indicate that family support worker Belanger had approached the agency at the end of 2000 about having the family support agreement extended. She noted that:

> *. . . . Family Support Worker Marion Belanger called the agency stating that she feels that the couple is doing quite well for young parents. The Family Support Agreement expired: November 30, 2000. Ms. Belanger stated that the family has done quite well and if the contract is renewed she would like to be recommended for the position. Marie stopped working with the family at the end of November 2000.*[241]

Chief-Abigosis testified that she did not recall speaking with Belanger and did not remember why the family support agreement was not renewed. Belanger testified that she did continue to work with the family after the file was transferred to Chief-Abigosis but she had no recollection of any CFS worker involvement with the family.[242]

I heard evidence that family support workers like Belanger were required to keep notes of their work, including their observations of families and children. These records were to be kept in the protection file maintained by the agency, with another copy in the family support worker's files.[243] But in this case, none of Belanger's notes could be found. Without her notes, Belanger had little independent recollection of this matter. She said she did remember Phoenix as a baby, and had some memory of being at the Kematch/Sinclair home, though she had no recollection of meeting Sinclair. She also did not recall being aware that Kematch was pregnant in the fall of 2000, which would have been during the time she worked with the family.

Belanger's last recorded contact with the family was December 13, 2000; she testified that she stopped working with the family because they vanished without notice or warning. She assumed they had moved, but agreed it was possible that they simply were not home when she visited.[244] Belanger acknowledged in her testimony that she had 46 entries on her timesheets, totaling roughly 100 hours of work on Kematch's file.[245]

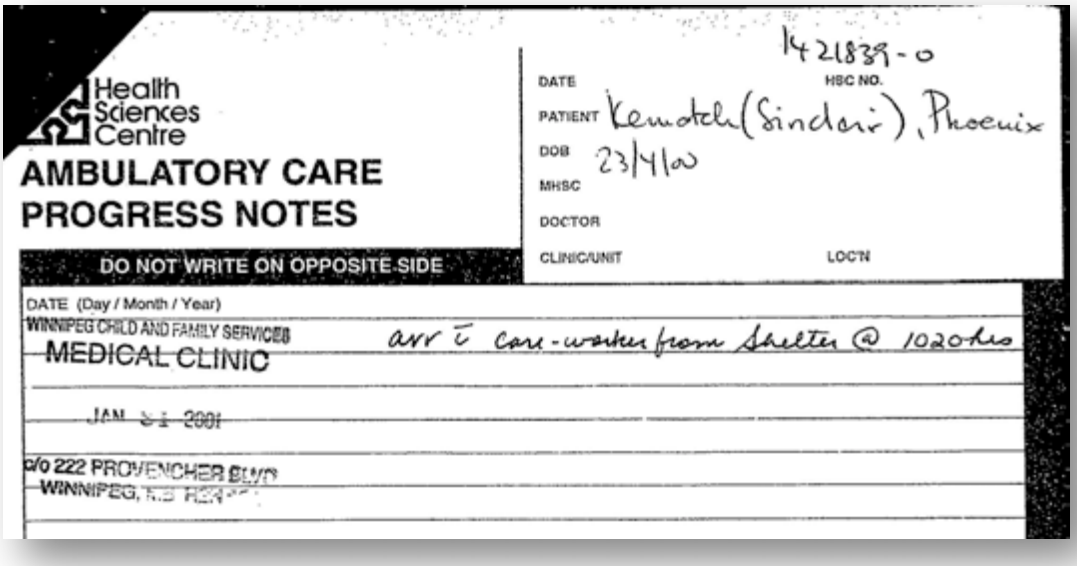
Agency witnesses acknowledged that a family support worker, assigned pursuant to the service agreement to work with the family and monitor their progress, was a significant component of the services provided by the agency. It is disconcerting that there is such a limited record of her services and of the impact they may have had on the family.

It is also troubling that the agency failed to renew the family support worker's contract, contrary to its obligations under the service agreement, and the lack of information in the file as to why it was not renewed is equally concerning.

The family support worker was a practical and effective resource for an agency whose workers repeatedly told me that workload demands left them hard pressed to meet their obligations to make contact with families. It is disappointing that the agency did not make effective use of such a resource in this case.

5.4.10 PHOENIX IS TAKEN TO A MEDICAL CLINIC

Another significantly troubling aspect of the evidence before me was this document, obtained from the Winnipeg Regional Health Authority's records:[246]



Health Sciences Centre

AMBULATORY CARE PROGRESS NOTES

DO NOT WRITE ON OPPOSITE SIDE

142839-0
DATE HSC NO.
PATIENT Kematch (Sinclair), Phoenix
DOB 23/4/00
MHSC
DOCTOR
CLINIC/UNIT LOC'N

DATE (Day / Month / Year)
WINNIPEG CHILD AND FAMILY SERVICES
MEDICAL CLINIC
arr c care-worker from shelter @ 1020hrs
JAN 31 2001
c/o 222 PROVENCHER BLVD
WINNIPEG, [illegible]

The document appears to indicate that Phoenix was seen at a medical clinic, accompanied by a caseworker from a shelter, on January 31, 2001. Chief-Abigosis testified that she had no knowledge that Phoenix possibly had received medical attention, nor did she know whether Phoenix had been in a shelter at that point. There is nothing in the Kematch protection file to answer these questions. I make no conclusion as to whether this lack of documentation resulted from a lack of communication—either between agency and health care providers or within the agency itself—or from inadequate record-keeping by agency staff. Regardless of the cause, the absence of any further information about the circumstances surrounding the creation of this document is seriously concerning, and leaves unanswered questions as to what was happening with nine-month-old Phoenix on January 31, 2001.

5.5 PHOENIX'S SISTER IS BORN, APRIL 29, 2001

5.5.1 2ND REFERRAL: NEW BABY IN THE FAMILY

The next record that was made in Kematch's protection file, after the visit by Chief-Abigosis on February 9, 2001, was dated April 30 that year. It was prompted by a phone call to the agency from a social worker at Women's Hospital at the Health Sciences Centre.

On April 29, 2001 another daughter had been born to Kematch and Sinclair. They named her Echo. The hospital social worker, referred to as "SOR#2," was responsible for assessments on the postpartum ward, including whether a patient was adequately prepared to take an infant home. SOR #2 obtained a BSW degree in 2000 and began working at HSC the same year. Typically, she would meet with parents and consult with other parties to see whether the parents had adequate supports and access to community resources. She testified that she had been asked by a Health Sciences Centre nurse to assess Kematch, with a note that Kematch's first child was in care, and she had care of her second child.[247]

On April 30, 2001 SOR#2 met with Kematch, Sinclair, and their new baby. She recorded the meeting in her Assessment Summary as follows:[248]

> *Thanks for this consult. Writer met with Samantha, CL/PF [common law/putative father] Steve & new babe, [redacted]. The couple indicated that a friend is looking after 1 y.o. daughter, Phoenix. They have all needed supplies. Chart reviewed – SW [social worker] saw couple last year when Phoenix was born & a referral was made to Wpg CFS as the couple had no baby supplies & had vague plans re: babe (see [redacted]'s consult of April 24/00).*
>
> *Samantha's worker is Delores Chief-Abigosis, who was unaware of Samantha's pregnancy. Writer informed Delores that Samantha & [redacted] are for d/c [discharge] today & that supplies are in place – Delores will follow up in community. No concerns prohibiting d/c at this time. No further SW [social work] indicated, ready for d/c*

As was recorded, after meeting with Kematch and Sinclair, hospital social worker SOR#2 called the agency and informed Chief-Abigosis that the family was ready for discharge and no further hospital social work was necessary. She testified that Kematch's history with child welfare mandated this call to the agency, but she had no other concerns at the time. She did not recall how she knew to direct her call to Chief-Abigosis, but her practice was to call CFS and confirm who the assigned worker was.[249]

Chief-Abigosis recorded the call from the social worker on April 30, 2001, as follows:[250]

> *April 30, 2001 Received PC from Women's Hospital from [redacted] SW to inform me that Samantha Kematch gave birth to a baby girl on April 29th, they named her [redacted] and baby and mother are doing fine. According to [redacted] the parents are quite attentive to the child and stated that they have all the necessary items for the child. Their daughter Phoenix, is approximately 1 year old and they have kept all her baby stuff. A friend of theirs is keeping Phoenix until Mom is released from the hospital. [Redacted] has no concerns and stated that the father, Steve Sinclair, has been actively visiting and participating in the care of the baby.*

I note that there was a nearly three-month gap between the time of Chief-Abigosis's last recorded contact with Phoenix's family on February 9, 2001 and the receipt of this call on April 30. Chief-Abigosis could not recall why there was such a gap, nor could she recall if she saw the family during that time. She testified that if she had been aware of Kematch's pregnancy, she would have noted it. No such record was made. She testified that she would have been concerned that, for the third time, Kematch had not disclosed her pregnancy to the agency, but could not recall if she ever confronted Kematch about this concern. She testified that it would have been important to investigate the supports the family had in their lives at the time of this new baby's birth, but could not recall if she actually did that.[251]

The fact that the agency was unaware of this pregnancy, which the couple had made no attempt to hide, illustrates the agency's lack of engagement with this young and vulnerable family.

In her testimony, Chief-Abigosis agreed that, based on her knowledge of the family at that time, a new baby could add additional stressors and could potentially put both children at risk. She said, however, that she could not recall if she conducted either a safety or risk assessment at that time. She did say that because of the ages of children, she would have assessed this family as high risk.[252]

Balan testified that she had an independent recollection of a conversation she had with Chief-Abigosis shortly after the baby's birth: she instructed Chief-Abigosis to schedule a follow up visit with the family to assess how they were managing, but to wait a few days to give the family time to settle into a routine.[253]

Although there was no concerning information in the referral from SOR#2, Balan's evidence was that a significant change in the family composition alone may require a new risk assessment.[254] Another possible risk factor, Balan testified, was the lack of information on the file: family support worker Belanger had not been to the home since December 2000, and Chief Abigosis had only one recorded visit in 2001.[255]

I find that the addition of a new baby to this family, combined with the family's history, demanded a new risk assessment. As the evidence disclosed, this family was experiencing significant stress. Certainly the agency needed to determine what supports the family had in place, and what supports they lacked. The agency failed to fulfill its obligations in this regard. This was in addition to its failure to maintain regular contact with the family under the terms of the service agreement.

5.5.2 WHO WAS CARING FOR PHOENIX?

From October of 2000 until Echo was born, Phoenix spent most of the time at the home of Edwards and Stephenson, Edwards testified. She said Sinclair asked her to look after Phoenix because Samantha was "hormonal" and was pushing her away. Phoenix would return home on some weekends and Sinclair would visit her during the week, but Edwards recalled Kematch coming to visit only once while she was pregnant with Echo. Edwards testified that Phoenix was with her when Echo was born, but went home to meet her sister and bond with her family. Stephenson testified that he believed that Phoenix spent more time with him and Edwards after Echo's birth because of the new baby in the home. Also, he said, Edwards wanted Phoenix around.[256] It is clear that from the time Phoenix was born, Edwards and Stephenson were significantly involved in caring for Phoenix.

The agency was not aware of the amount of time Phoenix was being cared for by someone other than her parents after she was returned to their care, even though it had an open file and ought to have been monitoring the home and Phoenix's well-being.

This is troubling. It shows that the agency was not effectively monitoring Phoenix's whereabouts, let alone her safety and well-being, which raises the question: How could the agency be performing any services in aid of protecting Phoenix when it took no steps to learn who was in fact taking care of the little girl? There is no question that Edwards and Stephenson loved Phoenix and no evidence other than that she was safe and well looked after in their care. But the very fact that her parents were not themselves caring for her was a matter the agency ought to have pursued. This would have been most relevant to its assessment of Kematch and Sinclair's parental capacity and motivation—issues that the agency had identified as a priority. At the time of Echo's birth, in addition to having no contact with Edwards and Stephenson, who were Phoenix's primary caregivers, it is clear that the agency had limited contact with Kematch and Sinclair.

Chief-Abigosis did note in her recording:[257]

> *The parents returned home with the child and appeared quite attentive in the care of the child. Parents have been observed as responsible in caring for the child and have accessed appropriate care caregivers to care for Phoenix in their absence. This is Samantha's third child and this is the third time that she has not disclosed to the Agency that she was pregnant.*

This information appears to have been based on the April 30, 2001 report from Women's Hospital. Chief-Abigosis could not recall how she knew Phoenix's caregivers were appropriate, or if she made any investigation of them, although she did state that this would be something she would want to do.[258] She recorded making one visit to the home on May 9, 2001, but no one was home.[259]

This family had been identified only one year earlier as having such significant needs that it was necessary to apprehend Phoenix at birth. It is true that recordings in the file indicate that the parents were making efforts, but the extent to which they were successful was unknown at this point. Further, the birth of a second child to this couple one year after Phoenix's birth was a factor that could increase risk and certainly needed to be assessed for the protection of both Phoenix and the newborn. When the agency failed to make meaningful contact with the family and assess Phoenix's well-being and her family's supports and needs, both before and after the birth of the new baby, (November 2000 to May 2001) it failed to protect Phoenix and support her family in accordance with *The Child and Family Services Act*.

5.6 NEW CONCERNS FOR PHOENIX AS HER PARENTS SEPARATE

5.6.1 3RD REFERRAL: REPORTS OF DOMESTIC ASSAULT, JUNE 18, 2001

The next information Chief-Abogisis received about Phoenix and her family came on June 18, 2001, in an email from social worker Elisabeth Woods. She wrote to Chief-Abigosis to express concerns about someone who may have been babysitting Phoenix, and about a report of violence in the home. Under the subject line, "Steve Sinclair and Samantha Kematch," the email reads as follows:[260]

> *Hi Delores:*
>
> *Steve's sister Angie Sinclair was very recently transferred to me. Angie has been awol from [redacted] a great deal lately. Much of the time she has spent with her brother Steve and his partner Samantha. Angie's group home staff believe that Angie may have been babysitting for Steve and Samantha. Given Angies functioning this would be of concern.*
>
> *Also of concern is a message I received from [redacted] wherein I was told that recently Steven had become violent and had assaulted both Angie and Samantha. Police were involved lately but I am not sure of what transpired. I was told today that Angie is staying with a fellow by the name of [redacted]. (I know [redacted] because he assaulted one of my other girls only months ago). [redacted] is also the birth father of Samantha's first born.*
>
> *For your information and or follow up.*
>
> *Hopefully by the time you read this – my information might be a little more clear.*

Hanson had returned from maternity leave on June 1, 2001 and had taken over supervision of Chief-Abigosis from Balan. She said she could not recall if she was aware of this email, but would have expected Chief-Abigosis to follow up on it within 24 to 48 hours.[261] There is no evidence in the file that Chief-Abigosis responded to the email.

5.6.2 4TH REFERRAL: CONCERNS FOR PHOENIX AND HER BABY SISTER

On June 29, 2001, Chief-Abigosis received an email from Balan, relaying concerns for Phoenix's safety. Balan testified that she may have been filling in for Hanson on that day. The email was copied to Cory Donald, who was identified by Chief-Abigosis as a co-worker. It reads as follows:[262]

> *Hi Delores, I received a call from Cher Prince/CRU late this morning. Cher advised that she had received a call from [redacted] refused to provide his name. [redacted] reports concerns about Samantha Kematch's children. Stated that on June 15th Samantha was out of the home with the small infant, the 1 year old remained in the home with Steven. Steven and Samantha live at 740B Magnus. SOR is concerned as he has not seen Samantha and babe in a few days, and alleges that Steven has a drinking problem and on-going conflict with Samantha. SOR feels there needs to be some check on the safety and well-being of the children.*
>
> *I asked Cory to do a field to the home to check on the well-being of the children today. I will have Cory send you an email with outcome of the field. Thanks, Angie*

When asked why Donald was sent to do the field visit when she was the assigned worker, Chief-Abigosis was unsure, but testified that she may have been away or unavailable. Her file recordings indicate that Donald did in fact go to the home, although the date of his attendance was not recorded in the file. This record reads as follows:[263]

> *7/4/01 10:40 AM*
> *Several concerns have been referred re the care of the children and the parents use of alcohol and family violence.*
>
> *Plan: Will field to 740A Magnus on July 4th*
>
> *Cory Donald on call worker -- field to the home during my absence from work -- according to Cory Donald that he had met with Steve at his home at 740B Magnus --Steve appeared sincere, open and honest in his discussion with Cory -- Samantha left the home and the two children are in care of their father. The house was clean and Steve did have assistance from extended family to care for the children if needed,*

Chief-Abigosis did not recall any specific conversation with Donald about his visit beyond what was recorded in her notes.[264]

5.6.3 5TH REFERRAL: KEMATCH ABANDONS CHILDREN, JULY 3, 2001

Another referral about Phoenix's family came to Chief-Abigosis on July 3, 2001, when a report was directed to her from the Intake & After Hours Unit (AHU). The report indicated that Kematch had abandoned Phoenix and Echo and left them in the care of Sinclair, then returned to the home with Winnipeg Police, to have Echo returned to her. The report notes that Kematch later phoned Sinclair and told him to come pick up the baby because she was not prepared to care for her. The report further stated "Sources reports that Samantha has nothing to do with Phoenix and dropped both the children off on dad about two months ago."[265]

That same day, another worker sent a memo to Chief-Abigosis documenting similar concerns that she had heard from Sinclair and two of his sisters. This memo was from Kathy Epps (now Peterson) who was the social worker who had been involved with Sinclair and some of his sisters when they themselves were wards. Epps had met with Sinclair and his sister Genni, and another sister at Ma Mawi, after Genni called her for advice. Peterson testified that Sinclair was quiet, shy, and sensitive, and she believed that she had a fairly good relationship with him. She was aware that his parents had been severe alcoholics, and their children were neglected. She believed that this led to significant mistrust of the system on Sinclair's part.

According to Peterson's memo, she was told that Kematch and Sinclair had separated, and that Kematch had Sinclair charged with assault and Sinclair and his sisters wanted to know what legal rights he had to the children:[266]

TO: DOLORES CHIEF-ABIGOSIS
FROM: KATHY EPPS
DATE: JULY 3, 2001

RE: [redacted]
Phoenix Sinclair
PARENTS: Samantha Kematch
Steven Sinclair

I was contacted today by [redacted] and [redacted] Steven. Steven was a ward of the Agency for a number of years and I was his worker. This was the situation as presented to me:

Steven has been caring for the children since Jun14th. On the 15th he had welfare changed to his name. Steven indicated that Samantha was drinking and out of control and not caring for the children. He has assumed responsibility for the children and he would like tot continue to do so.
Samantha reportedly has taken the Child Tax Credit and was drinking with it. Steven indicated that on Friday at approximately 2 AM an altercation broke out between himself, Samantha and Sheila (Steve's sister). Steve admits he had been drinking with Sheila but that this sister Genny was caring for his children at the time.
Steven reports that Sheila attacked Samantha and Steve pulled her off of Sam.
On Monday July 2nd WPS showed up at B - 740 Magnus where Steven resides and where he was caring for his daughter [redacted]. Phoenix was not at home last night. The officers stated that Steven was being charged with assaulting Samantha during the altercation that took place on the 29th. He has been accused of shaking Samantha. The officers took [redacted] and gave her into the care of her mother who is staying with [redacted] (Corner Bannerman and Aikens)
Steven is very concerned about his infant daughter and would like her returned to his care as he is convinced that Sam is unable to care for the child. [redacted] stated that Sam's first child is a Perm. Ward of Cree Nation.

I spoke with Steve who stated that he did not know he had a worker. He will call you and may come here after 2 PM.

FYI
Kathy Epps

This memo should have been a red flag to Chief-Abigosis, signalling the family's need for support and for protection of Phoenix and Echo. In particular I note the reference to Sinclair saying that Kematch was unable to care for her infant daughter and recalling that her first child was a permanent ward of Cree Nation CFCA. It is also concerning that Sinclair said he did not know he had a worker because by this time Chief-Abigosis had had conduct of the file since November 2000—a period of more than seven months.

Peterson testified that at the meeting in July 2001, Sinclair and his sister Genni told her that Phoenix was staying with Edwards, although this fact was not noted in her memo. Peterson said she did not make any notes other than the memo because at the time she was not the worker on the file. It was common for former clients to contact her informally. She said she did not follow up with Chief-Abigosis after she sent the memo, and she had no further involvement with the family about this incident.[267]

Sinclair recalled this meeting with Peterson. He testified that he contacted her because of the way Kematch had acted. He said Peterson's memo sounded like an accurate reflection of the concerns he raised with her at that meeting. He testified that after he and Kematch separated, he was taking care of Echo, and Edwards and his sister Sheila helped him with Phoenix. He did not recall Chief-Abigosis visiting him in July of 2001 and testified that they did not really have a relationship.[268]

Chief-Abigosis did not recall receiving Peterson's memo, but confirmed that it was on Kematch's protection file. She testified that this memo would have caused her concern and would have required an immediate response. She was surprised that Sinclair did not know that he had a worker. In her file, Chief-Abigosis noted that she received the information from Peterson on July 3, 2001 and tried to contact Genni Sinclair on July 5, but the telephone line was busy. Her records indicate that on July 6, 2001 she met with Sinclair at his home. Her file recording reads as follows:[269]

> *7/6/01 2:01 PM*
> *Field to 740B Magnus to meet with Steve. Steve was at home with his youngest child [redacted] – Phoenix was not at home she was at his friend Kim Edwards's home for the afternoon. Steve stated he gets her to watch her if he needs to go some where. The house was very clean although it was sparsely furnished, and there were about six kittens including the mother …. The youngest child, [redacted] was sleeping in a portable playpen in the living room near the kitchen. Steve invited this worker to the back of the apartment to what he considered his living room – he explained that he and Samantha are separated after she came home with a "hickey" on her neck – he stated she was with her ex-boyfriend [redacted] who is the father of her oldest child. Steve stated the child is in care of CFS. Steve stated he did not want anything more to do with Samantha and that he was charged with assault against her – Steve stated that she claims that he shook her up – Steve stated that his sister, Jenny, was there and witnessed the argument.*

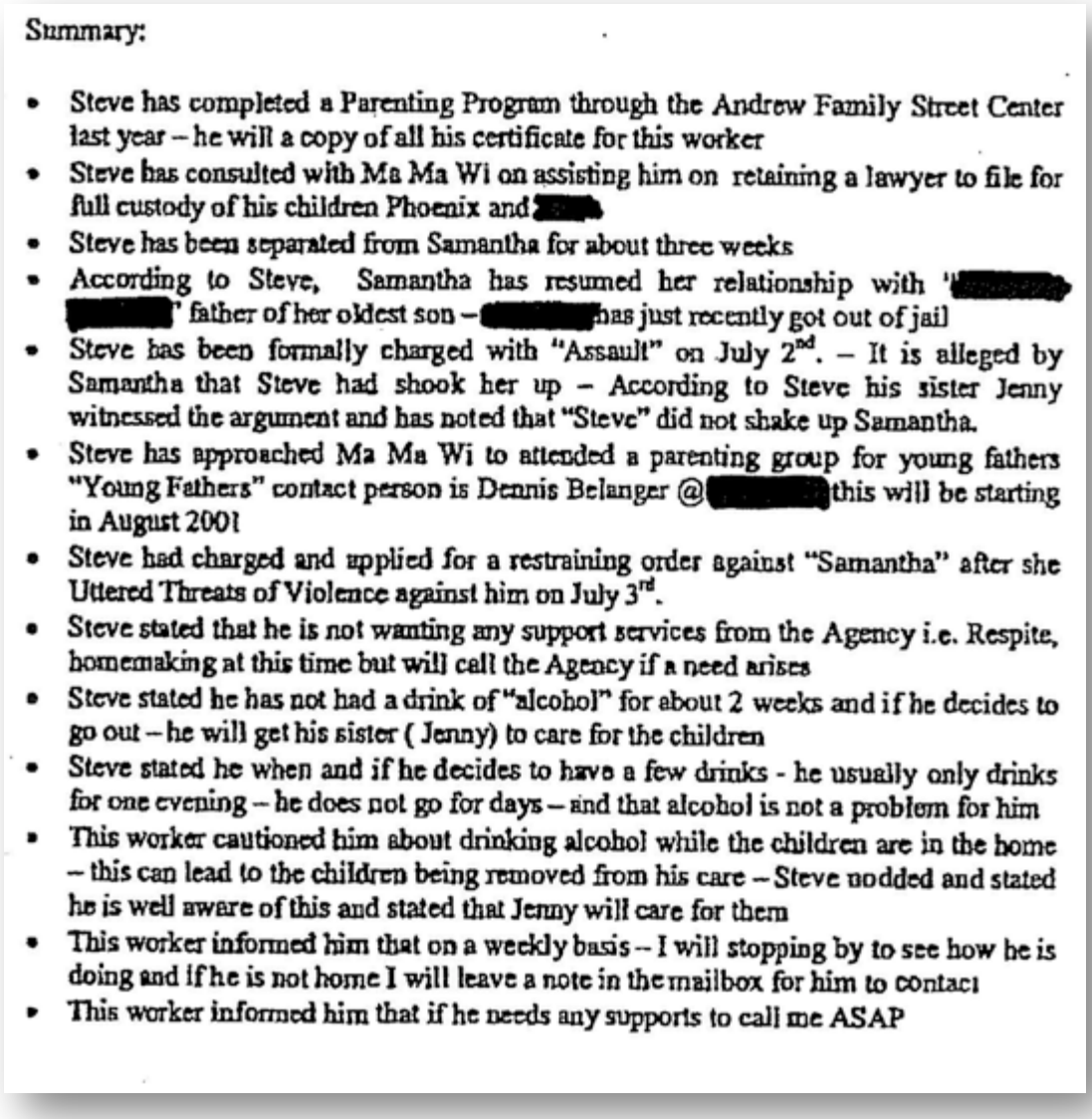
Another reason for Samantha trying to get back at him according to Steve – he stated his sister Sheila Sinclair had fought Samantha. He also stated that the WPS attended his home and arrested and charge him with assault – at that time the WPS took [redacted] and gave the child to Samantha. The child returned to his care about two days after this when Samantha brought [redacted] back on her own. Steve described [redacted] conditions as "being dirty and hungry and that she smelled badly". Steve stated he knew very well that Samantha could not care for her. Steve appeared to up front and honest in his answers.

During the time the worker was in the home – [redacted] woke up about 15 minutes into the visit – Steve retrieved her from the playpen and prepared a bottle of formula for her – all the time he held her in his arms – when Steve sat on the couch, he played with [redacted] and the child appeared very alert and responded to the noises and faces her father was directing towards her. While he fed her the formula he talked about his plans for the children – he stated that his main support for the children and him is his sister "Jenny" she works at the Ma Ma Wi center and he attended to the center almost daily. Steve stated that he takes the children to 601 Aikins if there is a need for medical attention and that Dr. Lipnowski sees [redacted] or he will call Envoy for assistance if they get sick and stated [redacted] is on "similac" formula and that she eats well.

This worker asked if he has a Ma Ma Wichitia worker assigned to him – Steve stated no – that he goes there and visits with all the workers – he did state that he will taking a parenting program for young fathers in August. Steve stated that he doing okay and if he needs any supports he would call the agency. Steve stated that he has changed all the welfare, child tax over to his name.

Chief-Abigosis testified that, at the time, she would have considered the file to be low risk, as the children were with Sinclair, who appeared to be a stable parent. She said that Kematch, who appeared to be the source of most of the concerns in the referrals she received, was no longer in the home or parenting the children. She testified that the purpose of her visit that day was to follow up on the concerns of the "collaterals" and to "see how the children were."

Chief-Abigosis acknowledged that she did not see Phoenix during her field visit on July 6, 2001. She also said she did not know anything about Edwards other than that she was a friend of Sinclair's and gave him a lot of support, and watched Phoenix. She did not know how much time Phoenix was spending outside the home, but agreed that it would have been concerning if Phoenix was spending three to four days a week elsewhere. She summarized her assessment of Sinclair in her file recording as follows:[270]



Summary:

- Steve has completed a Parenting Program through the Andrew Family Street Center last year – he will a copy of all his certificate for this worker
- Steve has consulted with Ma Ma Wi on assisting him on retaining a lawyer to file for full custody of his children Phoenix and [redacted]
- Steve has been separated from Samantha for about three weeks
- According to Steve, Samantha has resumed her relationship with '[redacted]' father of her oldest son – [redacted] has just recently got out of jail
- Steve has been formally charged with "Assault" on July 2nd. – It is alleged by Samantha that Steve had shook her up – According to Steve his sister Jenny witnessed the argument and has noted that "Steve" did not shake up Samantha.
- Steve has approached Ma Ma Wi to attended a parenting group for young fathers "Young Fathers" contact person is Dennis Belanger @ [redacted] this will be starting in August 2001
- Steve had charged and applied for a restraining order against "Samantha" after she Uttered Threats of Violence against him on July 3rd.
- Steve stated that he is not wanting any support services from the Agency i.e. Respite, homemaking at this time but will call the Agency if a need arises
- Steve stated he has not had a drink of "alcohol" for about 2 weeks and if he decides to go out – he will get his sister (Jenny) to care for the children
- Steve stated he when and if he decides to have a few drinks - he usually only drinks for one evening – he does not go for days – and that alcohol is not a problem for him
- This worker cautioned him about drinking alcohol while the children are in the home – this can lead to the children being removed from his care – Steve nodded and stated he is well aware of this and stated that Jenny will care for them
- This worker informed him that on a weekly basis – I will stopping by to see how he is doing and if he is not home I will leave a note in the mailbox for him to contact
- This worker informed him that if he needs any supports to call me ASAP

With respect to Sinclair's drinking, Chief-Abigosis testified that she took Sinclair at his word that this was not an issue. Her records indicate that she went to Sinclair's home again on July 10, 2001, but he was not home so she left a note asking him to call her at the office.

Consistent with testimony from agency workers, other witnesses who had contact with Kematch and Sinclair testified about the problems the couple was experiencing. Humenchuk said that after the birth of the new baby, Kematch and Sinclair attended the Boys and Girls Club even less frequently. She recalled that after the birth they separated and their behavior towards each other was hostile, volatile, and tense. Kematch was still attending infrequently to use the phone and to eat, but Sinclair not at all.[271]

As the family was becoming more and more isolated, this was precisely the time when the agency needed to reach out and offer them support. Instead, the agency retreated.

Chief-Abigosis had no direct contact with Phoenix nor with the individuals who were identified as her main caregivers–Edwards and one of Sinclair's sisters. Although Chief-Abigosis identified Sinclair as being a stable parent, this did not mean that he had the experience or skills, or supports, to provide the necessary care for his children. By seeing this file as low-risk, Chief-Abigosis was assessing only the immediate safety of the children and not the long-term risk of chronic neglect to which these children were potentially exposed. This failure to assess long-term risk is repeated throughout the agency's involvement with Phoenix and her family, as will be discussed later in this report.

Further, by assuming that Phoenix was safe because she was not with Kematch at the time, the agency failed to recognize that Kematch had equal legal rights to custody of Phoenix and was entitled to take her at any time. This is what eventually happened, with tragic results for Phoenix.

5.6.4 WARNINGS GO UNHEEDED

These three referrals to the agency about Phoenix's family, made in quick succession on June 18, June 29, and July 3, 2001, should have warned the agency that there may have been domestic violence in Phoenix's home; that she and her sister had no consistent care; and that Sinclair was now a single parent, caring for a newborn and a one-year-old, with limited resources and parental experience, and issues of substance abuse. Given Sinclair's history and these circumstances, the agency ought to have made immediate contact to find out what supports were in place for him.

There is no evidence that the agency conducted any such investigation, or even that it had any contact with Phoenix in the more than six months since February 9, 2001. This is extremely troubling.

5.7 PHOENIX'S BABY SISTER DIES, JULY 15, 2001

5.7.1 6TH REFERRAL: FAMILY NEEDS SUPPORT AFTER BABY'S DEATH

On July 15, 2001, five days after Chief-Abigosis's last attempted field visit, the agency received a referral from an SOR at the Health Sciences Centre Children's Emergency Centre. The referral was documented in an After Hours Unit form by Shannon Skogstad who sent it to Chief-Abigosis, with copies to Chief-Abigosis's supervisor Hanson; and Hanson's supervisor, Program Manager Darlene MacDonald. The body of the referral form reads as follows:[272]

PRESENTING PROBLEM/INTERVENTION:

The SOR called to inform this agency that [redacted] born April 29/01, was brought to the hospital, DOA at around 9:50 am today. This worker began asking specific questions in relation to the death of the baby and the SOR gave this writer WPS – Street Supervisor, Steve Bowen to speak to.

Steve informed this writer that according to Steve Sinclair, father of the deceased child, [redacted] had a cold and was running a fever. He had checked on her at 7am this morning and she was ok. He then stated that he checked on her again around 9:45 and she was not breathing. He called 911 and was transported immediately to the hospital. Apparently [redacted] was DOA.

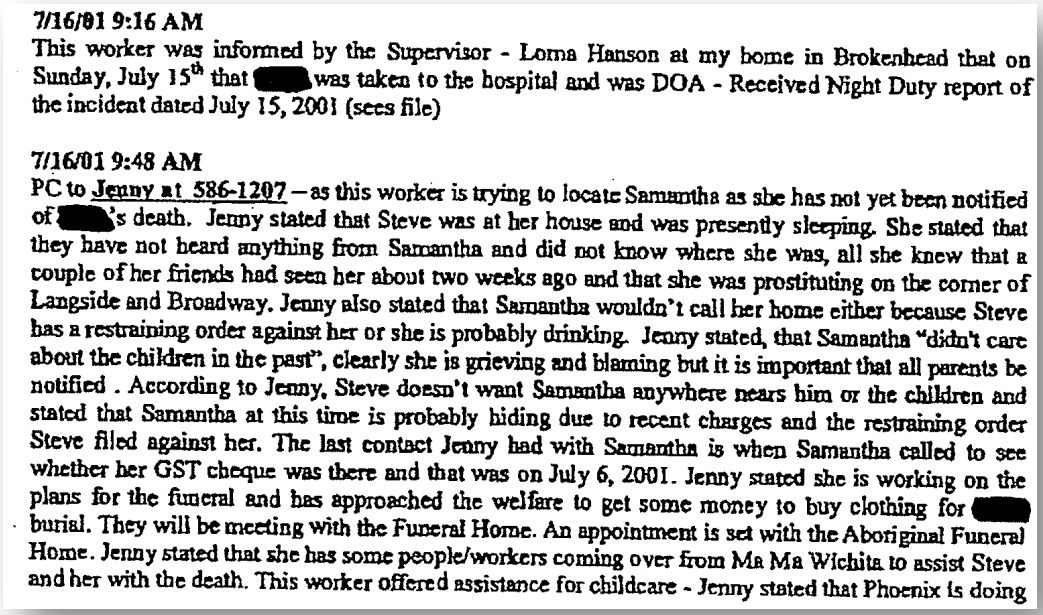
Apparently Steve Sinclair's partner and mother of the children, Samantha Kematch, are separated. According to Steve, Samantha abandoned him and the children a month or so ago.

The SOR stated that at this point there is no suspicion, however, the child abuse unit is currently in the home, which is apparently very hot. The SOR is concerned that Steve may need some support in the home and feels that it might be a good idea if we went to the home and spoke with him once he is finished at the hospital, which will be in about an hour or so. The hospital is going to be sending SCAN to the Child Protection Unit at the hospital for follow up. This writer notes that Phoenix is currently with Genni, Steve's sister, who lives a few doors away from him. Genni will be a support for him.

. . .

In regards to the suggestion that Sinclair might need some supports, Chief-Abigosis testified that she offered services, but both Sinclair and his sister Genni declined them. She could not recall what in particular she offered, but said the agency typically would have offered services such as grief counseling.[273]

In the closing summary that she placed on Kematch's protection file a month later, Chief-Abigosis said that Hanson had informed her of Echo's death while she was at home and her first response was to contact Genni Sinclair. Her file record reads as follows:[274]



7/16/01 9:16 AM
This worker was informed by the Supervisor - Lorna Hanson at my home in Brokenhead that on Sunday, July 15th that [redacted] was taken to the hospital and was DOA - Received Night Duty report of the incident dated July 15, 2001 (sees file)

7/16/01 9:48 AM
PC to Jenny at 586-1207 – as this worker is trying to locate Samantha as she has not yet been notified of [redacted]'s death. Jenny stated that Steve was at her house and was presently sleeping. She stated that they have not heard anything from Samantha and did not know where she was, all she knew that a couple of her friends had seen her about two weeks ago and that she was prostituting on the corner of Langside and Broadway. Jenny also stated that Samantha wouldn't call her home either because Steve has a restraining order against her or she is probably drinking. Jenny stated, that Samantha "didn't care about the children in the past", clearly she is grieving and blaming but it is important that all parents be notified . According to Jenny, Steve doesn't want Samantha anywhere nears him or the children and stated that Samantha at this time is probably hiding due to recent charges and the restraining order Steve filed against her. The last contact Jenny had with Samantha is when Samantha called to see whether her GST cheque was there and that was on July 6, 2001. Jenny stated she is working on the plans for the funeral and has approached the welfare to get some money to buy clothing for [redacted] burial. They will be meeting with the Funeral Home. An appointment is set with the Aboriginal Funeral Home. Jenny stated that she has some people/workers coming over from Ma Ma Wichita to assist Steve and her with the death. This worker offered assistance for childcare - Jenny stated that Phoenix is doing well and that she doesn't need any assistance at this time and will call the Agency if there is a need. This worker stated that the Agency would be available if there is any support needed.

Later that day, Chief-Abigosis was able to speak to Steve Sinclair. She recorded her conversation as follows: [275]

> *7/16/01 2:13 PM*
>
> *PC to Jenny's home to speak to Steve. He stated that he is staying at Jenny's home and her and his friend Kim Edwards are looking after that Phoenix. I offered my condolences and stated that if the Agency could help in anyway that he could contact us. I informed him that Samantha was made aware today of [redacted]'s death. Steve stated that he did not want Samantha anywhere near him or Phoenix. The funeral arrangements have been made for Wednesday, July 18, 2001 at 1PM. The Aboriginal Funeral Home is in charged of the funeral. Steve stated that he doesn't want Samantha or any of her family anywhere near the funeral. I share with Steve that this may pose a problem and to think over the matter carefully.*

Chief-Abigosis had contacted Kematch to tell her of Echo's death. The details of this conversation are recorded in her file as follows:[276]

> *7/16/01 2:27 PM*
> *Received PC from Samantha at 2:25 PM. She stated she wants to know about where Phoenix was and that she wanted her. This worker informed her that the child is with her father Steve and that he was caring for her. Samantha stated that the police told her that the child was with CFS. This worker informed her that at the time of [redacted]'s death that the child was being cared for by her father Steve. Samantha began to sound angry and stated that she wanted Phoenix and how we gave him Phoenix. I informed her that Steve was the primary caregiver of the children and that the Agency is aware that her and Steve have been separated for about one month. Samantha responded "yeah" – and that he had the child in his care and was the guardian. I further told her that "custody" or legal guardianship needs to settle by them and their lawyers. Samantha stated that they both have guardianship of the children, and where is it written that he has only guardianship. I informed that that it has to settled between them. Samantha got angry and stated "whatever" and hung up the phone. DCA*

Hanson recalled taking the lead with respect to this incident and helping Chief-Abigosis complete the necessary paperwork. Hanson testified that because the police had ruled out homicide, and because Phoenix was being cared for by Genni Sinclair (who had been determined a safe caregiver), there were no immediate safety concerns for Phoenix in the aftermath of Echo's death.[277]

Hanson testified that she prepared a letter, dated July 16, 2001, to Program Manager Darlene MacDonald, notifying her of Echo's death. She said the Notification of Death was to give MacDonald a general sense of the case plan and the agency's next steps after the death of a child. Hanson said she based her letter on information in the Kematch protection file; information on the agency's database, known as Child and Family Services Information System (CFSIS); and information from Chief-Abigosis. The letter summarized Winnipeg CFS's involvement with the family since Phoenix's apprehension on April 24, 2000, the day after her birth.[278] The letter concludes as follows:

CONCERNS OF ABUSE: There have never been any concerns regarding the parents harming the children.

ANTICIPATED ACTION OF AGENCY:

- to continue supporting Steve in regards to his parenting of his daughter Phoenix
- to assist Ms. Samantha Kematch in coping with the loss of her daughter.
- to continue monitoring family situation
- to help Samantha stabilize, as since her break-up from Steve she has been staying with various people and has had limited contact with her children.

POLICE INVOLVEMENT: To date we have no further information and the investigation is ongoing. We do not know at this point in time if any charges will be laid. An autopsy is to be completed today.

AGENCY ASSESSMENT:

It is our assessment that Steve has been parenting to the best of his abilities. That he and Samantha are presently separated and that Steve has been the primary caregiver to Phoenix and [redacted]

Our file was open as these are young parents, with limited experience, that both have child welfare histories. There have been concerns of the children receiving inappropriate care, but it was felt that this was more about education than actual purposeful neglect. Recently, the concerns have been more about the instability of the relationship and the fact that Steve is parenting on his own. It is unclear, whether any domestic violence has or has not occurred. Steve is stating that he did not assault Samantha. We have been unable to speak with Samantha regarding the alleged assault as she has been transient.

The worker states that Steve was providing appropriate care for his children. That he was and continues to receive support from his family. We will continue to support Steve and Samantha. At present it appears that Steve will continue to be the primary care giver. At present Samantha may have some personal issues to deal with before she can actively participate in her child's day to day life.

This assessment is not the first time that the agency identified the need to address Kematch's ability to parent, but there is no indication that the agency ever helped Kematch to resolve her problems. The assessment also correctly identified the agency's need to support Sinclair as the primary caregiver, and yet no further support or monitoring was provided. I recognize that Sinclair was reportedly being helped by family and friends and was not receptive to agency supports. Nevertheless I find that it should have been obvious to the agency that supports were indeed required for both Sinclair and Kematch, to ensure Phoenix's safety and well-being. The agency, in my view failed to deliver these services.

5.7.2 7TH REFERRAL: POLICE ARE CALLED TO THE FUNERAL CHAPEL

On July 18, 2001, CRU social worker Skogstad recorded another referral about a dispute between Kematch and Sinclair at the funeral chapel. Her CRU Intake Form, directed to Chief-Abigosis, reads as follows:[279]

PRESENTING PROBLEM/ INTERVENTION:
The SOR called to report that Samantha Kematch and her partner, Steven Sinclair are involved in a family dispute since the death of their daughter, [redacted], on July 15/01. According to the SOR the police actually had to attend the funeral chapel last night due to the tension which an outside source had indicated might lead to violence. In fact, Steve's side of the family were to view the body from 7:30 to 9:30 pm and Samantha's side of the family was to view the body from 10:00pm to midnight. In addition, the police were informed that a Niki Taylor, worker for the Boys and Girls Club, had actually examined little [redacted]s body last night at the funeral parlor. Apparently she has accused the police of missing marks on the body which of course are marks caused by the autopsy.

The SOR also relayed that according to Steve Sinclair, he was approached by Diane Redsky, Executive Director of Ma Mawi, and asked that he participate in a Sharing Circle with his ex, Samantha Kematch. Steve stated that he told Diane that he did not want to participate, and furthermore, he has an order stating that he is to stay away from Samantha, due to a prior domestic assault charge. Steve alleges that Diane told him that the "court order" does not matter and that he could attend the sharing circle.

The SOR has been told that Samantha Keematch and her family are upset that the funeral is not being held on the reserve. She also indicated that she wanted the funeral postponed and wanted to challenge the autopsy. She apparently wanted an inquest into the death of [redacted] before any funeral was held. These are but some of the issues the respective families are divided on.

The SOR maintains that it appears that [redacted] died from complications from pneumonia, and the autopsy has not revealed any evidence of child abuse thus far. The toxicology reports are not complete and the SOR suggests that the agency contacts him in September and gets the completed autopsy report.

Apparently Steve Sinclair has gone to a lawyer and is seeking Interim Custody of both Samantha, and the body of [redacted] The SOR stated that the funeral is at 1:00pm today and the police will not be attending.

This writer contacted the family's worker, Deloris Chief-Abigosis, at the Jarvis office and relayed the aforementioned. Deloris requested the information be written up and faxed over to place in the file.

Shannon Skogstad: CRU Social Worker

Chief-Abigosis could not recall the specifics of this incident and testified that she did not speak to Skogstad about it. She said she did attend the funeral on July 18, 2001, but could not recall whether Phoenix was there, or if she spoke to Sinclair, or if she offered him any additional supports after the funeral.[280] Sinclair recalled Chief-Abigosis attending the funeral; he testified that she was "trying" to be involved, around that time.[281]

The incident at the funeral home was another warning to the agency that Phoenix's parents continued to struggle with issues that required attention and resolution.

5.7.3 THE FAMILY, AFTER BABY'S DEATH

Humenchuk's last contact with Sinclair was at the funeral. Her last contact with Kematch was either at the funeral or shortly afterwards. She never heard about Sinclair again, but a few weeks later she heard from a friend of Kematch's that Kematch was drinking heavily. She testified that she never heard anything further about the family from any social worker.[282]

I find it unfortunate that the agency did not maintain contact with Humenchuk. She was a valuable contact and service provider, who had the trust of Kematch and Sinclair and important information that she could have shared: that Sinclair had withdrawn from his normal community activities and Kematch was engaging in substance abuse.

Edwards gave the following evidence about the family in the summer of 2001, following Echo's death:

> *A: After Echo passed away, Steve was, he was a real mess, like all he did was play his guitar and it was just one song for the longest time and sometimes that would entail drinking and it was actually him and his sisters, and his sisters, I don't believe that they're still married but his sister's husband asked me if I would take Phoenix back because they thought Phoenix would be safe and, to be honest with you, everybody believed that was the best place for Phoenix.*[283]

Edwards also gave a description of what Phoenix was like at the time:

> *A: She was one who got – she walking, running, around playing, trying to skateboard, trying to, trying to do everything that my kids were doing. She was –*
>
> *Q: She would have been just over a year.*
>
> *A: She would have been just over a year, yeah.*
>
> *Q: Was she talking?*
>
> *A: She was talking. She was talking by the time she was, oh I'd say 10 months. Not sentences or conversations, but she was talking. I'd say by the time she was 16, 17 months she was having, you know, small sentence structure and talking. You could communicate with her. She'd let you know what – she could speak when she wanted. She wasn't a child that would cry or, I hate using this term for a child, but she wasn't a child that would cry or whine for something. She would ask for it.*[284]

Sinclair testified that after Echo's funeral, Kematch was out of the picture and he had full care of Phoenix, but Phoenix was spending more time with Edwards and Stephenson because of the impact that Echo's death was having on him. Sinclair testified that he could always rely on Edwards.[285]

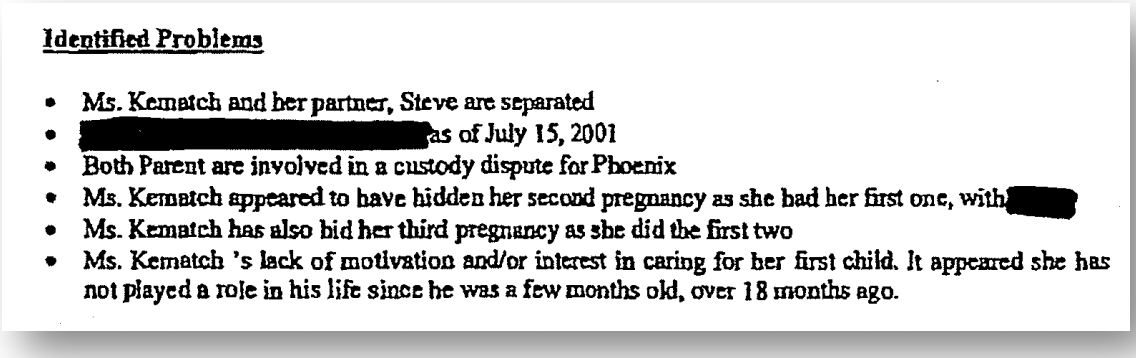
Edwards testified, and I accept, that from the fall of 2001, Phoenix was staying at her home most of the time. There was a period of six weeks when Sinclair did not come around at all. By the end of 2001, Phoenix's primary residence was Edwards and Stephenson's home, although Phoenix would spend a few days or weekends with Sinclair or with one of his sisters. This arrangement remained consistent for more than a year, through to the end of 2002. Edwards testified that when he came to her house, Sinclair would play with Phoenix and "he was right involved with, with Phoenix, that was his little girl."[286]

Chief-Abigosis' file recordings ended on July 17, 2001 and were signed off by her supervisor, Hanson, and placed on file effective July 24, 2001. She testified that she had given two weeks' notice that she was leaving the agency and was not actively servicing files after that date, although she continued to work at the agency into August, completing paperwork necessary to transfer her files.[287]

5.8 FILES ARE OPENED, CLOSED; PROBLEMS ARE UNRESOLVED

5.8.1 ONGOING PROBLEMS ARE IDENTIFIED

Because the agency at this time identified Sinclair as Phoenix's caregiver (even though in fact Edwards was providing most of her care), the Kematch protection file was closed and a protection file was opened in Sinclair's name. As the Kematch file was being closed, Chief-Abigosis prepared a case summary dated August 16, 2001.[288] The document was signed by Hanson, as supervisor, and also by Hanson on behalf of Chief-Abigosis. Chief-Abigosis believed that she created the document, but did not recall why she had not signed it.[289] The case summary includes the following:



Identified Problems

- Ms. Kematch and her partner, Steve are separated
- [redacted]as of July 15, 2001
- Both Parent are involved in a custody dispute for Phoenix
- Ms. Kematch appeared to have hidden her second pregnancy as she had her first one, with[redacted]
- Ms. Kematch has also hid her third pregnancy as she did the first two
- Ms. Kematch 's lack of motivation and/or interest in caring for her first child. It appeared she has not played a role in his life since he was a few months old, over 18 months ago.

- The couple's ambivalence regarding the long term plans for the child. They had not received any prenatal care and had not done anything in preparation for the birth of the baby. Also the parents initial reaction was they were unsure if they wanted to parent the child, there was an ambivalence regarding their commitment to the baby.

- Ms. Kematch 's reported flat affect and the reason for it. There was some concern that she may have been suffering from depression. Some form of psychiatric/psychological assessment with respect to Samantha was suggested.

- Due to the couple's young age and Ms. Kematch 's history, it was suspected they had limited parenting experience and skills.

The concluding page of the case summary noted the following:

Unresolved Problems

- The identified problems remain unresolved for Ms. Kematch

Recommendations for Future Intervention

If or when Mr. Sinclair and Ms. Kematch resolved their relationship and resume cohabitation, that the Agency accessed and monitor Ms. Kematch's parenting style. There are concerns expressed by Mr. Sinclair about her treatment and disciplined methods used on Phoenix.

Reason for Summary

That this file be closed Ms Kematch no longer has any of the children in her care. A new file under the name of Steve Sinclair has been open effective: July 6, 2001

Delores Chief-Abigosis/BSW
Social Worker

Lorna Hanson L. Hanson
Unit Supervisor

Dated: August 16, 2001

For the Sinclair file, Chief-Abigosis prepared a case transfer summary dated August 16, 2001. Again, Hanson signed the summary both as supervisor and on behalf of Chief-Abigosis. Hanson testified that she reviewed the summaries placed in both files and agreed with Chief-Abigosis' assessment.[290] The summary that was put in Sinclair's protection file identified these problems:[291]

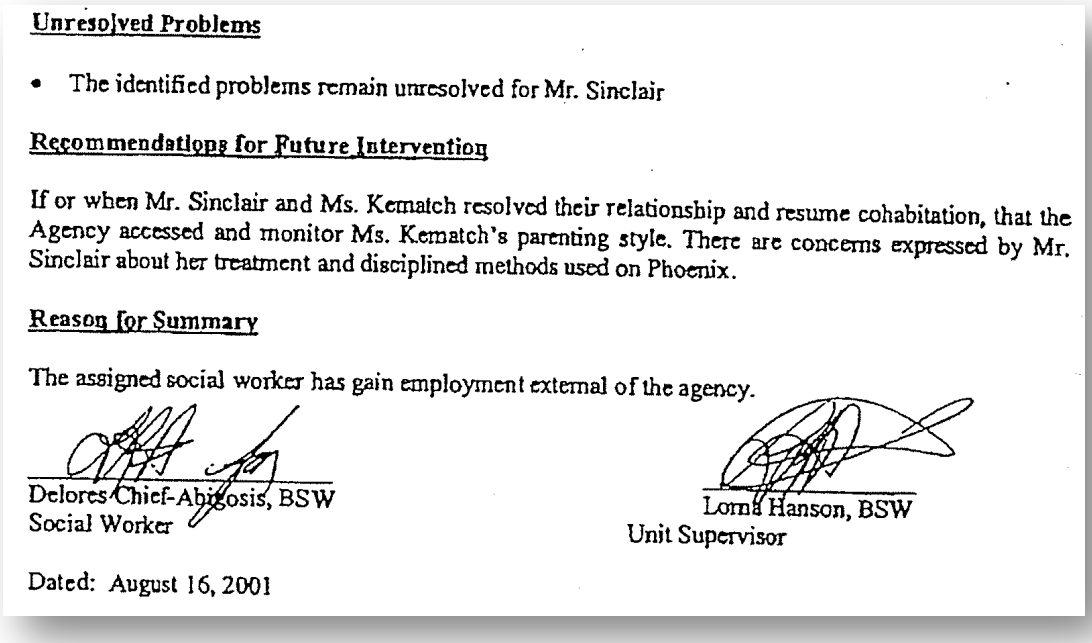
Identified Problems

- Mr. Sinclair has recently separated from his estranged wife Samantha Kematch (actual date unknown – in June 2001.
- Mr. Sinclair has been charged with assault against Ms. Kematch
- Mr. Sinclair has non-molestation order against Ms. Kematch and has charged her with "Uttering Threats"
- [redacted] Deceased as of July 2001
- Both Parent are involved in a custody dispute for Phoenix

- Mr. Sinclair has a strained relationship with Ms. Kematch extended family
- Ms. Kematch appeared to have hidden her second pregnancy as she had her first one, with [redacted]
- Ms. Kematch has also hid her third pregnancy as she did the first two
- Ms. Kematch 's lack of motivation and/or interest in caring for her first child. It appeared she has not played a role in his life since he was a few months old, over 18 months ago.
- The couple's ambivalence regarding the long term plans for the child. They had not received any prenatal care and had not done anything in preparation for the birth of the baby. Also the parents initial reaction was they were unsure if they wanted to parent the child, there was an ambivalence regarding their commitment to the baby.
- Ms. Kematch 's reported flat affect and the reason for it. There was some concern that she may have been suffering from depression. Some form of psychiatric/psychological assessment with respect to Samantha was suggested.
- Due to the couple's young age and Ms. Kematch 's history, it was suspected they had limited parenting experience and skills.

With reference to the note by Chief-Abigosis that Kematch hid her third pregnancy, it has been earlier mentioned that Humenchuk testified that she and other staff at the Boys and Girls Club were aware of the pregnancy and that Kematch made no effort to hide it.

The case summary concluded with the following:[292]



Unresolved Problems

- The identified problems remain unresolved for Mr. Sinclair

Recommendations for Future Intervention

If or when Mr. Sinclair and Ms. Kematch resolved their relationship and resume cohabitation, that the Agency accessed and monitor Ms. Kematch's parenting style. There are concerns expressed by Mr. Sinclair about her treatment and disciplined methods used on Phoenix.

Reason for Summary

The assigned social worker has gain employment external of the agency.

Delores Chief-Abigosis, BSW
Social Worker

Lorna Hanson, BSW
Unit Supervisor

Dated: August 16, 2001

Hanson testified that, at that time, the agency's plan was to keep Sinclair's file open, and monitor and try to address some of the identified problems relating to him in order to monitor Phoenix's safety, and assess the impact that the loss of the new baby was having on Sinclair.[293]

I find that this plan to keep the file open was necessary. The case summaries on the Kematch and Sinclair files, which were essentially identical, identified a number of outstanding issues regarding Kematch's parental capacity and motivation, and Sinclair's need for support, both personally and as a parent to Phoenix. As I have noted many times, these issues and the need to address them were identified and repeatedly documented by the agency, from the time of Phoenix's birth. Although Hanson correctly outlined a plan to keep the file open and address Sinclair's issues, again, no action was taken on the plan. Further, there was no plan at all in relation to Kematch, who had an equal right to have Phoenix in her care.

5.8.2 FILE IS SEEN AS "LOW RISK"

Hanson assigned conduct of the file to a new worker in late August, 2001, more than a month after Chief-Abigosis finished her work on the file. Hanson testified that she would have assessed the file as being towards "the lower end of risk" at that time. She testified that if she had taken any action herself on the file in the month before she reassigned it she would have recorded it, either directly on the file or in her supervisor's notes. There is no such record.[294]

Based on the absence of any recorded file activity, and her own testimony, I find that Hanson did not do any work on the file before it was reassigned. This is regrettable. In her July 16, 2001 letter to MacDonald[295] she had listed several items as "anticipated action of agency." According to that letter, the agency needed to continue supporting Sinclair as Phoenix's parent, and needed to continue monitoring the family situation. Hanson was aware of the parents' history, including their limited experience as parents, and issues relating to Kematch's parental capacity and motivation, which remained unaddressed. She recognized the need for the agency "to help Samantha stabilize" at this difficult stage in her life. That help was never given. Although Sinclair was at this moment the custodial parent, at any time Kematch was free to have Phoenix in her care, an option that she subsequently exercised, leading to the tragedy that resulted in this Inquiry.

Hanson's assessment that the file was at the "lower end of risk" is also concerning as it appears to take into account only the risk of immediate harm to Phoenix, ignoring the potential long-term harmful effects of leaving Phoenix in the care of parents who had significant unresolved issues of their own and who had not received any real assistance or support from the agency.

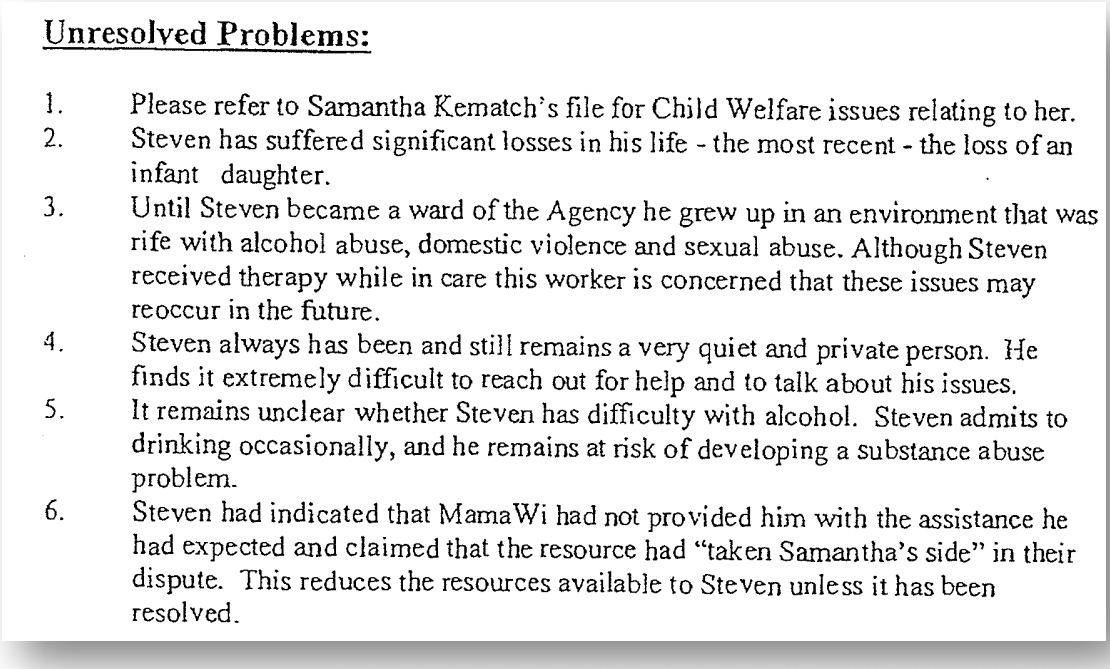
Kathy Peterson, who had met with Sinclair and his sisters in July 2001, was the new worker assigned to the Sinclair protection file. She obtained a BSW degree in 1984 and had been employed by Winnipeg CFS since 1990. Peterson testified that the file was assigned to her because she had known the family and had been Sinclair's worker when he himself was a child in care. She also said that at the time she took over the file, it was considered low risk: as a low risk file, it would still have received attention, but she did not consider it a priority.[296]

Peterson was unsure how many times Chief-Abigosis had actually met with Sinclair. She said she had not seen proof that Sinclair had completed the parenting course at Andrews Street Centre. She believed that Sinclair had consulted with a lawyer through Ma Mawi about custody of the children, but did not believe he had pursued it any further. Peterson never looked into the criminal charges reportedly laid against Sinclair. From her review of Chief-Abigosis' transfer summary, Peterson said that it was her understanding that all terms of the service agreement had been met. She did acknowledge the possibility that the family's circumstances could change, given the unknown extent of Sinclair's alcohol use and his possible reconciliation with Kematch. The concern with reconciliation was that Kematch had parenting issues that had not been addressed and Peterson believed that Kematch posed a higher risk to the children than Sinclair.

5.8.3 CASE PLAN IS ABANDONED; SINCLAIR FILE IS CLOSED

Peterson testified that by October 2001, the Sinclair protection file was "awaiting closure," meaning there were no services required by her unit and all that was left to do was close the file.[297] She testified that she had not had any contact with Sinclair or Phoenix since receiving the file in August.

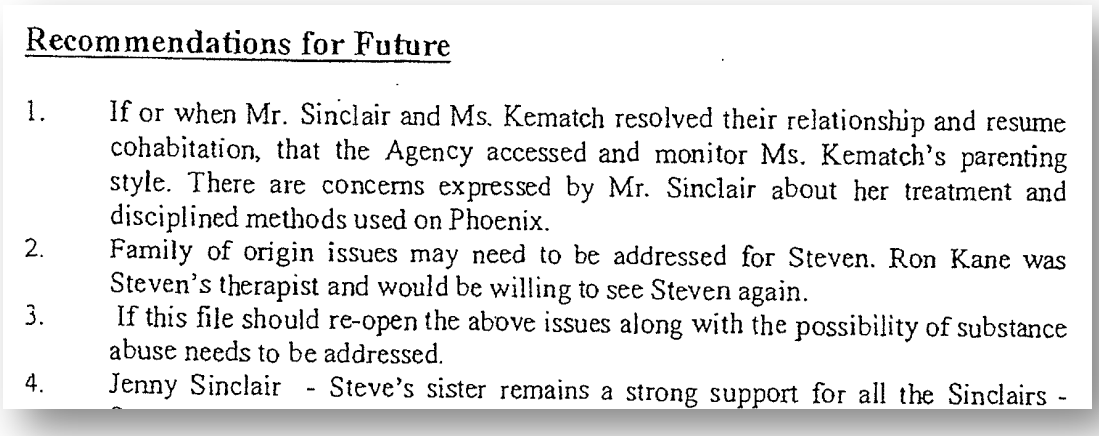
Peterson made a note of Sinclair's unresolved problems at the time of file closing, including the following:[298]



Unresolved Problems:

1. Please refer to Samantha Kematch's file for Child Welfare issues relating to her.
2. Steven has suffered significant losses in his life - the most recent - the loss of an infant daughter.
3. Until Steven became a ward of the Agency he grew up in an environment that was rife with alcohol abuse, domestic violence and sexual abuse. Although Steven received therapy while in care this worker is concerned that these issues may reoccur in the future.
4. Steven always has been and still remains a very quiet and private person. He finds it extremely difficult to reach out for help and to talk about his issues.
5. It remains unclear whether Steven has difficulty with alcohol. Steven admits to drinking occasionally, and he remains at risk of developing a substance abuse problem.
6. Steven had indicated that MamaWi had not provided him with the assistance he had expected and claimed that the resource had "taken Samantha's side" in their dispute. This reduces the resources available to Steven unless it has been resolved.

Peterson's closing summary also included recommendations for the future:[299]



Recommendations for Future

1. If or when Mr. Sinclair and Ms. Kematch resolved their relationship and resume cohabitation, that the Agency accessed and monitor Ms. Kematch's parenting style. There are concerns expressed by Mr. Sinclair about her treatment and disciplined methods used on Phoenix.
2. Family of origin issues may need to be addressed for Steven. Ron Kane was Steven's therapist and would be willing to see Steven again.
3. If this file should re-open the above issues along with the possibility of substance abuse needs to be addressed.
4. Jenny Sinclair - Steve's sister remains a strong support for all the Sinclairs -

I find the decision to close the protection file as of October 2001 to be most troubling. I have difficulty understanding how a seasoned social worker could, at that time, determine that this file was low risk. Phoenix may not have been at immediate risk of harm, but her parents' history and the recent stressors in their lives led to a risk that she would be in need of protection again in the near future. I also have difficulty understanding how the agency determined that it was appropriate to close the file despite the list of significant issues still outstanding

and the agency's failure to follow its own original case plan to keep the file open to monitor and address identified problems with Sinclair.

Peterson was aware when she assumed conduct of the Sinclair protection file that the couple's younger infant had died on July 15, 2001. She also understood that Sinclair had care of Phoenix, with support from his sisters, but that neither parent had sole legal custody. Peterson acknowledged that the extent of the work she performed on the Sinclair file was what she recorded in her March 2002 closing summary:[300] (References to "Steven" are to Steve Sinclair.)

> *This worker, Kathy Epps, resumed conduct of this file in late August 2001. This worker attempted to contact Steven a couple of times. Steven did not respond to my inquiries, however, his sister, Sheila, did, as this worker has had a relationship with all three of the youngest Sinclairs. Sheila had stated that Steven was doing well with Phoenix and that Jenny was helping out. Sheila had also mentioned that she was getting married. Sheila had assured this worker that she would pass along the message that I was available to meet with Steven to talk or provide service if needed.*
>
> *After another attempt to speak with Steven, this worker wrote a letter requesting that Steven attend to the office. Steven did not respond to the letter and no concerns have been directed to the Agency.*

The letter referred to in Peterson's closing summary was not contained in the Sinclair protection file. She said she may have forgotten to make a copy of the letter when she closed the file.[301]

Peterson testified that before closing the file, she and supervisor Hanson determined that there were no existing child protection concerns that would mandate services.[302] To mandate service, there needed to be a child protection problem that could be taken to court, and for which there was enough evidence that an apprehension order could be granted.[303] In this case, the risk to Phoenix was not high enough to warrant an apprehension, she said, and her view was that she could not force Sinclair to access voluntary services.

On the other hand, she testified that the file was still considered a protection file until it was closed and that involuntary services were mandated up until closing. But she and her supervisor decided that the family was no longer at high risk because they had met expectations and no new concerns had been raised. Peterson said she was quite certain that Sinclair and Kematch would not reconcile, based on her conversation with Sinclair and the history on file. The risk to Phoenix at that time was low or minimal because, she believed, the child protection concerns had been addressed.[304]

Peterson testified that when she prepared her closing summary in March 2002 she assumed Sinclair was still using Edwards and his sister Genni to look after Phoenix at time, based on what he had told her and Chief-Abigosis eight or nine months earlier. Peterson admitted to knowing nothing about Edwards. She was also aware at the time that Kematch could attempt to take Phoenix, and said she had

discussed this possibility with Sinclair and his sisters during their July meeting at Ma Mawi. Peterson testified that she had told Sinclair to call the police or CFS to assess the situation if that should happen.[305]

The Sinclair file was closed on March 27, 2002, with Hanson's approval. Hanson testified that she had no specific recollection of discussing Peterson's work on the Sinclair file with her, but stated that she would have discussed all her files with her periodically. She also testified that she would have kept a record of any discussions with Peterson in her supervisor's notes.[306] These are among the supervisors' notes that the agency could not locate.

The determination by the agency that Phoenix was not in a high-risk situation was clearly erroneous. The issues identified as unresolved were issues that posed a risk to her long-term safety and well-being. The agency's exclusive focus on Phoenix's immediate safety runs contrary to the child welfare system's legislative mandate to place equal importance on immediate and long-term safety and well-being, when considering whether a child is in need of protection.

Although Sinclair did not pose a risk to Phoenix's immediate safety, his history, including the recent death of Echo while under his care, cried out for long-term monitoring and support. The agency failed to support Sinclair as a parent and therefore failed to protect Phoenix. The agency ought to have been aware that Kematch posed a high risk to Phoenix and yet still was legally entitled to have Phoenix in her care. By closing the file without taking steps to address these issues, it failed to protect Phoenix.

For all intents and purposes, the agency provided no services to the family from the end of July 2001 until the next file opening in February 2003, despite the unresolved issues and concerns, and despite the work that the agency still needed to do with this family. This was an egregious error.

In final submissions, counsel for Chief-Abigosis, Peterson, and Hanson, stressed that Phoenix's file did not stand out as a high-risk matter because its issues were similar to those found in many other files in their caseloads at the time. While Chief-Abigosis acknowledged that she should have made more frequent visits to the family, her lawyer pointed out that the evidence from workers overall was that due to workloads and other files with higher risk and more severe problems, low risk files did not always get the attention they needed. Counsel submitted that it was "uncontested that a common problem at WCFS at the time was the need for social workers and supervisors to prioritize files and duties based on the severity of risk."[307]

There is no question that the evidence demonstrated that during the time services were delivered to Phoenix and her family, workload was an issue for agency staff. As Jay Rodgers, former CEO of Winnipeg CFS and current CEO of the General Authority, testified, workload has always been an issue for child welfare systems in many jurisdictions, including Manitoba.[308] In no way do I mean to minimize the impact that workload has on professionals' ability to perform their duties, and

later in this report I will discuss the issue of workload in more detail. But as counsel for the Department submitted, there is no evidence that workload had a direct impact on the services delivered, or not delivered in this case:

> *The totality of the evidence suggests that while workload was a general issue in the child welfare system (both in Manitoba and in all other Canadian jurisdictions), it was not a specific factor in the services provided to Phoenix Sinclair and her family.*[309]

Moreover, Chief-Abigosis characterized her caseload as manageable[310] and Peterson testified that workload did not affect the services she provided to Phoenix and her family.[311]

With respect to closing the file, Counsel for Hanson submitted that this decision was made because in October 2001 the risk to Phoenix was seen as low:

> *The decision to close the file would have been made between Ms. Peterson and Ms. Hanson in a supervision meeting in October 2001. Ms. Hanson testified that the decision was made because the risk to Phoenix was seen as low at the time. This assessment was made based on contact with the collaterals and the existence of Mr. Sinclair's support system, including external resources. Collateral contact with Mr. Sinclair's sister Sheila had been made. There were no concerns or reports provided to the Agency concerning the care of Phoenix or the conduct of Mr. Sinclair.*
>
> *Although Ms. Hanson agreed it would be ideal for Ms. Peterson to see Mr. Sinclair and Phoenix before the file was closed, she made attempts to do that, including a written request. If there are no child protection concerns, the Agency has no mandate to force a meeting with the family.*[312]

Regardless of whether there were external reports or concerns reported to the agency about Phoenix's care and Sinclair's conduct, the service agreement required the agency to take positive steps to monitor the family's circumstances, which it failed to do. The agency determined that there were no child protection concerns without taking the necessary steps to gather the information it required and in doing so, completely ignored the long-term risks to Phoenix's safety and well-being.

The decision to close the file despite the unresolved issues identified by Peterson in her closing summary showed that the agency failed to understand its mandate to support and protect families and children. To be clear, circumstances that would justify the apprehension of a child were not—and are not now—the sole criterion for identifying a child "in need of protection." This failure to appreciate the mandate of *The Child and Family Services Act* was consistent throughout the five years of Phoenix's life.

5.9 PHOENIX IS TREATED AT HOSPITAL, FEBRUARY 26, 2003

5.9.1 8TH REFERRAL: PHOENIX IN THE EMERGENCY WARD

On February 26, 2003, Stephenson took Phoenix to the hospital to have a foreign object removed from her nose. It had been there for months and was causing her pain.

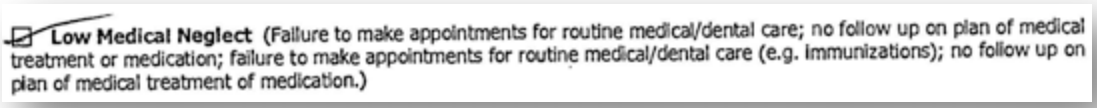
Roberta Dick was a social worker in the agency's Crisis Response Unit (CRU) in 2003. She obtained a BSW degree in 1990 and began working with Winnipeg CFS in 1992. On February 26, 2003, Dick received a call from the Child Protection Centre. This is a unit at the Children's Emergency Hospital, with workers well versed in suspicious injuries to children.[313] Dick summarized the referral as follows:[314]

PRESENTING PROBLEM/ INTERVENTION:

On February 26, 2003, [redacted] called to report that Phoenix was brought to Children's Emergency by her godfather on February 25, 2003. According to the SOR, Phoenix had a foreign body in her nose since November 2002. The godfather had told Steven to take Phoenix to the doctor at that time, but Steven never did. The godfather decided to bring her to the hospital for treatment.

The foreign body was removed from Phoenix's nose and the discharge in the nose was very foul smelling. The mucosa in her nose was red and sore. Antibiotics were prescribed, but [redacted] did not know if the antibiotics would be given to Phoenix or not. The hospital requested that this matter be assessed further given the concerns related to physical and medical neglect and inadequate care of the child.

Dick recommended that the case be followed up for further assessment, with a response time of five days. She testified that she addressed her report to Northwest Intake based on information she obtained from a CFSIS search showing that Phoenix was expected to be residing with Sinclair.[315] In deciding that a five-day response time was warranted, Dick used the safety assessment form that the agency required all CRU and AHU workers to use. The form contained three options for response time with regard to medical neglect: 24 hours for life threatening or serious cases; 48 hours for moderate cases; and 5 days for low medical neglect. Moderate medical neglect was described on the form as "Serious lack of medical and/or dental care causing suffering to the child." The option Dick selected was described as:[316]



Dick said she selected "low medical neglect" because the source of referral had stated that the injuries were not life threatening and that the call was mostly to ensure that the caregivers were following through on the treatment plan by giving Phoenix her antibiotics. She testified to having considered the moderate category, with a 48-hour response time, but chose the five-day response time to give the Intake worker some leeway and to accommodate workload demands.[317] Her supervisor, Diva Faria, agreed and signed off on Dick's assessment.

Sinclair testified that he knew that Phoenix had something in her nose and that he had taken her to a walk-in clinic where he was told that the blockage would come out on its own. He knew that Stephenson ultimately ended up taking her to the Children's Hospital.[318]

Stephenson testified that he was the "godfather" described in the referral from the hospital. He said he didn't give his name to the hospital because of his general distrust of the establishment at that time in his life. He said he had known about the foreign body in Phoenix's nose for some time and had told Sinclair about it. He thought it had been removed, but realized it had not been when he noticed a foul odour.[319]

Edwards testified that she also noticed the blockage in Phoenix's nose and told Sinclair to take her to the clinic. She was not sure if he did, but the problem did not go away so she took Phoenix to a walk-in clinic herself. She said the doctor told her that he couldn't treat Phoenix because Edwards did not have her medical information, but that she could remove the foam blockage with tweezers. She said she tried to do that with Stephenson's help, but Phoenix was screaming in pain, so Stephenson decided to take her to hospital.[320] Stephenson first testified that Edwards was not involved in getting Phoenix medical attention at this time,[321] but later said he did have a vague recollection of her trying to remove the blockage with tweezers.[322]

5.9.2 PHOENIX STAYS WITH HER CAREGIVERS

Edwards testified that she did not receive any phone calls from CFS after the February 2003 incident at the Children's Hospital, even though Phoenix was living primarily with her and Stephenson at 1331 Selkirk Avenue from then until June that year.[323]

Stephenson testified that he and Edwards had separated in December of 2002 and that it was he and his sons who were primarily taking care of Phoenix in 2003. Sinclair would drop Phoenix off and leave her there for days at a time. He said Edwards would come around sometimes and was still involved with Phoenix.[324]

I find that although the evidence is inconsistent as between Edwards and Stephenson as to who was primarily living at 1331 Selkirk Avenue as of 2003, the evidence was that this was Phoenix's home between February and June 2003. From time to time, either Stephenson or Edwards, or both, were present in the home while Phoenix was there.

5.9.3 SINCLAIR FILE IS TRANSFERRED TO NORTHWEST INTAKE UNIT

As supervisor of the Northwest Intake unit, Orobko received Sinclair's file from the CRU. He assigned the referral to worker Laura Forrest. She obtained a BSW degree in 1990 and began working with Winnipeg CFS the same year.

Forrest testified that she received Dick's CRU referral from Orobko on February 28, 2003. She had no independent recollection of her actions on the file, but she testified that she would have read the referral (the CRU form), and the safety assessment. She testified that she would have considered the response time stated in any safety assessment she received, but would have come to her own assessment. She also would have read the history on the file, but she could not recall whether she would have read the paper file or the electronic information contained in CFSIS.[325]

The work that Forrest performed was outlined in the transfer summary she prepared upon completion of her work with the family in late June 2003.[326] That summary contained both demographic information and an extensive history of the file.

On the day she first received the referral, Forrest called the Child Protection Centre for clarification of Phoenix's medical condition and the identity of the person who had taken her to hospital. She also visited Sinclair's home and recorded her visit as follows:[327]

Worker attended the home of Steven Sinclair. He presented at the door in a rather foul, but sober manner. He was also sporting a rather sizeable black eye, which he refused to discuss. Steven stated that Phoenix was still in the care of his friend and would remain there for a few days. Worker noted no noises from the home to suggest that Phoenix was in the home. Steven would not provide worker with the friend's name or address. Worker suggested that I needed to come back to see Steven and Phoenix to ensure her wellbeing and he stated "we will see about that". Worker left Steven with my card and informed him that I would return. Steven informed worker that he didn't need anything from the agency. He stated that he was unaware of Phoenix's ailment and that he always ensured that his daughter received proper medical care.

Forrest testified that Sinclair was uncooperative that day and she got the sense that he did not want to work with the agency. She knew that she still had to assess whether Phoenix was in need of protection, regardless of whether Sinclair wanted agency support. She agreed with the suggestion that she could not fully determine whether a child was in need of protection without seeing the child. [328]

Sinclair vaguely remembered Forrest coming to the home and not letting her in. He testified that he did not tell her that Phoenix was with Edwards and Stephenson "because then she would have gone down there and got up all in their face."[329]

After that first visit on February 28, 2003, the next time Forrest went to Sinclair's home was on March 12. She left her card because no one was home. Her file indicates that she tried again on March 31, but, "in the absence of other concerns, and with caseload demands," she did not try again until April 17, then May 1, and May 9, 2003. Each time she was unable to contact either Sinclair or Phoenix.[330] She testified that because of Sinclair's lack of cooperation, she did not know who Phoenix's caregiver was at that time.

Forrest testified that when caseload affected her ability to get out quickly, she would discuss this with Orobko, who encouraged her to record in the file the reason she was not able to attend. With respect to this referral, she said that at the time, it "wasn't really deemed a real high risk situation."[331]

Between May 9 and June 23, 2003, Forrest had no activity on Sinclair's protection file. She did not contact Sinclair's sisters or Kim Edwards because her personal style was to work directly with the client. She testified that contacting "collaterals" (such as Sinclair's sisters or Edwards) could impact her trust relationship with clients, and that privacy concerns could limit her ability to work with others who were not her clients.[332]

In his testimony, Orobko supported Forrest's action on this referral, saying that it was considered one of low medical neglect. He explained that the fact that a worker had not seen Phoenix in three months was a concern, but given their workload, they did their best. Orobko testified that when staff told him that their workload demands were affecting their work, he told them to note this on the file, as Forrest did in this case.[333]

In Orobko's view, the agency did need to see Sinclair interacting with Phoenix and to ensure that she was receiving her antibiotics, but the referral did not call for an immediate need to see her for protection concerns. He supported a case plan of direct contact by Forrest and he decided it was not necessary to reach out to extended family and significant others in Phoenix's life.[334]

While it appears that Forrest was diligent in trying to make contact with Sinclair and Phoenix, it is unfortunate that she was unable to dedicate more time to those efforts. In fact, the agency did not see Phoenix until after another referral several months later, in June 2003.

This is the only instance in the five years of the agency's file recordings relating to Phoenix where a worker recorded that workload demands had a direct impact on the services provided to Phoenix and her family.

5.10 PHOENIX IS APPREHENDED AGAIN, JUNE 21 2003

5.10.1 9TH REFERRAL: DRINKING PARTY AT PHOENIX'S HOME

On June 21, 2003 After Hours Unit (AHU) worker Bev Hutchison received a call about a drinking party the night before at Sinclair's residence. The anonymous caller said that Phoenix was in the home and not receiving adequate supervision. Hutchison went out to investigate. She met with Sinclair and told him that another team would be there later that evening to do a sobriety check, and to check on him and Phoenix. She prepared the following CRU Intake & AHU form, dated June 21, 2003, addressed to Forrest:[335]

PRESENTING PROBLEM/ INTERVENTION:

An anonymous adult male contacted the Agency to report that there was a drinking party occurring at the aforementioned address. He noted that he believed that there were three adults in the home, including dad and that there were two adults who he believed were passed out in the home. He noted that Phoenix was in the home and not receiving adequate supervision. He stated that police were in attendance at the home earlier this morning at approximately 4:00 a.m. to break up the drinking party.

P/C to WCP – worker spoke with dispatch who indicated that the last time that they attended the home was in April/03.

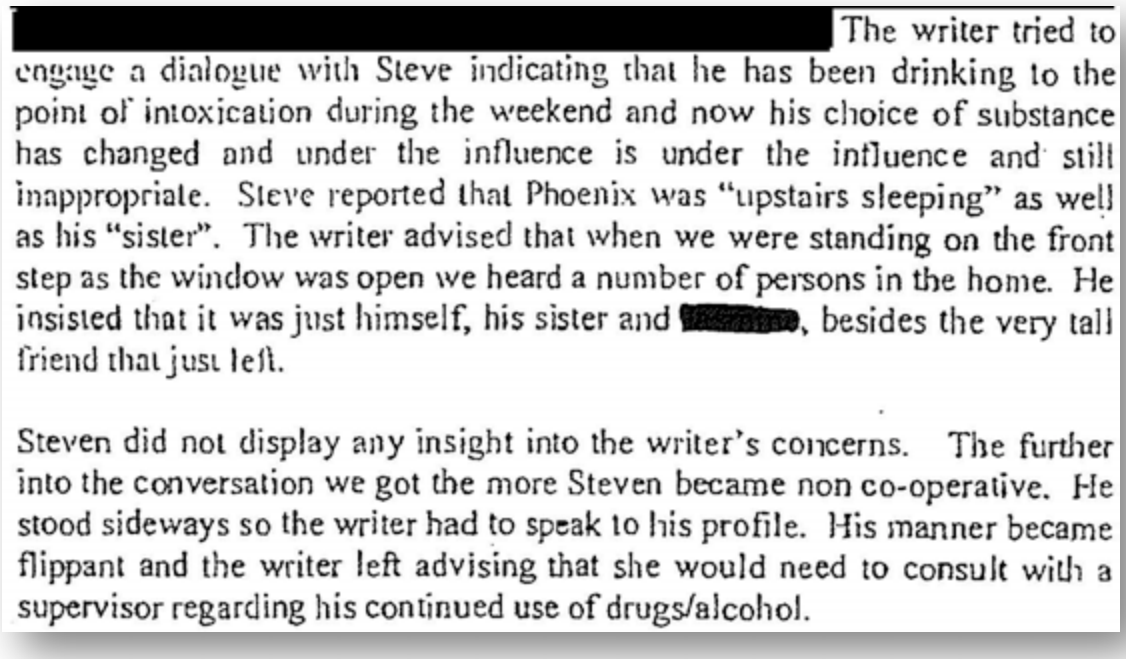
P/C to WCP – worker spoke with dispatch who indicated that the last time that they attended the home was in April/03.

This worker accompanied by co-worker Williams attended to the aforementioned address. Steven was present along with Phoenix who was playing in the front yard of A-740 Magnus. Steven was entirely cooperative with workers and admitted to drinking. He presented as same, although he was clearly able to hold a discussion with workers and did not present as so intoxicated he would be unable to care for Phoenix. Asked if there was anyone else in the home, (as Steven spoke with workers while sitting on the front step), Steven acknowledged that there was, and stated that he and his buddy Aaron had had "just a couple of beers" this morning. He indicated that his sister Angie was also present in the home. Asked if he was going to be continuing to drink today, he stated that he may or may not. He was warned and cautioned about ensuring that Phoenix had appropriate care should he continue to drink. He indicated clearly that he understood same and identified his sister, Jenny who lives at 756 Magnus as an appropriate careprovider to Phoenix and easily accessible and always willing to provide care. Steven was thanked for his cooperation and was also advised that another team would be out this evening to conduct another sobriety check. He acknowledged same.

For follow-up by p.m. staff;

Bev Hutchison- After Hours Unit

AHU worker Kim Hansen obtained a BSW degree in 1992 and began working in the AHU in 2001. She testified that on June 22, 2003 she started work at 4:00 p.m. and received Hutchison's report from her supervisor, who asked her to deliver food to the Sinclair house. Hansen went there with a co-worker and found that it smelled of marijuana and Sinclair admitted to having smoked. Hansen recorded their interaction as follows:[336]



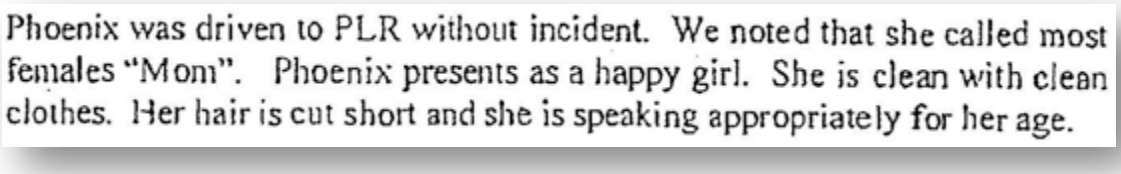
[redacted] The writer tried to engage a dialogue with Steve indicating that he has been drinking to the point of intoxication during the weekend and now his choice of substance has changed and under the influence is under the influence and still inappropriate. Steve reported that Phoenix was "upstairs sleeping" as well as his "sister". The writer advised that when we were standing on the front step as the window was open we heard a number of persons in the home. He insisted that it was just himself, his sister and [redacted], besides the very tall friend that just left.

Steven did not display any insight into the writer's concerns. The further into the conversation we got the more Steven became non co-operative. He stood sideways so the writer had to speak to his profile. His manner became flippant and the writer left advising that she would need to consult with a supervisor regarding his continued use of drugs/alcohol.

Hansen then telephoned to the acting supervisor and together they decided that Phoenix should be apprehended and brought into CFS care. Hansen phoned the Winnipeg Police Service, to help with the apprehension.[337] When the police arrived, Hansen entered the Sinclair home at about 6:30 am. She recorded that a number of young men scattered out the back door.[338] Once inside the home she spoke with Sinclair after several times requesting his attention. He was not cooperative.

Sinclair, in his testimony, recalled this apprehension. He said he had been drinking that night, but his sister was in the house watching Phoenix because he could not get in touch with Edwards.[339]

CFS apprehended Phoenix and drove her to a hotel. Hansen recorded her observations of Phoenix as follows:[340]



Phoenix was driven to PLR without incident. We noted that she called most females "Mom". Phoenix presents as a happy girl. She is clean with clean clothes. Her hair is cut short and she is speaking appropriately for her age.

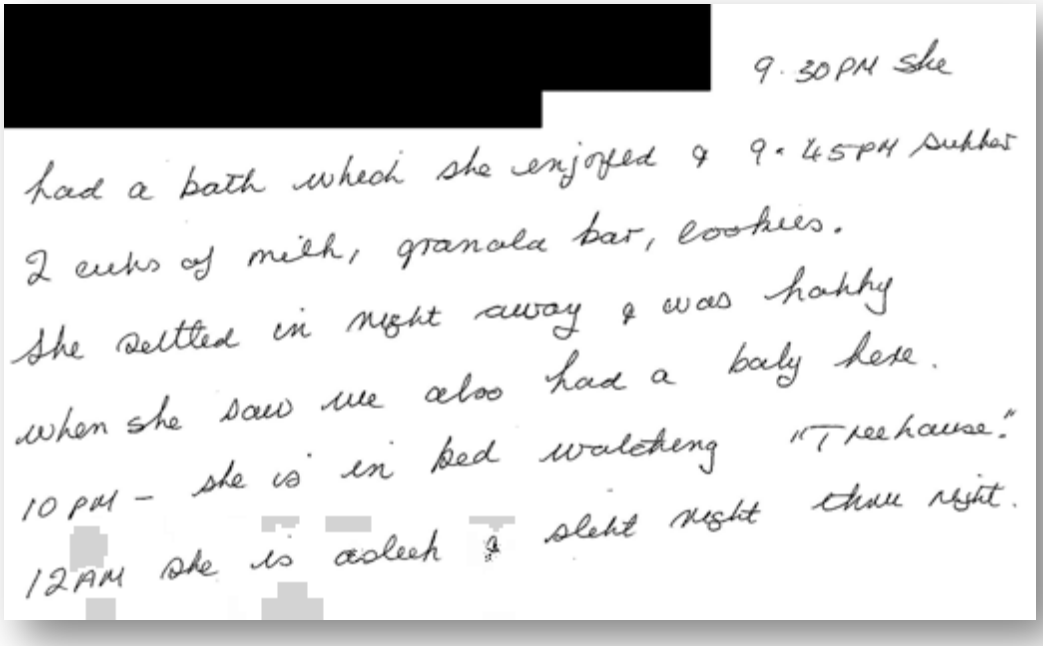
In her testimony, Hansen was asked to comment on the significance of Phoenix calling most females "mom." She said this was telling because it demonstrated Phoenix's lack of attachment to her mother.[341] Edwards and Sinclair, however, testified that in their experience, Phoenix did not call strange women "mom."[342] While this may not have been Edwards' or Sinclair's experience, I accept that this was what Hansen witnessed, and that she found it significant.

I find that Hansen's recording about Phoenix is one of the few times that a worker actually recorded information in the protection file about Phoenix and her developmental status.

At the time of this apprehension, Phoenix was three years old. Sinclair was asked to tell about her at that age:

> *Q: So was she speaking at the time?*
>
> *A: Learning how, yeah, she was – I didn't, I didn't push it on her. I let her do, let her, let her do it on her own, you know, can't force anything on a child.*
>
> *Q: And she was toilet trained?*
>
> *A: Yes.*
>
> *Q: Do you remember what kinds of things she liked to do?*
>
> *A: She loved watching movies, she loved playing outside. She, you know, loved running around the house in her diaper and her little, it was like a little skirt and it looked like rally piper (phonetic) skirt. So she just loved running around in that and just having a good time 'cause she had toys everywhere and she had three floors to play on.*
>
> *Q: Did you spend time playing with her?*
>
> *A: Oh, all the time, you know.*[343]

Notes taken by child care support workers who spent time with Phoenix in the first few days of her apprehension, beginning on the night she was taken into care, shed some light on what Phoenix was like at that time:[344]


[redacted] 9:30 PM She had a bath which she enjoyed & 9:45 PM Subbet 2 cups of milk, granola bar, cookies. She settled in right away & was happy when she saw me also had a baby here. 10 PM – she is in bed watching "Treehouse" 12 AM she is asleep & slept right thru night.

Emergency Assessment Placement Department

3 YR OLD

Children's Logs

Child's Name: Phoenix Sinclair Child Care Support Worker: Rachel [illegible]

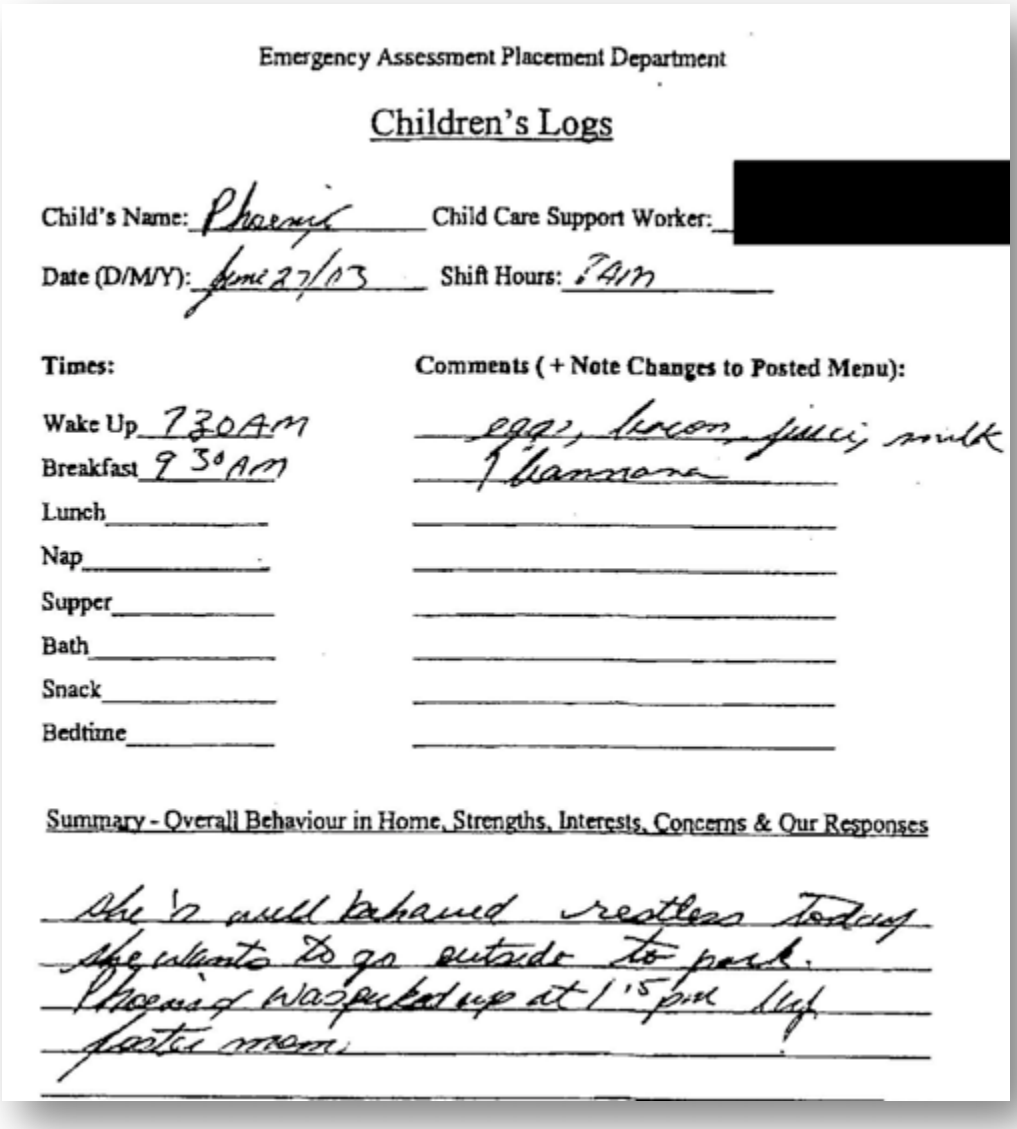
Date (D/M/Y): June 24/03 Shift Hours: 8 AM 8 pm

Times: Comments (+ Note Changes to Posted Menu):

Times	Comments
Wake Up 7	cereal, milk
Breakfast 8 AM	eggs toast hash browns chocolate milk
Lunch 12 05	
Nap 3pm-330pm	ham sandwich alpha getti
Supper	ice cream
Bath	
Snack	chicken nuggets fries juice smarties
Bedtime	3 cookies

Summary - Overall Behaviour in Home, Strengths, Interests, Concerns & Our Responses

no problems. * she is potty trained.
she is well behaved. She [redacted]



Emergency Assessment Placement Department

Children's Logs

Child's Name: Phoenix Child Care Support Worker: [redacted]

Date (D/M/Y): June 27/03 Shift Hours: 7AM

Times:	Comments (+ Note Changes to Posted Menu):
Wake Up 7:30AM	eggs, bacon, juice, milk
Breakfast 9:30AM	1 banana
Lunch	
Nap	
Supper	
Bath	
Snack	
Bedtime	

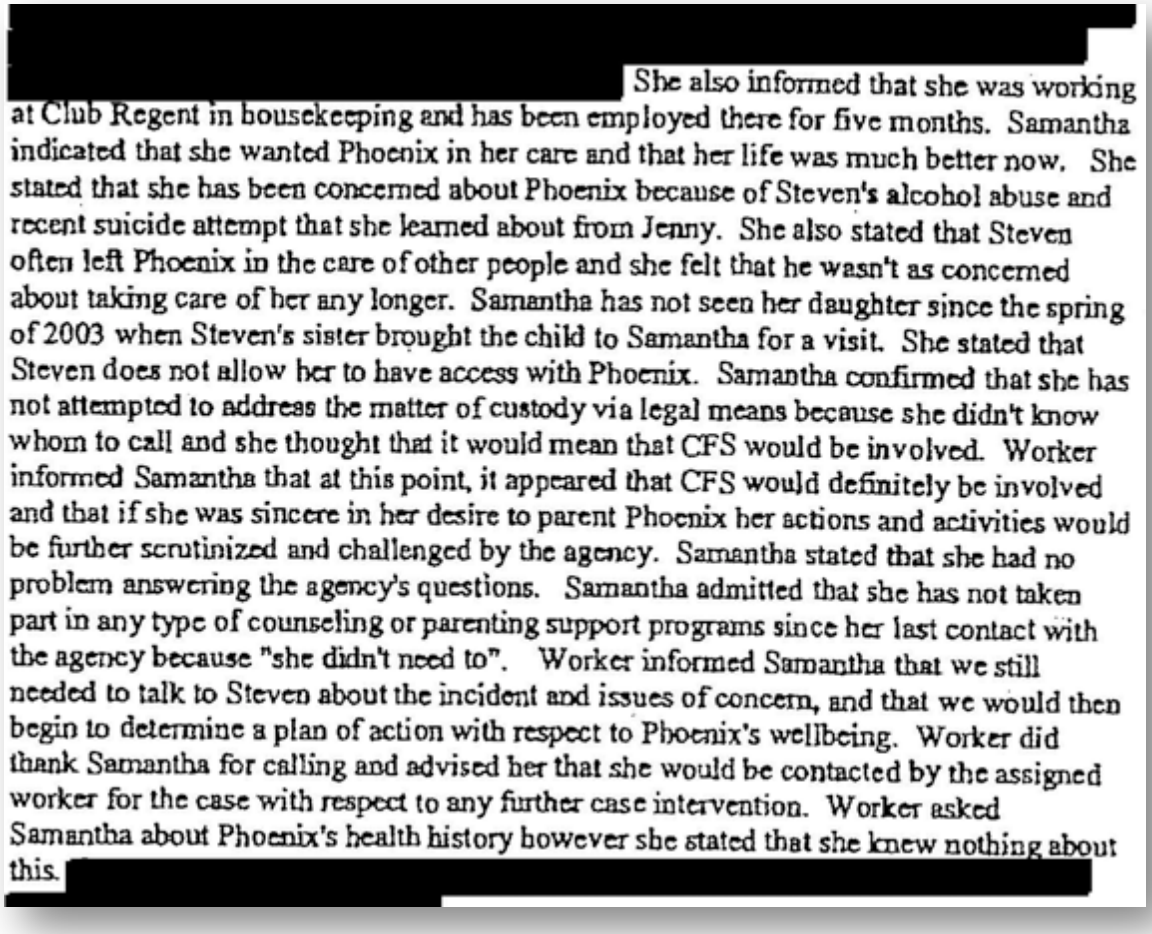
Summary - Overall Behaviour in Home, Strengths, Interests, Concerns & Our Responses

She is well behaved restless today she wants to go outside to park. Phoenix was picked up at 1:15 pm by foster mom.

The evidence showed that it was typical to record information about a child in a child in care file, which is created once a child is apprehended, but such information was not routinely documented in protection files.[345] This presents a problem because often a protection investigation does not result in a child being apprehended, so no child in care file is opened. The agency must ensure that information about the child, including developmental status, is recorded in a protection file for the information of any worker involved in assessing the child's safety and well-being. I find that the agency did not ensure this was done in Phoenix's case.

5.10.2 KEMATCH RE-ENTERS THE PICTURE

Forrest testified that she became aware that Phoenix had been apprehended when Hansen's AHU report was forwarded to her. She received a telephone call that day from Kematch, who had learned of Phoenix's apprehension from Sinclair's sister Genni. Forrest recorded the conversation as follows:[346]



[redacted] She also informed that she was working at Club Regent in housekeeping and has been employed there for five months. Samantha indicated that she wanted Phoenix in her care and that her life was much better now. She stated that she has been concerned about Phoenix because of Steven's alcohol abuse and recent suicide attempt that she learned about from Jenny. She also stated that Steven often left Phoenix in the care of other people and she felt that he wasn't as concerned about taking care of her any longer. Samantha has not seen her daughter since the spring of 2003 when Steven's sister brought the child to Samantha for a visit. She stated that Steven does not allow her to have access with Phoenix. Samantha confirmed that she has not attempted to address the matter of custody via legal means because she didn't know whom to call and she thought that it would mean that CFS would be involved. Worker informed Samantha that at this point, it appeared that CFS would definitely be involved and that if she was sincere in her desire to parent Phoenix her actions and activities would be further scrutinized and challenged by the agency. Samantha stated that she had no problem answering the agency's questions. Samantha admitted that she has not taken part in any type of counseling or parenting support programs since her last contact with the agency because "she didn't need to". Worker informed Samantha that we still needed to talk to Steven about the incident and issues of concern, and that we would then begin to determine a plan of action with respect to Phoenix's wellbeing. Worker did thank Samantha for calling and advised her that she would be contacted by the assigned worker for the case with respect to any further case intervention. Worker asked Samantha about Phoenix's health history however she stated that she knew nothing about this. [redacted]

5.10.3 THE AGENCY PREPARES FOR GUARDIANSHIP ORDER

Forrest prepared the paperwork required for bringing Phoenix into care and forwarded it to the legal department. Since Phoenix was apprehended without a court order, the agency needed an order to keep her in agency care.

Forrest then recorded having spoken the next day, June 24, 2003, with Sinclair's sister Genni, who told her that Sinclair had been caring for Phoenix only three or four times per month; the rest of the time Phoenix had been staying with "friends."[347]

On June 26, 2003, Forrest and a colleague made a field visit to Sinclair's home at 740B Magnus to serve the court papers in connection with Phoenix's apprehension, but they were unsuccessful in connecting with Sinclair. Forrest returned the papers to the legal department for forwarding to a process server.

With Phoenix's apprehension, Sinclair's protection file would be transferred from the agency's intake unit to its family services unit. Forrest prepared a transfer summary, including the following insightful and thorough assessment and statement of risk regarding Phoenix's parents:[348]

Concerns about Steven's care of Phoenix were presented to the agency in February 2003 after the child was brought to the hospital requiring medical assistance because a "foreign body" in her nose. The unidentified "godfather" who brought the child to the hospital had indicated that the child had been suffering in this state for a few months. The child was treated and released to the "godfather" with the subsequent referral to CFS for follow up regarding medical neglect. Attempts to address this issue with Steven netted little success, as the child was not present during the one occasion in which this worker was actually able to make contact with the family. No other issues or concerns were expressed to the agency until June 2003 when Phoenix was apprehended after Steven was found to be under the influence of substance, unable to care for her, and without appropriate caregivers to look after the child. Steven has refused to contact this worker despite requests for him to do so therefore nothing is known about his current state of functioning or intentions with respect to Phoenix. This worker has been able to glean some information from the child's mother, and maternal aunts and this investigation has determined that Steven's capacity to care for Phoenix has deteriorated. He has been leaving Phoenix in the care of others for extended periods of time and has been abusing alcohol and drugs, and associating with a negative peer group (Indian Posse). Concerns regarding medical neglect of the child and an alleged suicide attempt by Steven have also surfaced and while the information suggests that these concerns are not chronic, when one factors in the other issues it would appear that Steven is indeed struggling in his role as parent.

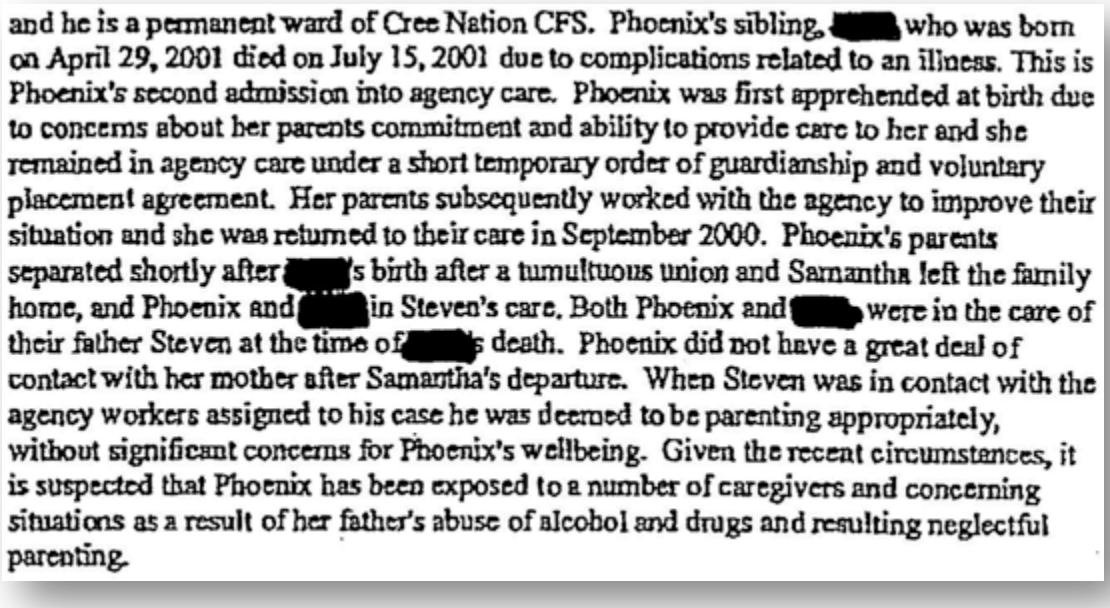
There are a number of issues to consider and to accommodate if this agency is to effectively work with this family. Both Steven and Samantha have had very difficult upbringings as a result of their dysfunctional families of origin and they view the system that was supposed to protect them (CFS) as being responsible for their troubles. Samantha has never demonstrated a true expression of commitment in her role as mother / parent. Of her three children she has really only parented Phoenix for any significant length of time. She has shown a pattern of leaving her children, and will occasionally surface in a time of crisis but does not follow through with her expressed desires at the time to care for her children. Steven, while very resistant and negative about CFS involvement, took on the responsibility of caring for his children without hesitation after his separation from Samantha and it would seem that he was able to adequately provide for and care for his children for a period of time and there were no overt concerns regarding his lifestyle. The family was dealt a somber blow when the child [redacted] passed away in July 2001 and the impact of such is really unknown as the agency's contact with the family was quite minimal at that time. One of Steven's siblings had noted during recent contact with agency AHS staff that Steven has been having a difficult time, with things getting worse since [redacted]'s death. Steven relies on his extended family for support however at this time we are only aware of one of his siblings (Jenny) as being one that is an appropriate or positive support person. Several of Steven's siblings have struggled with various issues and are also involved with CFS and have children in care. One of

Steven's siblings, Norma Jean Sinclair was charged in 1996 and convicted of manslaughter involving a child in her care. Steven's support system also seems to include members of the Indian Posse gang. Steven does not view the agency as being a support or a resource to him and this is unfortunate as the agency will need to be involved with him given the concerns with respect to Phoenix's wellbeing. Steven has refused to contact the agency since Phoenix's apprehension despite our efforts to contact him, and while we can speculate and be respectful of his reasons for such, it does not help in addressing the issues so that Phoenix can return to her parent's care.

Steven and Samantha have clearly indicated their mistrust and unwillingness to be involved with a child welfare agency however they have not demonstrated a capacity and commitment to ensure their child's wellbeing enough for the agency not to be involved. Unfortunately, because of their past involvement as wards of a child welfare agency they are not receptive to services from the agency and they deny or minimize any issues presented in an effort to keep the agency away from them. They would do anything, or nothing, to keep the agency at bay. It is this worker's opinion that it is this attitude and disregard for the agency that has probably resulted in this agency's previous termination of services, and not a lack of child welfare issues. If one looks back in previous recording the identified and unresolved problems are still very much present in the family's current situation. The problems haven't gone away, and now neither can the agency. The obvious struggle in commitment, questionable parenting capacity, along with an unstable home environment and substance abuse issues, and lack of positive support system all lend to a situation that poses a high level of risk to this child, for maltreatment and / or placement in agency care. Phoenix is in agency care now, and it would probably not be in her best interests to be returned to either parent at this time or until they can show something to indicate that they can and will be more responsible and protective of her.

Forrest also provided a profile of Phoenix herself in her summary:[349]

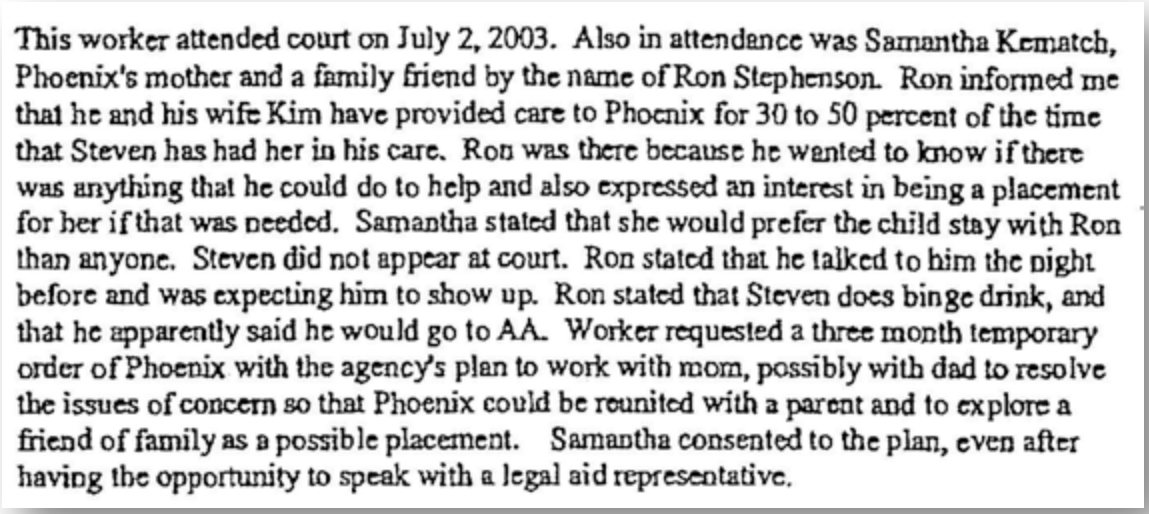
Profile: Phoenix Sinclair is the first of two children born to Samantha and Steven. She has a half sibling, [redacted] born to her mother and a previous partner in July 1998



and he is a permanent ward of Cree Nation CFS. Phoenix's sibling, [redacted] who was born on April 29, 2001 died on July 15, 2001 due to complications related to an illness. This is Phoenix's second admission into agency care. Phoenix was first apprehended at birth due to concerns about her parents commitment and ability to provide care to her and she remained in agency care under a short temporary order of guardianship and voluntary placement agreement. Her parents subsequently worked with the agency to improve their situation and she was returned to their care in September 2000. Phoenix's parents separated shortly after [redacted]'s birth after a tumultuous union and Samantha left the family home, and Phoenix and [redacted] in Steven's care. Both Phoenix and [redacted] were in the care of their father Steven at the time of [redacted]'s death. Phoenix did not have a great deal of contact with her mother after Samantha's departure. When Steven was in contact with the agency workers assigned to his case he was deemed to be parenting appropriately, without significant concerns for Phoenix's wellbeing. Given the recent circumstances, it is suspected that Phoenix has been exposed to a number of caregivers and concerning situations as a result of her father's abuse of alcohol and drugs and resulting neglectful parenting.

Having recommended that the file be transferred to a family services worker, Forrest included a suggested plan in her transfer summary. The plan included having the worker contact both parents to further assess their circumstances and determine what the parents needed to do, to have Phoenix returned to their care. Meanwhile, the agency would proceed in court to obtain a temporary guardianship order of three to six months, to allow for further assessment and implementation of a plan for reunification.[350]

Forrest's addendum to her transfer summary reveals that the agency obtained significant information when she attended Child Protection Court proceedings on July 2, 2003. Kematch was there, accompanied by a man with whom, she told Forrest, she had been in a relationship for two years. Forrest recorded the man's name and date of birth. (This man was not Karl Wesley McKay.) Kematch told her that the man had met Phoenix and had some knowledge of the situation, but she "did not feel comfortable discussing all the issues in front of him." At that same court appearance, Forrest met Stephenson. This is the first time that the agency had made contact with him, despite his having provided care for Phoenix for some time. Forrest recorded her conversation with Stephenson as follows:[351]



This worker attended court on July 2, 2003. Also in attendance was Samantha Kematch, Phoenix's mother and a family friend by the name of Ron Stephenson. Ron informed me that he and his wife Kim have provided care to Phoenix for 30 to 50 percent of the time that Steven has had her in his care. Ron was there because he wanted to know if there was anything that he could do to help and also expressed an interest in being a placement for her if that was needed. Samantha stated that she would prefer the child stay with Ron than anyone. Steven did not appear at court. Ron stated that he talked to him the night before and was expecting him to show up. Ron stated that Steven does binge drink, and that he apparently said he would go to AA. Worker requested a three month temporary order of Phoenix with the agency's plan to work with mom, possibly with dad to resolve the issues of concern so that Phoenix could be reunited with a parent and to explore a friend of family as a possible placement. Samantha consented to the plan, even after having the opportunity to speak with a legal aid representative.

Stephenson vaguely remembered being in court that day; he believed that Kematch had asked him to attend. He said he "probably" told Forrest that Edwards was living with him at the home at 1331 Selkirk Avenue despite the fact that she was not actually living there at the time, because he wanted to increase the chances that Phoenix would be placed with him. Stephenson also testified that he just wanted to keep Phoenix out of the system and that he already felt close to her at that point.[352]

Forrest testified that she obtained information from Stephenson to assess his suitability as a place of safety for Phoenix. She also exchanged emails with the supervisor of the Northwest Winnipeg Family Services Unit, Heather Edinborough. This was the unit that was assuming responsibility for providing service to Phoenix and her family.

> *I agree with Andrew Koster, one of the authors of the Special Case Review in Regard to the Death of Phoenix Sinclair, that this assessment at the point of transfer:*
>
> *. . . demonstrated the necessary conviction that it takes to keep children safe.*

Koster goes on to write:

> *This is the dedication to a child's well being that is required and should be sought and then nurtured by a child welfare organization. I believe that [s]he was trying to convey to the new ongoing worker that the agency needs to make sure that it did what was right for Phoenix. This is a highlight in the management of this case.*[353]

I agree with Koster's comments about this worker's assessment.

I also agree with Rhonda Warren, who prepared the Internal Case Review for the General Authority after the discovery of Phoenix's death, when she said, quoting significant observations made by Forrest:

> *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. An Intake worker clearly articulated this problem in an assessment done in June 2003. She states:*
>
> *"It is this worker's opinion that it is this attitude [resistance] and disregard for the Agency that has probably resulted in this Agency's previous termination of services, and not lack of child welfare issues. If one looks back in previous recording the identified and unresolved problems are still very much present in the family's current situation. The problems haven't gone away, and now neither can the Agency. The obvious struggle in commitment, questionable parenting capacity, along with an unstable home environment and substance abuse issues, and lack of positive support system all lend to a situation that poses a high level of risk to this child, for maltreatment and or placement in Agency care."*
>
> *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.*[354]

Forrest's assessment of what needed to be done by the agency to protect Phoenix and her family echoed Orobko's assessment in May 2000, when Phoenix was first apprehended soon after her birth. This second apprehension should have given the agency the opportunity to address the troubling issues that had been repeatedly identified.

The information that Forrest obtained from meeting with Kematch and Stephenson at the courthouse should have given the agency enough information to prompt a more intensive investigation: in the case of Kematch, to question her parental motivation given that she had not been actively parenting Phoenix since 2001, and doing an assessment of her partner who, according to Kematch, had contact with Phoenix; and in the case of Stephenson and Edwards, to explore the nature of the care they were providing to Phoenix and what, if any, further services the agency should provide to support them in safely caring for her. Stephenson, who attended the child protection court proceedings, was someone in Phoenix's life who clearly cared for her and wished to ensure she was safe and well cared for.

5.10.4 SINCLAIR SAYS HE IS UNREADY TO PARENT PHOENIX

Supervisor Edinborough testified that she received Sinclair's protection file around June 27, 2003 and assigned it to Stan Williams, on July 3. Edinborough obtained a BA degree in 1998 and a BSW in 1990, and began working with Winnipeg CFS the same year. Williams died in 2009 so did not testify at the Inquiry.

Edinborough testified that she chose Williams because he was a male Aboriginal worker who used culturally relevant ways of working with clients. As Sinclair had been resistant to agency services in the past, Edinborough believed that he might better relate to Williams.[355] Sinclair testified that he did develop a good relationship with Williams and that Williams treated him civilly. They had a mutual respect, he said, and Williams was a "good man" who "was trying to see what was best for me and the children."[356]

Edinborough remembered meeting with him about Sinclair's file and was able to offer her recollection of Williams' involvement. She recalled that he advocated strongly for Sinclair's parenting abilities despite his challenges. Edinborough gave the following evidence of Williams' advocacy on Sinclair's behalf:

> *Q: Did you meet with Mr. Williams over the course of the time that your unit had this file?*
>
> *A: I did.*
>
> *Q: Do you recall how often?*
>
> *A: I don't recall how often. I'm going to say biweekly because that's when we made every effort to have supervision. And in spite of the fact that I don't have a whole lot of concrete memories of, I mean absolute minute by minute memories of 2003, I do remember meeting with Stan about this case and one other on lots of occasions and I remember his presentation about it, I remember his demeanour, I remember his, I remember talking to him about this case.*
>
> *Q: Why is it that you have that recollection? Take your time.*
>
> *A: Stan would, would lean forward in his seat and he would, he would lock eyes with me and he would advocate for clients. He would, he would cite their strengths and their, their, what they had overcome in their life while still acknowledging where there were things that needed to occur. Even though I didn't know him very well, it was evident to me that we shared a lot of the same attitudes and beliefs and hope for, for kids and families and for this work. And I remember that Steve was absolutely one of the people that he advocated strongly for.*[357]

Edinborough testified that Williams developed his own case plan and although there was no documented plan on file, he shared it with her orally in their meetings.[358]

Williams' initial plan, which was referred to as "Plan A," according to Edinborough, was to help Sinclair resolve any issues—in particular, substance abuse—that would prevent Phoenix from being returned to his care, with the goal of returning her as soon as possible. Part of Plan A was to return Phoenix to Sinclair under an order of supervision and have a family support worker attend to the home to monitor and provide respite.[359]

Williams made handwritten notes, which were found in Sinclair's protection file. These indicate that he met Sinclair at his home on July 7, 2003 and they discussed ideas about Phoenix's care. On July 10 he noted that he provided Sinclair with the option of Plan A: that Sinclair attend substance abuse treatment at the Native Addictions Council with the intention of Phoenix being returned under an order of supervision. Williams began the paperwork to request a family support worker.[360]

After an unsuccessful attempt on July 21, Williams again met with Sinclair at his home on July 24, 2003. According to Williams' notes, this is when Sinclair told him that he was not ready to parent Phoenix, meaning Plan A was no longer an option. As a result, on July 29, 2003, Williams cancelled the request for a family support worker.[361]

Edinborough testified that "for a parent to say 'I don't want my child back,' should have been a way bigger red flag for us because it speaks to the parent's attachment to that child and that's a really big topic."[362] Edinborough also testified that this would have raised concerns about Sinclair's capacity to parent. She gave the following evidence about how this would have changed her approach to the file:

> *Q: If you had seen it as a flag at the time, what, if anything, would you have done differently?*
>
> *A: At that point nothing different, but come time to close the file, it would have caused me to ask different questions of the worker who wanted to close the file.*
>
> *Q: Such as?*
>
> *A: We have concerns about this attachment to this child. What can we do to assist in improving, increasing, strengthening that attachment? If – I'm not sure what specifically attachment related programs were available in '03, I know there are now, but there are therapists who could have done that work. I would have wanted a further assessment of his attachment to the child.*[363]

After Plan A was abandoned on July 24, 2003, Williams noted that it was time to go to Plan B, which was to request a three-month temporary order of guardianship.

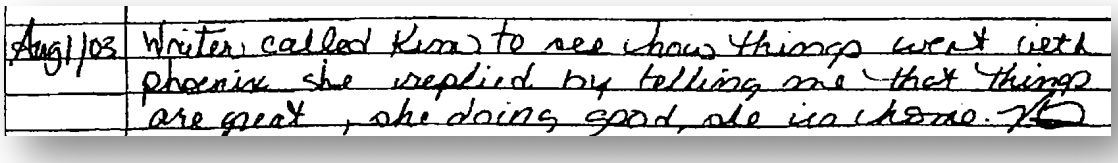
5.11 FRIENDS' HOME IS A "PLACE OF SAFETY"

5.11.1 PARENTS CONSENT TO TEMPORARY GUARDIANSHIP FOR PHOENIX

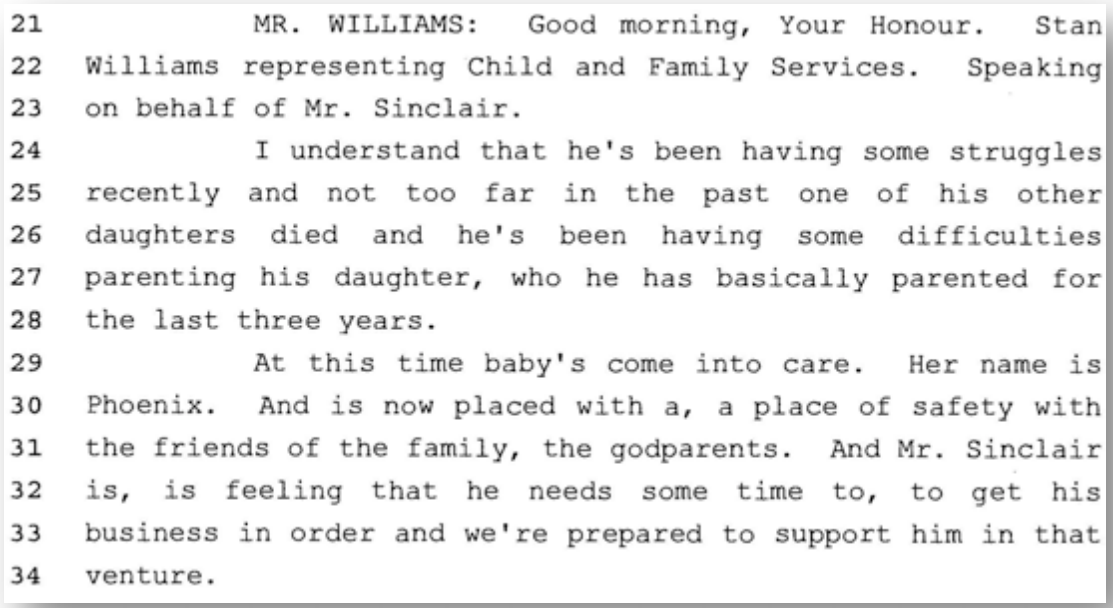
A "place of safety" was used by the agency to provide a specific temporary placement for a child who was in the agency's care. This was an alternative to foster care. According to Williams' notes, on July 29, 2003, he met with Edwards and Stephenson to discuss making their home a place of safety for Phoenix. This would

entail completing an application form, and passing a home inspection and various checks into their suitability as caregivers for Phoenix. Williams returned the next day to have Edwards and Stephenson sign the necessary forms.[364]

Edinborough testified that she and Williams discussed the appropriateness of Edwards and Stephenson's home as a place of safety. It was Williams' opinion that it was a preferable placement for Phoenix because they had previously cared for her and Sinclair was comfortable with them.[365] In terms of contact between the agency and Edwards, the protection file contains this entry dated August 1, 2003, by an unidentified worker:[366]

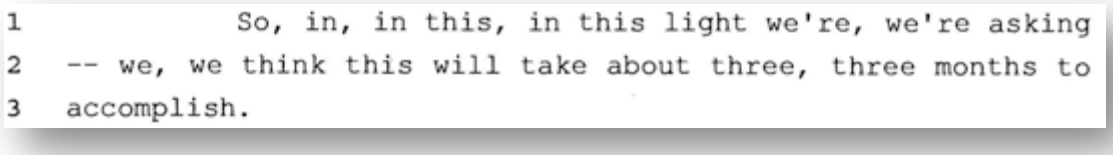

Aug 1/03 Writer called Kim to see how things went with Phoenix she replied by telling me that things are great, she doing good, she in home.

Pursuant to Williams' Plan B, on August 13, 2003, he attended court to apply on the agency's behalf for a three-month temporary guardianship order for Phoenix. The relevant portion of the court transcript from that day reads as follows:[367]


MR. WILLIAMS: Good morning, Your Honour. Stan Williams representing Child and Family Services. Speaking on behalf of Mr. Sinclair.

I understand that he's been having some struggles recently and not too far in the past one of his other daughters died and he's been having some difficulties parenting his daughter, who he has basically parented for the last three years.

At this time baby's come into care. Her name is Phoenix. And is now placed with a, a place of safety with the friends of the family, the godparents. And Mr. Sinclair is, is feeling that he needs some time to, to get his business in order and we're prepared to support him in that venture.


So, in, in this, in this light we're, we're asking -- we, we think this will take about three, three months to accomplish.

Both Sinclair and Kematch consented to this order. Since Kematch had provided her consent on July 2, 2003, the court granted the order to run for three months from that date. This meant the order would expire on October 2, 2003.

In her testimony, Edinborough said that because both parents had consented to the order, they would have had equal legal rights of access to Phoenix when it expired.[368] This was an important fact to recognize. It meant that when the order expired, either Kematch or Sinclair could legally resume parenting Phoenix. Given the unresolved and long-standing concerns about either of them doing so, which had been repeatedly identified by the agency, there ought to have been a plan to keep the file open long enough to work with the parents and monitor Phoenix's safety and well-being.

The place of safety worker who was involved in Phoenix's placement was Mario Rojas. He obtained a BSW degree in 1983 and had been working in child welfare since 1986, first as a frontline child protection worker, then as a place of safety worker from 2003. He described his role as providing direct support to care providers designated as a place of safety by Winnipeg CFS. Rojas was clear in his testimony that it was not within his role to perform child protection services.[369]

The records maintained by the place of safety program indicate that Phoenix was placed with "Kimberly Stephenson" on July 31, 2003, and discharged on October 3, 2003.[370] Rojas testified that he had no independent recollection of working with Williams on the Stephenson/Edwards file. Rojas also testified that he had no notes specific to his work with this family; all his notes were in the form of emails.[371]

Williams wrote on the place of safety form that the reason for Phoenix's placement was: "Parents ie. Dad, require time to 'straighten up' before he can parent."[372] Williams indicated on the form that all of the required checks had been conducted for both Edwards and Stephenson: a criminal records check, an abuse registry check, a CFS records check, and a reference check.

Williams' notes indicate that he visited the Stephenson home on July 29 and July 30, 2003.[373] Edwards recalled Williams' visits and described them in her testimony as follows:

> *Q: Do you remember those visits with Mr. Williams?*
>
> *A: Yes, I do.*
>
> *Q: What did he do when he came -- were these visits at that home on Selkirk Avenue?*
>
> *A: Yes, they were.*
>
> *Q: So what took place during the visits?*
>
> *A: Nothing really. Mr. Williams came and we went in and we sat at my kitchen table and that's where stayed the whole time that we had talked. He asked, he aked about the home.*

Q: What do you mean?

A: How many bedrooms, whether it had a basement, so forth. Told him that I had three bedrooms. He asked me about fire extinguishers. I told him that I had a fire or a smoke detector on the second floor as well as the main floor and we had fire extinguishers again on, one on the second floor and one on the main floor. He asked about whether we had one in the basement and I said that we did not, we didn't have smoke alarm in the basement, nor did we have a fire extinguisher and he informed me that I would have to purchase another fire extinguisher for the basement as well as put the two fire extinguishers that I did have up to date.

Q: Did Mr. Williams walk through the home at all?

A: No.

Q: Do you recall how long the visit with him lasted?

A: Generously speaking I think it last about 45 minutes, an hour.

Q: Do you recall what else he spoke about other than the house?

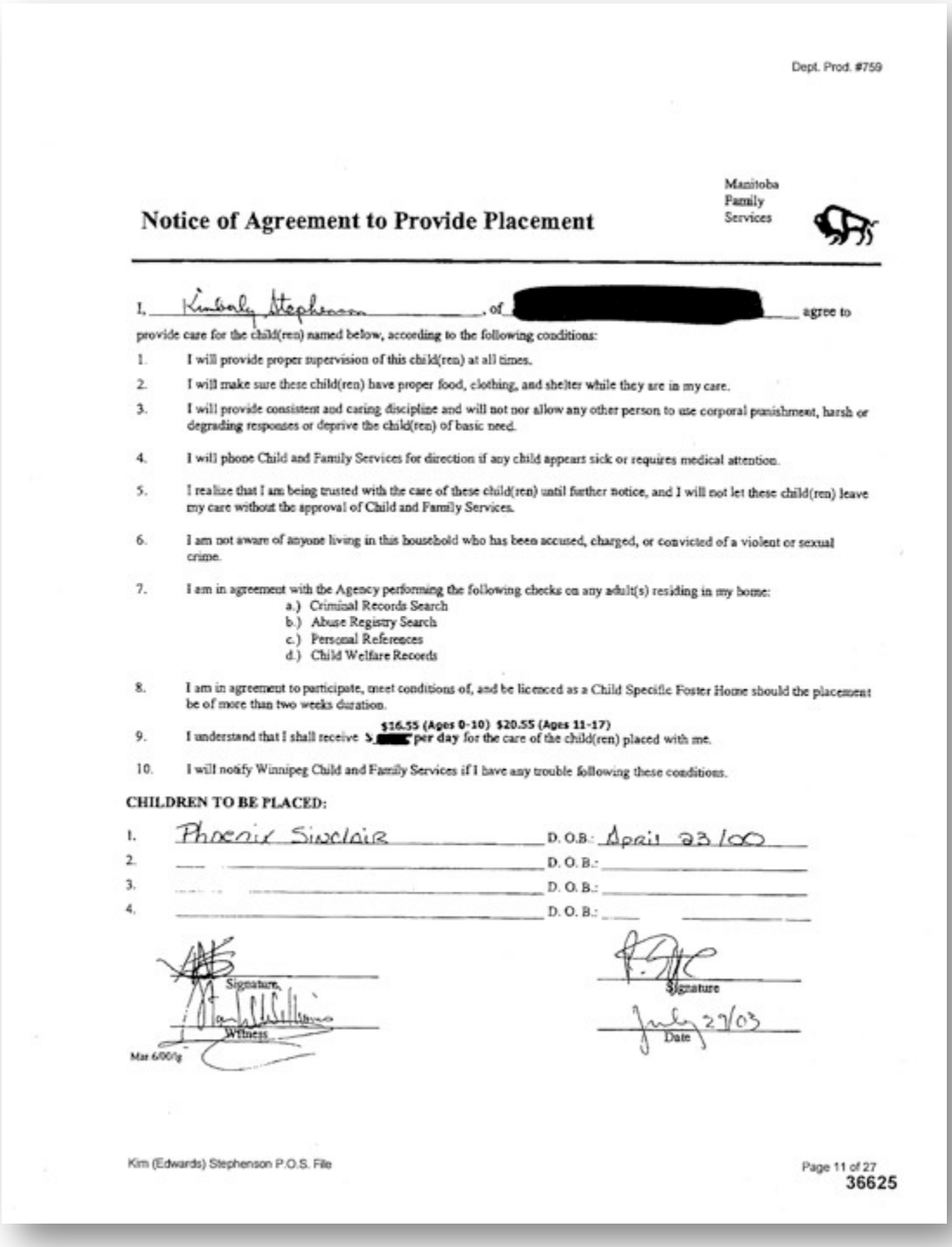
A: Yeah. He asked, because I told him that, you know, I did have friends that came over a lot. He asked who would be attending the house on a regular basis. So I gave him a list of mutual friends that I had spoke earlier about in regards to Steve and myself. Gave him Ron's name on that list and we talked about how he would try and have Phoenix -- because this is, this is – there was no guarantee that this point at the meeting. He told me that he would try very had to, to return Phoenix into my home and at that time, like in the conversation I'm sure I told him how I would look after Phoenix and in the situation that, you know, we were in till she turned of age. And I, and I distinctly recall him saying, and he didn't use words like the devolution or anything like that, but he did make mention that he may have to remove Phoenix from my home because it wasn't culturally appropriate and you know, I'm sure I said my opinion on, on that, but it wasn't like a long conversation or anything. And he said that there shouldn't be a problem putting her with me, it was just keeping her with me.

Q: On the long term?

A: On the long term.[374]

Edwards testified that Stephenson was at home during the meeting with Williams, but was not part of the conversation. She said it was a "very casual encounter" and Williams did not explain the legal significance of being a place of safety in "any great detail," but from her own experience with the system she knew that she could not legally give Phoenix back into the care of either Kematch or Sinclair. She also testified that "she was never at any point told that Steve could not come over and visit" or that he could not come and pick up Phoenix for open visits. Kematch was not discussed in any detail at that time. [375]

Edwards' place of safety file contained a document signed by Kimberly Stephenson (Edwards) and by Williams, dated July 29, 2003, titled "Notice of Agreement to Provide Placement:"[376]



Dept. Prod. #759

Manitoba Family Services

Notice of Agreement to Provide Placement

I, Kimberly Stephenson, of [redacted] agree to provide care for the child(ren) named below, according to the following conditions:

1. I will provide proper supervision of this child(ren) at all times.
2. I will make sure these child(ren) have proper food, clothing, and shelter while they are in my care.
3. I will provide consistent and caring discipline and will not nor allow any other person to use corporal punishment, harsh or degrading responses or deprive the child(ren) of basic need.
4. I will phone Child and Family Services for direction if any child appears sick or requires medical attention.
5. I realize that I am being trusted with the care of these child(ren) until further notice, and I will not let these child(ren) leave my care without the approval of Child and Family Services.
6. I am not aware of anyone living in this household who has been accused, charged, or convicted of a violent or sexual crime.
7. I am in agreement with the Agency performing the following checks on any adult(s) residing in my home:
   a.) Criminal Records Search
   b.) Abuse Registry Search
   c.) Personal References
   d.) Child Welfare Records
8. I am in agreement to participate, meet conditions of, and be licenced as a Child Specific Foster Home should the placement be of more than two weeks duration.
9. I understand that I shall receive $ [redacted] per day ($16.55 (Ages 0-10) $20.55 (Ages 11-17)) for the care of the child(ren) placed with me.
10. I will notify Winnipeg Child and Family Services if I have any trouble following these conditions.

CHILDREN TO BE PLACED:

1. Phoenix Sinclair D. O.B.: April 23 1000
2. _____ D. O. B.: _____
3. _____ D. O. B.: _____
4. _____ D. O. B.: _____

Signature

Witness

Mar 6/00/g

Signature

July 29/03
Date

Kim (Edwards) Stephenson P.O.S. File

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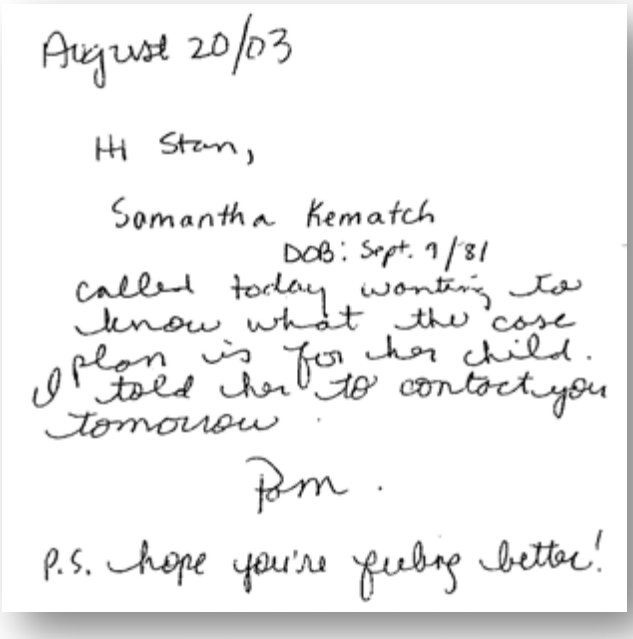
5.11.2 KEMATCH ASKS ABOUT PLAN FOR PHOENIX

While Edwards and Stephenson were caring for Phoenix as a place of safety, the CFS file records indicate that Kematch was making inquiries about her child. A handwritten note on the Sinclair file, dated August 20, 2003 from "Pam" to Williams, mentioned a phone call from Kematch. The note reads as follows:[377]



August 20/03

Hi Stan,

Somantha Kematch
DOB: Sept. 9/81
called today wanting to know what the case plan is for her child. I told her to contact you tomorrow.

Pam.

P.S. hope you're feeling better!

Edinborough testified that "Pam" was Williams' partner. She would have provided coverage for him when he was away on sick leave. Edinborough said that she was not aware that Kematch was involved or that she had called the agency during the time Williams handled the file.[378]

This is unfortunate, as it was a clear sign to the agency that, although its file was opened in Sinclair's name, Kematch, who had the same legal custody rights once the court order expired, was showing an interest in becoming involved. When Phoenix was no longer in Kematch's care, back in 2001, the protection file had been closed in her name and opened in Sinclair's name. The assessment and recommendation that was placed in each of their files on August 16, 2001 is reproduced above at section 5.9 of this chapter.[379]

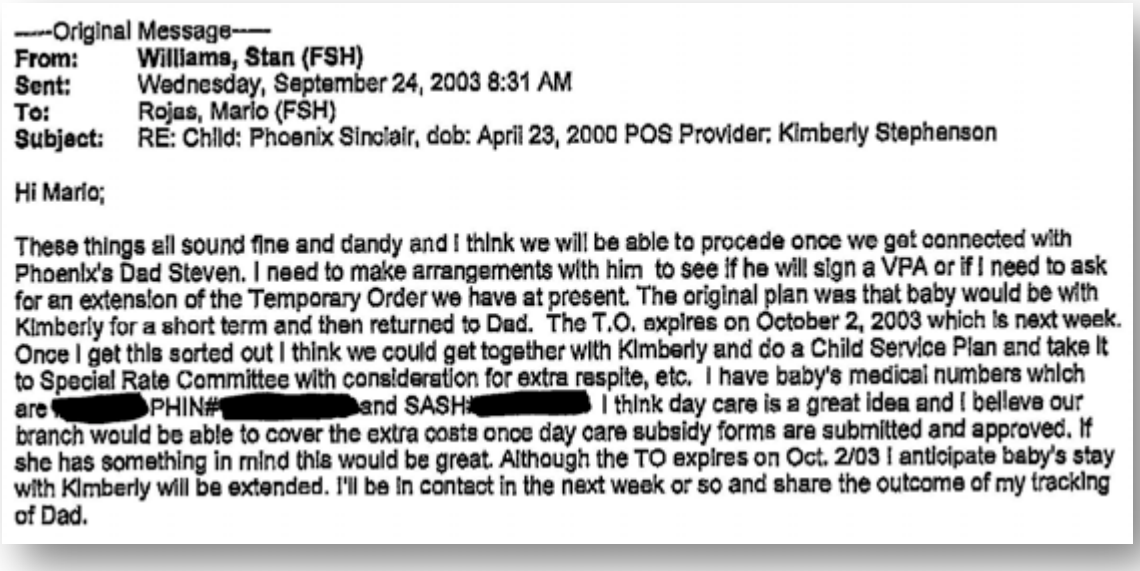
The information in that assessment regarding concerns about Kematch's parenting style signaled the need for follow-up by the agency if Phoenix were to fall into her mother's hands, as she eventually did.

5.11.3 PLAN FOR PHOENIX CHANGES ABRUPTLY

Further handwritten notes by Williams indicate that he called Edwards on September 10, 2003: Phoenix was doing fine but was recovering from the flu, and Sinclair was coming around more often, when he was sober. Also, finances had been flowing from the agency since August, 2003.[380]

Included in the place of safety file was an Application for a License to Operate and Maintain a Children's Foster Home, signed by both Edwards and Stephenson, and dated September 23, 2003. While Rojas had no specific recollection of meeting with the Stephensons, he testified that his practice was to complete the application with the care providers, and have them sign it if a child was going to stay at a place of safety for longer than 30 days.[381] The application included an opportunity for the applicants to explain their principal reasons for wanting to be foster parents. Edwards wrote: "Love (had child on and off since she was 3 mo. old)."[382]

In an email of September 24, 2003 Williams mentioned to Rojas the possibility that Phoenix's stay with the Stephensons would be extended beyond three months:[383]

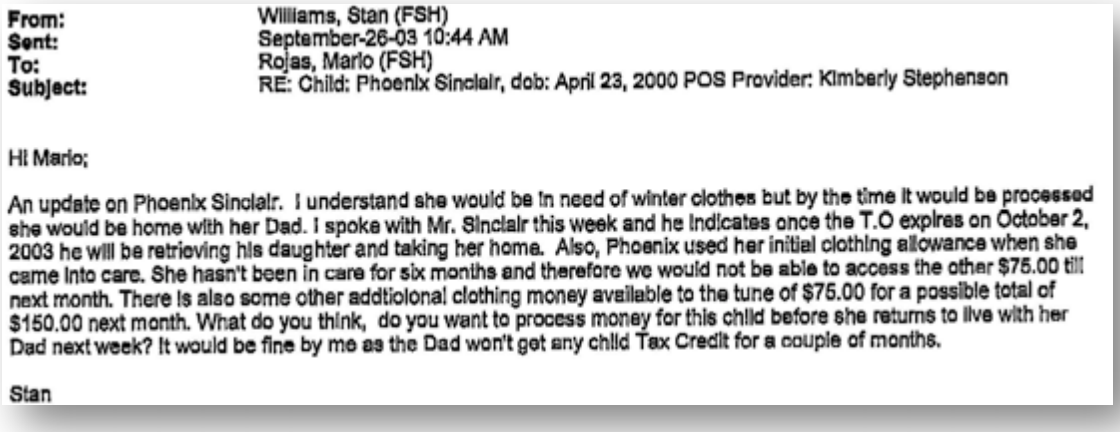


-----Original Message-----
From: Williams, Stan (FSH)
Sent: Wednesday, September 24, 2003 8:31 AM
To: Rojas, Mario (FSH)
Subject: RE: Child: Phoenix Sinclair, dob: April 23, 2000 POS Provider: Kimberly Stephenson

Hi Mario;

These things all sound fine and dandy and I think we will be able to procede once we get connected with Phoenix's Dad Steven. I need to make arrangements with him to see if he will sign a VPA or if I need to ask for an extension of the Temporary Order we have at present. The original plan was that baby would be with Kimberly for a short term and then returned to Dad. The T.O. expires on October 2, 2003 which is next week. Once I get this sorted out I think we could get together with Kimberly and do a Child Service Plan and take it to Special Rate Committee with consideration for extra respite, etc. I have baby's medical numbers which are [redacted] PHIN# [redacted] and SASH# [redacted] I think day care is a great idea and I believe our branch would be able to cover the extra costs once day care subsidy forms are submitted and approved. If she has something in mind this would be great. Although the TO expires on Oct. 2/03 I anticipate baby's stay with Kimberly will be extended. I'll be in contact in the next week or so and share the outcome of my tracking of Dad.

But two days later Williams told Rojas that the plan had changed and Phoenix would be returning to live with Sinclair:[384]



From: Williams, Stan (FSH)
Sent: September-26-03 10:44 AM
To: Rojas, Mario (FSH)
Subject: RE: Child: Phoenix Sinclair, dob: April 23, 2000 POS Provider: Kimberly Stephenson

Hi Mario;

An update on Phoenix Sinclair. I understand she would be in need of winter clothes but by the time it would be processed she would be home with her Dad. I spoke with Mr. Sinclair this week and he indicates once the T.O expires on October 2, 2003 he will be retrieving his daughter and taking her home. Also, Phoenix used her initial clothing allowance when she came into care. She hasn't been in care for six months and therefore we would not be able to access the other $75.00 till next month. There is also some other addtiolonal clothing money available to the tune of $75.00 for a possible total of $150.00 next month. What do you think, do you want to process money for this child before she returns to live with her Dad next week? It would be fine by me as the Dad won't get any child Tax Credit for a couple of months.

Stan

Rojas testified that while Edwards and Stephenson had applied for licensing as a foster home, once Phoenix was discharged from their care the application did not proceed.[385] There is no evidence as to why the agency did not follow up with Edwards and Stephenson about this application.

Edinborough testified that Williams had particular expertise in the area of alcohol addiction. She said he would have discussed with Sinclair the nature and frequency of his substance abuse and would have determined the level of treatment he needed. Williams eventually determined that Sinclair's issues were not so severe that he could not parent Phoenix. He shared with Edinborough his intention to return Phoenix to Sinclair's care, without any treatment. Edinborough testified that she believed Williams at the time, but later realized this was the wrong decision. She gave the following evidence:

> *Q: Okay. And then as we saw from the court proceedings and as we'll see when we look at Mr. Williams' notes, that plan did not get put into place and instead a different plan occurred.*
>
> *A: Right.*
>
> *Q: And how would you describe that plan?*
>
> *A: The next one? Well, it appears or it appeared that that [sic] there was some apparent willingness on Steve's part to attend counseling, however that didn't occur. Again, remembering Stan's support and advocacy for this client and Stan's own knowledge of addictions, his, his conversations, his meetings, his contacts, with Steve appeared to satisfy him that the need for external treatment was not immediate, was not pressing enough for it to be something that precluded Steven, Steve being unable to parent Phoenix. I can – that's, that's really all I can say about that. The plan ultimately became that, that Steve's reliance on alcohol was not so serious as to prevent him parenting his child. I know now that that was wrong. I, I believe now that that was wrong.*

Q: And at the time what did you believe?

A: At the time I believed that Stan knew his client best and believed in what he was telling me.[386]

Williams noted on October 2, 2003 that Sinclair was "ready and willing" to parent Phoenix and that she would be returned that day.[387] Edinborough testified that she recalled meeting with Williams to discuss the next steps on the file, after Phoenix was returned. Williams convinced her that the concerns had been addressed by the actions taken and that Sinclair was ready to parent Phoenix.[388]

Edwards had a different view. She testified that she told Williams that Sinclair was not ready, and that Phoenix would end up back with her. Her evidence is as follows:

Q: So in terms of when Phoenix went back to Steve's care officially, did you think that Steve was ready to parent?

A: No, I, I didn't really. . .

…

A: When he phoned and asked me I, if I believed that Steve was ready to take her back and I, at that time, said no. Not because of drinking, not because of drugs, not because of violence, not because of anything other than the fact that he was still grieving his daughter. He was still drinking but mainly because of the fact that Phoenix wanted to be in my home. She wanted to be – don't get me wrong, she loved being at her dad's but everything about her world was at my house. . .[389]

Edwards testified that she never heard back from Williams or from anyone at the agency about her concerns regarding Sinclair.

Sinclair recalled talking to Williams towards the end of the three-month guardianship order and saying that he was ready to have Phoenix returned to him. He testified that by this time he had had time to get over his emotional issues regarding Echo's death.[390]

5.12 PHOENIX IS RETURNED TO SINCLAIR OCTOBER 3, 2003

5.12.1 PHOENIX MOVES HOME; FILE IS CLOSED

Phoenix was returned to Sinclair's care on October 3, 2003.[391]

Sinclair recalled that Phoenix spent three or four days with him and then went to Edwards' house and to his sister Sheila's home. He said that Phoenix's family missed her and wanted to visit with her. He testified that he would drop her off and pick her up from wherever she was staying, so he always knew her location when she was not with him. He also said he would go and see her whenever she stayed somewhere else.[392]

Stephenson did not specifically remember Phoenix being returned to Sinclair, nor did he know if Sinclair was ready to parent at that time. He testified that as far as

he knew, alcohol had always been a problem with Sinclair and he believed it was still an issue at that time.[393]

Edwards recalled Phoenix being back at her place from time to time between October and December 2003. She remembered taking Phoenix Christmas shopping and decorating the Christmas tree.[394]

Sinclair's Winnipeg CFS protection file remained open until November 13, 2003. Edinborough testified that she understood it was Williams' intention to monitor the file for a month after returning Phoenix to her father. The file, however, contains no record of any home visits by the agency after Phoenix was returned, nor was Edinborough aware of any such visits by Williams. Williams' closing summary, dated November 13, 2003, reads as follows:[395]

Unresolved Problems:

Mr. Sinclair requested his child stay in care until he felt strong enough to care for her once again. He has had his time out and will parent Phoenix starting October 2, 2003. He has done no programming and as such is prone to returning to an unhealthy way of managing stresses in his life. He is aware of the need to arrange for appropriate alternative caregivers when he feels the need for a break or time out for respite.

Recommendations for Future:

In the event Mr. Sinclair returns to unhealthy ways of managing his life and caring for his daughter, it is recommended Phoenix be placed with Place of Safety Foster Parents, Rohan and Kimberly Stephenson. It is also recommended he attend to programming for lifestyle difficulties prior to him considering parenting his daughter Phoenix. It is anticipated a Temporary Order of six months to a year would be required.

Reason for Closing:

The three month Temporary Order Mr. Sinclair and Ms. Kematch consented to expired on October 2, 2003. Phoenix has been returned to live with her Dad and is no longer in care. Mr. Sinclair's file will close today as there are no outstanding child protection issues.

Stan W. Williams
Social Worker
Jarvis Office
944-6778

Heather Edinborough
Unit Supervisor
Jarvis Office
944-4595

Both Williams and Edinborough signed the closing summary. Edinborough testified that she agreed with Williams' assessment that there were no outstanding child protection issues at that time. She believed that Phoenix was not at high risk of maltreatment with Sinclair, despite Forrest's previous assessment that Phoenix would be at high risk with either parent.[396]

I find troubling several aspects of the closing summary prepared by Williams and approved by Edinborough. The determination that there were no outstanding child protection concerns seemed to overlook the fact that Sinclair had not begun to address his substance abuse issues. The substance abuse issues were identified when Phoenix was born and were obviously chronic. The agency knew that Sinclair had done no programming and so was "prone to return to an unhealthy way of managing stresses in his life." It acknowledged that in the event that Sinclair did return to unhealthy ways of caring for his daughter, the agency would need to obtain a temporary order of six months to a year and recommended that Phoenix be placed with Edwards and Stephenson if that were to occur. It is difficult to understand why the agency would adopt this passive approach rather than take the opportunity to protect Phoenix by obtaining the necessary court order to leave her in the care of Edwards and Stephenson at that time. It should have been obvious to the agency that Phoenix would not be safe with Sinclair, despite his best intentions, and that she would come to the agency's attention again.

Allowing Phoenix to leave her place of safety without any further court order also made her vulnerable to coming into Kematch's care. The agency should have considered this possibility and kept the file open. With the file closed, there was no opportunity to work with or monitor the family's progress and Phoenix's safety and well-being. As Edinborough candidly acknowledged this was an unfortunate decision:

> A: *Well, it's, it's contradictory certainly to say that everything's fine here, there's no child protection issues, even though he's done nothing and while Stan doesn't say that he's going to return, it clearly was in Stan's mind as well that Steve may return to unhealthy ways of managing his life. So it's, it's not very good and I don't mean his writing, I mean the work wasn't very good. It wasn't enough.*[397]

As will be seen, within a few months after Phoenix's return to Sinclair, she did come to the agency's attention again, in January 2004. At that point, Edinborough, when consulted by the Intake worker who had conduct of the matter, recommended having the file opened to the Family Services Unit so that ongoing services could be provided. This advice was appropriate and necessary but unfortunately, as will be seen, it was not heeded.

5.13 PHOENIX, KEMATCH, AND MCKAY, EARLY 2004

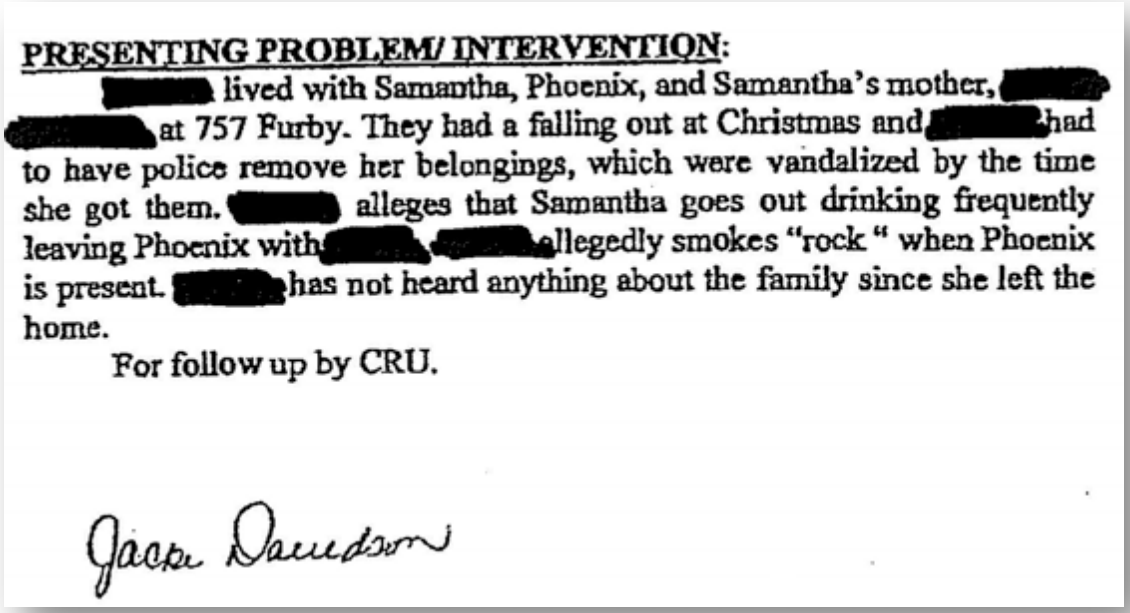
5.13.1 10TH REFERRAL: REPORT OF KEMATCH'S DRINKING AND DRUGS

By early 2004 Kematch had begun a relationship with Karl Wesley McKay. This is the man who eventually was convicted, along with Kematch, of murdering Phoenix some two years later.

McKay had a daughter who is referred to here as "Doe #4" and who came to know Phoenix. Doe #4 testified that in 2003 and early 2004, she lived with her infant son in an apartment on Furby Street and Notre Dame Avenue in Winnipeg. At the time, Kematch was living with her mother and Phoenix in the same apartment complex.[398]

It appears then, that Phoenix was back in Kematch's care within a matter of months of being returned to Sinclair following her second apprehension by the agency. The agency first became aware on January 15, 2004 that Phoenix was again living with her mother.

On that date a former roommate of Kematch's called the AHU with concerns about Phoenix. AHU worker Jacki Davidson recorded the call as follows:[399]



PRESENTING PROBLEM/ INTERVENTION:

[redacted] lived with Samantha, Phoenix, and Samantha's mother, [redacted] at 757 Furby. They had a falling out at Christmas and [redacted] had to have police remove her belongings, which were vandalized by the time she got them. [redacted] alleges that Samantha goes out drinking frequently leaving Phoenix with [redacted] allegedly smokes "rock " when Phoenix is present. [redacted] has not heard anything about the family since she left the home.

For follow up by CRU.

Jacki Davidson

Davidson obtained a B.Comm degree and had begun working in child welfare in the 1980s. She determined that the referral was not an emergency situation, primarily because the caller had not heard anything about the family since Christmas.[400] Davidson said that Phoenix's age was not a factor in her decision not to have the agency attend to the home that night.[401] Davidson transferred the referral to CRU employee Barbara Klos, who in turn referred it to the Intake Unit for investigation. Klos had worked in child welfare since 1981.

5.13.2 FILES ARE OPENED AND CLOSED: WHERE WAS PHOENIX?

Klos testified that the initial referral was opened under Kematch's name, until she determined that it should be opened under Sinclair's name at a different intake unit, because Phoenix had been on her father's budget with Employment and Income Assistance.[402] Klos recorded her activity on the file as follows:[403]

Prior to the case being assigned to a Central Intake worker, a request was made for CRU to check with E & I Assistance to determine where, in fact Phoenix actually resides, because, last November, the child was with her father, Steven Sinclair.

A call to E & I Assistance determined that Samantha Kematchs' file was closed to them in March/03 as she had no children with her. [redacted] Samantha's mother is on assistance on her own budget at 301-757 Furby St.; her birthdate is Sept. 3/56. At this time, Steven Sinclair is on E & I Assistance with Phoenix on his budget and they live at the address shown above.

A call was then made to SOR to obtain further information. From our conversation, it was found that she (SOR), was living with Samantha on Balmoral St. from sometime in Aug/03 until they both moved in with [redacted] at her Furby St. Address at the end of October. At some point in mid November, Samantha got a telephone call from Steven Sinclair's sister, Jen (?), saying that Steven had gone out and left Phoenix alone in the apartment. Samantha then went to Steven's place, picked up Phoenix and kept her with the other adults at the Furby St. address. As we continued to

talk and I asked questions, SOR told me that she discovered that some people came to pick up Phoenix around Jan. 2/04 and took her to their place in Selkirk? SOR further said that there has been much arguing going on among all the adults, but couldn't/wouldn't elaborate on exactly who was doing the arguing and what it was they were actually arguing about. In reading the closing dictation in the Sinclair file which is the most recent, it was found that Phoenix was in a POS with a family named Stephensen who lived on Selkirk Ave. It is believed that this may be the family who picked up Phoenix as in the last file recording closing summary in the Sinclair file it is recommended that Phoenix be placed with the Stephensens' should she return to "care". An attempt to speak with the Stepohensen family was unsuccessful as both the home telephone number along with Mr. Stephensen's work phone number are "out of service" at this time.

Given that the guardianship of Phoenix is with Mr. Sinclair and she is on his budget with E & I Assistance, it is felt that the Kematch file be closed at this time and that the Sinclair file be re-opened.

Calls were made to Stan Williams (Mr. Steven's former FSW worker; 4315), as well as to Mario Rojas (the Stephenson's former POS worker; 4510), in an attempt to find a more current phone number for the Stephenson family in order that they may be contacted. Unfortunately, neither was available and a message was left for both.

Given that there is a possibility of risk to young Phoenix and with the uncertainty of where the child actually is at this time, it is recommended this file be opened to Northwest Intake for investigation and assessment. Because this situation has been an on-going concern as it would appear from discussion with SOR, coupled with the history in both parents' files, a 5 day response time is indicated.

Barbara Klos, social worker
CRU

Diva Fama, supervisor
CRU

In her testimony, Klos said it would have been possible to send a team to investigate where Edwards and Stephenson lived if she thought there was an emergency. She also said she expected that the intake worker would contact the Stephensons.[404]

Klos testified that she gathered from her phone conversation with the source of referral (SOR) that Phoenix might have been living at the Stephensons' but she didn't recall whether she ever contacted Williams or Rojas to determine where Phoenix actually was residing.[405]

Diana Verrier, the supervisor who signed off on Klos' referral, testified that she would not have expected Klos to have made further attempts to find Stephenson's telephone number. Verrier supported Klos' recommended five-day response time. She felt this was reasonable, based on the issues identified and the belief that the Stephenson family had picked up Phoenix and she was in their care.

On Friday, January 16, 2004, Verrier sent the referral to Northeast Intake supervisor Doug Ingram, who assigned it to worker Lisa Conlin (then Mirochnick).[406] Ingram obtained a BSW degree in 1986 and began his career in child welfare that year. Conlin had a BA and obtained a BSW in 1994 and began working in child worker that year.

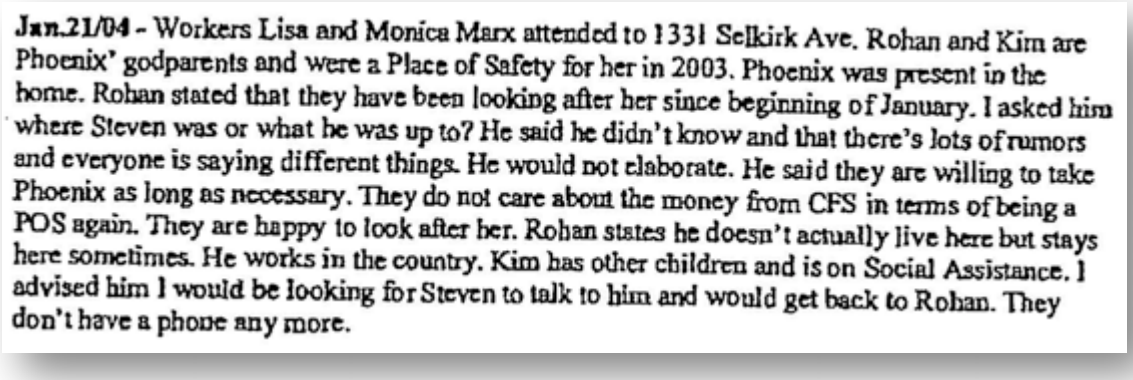
In his testimony, Ingram had no independent recollection of his involvement with this referral. He testified that his usual practice would have been to review it and assign it on a rotation basis.[407] That did not happen until Tuesday, January 20. This gave Conlin only one day if she was to respond within the five days recommended in Klos's CRU report.[408]

Ingram's evidence was that a five-day response time was appropriate, but he also acknowledged that given that Phoenix's whereabouts were unknown, and her young age, he would have wanted to follow up quickly.[409] After Conlin received the file on January 20, 2004 she wasted no time in locating Phoenix the following day.

Conlin testified that it was her practice to look at the client's CFSIS file upon being assigned a referral. In particular, she would look at the last closing summary. She testified that she would not have asked to see Kematch's protection file because the referral was not opened in Kematch's name.

5.13.3 PRIVATE ARRANGEMENT LEAVES PHOENIX VULNERABLE

On January 21, 2004, Conlin and a partner attended at Stephenson's home on Selkirk Avenue in Winnipeg. As recorded in the file, there, they found Phoenix at home with Stephenson:[410]



Jan.21/04 - Workers Lisa and Monica Marx attended to 1331 Selkirk Ave. Rohan and Kim are Phoenix' godparents and were a Place of Safety for her in 2003. Phoenix was present in the home. Rohan stated that they have been looking after her since beginning of January. I asked him where Steven was or what he was up to? He said he didn't know and that there's lots of rumors and everyone is saying different things. He would not elaborate. He said they are willing to take Phoenix as long as necessary. They do not care about the money from CFS in terms of being a POS again. They are happy to look after her. Rohan states he doesn't actually live here but stays here sometimes. He works in the country. Kim has other children and is on Social Assistance. I advised him I would be looking for Steven to talk to him and would get back to Rohan. They don't have a phone any more.

Conlin testified that based on her conversation with Stephenson, she understood that he lived at the home on Selkirk, but because he worked "in the country" he moved back and forth.[411] This information did not concern her. Conlin said she made no notes about Phoenix in the file, because nothing about the child's appearance concerned her. [412] She acknowledged that she did not spend any time talking or playing with Phoenix during that visit, nor did she review Phoenix's child in care file, despite knowing that she had been in care two months earlier.[413]

Conlin testified that she knew she had to assess Phoenix's well-being and that she did so based on Phoenix's appearance and the fact that she was with caregivers about whom there had never been any reported concerns. She said of her discussion with Stephenson about arrangements for Phoenix:

Q: Okay. Now you record that Mr. Stephenson said he and Kim were willing to take care of Phoenix for as long as necessary, and they didn't care about money from CFS in terms of being a place of safety?

A: Correct.

Q: A place of safety is a child specific foster care arrangement?

A: Right.

Q: And it's different from the arrangement under which Phoenix was currently living with Rohan and Kim; right?

A: Right.

Q: A place of safety is established in the context of a child coming into care; is that right?

A: That's right.

Q: And in that case the agency has legal guardianship while the child is in care for the child?

A: That's right.

Q: And under the living arrangement that Phoenix was in when you went to meet with Mr. Stephenson guardianship at that point remained with both of her parents?

A: Correct.

Q: So that meant that at any point when Phoenix was living with the Stephensons either parent could come and pick Phoenix up; right?

A: Well technically –

Q: Legally?

A: Legally right.

Q: And in that case neither Ron or Kim would have any legal authority to prevent them from doing that?

A: No, they wouldn't.

Q: So being a place of safety has more significance than just financial significance?

A: Oh absolutely, yes.

Q: Did you explain that to Mr. Stephenson?

A: At the time?

Q: Yes.

A: No.

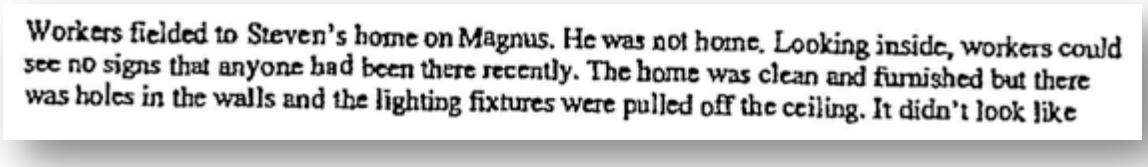
Q: We expect to hear evidence from Mr. Stephenson when he testifies that he has no recollection of you suggesting to him that he formalize the living arrangements that he had regarding Phoenix into a place of safety; is that right?

A: No, I wouldn't have suggested that. I think what I was getting at was that I was asking him whether it's a financial burden to keep her, so I wasn't discussing a formal place of safety with them, or suggesting it. I was just trying to find out whether they could afford to keep her.[414]

Conlin confirmed that she did not talk with Stephenson about putting Phoenix into daycare, or about providing respite for the Stephensons. She said that Stephenson had told her they did not need anything and were happy to keep Phoenix, but she acknowledged that she did not know anything about Stephenson's working hours or about Edwards' working hours or circumstances.[415]

Stephenson testified that no one from the agency ever offered to help support him in caring for Phoenix in terms of providing a clothing allowance, respite, or daycare. He said that if the agency had offered this type of support he may not have accepted it early on, but towards the latter part of 2003 and early 2004, he definitely would have accepted it.[416]

Conlin recorded that on the same day, January 21, 2004, she and a co-worker also went to Sinclair's home, on Magnus Street.[417] She noted her observations of the home as follows:[418]


Workers fielded to Steven's home on Magnus. He was not home. Looking inside, workers could see no signs that anyone had been there recently. The home was clean and furnished but there was holes in the walls and the lighting fixtures were pulled off the ceiling. It didn't look like anyone was staying there recently.

Conlin recorded that the next day she consulted with her supervisor, Ingram, who told her to contact the previous supervisor (whom Conlin indicated was Edinborough).[419] She also wrote: "Get in touch with Steven. Leave child with Rohan for now," which I take to be a record of an instruction by Ingram to contact Sinclair and leave Phoenix with Stephenson "for now."[420]

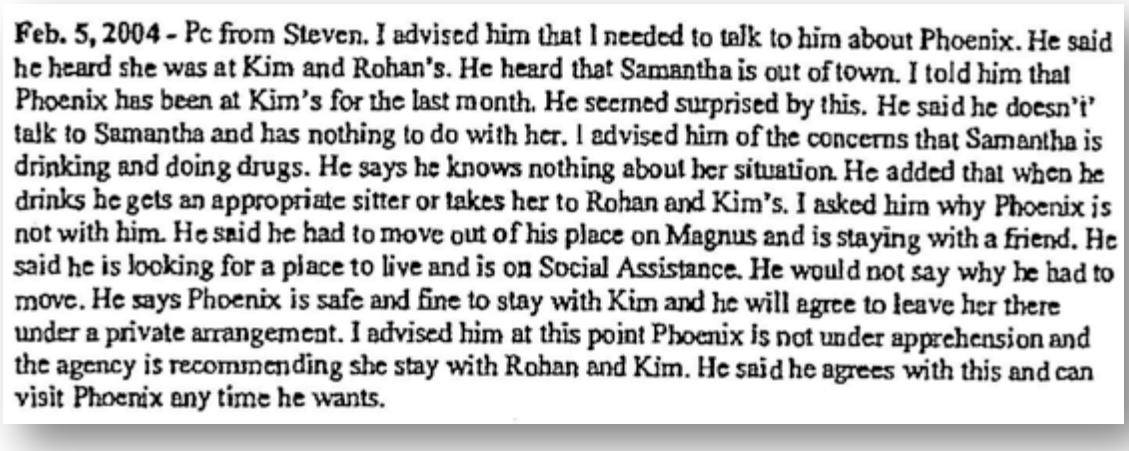
Conlin spoke with Edinborough that same day. According to Conlin's record, Edinborough recommended leaving Phoenix with the Stephensons and suggested transferring the file to Family Services so they could determine whether this ought to be the long-term plan.[421]

Edinborough, in her testimony, recalled Conlin telling her that Phoenix was no longer with Sinclair. She said she was disappointed that the living arrangement had fallen apart so quickly. She confirmed that she suggested transferring the file to Family Services because she felt there was a need for further follow up, but she was unaware of whether that had actually been done. She did not recall ever hearing back from Conlin.[422]

The next day, January 23, 2004, Conlin tried again to visit Sinclair at his home and left her card when she found no one there.[423] Conlin acknowledged that it would have been essential to meet with Sinclair and ascertain his plans for Phoenix, as she was supposed to be in his care.[424]

Days passed before Sinclair phoned Conlin on January 28, 2004, and left a voicemail message. They spoke when he called again a week later, on February 5. According to Conlin's notes, when asked about his intentions for Phoenix, Sinclair said she could stay with the Stephensons. He said, "He would like to get a place, a job and be more stable prior to Phoenix being returned to him."[425]

Conlin recorded their conversation in her closing summary:[426]



Feb. 5, 2004 - Pc from Steven. I advised him that I needed to talk to him about Phoenix. He said he heard she was at Kim and Rohan's. He heard that Samantha is out of town. I told him that Phoenix has been at Kim's for the last month. He seemed surprised by this. He said he doesn't' talk to Samantha and has nothing to do with her. I advised him of the concerns that Samantha is drinking and doing drugs. He says he knows nothing about her situation. He added that when he drinks he gets an appropriate sitter or takes her to Rohan and Kim's. I asked him why Phoenix is not with him. He said he had to move out of his place on Magnus and is staying with a friend. He said he is looking for a place to live and is on Social Assistance. He would not say why he had to move. He says Phoenix is safe and fine to stay with Kim and he will agree to leave her there under a private arrangement. I advised him at this point Phoenix is not under apprehension and the agency is recommending she stay with Rohan and Kim. He said he agrees with this and can visit Phoenix any time he wants.

Sinclair's comments to Conlin echo those he made to Williams the previous summer. That Sinclair did not feel ready to parent his child should have alerted the agency that it needed to provide supports, or monitor Sinclair's parenting more closely. From the time that Phoenix was born, Sinclair had repeatedly identified his need to find employment and childcare. He himself recognized that he would not be ready to parent Phoenix until these needs were met. The agency unfortunately provided no such supports.

This was the only documented contact that Conlin had with Sinclair. During the call she did not discuss with Sinclair the possibility of making a formal place of safety arrangement with the Stephensons instead of leaving Phoenix there in a private arrangement. She did not explain to Sinclair that under this private arrangement Kematch would be entitled to take Phoenix,[427] although she acknowledged in her testimony that she had identified in her own assessment that Phoenix would be at high risk in Kematch's care.[428]

Sinclair agreed that he had made a private arrangement to place Phoenix with the Stephensons but testified that he was unaware that Kematch had an equal legal right to take Phoenix from their home. He said Conlin never told him this and if he had known this, it would have caused him concern. He believed that he had legal guardianship and Kematch did not.[429]

In her closing summary, Conlin summarized her January 21 meeting with Stephenson at his home, and noted that, "They were warned and cautioned" that Phoenix was not to be returned to Sinclair "unless an assessment by this agency was done first."[430] Conlin did not document, nor did she recall, giving the same warning with respect to Kematch. Conlin acknowledged that, had she done so, she likely would have recorded it.[431]

5.13.4 FILE CLOSED AGAIN; PHOENIX IS AT RISK, FEBRUARY 13 2004

Conlin testified that Stephenson did not tell her that he had picked Phoenix up from Kematch in January 2004, but she assumed that he did, based on the timeline of events.[432] She saw the risk to Phoenix as low, as long as she remained in the Stephensons' care.[433]

The file was closed on February 13, 2004, and the closure was signed off by supervisor Ingram.

Conlin acknowledged that she did not follow through on Edinborough's recommendation to transfer the file to Family Services for follow up; rather, she dealt with the referral at the intake level and then closed the file,[434] mainly because she believed the agency had an agreement with the Stephensons and Sinclair that Phoenix would stay with the Stephensons and that she was safe there.[435]

Conlin justified her actions on the file by reference to *The Child and Family Services Act*'s principle of least intrusiveness: that is, that families and children have the right to the least interference with their affairs, to the extent compatible with the children's best interests. She believed that the private arrangement she made with the Stephensons and Sinclair complied with that principle.[436] Later in her testimony she acknowledged that she could have transferred the file to Family Services without apprehending Phoenix, as recommended by Edinborough, and that this option would not have been intrusive.[437]

With respect to Conlin's intake closing summary, Ingram testified that his typical practice was to review the document himself. If he had any issues with closing the file, he would have discussed them with Conlin. When reviewing a closing, he would look for "internal consistency," which meant whether the presenting problems that had been identified were adequately addressed by the time of closing.[438]

Ingram's evidence was that he did not know whether Conlin had spoken to either Stephenson or Edwards, but he believed that it would have been a good idea and he assumed that she did.[439]

Ingram testified that he did not believe that there was a need to transfer the Sinclair file to Family Services at the time, but he had no recollection of why that was the case.[440] He agreed that neither Kematch nor Sinclair was in a position to look after Phoenix. His explanation for closing the file was that Phoenix was safe with the Stephensons, who were willing to care for her on a long-term basis.[441] Ingram acknowledged that neither he nor Conlin did a formal risk assessment for Phoenix before closing the file.[442]

In her closing summary Conlin identified that:

> *Risk would be high if she was with either Steven or Samantha, low if she was in fact with the Stephensons.*[443]

I find that Conlin's assessment was appropriate, but in the circumstances should have led the agency to keep the file open.

Despite the various statements of risk contained in the file regarding both parents, and Edinborough's recommendation that the file be transferred to Family Services for ongoing monitoring and support, on February 13, 2004 the file was closed. This inappropriate decision by worker and supervisor had serious consequences for Phoenix. Closing the file meant that her safety and well-being would no longer be monitored. This was a lost opportunity to address the issues that had been left unresolved at the time that Phoenix was returned to Sinclair in October 2003.

The agency's services during this period failed to adequately protect Phoenix's safety and well-being. While it was true that Phoenix was safe so long as she was in Stephenson and Edwards' care, the informal arrangement with them could not keep her safe. The earlier place of safety arrangement carried with it a signed agreement confirming that Phoenix would not be given into anyone else's care, and legal guardianship of Phoenix remained with the agency. But this time, legal guardianship remained with either or both of the parents, each of whom the agency had identified as posing a high risk to Phoenix. This informal arrangement left Phoenix, already vulnerable, in an even more defenseless position.

Conlin did record in her closing summary that she sent the following letter to the Stephensons, outlining the agency's expectations and concerns:[444]

February 13, 2004

Rohan & Kim Stephenson
1331 Selkirk Ave.
Wpg MB
R2X0C9

Re: Phoenix Sinclair dob:April 23, 2000
Father: Steven Sinclair

I am writing to follow up with our conversation on January 21, 2004. At that time you indicated that you would be willing to care for Phoenix under a private arrangement for as long as is necessary. I have now spoken with Steven who has agreed that you can care for Phoenix. I have told Steven that the agency has serious concerns about his current lifestyle, as well as Samantha's. He has been advised that he is not to take Phoenix back into his care without contacting this agency and having a risk assessment done. So please be advised that the agency hopes you will continue to care for Phoenix and will contact us should this situation change.

Should you have any further questions please call this writer at 944-4679 or after hours at 944-4050.

Thank you,

Sincerely,

L Mirochnick

Lisa Mirochnick, B.A., B.S.W.
Social Worker

Conlin testified that she sent the letter via regular mail; she did not typically use registered mail or hand delivery. Conlin acknowledged that she did not follow up with the Stephensons after sending the letter, nor did she send a copy to Sinclair or Kematch.[445]

Conlin testified that she did not mention in the letter the possibility of Kematch taking Phoenix into her care because she was not focusing on Kematch, given that the file was Sinclair's, although she admitted this was an oversight on her part.[446] She was questioned about this omission:

> *Q: Is there any reason you made particular reference to Mr. Sinclair but not Ms. Kematch?*
>
> *A: Well, I, I did say that we had concerns about her lifestyle as well. Like, I do name her in this letter. I think probably the, the problem comes in that when a file is opened under the father's name, then my focus, or my focus as a worker just becomes that person. So I mean, looking back on it now I can see that because her file wasn't opened, I didn't do follow up with her specifically so my focus was on Steve and Phoenix and his file. So I mean, I did mention her, that we had concerns about her, but this situation more focused on Steve because that's who was supposed to be caring for her at the time.[447]. . .*
>
> *Q: So there's certainly nothing in your file recording, from your closing summary from February of '04 that talks about any investigations you did regarding Ms. Kematch's living status?*
>
> *A: No, because, like I said, this was Steve's file so I was focused on him.*
>
> *Q: So you weren't focusing on Ms. Kematch when you had this file?*
>
> *A: No.*
>
> *Q: And you think that's --*
>
> *A: Because her file hadn't been opened.*
>
> *Q: When you got it?*
>
> *A: Right. So, like, I didn't have the expectation to follow up with her.[448]*

Edwards testified that she did not have any conversation with Conlin, nor did she ever receive the letter.[449] Stephenson testified that he might have received it; it seemed familiar. He understood it to mean that Sinclair had agreed to leave Phoenix in their care and that they were not to return her to him without contacting the agency. He did not understand it to mean that Phoenix could not be returned to Kematch's care, as this was not stated in the letter. However, he said this would not have mattered and he would not have contacted CFS in any event, due to his distrust and what he saw as his marginalization. Stephenson did say that he would not have let Phoenix go back with Kematch if he thought that she posed a serious risk to Phoenix, but at the time, he didn't have any reason to think that.[450]

Conlin's letter did not convey a sense of urgency and did not impose an obligation to alert the agency should either Sinclair or Kematch take Phoenix. After sending the letter, the agency closed its file. There was no follow up to see whether Stephenson and Edwards understood the significance of the letter, or whether they had even received it. There was no further contact with them.

During her involvement with the Sinclair file, Conlin did not attempt any contact with Kematch because, as she explained in her testimony and her closing summary, Kematch was not the custodial parent. The summary recorded Sinclair's statement that he wanted to become more stable and find a home and job before parenting Phoenix again, and concluded with an account of Sinclair's known circumstances at the time:[451]

File information shows that Phoenix was apprehended at birth and then returned to parents 5 months later. Phoenix was again apprehended in June 2003 and remained in care under a three month temporary order. She was then returned to Steven in October/03. It appears from current information that he only parented for one month, until mid November and then Phoenix somehow ended up at Samantha's. It appears from Steven's actions and lack of ability to clarify his situation, that he either cannot or is choosing not to parent Phoenix. There have been previous concerns about Steven abusing substances and the previous file closing states he did not obtain any type of programming to address his issues. There is currently no direct evidence or reports regarding what Steven is doing currently. Worker spoke with his E&IA worker who also did not know that Phoenix wasn't with him, or that he was moving. She spoke with him today and found all this out. She has no new information to add about his situation. She is taking Phoenix off his budget and he will be required to look for work. She suspects he must have some type of illegitimate income as he is not concerned about losing the funds, and has not been given any money for February.

This worker cannot make an accurate assessment of Steven's current lifestyle due to lack of information provided. This worker would therefore determine that Phoenix would be at high risk of coming into care should she return to Steven's care. She would also be at high risk of coming into care should she be found in Samantha's care. Worker has therefore safety planned with the current caregivers to Phoenix, the Stephensons. They have agreed with this worker's assessment and have agreed to keep Phoenix in their care under a private arrangement. They will allow Steven to visit Phoenix in their home whenever he wants, though he has not come to date (Jan. 21). Due to the fact that a private arrangement has been agreed to between Steven and the Stephensons, worker is recommending this file be closed at this time.

Statement of Risk:
Risk is low as long as Phoenix remains with the Stephensons. Should she be found in the care of Steven or Samantha, risk would change to high.

Recommendations:
Worker is recommending this file be closed to Northeast Intake.

Closed on Intake: February 13, 2004

Intake Worker: Lisa Mirochnick

Intake Supervisor: Doug Ingram

5.14 KEMATCH TAKES PHOENIX TO LIVE WITH HER, EARLY 2004

5.14.1 PHOENIX IS CARED FOR BY FRIENDS

By early 2004, Edwards and Stephenson had separated. Stephenson continued to reside at 1331 Selkirk Avenue. He testified that he and his sons were Phoenix's primary caregivers towards the latter part of 2003 and early 2004. He was working the night shift and his children would take turns leaving late for school in the mornings, until he arrived home from work to look after Phoenix. He would work at night and stay up during the day watching her.[452]

The evidence from Sinclair, Edwards, and Stephenson demonstrated that Phoenix was well loved by all of them. This is an excerpt from Stephenson's testimony about Phoenix at the time:

> *Q: Yeah. Did you – was Phoenix – do you remember if she was potty training?*
>
> *A: Yes, she was.*
>
> *Q: And did you have anything to do with that?*
>
> *A: Yes, I did.*
>
> *Q: Can you just give a bit of a description what Phoenix was like?*
>
> *A: About yay high, dark hair, yeah no she was great.*
>
> *Q: She was a good kid?*
>
> *A: Yeah, she was wonderful. She was fun.*
>
> *THE COMMISSIONER: You loved her?*
>
> *THE WITNESS: And beautiful. She was incredible.*[453]

In the spring of 2004 Kematch was pregnant again, according to a friend of hers who testified as SOR #5. She had known Kematch when they were younger, but reconnected with her at the Healthy Baby Program in March 2004. This bi-weekly program provided information about prenatal and postnatal care, as well as resources, food, and coupons.[454]

SOR #5 testified that she never saw Phoenix at the Healthy Baby program with Kematch. When she would ask about Phoenix, Kematch would say that she was with family, or she was "on the road" with Kematch's boyfriend. The witness testified that she knew that Kematch's boyfriend's name was "Wes," and that he was the father of the baby that Kematch was expecting.[455]

5.14.2 KEMATCH PICKS UP PHOENIX

In the spring of 2004 Kematch went to the Stephensons' house to pick up Phoenix. Edwards did not recall the specific date but believed it was before Phoenix's 4th birthday at the end of April 2004. She recalled that she wasn't at home at the time but found out later from Stephenson what had happened.[456]

Stephenson testified about the day that Kematch came to his house to get Phoenix. This turned out to be the last time he saw Phoenix:

Q: Okay. Do you remember the last time you saw Phoenix?

A: Yes, I do.

Q: Can you – are you able to tell us what happened that day?

A: Yeah. Sam showed up with Bertha –

Q: Bertha being her mother?

A: Bertha being her mother, and wanted to take Phoenix. Sam actually didn't seem that enthusiastic about the whole thing, but it was Bertha that was saying, you know, we'd like to – want to raise our own kids, and you know, all this, this stuff. I assumed that they would take her and then Sam would get sick of her in two days, and bring her back. I was reluctant to let her go. Had I known Bertha was a crack head, and I certainly wouldn't have.

Q: You didn't know that at the time; did you?

A: No, I didn't know that at the time. Yeah, I – like I said I was reluctant, but I was also exhausted, and Phoenix wanted to go, and yeah, so, so I let her go.

Q: So Phoenix was excited that mom and grandma were picking her up?

A: Yeah, she was, and like I said I thought it would be a short-lived thing because Sam didn't really seem enthusiastic about it at all.

Q: Did you, did you have any knowledge of what was going on with Sam at that time in her life?

A: No.

Q: Nothing.

A: None whatsoever.

Q: We heard from Steve yesterday that he recalls you phoning him to ask if it was okay if Sam took Phoenix.

A: Right.

Q: Is that accurate?

A: No, that is not accurate?

Q: And you sound fairly certain of that. How, how is it you can say that?

A: Because I had no idea where Steve was at that time, and I'm pretty sure he didn't have a phone number.

Q: What about Kim, did, did she call you and, and ask about Phoenix after that?

A: Probably.

Q: And I take it you didn't call Child and Family Services when this happened?

A: No. Like I said I, I thought she'd be back the next day.

Q: And you aren't – I mean at that time you didn't have a concern that she was in any danger?

A: No.

Q: Did CFS ever get in touch with you to talk to you about where Phoenix might be or, or anything like that?

A: I don't think so, no. Like I said I don't think I had any further contact with them at all.[457]

Edwards testified that when Kematch had not returned Phoenix after a few days, she asked Sinclair if he knew when Phoenix was coming back. She said it was at that point that she suggested phoning CFS. She said she did make a call that day, but Sinclair wasn't with her at the time. She could not recall whether she used her cell phone, or a neighbour's phone.[458] She described her call to Northwest CFS:

Q: Why were you calling CFS?

A: I was calling CFS to speak with Stan Williams, just because Phoenix was in my home, she's been raised in my home for all this time and her mom had her. So I was phoning to, for to get Stan involved, hopefully to bring Phoenix back to me or Ron or Steve, someone that she had been raised with and not the stranger she was with and I understand that she was with her mother, but …

Q: How did you know what number to contact Mr. Williams at?

A: I didn't. I think I just phoned Northwest Child and Family Services number. Like I didn't have a piece of paper I referred to. I'm the type of person who utilizes 411 all the time.

Q: What happened when you phoned CFS?

A: Not a lot. I phoned and I got, I'm assuming, an intake worker and I asked for Stan Williams. I was put on hold for, it wasn't a long time, and the same person that answered the phone came back and said that Mr. Williams wasn't available and she took a message for him to return my call. That call was never, wasn't returned by Stan and I believe it was the next day I called back to the office and just spoke with the intake and unfortunately I didn't get that person's name. I wouldn't think of doing something like that at the time. I do now, but not then. And I was given the information that Phoenix was with her mother and that I was no longer her foster mother and that Phoenix was no longer my concern.[459]

Edwards also testified that she tried to contact the Winnipeg Police, but was told that she had no authority and if Sinclair had a concern he would have to make the call himself. Edwards was unsure whether Sinclair called either CFS or the police.[460] She said she did not have much contact with him after this, until after Phoenix's death was discovered in 2006.[461]

Stephenson testified that he didn't search for Phoenix, other than to ask people if they had seen her.

Sinclair testified that he later moved to a reserve in Ontario. He said he didn't try to contact Kematch or her family because he didn't know where they were. He testified that his sister was still in touch with her and told him that Kematch had said that Phoenix "was okay and she was fine." He testified that he would call and

check in with his sister every couple of days. He did not know that Kematch had a new partner, or that eventually, she would move to Fisher River.[462]

Sinclair, Edwards, and Stephenson said they made some efforts to inquire about Phoenix, including calls to CFS, the police, and friends. But Kematch had legal entitlement to have Phoenix in her care, something Edwards and Stephenson did not. Sinclair had raised issues on occasion, but according to his evidence, he was receiving reports from his sister that Kematch and Phoenix were doing fine.

5.15 EIA ASKS: WHERE IS PHOENIX LIVING?

5.15.1 11TH REFERRAL: EIA HAS CONFLICTING INFORMATION

On May 11, 2004, shortly after Kematch picked up Phoenix from the Stephensons, the agency received a call. An employee of the Employment and Income Assistance (EIA) program, who testified as SOR #3, had a concern about Phoenix's whereabouts.

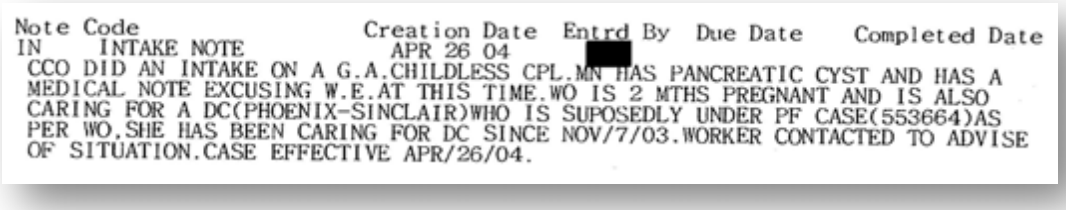
SOR#3 was Sinclair's EIA caseworker at the time.[463] Her role was to administer funds for basic needs including rent; help him find employment; and manage the case. She testified that as an EIA worker she also had an obligation to look out for a child's safety and well-being.[464] If she received information from a child welfare worker, she could add a case alert to SAMIN, EIA's electronic database.[465]

She explained that SAMIN contained demographic information about clients, including name, social insurance number, health number, residence, medical needs, previous employment information, basic financial needs, date of birth, and others in the household collecting EIA benefits. This could include spouses or partners and dependent children. Paper files included application forms, photo identification, rental information, and any forms that could not be entered into SAMIN. All EIA caseworkers had access to the files of everyone in the system, including Sinclair's entire EIA file.[466]

The SAMIN system contained brief reports of client contacts with EIA, which yielded the following information about Sinclair:

- He told his previous EIA worker[467] on February 5, 2004 that his child was living with her godfather, because Sinclair did not have a place of his own.[468]
- On February 9, 2004 he told the same worker that his child was temporarily with godparents, and he was giving them money for food.[469]
- On March 11, 2004 he said he was still looking for place to live with his child; she had returned to the godfather's home the week before.[470]
- Sinclair called on April 13, 2004 to say that he was rent-sharing with a cousin for May and his daughter was still living with him.[471]

EIA records also showed that on April 26, 2004, a different EIA worker, Christian Okotcha,[472] placed a note in Sinclair's file about EIA client, Karl Wesley McKay. The note said that a "childless couple" had applied for EIA benefits and that the female member of the couple was two months pregnant and caring for a dependent child – Phoenix Sinclair. The note reads as follows:[473]



Note Code		Creation Date	Entrd By	Due Date	Completed Date
IN	INTAKE NOTE	APR 26 04	[redacted]		

CCO DID AN INTAKE ON A G.A.CHILDLESS CPL.MN HAS PANCREATIC CYST AND HAS A MEDICAL NOTE EXCUSING W.E.AT THIS TIME.WO IS 2 MTHS PREGNANT AND IS ALSO CARING FOR A DC(PHOENIX-SINCLAIR)WHO IS SUPOSEDLY UNDER PF CASE(553664)AS PER WO,SHE HAS BEEN CARING FOR DC SINCE NOV/7/03.WORKER CONTACTED TO ADVISE OF SITUATION.CASE EFFECTIVE APR/26/04.

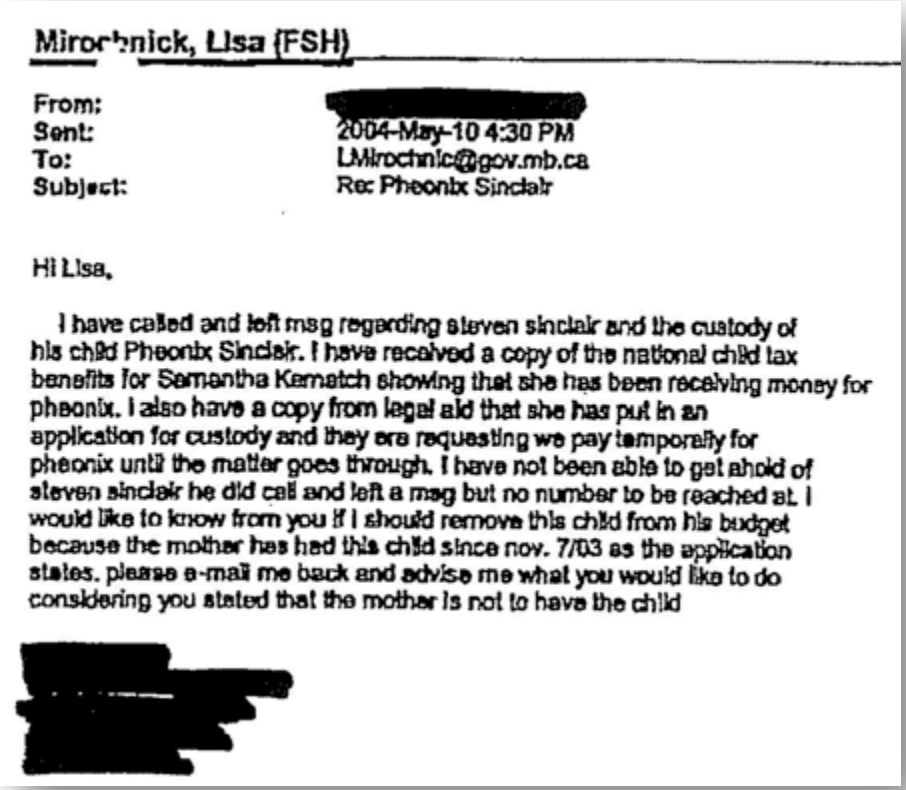
SOR#3 explained that this information had been added to Sinclair's file because it conflicted with other information EIA had been given, that Phoenix was in Sinclair's care.[474]

Further, EIA records contain an EIA application by McKay, signed by both McKay and Kematch on April 26, 2004,[475] listing Kematch as McKay's common-law spouse as of January 1, 2004 but making no mention of Phoenix.

Having spoken to Sinclair on April 13, 2004 and then receiving this information from McKay's EIA worker on April 26, SOR#3 made a further entry on May 5, 2004: she noted that Sinclair's rent form stated that there were two adults and one child residing in the home. She noted that she had been unable to contact Sinclair to find out where Phoenix was, and on whose budget Phoenix should be placed.[476]

EIA records also contain a fax, dated May 10, 2004, from Okotcha to SOR#3.[477] It attaches a copy of a Canada Child Tax Benefit Notice dated January 20, 2004, showing that Kematch had been receiving benefits for Phoenix. It also attached a memo from Legal Aid Manitoba, dated May 6, 2004, addressed to Okotcha, saying that an application for legal aid had been made with respect to custody of Phoenix Sinclair. A handwritten note on the memo said: "Phoenix has been in Ms. Kematch's care & control since Nov 7/03, however, the child continues to be on Nelson Sinclair's budget. Please amend your records to provide benefits to Ms. Kematch for Phoenix, temporarily, until the matter is confirmed in court."[478]

In her efforts to determine where Phoenix was living, SOR#3 sent this email to Conlin on May 10, 2004:[479]



Mirochnick, Lisa (FSH)

From: [redacted]
Sent: 2004-May-10 4:30 PM
To: LMirochnic@gov.mb.ca
Subject: Re: Pheonix Sinclair

Hi Lisa,

I have called and left msg regarding steven sinclair and the custody of his child Pheonix Sinclair. I have received a copy of the national child tax benefits for Samantha Kematch showing that she has been receiving money for pheonix. I also have a copy from legal aid that she has put in an application for custody and they are requesting we pay temporarily for pheonix until the matter goes through. I have not been able to get ahold of steven sinclair he did call and left a msg but no number to be reached at. I would like to know from you if I should remove this child from his budget because the mother has had this child since nov. 7/03 as the application states. please e-mail me back and advise me what you would like to do considering you stated that the mother is not to have the child

[redacted]

SOR#3 could not recall how she obtained the information that Kematch should not have had Phoenix in her care.[480] In her testimony, Conlin acknowledged that she would have received the email, although she had no recollection of it, nor of speaking with SOR #3. She also did not recall discussing the matter with Ingram.[481]

Three months earlier, on closing Sinclair's protection file, Conlin had cautioned that should Phoenix be found in the care of either parent, the level of risk to her would change to high.[482] The information from SOR #3 that Phoenix was now in Kematch's care should have alerted Conlin that this was now a high-risk situation requiring immediate action to protect Phoenix. I fail to understand why she did not act.

SOR#3 called the Crisis Response Unit (CRU), on May 11, 2004, to advise the agency about her concern that Kematch was reporting that Phoenix was now in her care. CRU worker Debbie De Gale received the referral. De Gale obtained a BSW degree in 1986. She began working in child welfare in 1987 and with the CRU in 2003.

5.15.2 AGENCY OPENS SINCLAIR PROTECTION FILE, MAY 11, 2004

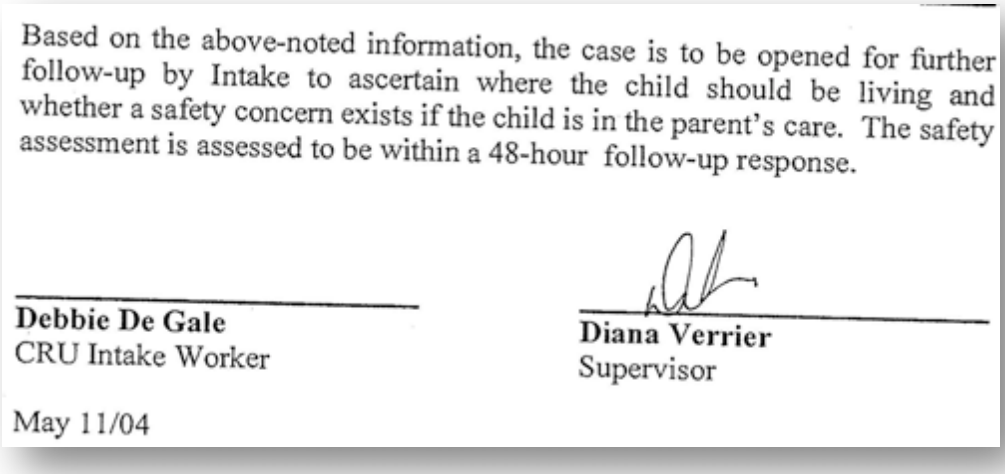
De Gale testified that she would have taken notes of her conversation with SOR#3 and transferred them to a typed document.[483] She said she checked CFSIS and saw a note that Phoenix was supposed to be in the Stephensons' care and should not have been removed without the agency's approval.[484] As a CRU worker, she created reports for her supervisor. This was her report:[485]

PRESENTING PROBLEM/ INTERVENTION:

[redacted] called to report that Samantha has brought in a letter from her lawyer claiming that she has been caring for Phoenix since Nov. /03 and requested that she be provided financial assistance for phoenix. [redacted] stated that the father, Steven Sinclair, has been receiving assistance for Phoenix however, he has been giving it to family friends, Kim and Rohan Stevenson. [redacted] was concerned about Phoenix being in her mother's care, as it was [redacted] understanding from the previous CFS worker that she would be at risk in either her mother or father's care. Upon checking CFSIS, this worker was able to confirm this to be true. [redacted] provided updated demographic information on all concerned. This worker advised [redacted] that I will look into this matter and get back to [redacted]

De Gale then noted her unsuccessful attempts to speak with the Stephensons and Sinclair. She also recorded a telephone conversation with Kematch, as follows:[486]

P/c to Samantha. She claimed that she has been caring for Phoenix since last November. This worker asked her how that came to be since, just in Feb. , phoenix had been privately placed with Kim and Rohan Stevenson. Samantha claimed that it was in fact her, who had placed Phoenix with the Stevenson and not Steven. This worker asked her how long Phoenix had been staying with the Stevensons. Samantha stated that Phoenix had been at the Stevenson's for a month. This worker asked her why she would put Phoenix to stay with the Stevensons for that length of time, especially given the fact that she had only come back into her care recently (according to Samantha). Samantha then appeared to be at a loss for words, then suddenly she uttered a profanity and hung up the phone on this worker.



Based on the above-noted information, the case is to be opened for further follow-up by Intake to ascertain where the child should be living and whether a safety concern exists if the child is in the parent's care. The safety assessment is assessed to be within a 48-hour follow-up response.

Debbie De Gale
CRU Intake Worker

Diana Verrier
Supervisor

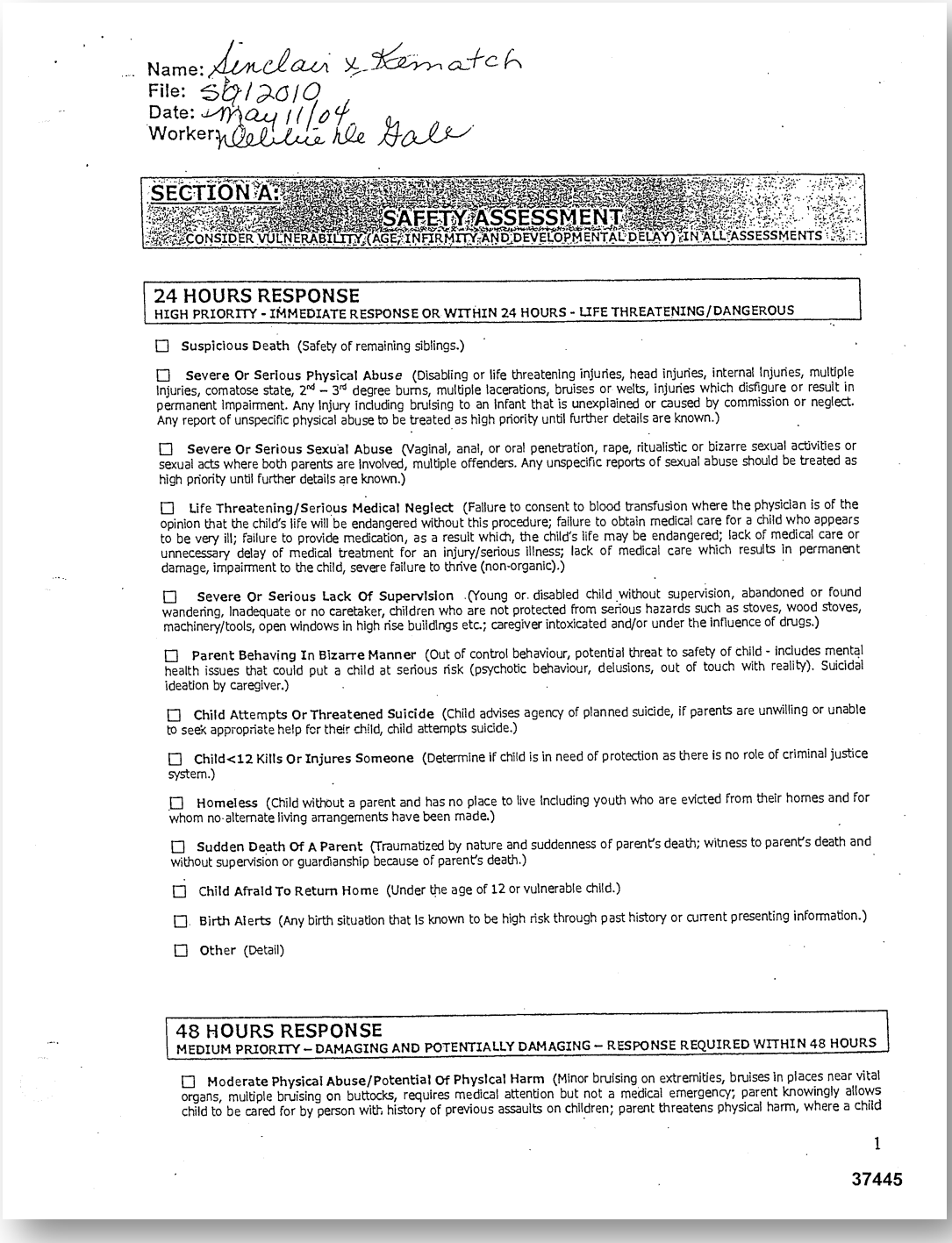
May 11/04

De Gale also completed a Safety Assessment form, which was placed in the Sinclair file.[487] The form listed a number of potential concerns categorized by response times; the worker was to check those that applied. She testified that she checked "Neglect" and "Other," next to which she wrote "Substance Abuse." Both of these concerns were listed as "Medium Priority," requiring a 48-hour response. Under the heading, "Safety Decision," the worker could choose from these options: Immediate; 24 Hours; 48 Hours; Within 5 Days; and More than 5 Days. De Gale said she selected the 24-hour response option: even though she had not checked any of the 24-hour response factors because they were not appropriate in this case, she believed that a 24-hour response was required.

De Gale was asked during her testimony about how she assessed risk relating to young children, and Phoenix in particular:

> *Q: When you were a CRU worker, did you understand that young child or developmental age was a criterion to be taken into account when assessing risk?*
>
> *A: Yes.*
>
> *Q: And did you understand it to be something that could lead to a response time of responding within 24 hours?*
>
> *A: Yes.*
>
> *Q: What did you understand "young child or developmental age" to mean?*
>
> *A: A child, a child who is not able to talk, not able to make a phone call, somebody who is not able to protect themselves, somebody who may have been handicapped, somebody who's not able to feed themselves or take care of themselves in any way.*
>
> *Q: During the time that you delivered services to Phoenix Sinclair and her family, did you understand Phoenix to fall within this category of young child or developmental age?*
>
> *A: Yes.*[488]

De Gale's Safety Assessment is reproduced here:



Name: Sinclair & Kematch
File: 5912010
Date: May 11/04
Worker: Debbie de Gale

SECTION A: SAFETY ASSESSMENT
CONSIDER VULNERABILITY (AGE, INFIRMITY AND DEVELOPMENTAL DELAY) IN ALL ASSESSMENTS

24 HOURS RESPONSE
HIGH PRIORITY - IMMEDIATE RESPONSE OR WITHIN 24 HOURS - LIFE THREATENING/DANGEROUS

☐ **Suspicious Death** (Safety of remaining siblings.)

☐ **Severe Or Serious Physical Abuse** (Disabling or life threatening injuries, head injuries, internal injuries, multiple injuries, comatose state, 2nd – 3rd degree burns, multiple lacerations, bruises or welts, injuries which disfigure or result in permanent impairment. Any injury including bruising to an infant that is unexplained or caused by commission or neglect. Any report of unspecific physical abuse to be treated as high priority until further details are known.)

☐ **Severe Or Serious Sexual Abuse** (Vaginal, anal, or oral penetration, rape, ritualistic or bizarre sexual activities or sexual acts where both parents are involved, multiple offenders. Any unspecific reports of sexual abuse should be treated as high priority until further details are known.)

☐ **Life Threatening/Serious Medical Neglect** (Failure to consent to blood transfusion where the physician is of the opinion that the child's life will be endangered without this procedure; failure to obtain medical care for a child who appears to be very ill; failure to provide medication, as a result which, the child's life may be endangered; lack of medical care or unnecessary delay of medical treatment for an injury/serious illness; lack of medical care which results in permanent damage, impairment to the child, severe failure to thrive (non-organic).)

☐ **Severe Or Serious Lack Of Supervision** (Young or disabled child without supervision, abandoned or found wandering, inadequate or no caretaker, children who are not protected from serious hazards such as stoves, wood stoves, machinery/tools, open windows in high rise buildings etc.; caregiver intoxicated and/or under the influence of drugs.)

☐ **Parent Behaving In Bizarre Manner** (Out of control behaviour, potential threat to safety of child - includes mental health issues that could put a child at serious risk (psychotic behaviour, delusions, out of touch with reality). Suicidal ideation by caregiver.)

☐ **Child Attempts Or Threatened Suicide** (Child advises agency of planned suicide, if parents are unwilling or unable to seek appropriate help for their child, child attempts suicide.)

☐ **Child<12 Kills Or Injures Someone** (Determine if child is in need of protection as there is no role of criminal justice system.)

☐ **Homeless** (Child without a parent and has no place to live including youth who are evicted from their homes and for whom no alternate living arrangements have been made.)

☐ **Sudden Death Of A Parent** (Traumatized by nature and suddenness of parent's death; witness to parent's death and without supervision or guardianship because of parent's death.)

☐ **Child Afraid To Return Home** (Under the age of 12 or vulnerable child.)

☐ **Birth Alerts** (Any birth situation that is known to be high risk through past history or current presenting information.)

☐ **Other** (Detail)

48 HOURS RESPONSE
MEDIUM PRIORITY – DAMAGING AND POTENTIALLY DAMAGING – RESPONSE REQUIRED WITHIN 48 HOURS

☐ **Moderate Physical Abuse/Potential Of Physical Harm** (Minor bruising on extremities, bruises in places near vital organs, multiple bruising on buttocks, requires medical attention but not a medical emergency; parent knowingly allows child to be cared for by person with history of previous assaults on children; parent threatens physical harm, where a child

1

37445

has been previously been harmed under similar circumstances and parent without parental capacity with no effective support system.)

☐ **Moderate Sexual Abuse/Potential Or Sexual Abuse** (Isolated instance of fondling or touching, adult exposing self to child, making sexual suggestions to the child, sexual kissing, adult voyeurism, invitation to sexual touching; situations or parental behaviours which could result in child being sexually abused; knowingly allows child to be cared for by person with history of previous sexual interference; engaged in prostitution; child present at or exposed to incidents of sexual abuse; conditions of previous incident of sexual abuse present). Individual on the Abuse Registry has access to children.)

☐ **Moderate Medical Treatment** (Serious lack of medical and/or dental care causing suffering to the child.)

☐ **Moderate Lack Of Supervision** (Child under 12 years or vulnerable child frequently out late at night and their whereabouts are unknown to the parents or they are without appropriate supervision; child who is left on their own for extended periods of time.)

☐ **Emotional Abuse/Potential Of Emotional Harm** (Chronic rejection, isolation, humiliation and emotional deprivation of child – hate the child, deprive child of affection or cognitive stimulation, inappropriate or unrealistic criticism, threats, humiliation, accusations or expectations of or towards the child, terrorizes the child, isolates the child in an unreasonable manner for inappropriate periods or corrupting the child, unwanted child, child is viewed and treated differently; where conditions of previous emotional abuse are present; inadequate parental capacity with no effective support system.)

☐ **Neglect** (Overall care chronically/persistently inadequate; caregivers lack food; physical living conditions pose a risk to children - unsanitary, no heat or water.)

☐ **Family Violence** (Exposed child to family violence or severe conflict, child witness to serious or repeated family violence, potential victim of assault if continues.)

☐ **Runaway, Or Missing Child** (Based on frequency/duration of previous episodes of running away, length of absences and child of special needs, disability of vulnerability.)

☐ **Other** (Detail) Substance Abuse

WITHIN 5 DAYS RESPONSE

☐ **Parents Refuse Treatment (Non-Medical) For Child** (Mentally, developmentally or emotionally needy child or denied treatment which could result in harm or developmental impairment for the child.)

☐ **Low Medical Neglect** (Failure to make appointments for routine medical/dental care; no follow up on plan of medical treatment or medication; failure to make appointments for routine medical/dental care (e.g. immunizations); no follow up on plan of medical treatment of medication.)

☐ **Lack Of Supervision** (Historical evidence of children frequently left alone or truant and/or whereabouts generally unknown.)

☐ **Low Sexual Abuse** (Exposure to child pornography.)

☐ **Low Physical Abuse** (A single bruise on an older child, excessive discipline – spanking, hair pulling, scratches – incidents where no medical attention is required, where the child is not afraid to be at home and the minor injury may be completely innocent.)

☐ **Child <12 Causes Significant Property Damage** (Child out of control of parents; vandalized extensively; set fire to property or has stolen or damage cars.)

☐ **Other** (Detail)

SECTION B: SAFETY DECISION

Consider the safety of all children in the home. Review and consider any previous history that is available.

☐ Immediate Response (Go to Section C)

☒ 24 Hours Response (Go to Section C)

☒ 48 Hours Response (Go to Section C)

☐ Within 5 Day Response (Go to Section D)

☐ More Than 5 Days (Go to Section D)

SECTION C: SAFETY PROTECTION PLAN

Describe the safety protection plan as follows:

- What actions have or will be taken to protect each child in the family as they relate to the current safety concerns and;
- Who is responsible for implementing each plan component.

Actions/Services to Protect Child(ren)	Completed by Whom	Date
☐ Child removed to safe place or apprehended		
☐ Alleged perpetrator/offender denied access		
☐ Committed protector with the child		
☐ Supports (Agency or Family) utilized		
☐ Concern investigated and unsubstantiated		
☐ Concern investigated – risk determined to be low		
☐ Concern investigated – risk determined to be low		
☐ Other – explain		

SAFETY PLAN: (Details in Point Form)

SAFETY PLAN MODIFIED: (Details in Point Form)

Safety Plan in Effect Until:

Modified by:

Date:

UNABLE TO COMPLETE SAFETY PLAN: (Details In Point Form)

SECTION D: RESULTING CASE ACTION TAKEN

UNIT: ☐ AHU ☑ CRU

CASE TO: ☑ INTAKE ☐ ABUSE ☐ CRU ☐ CASE CLOSED

WORKER: Debbie De Gale

DATE OF ASSESSMENT: May 11/04

SUPERVISOR CONSULTED: ☐ Yes ☑ No

DATE REVIEWED:

De Gale testified that she selected "neglect" as one of the presenting issues because of a phone call she had received on May 11, 2004, the same day she spoke to Kematch, from someone claiming to be an aunt of Kematch or Sinclair. DeGale recalled being told that the aunt was worried about Phoenix because she didn't know which parent she was with; she was concerned that she was being neglected and that the parents had a history of being mean to her. The aunt said that after Kematch told her that Phoenix was with Sinclair she had tried to contact him but heard he was in Ontario.[489]

De Gale testified that she recorded the information about the telephone call from the aunt, but it was not in her May 11, 2004 CRU report. She said she also called child welfare agencies in Ontario and on-reserve care in Manitoba to see if they had any record of Kematch, Sinclair, or Phoenix and would have recorded this information as well, but this also is missing from the report.[490] De Gale testified that she believed that the information about the telephone call from the aunt had been removed from her CRU report, though she was not sure who would have done that.[491]

The CRU report found in the file and referenced above is not signed by De Gale. She testified that it was always her practice to sign her completed CRU reports.[492] I accept her evidence that the report located in the protection file is not the report she handed in with her Safety Assessment. There was no evidence before me to explain how this occurred.

The CRU report was, however, signed by De Gale's supervisor, Verrier. Verrier had a BA degree and a BSW, obtained in 1992. She began working in child welfare that year. She had no recollection of her involvement in this referral, but did know that there were unsigned reports in her unit on occasion.[493] Verrier's evidence was that she would occasionally make changes to a worker's report if the worker had already left for the day, but she would always leave a note in the report that it was supervisor-reviewed.[494] Verrier testified that there would have been no need to remove information from a worker's report because it was important that the report contain all relevant information; further, it would be unethical to do so.

De Gale also believed that her Safety Assessment form had been altered. Her check mark beside the 24-hour response option had been crossed out and initialed, and the 48-hour response box had been checked. De Gale testified that the initials beside the cross-out were not hers, but appeared to be Verrier's.[495]

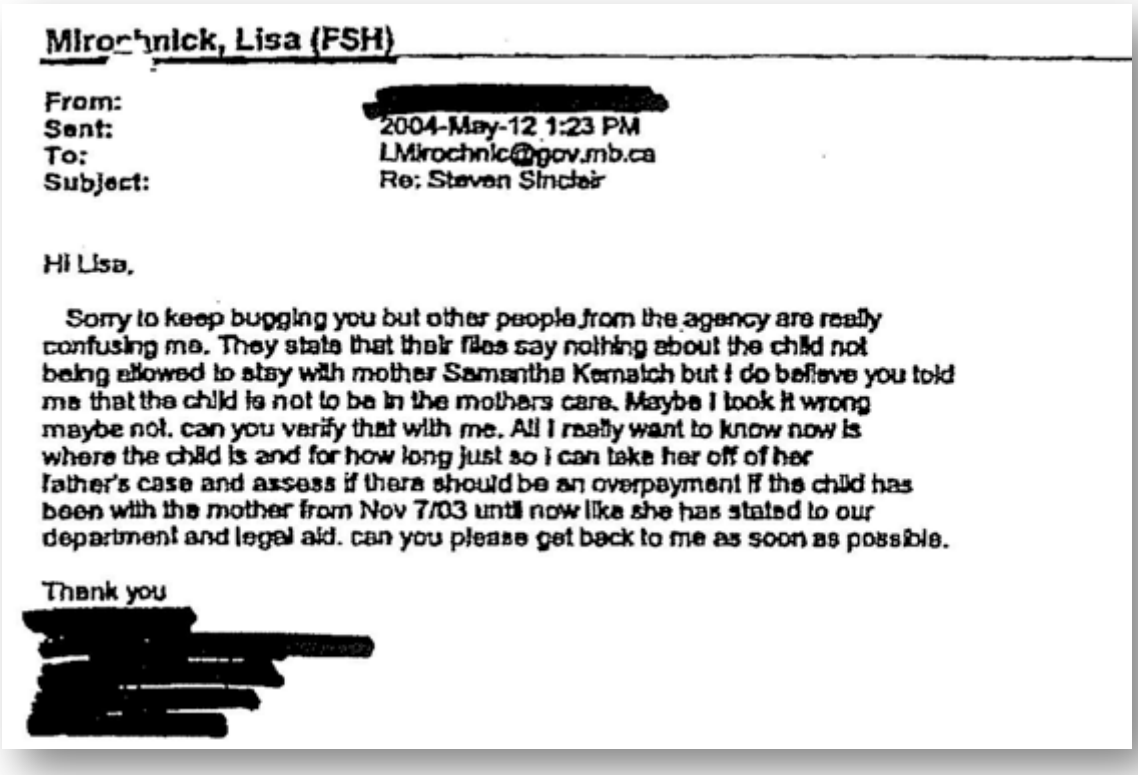
With no recollection of any involvement with this referral, Verrier conceded that the initials might have been hers. In her testimony, Verrier said it appeared to her that someone must have determined that De Gale made a mistake in checking the 24-hour response time box because the presenting issues she had checked both fell under the 48-hour heading. While she was unsure if she was responsible for changing De Gale's Safety Assessment, she testified that one of her duties as supervisor was to correct "obvious mistakes" and she believed this change was an example of that.[496] This explanation appears reasonable to me.

Verrier's view was that the issues in the referral from SOR#3 were typical of the files that came through CRU. She was not certain that this referral indicated a high risk to Phoenix, though she believed there was a need for further assessment as to whether Phoenix ought to be in Kematch's care. When asked if Kematch's tone and behaviour on the phone with De Gale would have escalated the risk assessment, Verrier stated that it would "inform it, but it would not necessarily escalate it." She agreed that the situation needed to be assessed, but 48 hours would have been an appropriate response time. [497]

I find that De Gale's assessment of the need for a response within 24 hours was appropriate. Her explanation for completing the form as she did was reasonable, but because her recommended response time did not match the concerns indicated on the form, her intention was unclear. She did correctly identify Phoenix's vulnerability, given her young age, and took note of the caution from previous worker Conlin's closing summary, that should Phoenix be found in the care of either of her parents, she would be at high risk.

5.15.3 EIA WORKER PURSUES CONCERNS

While Winnipeg CFS investigated SOR#3's referral, another email from her to Conlin the next day, May 12, 2004, shows the diligence with which this EIA worker pursued her concerns:[498]



Mirochnick, Lisa (FSH)

From: [redacted]
Sent: 2004-May-12 1:23 PM
To: LMirochnic@gov.mb.ca
Subject: Re: Steven Sinclair

Hi Lisa,

Sorry to keep bugging you but other people from the agency are really confusing me. They state that their files say nothing about the child not being allowed to stay with mother Samantha Kematch but I do believe you told me that the child is not to be in the mothers care. Maybe I took it wrong maybe not. can you verify that with me. All I really want to know now is where the child is and for how long just so I can take her off of her father's case and assess if there should be an overpayment if the child has been with the mother from Nov 7/03 until now like she has stated to our department and legal aid. can you please get back to me as soon as possible.

Thank you

[redacted]

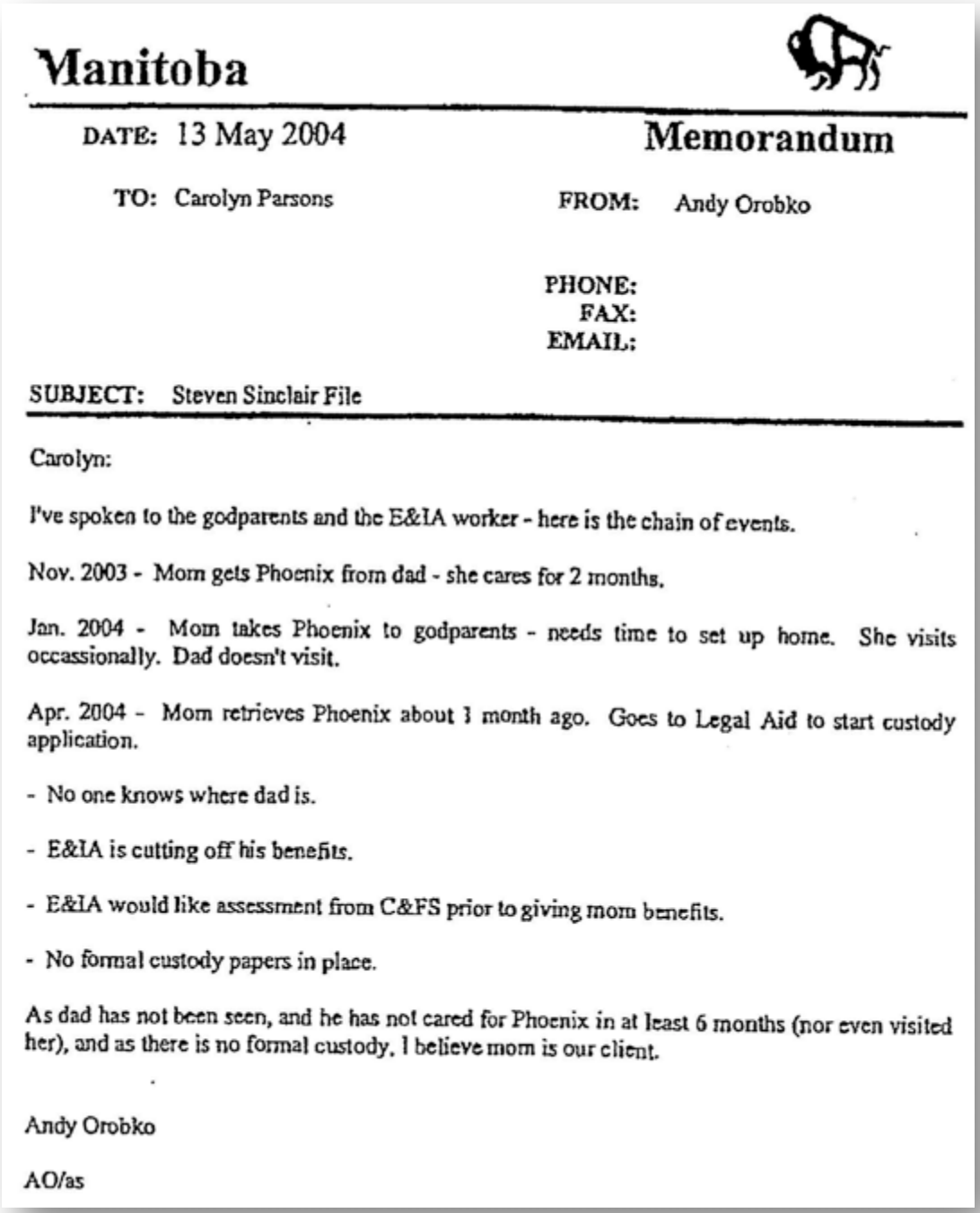
SOR#3 did not recall with whom at Winnipeg CFS she had been communicating before she sent this email to Conlin, nor do the agency's records shed any light on the issue.[499]

Conlin testified that she had no recollection of communicating with this EIA worker in May 2004. Although the email was printed in Conlin's name, she had no explanation for how it ended up in Kematch's protection file. Given that she did not have an open file at the time of this communication, Conlin said she would not even have made a case note about the phone call[500] and typically, would not have printed a hard copy of an email.[501] I find it surprising that she would not have made a note of such a call, given the acknowledged contribution that collateral sources of information such as this EIA worker can make in bringing protection concerns to the agency's attention.

5.16 AGENCY LEARNS THAT PHOENIX IS WITH KEMATCH

SOR #3's referral was passed on to Orobko in Northwest Intake. This unit covered northwest Winnipeg, where Sinclair was last known to be living. Orobko testified that when he reviewed the file, something triggered him to investigate. He contacted people he referred to as "the godparents", and the EIA worker (SOR#3) and it became clear to him that Kematch—not Sinclair—was now Phoenix's primary caregiver.

Because Kematch lived in central Winnipeg, Orobko wrote a memo to his colleague Carolyn Parsons, a supervisor at Central Intake, to indicate that the file actually belonged there and would need to be opened under Kematch's name for follow up.[502] This is the memo, dated May 13, 2004:[503]



Manitoba

Memorandum

DATE: 13 May 2004

TO: Carolyn Parsons

FROM: Andy Orobko

PHONE:
FAX:
EMAIL:

SUBJECT: Steven Sinclair File

Carolyn:

I've spoken to the godparents and the E&IA worker - here is the chain of events.

Nov. 2003 - Mom gets Phoenix from dad - she cares for 2 months.

Jan. 2004 - Mom takes Phoenix to godparents - needs time to set up home. She visits occassionally. Dad doesn't visit.

Apr. 2004 - Mom retrieves Phoenix about 1 month ago. Goes to Legal Aid to start custody application.

- No one knows where dad is.

- E&IA is cutting off his benefits.

- E&IA would like assessment from C&FS prior to giving mom benefits.

- No formal custody papers in place.

As dad has not been seen, and he has not cared for Phoenix in at least 6 months (nor even visited her), and as there is no formal custody, I believe mom is our client.

Andy Orobko

AO/as

That same day, SOR#3 recorded that Orobko told her that Kematch had taken Phoenix back into her care in April.[504] By May 13, 2004, therefore, the agency was well aware that Stephenson and Edwards were no longer caring for Phoenix and that she was in Kematch's care.

5.16.1 PHOENIX IS ADDED TO MCKAY'S EIA BUDGET

As of May 2004, the agency was aware that Phoenix was back in Kematch's care. But there is nothing to indicate that the agency was aware of important information contained in EIA records: that Kematch and McKay had applied for benefits as a couple, with Kematch saying that she had been caring for Phoenix since November 2003; and that as of May 28, 2004, Phoenix was removed from Sinclair's EIA file and placed as a dependent on McKay's.[505]

SOR#3, in her testimony, explained the significance of the addition of Phoenix as a dependent on McKay's budget, in terms of access to information about both Phoenix and McKay:

> *Q: So, so you've said that as of May 28, '04, if a worker typed in Phoenix's name into the EIA system they would see that she was on Wes McKay's budget.*
>
> *A: Correct.*
>
> *Q: And after May 28, '04, if a worker had typed in Phoenix's name, would they have been able to see that Phoenix had been on Mr. McKay's budget even if she were no longer on his budget?*
>
> *A: Yeah, it would show all files that Phoenix would have been on, on our system.*
>
> *Q: Okay. And then that would show the information about the file, the, the client themselves, Mr. McKay.*
>
> *A: Yes.*
>
> *Q: Including his date of birth?*
>
> *A: Correct.*[506]*. . . . .*
>
> *Q: I'm saying generally, if, if a CFS worker called and said they were investigating a child protection concern and needed an individual's date of birth, was that information that you would have shared?*
>
> *A: If it was required for, for protection, very likely, yes.*[507]

5.16.2 KEMATCH FILE IS OPENED AT INTAKE

After the file was opened in Kematch's name and sent to the Central Intake Unit on May 13, 2004, Supervisor Parsons assigned it to worker Tracy Forbes. Parsons obtained a BSW degree in 1980. She had been working in child welfare since 1982 and had been a supervisor in the Central Intake Unit since 2000. Forbes had BA, BSW, and MSW degrees and had been an intake worker since 1996.

Forbes testified that in 2004, it was not typical for the paper file to be transferred to her when she received a CRU report. She would get information about the file from the CRU worker's summary and from CFSIS.[508]

Forbes said she had some recollection of Kematch's file.[509] She said she reviewed Orobko's memorandum and De Gale's CRU referral, but not Sinclair's file, although she agreed that it might also have contained important or relevant information.[510] Forbes said she read the note in Conlin's closing summary that the risk to Phoenix would be high if she were in the care of either Kematch or Sinclair. She was unsure how she would have come to see that summary, given that it was in Sinclair's protection file, but speculated that she may have pulled it from CFSIS or received it from Parsons, since it was referred to in De Gale's CRU referral.[511]

Forbes testified that De Gale's CRU referral signified to her that the first course of action should be to determine whether Phoenix was in the care of her mother; and then whether there were protection concerns that would actually place her at high risk. The history on the file would need to be considered and would form part of her risk assessment, but did not necessarily dictate the level of risk.[512] Forbes said that as an intake worker, she had the ability to assess risk herself and determine whether to follow the response time indicated by the CRU worker. Workload would be a factor; the response time given in a CRU report was often impossible to meet, she said.[513]

Forbes testified that her initial assessment was that there was no immediate risk to Phoenix because no community referrals had indicated that she was at risk. Nevertheless, she did go out within 48 hours, complying with the response time articulated in De Gale's CRU report.[514]

Forbes said she was aware that it appeared that Kematch did not have Phoenix in her care between June 2001 and November 2003, but in the Aboriginal community it was not unusual for other family members and friends to participate in the raising of children.[515] She was also aware that Kematch's first child and Phoenix had both been apprehended at birth, but she understood that the concerns that arose at Phoenix's birth had been resolved, since she had been returned to her family.[516]

I have difficulty understanding how she could reach that conclusion, given Conlin's assessment. Forbes explained her interpretation that Conlin had made a high risk assessment as a precaution, having not met with Kematch.[517] She said it was not unusual for workers to classify a situation as high risk if they didn't have enough information to do an accurate assessment.[518] I find Forbes' dismissal of Conlin's precaution, without further investigation, to be superficial at best. Once she had conduct of the file, Forbes ought to have done a thorough review of the history.

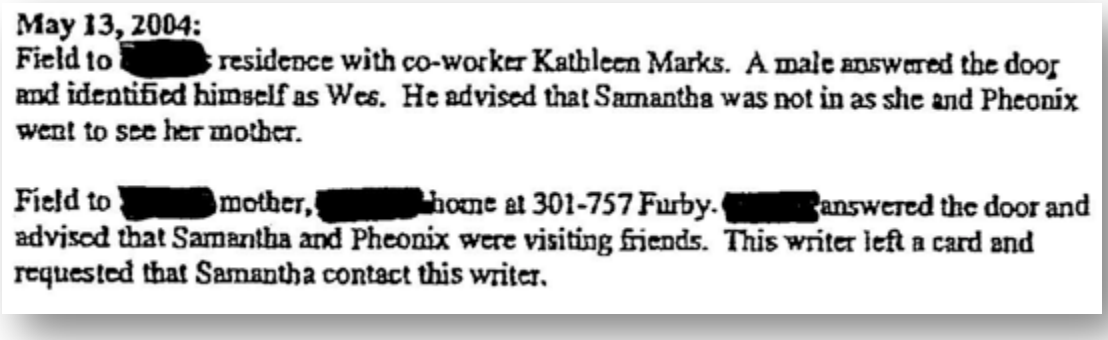
While it is true that Phoenix had been returned to both parents in September 2000, the Kematch protection file showed that by August 2001 she was no longer in Kematch's care. The closing summary prepared by Chief-Abigosis on August 16, 2001 said the file would be closed because Kematch no longer had any children in her care. It identified a number of unresolved problems relating to Kematch's parenting ability and recommended that "If or when Mr. Sinclair and Ms. Kematch

resolved their relationship and resume cohabitation, that the Agency access and monitor Kematch's parenting style. There are concerns expressed by Mr. Sinclair about her treatment and disciplined methods used on Phoenix."[519]

Forbes testified that she did not have any contact with the Stephensons; she knew that De Gale had tried to contact them but the agency had the wrong number for them.[520]

Forbes recalled that when she first received the file, there were no specific protection concerns. This was unusual, so she consulted with Parsons on how to proceed. Forbes said Parsons instructed her to do a general outreach to the family, and to see if any concerns from the prior history were evident.[521]

Forbes' intake closing summary contains a synopsis of her work including her May 13, 2004 visit to Kematch's home:[522]



May 13, 2004:
Field to [redacted] residence with co-worker Kathleen Marks. A male answered the door and identified himself as Wes. He advised that Samantha was not in as she and Pheonix went to see her mother.

Field to [redacted] mother, [redacted] home at 301-757 Furby. [redacted] answered the door and advised that Samantha and Pheonix were visiting friends. This writer left a card and requested that Samantha contact this writer.

She testified that when she went to the home that day, her intention was to see Phoenix and determine whether she was in Kematch's care.[523] Kathleen Marks was her intake partner.[524]

Forbes testified that when she encountered "Wes" at the door that day, she didn't ask him any questions or identify herself because she didn't know anything about him and she was cautious about breaching confidentiality. She did identify herself to Kematch's mother because she knew who she was, but did not ask her any questions about Kematch or Phoenix or their circumstances.[525]

Parsons testified that she had a conversation with Forbes after that first attempted visit to Kematch on May 13, 2004, about whether the file should be referred to the After Hours Unit (AHU) for further follow up. She said her advice to Forbes was that it didn't make sense to refer the file to AHU based on the information they had; they needed to continue to try to meet with Kematch and to complete an assessment.[526] There were no notes or file recordings of any consultation or conversation between Forbes and Parsons.

The next day, May 14, 2004, Forbes received a message from an EIA worker, telling her that Phoenix had been added to Kematch's budget. Forbes testified that she did not ask whether anyone else was on the budget, despite her face-to-face meeting with "Wes" at Kematch's door the previous day.[527] As I learned from the previously

discussed evidence of EIA worker SOR #3, if Forbes she had asked the question she would have learned that Kematch by then was on McKay's EIA budget.

On May 17, 2004, Forbes sent a letter to Kematch, letting her know that she was trying to contact her.[528] On June 2, she tried another field visit to 15-747 McGee Street but no one answered the door. She left her card.[529] Forbes testified that she did field visits during regular working hours. She had the option of using the After Hours Unit to visit at other times, but this was typically done only when there was deemed to be imminent risk to a child.[530]

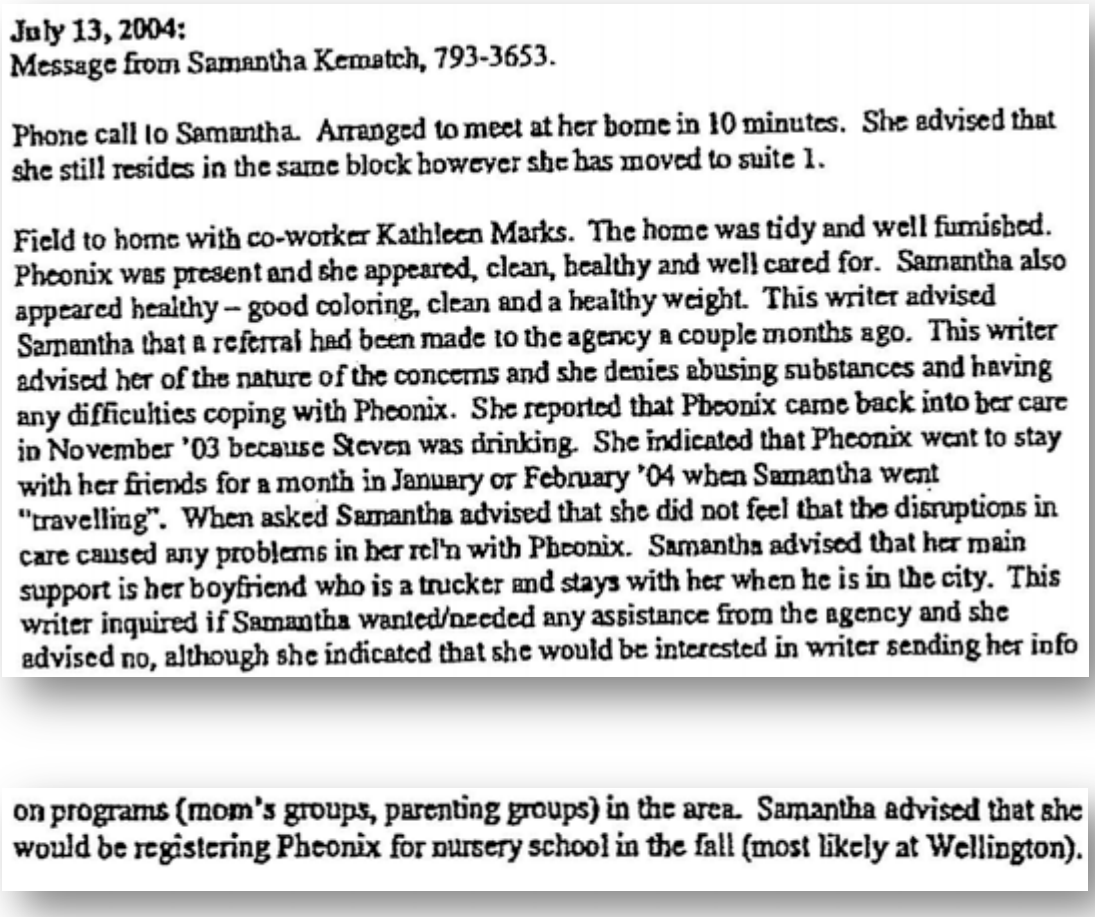
Given that Phoenix was vulnerable because of her age; in light of the history and risk assessments on file by Chief-Abigosis, Forrest, and Conlin; and given that the agency still had not done an assessment of Kematch's parental capacity and motivation, I am at a loss to understand on what basis the worker could determine that there was no imminent risk to Phoenix. The agency's approach to investigating this referral was inappropriately passive.

Forbes sent a second letter to Kematch on June 15, 2004 informing her that her file could not be closed until she met with the agency. Six days later, on June 21, Kematch phoned Forbes and agreed to meet with her on June 29. But on June 28 Kematch called again, asking to change the appointment because she was moving to a different apartment in her complex. Forbes urged Kematch to keep the appointment and Kematch agreed.[531] When Forbes went to Kematch's apartment on June 29, 2004, she was unable to gain entry: the complex was locked and did not have a buzzer system.[532] Forbes did not make contact with Kematch that day.

Forbes's file recording shows that more than a week later, on July 9, 2004, she emailed Kematch's EIA worker requesting the new address.[533] No record of this email was found on file and Forbes testified that she might not have printed it. She testified that she did not receive a response, because she would have documented it if she did.[534]

EIA information about this family at this time was that as of April 26, 2004, Kematch and McKay had applied for EIA benefits, which had the effect of adding Kematch to McKay's EIA budget,[535] and as of May 28, Phoenix was added as well.[536] But Forbes testified that she did not ask the EIA worker about "Wes" because she didn't have any concerns about him.[537] She also did not perform a prior contact check in CFSIS to see if he had a history with the child welfare system. She said that in 2004 it was not the practice to do a prior contact check on every individual encountered on a file.[538]

There is no record in the file of a response from the EIA worker, nor any further activity by Forbes until four days later, on July 13, 2004, when she received a message from Kematch. Forbes arranged to meet with her immediately and went to Kematch's new suite at 1-747 McGee Street, with her co-worker Marks. Her record in her closing summary reads as follows:[539]



July 13, 2004:
Message from Samantha Kematch, 793-3653.

Phone call to Samantha. Arranged to meet at her home in 10 minutes. She advised that she still resides in the same block however she has moved to suite 1.

Field to home with co-worker Kathleen Marks. The home was tidy and well furnished. Pheonix was present and she appeared, clean, healthy and well cared for. Samantha also appeared healthy – good coloring, clean and a healthy weight. This writer advised Samantha that a referral had been made to the agency a couple months ago. This writer advised her of the nature of the concerns and she denies abusing substances and having any difficulties coping with Pheonix. She reported that Pheonix came back into her care in November '03 because Steven was drinking. She indicated that Pheonix went to stay with her friends for a month in January or February '04 when Samantha went "travelling". When asked Samantha advised that she did not feel that the disruptions in care caused any problems in her rel'n with Pheonix. Samantha advised that her main support is her boyfriend who is a trucker and stays with her when he is in the city. This writer inquired if Samantha wanted/needed any assistance from the agency and she advised no, although she indicated that she would be interested in writer sending her info on programs (mom's groups, parenting groups) in the area. Samantha advised that she would be registering Pheonix for nursery school in the fall (most likely at Wellington).

This visit to Kematch's house was the first in-person contact that Forbes had with the family, despite having had the file for two months. Forbes said she believed she would have told Kematch at this meeting that the agency had concerns about her ability to adequately care for Phoenix, and would have focused on concerns about drug and alcohol use.[540]

Forbes testified that she included in her record a note of Kematch's healthy appearance because that was a possible indicator that she was not abusing drugs and alcohol. She included information about Phoenix to show that there was nothing about her appearance to indicate that she was not being well cared for or that she was being neglected.[541] Forbes could not recall how much time she spent with Phoenix, but testified that she did not speak with her away from Kematch.[542]

Forbes said she knew that the "Wes" who had answered the door on May 13, 2004 was the boyfriend that Kematch referred to, but she didn't ask about him because she had no reason to be concerned about him and she had no further contact with him.[543]

5.17 KEMATCH FILE CLOSED: "NO APPARENT CONCERNS"

On July 14, 2004, the day after their meeting, Forbes sent a letter to Kematch with information about community resources.[544] Her Intake closing summary contained the following assessment of the family:[545]

ASSESSMENT:

In May '04 an Employment and Income Assistance worker contacted the agency to report that Samantha wanted Pheonix added to her budget as she was in her care. The EIA worker was concerned as she recalled that there were concerns about Samantha's ability to provide care. The EIA worker was not specific in the concerns identified, but simply wanted an assessment completed to determine if Pheonix was safe in Samantha's care.

The family has an extensive history with the agency starting when Samantha had her first child [redacted] in '98. [redacted] was apprehended at birth and eventually became a Permanent Ward. It became apparent that Samantha could not parent once she was provided an opportunity to do so in a supported living situation. In April '00 Samantha gave birth to a second child, Pheonix who was apprehended at birth. Pheonix was returned to parents 4 months later. In April '01 Samantha gave birth to [redacted]. Concerns were expressed regarding alcohol abuse and domestic violence. [redacted] died in July '01 from natural causes while in Steven's care. Samantha and Steven separated sometime around June '01 and Pheonix remained with Steven until June '03 when she came into care due to parents abusing substances. Pheonix was returned to Steven in October '03.

This writer made repeated efforts to meet with Samantha, but was not successful in doing so until July 13, 2004. Samantha denied abusing substances and maintained that she was coping well. Pheonix appeared healthy and well cared for and Samantha did not present as a crack user would be expected to – she was not jittery nor was she thin and drawn looking. She reported that Pheonix came into her care in November '03 due to Steven allegedly abusing substances. Pheonix reportedly stayed with friends for a month or so at the beginning of this year while Samantha "traveled". Samantha declined offers of service, but requested information on resources in the community be sent to her.

Given that there are no apparent child protection concerns this file can be closed.

Despite other workers having classified the risk to Phoenix, in Kematch's care, as high, Forbes listed it as low because there were no signs that Kematch was abusing substances and Phoenix appeared well cared for.[546] Forbes noted in her testimony that she had actually met with Kematch and Phoenix, whereas others had not.[547] Forbes also said she had contemplated transferring the file to Family Services, but typically could not send a file solely for monitoring, without a plan.[548] For reasons I will explain in my discussion of the actions of supervisor Parsons, I find the recommendation to close the protection file at this stage, without having done an adequate child protection investigation, to be indefensible.

5.17.1 SUPERVISOR FAILS TO ENSURE BEST PRACTICE

According to supervisor Parsons, the two months that Forbes took to actually contact the family was acceptable, given the realities of the job and workload. But she admitted it was not best practice.[549]

As to the failure to investigate and assess McKay, Parsons said it was not clear at the time how involved he was in parenting Phoenix, but agreed that this would be part of the information that Forbes ought to have been looking for.[550] Parsons testified about what she would have expected from a worker:

> *Q: Okay. Now, you did say when Ms. Forbes met with Ms. Kematch you would have expected her to ask about Wes McKay at that point?*
>
> *A: Yes, that would have been the opportunity to ask further questions about him.*
>
> *Q: There was -- privacy concerns wouldn't have come into play at that point?*
>
> *A: No.*
>
> *Q: Okay. Would you have expected her to get his full name?*
>
> *A: Yes, best --*
>
> *Q: And how much time -- sorry, I don't want to interrupt you if you --*
>
> *A: Yes, best practice would have been to have his full name.*
>
> *Q: Full name --*
>
> *A: And what he was doing there.*
>
> *Q: What he was doing there, how much care, if any, he was providing to the child?*
>
> *A: Yes.*
>
> *Q: You'd want to know if he had kids of his own, of his own in the house*
>
> *A: Yes.*
>
> *Q: Okay. Would you want to know -- what, what other sort of information would you expect her to ask about Mr. McKay?*
>
> *A: Best practice --*
>
> *Q: Best practice.*
>
> *A: -- is that you would, you would want to know the same things about him if he was parenting as you would Ms. Kematch.*
>
> *Q: Okay. So you'd want a full background of him as much as possible?*
>
> *A: Yes.*
>
> *Q: Getting that information, assuming you were able to get a name, would you expect a prior contact check to be performed --*
>
> *A: Yes.*
>
> *Q: -- after that?*
>
> *A: Yes.*[551]

5.17.2 MCKAY IS KNOWN AS A "THREAT TO CHILDREN"

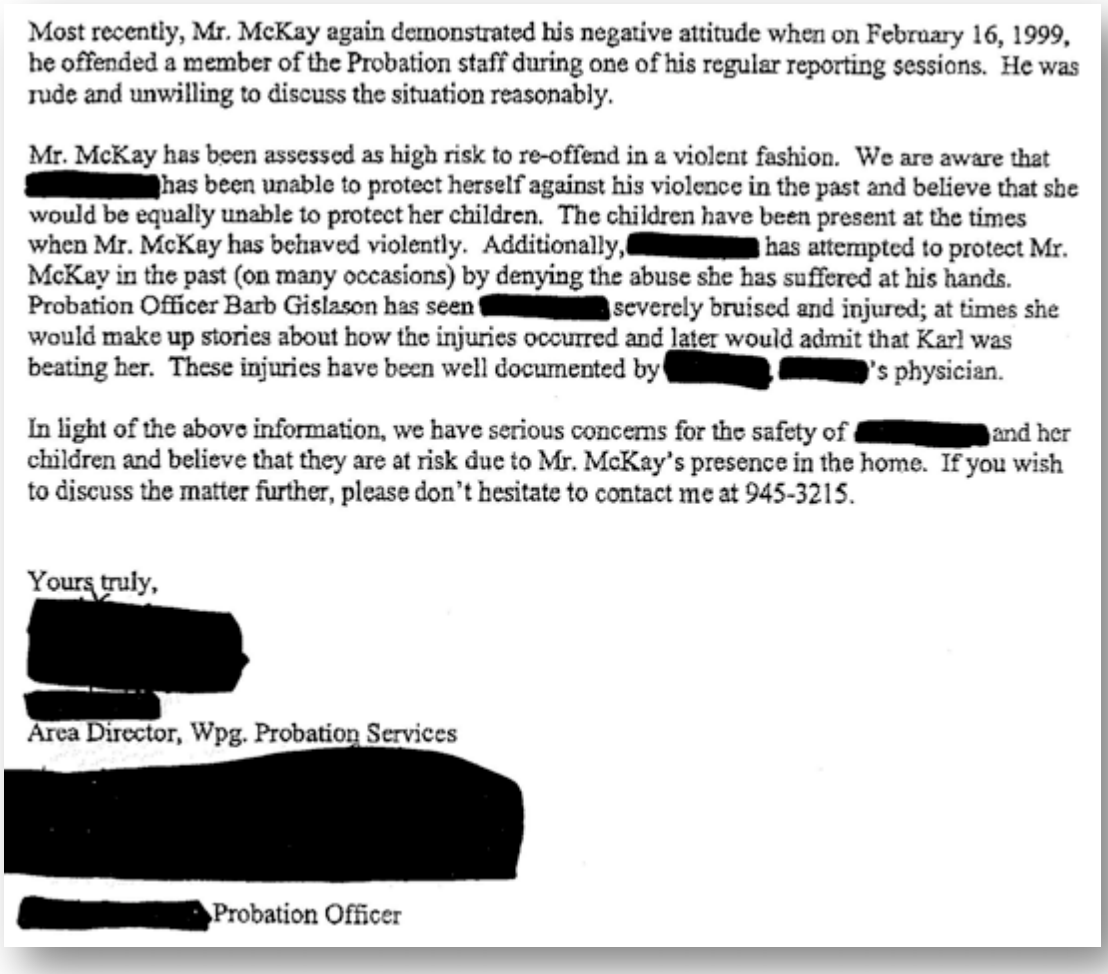
At this time, the agency knew that a man named "Wes" was living with Kematch, but had not obtained his full name. The Department of Family Services and Labour has acknowledged on behalf of the agency that between May 2004 and April 2005, a prior contact check in CFSIS for "Karl Wesley McKay" would have given a worker access to information from four protection files and four child-in-care files. Included in those files are documents from the protection file of one of McKay's former common-law partners, referred to as "Ms. X" in the Inquiry's proceedings. These date back to 1998 and reveal McKay's history of domestic violence. One agency record, dated June 15, 1998, noted that a worker had received the following information about McKay's criminal behaviour:

> *-Has a lengthy list of convictions and charges dating back to 1991. Numerous assault charges, failure to comply, etc.*
>
> *-With respect to [redacted] WPS confirm Carl [sic] has been arrested on three separate occasions for assaulting [redacted].*
>
> *-06\06\09 Charged with assault, charges stayed 11\96.*
>
> *-21\09\97 Charged with assault with a weapon, charges stayed 11\97.*
>
> *-21\09\97 Charged with uttering threats, charges stayed 11\97.*
>
> *-23\09\97 Charged with assault, charges stayed 11\97.*
>
> *-23\06\96 Charged with assault on a 22 year old female, probably [redacted].*[552]

Another document that was available on CFSIS says that the two children of McKay and Ms. X were made permanent wards of Southeast Child and Family Services on August 18, 2000. This document, dated September 18, 2000, states:

> *"Carl Wesley McKay poses a threat to the children both directly and indirectly in terms of his propensity for violence."*[553]

In addition, Ms. X had a paper file totaling 832 pages. The Department acknowledged that between May 2004 and April 2005 a worker would have had access to this file.[554] Among the documents in the file were letters about McKay, sent from Probation Services to Northwest Winnipeg CFS.[555] One of those letters, dated February 18, 1999, concluded with the following:



Most recently, Mr. McKay again demonstrated his negative attitude when on February 16, 1999, he offended a member of the Probation staff during one of his regular reporting sessions. He was rude and unwilling to discuss the situation reasonably.

Mr. McKay has been assessed as high risk to re-offend in a violent fashion. We are aware that [redacted] has been unable to protect herself against his violence in the past and believe that she would be equally unable to protect her children. The children have been present at the times when Mr. McKay has behaved violently. Additionally, [redacted] has attempted to protect Mr. McKay in the past (on many occasions) by denying the abuse she has suffered at his hands. Probation Officer Barb Gislason has seen [redacted] severely bruised and injured; at times she would make up stories about how the injuries occurred and later would admit that Karl was beating her. These injuries have been well documented by [redacted]'s physician.

In light of the above information, we have serious concerns for the safety of [redacted] and her children and believe that they are at risk due to Mr. McKay's presence in the home. If you wish to discuss the matter further, please don't hesitate to contact me at 945-3215.

Yours truly,

[redacted]

Area Director, Wpg. Probation Services

[redacted]

[redacted] Probation Officer

The author of this letter was Miriam Browne, currently the Executive Director of the Manitoba Institute of Registered Social Workers. When she wrote the letter, she was McKay's probation officer.[556]

5.17.3 INFORMATION ABOUT MCKAY WOULD HAVE KEPT FILE OPEN

Parsons testified that if she had had this information about McKay, which was contained in the agency's files, she would not have recommended closing the Kematch file. Instead, she would have recommended that it be transferred to a Family Services Unit for ongoing services. At the very least, she said, the agency would have had grounds to ask McKay to voluntarily remove himself from the family during the investigation. If he refused, the agency would have had grounds to apprehend Phoenix.[557]

But according to Parsons, based on the investigation that the agency did conduct, which did not include an assessment of McKay, there was no basis for transferring the file for ongoing services. There were no indications of drug or alcohol problems and Phoenix appeared in good health. It was difficult to do an in-depth assessment without any clearly defined presenting problems. She testified that at

the time she signed off on closing the file, she believed that Phoenix was safe, based on the one contact that Forbes had made with the family. [558]

Several aspects of the services delivered during this period are of concern. First, the delay in making physical contact with the family was unacceptable. According to the May 11, 2004, referral from the EIA worker, it was unclear where four-year-old Phoenix was living. It was suspected that she was with one of her parents. The agency's most current assessment was that Phoenix would be at high risk if in the care of either parent. Yet no one from the agency laid eyes on her for more than two months.

Parsons was questioned about her assessment of the risk to Phoenix:

Q: But ultimately if, if you can't determine whether or not the home is a high risk or a low risk, because the investigation hasn't been done, how can you close the file?

A: Because when I looked at it the work to determine the child's safety was done, and there was nothing substantiated to transfer the file on for ongoing services when we -- when Tracy, Ms. Forbes went out there was no indication that there were problems at that point in time with, with alcohol and drugs. Ms. Forbes saw Phoenix, and, and found her to be in good health, and, and appearing to, to be well, and the same for Ms. Kematch. She was somewhat receptive and certainly that was another -- something that I look at as a supervisor, she was, she was not -- it took awhile to, to connect with her, but when we did she was open to having Tracy come into her home and sit down and, and talk about what her experience was, and how she had come to parent Phoenix again, and what her plans were, so I think those were all things that were taken into consideration that we -- and I think because of the time it was we were at that point in time looking for specific incidents that would translate into -- to risk. We weren't taking the time to really do in-depth assessments, and ask lots of questions, unless we had something to really go on to start with, so I think you can see a very different summary from the one that you see with Ms. Kematch than you would with another file that had been presenting as more difficult, and having had more, more eminent concerns to it. You would have seen a different recording style and a lot more information, and, and that's unfortunate, and -- but that's a reality.

Q: Is that -- is this case an example of, of what you mentioned before when, when the lesser priority cases would sort of be overlooked for the higher priority cases?

A: Unfortunately, yes, and that's the way it came into the unit.

Q: Well it came in with a 48-hour response time.

A: It came in with a 48-hour response time, but with a very low level of concern.

Q: And that's how you read –

A: Yes.

Q: But if you looked at the prior summary done by Ms. Mirochnick it talked about being a high risk if, if Phoenix ends up with Samantha Kematch.

A: Without seeing Ms. Kematch.

Q: That's what you understood?

A: Yes.[559]

She earlier testified as to risk assessment:

Q: What was the role of, of Intake in this file at this point?

A: The role of Intake was to assess Phoenix's safety with her mom, and -

Q: Okay. What -- first what does "safety" mean?

A: Whether or not she's being cared for, or whether or not there are any indications of neglect or, or abuse.

Q: Is that a, a long term thing "safety" or is it just immediate --

A: It's a short term.

Q: Just immediate safety?

A: Yes.

Q: So you're assessing the safety of a child at present?

A: Yes.

Q: And what about long term?

A: And looking at risk longer term.

Q: Risk is a long term?

A: Risk is a longer term.

Q: And what is it -- what goes into the risk there, what, what do you look at in the long term?

A: In the longer term best practice, and so we're looking at what resources the family has, what capacity the family has, are there any indications of mental health, or developmental concerns of the parents. Is there some stability, we're looking at the household, we're looking at, at who the child is, having all, all of those things and, and more that enter into looking at risk.

Q: So a lot of, a lot of factors go into that risk assessment?

A: Yes.

Q: And that risk assessment is something you -- the workers are required to do as part of intake?

A: Well -- and assessment is really always risk assessment, and you're -- yes.

Q: You want to make sure that the child, in this case Phoenix, is, is safe and in the home in the long term?

A: As much as you can.

Q: Not just the immediate risk if something's happening at that point in time, but whether or not the child is going to be safe in that home?

A: Yes.[560]

Despite Parsons' testimony about the assessment that ought to have been done in this case, it was not done. Instead the file was closed.

The discounting of the earlier "high risk" assessments on the basis that those workers had not met with Phoenix and Kematch ignored Kematch's significant history and the agency's repeated identification of unresolved concerns about her parental capacity and motivation, which had never been addressed.

The agency's failure to keep the file open and investigate further reflected a general misunderstanding by agency staff of the notion of risk assessment. The assessment of risk to Phoenix was changed even though there had been no change in the circumstances that had led to the original assessment.

That this file was so often assessed as "low-risk" and "low priority" demonstrates a fundamental lack of understanding of the factors that contribute to long-term, chronic neglect, as described by Trocmé. By the spring and summer of 2004 the agency had ample evidence that Phoenix was at such risk.

With respect to assessing her immediate safety, I am further troubled by the failure to do any assessment of McKay when it became clear that he was a new person involved in the care of Phoenix.[561] An investigation into whether he had any history with the child welfare system was essential to any assessment of Phoenix's immediate safety and ongoing well-being. The agency ought to have obtained McKay's full name and date of birth and done a prior contact check. A prior contact check on Karl Wesley McKay, had it been done immediately after the agency learned of Kematch's new boyfriend, would have revealed disturbing information.

Finally, I find that the agency's assessment that Kematch was not abusing substances and that Phoenix appeared well cared for was superficial and inadequate, having been made on the basis of a single visit in which the worker did not even speak directly with Phoenix.

5.18 KEMATCH IS PREGNANT A FOURTH TIME, SPRING 2004

During the spring of 2004, Kematch was pregnant with her fourth child. McKay was the father. Medical records show that Kematch did obtain prenatal care during this pregnancy.

A social worker from the Health Sciences Centre Women's Hospital who testified as SOR#4 said a nurse consulted her about Kematch on May 30, 2004.[562] SOR #4 obtained a BSW degree in 1981. The nurse had indicated that Kematch was in her fourth pregnancy; that her first child lived with his father; that one of her children had died at 2 ½ months of age; and that her second child had been apprehended for three months before being returned to her care.

The hospital social worker met with Kematch on June 28, 2004. A transcript of her handwritten notes of the meeting reads as follows:[563]

> *Mtg w/ Samantha. She currently lives c/l w/ PF McKay & 4 yo daughter. PF is a long distance truck driver. He has older children who live with their mom [redacted]. Samantha does have anxiety w/ this preg b/c of the death of her 3rd child. This child [redacted] had been staying w/ her PF at the time so autopsy info was shared w/ him not Samantha/she had been told the death was pneumonia related but also saw other info that indicates SIDS. Her 4 yo daughter had also lived w/ her PF to Nov/03 when returned to live w/ Samantha she says PF was drinking and left child w/ a cousin who asked her to assume care. PF hasn't been in touch to inquire as to the child's well being but CFS have set mtg w/ her to as she says see if she is "stable". She denies any current etoh/drug use on her part. She had been on EIA but as PF working he will support her. She plans to parent esp newborn w/ PF's help. Has some friend & a brother help for childcare. She had attended Healthy Start Grp. but not now. She would be receptive to PHN fu prenatally for reassurance w/ preg. Aware of prenatal benefit but feels wouldn't qualify w/ PF's job. She lives near [Women's] Hosp so no diff getting to appts. Difficult to talk about [redacted]'s death but receptive to support/med for present preg. Writer will refer to PHN/will review CFS at deliv re: any follow-up plan…*

After the meeting, the social worker made a referral to public health nurse Mary Wu, on June 28, 2004, for follow up with Kematch.[564] Wu had been employed as a Public Health Nurse since 1988.

Wu testified that the services she provided to new mothers were voluntary. Generally, the hospital would obtain the mother's consent before she would receive a referral. The referral usually came after a mother had returned home, but sometimes she would see clients during pregnancy.[565] Kematch's file was such a prenatal referral.

Wu said that if a mother raised other issues, including concerns with other children in the home, she would address them, or refer them to another service provider. She was required to keep files and record any interaction she had with a client or with other agencies. She testified that if she had a child protection concern as a result of her interaction with a client she would report it to child welfare, and had done so in the past. [566]

Wu had a limited recollection of her interaction with Kematch in 2004, but had made a record in her chart, beginning on June 29, 2004.[567] Her notes recorded her conversation with the hospital social worker (SOR #4) on June 28, 2004, in which she was told that Kematch did not like to talk about the loss of her baby or the apprehension of her first child; and she noted that there were "no substance abuse issues" and that the "current partner is a long distance truck driver." In her chart, she listed Phoenix as another child in Kematch's care at the time.

Wu said she filled out a Winnipeg Regional Health Authority Public Health Family Information form,[568] which collects demographic information about people living in a client's home. On the form she listed Kematch, "Wes McKay," and Phoenix Sinclair, and their dates of birth. She didn't remember when she had received McKay's date of birth. [569]

On July 7, 2004 Wu noted that she tried to call Kematch but her telephone had been disconnected. She went to Kematch's home the next day and was told by the caretaker that Kematch had moved without leaving a forwarding address or phone number.[570]

On August 4, 2004 the hospital social worker gave Wu a new address and telephone number for Kematch[571] and Wu was successful in speaking to her by phone. Kematch was receptive, and they agreed to a home visit the next day.

Wu's notes indicate that the apartment was sparsely furnished, but clean, and Kematch was doing well. Wu and Kematch discussed the Healthy Baby and Baby First programs. Baby First taught families how to play with and stimulate their newborns so as to increase attachment. As a Public Health Nurse, Wu tried to encourage bonding and attachment between parents and newborns.[572] She noted that Kematch was receptive and pleasant at that visit.

On September 23, 2004 Wu recorded that she had reserved a spot for Kematch in the Baby First program. When she called Kematch to tell her, "Wes" answered the phone. He said Kematch was at school and he would ask her to call back.[573] There is no indication that Kematch did return the call.

The social worker, SOR #4 met with Kematch again on November 22, 2004, at the prenatal clinic at the Health Sciences Centre. She made notes of their meeting:[574]

> *Mtg w/ Samantha. Continues to live w/ PF & Samantha's 5 yo daughter. PF not working but also not helping w/ childcare or household tasks. Samantha does not plan to bring him for L&D prefers to come on her own. PF's niece lives in same apt block & will care for 5 yo thru hosp. stay. Samantha says she is on social assistance/the apt is in PF's name. She's unsure of long term plan for relationship. PHN Mary Woo who was asked to provide support thru preg visited x one/was to revisit but did not. Samantha has attended couple of Healthy Start Grp meetings at Stella Mission but felt some lack of fit w/ this grp & is not continuing. Her family she "doesn't bother with". CFS met w/ her & said they were closing her file. Samantha lacks a support system. Writer discussed income support services. CFS again re: respite or parent teaching or Family Centre / Family Community Centre discussed (located fairly near her home). Samantha encouraged to utilize community support in light of lack of partner/family support. Writer will cont to support to delivery.*

SOR #4 testified that it was her practice to document an expecting mother's current living situation, including whether there were other children in the home. This information would be relevant in assessing the supports Kematch would need during her pregnancy.[575] She also said that if a client lacked her own support

system (as did Kematch), she would let her know about other supports, including Child and Family Services. Although families were often mistrustful of CFS, it seemed to the worker that Kematch was not resistant to CFS contact.[576]

5.19 PHOENIX IS REGISTERED FOR NURSERY SCHOOL, FALL 2004

In her record of her July 13, 2004 visit with Kematch, Forbes had noted that Kematch said she would be registering Phoenix for nursery school in the fall and, according to Wellington School records, she did.[577] On a school form, which she signed on August 30, 2004,[578] she said that Phoenix was living at the McGee Street apartment. Kematch was named as Phoenix's parent or legal guardian. There was no information about Sinclair.

Another document she signed that day, which was kept in the Wellington School files, listed herself and "Wes McKay" as those who were entitled to bring Phoenix to and from school.

Angeline Ramkissoon, the school Principal at the time, testified that typically after these forms were completed, the teacher and principal would meet with the family and the student. Reviewing the school's records, Ramkissoon found that a meeting had been set for September 4, 2004, but did not take place.[579]

Winnipeg School Division records show entrance and exit dates for Phoenix of September 16 and September 29, 2004.[580] Ramkissoon testified that she never met Phoenix, Kematch or McKay. She also said that none of the professional staff at the school remembered meeting Phoenix; she expected that there would be a record if they had met either her or her parents.[581]

5.20 KEMATCH'S NEW BABY IS BORN, NOVEMBER 30, 2004

5.20.1 12TH REFERRAL: HOSPITAL ALERTS AGENCY OF NEW BABY

Kematch delivered a baby girl on November 30, 2004. A nurse sent a postpartum referral to hospital social worker SOR #4, noting that Kematch lived with her four-year-old daughter and "Wes McKay," and that McKay was not working and was not helpful around the house.[582]

SOR #4 met with Kematch and McKay at the hospital on December 1.[583] She noted the following:[584]

> *PP mtg w/ Samantha & PF. PF did attend for the birth. While tired describes self as generally doing okay PP. Older daughter is with PF's niece for hosp stay. Going well w/ newborn breastfeeding. Eager for hosp D/C / lives just across street from hosp. CFS hx reviewed / currently not involved / file closed July/04. Additional supports were discussed w/ Samantha Nov 22/04. She has info on CFS/Family Centre if decides she wants to seek additional help – PF is fulltime in the home. Aware of Family Community Centre – PHN should fu. Writer to fu to D/C.*

Kematch was discharged from the hospital later that day.

After meeting with Kematch and McKay at the hospital, SOR #4 called the agency to advise that Kematch had given birth to a baby girl. She testified that she made the call because of Kematch's contact with the agency during her pregnancy, and her history with child welfare.[585] Throughout her interaction with Kematch, SOR #4 never saw Phoenix.[586]

Shelley Willox (formerly Wiebe) was the CRU worker who received the call. She made a report of the conversation. Willox had BA and BSW degrees and began working in child welfare in 1999. (References to "Steven" and "Pheonix" are to Steve Sinclair and Phoenix.) Under the heading, "History," she wrote:[587]

> *Samantha became a ward of Cree Nation Child and Family Services in 1993. Samantha was in care as a child due to her mother's alcoholism, neglect, abandonment and abuse.*
>
> *The family has an extensive history with the agency starting when Samantha had her first child [redacted] in '98. [Redacted] was apprehended at birth and eventually became a Permanent Ward. It became apparent that Samantha could not parent once she was provided an opportunity to do so in a supported living situation. In April '00 Samantha gave birth to a second child, Pheonix who was apprehended at birth. Pheonix was returned to parents 4 months later. In April '01 Samantha gave birth to [redacted]. Concerns were expressed regarding alcohol abuse and domestic violence. [Redacted] died in July '01 from natural causes while in Steven's care. Samantha and Steven separated sometime around June '01 and Pheonix remained with Steven until June '03 when she came into care due to parents abusing substances. Pheonix was returned to Steven in October '03.*
>
> *In May '04 an Employment and Income Assistance worker contacted the agency to report that Samantha wanted Pheonix added to her budget as she was in her care. The EIA worker was concerned as she recalled that there were concerns about Samantha's ability to provide care. The EIA worker was not specific in the concerns identified, but simply wanted an assessment completed to determine if Pheonix was safe in Samantha's care.*
>
> *Intake made repeated efforts to meet with Samantha, but was not successful in doing so until July 13, 2004. Samantha denied abusing substances and maintained that she was coping well. Pheonix appeared healthy and well cared for and Samantha did not present as a crack user would be expected to – she was not jittery nor was she thin and drawn looking. She reported that Pheonix came into her care in November '03 due to Steven allegedly abusing substances. Pheonix reportedly stayed with friends for a month or so at the beginning of this year while Samantha "traveled". Samantha declined offers of service, but requested information on resources in the community be sent to her.*

Sinclair and McKay, with his McGee Street address, were listed under the heading "Significant Others." Under the heading, "Presenting Problem/Intervention," Willox wrote:

> *SOR called to report that Samantha was admitted to hospital yesterday and delivered her fourth child, a baby girl by the name of [redacted]. [SOR] states that [redacted]'s birth weight was 3837 grams, and the Apgars were 9 & 9.*
>
> *SOR states that Samantha did receive good pre-natal care prior to the birth of this child, and notes that there are no known health concerns with respect to [redacted] at this time. SOR reports that there was no reported drug or alcohol use during this pregnancy.*
>
> *SOR states that Samantha disclosed that she was previously involved with the Agency back in the summer of 2004, due to concerns with respect to her four year old daughter, Pheonix. SOR states that Pheonix is currently residing in the home of Samantha and her common-law partner, Wes McKay (date of birth unknown). SOR notes that Wes is the father to this new child, and is expected to be a support to Samantha.*
>
> *After reviewing the recorded documentation on CFSIS, this worker consulted with supervisor, Faria, with respect to the Agency's role with respect to this matter. Faria agreed that this matter should be referred to intake for ongoing follow up and assessment of the home environment at this time.*
>
> *On Dec.1/04 this worker left a voice message for the SOR, asking that she reconnect with the Agency to report Samantha's expected date of discharge.*
>
> *On Dec.1/04 this worker contacted EIA to inquire about the demographic information of Samantha's common-law partner, Wes McKay. Worker was advised by EIA that Samantha only has one child listed on her budget, and that there is not expected to be a common-law partner residing in the home. Therefore the date of birth for Wes McKay could not be obtained.*
>
> *On Dec.1/04 at 12:00pm this worker reconnected with the SOR, [redacted] at Women's Hospital at phone number [redacted]. Worker asked [redacted] when the expected discharge date would be for Samantha and [redacted] advised that Samantha might be leaving today after 5:00 pm, or sometime tomorrow, depending on the hospital's need for the bed.*
>
> *The safety assessment is completed and on file. Based on the information provided by the SOR and the Safety Assessment, at the time of writing, is considered as within a 48-hour response.*

The report concluded with "Recommendations:"

> *It is recommended this file be opened for assessment and intervention.*

After receiving the referral, Willox recorded that she consulted with her supervisor, Diva Faria, about the agency's response. Faria obtained a BSW degree in 1992 and had been a CRU supervisor since 2000. Faria agreed with her recommendation "that this matter should be referred to intake for ongoing follow up and assessment of the home environment at this time."[588]

Willox testified that the decision to transfer the file to Intake was based on its history, including the previous apprehensions of two of Kematch's children; the death of one of her children; and concerns about alcohol abuse and domestic violence.[589] She said that a newborn could add stressors to a family, so a referral would allow the agency to see how the family was functioning and whether there was a risk to Phoenix or to the newborn.[590]

5.20.2 CONFUSION OVER ACCESS TO MCKAY'S HISTORY

Willox testified that as part of her investigation she wanted to complete a CFSIS check to determine whether McKay had a history with the child welfare system. For this she said she needed his date of birth. She was not able to get it from the hospital social worker, so she called Employment and Income Assistance on December 1, 2004.[591]

Willox reached EIA employee, Helen Waugh, with whom she had spoken on the phone many times before. She could not recall if she asked Waugh whether McKay had a file himself, but based on her recordings, she assumed that she did not.[592]

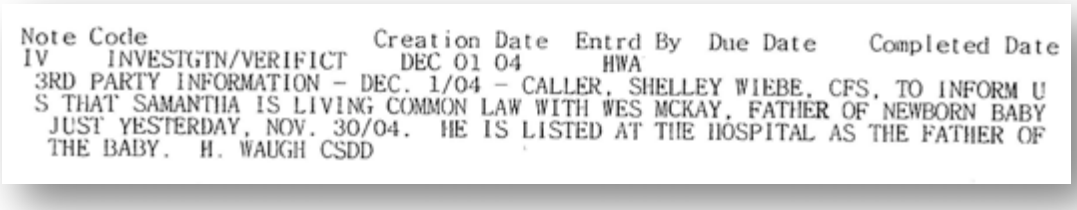
Waugh testified that in 2004, if a child welfare worker asked for information about a particular individual, she provided it.[593] Typically, child welfare agencies would contact her for an address for a client, or to find out if a client was receiving income assistance.[594]

Neither witness had an independent recollection of this conversation.[595]

According to Willox's record, Waugh told her that Kematch had only one child listed on her budget and no common-law partner was expected to be residing in the home, "Therefore the date of birth for McKay could not be obtained."[596]

Waugh testified that whether there was a common-law partner residing in the home was not something she would have discussed with Willox.[597] But if Willox had asked for Wes McKay's birthdate, and if she had it, she would have provided it.[598] She also said that if that request had been made, she would have recorded it.[599]

Waugh documented the conversation as follows:[600]



Note Code | Creation Date | Entrd By | Due Date | Completed Date

IV INVESTGTN/VERIFICT DEC 01 04 HWA

3RD PARTY INFORMATION - DEC. 1/04 - CALLER, SHELLEY WIEBE, CFS, TO INFORM U S THAT SAMANTHA IS LIVING COMMON LAW WITH WES MCKAY, FATHER OF NEWBORN BABY JUST YESTERDAY, NOV. 30/04. HE IS LISTED AT THE HOSPITAL AS THE FATHER OF THE BABY. H. WAUGH CSDD

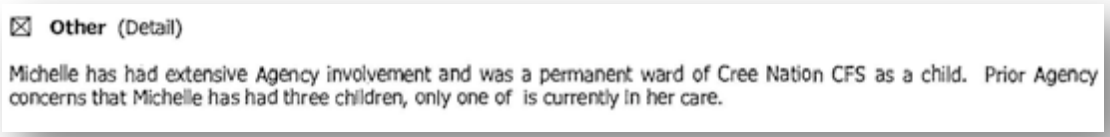
Willox could not recall whether she mentioned Phoenix to the EIA worker, but she said she did know that Phoenix was attached to Kematch's budget.[601]

Based on their respective recordings of this conversation, I find that there was miscommunication between these two witnesses as to the reason for the agency's call. Willox testified she was looking for McKay's birthdate, whereas Waugh understood that Willox was calling to inform EIA of Kematch's living arrangements. Phoenix is not mentioned in the recordings of either witness.

This miscommunication was most unfortunate in light of the evidence I heard from the EIA worker who made the referral to the agency in May 2004, indicating that Phoenix was already on McKay's budget. Those EIA records contained McKay's date of birth. As it turns out, all of this information could have been obtained simply by typing Phoenix's name into the EIA system anytime after May 28, 2004.

5.20.3 INTAKE RETURNS FILE FOR FURTHER INVESTIGATION

After contacting EIA, Willox called back to the hospital to find out Kematch's expected discharge date,[602] which would be a determining factor in assessing response time.[603] She learned that Kematch would be discharged that day or the next, and recommended that the file be referred to Intake for assessment and intervention. In doing so, she took into account not only Kematch's history, but also that she had a new baby and there was a new adult in the home.[604] She considered the age of the children in selecting a 48-hour response time, rather than five days.[605] She recorded her reasons as follows:[606]



☒ **Other** (Detail)

Michelle has had extensive Agency involvement and was a permanent ward of Cree Nation CFS as a child. Prior Agency concerns that Michelle has had three children, only one of is currently in her care.

(Willox testified that the reference to "Michelle" instead of Samantha was a clerical error.)[607] Willox submitted her completed CRU report and safety assessment to Faria for final review.[608]

At this time, Faria was a supervisor in the Crisis Response Unit (CRU) for Winnipeg CFS. She did not have any recollection of her involvement with this file, but believed that there was nothing unique or unusual about it.[609] She said that, based on the nature of the referral, the agency's role was to determine whether there were child protection concerns for any of the children in the home.[610]

She said she agreed with Willox that the matter should be sent to Intake for ongoing follow up and assessment based on the family history; the presence of two young children in the home, including a newborn infant; and the fact that there was a new adult living in the home, who was not Phoenix's biological father.[611]

Faria testified that they would have looked into the information in the referral about the man who was identified as the father of the new infant, but the main focus would be on the primary caregiver. Prior contact checks of secondary caregivers were not required at that time.[612]

Even so, Faria testified that "it was significant to assess any adults in that home that might be providing care to those children," so she would have expected Willox to do a prior contact check on CFSIS for Wes McKay.[613] She said she did not recall if Willox ever reported having done that check,[614] and would not have expected her to record the results, [615] but she understood that Willox was contacting EIA to get McKay's birth date so she could make a definitive identification on CFSIS. This, she said, would be a normal course of action.[616] She described the process as follows:

> *A: . . . . So if I'm an intake worker I'm getting a referral on Samantha Kematch with a common-law partner, Wes McKay, it's automatic that you do a CFSIS check on both names. You just would not do it on one and not the other. But without a birth date there's absolutely -- I mean unless it was a really unusual name, it would be unlikely that she would be able to make a definitive match.*[617]

The evidence as a whole does not support Faria's statement that without a birthdate a definitive match likely could not have been made on CFSIS. If Willox had obtained McKay's full name, the correct record would have appeared in her search results.[618] Her efforts to obtain his birthdate from the EI worker and from the public health nurse were a substitute for seeking identifying information directly from McKay or Kematch. I cannot overemphasize my concern that no one from the agency ever asked either McKay or Kematch for the needed information. Kematch had no hesitation in identifying McKay as her partner in her contact with the public health nurse, with EIA, and with the school where she registered Phoenix for nursery school. If the agency had got the information from her or from McKay, they could have searched his CFSIS records without any difficulty. If the information had been denied to them, that itself would have been a red flag.

I find that the decision by Willox and Faria to transfer the matter to Intake was appropriate. I base this finding on Faria's evidence about risk assessment and the role of CRU. Faria testified about her understanding, as a CRU supervisor, of a young child's particular vulnerability:

Q: And were you aware when you were a crisis response supervisor that a young child had a particular vulnerability?

A: Yes.

Q: What was the reason for that vulnerability?

A: Well, we would be looking at the age of the child but we would also be looking at the developmental capacity of the child. But age of the child was significant, especially if a child was under the age of five, often because they're non-verbal, often because children under the age of five, you know, that can create a stressful home environment as anybody who's parented young children would know and also if those children are not in school or connected to day care, they're, they're isolated and there's less eyes on them in terms of the community being able to identify concerns or be able to collaborate, collaborate information about safety.[619]

Faria confirmed that the child welfare system relies heavily on such sources as health care workers, EIA workers, and members of the public to bring concerns about child protection matters to its attention.[620]

She testified about the reasons why the Crisis Response Unit would refer a file to Intake. CRU workers were involved in urgent matters and were not expected to have long-term contact with a file. They did not have the capacity to conduct the type of investigation that would be done at Intake. If more information were needed before the agency could determine whether there were child protection concerns, according to Faria that would "absolutely" be a reason for referral to Intake.[621]

I find that for all of the following reasons, the recommendation to keep the file open to allow for assessment and investigation by Intake was necessary: Phoenix's young age; Kematch's history; the presence of a new man in the household who had not been assessed by the agency; and the additional stressor of a new baby.

Unfortunately, that recommendation was not followed. The next day, December 2, 2004, Willox received the referral back from Faria for ongoing follow up and assessment by her. There is no explanation in the file as to why this happened, nor could either Willox or Faria recall in their testimony why the file did not go to Intake.[622]

Parsons testified to having some recollection of receiving the file from Faria after the December 1, 2004 referral. She was not able to recall the situation with any certainty, but testified as follows:

Q: -- the specific issue is a file being referred from CRU, sent up to Intake, and then Intake rejecting the file, that's the context, that's -- and you're familiar with that?

A: Yes.

Q: Is, is that something you're able to recall?

A: Not with great certainty. I believe, I believe that the Shelly Wiebe file that came up -- that came up -- that, that was opened as a result of a call from the hospital with the birth of another child, I believe that I saw that intake and had a discussion with Diva (phonetic) about whether or not there was sufficient information to -- for Intake to follow up on that, or whether CRU could make some further inquiries, and -- but I don't have a clear recollection of having that conversation, but when I'm looking at it I'm thinking that that's something that I could possibly have done.

Q: So it's not a -- you don't have a clear recollection, but that might have occurred?

A: Yes.

Q: Okay. And do you recall -- would you have ever actually outright rejected a file --

A: No.

Q: -- from the CRU?

A: No, and I, I don't recall ever rejecting a file from CRU. My recollections are of having conversations with whoever the CRU supervisor was and coming to an agreement one way or the other to either take the file and work on it, or to have, to have CRU do further work.

Q: Okay. So it would be some sort of an negotiated agreement between you and the CRU supervisor?

A: Yes.[623]

Parsons testified that, when the file went back to CRU, she expected that more investigation would be done to get a better understanding of the situation,[624] and that CRU would do a prior contact check on McKay.[625]

Willox's actions once she received the file back from Faria are documented in her closing summary as follows:

Interventions:

On Dec.2/04 this worker received the above referral information back from CRU supervisor, Faria, for ongoing follow up and assessment. Worker was directed by Faria to connect with the mother, offer the family supports, and close the file to CRU – if the Agency is unable to mandate services within the home at this time.

On Dec.2/04 at 2:33 pm this worker attempted to contact Samantha a home number [redacted]. Worker left a voice message asking Samantha to return the phone call.

On Dec.3/04 at 1:03 pm this worker attempted to contact Samantha Kematch at phone number [redacted]. There was no answer. Worker left a voice message asking Samantha to return the phone call today before 4:30 pm at [redacted].

On Dec.3/04 at 1:10 pm this worker contacted the SOR, [redacted] at Women's Hospital at [redacted]. Worker spoke to [redacted] and asked her to provide the discharge date for Samantha. [Redacted] confirmed that Samantha was discharged from the hospital on Wednesday night.

On Dec.3/04 at 1:15 pm this worker consulted with supervisor, Faria, regarding this matter and the Agency's inability to connect with Samantha via phone at this point in time. Faria suggested that worker contact the PHN involved with the family, inquire if Public Health has been out to the home, and if there are no concerns identified by the PHN worker is to close the protection file.

On Dec.3/04 at 1:18 pm this worker contacted the WRHA office located at 490 Hargrave at phone number [redacted], to inquire about the name of the PHN that would service the area of McGee Street. Worker was advised that the PHN assigned to work with Samantha Kematch is Mary Wu at phone numer[redacted].

On Dec.3/04 at 1:25 pm this worker attempted to contact the PHN for Samantha Kematch, Mary Wu at phone number [redacted]. Worker left a voice message asking Mary to return the phone call today regarding her client, Samantha Kematch. Worker indicated that the Agency has some questions and things that we would like to discuss with respect to Samantha.

On Dec.3/04 at 4:02 pm this worker received a return phone call from the PHN for Samantha Kematch, Mary Wu at phone number [redacted]. Worker questioned Mary if she had been out to the family home to see Samantha and the baby yet, and if she has any concerns. Mary advised that she has been to see Samantha since her discharge from hospital. Mary questioned why worker was contacting public health, and asked if Samantha was aware that WCFS was contacting her for information. Worker advised Mary that the Agency has previously had extensive involvement with Samantha, and indicated that Samantha has four children – only two of which are in her care. Worker reported that the Agency has had some pretty serious concerns in the past, and is wondering if public health as any concerns at this time. Mary advised that she has been recently advised at training sessions that she is not to share information with WCFS due to PHIA. Worker advised Mary that the Agency has attempted to contact Samantha on two occasions now, and notes that if Samantha is to check her voice mail she will see that the Agency is trying to contact her. However worker advised Mary that the Child and Family Services Act supercedes PHIA, and indicated that any professional is obligated to contact WCFS to report risk to a child if there are concerns. Mary advised that she is aware of this, but has been advised at recent training not to discuss cases with WCFS. Mary indicated that WCFS does not share information with public health due to the confidentiality act. Worker indicated that all the Agency is asking at this time, is if Mary has been to the home and if she has any concerns.

Mary advised that she would like to contact Samantha before answering this question, to advise her that WCFS is calling her asking for information. Worker again advised Mary that she is obligated to report any child protection concerns to the Agency, and therefore questioned Mary why she would not simply come out and say that she does not have any concerns if she is not willing to report a risk to the child. Mary indicated that she can not say at this time. Worker asked for the name of Mary's supervisor, so that future incidents such as this – that involve a lack of communication between Agencies, can be rectified at the managerial level. Mary indicated that her supervisor is Nettie Strople at phone number [redacted]. Worker provided Mary with the name of the CRU supervisor, Diva Faria, at phone number [redacted]. This information was provided to Faria for ongoing follow up.

Recommendations

After consultation with the public health nurse, and a review of the information attached on CFSIS, it was determined that there does not appear to be a known risk to the children residing in Samantha's care at this time. Therefore the matter is being closed at CRU, until further information or a request for services is brought to the Agency's attention.

The summary is signed by Willox (Wiebe), as CRU social worker; and by Faria, as Unit Coordinator.

As her note of December 2, 2004 shows, when Willox received the file back from Faria, her instructions were to connect with Kematch, offer supports, and then close the file "if the Agency is unable to mandate services within the home at this time." She testified that this meant that unless the agency was able to identify child protection concerns, the file would be closed.[626]

When Willox could not reach Kematch by phone, Faria suggested that she contact the family's public health nurse to see if she had been to the home. If that nurse didn't identify any concerns, Willox was to close the file even without having connected with Kematch, or seeing the children.

5.20.4 AGENCY RELIES ON PUBLIC HEALTH NURSE FOR FAMILY CONTACT

I am troubled that the agency's attempts to connect with the family at this point were limited to phone calls and voice messages. No one physically left the office to visit the home.

Willox's counsel pointed to evidence that both Intake and CRU at this time were operating under overwhelming workloads. CRU was sometimes asked to keep referrals longer than the usual 24 to 48 hours, and to increase its investigative work. I am told that the pace at CRU was often hectic and stressful, and sometimes the unit had to function at below the required staff level. Willox said CRU was overworked and lacked proper resources to provide services. This may, in a general way, explain how CRU was functioning, but the evidence was that half of CRU's workers at any given time were assigned to field work and there is nothing in the

evidence to explain why no CRU worker actually went to the family's home between December 1 and December 7, 2004, when the unit had conduct of this file. This was most unfortunate, given the still-unresolved issues relating to Kematch's parenting capacity and motivation, and now the addition of a new baby and a new partner in the home as well.

As for relying on the public health nurse to identify child protection concerns, Faria testified that the standard at the time allowed for the use of reliable collateral sources of information to confirm the safety of a child in situations where no actual protection concern was mentioned in the referral.[627]

In her testimony about her contact with the public health nurse, Willox relied on the records she made at the time,[628] because she had no independent recollection of that conversation.[629] She had noted that she advised the public health nurse that the agency had had "some pretty serious concerns in the past" and was wondering if public health had any "concerns" at that time; she could not recall whether she made specific reference to "child protection concerns."[630] With no specific protection concern identified in the December 1, 2004 referral, she was following up as a precaution, based on the family history.[631] She also testified that she was primarily focused on the new baby and may not have specifically asked Wu about Phoenix.[632] She was unsure whether she had any indication that Wu was even aware of Phoenix's existence.[633]

According to Wu's record of the telephone conversation, her response was that she had recently learned at training sessions that she was not to share information with the agency because of *The Public Health Information Act*. Wu told Willox that she needed to speak to Kematch before answering Willox's questions. Her note read: "Advised writer did not have concerns w/ family & further discussion is prohibited w/o client's consent."[634]

Wu testified that if Willox had asked her whether she had seen Phoenix, she would not have been permitted to share this information.[635]

Willox testified that from their conversation, she understood Wu to be saying that, as a public health nurse, she understood her obligation to report any child protection concerns[636] and she had no such concerns. She testified as follows:

> *Q: What did you understand to be the situation with the family by the end of your conversation with Ms. Wu?*
>
> *A: Ms. Wu had been out to the family home, had seen Samantha and the new baby. Had provided the services that she does as a child -- as a public health nurse. She did not, she knew she was obligated to report and did not have protection concerns at that time to report.*

Q: So was it your understanding, by the end of your conversation with Ms. Wu, that she did not have child protection concerns?

A: Based on the way I have recorded this, yes, my assumption is that she knew she was obligated to report if she had a protection concern but she was not reporting any at that time.[637]

Willox said that when Wu spoke of needing to seek Kematch's permission, she understood her to mean that she needed permission to discuss her involvement with Kematch generally—not that she needed permission to say whether she had child protection concerns.[638]

Although she could not remember a specific discussion with Faria, Willox believed she shared with her the outcome of this conversation, and her frustration in trying to obtain information. She believed that she shared Wu's supervisor's name and phone number with Faria so she could follow up on the information that she had been unable to get from Wu.[639]

Willox said she did not get back to Wu to ask whether she had received Kematch's consent to speak with the agency, because no protection concerns had been identified. She believed that Faria would follow up at the supervisory level and would let her know if more was required from her.[640]

Wu's notes indicate that she told Kematch about her conversation with Willox during a home visit three days later, on December 6, 2004.[641] She received Kematch's consent to share information, should the agency call again but she didn't phone Willox back at that point, because she had no child welfare concerns to report.[642]

Willox did not recall whether she asked Wu for McKay's date of birth, which she had been unsuccessful in obtaining from either the hospital social worker, or EIA worker Waugh.[643] Neither did Wu remember whether Willox asked any questions about McKay at all.[644]McKay's date of birth was, in fact, recorded in Wu's file,[645] but Wu said she would not have been permitted to give it to Willox.[646]

5.21 AGENCY CLOSES FILE: "NO KNOWN RISK"

5.21.1 NO PRIOR CONTACT CHECK IS DONE ON MCKAY

Willox did not recall whether she did a prior contact check for McKay.[647] She could not remember whether Faria asked her to do it, or if she discussed McKay with Faria at all.[648] She knew at that time that it was important to assess a new adult living in the home with a child, and she expected that the file would be referred to Intake where a thorough assessment would be done.[649]

But a week after her recommendation that the file go to Intake, with Faria's approval, Willox recommended on December 7, 2004, that the file be closed:

After consultation with the public health nurse, and a review of the information attached on CFSIS, it was determined that there does not appear to be a known risk to the children residing in Samantha's care at this time. Therefore this matter is being closed at CRU until further information or a request for services is brought to the Agency's attention.[650]

When asked what happened between December 1 and December 7 to bring about this change, Willox testified:

> A: *Well, I guess a variety of things, one of which the file did not proceed to intake, as I had originally recommended. In fact, it was returned to me the following day on the first day of backup for me to do additional follow up, to contact Ms. Kematch, via phone, as requested by my supervisor, to offer her supports. When that course of action did not work, I had gone back to Diva to request -- or to inquire about what other course of action she would like me to take and at that point she asked me to connect with Public Health and in doing so I, as I documented, gathered the information that I did from Ms. Wu, and as there were no protection concerns being reported from the source of referral or from Ms. Wu, at that point in time, as per Diva's recommendation, that if services could not be mandated whereby a child protection concern was not identified, to close the matter at CRU.*[651]

The Inquiry heard no evidence that the agency ever—in the context of its services to Phoenix and her family—accessed or reviewed the information it had in its own files about McKay's disturbing history. This was a major failure by the agency.

5.21.2 NO ONE SEES PHOENIX

Willox confirmed that at the time she recommended the file be closed, the agency had not seen Phoenix and she had no information that the public health nurse, or anyone else, had seen her.[652] She said she essentially relied on her telephone conversation with Wu and the information provided by the hospital social worker to determine that there were no child protection concerns.[653]

Wu's notes indicate that she had visited Kematch on December 2, 2004, after receiving a postpartum referral. "Wes" was at home, awaiting surgery for a pancreatic cyst, and he was receptive to the home visit, according to her notes.[654] Wu could not recall if she asked about Phoenix at that visit, and there was no indication in her notes as to whether Phoenix was present. Her primary focus was on Kematch and not on assessing child welfare concerns.[655]

Wu testified that she was aware that Kematch had another child in her care, but she didn't know at the time that the child was Phoenix. Her notes do not contain any reference to a child other than the new baby.

Wu's visit to Kematch on December 6, 2004, during which Wu had asked for her consent speak with CFS, was their last contact. Wu's notes show that she left voicemail messages for Kematch on December 7 and December 9, 2004, to schedule another home visit. On February 25, 2005 Wu wrote a letter saying that

the file would be closed if Kematch failed to contact her by the end of March. Wu heard nothing back and closed her file for Kematch on May 26, 2005.[656]

Faria did not have any recollection of following up with Wu's supervisor after Willox's conversation with Wu. She testified that information-sharing issues with Public Health were not uncommon, but she would not have closed the file before speaking to the supervisor if Willox's conversation with Wu had led her to believe that there were any protection concerns.[657]

Faria confirmed that the December 7, 2004 CRU report, which was her basis for authorizing closure of Kematch's Protection File, contained no information at all about Phoenix.[658]

Faria testified to a number of factors that led to her decision to close the file:

- no new child protection concerns;
- no concerning information about the common law partner;
- no report of child protection concerns by the public health nurse who had visited the home;[659] and
- regular prenatal care with this pregnancy, and the birth of a healthy infant.[660]

5.21.3 FILE CLOSING FAILS TO PROTECT PHOENIX

There are a number of areas in which the agency failed in its mandate to protect Phoenix between December 1 and December 7, 2004, while this file was open. Most significant is the inexplicable reversal of its decision to keep the file open for thorough assessment and investigation by Intake. The decision to refer to Intake had been based on identified risks to Phoenix's safety and well-being. But instead of the file going to Intake for further work, the agency closed the file without any contact at all with the family, and with none of its workers having laid eyes on Phoenix.

Supervisor Faria testified that child welfare standards at the time allowed the agency to rely on Wu's information to determine that there were no child protection concerns.

Jay Rodgers was CEO of the agency at the time of this file opening. He was asked for his understanding of the standard Faria relied on, which stated ". . . the worker ensures the safety of the child either through direct contact or through confirmation of the child's safety by a reliable source." He said that what would make a "reliable source" an appropriate substitute for the worker's direct contact would be the source's own contact with the child. He thought that the standard referred to immediate safety, and not whether there might be ongoing concerns that would require further investigation.[661] On December 1, 2004 the agency certainly had been of the view that there were concerns requiring further investigation.

The information that the public health nurse was able to share with the agency was limited by *The Personal Health Information Act*. With no reason to believe that she had even seen Phoenix, the agency should not have relied on her observations as a substitute for conducting its own assessment. The onus was on the agency to do its own investigation. I fail to understand why, between December 1 and December 7, 2004, the agency made no efforts to go to the home, assess the family, and ask for the information it needed about McKay so it could do a CFSIS check and learn of his child welfare history.

The agency's communications with EIA also bears comment. Throughout the Inquiry, the evidence was clear that the agency, and the child welfare system as a whole, rely on information from collateral sources such as EIA and public health nurses to bring child protection concerns to its attention and to assist in its investigations.

It appears that Willox did not ask appropriate questions of the EIA worker. Specifically, she did not ask what information EIA had about Phoenix, and whose budget she had been on. An EIA search of Phoenix's name at this time would have shown her to be on McKay's budget. Linking Phoenix to McKay would have yielded the information the agency was seeking about the identity of the man living with Kematch, including his date of birth. EIA supervisor Timothy Herkert agreed with the statement that with "a few clicks of the mouse," a worker could have found out each person on whose budget Phoenix had been listed.[662] The identification of McKay would then have allowed for a CFSIS search of McKay's contact with the child welfare system. Unfortunately, it seems that CFS workers did not understand how the EIA recording system worked. Such knowledge would certainly have facilitated CFS's child protection investigations.

In her final submission, counsel for Faria submitted:

> *CRU was not structurally or operationally designed to conduct full investigations, like those conducted at tier two Intake and Abuse levels (Faria, January 21, 2013, p.24). It was a crisis response unit, dealing with high risk, emergency matters. Operationally, the responsibility was short term involvement, it did not have the same capacity to hold cases and do extensive types of investigations. That was done at Intake (pp. 200-201). CRU managed grave and serious cases as they were all within immediate to 48 hours response times. They were all high risk, complicated, and difficult cases to manage (p. 21).*[663]

I acknowledge and accept that CRU was not designed to conduct full investigations. But part of its role as a "triage" unit was to identify when a matter needed to be transferred to a unit that could do the required assessment and investigation. In this case, after having first decided to do just that, the agency satisfied itself that its earlier child protection concerns were no more, and closed the file.

At the time it closed the file the agency had not spoken with or seen Kematch, McKay, or Phoenix. It had no information about Phoenix's well-being from any reliable source, the public health nurse never having indicated that she saw or knew about Phoenix; nor did it investigate whether McKay had a history with the child welfare system.

5.22 PHOENIX'S HOME LIFE, THROUGH THE EYES OF OTHERS

Friends and family members who saw Kematch and McKay and the children during this time grew concerned for the family. A number of them told the Inquiry about their observations of the couple's relationship and parenting style, and about their concerns for Phoenix, especially after the birth of the new baby.

5.22.1 KEMATCH AND MCKAY AS PARENTS TO PHOENIX, BEFORE AND AFTER BABY

A relative of Kematch, who testified as SOR #10, said she met Phoenix on the day she was born. She testified that she began looking after her in the summer of 2003. She knew Kematch, Sinclair, Edwards, and Stephenson. [664]

When asked about Kematch's relationship with Phoenix in early 2004, this witness said she never saw any physical abuse but "she wasn't a good mother. She was very mentally and emotionally abusive to the little girl." She said that when apart from her mother, Phoenix was "a loving little girl" who liked to dance and play. But around her mother, she was timid and withdrawn. "She would go to her own little place and stay there."[665]

By early 2004, Kematch was in a relationship with McKay. This witness met McKay a "handful" of times. She knew he was a truck driver and "knew he liked his alcohol and he was physically abusive with Samantha."[666] She said she saw Phoenix for the last time in the spring of 2004.[667] Kematch brought her new baby to visit when she was about two months old, and continued visiting about once or twice a month for a time, but Phoenix was never with them. Whenever she asked about Phoenix, Kematch always said she was with McKay's niece.[668]

Ashley Roulette was one of McKay's nieces. Her mother was McKay's sister. She said McKay was close with her family but she described him as "mean." She knew him to be violent with women and children.[669] She said it was "scary" when McKay looked after her as a child. When she was 15 or 16 years old, in 2003 or 2004, she said, McKay punched her in the face, leaving her with two black eyes.[670]

She testified that she had met Kematch and Phoenix through other family members before they moved into the apartment with McKay in early 2004. She remembered that the first time she met Phoenix, "she was really happy;" she always wore "a little bucket cap," she had shoulder length hair and chubby cheeks and was "happy, joyful, like any other normal kid." She said Kematch was playing with Phoenix and having fun, "what any other mother would look like with their child."[671]

In 2004 and 2005 Ashley lived in her sister Amanda McKay's apartment, on the third floor at 747 McGee Street, where Kematch and McKay were living together in a first floor apartment. During the time that they lived in the same building, Ashley spent time with Kematch, and sometimes with Phoenix, she said.[672] For about a month after Kematch and Phoenix moved in, Ashley would visit them about twice a week, she said.[673] She noticed that Phoenix's behaviour and appearance had changed from their first meeting. She seemed quiet, her hair was shorter, and she had a bruise on the side of her face.[674] Ashley said she asked about the bruise and was satisfied with Kematch's explanation that Phoenix had fallen.[675] She recalled having concerns about Kematch's relationship with McKay. She remembered seeing Kematch with a black eye, and sometimes she would not see her at all for a few days.[676]

When Ashley visited Kematch and McKay after their baby was born, Phoenix would be in the apartment's one bedroom. Kematch would say that she was there because "she wasn't listening," or "she was being bad." Ashley remembered a "chain link" lock above the door handle to the bedroom. She never saw Phoenix outside of the bedroom during any of these visits, nor did she ever see Phoenix being allowed to use the bathroom, so she would have "accidents" in the bedroom.[677]

The woman who testified as Doe #4 was McKay's older daughter. She and Kematch had lived in the same building on Furby Street in late 2003 and she remembered Phoenix as a happy little girl who played with her son. After Kematch moved to McGee Street, Doe #4 would see her there, at Amanda McKay's apartment in the same building. Doe #4 babysat Phoenix a couple of times at Amanda's apartment. She said that by this time, in 2004, Phoenix was quieter. She seemed smaller and had a couple of bruises.[678]

Lisa Bruce was another niece of McKay, and a cousin to Ashley Roulette and Amanda McKay. Bruce had known McKay throughout her life and said she had had a close relationship with him, although she had seen an abusive side to him when she was a child: she had seen him push and swear at one of his former partners, the woman who testified as Doe #3.[679]

Bruce first learned that McKay was in a relationship with Kematch around May 2004. He brought Kematch and Phoenix with him one day when he was teaching Bruce to drive. At a restaurant Kematch and McKay bought a sandwich for Phoenix and Bruce said they treated Phoenix well that day, although they did once grab her roughly when she began to "veer off" as they walked on a downtown street. Bruce described Phoenix that day as a "happy kid, chubby cheeks, and she had nice, long hair."[680]

Bruce was 17 at the time and had her own apartment in the same building on McGee Street. She said she babysat Phoenix there six or seven times before the new baby was born in November 2004.[681] A couple of times, Ashley Roulette or another

cousin was with her. Bruce recalled that initially Phoenix was well behaved, talkative, had a good appetite and did not have any problems using the toilet.[682]

After the new baby was born, Bruce noticed Phoenix become quieter and more distant. She did not look happy. Her physical appearance changed and she became pale and seemed to be getting "skinnier," Bruce said.[683] When asked to compare McKay and Kematch's treatment of the new baby, with their treatment of Phoenix, she said:

> A: *It was like they just pushed Phoenix aside and they were, like, overprotective of their baby.*[684]

McKay became "more stern" and "more violent" toward Phoenix, Bruce testified. One day, as they were sitting down for dinner, McKay "out of nowhere grabbed her hat off her head and threw it on the ground. And it kind of looked like he, like, kind of grabbed her hair at the same time."[685]

She noticed that Kematch "started calling her down more," in front of others. She would call Phoenix "a little whore or a little bitch."[686] When Bruce was asked whether she had ever seen Kematch being physically abusive of Phoenix, she had this to say:

> A: *On one occasion I know when Phoenix was going around the, the baby, she went and grabbed Phoenix and pushed her and was calling her a little slut, like, pushed her towards the ground.*[687]

She said she had seen Kematch use crack cocaine, "maybe twice." The first time was after the new baby was born: McKay was working away and he had phoned and asked her to check up on Kematch.[688]

Bruce first noticed a chain link lock above the door handle on the bedroom door "not too long after the baby was born."[689]

She said she saw Phoenix with a black eye, around February 2005. When she asked about it, Kematch and McKay told her that Phoenix had fallen. When she saw bruising on Phoenix's face a second time and Kematch and McKay told her that Phoenix had hurt herself, she did not believe them.[690]

Jeremy Roulette was Bruce's brother. He was a foster child of the woman who testified as Doe #3, and he grew up with her children. Doe #3 had lived with McKay for a time and had two sons with him. (They testified as Doe #1 and Doe #2.) McKay was in their household from the time Jeremy was six or seven years old until he was nine or ten and was abusive to him during that time, he said.[691]

Jeremy didn't have much contact with McKay again until early 2005, when some of his family members were living in the apartment building on McGee Street. During that time he visited Kematch and McKay and their new baby a couple of times a week, but never saw Phoenix allowed out of the bedroom. She would try to come out, he said, but Kematch and McKay would put her back, and sometimes "they would put her in there pretty rough."[692]

Amanda McKay was another of McKay's nieces, and a sister to Ashley Roulette. She also saw changes after the new baby was born. She said Kematch became "distant, like she didn't care," in her parenting of Phoenix. She would yell at Phoenix "for nothing." She said, "Phoenix changed a lot because she wouldn't talk anymore. She wouldn't even look at me sometimes."[693] When she asked Kematch and McKay about a bruise on Phoenix's face, they told her that she had slipped and fallen in the tub.[694] She said she once saw Phoenix being made to sit on the toilet all day:

> *A: I walked in and I asked where Phoenix was, they said she was on the toilet and I asked why. And they said because she peed herself so they were making her sit there all day.*[695]

A friend of Kematch testified as SOR #9. She said she noticed that after the new baby was born, Phoenix was always in the bedroom and the door was usually closed.[696] She testified that she called CFS at one point because of Kematch's lack of patience with Phoenix.[697] She said she gave Kematch's name and address and asked the person who answered the phone "to see, to go check on her, like, that she was, I don't know, like, neglected, kind of. Like, she was always in the room and . . . I don't even know if she had – just, she wasn't, like, she wasn't being cared for. Like, she was, but she wasn't."[698] SOR #9 could not recall exactly when she made the call, but believed it was about a month or two before Kematch and McKay moved to Fisher River in the spring of 2005.[699]

When asked whether CFS contacted Kematch, she said she didn't know whether this was in response to her call, but Kematch told her that CFS had knocked on her door and she had made up a story—that she had company—and refused to let them in.[700] SOR #9 was questioned about her response to this information from Kematch:

> *Q: And she told them that she had company when, in fact, she really didn't; right?*
>
> *A: Yeah.*
>
> *Q: And did that cause you some suspicion, as to why she wouldn't want them to come in and see Phoenix?*
>
> *A: Yeah.*
>
> *Q: And you, of course, had already called CFS by that point; right?*
>
> *A: Yeah.*
>
> *Q: You ever think about calling them again about what Samantha had now told you, how she tried to dodge them and pretend she had company?*
>
> *A: No.*[701]

The agency's files do not document a call from this witness, but they do record a visit to Kematch's apartment in March 2005 when Kematch refused to let workers in, on the basis that she had company. More will be said about that visit later.

Although counsel for the Department and agency did not cross-examine this witness, in its final submission the Department argued:

> *Another issue related to information gathering is that of the alleged calls to CFS. There are six instances of witnesses claiming to have notified CFS about Phoenix Sinclair, but the CFS records do not have any record of such calls. If these calls were, in fact, made and ignored by a child welfare agency, that would be of grave concern to the Department and to the administration of any CFS agency. However, in many cases the alleged caller was unable to identify who they spoke to and which agency was involved. Further, no one has explained why a CFS Agency (whose job it is to receive child protection calls) would not take a call, would make no record of the call and would refuse to act on the information. Quite simply, this does not make sense. It is submitted that the totality of the evidence on these alleged calls suggest that either there was no call at all or no caller ever raised a child protection concern.. . .*
>
> *The third alleged notification to CFS is by SOR No.9 in March 2005. SOR No.9 gives only a vague description of the information she says that she told CFS. She does not recall what number she said she called, who she talked to, when she called CFS, or what the person at CFS said to her. The details of this alleged call are too vague, it is submitted, to draw a conclusion that a child protection call was indeed made to CFS as alleged.*[702]

Although this referral does not appear in CFS files, I accept the witness's testimony that she made a call to CFS. Other aspects of her testimony are consistent with the totality of the evidence. Her evidence about seeing Phoenix in the bedroom is consistent with the evidence of a number of witnesses, and her evidence about Kematch's interaction with the agency in March 2005 is consistent with the agency's records.

Kematch's friend who testified as SOR #5, has been mentioned earlier. She had become friendly with Kematch and the witness who testified as SOR #6 when the three lived at a facility for pregnant teens in 1998. She reconnected with Kematch at the Healthy Baby Program in 2004 and they stayed in touch throughout that summer.[703] She provided some insight into Kematch's behavior towards Phoenix during that time.

Kematch would come to her house on occasion, but brought Phoenix with her only once. When asked about Phoenix, Kematch would say that she was with family, or with McKay. SOR # 5 said she was concerned about Phoenix being with McKay so often, considering she was not his child.[704] The witness told of one summer day when Kematch did bring Phoenix to her house. She said that Phoenix was "quiet and polite," but Kematch got angry with her for getting her clothes dirty.[705]

According to her testimony, the only other time SOR # 5 saw Phoenix was sometime in the fall of 2004. They were walking together to a bus stop and Kematch was having Phoenix mimic her by saying things like, "I'm a fucking bitch."

She didn't remember ever seeing Kematch holding Phoenix's hand as they walked.[706]

Around Christmastime 2004, Kematch came to her house. She had gifts with her from someone else, to be given to Phoenix. Kematch was curious to see the gifts, so she opened them herself. When she left she didn't take the gifts with her, saying that Phoenix was too bad and didn't deserve them.[707]

SOR #5 testified about a visit that she and SOR #6 made to Kematch's apartment in the winter of 2004/2005. Kematch's new baby was there, but she didn't see Phoenix. The three women decided to go downtown together, with the baby. She said that before they left the apartment, Kematch locked the bedroom door, reaching up to use a lock that was separate from the door handle. Shortly after they arrived at their destination, Kematch said she had something to do, that she was going home, and left.[708]

SOR #5 said that Kematch once stayed overnight at her house toward the end of 2004 or early in 2005. Her understanding was that Kematch was intending to leave McKay, but she went home next morning. Phoenix was not with her.[709]

5.22.2 FRIENDS CALL THE AGENCY WITH CONCERNS FOR PHOENIX

SOR #5 said she had concerns about Phoenix, after hearing from Kematch that Phoenix was touching herself and "acting out." She also testified that Kematch told her that Phoenix was wetting the bed.[710] She said she told her own social worker, Della Fines, about her concerns in the winter of 2004-2005, and Fines told her to call Intake:

Q: Do you remember what you told her?

A: I remember telling her that I had concerns about Phoenix. And she told me to call intake.

Q: Do you remember whether you were more specific in talking to Ms. Fines about your concerns or did you just say you had concerns about Phoenix?

A: I'm pretty sure I told her that I was concerned about Phoenix being around Wes so much, more concerned that Wes was not her dad.

Q: And Ms. Fines told you to call CFS intake?

A: Yeah.

Q: We're going to come back to your discussion with Ms. Fines in a minute. Did you call intake?

A: Yes.

Q: Do you remember what number you called?

A: 944-4050.

Q: And how did you know what number to call?

A: Because that's the number I called when I put myself in care.

Q: Do you remember what time of year you made the call?

A: In the winter. I remember it being like.. don't remember when, though. Pretty sure it was winter.

Q: Do you remember what time of day you made the call?

A: It was in the evening.

Q: Do you remember what phone you used?

A: No. I'm pretty sure I used a cell phone, though.

Q: Do you remember who the cell phone was registered to?

A: It would have been my ex-husband.

Q: Are you certain that you used a cell phone?

A: I'm pretty sure I used a cell phone. I don't – I never really had a house phone because I had a cell phone.

Q: Was anyone with you when you made this call?

A: I can't remember.

Q: Can't remember whether you were alone or whether you had anyone with you when you made the call?

A: I'm, I'm pretty sure SOR 6 was with me when I made the call.

Q: Now, do you remember what information you gave intake when you made the call?

A: I told intake I was concerned about Phoenix and that I was, I thought that somebody should go and, like, check on them. And the intake worker asked me what my name was, and I told her I didn't want to tell her, I would like to remain anonymous. And she said that unless I gave her my name she couldn't take my complaint seriously.[711]

On cross-examination, counsel for the agency referred SOR #5 to the statement she gave to the RCMP in March 2006, shortly after Phoenix's death was discovered,[712] and she confirmed that the statement accurately recorded the details of her conversation with CFS:

Q: Thank you. And this statement would have been given in 2006, in March, which was just a little bit over a year after the, after the events in question occurred. This call to Winnipeg CFS was in early 2005. We're now in March of 2006, so a little bit more than one year later you're being brought in to the RCMP office and you are giving them a statement. I'm suggesting, one -- I'm suggesting to you that your, your memory would have been better in 2006 than it is today, in 2013. That fair?

A: Yes.

Q: And if we look at the bottom half of this page, you'll see the RCMP officer's name, looks like Rouire, and there's a long transcript of your answer. And the second paragraph, at the bottom of the page, it's, it's evident that they're talking about, you're talking about this call to CFS. You said:

"... called CFS at the beginning of 2005 in the winter, it was after New Years. ... I told CFS, you know, 'We have concerns."

et cetera. So that's -- I'm just identify. It's, it's about the same incident here that you testified to this morning, which is your call to CFS, correct?

A: Say that again?

Q: You're describing --

A: (Inaudible) --

Q: There was only one time that you called Winnipeg CFS after-hours and this was that one time, correct?

A: Yes.

Q: Yes?

THE COMMISSIONER: What you're being asked --

THE WITNESS: Yes.

THE COMMISSIONER: All right.

BY MR. MCKINNON:

Q: And if you see about halfway down that page -- sorry, halfway through that paragraph, they said, and it's in quotes:

"'Well then how come you're calling us?'"

And you said:

"I was ... 'Because there's something wrong with the little girl.' And I said, 'It doesn't take, you know, rocket science to figure something out. Like her little girl can't use the bathroom properly."

So the first thing you, you told the RCMP that you reported to Winnipeg CFS was that the little girl can't use the bathroom properly. That's the first thing you said when you called Winnipeg CFS, was the bathroom issue?

A: I don't recall it being the first thing I said.

Q: And then you said the little -- sorry, you said:

"[She] barely talks to anybody."

And then you said:

"She does whatever her mom says.'"

And then you go on to say --

A: Okay.

Q: You go, on the next page you say:

"You know like, she was so obedient. I thought maybe Sam was ... like ... really kick-ass mom because, you know, when Phoenix came to ... like I only seen Phoenix [on these] two times. . . .

THE COMMISSIONER: See, see, Witness, what those three things that Mr. McKinnon has just outlined are things that are recorded as having been said by you to the RCMP when they interviewed you in 2006 or thereabouts, and the question is whether you agree that those are the things that you told the CFS when you made your call about Phoenix.

THE WITNESS: I will agree.[713]

Further material from her statement to the RCMP was read to the witness:

Q: So then the next page, the constable says:

"What exactly did you tell them?

I told them about her not using the bathroom properly and how she's always with Wes, and . . . concerns about getting locked up."

So those are other things that the RCMP statement contained as to items that you told CFS.[714]

The statement indicates that she told the RCMP that the call was made near her birthday,.[715] which was at the end of February. This was consistent with her testimony at the Inquiry.[716]

SOR #5 testified that over the past eight years she had had a number of cell phones with different numbers and she could not remember which phone she used to make the call to CFS. She also said she may have called from a landline. She believed that CFS would have kept a record of her call.[717]

She testified she had been reluctant to give her name to CFS because Kematch was a close friend, and she didn't want her to find out that she had made the call.[718]

SOR #6 had become friendly with Kematch and SOR #5 when they lived together at a facility for pregnant teens and she and Kematch stayed in touch after they left, in 1999.[719] They lost contact around 2001, but reconnected sometime in 2004 when Kematch contacted her, looking for cigarettes. It was then that SOR #6 met Phoenix, whom she described as "happy and carefree."[720]

She remembered the same visit to Kematch's apartment that SOR #5 described, in December 2004 or January 2005. She did not see Phoenix that day but she did notice a pair of toddler's boots by the door. They still had a tag on them and were attached with a string, as they would be in a store. They looked like they had never been worn, she said. The three women planned to go downtown with Kematch's baby, but before locking the door to the apartment itself, Kematch locked her bedroom door, using a lock that was separate from the handle.[721]

On another occasion that winter, SOR #6 was at Kematch's apartment when the two decided to walk to the corner store. She testified that Kematch bundled up the baby and carried her. After they returned, SOR #6 heard a sound, like someone crying or a sick child moaning, coming from the bedroom. She said Kematch went into the bedroom. A few seconds later the moaning stopped, and she came out. The sound didn't come from Kematch's baby, who was in the living room.

SOR #6 said she did not see Phoenix that day.[722] Kematch told her that Phoenix was with Sinclair's sister.[723]

SOR #6 testified that she never witnessed Kematch physically or verbally abuse Phoenix and she never saw Phoenix misbehave.[724] But once, while talking with Kematch on the phone, she overheard her speak to Phoenix in a way that concerned her: Kematch was bathing Phoenix at the time and told Phoenix that if she wouldn't "play with" herself so much, she wouldn't "stink so much."[725]

She said she discussed her concerns with her foster mother, SOR #7, and with her friend SOR #5, beginning sometime during the winter of 2005.[726] She testified that she and SOR #5 tried to notify CFS of their concerns. Specifically, she said she was present when SOR #5 made the phone call to CFS that is discussed above. Her understanding was that CFS wanted their names, which made her uncomfortable. But because they did not give their names, she was not certain that CFS would follow up on their concerns.[727]

More will be said later about my findings with respect to this call. However, it is apparent from the evidence that these two witnesses had concerns about Phoenix's safety and well-being and that these concerns needed to be investigated by the appropriate authorities. Such investigation did result from another call to the agency, which is discussed immediately below.

5.23 FRIENDS RELAY CONCERNS FOR PHOENIX, SPRING 2005

5.23.1 KEMATCH INTENDS TO LEAVE WINNIPEG

SOR #6 testified that she told her former foster mother, SOR #7, about the concerns for Phoenix that she and SOR #5 shared, and about their call to CFS:

A: … I ended up calling SOR 7.

Q: Your foster mother?

A: Yes.

Q: And what –

A: Because…

Q: Did you say to her?

A: I just told her I had some concerns and that we, me and SOR 5, that, we didn't feel that they were going to – that CFS wasn't going to do anything because we didn't want to give our names to them. And I just thought that – I told SOR 7 that I thought she would be able to get through to them because she works with them and works for them.

Q: Do you remember if you were specific about what concerns you had when you talked to your foster mother?

A: I, I honestly can't remember what I – word for word. But I know I told her I was concerned, and I just wanted someone to check.

Q: Do you know if SOR 7 did make a call to CFS?

A: Yes.

Q: How did you find that out?

A: Because one of, on one of the occasions when I spoke to Sam after that, after SOR 5 and SOR 7 phoned CFS, that I remember Sam phoned me and she was pretty upset and angry, and she said that CFS came to her door twice. . .

A: And she said she thought it was that lady down the hall in her apartment that they're living at. I don't –. . . .

Q: When you found out that CFS had contacted Samantha, how did you feel about that?

A: I felt like, I felt kind of relieved that at least they were involved and, and if, if anything was going on that they'd find it out and do something.[728]

SOR #5 testified that Kematch telephoned her to say that CFS had come and inspected her house but everything was fine. She said Kematch told her she suspected that the informant was a neighbour down the hall in her apartment building, and she was going to go to "Fisher Branch," where CFS could not bother her. SOR #5 understood that Kematch, McKay, and the children did in fact leave for Fisher River after that.[729]

I accept that SOR #5 and SOR #6 made a call to CFS even though it was not documented by the agency. The Department acknowledged that the AHU did not keep a log of calls, but this was not something that SOR #5 knew when she described that call in a statement to the RCMP in March 2006. At the hearing she said she was surprised to learn that a log had not been kept. While she could not recall the specific date she made the call, she had a general recollection of the timeframe. The evidence of these two witnesses at the Inquiry was consistent as to the timing and content of the call.

I am satisfied that these two witnesses had genuine concerns for Phoenix's safety and well-being and that they took the steps they said they did to bring those concerns to the agency's attention. When SOR #6 thought, quite correctly as it turns out, that the agency would not respond to their call, she prevailed upon her former foster mother, to contact CFS. This is the call that resulted in Kematch's protection file being opened in March 2005, as will be discussed below.

In its submission, the Department argued that either SOR #5 did not call CFS, or if she did, her call did not raise a child protection concern.[730] It did not directly challenge the witness as to whether she made the call.

The Department referenced the report of an investigator retained by the Commission who reviewed cell phone records for one cell phone number SOR#5 had identified to the Commission as possibly being the number from which she made the call. The investigator could not locate a record of a call from that number to CFS, but the witness testified that she has had other cell phones over the years and couldn't recall their numbers, nor which one she used to make the call.

The investigator's review neither supports nor refutes SOR #5's testimony that she made the call.

The agency's submission that if this call was made, it did not raise child protection concerns, is not consistent with the evidence. The information SOR #5 said she reported clearly raised child protection concerns. According to her statement to the RCMP in March 2006, which she confirmed at the Inquiry, she told the AHU worker that she was concerned that Phoenix was always with McKay, that she was being locked up, [731] and that there was something wrong with the child because she could not use the bathroom properly, she barely talked to anyone, and she did whatever her mother said.[732]

By its own admission, in 2005 the agency did not keep records of calls it received.[733] It is therefore not in a position to provide conclusive evidence as to whether it received this call or not. I prefer the evidence of two witnesses who have specific recollections of this particular call, to the evidence of an agency that received thousands of calls each year.

The agency's failure to respond to concerns raised by SOR #5 and SOR #6 was a clear failure by the agency to act in accordance with its mandate. Throughout the Inquiry child welfare staff testified that the system relies on the community to bring concerns to its attention. That being the case, it is incumbent on the system to take care to be receptive to those calls.

The only record of a CFS investigation after December 2004 is one that followed a referral by SOR #7, in March 2005.

5.23.2 "A VERY BROKEN YOUNG WOMAN"

SOR #7 testified that she had been a childcare support worker for Winnipeg CFS since 1995, and had also been a foster parent. She became the foster mother to SOR #6 and her baby when they left the facility for pregnant teenagers in 1998.[734] She knew that SOR #6 had met Kematch there,[735] and that Kematch had left the facility without her baby. She met Kematch during the months that SOR #6 was living in her home. Her impression of Kematch was that "she was a very broken young woman who had a very negative influence on SOR#6 and who had associations and behaviours that were of pretty grave concern."[736]

SOR #7 testified that she knew some of Kematch's history as a mother; she knew that Kematch had had other children after her first was apprehended but she didn't know the names of any of them until SOR #6 telephoned her with concerns about Phoenix, in 2005.[737] She testified about that conversation:

> *Q: Okay. Do you remember how SOR 6 communicated her concerns to you? In other words, did she speak with you in person, or on the phone?*
>
> *A: She called me.*

Q: What did she tell you?

A: She told me she was worried about Samantha Kematch's daughter, Phoenix, that she wanted me to call CFS because she felt that she couldn't do it and she wouldn't be believed. She asked me to call because she, she had been going out with Samantha, hanging out with her a little bit. She was reluctant to even tell me that, but she did. And she said that on one occasion they were leaving the house, the apartment, rather and Samantha had locked the door to one of the bedrooms when she was leaving and SOR 6 thought that she heard noises from behind the door. She might have used the word "whimpering". So she was concerned that Samantha Kematch might be locking Phoenix up and she had concerns that she might be abusing her and trying to hide it.[738]

5.23.3 13TH REFERRAL: A FOSTER MOTHER CALLS CFS, MARCH 5, 2005

SOR #7 explained why she telephoned CFS after this conversation with her former foster daughter:

Q: So what did you do after you spoke with SOR 6 on the phone?

A: I immediately called Winnipeg Child and Family Services after hours.

Q: Okay. What was it that prompted you to call CFS?

A: SOR 6 had all kinds of knowledge of all kinds of things and it was the only time that she ever asked me to do anything like that.

Q: Did you have any reason to question whether SOR 6 was sincere in her concerns that she expressed to you?

A: None. I trusted her judgment on it completely.[739]

SOR #7 testified about her call to CFS:

Q: So please tell the Commissioner what happened when you phoned CFS?

A: I started to tell the woman on the phone the concerns that had been related to me and I didn't get very far before I was told, I'll have to stop you right there. I can't accept this information, because it is third hand.

Q: Because it was third hand?

A: Um-hum.

Q: Now, how much information had you provided to the worker, at the point where the worker told you to stop?

A: I had probably only told her that a former foster child was relating concerns to me regarding the care of a child. I don't know if I had stated the name at that point or not.

Q: The name of the child about whom you were calling, you mean?

A: Yeah, I don't know if I had given Phoenix's name at that juncture in the phone call or not.

Q: So you said the worker told you to stop and just tell me again, what was your understanding as to why the worker wanted you to stop?

A: Because I was not a firsthand witness to anything. Because the information came to me from someone who suspected something.

Q: What was your response when the worker on the phone told you this?

A: Well, I got pretty angry with her.

Q: And what did you say?

A: I told her that she would have to accept the information from me, because it was valid and important information. I don't know if I used those exact words, but I told her that was the only way she was going to get that information and that she needed to have it, because this child was in need of protection.

Q: Did you say anything else to the worker?

A: I can't recall everything that I said, but I did give her information about, I gave the mother's first and last name. I stated that they lived behind the Maryland Hotel. I gave the first name of the child, Phoenix. I stated that my former foster child had concerns that she was hurting her, because she was locking the bedroom door when she was leaving and that she heard sounds from behind that door. . . .

Q: So the phone call proceeded and that's when you told the worker the things that you've just identified for us?

A: That's when I got her to listen to more detail. I also remember insisting that she must have this woman somewhere in her system, because she – it wasn't her first involvement with child welfare, that she, you know, she must have her somewhere and I indicated that – sorry. I can't remember my exact words, but I indicated that it wasn't shocking that she might be hurting the child, what was shocking was that somebody had placed a child with her. That there had been somewhere, along the line, a grave error made.

Q: You said you told the worker that you were a foster parent?

A: Yes.

Q: Did you also tell them that you worked for Child and Family Services?

A: I believe that I did.

Q: Did you tell them how old Phoenix was?

A Yes.. . . .

Q: Okay. You said that you identified to the worker, the CFS worker, that Ms. Kematch had a CFS record herself?

A: I think I said something to the effect that she must have a file a mile long, or a metre deep, or something like that, that she must, somewhere in her resources, have access to information to find that address. Because she was trying to say that they couldn't go because they wouldn't, didn't have the address. . . .

Q: Okay. At the time that you made the call to CFS, do you recall whether you used the word "abuse"?

A: I don't recall. I don't recall whether I said abuse or hurt.

Q: Okay. How long did the call last?

A: I can't say for sure, five, 10 minutes maybe, not longer.

Q: At the end of the call, were you satisfied that CFS was going to look into your concerns?

A: I hoped that they would. I told her that, told her that if anything happened to that child, I would hold her personally responsible.[740]

This call was taken by AHU worker Davidson, who had received the January 2004 call that triggered the investigation by Conlin. Davidson recorded the information from her telephone conversation with SOR #7 on a "CRU Intake & AHU Form." (Again, references to "Stephen" and "Pheonix" are to Steve Sinclair and Phoenix.)

She wrote:[741]

HISTORY: taken from CRU open/close Dec 1/04

Samantha became a ward of Cree Nation Child and Family Services in 1993 Samantha was in care as a child due to her mother's alcoholism, neglect, abandonment and abuse.

The family has an extensive history with the agency starting when Samantha had her first child [redacted] in '98. [Redacted] was apprehended at birth and eventually became a Permanent Ward. It became apparent that Samantha could not parent once she was provided an opportunity to do so in a supported living situation. In April '00 Samantha gave birth to a second child, Pheonix who was apprehended at birth. Pheonix was returned to parents 4 months later. In April '01 Samantha gave birth to [redacted]. Concerns were expressed regarding alcohol abuse and domestic violence. [Redacted] died in July '01 from natural causes while in Steven's care. Samantha and Steven separated sometime around June '01 and Pheonix remained with Steven until June '03 when she came into care due to parents abusing substances. Pheonix was returned to Steven in October '03.

In May '04 an Employment and Income Assistance worker contacted the agency to report that Samantha wanted Pheonix added to her budget as she was in her care. The EIA worker was concerned as she recalled that there were concerns about Samantha's ability to provide care. The EIA worker was not specific in the concers identified, but simply wanted an assessment completed to determine if Pheonix was safe in Samantha's care.

Intake made repeated efforts to meet with Samantha, but was not successful in doing so until July 13, 2004. Samantha denied abusing substances and maintained that she was coping well. Pheonix appeared healthy and well cared for and Samantha did not present as a crack user would be expected to – she was not jittery nor was she thin and drawn looking. She reported that

Pheonix came into her care in November '03 due to Steven allegedly abusing substances. Pheonix reportedly stayed with friends for a month or so at the beginning of this year while Samantha "traveled". Samantha declined offers of service, but requested information on resources in the community be sent to her.

The name of the Source of Referral is redacted, but the person is identified as "Agency foster parent." The intake form continues:

PRESENTING PROBLEM/INTERVENTION:

[Redacted] spoke to an ex foster child today. She refused to provide me with the person's name. This person told [redacted] that she suspects that Samantha Kematch is abusing her daughter Phoenix. [Redacted] does not have any details as to what this alleged abuse might be. Also this person suspects that Samantha may be locking Phoenix in her bedroom. I explained that we need to speak directly to [redacted]'s SOR, but despite being an agency foster home she refused to disclose the name. [Redacted] does not have an address or phone number for Samantha other that she lives in apartment one beside the Maryland hotel. I explained that without an address we will be unable to follow up. The last address on CFSIS is on McGee.

For consideration by CRU.[742]

SOR #7 testified that Davidson's report was a "distilled" version of what she reported; she said that what was missing from the report was "[t]he lengths that I went to, to get her to even take the complaint."[743] She went on to say, later in her testimony:

> *A: I just remember arguing with her. I remember trying to convince her that although it wasn't firsthand information, that she needed to trust this girl's intuition, that her judgment about these things wouldn't, wouldn't be off, that it wasn't, it wasn't a game. Don't remember using those words, but I remember working to convince her that it was a real concern.*[744]

Davidson remembered this call, and testified that it stood out to her because she was dealing with an agency foster mother who was providing information that she had received second-hand, from her ex-foster child.[745] Davidson denied that she told the caller to stop, or that she could not take the information from her. She said she might have told her to slow down, but would not have told her she would not accept her information. Davidson testified that she regularly took information from anonymous callers.[746] She had no recollection of SOR #7 saying that she would hold Davidson personally responsible if anything happened to the child but this was not an unusual threat, and because it was not child welfare information it was not something she would have included in her report.[747]

Davidson recalled emphasizing with the caller the importance of obtaining information directly from the source, to get the details that would allow child welfare workers to do their job more effectively. She described their discussion as

"memorable,"[748] but she had no recollection of her earlier involvement with this file in January 2004.[749]

I commend SOR #7 for persisting in conveying to the agency that the safety of a child required its attention. As a result of her persistence, a file was opened and the matter moved forward.

5.23.4 REPORT OMITS IMPORTANT RECENT DEVELOPMENTS

Davidson acknowledged that in documenting this call, she cut and pasted the same history section that Willox had included in her December 1, 2004 CRU Report. This did not include Willox's report on the most recent activity on the file.[750] Significantly, Davidson's report did not include the information that the agency had learned with the December 1, 2004 intake: that Kematch had given birth to a new child, whose father was "Wes McKay." It also did not include information about the services delivered by Willox at that time.

Davidson acknowledged that this was an error on her part,[751] but said she would expect that the worker receiving her report would do his or her own check and the error would have been "immediately evident," because Willox's report would have been readily accessible.[752] Davidson's report made no mention of McKay's possible presence in Phoenix's home.

5.23.5 WHAT DOES "ABUSE" MEAN?

Davidson did not believe that SOR #7 told her that she worked for CFS, but did remember being told that she was a foster mother. Testifying about the information she received in the call, Davidson said that "abuse" can mean many things to many people, so it would have been useful to have details of the allegation.[753] Davidson explained that locking children in a bedroom is not an uncommon practice:

> *Q: She used the word "abuse" with you and then she said that Samantha may be locking Phoenix in her bedroom?*
>
> *A: Correct.*
>
> *Q: In terms of whether or not that would be an emergency, when you, when you have a young child like Phoenix at the time, would that factor into it, Phoenix is young and the allegation is of a general abuse, being locked in the bedroom as well?*
>
> *A: Well locking young children in a bedroom is -- it's not, it's not an uncommon thing. Sometimes kids, sometimes -- it, it depends on the level of parenting. Sometimes parents sleep in and kids are too young to be wandering the streets alone, and have opened their bedroom door and gone out on the streets, and are wandering around. I mean it's something that we certainly go and speak to the parent about, and the dangers of a child being locked in in case of a fire, but I mean again is it better to have a child wandering the streets? I mean we encourage parents to always be aware and care for their children, and not have the need to lock the child in their room.*

Q: So that's one possibility of what this call might be about?

A: Yes.

Q: But it could also be equally consistently with it being some severe abuse and maltreatment?

A: That certainly wouldn't spring to mind immediately, that wouldn't be my first thought.[754]

Davidson did not consider this situation to be an emergency requiring a field visit that night; the file could go to CRU for follow up.[755] Davidson's involvement with the referral was complete once she prepared her report. It was submitted to her supervisor, Verrier, who authorized the transfer of the matter to the CRU.

I find that this witness's approach to this referral fell short of expectations. For instance, she downplayed the importance of the file history, in making her report. She testified that she did not expect the next worker to rely on her history; that as an AHU worker, she was just providing a "thumbnail of what has happened before."[756] This was in stark contrast to evidence I heard throughout the Inquiry as to the importance of accurately recording and reviewing history for the benefit of the next worker.

A review of the history would have shown that Kematch's protection file had been opened by the agency just four months earlier. At that time, the agency received information that there was both a new partner and a new baby in the home Kematch shared with Phoenix. The file also showed that the agency had not investigated the new partner's identity, or whether he had a child welfare history. Witnesses who were involved with that earlier file opening had testified that, although the new partner should have been investigated, no child protection concerns were raised at the time. Now, those concerns were being raised. This should have signaled to the agency that this matter needed to be taken seriously, and fully investigated. The information from the most recent file opening ought to have been included for the benefit of the next worker.

Verrier, Davidson's supervisor, testified that she would likely have first received Davidson's intake report when she arrived at work on Monday morning, March 7, 2005. Verrier had no recollection of the file, so couldn't say whether at that time she would have remembered her earlier involvement with the family in May 2004, although she would have seen it recorded in the history section of the report. Her first decision, she said, would have been to decide whether the file should be "opened up to Intake," or was it a matter for CRU. She didn't recall why she assigned it to a CRU worker, but surmised it was so that the worker could find the address, as none was given in Davidson's report.[757] Looking back at it at the time of her testimony, Verrier believed that there was no imminent danger, and "with today's eyes," she thought that she probably would have considered that the matter as presented would warrant a 48-hour response.[758]

5.23.6 WORKER MAKES EFFORT TO CONTACT FAMILY

Richard Buchkowski was the CRU worker to whom Verrier assigned Kematch's protection file. Buchkowski obtained a BA degree in 1984 and began working for Winnipeg CFS in 1995 and CRU in 1999. Buchkowski testified that when he received the AHU report prepared by Davidson, a brief history was provided, as well as the problem: that Phoenix was being abused and locked in a room.[759]

On the morning of March 7, 2005 Buchkowski made a field visit by himself to the apartment building but could not get in. He went back in the afternoon, but again couldn't get into the building. He testified that although this was a routine call, the extensive history of this file informed his response time. He speculated that he must have considered the referral a high priority, as he went out by himself even though it was not typical for workers to do field visits on their own. But he did not consider this an abuse referral, because the abuse allegation was not defined.[760]

Buchkowski recorded his work and appended his report to the end of Davidson's:[761]

File assigned to Richard Buchkowski on March 7, 2005.

Placed a call to Employment and Income Assistance who do not have a listing of this family.

Placed a call to Winnipeg One School Division who provided demographic information of last known address. As well Phoenix is "inactive" as she has not registered for school since September 2004 when she attended Wellington School.

Attended to the home at 10:45 am, could not get into the building.

Placed another phone call to Employment and Income Assistance to find out family at this address and was informed it is Samantha which is an active file.

Attended to the home at 2:30 pm, waited for about 5 minutes, and could not get into the building.

RECOMMENDATIONS

It is recommended this file be opened to Intake.

Richard Buchkowski
Crisis Response Unit

Ms. Diana Verrier,
Crisis Response Unit Supervisor

Buchkowski testified that when he attended at the apartment block in the afternoon, his shift was ending, which is why he waited only five minutes.[762]

It was appropriate that Buchkowski considered this referral to be a high priority and tried to make immediate contact with the family. I also recognize his efforts to locate Phoenix and her mother: he called the school division for information and made a note in the file that Phoenix had not registered for school since September 2004 when she attended Wellington school. This was a lead that the next worker ought to have pursued, in investigating Phoenix's circumstances.

5.23.7 NEXT WORKER FAILS TO GAIN ENTRY TO KEMATCH'S APARTMENT

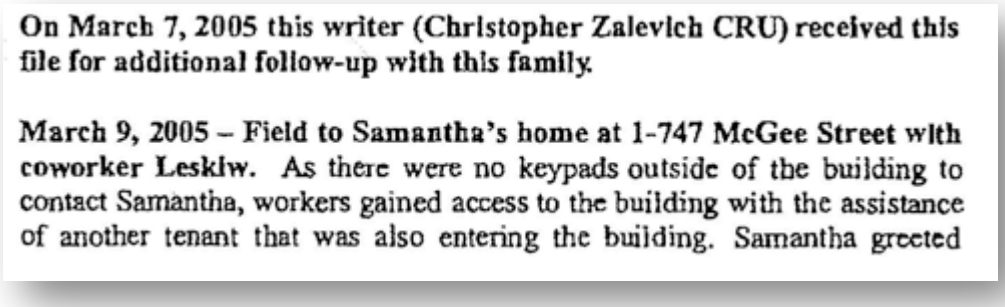
The file recording shows that after Buchkowski's recommendation was signed off by him and by supervisor Verrier that same day, March 7, 2005, CRU worker Christopher Zalevich received the file for follow up. Zalevich obtained a degree in human ecology in 1999 and began working with Winnipeg CFS in 2001.

The file was assigned to him by his supervisor, Faria. She testified that the significant problems she saw when she received the report were the "non-specified" allegation of abuse, and the report that Kematch was locking Phoenix in the bedroom.[763] She testified that she did not recall her previous involvement with the family three months earlier, in December 2004.[764] She said her expectation was that Zalevich would review the history, including the most recent file recording from December 2004.[765]

Zalevich testified that he would have reviewed the paper CRU Intake & AHU Form prepared by Davidson and added to by Buchkowski.[766] His understanding was that Buchkowski had done some follow up and had recommended that the file go to Intake. He did not speak to Buchkowski or Davidson and had no knowledge of how or why the file came to him, in CRU, rather than being sent to Intake as had been recommended.[767]

Davidson noted that the file had been closed most recently in December 2004, although she did not include in her report the history of that contact with the agency. Zalevich could not recall whether he reviewed the file's earlier history, nor whether he knew why Kematch's protection file had been opened in December 2004. He testified that he saw this referral as serious enough to require a field response, but not as "a very serious referral that required an immediate response."[768]

Zalevich testified that his unit was working the phones the day he received the referral. His unit switched to back up, or field work, the next day, March 8, 2005. He went to Kematch's apartment the following day, March 9, with his co-worker, Bill Leskiw. Leskiw held BA and BSW degrees and began working as a social worker in 1985. He did not recall why he didn't go on March 8, but speculated that it could have been due to sickness or prioritizing other files. Field visits were done in pairs to minimize risk and to add a second perspective, he said. Zalevich was unsure what information Leskiw had been given, but testified that it was his practice to brief his co-worker and it would have been his responsibility to familiarize Leskiw with the specifics of the referral.[769] Zalevich recorded his visit to Kematch's apartment as follows:[770]



On March 7, 2005 this writer (Christopher Zalevich CRU) received this file for additional follow-up with this family.

March 9, 2005 – Field to Samantha's home at 1-747 McGee Street with coworker Leskiw. As there were no keypads outside of the building to contact Samantha, workers gained access to the building with the assistance of another tenant that was also entering the building. Samantha greeted

workers at the door with a somewhat shy demeanor but did not want to allow workers into her apartment as she had someone visiting with her. Workers could hear that the television was quietly on. This writer did not notice any sounds of a party occurring or that there was more than one other adult in the home.

Agency workers spoke with Samantha in the hallway and provided her with the details of the presenting problem. Samantha was curious about who called and was advised that the Agency cannot legally provide that information. Samantha accepted this and speculated that she knew who the SOR was.

Workers initially advised Samantha that the referral was about an allegation of her abusing Phoenix. Samantha responded by saying that she had yelled at Phoenix a few days ago and seemed surprised that someone may have heard her. This writer then indicated that the referral indicated that it was believed that Samantha had locked Phoenix in her bedroom. Samantha stated that she and Phoenix share a bedroom. This writer then asked if the bedroom door has a lock on the outside of the room. Samantha confirmed that there is a lock on the outside of the door. Workers warned Samantha that it is not safe to lock her in the room in the case of a fire. Samantha agreed.

At this time Samantha could hear that her youngest child, [redacted] was becoming upset inside the apartment. Samantha returned into her apartment and brought [redacted] into the hallway. [redacted] appeared to be a content, healthy, clean, and well-dressed baby. She was smiling and comfortable with Samantha.

Workers asked if Phoenix is attending school or daycare. Samantha advised that she is not in daycare and will be attending school next September.

This writer asked if there was anything that Samantha needed support with from the Agency and if she also has supports as a parent. Samantha indicated that she was doing well and did not require agency supports.

This writer provided Samantha with an Agency card should she require any Agency supports.

Zalevich testified that his intention in going to the apartment was to determine whether the information from SOR #7 was accurate: that is, whether Phoenix was being abused. He said he did not see another person in the apartment, but he believed Kematch when she told him she had a visitor. He could not recall whether he asked Kematch if he could enter the apartment, but he did not record such a request and he testified that this was something he typically would record, had he made the request.[771] I therefore find that Zalevich did not ask to enter the apartment.

Zalevich acknowledged that he viewed this as a vague referral, involving undefined abuse, and that this explained, in part, why he did not insist on entering the apartment. Also, he heard nothing from the doorway to indicate a party going on inside. He said that he needed to go to the apartment to see whether the referral was substantiated in any way and, given the allegation of a locked bedroom door and the suspicion of abuse, "ideally" he would have gone inside. He justified his actions on the basis that social workers operated under a principle of "least intrusive measures" and he decided to err on the side of respecting Kematch's privacy.[772]

Zalevich testified that he was not aware of McKay's relationship with Kematch at the time. He did not recall asking Kematch if any other adults were living in the home or who the father of her younger child was. He did not record any such questions and he agreed that he likely would have, had he asked them.[773] Accordingly, I find that he did not ask Kematch these questions.

Zalevich testified that he accepted Kematch's response to the allegation that she was abusing Phoenix: that she had yelled at Phoenix a few days earlier and was surprised that someone had heard.[774] He said it was his opinion that Kematch was indeed locking Phoenix in the bedroom and while he believed that this was an unsafe practice, it did not necessarily mean that Phoenix was in need of protection. He speculated that "it could be that she's getting a time out." He did not ask any questions about the lock.[775]

As to his inquiries about whether Phoenix was attending school or daycare, Zalevich testified that possibly he was trying to ascertain Phoenix's whereabouts that day, or find out whether she was registered for kindergarten. He said he was aware that she had been registered at Wellington School in the fall of 2004 and was reported as not attending. He confirmed that he did not ask Kematch why that was the case, nor did he contact Wellington School for further information about Phoenix.[776]

Zalevich testified that he knew that the child he saw that day was not Phoenix. He said he took Kematch's word that she did not need any help parenting, based on his observation that she appeared to be doing well with the younger child. He didn't remember whether he was aware at that time that Kematch had a history of declining agency offers of support.[777]

Zalevich testified that he could not recall whether he ever asked to see Phoenix, but speculated that he did, based upon his documented inquiries as to whether she was in school or in daycare. In any event, he did not record any information about Phoenix's whereabouts. It was his understanding that she was not in the apartment at that time.[778] Zalevich acknowledged in his testimony that he did not see Phoenix that day and I find that he did not even ask to see her.

After his visit to the apartment on March 9, 2005, Zalevich's recommendation that the file be closed was recorded in his CRU report:[779]

RECOMMENDATIONS:

This file was opened by the AHU after a call to them was made onSaturday March 5th, 2005. They were advised that the caller believed that Samantha is abusing her daughter Phoenix although there were no details surrounding the abuse other than the caller believing that Samantha was locking Phoenix in her bedroom. The caller did not have an address for Samantha other than that she lives in apartment #1 beside the Maryland Hotel. The AHU explained that without an address, they could not follow up. Worker Buchkowski located Samantha's address as being #1-747 McGee but could not gain access to the building.

This writer and worker Leskiw met with Samantha at #1-747 McGee Street. Samantha presented as calm and somewhat shy. She did not want to allow workers into the home as she had company. Workers warned and cautioned Samantha about locking Phoenix in her bedroom. Workers viewed [redacted] appeared to be healthy and well-cared for.

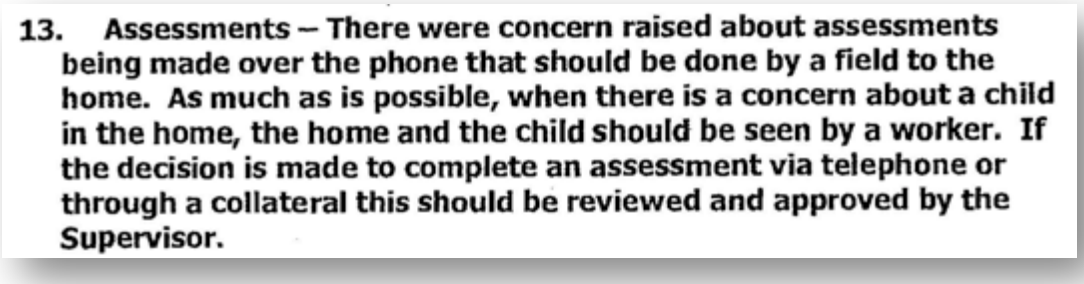
Workers did not note any protection concerns and so this matter can be closed to the Crisis Response Unit at this time.

Christopher Zalevich
CRU Social Worker
March 9, 2005

Diva Faria
CRU Supervisor
March 9, 2005

Zalevich testified that in making his recommendation to close the file, he took into account Phoenix's age, Kematch's explanation for the referral of abuse, and the healthy appearance of Kematch's younger child. Based on those factors, he believed that Phoenix was safe, despite not having seen her.[780]

He acknowledged in his testimony that at the time he understood that it would have been best to see Phoenix and he confirmed that he was present at a CRU meeting on February 3, 2004, where the need to see children was discussed.[781] The minutes of that meeting specifically state:[782]


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

He also acknowledged that there was nothing preventing him from recommending that this file be kept open longer for further investigation.[783]

5.23.8 WORKER AND SUPERVISOR CONFER ABOUT CLOSING THE FILE

Zalevich testified that at some point after returning to the office from his visit to Kematch, he met with supervisor Faria. He could not recall this was before or after he typed up his notes, but the meeting took place in Faria's office and Leskiw was present.[784] There was no record of this meeting in his file recordings, but Zalevich testified about his recollection of it:

> *Q: What do you recall of the conversation?*
>
> *A: I remember reviewing what had happened. I don't remember exactly what I said. I had asked if -- I don't know how I asked her the question or what words I used, but I remember we had discussed briefly that -- should this be closed or not, and part of that conversation had -- was around whether Phoenix had been seen, and, and I said that she had not been seen.*
>
> *Q: Did Ms. Faria specifically ask you that?*
>
> *A: I don't remember if that point came up because she asked me or because I volunteered that information.*
>
> *Q: Okay.*
>
> *A: And she said that ideally, yes, she should have been seen, but that this file could be closed.*
>
> *Q: What was your response to that?*
>
> *A: I closed the file.*[785]

Zalevich testified that during this meeting Leskiw did not comment as to whether Phoenix should have been seen.[786]

At the time he testified, Leskiw had no recollection of his involvement with this referral. He described his role in this case as primarily "backup." He was there for safety reasons. He had no recollection of what he might have known about the referral when he accompanied Zalevich to the apartment; at that time there was no requirement that the backup worker review the referral. In fact, he testified that he had likely not reviewed anything before going out with Zalevich because that was not standard procedure at the time.[787] Leskiw did not make notes of his own on this referral.

He did not recall whether either of them had asked to see Phoenix. He said he would have deferred to the primary worker, Zalevich, to decide whether Phoenix needed to be seen.[788] He said that Kematch's confirmation of the report about locking Phoenix in her room might have called for a look at the door, but not necessarily at Phoenix herself. If this was the first such report, and Kematch was unaware that it was inappropriate to lock a child in a room, he saw this as an educational opportunity, "a warn and caution," he said.[789]

Leskiw had no recollection of being at the meeting with Zalevich and Faria, but said he had no reason to disagree with Zalevich's testimony that he was present. He had no further involvement with this referral after that time.[790]

Faria testified that she would have expected Zalevich to go to the apartment and meet with Kematch, to discuss the concerns that had been presented. She also testified that it would have been best practice for the workers to see Phoenix. The fact that that the information from SOR #7 was "second hand" did not diminish the need to see the child, but did make it more difficult to know what specifically was being alleged, she said.[791]

Faria testified that she did not assign Leskiw to accompany Zalevich on the call, but it was not uncommon for workers to go on field visits together. She said Zalevich would have had responsibility for the file and that Leskiw would be a "second set of eyes." She did not expect Leskiw to review the CRU report before going on the call.[792]

The conversation with the workers would need to be confidential, so if Kematch had a visitor in her home, Faria said she could see why they would talk with her in the hallway. She also said she did not necessarily expect them to view the lock on the bedroom door, but did expect them to discuss with the mother the allegation that Phoenix was being locked in the room.[793]

She also expected that Zalevich and Leskiw would ask Kematch who else was living in the home at the time,[794] which they did not do.

5.24 KEMATCH FILE IS CLOSED FOR THE LAST TIME

5.24.1 WORKERS FIND NO PROTECTION CONCERNS

Faria could not recall what discussions she had with Zalevich or Leskiw about their visit to the home before she signed off on Zalevich's recommendation to close the file, but she testified that she would have considered those discussions as well as the written report.[795]

When asked what she understood the workers to have done by way of investigating the allegation of suspected abuse of Phoenix, she said that they had discussed "the non-specified allegation of abuse," which Kematch had identified as "yelling;" and they had spoken to her about the concern that a child was being locked in her room, "which is never an acceptable parenting practice," and about the associated safety issues.[796]

Faria testified that at that time she had no child protection concerns.[797] She gave the following testimony about her reasons for deciding to close the file:

> *Q: You agreed with Mr. Zalevich's recommendation to close the file?*
>
> *A: Yes.*
>
> *Q: At the time that you authorized the file to be closed, how were you able to satisfy yourself as to Phoenix's safety and well being? That there were no child protection concerns considering that Ms. Kematch had not allowed the workers into her home, Phoenix had not been seen by the workers, the recording contained no information about the father of the baby living in the home, the file history showed Ms. Kematch had an extensive history with CFS and the fact that Phoenix was of a young and vulnerable age, how were you able, given all of that, to make a recommendation or to authorize closing the file.*
>
> *A: Again, I can only go on what's in the written record. I do not remember what discussions I would have had in addition to this document with respect to what follow up Chris or what questions would have been asked. Regular practice, best practice of CRU was that children be seen. That was communicated to our staff and that's in a minute, in one of our unit meeting minutes and that's something that we strived for in terms of ensuring that happened. Were there times that that didn't occur? Yes. And when you look at that unit meeting minute we're clearly identifying that there's, that those concerns do happen and that's, that, you know that were striving for the best practice really is to see children whenever possible.*
>
> *At the time there was no specific requirement in the standard that we have face-to-face contact with all children in, when conducting an investigation. That standard came into effect in 2008 in the introduction of the case management standards. We had sent this case up to intake. It was refused or declined by intake. There was no standard that, that the children be, that there be face-to-face contact on all protection investigations. That was a best practice standard that we set for ourselves and we tried to achieve. Did we do that on every case? Absolutely not. Looking at, in light of the fact that I do not remember what conversations I would have had with Mr. Zalevich, with respect to his assessment, looking strictly at the report in front of me, I can only speculate but I think it potentially could have been, you know, the nature of the referral. We have an allegation of non-specific abuse and we also have an allegation of a child being locked in their room which does not meet the referral for criteria for abuse.*
>
> *So based on, based on the nature of the referral and comparing that to the gravity of other situations we were managing at CRU, as well as based on the recommendations of Chris who, who was a younger staff but had seven months of abuse experience and, you know, even though the recommendation wasn't made by Bill, Bill did attend. Bill was a seasoned 15-year veteran of child welfare and if he had, you know, if Bill had concerns or if he felt that*

> *something else needed to occur, he would have definitely brought that to Chris's attention or to my attention.*
>
> *So based on the nature of the referral and based on the recommendations of Chris, I made the decision to close the case.*[798]

When asked how she reconciled what she understood to be best practice—seeing the child who was the subject of a protection concern—with her authorization to close the file in March 2005, knowing that Phoenix had not been seen, Faria could only speculate. She said her decision would have been based on these facts: workers had spoken to the parent about the concerns that had been raised; the workers who attended the home identified no protection concerns; and standards at that time did not require face-to-face contact with all children in protection investigations.[799]

In any event, Zalevich testified that he did not refer to standards in carrying out his work, but was governed by best practice.[800]

Similarly, Leskiw testified that in 2005, he would not typically reference a standards manual in his work, unless something specific was brought forward in a unit meeting with regards to a change in a standard, or a new focus.[801]

Notwithstanding that she explained her decision on this referral with reference to the standards, Faria testified that she did not consider the standards themselves in carrying out her work in 2004 and 2005. Rather, she said her work was guided by *The Child and Family Services Act*, best practice, clinical experience, peer consultation, management consultation, and training.[802]

The evidence was that the standards appeared in different versions between 1988 and 2005 and that there was some confusion over which version applied. More will be said about this later in chapters dealing with the evidence reviewed in Phase Two.

In its final submission, the Department summarized evidence heard at the Inquiry with respect to standards as follows:

> *At the time services were delivered to Phoenix and her family, Winnipeg CFS primarily relied upon supervisors to make themselves aware of, and to ensure their staff complied with, provincial standards. A number of witnesses made reference to the "blue binders" which contain the provincial standards and were kept in the supervisor's office or somewhere on the unit to be used as a reference source. These "blue binders" were the 1988 provincial standards which are sometimes referred to as the "foundational standards".*
>
> *Although many workers were unaware of provincial standards, most testified that they were aware of Winnipeg CFS' policies and procedures sometimes referred to as the "Program Manual". It is submitted that the policies and procedures of WCFS incorporated the 1988 provincial standards.*

During the time services were delivered to Phoenix and her family, there were two policies of particular relevance. First, there was the "Intake Program Description and Procedures" of July 2001 (found at CD 992) (hereinafter referred to as the "Intake Manual"), and second there was the WCFS "Orientation Manual" of May 2004 (found at CD 1635).

It is important to understand that provincial standards are often very general in their application and were frequently referred to as "minimum standards". Provincial standards were not, and to this day are not, intended to instruct workers or supervisors on how to conduct day-to-day case management. Therefore, the Intake Manual and the Orientation Manual were used to embed provincial standards into everyday practice.[803]

5.24.2 MANDATE OF THE CRU AND AHU UNITS EXPLAINED

Faria confirmed her familiarity with the document entitled "Winnipeg Child and Family Services Intake Program Description and Procedures."[804] In particular she was referred in her testimony to the Program Description of the mandate of the Crisis Response Unit and After Hours Unit, which reads as follows:[805]

PROGRAM DESCRIPTION

In creating a working definition as to what the mandate, duties and protocols could be for the AHU and CRU, we have borrowed from the definition and philosophy of the Agency's Case Management Standards Intake definition:

The CRU and AHU mandate is to process all referrals for service to the Agency, to gather and screen information, to determine the validity of the referrals, and to assign priority levels to referrals to ensure further assessment or investigation occurs if required. As well, the CRU and AHU would have the primary obligation to ensure the safety and well-being of children at risk (as prescribed in the Child and Family Services Act, Part III, Child Protection), which may include responding to and investigating allegations of serious physical and/or sexual abuse and/or neglect.

The case management decisions at the CRU and AHU would include:

- Is the referral eligible and/or appropriate for Winnipeg Child and Family Services?
- Are the children safe or in need of protection?
- What immediacy of response does the referral warrant?
- Will the referral be opened to the Agency, and (if so), under what case category?
- Can the case be opened and closed at the CRU and AHU level? If so, what are the criteria for doing so?

Faria confirmed that this description matched her understanding of the role of the CRU while she was a supervisor.[806] A CRU worker had a number of options following assessment and intervention including recommending transfer of a file to Abuse Intake, or General Intake; and recommending that the file be closed. She testified that before a file could be closed, a worker would need to complete an assessment and determine that there were no known protection concerns.[807] She agreed that a file would be referred to Intake if more investigation were needed to determine whether there were child protection concerns, because CRU workers had limited opportunity to investigate.[808]

Faria discussed the role of the CRU in the context of the mandate of the child welfare system as a whole. She agreed that one of the main functions of the child welfare system was, and is, to determine whether a child is in need of protection, taking into account the child's life, health, and emotional well-being.[809]

5.24.3 WORKERS NEED FACE-TO-FACE CONTACT WITH THE CHILD

Faria testified that, as a CRU supervisor, she was aware that children under the age of five were particularly vulnerable, especially if they were not in school or connected to daycare because:

> *A: . . . . they're isolated and there's less eyes on them in terms of the community being able to identify concerns or be able to collaborate, collaborate information about safety.*[810]

Seeing the child has always been the most basic step required of a child welfare worker investigating protection concerns. This was made clear by a number of witnesses before the Inquiry. For example, Dr. Linda Trigg, who was CEO of the agency from 2001 to 2004, testified as follows:

> *Q: During your tenure can you remember what, if any, requirements there were for workers to have face-to-face contact with a child in the context of doing a child protection*
>
> *A: You couldn't do a child protection investigation without having face-to-face contact with a child.*
>
> *Q: Would there have been any doubt about that within the agency when you were there?*
>
> *A: It's impossible to do an abuse investigation if you don't talk to or see the child.*
>
> *Q: Or -- now you've used the term abuse investigation. Does the same apply if you call it a child protection investigation?*
>
> *A: Yes.*[811]*. . .*
>
> *Q: So when a call came into CRU, to the crisis response unit, about suspected abuse and it's --*
>
> *A: Right.*

Q: -- no more specific than that, and the workers go out to investigate that call, is that a child protection investigation?

A: Yes.

Q: Okay. And so when I said was there any doubt in the agency that when you're doing a child protection investigation you have to have contact with the child who is the subject of the investigation?

A: I would think not.

Q: No doubt.

A: Although my understanding in the Phoenix Sinclair case, in one instance, it did not occur.

Q: Yes. But in terms of a requirement to do it there would not have been any doubt that it was necessary. You're nodding but we have to pick up –

A: Yes.[812]

Jay Rodgers, who was CEO of the agency from 2004 to 2005, testified:

Q: . . . . Was there every any doubt, during the time that services were delivered to Phoenix and her family, that the child who was the subject of a child protection investigation needed to be seen in determining her safety?

A: No.[813]

Darlene MacDonald, who was Program Manager for Services to Children and Families from 1999 to 2006, testified:

Q: In that circumstance, and with the history of the family, and Ms. Kematch, should Phoenix have been seen before determining that there was no safety issue?

A: Yes, the child should have been seen.[814]

Patrick Harrison, who was Program Manager for CRU and AHU Intake from 2003 to 2005, testified:

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

A: Yes.

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

A: It would have been best practice to see Phoenix.

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

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

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

A: That would be, that would be important, yes.[815]

Dan Berg, who was the Assistant Program Manager to whom Faria reported, testified that it would have been best practice, and that it would have been advisable, to have seen Phoenix.[816]

When asked whether anything prevented the agency from seeing Phoenix before the file was closed again, Faria said she could only speculate. It could have depended on many factors, including whether the CRU was dealing with more urgent matters that day. The CRU handled high risk, imminent matters and did not have the same capacity to hold cases and conduct extensive investigations, as Intake would. According to Faria, the fact that the case did not go to Intake contributed to the agency's inability to achieve best practices in this case.[817]

5.24.4 AGENCY MISSES ITS LAST OPPORTUNITY TO INTERVENE FOR PHOENIX

Faria testified that she did not refer the matter to Intake after Zalevich and Leskiw had failed to see Phoenix, because two social workers were reporting no noted protection concerns. Although she understood that Intake had previously refused to accept the file, she confirmed that if she had felt there were child protection concerns, or was unsure but saw the need for further investigation, she could have insisted to her assistant program manager that Intake needed to accept the file.[818]

Ultimately, Faria testified:

> A: *No. If I felt that there were child protection concerns, I would have not have closed this case.*[819]

I find that the agency's actions on what turned out to be its final opportunity to deliver services to Phoenix and her family, were woefully inadequate.

There was no basis upon which the agency could reasonably determine that there were no child protection concerns for Phoenix. It had received a report that Phoenix was potentially being abused and locked in a room. Kematch confirmed that there was a lock on the outside of the bedroom door.

The agency made its determination without seeing Phoenix, without entering the apartment, without investigating other adults in the home, and without considering the extensive history of agency involvement and unresolved concerns in this file.

The agency opened Kematch's protection file in response to the call from SOR #7, but failed to fulfill its mandate to protect Phoenix. Having been notified of child protection concerns, the agency was obliged to assess and investigate them. It failed to do so. That has to be seen as tragic. A proper investigation would have revealed important information, and would have afforded the agency the opportunity to extend to Phoenix the protection she needed and deserved.

Further, the evidence was clear that there needed to be face-to-face contact with Phoenix. She was within the most vulnerable category of children: she was not yet five years old, and because she was not attending school or daycare, she was not visible to the community.

Faria based her decision to close the file on her professional judgment and that of her workers, that there were no protection concerns.[820] She testified that the ability of a worker to make an informed judgment can be affected by many factors and that although workers strive to achieve best practices, they do not succeed every time.[821]

In her final submission, counsel for Faria stated:

> *While it cannot be said that workload was a specific and direct contributing factor on any service delivered to Phoenix in 2003 to 2004, it, in combination with all of the other systemic difficulties contributed to an organizational culture and impacted service delivery generally.*[822]

I accept that CRU was often busy, and there were indeed systemic difficulties that affected service delivery generally. Wright testified that it is "very difficult" for front line workers and supervisors to meet best practices when they do not have organizational support.[823] Counsel for Faria argued that striving for best practices is not just for front line workers and supervisors: senior management must also be committed to best practices, which means providing workers and supervisors with training, evaluation, quality improvement, and resources. She cited Wright's report about the need for evaluation, quality assurance, and service monitoring.[824] I accept the importance of striving for best practice at the organizational level of the child welfare system. I will discuss how that system has addressed these issues since the tragic death of Phoenix, in the chapters relating to Phase Two.

There is however, no evidence to support a finding that lack of organizational support significantly impacted the services that were delivered, or not delivered, to Phoenix and her family.

It was incumbent on the agency to determine whether there were child protection concerns—not only for Phoenix's immediate safety, but also for her long-term safety and well-being. If CRU workers could not make that determination because of workload, or because the unit was not set up to keep a file for more than a day or two, then the agency's obligation was to transfer the file to its intake unit. Instead, the worker and supervisor exercised their clinical judgment to conclude that there were no child protection concerns and closed the file. This was a catastrophic mistake.

5.25 PHOENIX MOVES TO FISHER RIVER

5.25.1 CONCERNS PERSIST AFTER THE MARCH 2005 INVESTIGATION

Kematch's friend SOR #6 told of visiting Kematch's apartment one day in March 2005. When Kematch brought Phoenix from the bedroom, Phoenix looked nervous and more reserved than she had the first time she saw her, some months earlier.[825]

SOR #6 testified that she and Kematch walked with Kematch's baby and Phoenix to a friend's apartment. There, she took this photograph of Phoenix:[826]

When she was asked if there was a difference in Kematch's treatment of her two children, she said Kematch seemed proud of the baby and cared about her, but she showed no affection towards Phoenix.[827]

Lisa Bruce testified that she went to pick up Phoenix one day, to take her to a Brownies program at the Indian Metis Friendship Centre. But when she arrived at Kematch and McKay's apartment, they told her that Phoenix wasn't there, and that she was being bad.[828]

Bruce testified that when she did not see Phoenix for another couple of weeks, she called CFS to say that she had concerns about a little girl named Phoenix, who was her uncle's stepdaughter. She testified that this was likely in May 2005. The person who answered her call, who Bruce believed was a receptionist, asked for her name, address, and age. When Bruce replied that she was 17, the receptionist told her that a parent or guardian would have to make the report for her.[829] Bruce hung up before relating her specific concerns.[830]

At the time, Bruce was living on her own. Her mother lived in Fort Alexander. Bruce testified that she did not speak to an adult about her concerns, and didn't tell her mother about the call to CFS until much later, "after everything happened."[831]

5.25.2 FAMILY'S MOVE TO FISHER RIVER BECOMES KNOWN

As reported above, SOR #5 testified that when Kematch told her about CFS coming to her door in March 2005, Kematch went on to say that she and her family would move to "Fisher Branch," where CFS couldn't bother her.

Bruce testified that she knew that Kematch and McKay were moving to Fisher River, though they never told her why they were going.[832] In May 2005 she moved into their apartment at 747 McGee. She never saw Phoenix again.[833]

EIA records show that Kematch advised her EIA worker that she was moving to get away from certain people who were coming to her home, and that she had given notice to her landlord.[834] EIA records also show that as of April 11, 2005 Kematch had decided to move to her reserve and EIA could close her file.[835]

EIA supervisor Herkert confirmed that if a CFS worker had called EIA after April 11, 2005, trying to locate Kematch because of a child protection investigation, EIA would have disclosed its information about her move.[836]

5.25.3 THE FAMILY MOVE INTO THEIR NEW HOME

Shirley Cochrane is Band Assistance Administrator for Fisher River First Nation and testified as to the band assistance records. The records indicate that on April 18, 2005 McKay applied for band assistance for the family, listing Kematch as his spouse, and Phoenix as one of his three children.[837] Cochrane confirmed that CFS and Band Assistance worked closely together and shared information.[838]

According to Cochrane, policy in 2005 required that a child who was claimed as a dependent be seen by Band Assistance, but they didn't keep records of whether a child had been seen.[839]

Cochrane testified that band assistance recipients picked up their cheques in person at the band office. Records show that from May 1 to November 1, 2005, McKay received a series of 11 cheques,[840] signed by various individuals including Cochrane herself, the Chief, council members, and the Chief Financial Officer. A December 1, 2005 assistance cheque payable to McKay was later voided.[841]

In 2005, Angela Murdock owned a house on Provincial Road 224 in Fisher River. This was a busy road, being the main road through the reserve.[842] She rented the house to McKay in 2005, when she was living elsewhere. She didn't know anything about McKay, Kematch, or their family. The arrangements were made through her mother, who lived on the reserve. Murdock said she didn't know whether there were children in the family. The rental agreement was made orally and there were no written records. The rent was paid by monthly bank deposits, she said.[843]

Murdock believed that Kematch and McKay lived in her house for six to seven months.[844] They paid their rent on time, until the last month. When she phoned McKay, he told her he had given the money to someone else who spent it, so she went to the house to try to collect the rent. Kematch answered the door only a crack and didn't let her in. Murdock testified that she never went into the house and didn't know that any children were living there.[845]

Murdock recalled telling Kematch and McKay that they had to leave after missing the rental payment, but she couldn't remember when they moved out. She never saw them again.[846]

5.25.4 MCKAY'S SONS JOIN THE FAMILY

McKay's ex-partner testified as Doe #3. She and McKay had two sons, who testified as Doe #1 and Doe #2, who were about 12 and 14 years old at this time. After McKay moved to Fisher River, Doe # 3 decided it would be a good idea for the younger boy, Doe # 1, to spend some time with his father.[847]

She testified that in 2005 she had heard that McKay "had a new girlfriend, they were getting married, he was a Christian."[848] She had met Kematch once when Kematch came to her house. She remembered her as "very quiet and shy."[849] She had heard that Kematch had a daughter.[850]

Jeremy Roulette testified that he was at Doe #3's house the day McKay came to pick up the younger boy to take him to Fisher River, toward the middle or end of April 2005. It was Jeremy's understanding that by that time Kematch and McKay were already living in Fisher River.[851] He saw Phoenix in the backseat of McKay's car. She took her hat off and showed him an injury on her forehead. He said it looked like a "gouge," and seemed not to have received medical attention. He thought it was already a day or two old because a scab had formed. When he asked Phoenix what happened, McKay spoke for her, and Phoenix repeated what he said: that she hurt herself. Jeremy did not believe McKay and said he would not have put it past McKay to do that to somebody.[852]

He testified that he went inside and told Doe #3 about what he had seen, expecting that she would "call somebody or tell somebody about it." Jeremy had had his own experiences with law enforcement and with child welfare that left him reluctant to make a report himself.[853]

Doe #3 recalled this conversation but said they never discussed contacting CFS.[854] She testified that Jeremy told her "that the little girl had a gash on her forehead and her eyes were rolling back." She said she overheard Jeremy ask McKay what had happened, and McKay answer that she banged her head on a corner of a coffee table, and that they were going to take her to Children's Emergency.[855]

Doe #1 testified about seeing Phoenix that day as well. He had first met her about a year earlier, and described her as a healthy toddler then, with long shiny hair. But the day that Kematch and McKay came to pick him up to take him to Fisher River, Phoenix was in the car, looking very different. He described what he saw:[856]

> *A: She looked like, she looked rough, man. She looked all beat up and shit, like she didn't look like she did when I first met her. Now, I mean, she's just like all skinny and whatever. She just didn't look the same.*

5.25.5 THE FAMILY IN FISHER RIVER

Records kept by the Fisher River Health Centre provide some confirmation as to where Kematch and McKay were living throughout the summer and fall of 2005. They show that on May 13, Kematch attended the Health Centre for a pregnancy test. Her fifth pregnancy was confirmed, and Kematch obtained some prenatal care there that year. Cindy Hart, Director of Health at the Fisher River Health Centre, testified that Kematch and McKay both received services from the Health Centre between May and October 2005.[857]

Keith Murdock lived across the road from Kematch and McKay. He recalled thinking that there were children living in the home because he had seen children playing outside. From a distance they appeared to be a boy and a girl, maybe 8 to 10 years old. He described them as "normal kids playing around in the front yard." He didn't know who they were, and he was unable to tell if Phoenix was one of the children. He didn't see anything that concerned him.[858]

Murdock recalled that in 2005 McKay worked as a part-time school bus driver when regular drivers were not available. He saw McKay driving the bus when it picked up Murdock's own children for school.[859]

Florence Bear lives at Peguis First Nation, the reserve adjacent to Fisher River. Her sister Madeline Bird worked for Intertribal Child and Family Services in 2005. This is the child welfare agency located on the Fisher River reserve. Bear's grandfather and McKay's father were brothers, but she didn't consider herself close to McKay.[860] Bear recalled a brief encounter with McKay and Kematch in the parking lot of Marciniak's store, north of Fisher River, sometime in the spring of 2005. She was with her sister Darlene Garson.[861] She remembered looking in the window of McKay's car and asking whose child the "little boy" was. McKay said she was Kematch's girl and that she was "too ugly to be his child." The child was Phoenix.[862] Bear said Phoenix looked sad.[863]

Garson lived on Provincial Road 224, two houses away from the house Kematch and McKay were renting. She estimated that it was a five-minute walk between their houses. Garson also recalled the encounter at Marciniak's store. McKay's stepmother was in the front of the car, and Kematch, the baby, and Phoenix were in the back. She also thought that Phoenix was a boy, because she had short hair.[864]

Garson said she visited McKay's house three times but never saw Phoenix, or any sign that a girl of Phoenix's age had been living there. McKay came to her home three times, she said, but neither Phoenix nor the baby was with him. When he came to her house with Kematch one day, Garson asked him where Phoenix was. He said she was with her "granny," and Kematch and McKay started laughing. Garson testified that she did not think anything about that reaction at the time.[865]

She remembered once seeing McKay and Kematch walk by her house pushing a baby in a stroller, with an older female child walking behind them. Garson couldn't remember when this happened, but she recalled Kematch yelling and swearing at the older child, telling her "f-ing hurry up and walk." Garson saw this from a distance, and didn't recognize the little girl.[866]

Alison Kakewash was one of McKay's nieces. She described McKay as "mean" and "wicked." She testified that Kematch and McKay stayed at her mother's house in Fisher River in the spring of 2005, before they moved into Murdock's house. Kakewash was living in Fisher River at the time and visited her mother's house while Kematch and McKay were staying there. She recalled seeing their baby girl at the house, but not Phoenix. Kakewash said that her mother (now deceased) eventually told them to leave.[867]

Kakewash, who was 19 at the time, said she visited Kematch and McKay at the Murdock house "six to ten times or more," the last time being in July 2005. She said she saw Phoenix there twice. The first time, Phoenix was happy, but afraid. She looked small, skinny, and unhealthy, and her hair was short. Kakewash told of McKay getting angry at Phoenix. She said he grabbed her roughly by the arm, shoved her into a dark room, and called the child "a fucking bitch."[868]

Kakewash was at the house for a couple of hours that day, and Phoenix didn't come out of the room. She said that both she and Kematch asked McKay if he was going to let her out, and McKay said, "No," and offered no explanation.[869]

Kakewash described the second, and last, time she saw Phoenix, at the Murdock house:[870]

> *A: . . . She was in the room, first room on the left. I went to the door, opened it, and she was standing there with a blanket over her head. She was in a panty and she was just standing there looking at me. And I asked her what her name was 'cause I didn't know if that was Phoenix or not but she just stood there and my uncle told me to get out of that room, shut the door and get out, so I did.*

She said the room was dark and Phoenix looked sad. McKay told her that he was not going to let Phoenix out of the room because she was a bad little girl.[871]

Kakewash testified that what she saw had caused her concern. She said she told her mother that McKay was "mean" to Phoenix, and she considered making a report to CFS, but ultimately did not because she was afraid that McKay might retaliate against her.[872]

5.25.6 MCKAY'S SONS WITNESS PHOENIX'S ABUSE

Doe #1, only 12 years old at the time, witnessed Kematch and McKay commit horrific abuse of Phoenix during the time he lived with them at Fisher River.

When Doe #1 moved into the house, Kematch, McKay, their baby daughter, and Phoenix were already living there. At first, Phoenix slept in the room to the left of the front door of the house, he said, but after a couple of weeks, Kematch and McKay put her in the basement. He testified that Phoenix mostly stayed in her room, being let out on occasion. She was out in the community only a couple of times. He did not remember people visiting in the house.[873]

Doe #1 testified that Kematch and McKay would yell at Phoenix and call her degrading names, and they barely fed her. He said that the basement where they made Phoenix spend most of her time was cold and dark. He would try to feed her when Kematch and McKay were not around. He testified that Kematch and McKay never took Phoenix to the doctor or sought any medical attention for her.

The physical abuse started with spankings and then escalated, he said. He saw McKay hit Phoenix with a pole, a broomstick, and a fridge handle, and he saw him stomp on her. He also saw McKay shoot Phoenix with a BB gun, and choke her until she passed out—a "game" that McKay called "choking the chicken." Doe # 1 also saw Kematch hit Phoenix with her fists and saw both Kematch and McKay force Phoenix to eat her own vomit.[874]

Doe #2 spent less time in the Fisher River house than his younger brother but was also witness to the horrible abuse that Phoenix suffered. He said he went to the house four or five times between April and July 2005. He testified that Kematch and McKay yelled at Phoenix. He never saw them give her food, and when he tried to feed Phoenix, Kematch yelled at him.[875]

His mother, Doe #3, testified that she gave money to Kematch and McKay from time to time because the boys were calling from Fisher River to tell her they were hungry and had no food.[876]

5.26 PHOENIX IS MURDERED

5.26.1 MCKAY'S SON WITNESSES PHOENIX'S DEATH

Kematch and McKay's abuse culminated in Phoenix's death in June 2005. Doe #1 testified to having witnessed the beating that took her life. He said McKay beat Phoenix for 15 to 20 minutes, in the basement, with Kematch watching from the basement stairs. Doe # 1 said he was scared, and peeked from around the corner. When Phoenix was dead, Kematch and McKay left the house:[877]

> *A: "They told me they were going to go to my grandpa's, go get some pie and go check up on him, and then they left with my little sister [the couple's baby], told me to watch her."*

Doe #1 testified that he went to the basement to check on Phoenix after they left:[878]

> *A: … Went downstairs, checked it out, thought she was laying there. And then, and when I just checked it out, touched her, she's all cold and shit. Was all cold. And I put my hand by her mouth. She wasn't even breathing.*

He telephoned his grandfather's house to speak to his father but did not tell his grandfather what had happened.[879]

5.26.2 KEMATCH AND MCKAY REMOVE PHOENIX'S BODY FROM THE HOME

Kematch and McKay soon returned to the house. Doe #1 testified that they brought Phoenix upstairs, put her in the bathtub, tried running water on her, and tried CPR. Then they wrapped up her body and put her in the trunk of McKay's car.

Doe #1 testified that he was the only witness to these events, except for Kematch and the baby.[880] Kematch and McKay told him "that if anybody asks, that she went to go live with her dad in Winnipeg."[881]

After Phoenix was killed, Kematch and McKay took him back to his mother's home in Winnipeg. He believed that over that weekend they cleaned up and painted the basement of the rented house. Then they returned to Winnipeg to pick up both boys and brought them back to Fisher River. By that time, "everything was all painted and cleaned up."[882]

5.26.3 THE FAMILY, AFTER PHOENIX'S DEATH

Alison Kakewash testified that she visited Kematch and McKay about a week after she had last seen Phoenix. She knocked at the back door of the house and let herself in. She said that on entering the house, she had a "bad feeling." She saw dried "drips of blood" on the landing inside the back entrance to the house.[883]

Kematch, McKay, and their baby were inside. Kakewash testified that Kematch was "on the computer, weeping." McKay appeared busy, going up and down the basement stairs. She testified that this was unusual. She usually saw McKay sitting down or lying in bed. When Kakewash asked about Phoenix, Kematch said, "We sent her back." Kakewash said she was told that Phoenix was sent to live with her father because she was "too bad." Kakewash recalled asking Kematch why she was upset, but McKay cut Kematch off, saying, "she's having a bad day." Kakewash said she was shocked to learn that Phoenix was sent to live with her father, because "she wasn't bad when I seen her, those two times I seen her, she did not look bad at all. She looked sweet, innocent girl."[884]

Kakewash testified that she kept the visit short because she was scared. She didn't give any thought to contacting CFS or the police because she accepted what Kematch and McKay told her.[885]

Cecilia Stevenson lived three miles or so from Fisher River. She was related to Doe #3 and was quite close to her. She had met McKay more than 20 years before the time of her testimony at the Inquiry. She said he was "always very polite, very personable, talkative." Stevenson had never seen McKay behave violently and only learned many years later from Doe #3 that he had been abusive during their relationship. Stevenson had known Doe #1 and Doe #2 since they were babies.[886]

Stevenson testified that she spent time with Doe #1 around early June 2005. He called, wanting to come for a visit, so she took him to her house in Peguis. He played with her grandson, but he didn't mention anything to her about Phoenix, Kematch, or McKay.[887] Doe #1 came to Stevenson's house again a few days or a week later, and again made no mention of Phoenix, Kematch, or McKay.[888]

In his testimony, Doe #1 said he never told Stevenson about what was happening to Phoenix because he was afraid.[889]

5.26.4 DOE #3 HEARS OF PHOENIX'S ABUSE

Doe #3 stayed in touch with her younger son, Doe #1, while he was in Fisher River. She testified that they would chat using a webcam "once every few weeks," and would speak on the phone. She said her son looked "scared, and he looked like he was in a rush to get off the computer" when they spoke on the webcam. He told her that his father was "mean" to him.[890]

He also told her that Kematch and McKay would spank and hit Phoenix, and lock her in a bedroom.[891] Doe #3 testified that she never saw Phoenix over the webcam.[892] She said that about two to six weeks after her son began staying there, he told her he wanted to come home. She understood that his reason was that there was nothing for him to do.[893]

She remembered being with the Doe #1 and Doe #2 at a restaurant during the summer of 2005. They told her that Kematch and McKay shot at the little girl with a pellet gun, and they told her about a "game" called "choking the chicken." In this "game" McKay would grab Phoenix and choke her, and Kematch and McKay would laugh. She said her sons told her these things more than once, including over the phone and on the webcam from Fisher River.[894]

Doe #1 recalled staying in touch with his mother during this time.[895] His evidence was that he had told her about some of the "lickings" he saw Phoenix receive. He also recalled their conversation in the restaurant, about the "choking the chicken" game. He said he feared for his safety while he was living in Fisher River. McKay got angry with him one time that summer and grabbed his BB gun and pointed it at him, he said. It was a couple of months after he moved to Fisher River that he asked his mother to have him brought back to Winnipeg permanently.[896]

Doe #3 testified that she believed that she made a telephone call to a CFS agency to report that her boys had no food and she was concerned about them. She believed she mentioned Kematch's daughter, but could not be more specific. She could not recall whether she told the person anything of what she had heard about Kematch and McKay's treatment of the little girl. She said she got the agency's phone number from directory assistance, and spoke to someone who told her that everyone was on holidays. She believed someone would get back to her, but no one ever did. She could not recall the date of this call, but believed it was before the two boys came home on July 13, 2005.[897]

No CFS record of such a call could be found.[898] Grant Wiebe was a worker with MacDonald Youth Services, which had provided counseling to Doe #3 and Doe #1 in 2005. His records from November 2005 indicate that Doe #3 told him that she had reported suspected abuse of a young girl to child welfare in the summer of that year: [899]

> *The client also reports that while in the home a four-year-old girl was being abused by the father and the stepmother. The client informed his mother secretly via the Internet of the ongoings and the mother contacted Child and Family Services. The mother reports that the family was then investigated and the client and his older brother were returned home.*

Wiebe testified that he recalled the meeting he had with Doe #1 and Doe #3 when this information was discussed. He testified that he did not contact child welfare himself because, he said, "I did not believe I had further information to add beyond what had been reported already, and I believe the information that had been provided to CFS had been investigated."[900]

While I find that it is likely that Doe #3 called a Child and Family Services agency in the spring or summer of 2005, referencing a four-year-old girl, the evidence does not indicate which agency she called, when the call was made, or what was said by whom. No further conclusions can therefore be made about this evidence. I do not hold Doe #3 for the lack of detail in her evidence. Years have passed since these events, and by her own evidence, she and her sons were traumatized by their involvement in this tragedy.

5.26.5 INTERTRIBAL CFS INVESTIGATES SONS' SITUATION, JULY 2005

In July of 2005, Intertribal Child and Family Services received a referral about an inadequate care provider for two boys at McKay's house in Fisher River. Workers Madeline Bird and Violet Sinclair investigated. At the Kematch and McKay home they found Doe #1 and Doe #2 with someone who was subject to an outstanding arrest warrant. They contacted Doe #3 and made arrangements for her sons to be returned to her.

Violet Sinclair, who went into the basement, testified that she saw no signs of a little girl having lived in the house.[901] Bird testified that in her conversation with Doe #3, there was no mention of Phoenix Sinclair, or of a girl being abused.[902]

Doe #1 testified that he did not mention Phoenix to the workers who came to the house on July 12, 2005, because he was scared.[903]

5.26.6 NO ONE KNOWS PHOENIX IS MISSING

Bear recalled a day in August 2005 when she picked up Kematch and McKay from their rented house to take them to a social gathering at her home in Peguis. She didn't go inside their house that day. She didn't ask about Phoenix and neither Kematch nor McKay mentioned her. She didn't notice toys or any signs of children in the yard.[904] There were about 25 people gathered at her house that day, including her sisters, Bird and Garson. They were there for a couple of hours, but Bear did not remember anyone mentioning Phoenix's name.[905]

In May 2005, Ashley Roulette was communicating with Kematch through an instant messenger service and sometimes webcam. She learned from Kematch that Kematch and McKay had moved to Fisher River "because CFS was bothering them."[906] Ashley Roulette never saw Phoenix over the webcam, but did see Kematch and McKay's infant daughter. She testified that they discussed Phoenix "once in a while" and Kematch would say that Phoenix was with her father.[907]

McKay's niece Amanda McKay also kept in touch with Kematch in Fisher River through instant messenger and webcam. She testified to having seen Phoenix via webcam, playing in the background, but couldn't see her clearly and never spoke with her during those chats.[908]

During that summer, McKay asked if Kematch could stay in her apartment in the McGee Street complex while he was on the road, driving his truck. Amanda was staying in Pine Creek at the time, and she allowed Kematch to use her apartment. By the time Amanda returned in September 2005, Kematch had already moved out.[909]

Ashley Roulette testified that she lived with Kematch in Amanda's apartment between June and the beginning of August 2005. Kematch had her infant daughter with her, but not Phoenix. McKay wasn't there. Roulette understood that he was working on the road at the time. During this time, when Roulette asked about Phoenix, Kematch said she was living with her father in Ontario, "and if I asked when – if she would ever come back, she would just say no."[910]

Amanda saw Kematch at the end of August 2005 when Kematch and McKay were in Pine Creek for a funeral, with their baby daughter. She testified that when she asked them about Phoenix, they told her she was living in Ontario with her father. Amanda didn't know who Phoenix's father was.[911]

Lisa Bruce communicated with McKay by webcam when he lived in Fisher River. She also spoke with Doe #1. Bruce never saw Phoenix over the webcam and never spoke to McKay or Doe #1 about Phoenix. [912] Bruce recalled that Kematch and McKay came back to Winnipeg with their baby for a visit in August 2005, and Phoenix was not with them. Bruce did not recall asking them about Phoenix during that visit.[913]

Doe #4 lost contact with McKay and Kematch in early 2004, but reconnected with them in July 2005, when the couple gave her a ride to a barbeque. They did not have their baby girl or Phoenix with them. When she asked about Phoenix they told her that she "was with her aunt in Ontario." Doe #4 did not ask any more questions after that. She knew who Phoenix's father was but had not had any contact with him.[914]

6 PHOENIX'S DEATH IS DISCOVERED

6.1 AN AUNT'S INQUIRIES GO UNHEEDED, AUGUST 2005

6.1.1 PHOENIX'S AUNT MAKES INQUIRIES

As reported earlier, Kematch would visit her aunt, SOR #10, after her new baby was born in November 2004. The baby would be with her, but never Phoenix. Whenever asked, Kematch would say that Phoenix was staying with McKay's niece,[915] but her aunt continued to inquire:

> *Q: Now, going into the summer of 2005, did you continue to ask where Phoenix was?*
>
> *A: Every time I saw Samantha, that was the first question out of my mouth.*[916]

Eventually SOR #10 took matters into her own hands. She testified that she spent a whole day around mid-August 2005 contacting CFS agencies in Manitoba in search of information about Phoenix.[917] She didn't know which CFS agencies she should contact, so she asked an acquaintance of Kematch's about Steve Sinclair's band. She testified about how she went about trying to find information about Phoenix:

> *Q: Where did you find the phone numbers? How did you know where to call?*
>
> *A: Phone books, a lot of it was done through phone books and 411, assistance directory and that's how I got a hold of all my numbers.*
>
> *Q: And do you know who answered your calls?*
>
> *A: Most of the people were, that I had talked to were from the front desks of the agencies. It was never any actual social worker that I had spoken to, up until Nicole.*
>
> *Q: And do you remember what information you gave the people you talked to on the phone?*
>
> *A: Yes, I do.*

Q: What did you tell them?

A: I told them that I was an aunt that was looking for my niece by the name of Phoenix Victoria Hope Sinclair, born April 23rd, 2000. And that I hadn't seen or heard from her and I was concerned and that I wanted to get a hold of the social worker that was, that was caring for her at the time. That way, I could at least try to get some kind of knowledge or clearance that I knew she was okay, or that I could see her again.

Q: Did you say whether you had concerns about Phoenix?

A: I told them I was worried about her wellbeing because I knew how Samantha was and I told them that every time Samantha had come into the city, that Phoenix was never with her and that was a bit of a concern for me, because she was always bringing in the other child, but never Phoenix.

Q: You said up until you spoke to Nicole, you didn't get names of workers; right?

A: No, I did not.

Q: But do you recall what the workers said to you, in response to your call?

A Every time I had, had given Phoenix's full name and her date of birth, knew one, no one knew of her, or has heard of her, so they said they couldn't help me because she wasn't in the system.

Q: Do you recall whether they asked you any questions?

A: No, they did not.[918]

She testified that the agency at Sinclair's band at Lake St. Martin directed her to a worker named "Nicole," who directed her to Stan Williams. She said she contacted Williams and told him that she was Phoenix's aunt by marriage and she was looking for Phoenix. SOR #10 recalled being told by Williams that because she was not a blood relative, he could not disclose any information to her. His last words to her were that Phoenix was doing "fine and well."[919]

6.1.2 WORKERS SEARCH CFSIS FOR PHOENIX IN AUGUST 2005

Through CFSIS, the Department of Family Services can track certain searches that workers conduct on the system. Before April 1, 2005 CFSIS could track only a "search for person." After that date, the system could also track a prior contact check, and a "search for address."[920] The Department provided the Commission with a report of CFSIS searches conducted by CFS workers for the name "Phoenix Sinclair." It shows that on August 24, 2005 a variety of CFSIS searches were conducted by a number of workers, as detailed below.[921]

Jennifer Strobbe was a social worker at the CRU in 2005. She would receive a variety of phone calls from members of the community, including reports of abuse or neglect. According to her testimony, when taking a call, she would generally begin by asking the purpose of the call. Then she would ask for demographic information, which she would enter into CFSIS, to see if the family had had prior contact with the agency. As of May 2005, she would also search the intake module,

which was at that time a new application for logging new referrals. CFSIS searches were a part of her daily duties, but she didn't do them randomly, she said, meaning that a search was always prompted by an inquiry of some sort.[922] Winnipeg CFS records[923] show that on August 24, 2005 Strobbe performed the following searches on the CFSIS system for variations of Phoenix's name:

"pheonix, sinclair" at 11:05 a.m.

"F,01 Jan 00, Sinclair, Phoenix" at 3:26 p.m.

"sinclair, phoenix" at 3:29 p.m.

"phoenix, sinclair" at 3:29 p.m.

"phoenix sinclair" at 3:31 p.m.

(January 1, 2000 was the default birthdate she used if she didn't know a person's actual birthday, Strobbe said.) She testified that although the records show that she performed the above searches, she had no recollection of them, nor could she explain why she did them, or what the results were.[924]

Four minutes after Strobbe's first search on August 24, 2005, family service worker Stan Williams, who is now deceased, performed this CFSIS search:

"F, 01, Jan 00, sinclair, phoenhix" at 11:09 a.m. [925]

Strobbe had no recollection of any interaction with Williams about this matter. There was no indication that Strobbe had opened a file relating to Phoenix or her family. She could only speculate that she did not open a referral because she had received no information giving rise to a child protection concern that would require follow up.[926]

She testified that she did not retain notes unless a file was opened. Her usual practice as a call came in, was to make handwritten notes of the name of the individual, and any protection concerns. She kept her notes in her desk and shredded them when she left her position with CRU.[927]

She had no recollection of receiving a call from SOR #10, but she testified that her CFSIS searches for Phoenix likely would have been prompted by a phone call. If she had been given the information that SOR #10 said she provided about her concerns for Phoenix, she would have asked some questions, Strobbe testified. If there were no protection concerns, she would not have done anything further. She also said that *The Child and Family Services Act* would have prevented her from sharing information about Phoenix with an aunt.[928]

The fact that she ran multiple searches in one day was not an indication that she had a particular concern about this child, Strobbe said. Before she could open a file, she needed to be presented with a child protection concern that warranted further investigation. She agreed that this decision was hers to make, and that in this case, she did not create a report of the call, or of her searches.[929]

She further testified that without additional information, she would not have considered the fact that an aunt had not seen Phoenix in a long time to be a child protection concern, even in a family with a history of involvement with child welfare. There may have been many reasons for past involvement, which were not necessarily current child protection concerns, she said.[930]

Marie Chammartin was the receptionist and switchboard operator at the intake unit. She was not herself a social worker. She received calls from members of the public as well as from police, hospitals, and other agencies.[931] For calls involving a child welfare matter, her practice was to write down on a piece of paper information such as the child's name and birthdate, and the mother's name. Then she would do a prior contact check. If that check showed that there was an open file, she would transfer the call to the social worker. If there was a closed file, or if it was a new matter, the call would go to the Crisis Response Unit.[932] If a call could not get through to CRU, she would take a message and write a brief overview of the presenting problem, for the CRU worker. From time to time, a caller would ask for a particular worker, in which case she would simply transfer the call to that person.[933] She shredded her notes of demographic information at the end of the day.[934]

Records show that Chammartin performed these prior contact checks on August 24, 2005:

> *"F, 01 Jan 00, Sinclair, Phonix" at 2:50 p.m.*
>
> *"F, 01 Jan 00, Sinclair, Phoenix" at 2:56 p.m.*
>
> *"F, 01 Jan 82, Kematch, Samantha" at 2:57 p.m.* [935]

Chammartin had no recollection of these searches, but she did not do random checks, so any check done would have been in response to a call, she said.[936] She also had no recollection of talking to any workers about Phoenix Sinclair, or of receiving a call from SOR #10, or of referring it to CRU.[937] She explained that she received a high volume of calls and after such a long time, would not remember a specific call.[938]

Given that she is shown to have conducted searches from 2:50 to 2:57 p.m. and Strobbe conducted multiple searches after 3:00 p.m. that same day, it is a fair assumption that she may have transferred the referral call to Strobbe at CRU, according to Chammartin's testimony.[939]

Harold Miller was another intake receptionist, who worked the same shift as Chammartin. When shown a record of a search for Kematch done by Miller at 10:54 a.m. that day, and another by CRU worker Strobbe at 11:05 a.m., Chammartin agreed that it would be a fair assumption that Miller also transferred a call to Strobbe.[940]

Deanna Shaw was a family services worker with Metis Child and Family Services in August 2005. She had her own caseload and did not receive calls from the community, as would a worker in the CRU. A call would be transferred to her from the CRU if it concerned a case that had been assigned to her. She would use CFSIS to do a prior contact check to find out whether a case was open or closed, and to find a family's history.[941]

Records show that Shaw performed four searches for variations on Phoenix Sinclair's name on August 24, 2005: [942]

"U, 01 Jan 00, Sinclair, Victoria Hope, Phoniex" at 2:14 p.m.

"ph%sinclair" at 2:15 p.m.

"phoniex, sinclair" at 2:15 p.m.

"phoneix, sinclair" at 2:15 p.m.

Shaw had no recollection of having performed these searches, nor of the results, nor did she recall having any contact with Stan Williams about Phoenix or about these searches.[943]

She testified that if she had received information from an aunt that Phoenix had not been seen for a while, even given the family's extensive history with CFS, this would not have been enough for her to refer the matter for further investigation because many children are moved around. But if she had received more specific information that Phoenix was being hurt, she would have made a referral to Intake.[944]

Shaw testified that she would not typically make notes about a call unless the call related to one of her own files; but if the call raised immediate child protection concerns, she would document it and would make a referral in writing, and probably orally as well, to the CRU.[945]

Nicole Lussier was another family services worker with Metis CFS in 2005. She too did not typically receive phone calls from the community. Calls that pertained to her caseload would be transferred to her from the receptionist. Like the other workers, she testified that she would perform CFSIS searches and prior contact checks during the course of her work, but only when prompted by developments in her cases. [946]

Records[947] show that Lussier performed this search on August 24, 2005:

"F, 01 Jan 00, sinclair, phoenix" at 1:57 p.m.

Lussier had no recollection of performing this search, and no recollection of a conversation with SOR #10. She did not remember telling SOR #10 that the case had been transferred to Stan Williams, although she agreed, "anything is a possibility." She said she knew Williams and he was working with her at Metis CFS at that time.[948]

Lussier testified that she would have made a note of such a call. She kept these notes in a box and when the box was full the contents would be shredded. It took about four to six months to fill the box, she said.[949]

The call reported by SOR #10, even with the child's recent history with CFS, would not have prompted her to refer the matter to Intake, Lussier said. Without something more specific about abuse or neglect, she would have interpreted this as an information-seeking call, and might have suggested that the caller contact the CRU.[950]

Counsel for the workers who did these CFSIS searches on August 24, 2005 submitted that there is no evidence that they did anything that should cause the Inquiry any concern whatsoever. There was no evidence of a policy requiring social workers to keep a written record of the reason for every computer search. If the workers did speak to SOR #10, it is not known what words were spoken, and SOR #10 acknowledged that she did not specifically say to any of the social workers that she had concerns for Phoenix's safety. Counsel pointed to the evidence of CRU worker Strobbe, for example: she testified that if she had been given information to suggest that a child was missing, she would have investigated further. Counsel submitted that the workers would have had no reason to keep notes of their discussions with SOR #10, or to open a file and investigate further.[951]

I accept SOR #10's evidence that she called a number of CFS agencies on August 24, 2005, and that these calls explain the CFSIS searches for Phoenix and Kematch that were done that day. I accept SOR #10's evidence that in these calls, she expressed her concern that she had not seen or heard from Phoenix and that every time Kematch came into the city she brought her other child, but never Phoenix. I also accept her evidence as to the conversation she had with Williams. On cross-examination she acknowledged that although her concerns for Phoenix's safety were based on her knowledge of how Kematch treated her, she did not convey this to any worker.[952] She also testified on cross-examination that she would have given workers any information she had, and that she was frustrated because workers didn't question her or ask her for details.[953]

Sandra Stoker is CEO of All Nations Coordinated Response Network (ANCR), which is the agency currently responsible for all intake functions in Winnipeg. She testified that if a family member called the agency saying that they had not seen a five-year-old relative for months, the worker should do a search and ask further questions, such as: Is it unusual that you have not seen the child? When was the last time you saw the child? Have you talked to the parents? She said this type of call should be recorded.[954]

A review of the information contained in CFSIS would have told any worker performing a CFSIS search that the agency had opened Kematch's protection file as recently as March 2005 and December 2004. It would also have shown that the agency had not had seen Phoenix since July 2004.

SOR #10's report to CFS workers, combined with the available history of this family, ought to have prompted those workers to ask further questions. But in any event, the information they did receive, against the background of the family's history as revealed on CFSIS, ought to have triggered an investigation and assessment of Phoenix's safety and well-being.

The Inquiry heard extensive evidence that young children are particularly vulnerable because they are isolated from the eyes of the community. It also heard repeatedly from workers that the system relies on reports from the community to bring child protection concerns to its attention, and yet the workers who performed CFSIS searches on August 24, 2005 in response to calls by a concerned family member failed to investigate whether Phoenix was in fact in need of protection. And because they failed to open a file, their actions were not subject to supervisory review, which I have been told is a form of quality assurance within the agency.

One of the questions that I am mandated to answer is, why the death of Phoenix Sinclair remained undiscovered for months. The evidence that these workers failed to appropriately respond to the reports that were made about Phoenix on August 24, 2005, points towards an answer. Unbeknownst to anyone but Kematch, McKay, and Doe #1, Phoenix had been murdered some two months earlier.

6.2 KEMATCH AND MCKAY RETURN TO WINNIPEG

6.2.1 FAMILY MOVES BACK TO MCGEE STREET WITHOUT PHOENIX

Kematch and McKay left Fisher River and moved back to Winnipeg in the autumn of 2005. Doe #4 went to Fisher River in October or November to help Kematch pack. Kematch and McKay picked her up in Winnipeg, and McKay was dropped off at the Seven Oaks Hospital. She stayed for one night in Fisher River with Kematch and the baby. Doe #4 didn't go to the basement, and saw nothing suspicious in the house.[955] She witnessed Kematch, who was again pregnant, using crack and told her it was wrong to smoke crack while pregnant. She testified that she didn't call CFS about this because she did not want Kematch and McKay's baby to be taken away.[956]

SOR #9 testified that Kematch and McKay lived with her in Winnipeg for about a month before moving in to their own apartment, again on McGee Street. They had their baby daughter with them.[957] She said they told her that Phoenix had been apprehended by CFS when it was discovered that one of McKay's nephews, who was subject of an arrest warrant, was watching his kids in Fisher River while he and Kematch were on the road. They told her that the nephew was picked up, McKay's sons went back with their mother, and Phoenix was apprehended.[958]

Lisa Bruce asked about Phoenix after Kematch and McKay moved back to Winnipeg in the fall of 2005. She recalled being told that Phoenix had gone to live with her father in Ontario. She didn't know who Phoenix's father was. [959]

Amanda McKay said that she saw Kematch and McKay at their baby girl's first birthday party in November 2005. When they were asked about Phoenix, they said she was living with her father.[960]

6.2.2 KEMATCH'S FIFTH PREGNANCY

During her pregnancy with her fifth child, Kematch was once again referred by a nurse to hospital social worker SOR #4, at the Women's Hospital. This referral, dated September 12, 2005, noted that Kematch's due date was December 12, 2005 and that she was living with her nine month-old, and her five-year-old daughter.[961] This reference to Phoenix was, sadly, untrue.

SOR#4 met with Kematch on October 6, 2005 to assess her situation and find out if Kematch was looking for any further supports.[962] She made notes of their meeting:

> *Samantha is known to writer from pregnancy of last year. She continues to parent her 5 yo & now 11 mo daughter. Continues in a relationship w/ PF Wes McKay. She says she has been living at Koostatak but likes city better & may shortly move back. PF's sister/family continue to supports [sic]. Presently, despite preg w/ 11 mo at home feels things are going well not feeling need of social work support at this time. There were no child protection concerns or CFS invol. at last delivery & as pt feels coping well/not identifying issues S.W. fu need not continue unless requested by patient.*[963]

SOR #4 testified that she based her assessment on the information she received from her last contact with CFS. She believed that CFS had not followed up on the referral she made to it on December 1, 2004 and because of that, she did not make a referral to CFS during this fifth pregnancy. Her information that Kematch's 11-month-old baby and five-year-old were in her home, contributed to her belief that CFS had no child protection concerns.[964] Of course that information, so far as it concerned Phoenix, was mistaken.

SOR #4 said she was unaware that Kematch had been the subject of a CFS referral again in March 2005. Kematch did not tell her, nor did CFS report this information to her. When Kematch gave birth in December 2005 at Women's Hospital, SOR #4 testified that she had no information that would raise child protection concerns.[965]

6.3 MCKAY'S SON DISCLOSES PHOENIX'S DEATH

On February 28, 2006, Doe #3 took her older son, Doe #2, to a walk-in-clinic.[966] In the waiting room, after seeing the doctor, Doe #2 told his mother that "his dad had killed the little girl."[967] Doe #2 told her that he was not in the house on the day that Phoenix was killed and did not know that she had died until his younger brother told him, after they returned to Winnipeg, that Kematch and McKay had killed her.[968]

Doe #3 recalled that Doe # 2 seemed scared when he revealed this to her. When she went home and talked to Doe #1, he got mad at his brother for telling her what had happened.[969]

Doe #3 testified that she contacted Intertribal Child and Family Services the same day that her son disclosed the murder to her,[970] and Doe #1 recalled that his mother began making calls as soon as she returned home from the clinic on February 28, 2006.[971] ICFS records indicate that the call came on March 6, 2006.[972]

Doe #1, who had witnessed the murder in June 2005, explained what finally prompted him to disclose it to Doe #2 some eight months later. He testified that when he visited Kematch and McKay at their home in Winnipeg, McKay appeared to be putting a table together. He said he saw McKay "smash" the baby girl's hand with a screwdriver, "and after I seen that, I was like, shit, you know, I ain't going to fucking let him do it again, and that's when I said something." A couple of days later he told his brother, Doe #2, about Phoenix's death.[973] Doe #2 didn't tell anyone right away, but eventually made the disclosure to his mother.[974]

6.4 ICFS RECEIVES REPORT OF PHOENIX'S MURDER

Doe #3's call to ICFS was received by Randy Murdock, a program coordinator in the Winnipeg office. His notes indicate that Doe #3 gave him the details of Phoenix's murder and burial as disclosed to her by her sons. Murdock telephoned ICFS Executive Director Shirley Cochrane to inform her of the call he had received, and to ensure that he was taking the appropriate steps. Then he phoned the police.[975]

Doe #3 testified that police officers came to her house the same day she spoke to Murdock.[976] Police records indicate that they interviewed her and learned the details of her son's disclosure of Phoenix's murder, and information about the identities of Kematch and McKay.[977]

Murdock contacted the RCMP the next day to make sure they were following up on his phone call and was referred to Constable Robert Baker. Based on their conversation, Murdock undertook to look for CFS information about the family. He told Baker on March 7, 2006 that ICFS did not have an open file, but that Winnipeg CFS had had contact with the family.[978] He testified that he found this information by doing a CFSIS search of Kematch. Murdock testified that his notes indicate that he told Baker, among other things, that Winnipeg CFS had closed a protection file on March 9, 2005 and that the assigned worker had been Christopher Zalevick [*sic*].[979]

6.5 RCMP INVESTIGATE THE DISAPPEARANCE OF PHOENIX SINCLAIR

Corporal Robert William Baker of the RCMP was the lead investigator assigned to the missing person and homicide investigation of Phoenix Sinclair.

In 2006, Baker was a member of the Serious Crimes Unit, based out of Winnipeg. He became involved in the investigation after his Sergeant was advised that Doe #3 had disclosed to child welfare that her sons had witnessed a homicide. He testified that ICFS had made a report to the Winnipeg Police Service, who determined that the offence had occurred in the RCMP jurisdiction of Fisher River. Baker was asked to head up the investigation to determine the whereabouts of Phoenix Sinclair and if indeed there had been a homicide.[980]

Baker contacted Corporal Ken Genaille of the RCMP Fisher Branch detachment. Genaille was not aware of anyone missing in the community.[981]

On March 8, 2006, Baker checked with the Winnipeg School Division and learned that Phoenix was last in its system in September 2004 and "only for a month and not since."[982] That same day, he also checked the Canadian Police Information Centre (CPIC) database, in an attempt to determine the whereabouts of McKay, Kematch, and Phoenix. CPIC is a database managed by the RCMP and accessible to all police agencies across Canada. It includes criminal records, firearms records, missing persons reports, and a variety of other information of use to law enforcement. Baker testified as to the results of his CPIC search:

> A: *There were no results for Phoenix Sinclair. There was nothing on the system that, or the CPIC system that she was reported missing and recorded there as such. There was nothing there for Samantha Kematch, but there was for Karl Wesley McKay and what I noted were there were three violent convictions for, for assault and there were other convictions for failing to comply with court orders, breaches, that sort of thing.*[983]

Baker then contacted the Child Protection Branch to determine whether they had had any involvement with Phoenix and was advised that they would retrieve her file.[984] Baker explained the method he used to locate this missing child:

> A: *. . . to find missing children is much more difficult than finding missing adults. It depends on the circumstances. To find a missing child in this case, there was an allegation of foul play, of homicide. There was involvement with Child and Family Services. And so these were likely avenues of investigation I determined at that time would assist in locating her or finding out what happened. For other children it might be different to – in a child's life, around the child the central figures are the child's parents, the child's family, the child's siblings and extended family and it moves out to friends and the community, the community leaders, schools, to Child and Family Services and then finally out to the police and in a missing child investigation you would follow that, you would follow those aspects of involvement in a child's life and make inquiries with family and friends and school and that sort of thing. But*

in this, in this instance it was a little bit different because Child and Family Services at the outer area was already involved. So I started the investigation from those, from those areas.[985]

Baker took statements from both boys and their mother (Doe #1, Doe #2, and Doe #3) and learned that Doe #1 had witnessed the torture and murder of Phoenix Sinclair and that Phoenix's body had been disposed of in the woods.[986]

On March 9, 2006, Baker spoke to EIA employees about Kematch and McKay. He said he had contacted them earlier, for information in the course of his investigation. Now, his plan was for EIA to determine if, in fact, Kematch and McKay had Phoenix with them. He would use EIA employees to ask for access to Phoenix on the pretense that they were seeking confirmation of the family's dependents, as they were claiming EIA benefits for her.[987]

That same day, Provincial Welfare Investigators Ed Mann and Lyle Moffatt went to the McKay apartment on McGee Street. They asked Kematch and McKay to let them see Phoenix and were told that she was with an aunt. Mann and Moffatt then asked Kematch to bring Phoenix to meet them that afternoon at Winnipeg's Portage Place Mall.[988]

6.6 KEMATCH AND MCKAY ARE ARRESTED

At the meeting with the EIA Investigators at the mall, Kematch produced a little girl who was not Phoenix, according to Baker's testimony. At that point, police arrested Kematch for Phoenix's murder.[989] McKay was arrested later that same evening.[990]

Baker recalled Kematch's reaction upon being informed that she was being arrested for the murder of her child:

> *A: . . . Samantha Kematch is – her reaction, in my experience her reaction to this, her reaction to most anything was, was – she was very, she comes across as very non-emotional and I interviewed her later on for two hours and the only – she had no emotion about Phoenix Sinclair that I observed. Her only emotion that she had was about her own predicament.*[991]

Baker's description of Kematch upon her arrest is tragic and telling, in that it is entirely consistent with the observations by CFS workers who described her "flat affect" when Phoenix was born.

On March 10, 2006, McKay provided a warned videotaped statement to the RCMP about what happened to Phoenix. The RCMP's executive summary of the investigation into Phoenix's murder summarizes the information obtained from McKay:[992]

McKay confessed that he murdered Phoenix Sinclair on June 11, 2005 in the basement of his house in Fisher River, Manitoba.

He stated that Phoenix was making noise in the basement, so he tossed her into a pile of clothing and added that Samantha Kematch was present when this occurred. He stated that Phoenix was still breathing when he and Samantha left to go to his father's place and that soon after his son [Doe #1] called him and told him that Phoenix was not breathing.

McKay stated he and Samantha went home and attempted to revive Phoenix by performing CPR on her. When this was not successful, he put her into the bathtub with warm water. McKay stated that when he realized Phoenix was dead, he took her to the basement where he and Samantha wrapped her in clear plastic and bound her with packing tape. McKay stated that they also wrapped a raincoat around the outside of the plastic.

McKay stated that they waited until it was dark and then he and Samantha put Phoenix's body into the trunk of his Tempo. They drove out to the dump where they buried her a foot deep into the ground.

The RCMP also obtained a cautioned statement from Kematch, the same day. The executive summary describes its contents:[993]

She stated she was present when Phoenix was found, but emphasized that she was not responsible for Phoenix's death. Samantha stated that she and Karl wrapped Phoenix in black plastic garbage bags and a rain coat, and that Karl carried her upstairs once it was dark outside and put her in the trunk of the car.

She advised she and Karl drove to a heavily treed area past the garbage dump. A shallow grave was dug by both Samantha and Karl and Phoenix was buried there.

She stated she believed Phoenix died as a result of being pushed by Karl.

She observed a gash on Phoenix's back from a nail on the wall and also saw blood on the floor, possibly from Phoenix's head.

She admitted to beating Phoenix with a bar the night before she died, because Phoenix had been crying. She described choking Phoenix, and keeping her in a pen in the basement because she would "piss and shit herself".

She stated that they rarely clothed Phoenix for this reason. Samantha described incidents of abuse toward Phoenix, but cast the blame on Karl. Samantha admitted she forced Phoenix to eat her own vomit and stated Karl used to shoot at Phoenix with a BB gun, "just for fun".

> *Samantha stated that there was blood on the basement floor where Phoenix was found. She and Karl cleaned the blood from the floor and repainted it. She stated that if anyone were ever to ask about Phoenix's whereabouts, the story they provided was that she had gone to live with her father in Ontario.*

On March 15, 2006, Kematch and McKay were charged with first-degree murder in the death of Phoenix Sinclair. By that time, Phoenix's body had not yet been located. Two days later, Baker and Corporal Norm Charette of the RCMP met with McKay at Headingley Correctional Institution, to ask for his cooperation in locating Phoenix's body. McKay agreed to accompany them to Fisher River to show them where he had buried her.[994]

On March 18, 2006, forensic experts removed snow from the site where McKay indicated that he and Kematch had buried Phoenix. It was apparent that a shallow grave had been disturbed by animals. A body recovery team consisting of the Chief Medical Examiner, RCMP Forensic Identification Unit, and RCMP Serious Crimes investigators searched the area. There was evidence that this was where she had been buried but her body was not found there. Ultimately, with the assistance of the Department of Anthropology at the University of Winnipeg, soil taken from the area was found to contain bones and flesh, along with materials that had been used to wrap her body. DNA tests proved that the remains were those of Phoenix Sinclair.[995]

The RCMP investigation concluded that Kematch and McKay had continued to collect financial benefits for Phoenix for nine months following her death.[996]

6.7 SINCLAIR LOOKS FOR PHOENIX IN MARCH 2006

Steve Sinclair testified that when the police informed him that Phoenix was missing in March 2006 he immediately went looking for her at schools in central Winnipeg, where he had heard she had attended. He said he was told by Ramkissoon, the Principal of Wellington school at the time, that they had not seen her and they could not divulge any other information.[997]

Ramkissoon testified that she was interviewed by the RCMP on March 10, 2006. She told them that a young man had come in that day asking about Phoenix, saying that he was her father.[998] She described him as very agitated and distressed.[999]

6.8 KEMATCH AND MCKAY ARE CONVICTED OF PHOENIX'S MURDER

The Crown proceeded by way of direct indictment with its prosecution of Kematch and McKay for first-degree murder in Phoenix's death.[1000] They were tried together at a trial before a jury, presided over by Madam Justice Karen Simonsen of The Manitoba Court of Queen's Bench, between November 5 and December 12, 2008.[1001] Doe #1 and Doe #2 were key witnesses, called by the Crown. On December 12, 2008, the jury returned its verdict, finding both Kematch and McKay guilty of first-degree murder in the death of Phoenix Sinclair. Both were sentenced to lifetime imprisonment without eligibility for parole for a period of 25 years.[1002]

Kematch and McKay appealed their convictions to The Manitoba Court of Appeal. The appeals were heard on October 13 and 14, 2009. On March 4, 2010 the Manitoba Court of Appeal dismissed both appeals.[1003]

7 HOW DID THIS TRAGEDY HAPPEN?

During this Inquiry I stated, and I say again, that the professional responsibilities of a social worker are complex, difficult, and often stressful. This is particularly so for those who choose child welfare as their avenue of service. Family discord, disruptions, and sometimes acts of violence confront those doing fieldwork. They are often unwelcome in the homes of the families they serve, yet their presence there is essential to the discharge of their duties.

Despite these taxing conditions, some good work was done on this file. An example was the case plan and summary prepared by supervisor Orobko at the Northwest Intake Unit of Winnipeg Family Services following the first referral about Phoenix on the day after her birth, when she was immediately apprehended and taken into care. Within a week the supervisor had met with Phoenix's parents and he soon prepared a detailed case plan and a well-considered summary to guide the provision of services to the family. The following paragraph from that summary bears repeating:

> *The assigned worker shall have two primary issues to sort through in the coming months. Firstly, the question of parental motivation and commitment will need to be assessed and weighed on an on-going basis. Secondly, it will be necessary to determine Samantha's parental capacity. The preceding case plan should serve to quickly help the assigned worker with these matters so that long term planning can quickly occur for Phoenix.*

Though these words were there to be seen each time the file was opened—from May 2, 2000, when they were written, until March 9, 2005 when Phoenix's file was closed for the last time—they were never acted upon. Had those assessments been done, the services provided to this family would have taken a different course.

Within days of Phoenix's birth, Orobko had identified a lack of parental motivation. That lack of motivation and commitment was identified repeatedly, yet nothing was done about it. Kematch's parental capacity was questioned, but

never measured. Her "flat affect" and her indifference towards Phoenix were frequently observed, but never addressed.

The assessments identified by Orobko as necessary could have yielded critical information about the risks her parents posed to Phoenix's immediate and long-term safety and well-being. Phoenix should never have been returned to the care of either parent until those two assessments were complete, their results known, and the professional judgment of a responsible social worker applied to a determination of what was best for Phoenix.

But time and time again, the focus was limited to the short term. A worker would determine that there were no immediate protection concerns, the file would be closed, and the agency's services to the family would stop, until the next referral. Parental motivation, commitment, and capacity were ignored. No consideration was given to the potential long-term harmful effects of leaving Phoenix in the care of parents who had significant unresolved issues of their own.

Other good work on this file was done by Laura Forrest, the Northwest Intake Unit social worker who had initial responsibility for the file following the February 2003 referral from Children's Emergency Hospital. No clearer statement of the dynamics of the interaction between this family and the child welfare system can be found than what Forrest wrote when the file was transferred to Family Services after Phoenix's second apprehension in early summer 2003:

> *Steven and Samantha have clearly indicated their mistrust and unwillingness to be involved with a child welfare agency however they have not demonstrated a capacity and commitment to ensure their child's wellbeing enough for the agency not to be involved. Unfortunately, because of their past involvement as wards of a child welfare agency they are not receptive to services from the agency and they deny or minimize any issues presented in an effort to keep the agency away from them. They would do anything, or nothing, to keep the agency at bay. It is this worker's opinion that it is this attitude and disregard for the agency that has probably resulted in this agency's previous termination of services, and not a lack of child welfare issues. If one looks back in previous recording the identified and unresolved problems are still very much present in the family's current situation. The problems haven't gone away, and now neither can the agency. The obvious struggle in commitment, questionable parenting capacity, along with an unstable home environment substance abuse issues, and lack of positive support system all lend to a situation that poses a high level of risk to this child, for maltreatment and / or placement in agency care. Phoenix is in agency care now, and it would probably not be in her best interested to be returned to either parent at this time until they can show something to indicate that they can and will be more responsible and protective of her.*

Despite this warning, and with the issues of motivation, commitment, and parental capacity still unresolved, Phoenix was returned to her father three months later. Not long after, Kematch took Phoenix to live with her. From that point, Phoenix was at the mercy of McKay, whose identity was never researched but about whom the agency had ample disturbing information.

By not accessing and acting on the information it had, and by not following the roadmaps offered by clear-thinking workers, the child welfare system failed to protect Phoenix and support her family.

In considering the services provided and—more significantly—those that were not provided to this family under *The Child and Family Services Act*, I have identified certain failures that were ongoing, throughout the time that agency files were open. In particular, the agency failed throughout to make adequate face-to-face contact with the family, and especially with Phoenix herself. The agency failed to keep current in its understanding of Phoenix's safety and well-being. Case plans were prepared and then not followed. Files were closed when further investigation was warranted.

Other failures occurred in particular circumstances. For example, the family support worker who was placed in the Sinclair/Kematch home when Phoenix was returned on September 5, 2000, should not have been discontinued. She was a great help to young parents who were clearly bewildered by their new responsibilities. The agency failed in letting that arrangement lapse before the end of the term of the service agreement, leaving Sinclair and Kematch without the support that they obviously needed. There was no offer to resume the service even after the arrival of the couple's second baby in April 2001.

Soon after that new baby's birth, Sinclair became a single parent of both children. When the baby died at two and a half months while in his care, the agency failed to offer him meaningful support at this stressful time of his life.

After Phoenix was apprehended a second time, she was returned to Sinclair. Despite continuing uncertainty as to whether he was capable of assuming the responsibility of a single father, six weeks later his file was closed. There is no record of any support given to him during those weeks following Phoenix's return. This file should have been kept open longer. Social workers should have kept current with developments and relationships within the home, and should have provided Sinclair with the support he needed, to succeed as a father to Phoenix.

The agency failed the family again between mid-January and mid February 2004, when it became aware that Phoenix was in the care of her mother or grandmother. Its investigation of the report that 'rock' was being smoked in Phoenix's presence was inadequate.

The steps taken as the agency worked with Edwards and Sinclair to achieve a safe environment for Phoenix left her vulnerable to falling into the custody of her mother, whose parenting ability, according to the agency's own information, was questionable at best and disastrous at worst.

At the top of the list of failures, however, must go the failure to recognize Karl Wesley McKay's identity and background. He was Kematch's partner from July 13, 2004 onwards, and his violent past would have been revealed by a search of the agency's own files. He was a dangerous man, from whose violence the agency could have, and should have, saved Phoenix.

I cannot end this chapter without a mention of the events of those five critical days in March 2005. On March 5, 2005 the agency received a report that Phoenix was being abused by her mother and was perhaps being locked in a bedroom. A file was opened in Kematch's name, an investigation was done, and the file was closed on March 9. All this was done within five days, without anyone having laid eyes on Phoenix, and despite the history of this dysfunctional family—including details of Karl Wesley McKay's violent past—all easily available in the agency's own files to any worker who took the time to look.

These failings that I have mentioned, both general and specific, were the result of work carried out by social workers who were assigned to files as they were opened. What must be appreciated is that in all instances this work was carried out under the guidance of supervisors who were charged with the responsibility that attends appointment to such senior and critically important positions. It was designated supervisors who recorded their approval each time a file was closed.

A fundamental question that calls out for an answer by this Inquiry is this: How did such a tragedy happen? Various parties with standing before this Inquiry offered their answers.

The Department, in its written submission, made the following acknowledgment:

> *As was acknowledged on the first day of this Inquiry, all of the services that were delivered to Phoenix and her family were from Winnipeg CFS. If services were not provided, Winnipeg CFS was the responsible agency.*[2] *Winnipeg CFS had an organizational responsibility to provide the environment and professional foundation for the delivery of effective and efficient child protection services that are consistent with standards. To the extent that it failed to do this during the time that services were delivered to Phoenix and her family, Winnipeg CFS accepts responsibility.*[1004]

The Department further acknowledged, "The evidence heard at this Inquiry demonstrated that there was a failure in the delivery of services by Winnipeg CFS to Phoenix and her family."[1005] The Department submitted that what went wrong in this case was that workers and their supervisors did not ask the right questions, as they went about their work. They focused only on immediate safety concerns rather than on long-term risks to Phoenix's safety and well-being.

I agree. But in some cases, even when the agency asked the right question and did an appropriate assessment, it failed to follow through on providing the services that it had identified as necessary.

Counsel who represented individual workers and supervisors highlighted systemic failings within the child welfare system at the time, including excessive workload, lack of staff training, and confusion about workplace standards.

I agree that the evidence disclosed a child welfare system challenged by heavy workloads, and staff whose training and knowledge of standards was limited. In these respects, the system failed to meet best practices at an organizational level, as described by Dr. Wright. In this particular case, however, I do not find evidence that these organizational challenges had a direct impact on the services that were, or were not, delivered to Phoenix and her family.

Having said that, there is no question that the child welfare system has always faced many challenges in carrying out its mandate, and those challenges will continue.

I believe that the child and family services workers who testified at this Inquiry wanted to do their best for the children and families they served. I believe that they wanted to protect children. However, their actions and resulting failures so often did not reflect those good intentions.

When I consider the evidence in its totality, I find that often what was missing was a fundamental understanding by staff of the mandate of the child welfare system and of their own role in fulfilling that mandate. For the most part, workers and supervisors lacked an awareness of the reasons why families come into contact with the child welfare system and of the steps they needed to take to support those families. The focus on short-term safety concerns to the exclusion of long-term risk is an example of this lack of understanding.

All staff working within the child welfare system must recognize that the people who need their help have capabilities of various sorts and must be supported to fulfill their potential so that they are ultimately able to sustain themselves and their families.

When Phoenix came to the attention of the child welfare system at her birth, the signs were clear that she and her parents would need intensive long-term support. It was up to the system to identify the family's needs and strengths, and provide the services necessary to protect Phoenix and support her family. The system and in particular, Winnipeg Child and Family Services, failed to do that.

> *Witnesses who testified at the Inquiry often described the issues presented by Phoenix and her family as "routine," "typical," and "standard." They said that many of the families they worked with presented similar challenges, including substance abuse, histories with the child welfare system, and lack of parenting skills. Staff who work with families and children must constantly remind themselves that each file represents a person or a family with a constellation of needs, whose basic human dignity must be respected. If their challenges are not unique, they are no less serious and worthy of attention and best efforts.*

Some witnesses did acknowledge this fact, but it bears repeating and emphasizing. And if issues such as poverty, inadequate housing, substance abuse and childhood histories with the child welfare system are common among families who come in contact with the system, then these issues must be understood as needing appropriate attention.

I recognize that child welfare workers alone cannot be expected to solve problems such as poverty, but they can be expected to identify how those issues affect the families for whom they are responsible, and to take whatever steps are available. For example, in this case, the psychiatrist who was consulted by the agency noted that Phoenix's father wanted to find work for himself and daycare for Phoenix. Another worker recognized that Sinclair needed help to overcome his addictions. Sadly, throughout the five years the agency was involved with this family, it never made an attempt to provide these practical supports.

Another matter requiring comment is that the agency's services to Phoenix and her family were provided through a hierarchy of staff, starting with the frontline worker, up to the Chief Executive Officer. The evidence showed that for the most part, only frontline workers and their supervisors had any knowledge of what was happening with a given family. However, Jay Rodgers, who was CEO of the agency during the last three times the family came to the agency's attention, testified that if mistakes were made, responsibility lay with the agency because the organization did not support its staff with adequate training, or resources, or advocacy, or whatever else was needed.[1006]

Despite the Department's admissions of failure, and acceptance of responsibility, neither the Department nor the Agency apologized at the Inquiry, either for their failings or for the loss of Phoenix. I find this regrettable and express the hope that an apology will be forthcoming.

Responsibility to protect children is a shared responsibility—shared within the agency and child welfare system itself, and with the larger community as a whole. The very first principle stated in *the Child and Family Services Act* is this: "The safety, security and well-being of children and their best interests are fundamental responsibilities of society." I consistently heard throughout the Inquiry that the child welfare system alone cannot protect children from the many vulnerabilities that life can bring. I agree. Individuals working within government agencies such as Employment and Income Assistance, community-based organizations, and others, all must play their part. I discuss the role of community-based organizations in particular when I come to the evidence I heard in Phase Three of the Inquiry.

Although responsibility is shared, individual staff are personally accountable for the work they are tasked with doing. Although they perform their jobs within a large system, workers are individually responsible, within the scope of their employment, to assist the people who come to their attention. Each worker who is specifically charged with protecting children needs to be aware of his or her individual personal and professional responsibility. As Wright identified, best

practice involves strong personal commitment from staff in working with families and developing relationships. If workers find that they cannot achieve what they set out to do in protecting a child or supporting a family, they must make that fact clear to their supervisor, who must then ensure that appropriate steps are taken.

Having considered the services provided and not provided to Phoenix and her family, and the circumstances surrounding her death, I come to this further question that I was asked to address: How did her death remain undiscovered for nine months? The evidence leads to a number of answers.

First, the only living witness to the crime, besides the perpetrators themselves, was a child who understandably feared for his own safety. He had seen the cruelty that his father and Kematch were capable of. He testified that when he was still in Fisher River after Phoenix had been killed, he had thought about calling the police. But it was a long road to their house and his father would see them coming. He began to imagine what McKay might do to him and his baby sister before the police could even get there. "Anything could happen," he said. Eventually he did speak up to save his little sister, when he told his brother what happened to Phoenix.

The killers, McKay and Kematch, concocted their own story for friends and family who might ask about Phoenix. With Sinclair having moved away and out of touch, it was easy to say that Phoenix was with her father. He did seem to have a stronger relationship with her than did her mother, so those who knew the family were prepared to accept that story.

Being not yet school age and not enrolled in nursery school or daycare, or any programs of any kind, Phoenix didn't have a profile in the community and had no other adults who might come looking for her.

When Kematch's aunt did go looking it was too late, but her inquiries might have led to an earlier discovery of Phoenix's death. The aunt became concerned at not having seen Phoenix and made a series of phone calls to various child welfare agencies in August 2005, hoping to prompt an investigation. Had her information been considered in the context of this family's child welfare history and the serious issues that remained unaddressed and unresolved, the story might have ended sooner.

Having considered all the evidence of the many witnesses who testified about the events of Phoenix's short life, and about the services provided and not provided to her and her family, I am left to conclude that the agency failed to understand why Phoenix was in need of protection and therefore failed to address the circumstances that put her at risk. And it failed to understand the needs and strengths of those who had the potential and responsibility to protect and nurture her. Ultimately, Phoenix became invisible, and then she disappeared.

[146] March 23, 2011, OIC 89/2011
[147] Transcript, December 5, 2012, p. 12, l. 9—p. 14, l. 15
[148] Exhibit 14, p. 2-3
[149] Exhibit 14, p. 3-4
[150] Transcript, December 5, 2012, p. 3 l. 22—p. 7, l. 5
[151] Exhibit 14, p. 4-5
[152] Transcript, December 5, 2012, p. 10, l. 17—p. 11, l. 18
[153] Transcript, November 21, 2012, p. 168, l. 6-9
[154] Transcript, December 5, 2012, p. 13, l. 11—p. 14, l. 11
[155] Transcript, November 21, 2012, p. 171, l. 9—p. 173, l. 3
[156] Commission Disclosure 1790, p. 36794
[157] Commission Disclosure 1789, p. 36794
[158] Commission Disclosure 1795, p. 37107-37108
[159] Transcript, December 5, 2012, p. 16, l. 16—p. 18, l. 14
[160] Commission Disclosure 1795, p.37108-37110; Commission Disclosure 1790, p. 36731, 36736
[161] Transcript, November 21, 2012, p. 172, l. 8-17
[162] Transcript, December 5, 2012, p. 15, l. 15-23
[163] Transcript, September 6, 2012, p. 119, l. 18—p. 120, l. 8
[164] Commission Disclosure 1795, p. 37039
[165] Transcript, December 5, 2012, p. 18, l. 18—p. 19, l. 19
[166] Transcript, December 5, 2012, p. 19, l. 20-25
[167] Commission Disclosure 1795, p. 37040
[168] Transcript, September 6, 2012, p. 128, l. 23—p. 129, l. 7
[169] Commission Disclosure 1795, p. 37040
[170] Commission Disclosure 1795, p.37040-37042
[171] Commission Disclosure 1795, p. 37043
[172] Transcript, September 6, 2012, p. 82, l. 12-25
[173] Commission Disclosure 1795, p. 37035-37036
[174] Transcript, November 21, 2012, p. 167, l. 15-16
[175] Commission Disclosure 1795, p.37036-37037
[176] Commission Disclosure 1795, p. 37037
[177] Transcript, September 7, 2012, p. 141, l. 4—p. 142, l. 13
[178] Transcript, November 14, 2012, p. 58, l. 5—p. 59, l. 18
[179] Commission Disclosure 1795, p. 37034
[180] Commission Disclosure 1795, p. 37093
[181] Commission Disclosure 1795, p. 37094
[182] Transcript, September 7, 2012, p. 124, l. 1—p. 126, l. 10
[183] Commission Disclosure 1722
[184] Transcript, November 29, 2012, p. 18, l. 3—p. 23, l. 24
[185] Transcript, November 29, 2012, p. 14, l. 19—p. 15, l. 9
[186] Commission Disclosure 1795, p. 37027
[187] Transcript, November 14, 2012, p. 189, l. 21—p. 190, l. 9
[188] Commission Disclosure 1795, p. 37281; Commission Disclosure 1795, p. 37282
[189] Commission Disclosure 1795, p. 37031
[190] Commission Disclosure 1795, p. 37031
[191] Commission Disclosure 1795, p. 37288
[192] Transcript, November 15, 2012, p. 68, l. 14-25
[193] Transcript, November 15, 2012, p. 69, l. 10—p. 70, l. 8
[194] Transcript, November 15, 2012, p. 74, l. 23—p. 75, l. 23

[195] Commission Disclosure 1795, pg. 37117-37123
[196] Commission Disclosure 1795, p. 37031
[197] Transcript, November 15, 2012, p. 108, l. 2—p. 109, l. 15
[198] Transcript, November 15, 2012, p. 92, l. 10—p. 94, l. 6
[199] Commission Disclosure 1795, p. 37115
[200] Transcript, November 15, 2012, p. 104, l. 21—p. 105, l. 6
[201] Transcript, November 19, 2012, p. 11, l. 2—p. 12, l. 9; Commission Disclosure 1801, p. 37994
[202] Transcript, November 15, 2012, p. 129, l. 6—p. 135, l. 19
[203] Transcript, November 19, 2012, p. 29, l. 20-23
[204] Transcript, November 19, 2012, p. 15, l. 7-10
[205] Commission Disclosure 2069, p. 43559-43560
[206] Transcript, November 19, 2012, p. 37, l. 17—p. 38, l. 11
[207] Commission Disclosure 1795, pg. 37032
[208] Transcript, November 19, 2012, p. 46, l. 1-19
[209] Transcript, November 15, 2012, p. 184, l.3-24
[210] Transcript, November 19, 2012, p. 35, l. 16—p. 36, l. 7
[211] Transcript, November 29, 2012, p. 238, l. 21—p. 240, l. 25
[212] Transcript, November 29, 2012, p. 35, l. 18—p. 36, l. 6
[213] Transcript, November 22, 2012, p. 245, l. 7—p. 246, l. 7
[214] Transcript, February 4, 2013, p. 4, l. 17—p. 5, l. 13
[215] Transcript, February 5, 2013, p. 109, l. 7-16
[216] Commission Disclosure 1797, p. 37595
[217] Exhibit 14, p. 7
[218] Transcript, December 12, 2012, p. 10, l. 6—p. 45, l. 11
[219] Transcript, December 5, 2012, p. 35, l. 14-25
[220] Transcript, April 23, 2013, p. 70, l. 22 – p. 71, l. 16
[221] Transcript, November 14, 2012, p. 141, l. 2-22
[222] Commission Disclosure 1795, p. 37032
[223] Commission Disclosure 1795, p. 37033
[224] Transcript, November 15, 2012, p. 114, l. 1-19
[225] Transcript, December 5, 2012, p. 32, l. 23 – p. 33, l. 1-13
[226] Transcript, November 15, 2012, p. 116, l. 11—p. 117, l. 12
[227] Transcript, December 5, 2012, p. 34, l. 7-25
[228] Commission Disclosure 1795, p. 37025
[229] Transcript, November 14, 2012, p. 138, l. 10-22
[230] Transcript, November 27, 2012, p. 208, l. 9—p. 209, l. 14
[231] Transcript, November 27, 2012, p. 219, l. 15—p. 223, l. 12
[232] Transcript, November 28, 2012, p. 20-22; Commission Disclosure 1795, p 37071-37072
[233] Transcript, November 26, 2012, p. 97, l. 25—p. 104, l. 6
[234] Commission Disclosure 1795, p. 37009, 37022
[235] Commission Disclosure 1795, p. 37023
[236] Commission Disclosure 1795, p. 37009
[237] Commission Disclosure 1795, p. 37009-37010
[238] Transcript, November 26, 2012, p. 172, l. 24—p. 175, l. 25
[239] Transcript, November 26, 2012, p. 144, l. 18—p. 162, l. 25
[240] Exhibit 27
[241] Commission Disclosure 1795, p. 37022
[242] Transcript, November 20, 2012, p. 76, l.25—p. 77, l. 5

[243] Transcript, November 20, 2012, p. 29, l. 11—p. 30, l. 14; Transcript, November 28, 2012, p. 26, l. 7-21
[244] Transcript, November 20, 2012, p. 99, l. 9-19
[245] Exhibit 14
[246] Commission Disclosure 1789, p. 36740
[247] Commission Disclosure 1790, p. 36779, 36780
[248] Commission Disclosure 1790, p. 36779
[249] Transcript, November 19, 2012, p. 140, l. 17—p. 141, l. 8
[250] Commission Disclosure 1795, p. 37003
[251] Exhibit 27
[252] Transcript, November 26, 2012, p. 183, l. 19—p. 185, l. 6
[253] Transcript, November 27, 2012, p. 164, l. 23 – p. 165, l. 23
[254] Transcript, November 27, 2012, p. 157, l. 2-16
[255] Transcript, November 28, 2012, p. 118, l. 21—p. 119, l. 13
[256] Transcript, December 12, 2012, p. 10, l. 6—p. 15, l. 20
[257] Commission Disclosure 1795, p. 37003
[258] Transcript, November 26, 2012, p. 182, l. 6—p. 183, l. 2
[259] Commission Disclosure 1795, p. 37003
[260] Commission Disclosure 1795, p. 37069
[261] Transcript, November 29, 2012, p. 80, l. 16—p. 83, l. 8
[262] Commission Disclosure 1795, p. 37067
[263] Commission Disclosure 1795, p. 37011
[264] Transcript, November 26, 2012, p. 197, l. 22—p. 199, l. 13
[265] Commission Disclosure 1795, p. 37062-37063
[266] Commission Disclosure 1795, p. 37004, 37066
[267] Transcript, November 20, 2012, p. 221, l. 3—p. 227, l.10
[268] Transcript, December 5, 2012, p. 46, l. 24—p. 49, l. 15
[269] Commission Disclosure 1795, p. 37011-37012
[270] Commission Disclosure 1795, p. 37012
[271] Transcript, November 21, 2012, p. 189, l. 19—p. 191, l. 8
[272] Commission Disclosure 1795, p. 37057-37058
[273] Transcript, November 26, 2012, p. 232, 23—p. 233, l. 9
[274] Commission Disclosure 1795, p. 37005-37006, and 36999-37008
[275] Commission Disclosure 1795, p. 37007
[276] Commission Disclosure 1795, p. 37007
[277] Transcript, November 29, 2012, p. 114, l. 8—p. 119, l. 5
[278] Commission Disclosure 1795, p. 37052-37056
[279] Commission Disclosure 1795, p. 37050
[280] Transcript, November 27, 2012, p. 5, l. 17—p. 12, l. 12
[281] Transcript, December 5, 2012, p. 81, l. 15—p. 82, l. 22
[282] Transcript, November 21, 2012, p. 197, l. 18—p. 199, l. 9
[283] Transcript, December 12, 2012, p. 14, l. 15—p. 16, l. 23
[284] Transcript, December 12, 2012, p. 50, l. 1-15
[285] Transcript, December 5, 2012, p. 51, l. 17-23
[286] Transcript, December 12, 2012, p. 20, l. 14—p. 21, l. 11
[287] Transcript, November 27, 2012, p. 13, l. 15—p. 14, l. 2
[288] Commission Disclosure 1795, p. 36999-37008
[289] Transcript, November 27, 2012, p. 18, l. 24—p. 19, l. 25
[290] Transcript, November 29, 2012, p. 68, l. 11—p. 69, l. 20; p. 74; l. 10—p. 75, l. 9
[291] Commission Disclosure 1795, p. 37387

[292] Commission Disclosure 1795, p. 37408
[293] Transcript, November 29, 2012, p. 162, l. 7-17
[294] Transcript, November 29, 2012, p. 150, l. 24—p. 164, l. 22
[295] Commission Disclosure 1795, p. 37055
[296] Transcript, November 19, 2012, p. 176, l. 4—p. 178, l. 13
[297] Transcript, November 19, 2012, p. 209, l. 25—p. 211, l. 7
[298] Commission Disclosure 1796, p. 37395
[299] Commission Disclosure 1796, p. 37395
[300] Commission Disclosure 1796, p. 37394
[301] Transcript, November 20, 2012, p. 21, l. 14-25
[302] Transcript, November 20, 2012, p. 21, l. 5-13
[303] Transcript, November 20, 2012, p. 126, l. 23—p. 129, l. 12
[304] Transcript, November 20, 2012, p. 171, l. 5—p. 172, l. 2
[305] Transcript, November 20, 2012, p. 159, l. 16—p. 165, l. 4
[306] Transcript, November 22, 2012, p. 176, l. 14-21
[307] Final Submission of the MGEU and Appendices of Social Workers Represented by Myers Weinberg LLP, para. 325
[308] Transcript, February 4, 2013, p. 92, l. 13—p. 93, l. 12
[309] Final Submission of the Department of Family Services and Labour Including Winnipeg CFS, para. 70
[310] Transcript, November 26, 2012, p. 88, l. 21-23
[311] Transcript, November 19, 2012, p. 177, l. 5-17
[312] Final Submission of the MGEU and Attached Appendices of Social Workers Represented by Myers Weinberg LLP, para. 398; Transcript, November 29, 2012, p. 167-177
[313] Transcript, November 22, 2012, p. 75, l. 20—p. 76, l. 2
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[315] Transcript, November 22, 2012, p. 105, l. 6—p. 106, l. 9
[316] Commission Disclosure 1796, p. 37464-37466
[317] Transcript, November 22, 2012, p. 110, l. 1—p. 112, l. 12
[318] Transcript, November 22, 2012, p. 51, l. 24—p. 52, l. 10
[319] Transcript, December 6, 2012, p. 23, l. 2—p. 27, l. 5
[320] Transcript, December 12, 2012, p. 21, l. 24—p. 24, l. 5
[321] Transcript, December 6, 2012, p. 28, l. 4-7
[322] Transcript, December 6, 2012, p. 129, l. 1-14
[323] Transcript, December 6, 2012, p. 24, l. 9-11
[324] Transcript, December 6, 2012, p. 22, l. 8—p. 30, l. 8
[325] Transcript, November 21, 2012, p. 36, l. 9—p. 44, l. 10
[326] Commission Disclosure 1796, p. 37365-37377
[327] Commission Disclosure 1796, p. 37368
[328] Transcript, November 21, 2012, p. 57, l. 9—p. 64, l. 1-4
[329] Transcript, December 5, 2012, p. 54, l. 1-7
[330] Commission Disclosure 1796, p. 37368
[331] Transcript, November 21, 2012, p. 74, l. 4—p. 80, l. 18
[332] Transcript, November 21, 2012, p. 75, l. 18—p. 77, l. 3
[333] Transcript, November 22, 2012, p. 191, l. 14—p. 193, l. 7
[334] Transcript, November 22, 2012, p. 199, l. 12—p. 239, l. 11
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[336] Commission Disclosure 1796, p. 37383
[337] Transcript, November 22, 2012, p. 157, l. 14—p. 161, l. 16
[338] Commission Disclosure 1796, p. 37383

[339] Transcript, December 5, 2012, p. 55, l. 25—p. 56, l. 7
[340] Commission Disclosure 1796, p. 37384
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[344] Commission Disclosure 1797, p. 37660, 37666
[345] Transcript, November 21, 2012, p. 98, l. 23—p. 99, l. 18
[346] Commission Disclosure 1796, p. 37369
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[352] Transcript, December 6, 2012, p. 30, l. 24—p. 35, l. 25
[353] Commission Disclosure 1, p. 30
[354] Commission Disclosure 1802, p. 38018
[355] Transcript, November 30, 2012, p. 46, l. 12—p. 47, l. 11
[356] Transcript, December 5, 2012, p. 57, l. 4—p. 87, l. 1
[357] Transcript, November 30, 2012, p. 69, l. 18—p. 70, l. 17
[358] Transcript, November 30, 2012, p. 70, l. 18—p. 71, l. 17
[359] Transcript, November 30, 2012, p. 112, l. 2—p. 117, l. 4
[360] Commission Disclosure 1796, p. 37454-37456
[361] Commission Disclosure 1796, p. 37453, 37519
[362] Transcript, November 30, 2012, p. 103, l. 8—p. 104, l. 9
[363] Transcript, November 30, 2012, p. 105, l. 2-14
[364] Commission Disclosure 1796, p. 37519
[365] Transcript, November 30, 2012, p. 122, l. 17—p. 123, l. 4
[366] Commission Disclosure 1796, p. 37519
[367] Commission Disclosure 1731, p. 35124-35125
[368] Transcript, November 30, 2012, p. 125, l. 20 – p. 126, l. 11
[369] Transcript, December 3, 2012, 46, l. 11—p. 85, l. 21
[370] Commission Disclosure 1780, p. 36617
[371] Transcript, December 3, 2012, p. 92, l. 3-13
[372] Commission Disclosure 1780, p. 36620
[373] Commission Disclosure 1796, p. 37519
[374] Transcript, December 12, 2012, p. 59, l. 1—p. 61, l. 3
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[377] Commission Disclosure 1796, p. 37518
[378] Transcript, November 30, 2012, p. 124, l. 9—p. 125, l. 15
[379] Commission Disclosure 1796, p. 37408; Commission Disclosure 1795, p. 37008
[380] Commission Disclosure 1796, p. 37520
[381] Transcript, December 3, 2012, p. 76, l. 6—p. 77, l. 21
[382] Commission Disclosure 1780, p. 36636
[383] Commission Disclosure 2071, p. 43571
[384] Commission Disclosure 2071, p. 43571
[385] Transcript, December 3, 2012, p. 88, l. 3-19
[386] Transcript, November 30, 2012, p. 85, l. 16—p. 86, l. 13
[387] Commission Disclosure 1797, p. 37674

[388] Transcript November 30, 2012, p. 123, l. 20—p. 124, l. 8
[389] Transcript, December 12, 2012, p. 89, l. 24—p. 91, l. 6
[390] Transcript, December 5, 2012, p. 59, l. 17—p. 60, l. 1
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[394] Transcript, December 12, 2012, p. 93, l. 3-11
[395] Commission Disclosure 1796, p. 37361-37362
[396] Transcript, November 30, 2012, p. 145, l. 6—p. 157, l. 9
[397] Transcript, November 30, 2012, p. 142, l. 3-10
[398] Transcript, April 23, 2013, p. 10, l. 21 – p. 11, l. 24
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[402] Transcript, December 3, 2012, p. 136, l. 19 – p. 137, l. 18
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[404] Transcript, December 3, 2012, p. 148, l. 7 – p. 149, l. 14
[405] Transcript, December 3, 2012, p. 160, l. 3 – p. 162, l. 22
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[407] Transcript, December 4, 2012, p. 152, l. 16 – p. 153, l. 12; Transcript, December 4, 2012, p. 162, l. 8-13
[408] Transcript, December 4, 2012, p. 216, l. 2-7
[409] Transcript, December 4, 2012, p. 163, l. 7-20
[410] Commission Disclosure 1796, p. 37352
[411] Transcript, December 3, 2012, p. 223, l. 5-9
[412] Transcript, December 3, 2012, p. 224, l. 20 – p. 225, l. 3
[413] Transcript, December 3, 2012, p. 223, l. 19 – p. 224, l. 16
[414] Transcript, December 3, 2012, p. 225, l. 4 – p. 227, l. 2
[415] Transcript, December 4, 2012, p. 43, l. 4-25
[416] Transcript, December 6, 2012, p. 51, l. 11-24
[417] Commission Disclosure 1796, p. 37352
[418] Commission Disclosure 1796, p. 37352-37353
[419] Transcript, December 3, 2012, p. 229, l. 1-3
[420] Commission Disclosure 1796, p. 37353
[421] Commission Disclosure 1796, p. 37353
[422] Transcript, November 30, 2012, p. 183, l. 8 – p. 185, l. 15
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[427] Transcript, December 4, 2012, p. 1, l. 24 – p. 2, l. 10
[428] Transcript, December 4, 2012, p. 33, l. 13-24
[429] Transcript, December 5, 2012, p. 63, l. 11 – p. 68, l. 6
[430] Commission Disclosure 1796, p. 37354
[431] Transcript, December 4th, 2012, p. 14, l. 21 – p. 15, l. 3
[432] Transcript, December 4, 2012, p. 29, l. 25; p. 30, l. 1-15
[433] Transcript, December 4, 2012, p. 13, l. 13-17
[434] Transcript, December 3, 2012, p. 229, l. 1 – p. 230, l. 10
[435] Transcript, December 4, 2012, p. 34, l. 17-22
[436] Transcript, December 4, 2012, p. 90, l. 21 – p. 91, l. 14
[437] Transcript, December 4, 2012, p. 127, l. 21 – p. 129, l. 24

[438] Transcript, December 4, 2012, p. 166, l. 1 – p. 167, l. 23
[439] Transcript, December 4, 2012, p. 182, l. 1 – p. 183, l. 1
[440] Transcript, December 4, 2012, p. 188, l. 18 – p. 189, l. 16
[441] Transcript, December 4, 2012, p. 189, l. 19 – p. 191, l. 6
[442] Transcript, December 4, 2012, p. 197, l. 11-16
[443] Commission Disclosure 1796, p. 37354
[444] Commission Disclosure 1796, p. 37449
[445] Transcript, December 4, 2012, p. 17, l. 13-25
[446] Transcript, December 4, 2012, p. 22, l. 2-7
[447] Transcript, December 4, 2012, p. 18, l. 10-22
[448] Transcript, December 4, 2012, p. 18, l. 10 – p. 20, l. 19
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[450] Transcript, December 6, 2012, p. 57, l. 17—p. 60, l. 17
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[453] Transcript, December 6, 2012, p. 53, l. 1-14
[454] Transcript, January 9, 2013, p. 75, l. 17 – p. 76, l. 8
[455] Transcript, January 9, 2013, p. 76, l. 18 – p. 77, l. 7
[456] Transcript, December 12, 2012, p. 42, l. 13 – p. 43, l. 7
[457] Transcript, December 6, 2012, p. 63, l. 6 – p. 65, l. 9
[458] Transcript, December 12, 2012, p. 116, l. 22 – p. 118, l. 3
[459] Transcript, December 12, 2012, p. 118, l. 4 – p. 119, l. 6
[460] Transcript, December 12, 2012, p. 119, l. 23 – p. 120, l. 13
[461] Transcript, December 12, 2012, p. 124, l. 18-21
[462] Transcript, December 5, 2012, p. 71, l. 12 – p. 73, l. 9
[463] Transcript, December 10, 2012, p. 13, l. 9-11
[464] Transcript, December 10, 2012, p. 7, l. 7-11
[465] Transcript, December 10, 2012, p. 9, l. 18 – p. 10, l. 4
[466] Transcript, December 10, 2012, p. 14, l.1-7
[467] Transcript, December 10, 2012, p. 15, l. 11-18
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[469] Commission Disclosure 1580, p. 28656
[470] Commission Disclosure 1580, p. 28654
[471] Commission Disclosure 1580, p. 28653
[472] Christian Okotcha is referred to in EIA records as "CCO"
[473] Commission Disclosure 1580, p. 28652
[474] Transcript, December 10, 2012, p. 28, l. 3 – p. 30, l. 13
[475] Commission Disclosure 1578, p. 28242-28254
[476] Commission Disclosure 1580, p. 28652
[477] Commission Disclosure 1580, p. 28753-28755
[478] Commission Disclosure 1580, p. 28755
[479] Commission Disclosure 1795, p. 36968
[480] Transcript, December 10, 2012, p. 41, l. 24 – p. 42, l. 2
[481] Transcript, December 4, 2012, p. 45, l. 11 – p. 48, l. 11
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[485] Commission Disclosure 1795, p. 37346
[486] Commission Disclosure 1795, p. 37346-37347
[487] Commission Disclosure 1796, p. 37445-37448
[488] Transcript, December 10, 2012, p. 89, l. 25 – p. 90, l. 19

[489] Transcript, December 10, 2012, p. 110, 14 – p. 111, l. 14
[490] Transcript, December 10, 2012, p. 111, l. 17 – p. 113, l. 15
[491] Transcript, December 10, 2012, p. 188, l. 6 – p. 189, l. 3
[492] Transcript, December 10, 2012, p. 117, l. 8-12
[493] Transcript, December 11, 2012, p. 103, l. 10 – p. 104, l. 13
[494] Transcript, December 11, 2012, p. 78, l. 7-20
[495] Transcript, December 10, 2012, p. 103, l. 20 – p. 117, l. 4
[496] Transcript, December 11, 2012, p. 108, l. 24 – p. 110, l. 4
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[501] Transcript, December 4, 2012, p. 49, l. 25 – p. 50, l. 4
[502] Transcript, November 22, 2012, p. 206, l. 8 – p. 209, l. 3
[503] Commission Disclosure 1796, p. 37444
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[506] Transcript, December 10, 2012, p. 54, l. 17 – p. 55, l. 6
[507] Transcript, December 10, 2012, p. 55, l. 18-23
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[509] Transcript, December 17, 2012, p. 35, l. 7-10
[510] Transcript, December 17, 2012, p. 51, l. 22 – p. 52, l. 23
[511] Transcript, December 17, 2012, p. 55, l. 6 – p. 56, l. 22
[512] Transcript, December 17, 2012, p. 33, l. 15 – p. 34, l. 18
[513] Transcript, December 17, 2012, p. 37, l. 24 – p. 38, l. 14
[514] Transcript, December 17, 2012, p. 40, l. 12 – p. 41, l. 10
[515] Transcript, December 17, 2012, p. 41, l. 21 – p. 42, l. 9
[516] Transcript, December 17, 2012, p. 44, l. 21 – p. 46, l. 16
[517] Transcript, December 17, 2012, p. 58, l. 11 – p. 60, l. 11
[518] Transcript, December 17, 2012, p. 60, l. 12 – p. 61, l. 19
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[523] Transcript, December 17, 2012, p. 77, l. 10-15
[524] Transcript, December 17, 2012, p. 78, l. 8-25
[525] Transcript, December 17, 2012, p. 79, l. 5 – p. 81, l. 16
[526] Transcript, December 18, 2012, p. 49, l. 5-16
[527] Transcript, December 17, 2012, p. 81, l. 17 – p. 82, l. 9
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[529] Commission Disclosure 1795, p. 36956
[530] Transcript, December 17, 2012, p. 84, l. 6-19
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[532] Transcript, December 17, 2012, p. 87, l. 9-22
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[534] Transcript, December 17, 2012, p. 89, l. 6-23
[535] Transcript, December 10, 2012, p. 34, l. 1-7
[536] Transcript, January 22, 2013, p. 162, l. 19 – p. 164, l. 5
[537] Transcript, December 17, 2012, p. 90, l. 16 – p. 91, l. 22
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[540] Transcript, December 17, 2012, p. 93, l. 17 – p. 94 l. 21
[541] Transcript, December 17, 2012, p. 95, l. 4 – p. 96, l. 5
[542] Transcript, December 17, 2012, p. 96, l. 6-20
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[546] Commission Disclosure 1795, p. 36957
[547] Transcript, December 17, 2012, p. 112, l. 20 – p. 113, l. 14
[548] Transcript, December 17, 2012, p. 207, l. 15 – p. 209, l. 15
[549] Transcript, December 17, 2012, p. 69, l. 20 – p. 71, 15
[550] Transcript, December 18, 2012, p. 73, l, 10 – p. 74, l. 21
[551] Transcript, December 18, 2012, p. 83, l. 18 – p. 85, l. 7
[552] Exhibit 19, Appendix A, p.15.
[553] Exhibit 19, Appendix A, p. 10501-10506
[554] Exhibit 19, p. 3
[555] Exhibit 19, Appendix "B", p. 59 -64
[556] Browne testified on December 19, 2012
[557] Transcript, December 18, 2012, p. 87, l. 14 – p. 88, l. 5; p. 89, l. 3 – 11
[558] Transcript, December 18, 2012, p. 76, l. 12 - p. 81, l. 1-9
[559] Transcript, December 18, 2012, p. 80, l. 5 – p. 81, l. 25
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[563] Commission Disclosure 1790, p. 36767
[564] Commission Disclosure 1790, p. 36768
[565] Transcript, January 8, 2013, p. 178, l. 13 – p. 179, l. 12
[566] Transcript, January 8, 2013, p. 179, l. 13 – p. 184, l. 6
[567] Transcript, January 8, 2013, p. 188, l. 25 – p. 189, l. 6; Commission Disclosure 1791, p. 36810
[568] Commission Disclosure 1791, p. 36799
[569] Transcript, January 9, 2013, p. 1, l. 24 – p. 3, l. 11
[570] Commission Disclosure 1791, p. 36810
[571] Commission Disclosure 1791, p. 36811
[572] Transcript, January 8, 2013, p. 198, l. 3-6
[573] Commission Disclosure 1791, p. 36812
[574] Commission Disclosure 1790, p. 36763.
[575] Transcript, December 19, 2012, p. 137, l. 12-23
[576] Transcript, December 19, 2012, p. 137, l. 24 – p. 138, l. 19
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[579] Transcript, December 19, 2012, p. 71, l, 3 – p. 72, l. 24
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[584] Commission Disclosure 1790, p. 36764
[585] Transcript, December 19, 2012, p. 151, l. 14 – p. 152, l. 1
[586] Transcript, December 19, 2012, p. 151, l. 8-10
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[588] Commission Disclosure 1795, p. 36951
[589] Transcript, January 7, 2013, p. 63, l. 22 – p. 65, l. 15

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665 Transcript, January 21, 2013, p. 168, l. 18 – p. 170, l. 5
666 Transcript, January 21, 2013, p. 171, l .16-22
667 Transcript, January 21, 2013, p. 172, l. 1-3
668 Transcript, January 21, 2013, p. 172, l, 4 – p. 173, l. 9
669 Transcript, April 16, 2013, p. 2, l. 11 – p. 4, l. 19
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PHASE TWO - THE CHILD WELFARE SYSTEM AND ITS RESPONSE

This phase of the Inquiry focused on the lessons learned from Phoenix's death.

Many changes were made to Manitoba's child welfare system in the wake of the discovery of Phoenix's death and the subsequent examination of the child welfare services that had been delivered to her and her family. Among the immediate responses were the six reviews that were listed in the Order in Council that appointed this Commission and are described in Chapter 2 of this report. To avoid duplicating the work of those reviews, and so that my recommendations will be relevant to the current state of child welfare services in Manitoba, I am instructed to consider the findings of those reviews, and the implementation of their recommendations. I may accept the reviews as conclusive, or give them any weight I consider appropriate. The Commission's focus of course was on those recommendations and changes that are most relevant to the facts that were presented in Phase One of the Inquiry, about Phoenix's life and death.

Witnesses who were put forward during Phase Two by the Department of Family Services, the child welfare Authorities, and ANCR were asked for evidence about the most significant changes that have been made to the child welfare system since Phoenix's death was discovered. In particular, they were asked to speak about what influence, if any, those changes could have had on the services that were delivered to Phoenix and her family.

The most significant change, I heard, was the implementation of a new model of child welfare service delivery, called "differential response." This model emphasizes prevention and early intervention, building relationships with families, and keeping children safe in their homes. It relies on partnerships with other government departments and with community-based organizations, to better serve families and children.

Other important changes that are discussed in this section of my report relate to a range of issues including $42 million in new funding; quality assurance and accountability; education and training; standards; CFSIS; workload adjustments; and the legislative structure of the child welfare system that followed upon the Aboriginal Justice Inquiry—Child Welfare Initiative.

In Phase Two I also heard from witnesses put forward by the Assembly of Manitoba Chiefs and Southern Chiefs Organization. They testified about current issues surrounding the delivery of child welfare services to and by First Nations people, including the impact of changes that have already been implemented and what further changes are needed.

The Manitoba Government Employees Union, to which many of the child welfare workers who testified belong, also gave evidence about the effect of the changes that have been made and what further changes it sees as necessary.

The Dean of the Faculty of Social Work, University of Manitoba, assisted the Commission with evidence as to the Faculty's role in educating child welfare workers.

Most of the evidence heard in this Phase came from witnesses put forward by the General Authority and the Southern Authority primarily because the agencies that were the focus of this inquiry now come within the responsibility of those two Authorities. This explains why, in a number of matters reviewed in this report, there is limited comment from either the Northern Authority or the Metis Authority.

It became apparent during the public hearings that it would not be necessary to hear testimony from the writers of the two fact-specific reports referenced in the Order in Council (the Section 10 and Section 4 Reports). I made this decision because I heard directly from the witnesses who were involved in providing services to Phoenix and her family. To the extent that the reports commented on their work, those workers and supervisors were given full opportunity to respond during their oral testimony. The reports were put in evidence during the public hearings and all counsel were entitled to refer to the reports in their final submissions.

Commission Counsel did call evidence from some of the authors of the other reports listed in the Order in Council, including former Children's Advocate, Billie Schibler, and Auditor General Carol Bellringer. Ombudsman Irene Hamilton was not compellable to testify and so was not called as a witness, although her reports on the progress of the implementation of her recommendations were put in evidence.

8 CHANGES FOR CHILDREN: GOVERNMENT'S 2006 RESPONSE TO REVIEWS

In response to the external reviews that were sparked by the discovery of Phoenix Sinclair's death, the Government announced in October 2006 a commitment of $42 million in new funding to implement the recommendations made in those reviews. Since then, the Department of Family Services has collaborated with the Authorities to address all 295 recommendations contained in the external reviews, the Department told the Inquiry. At the date of its final submissions, about 250 of those recommendations had been implemented and work was proceeding towards implementation of the remainder.[1007]

Rodgers, who at the time was Director of the Child Protection Branch, played a significant role in developing the Government's response, which was articulated in a document titled *Changes for Children: Strengthening the Commitment to Child Welfare*.[1008]

At the outset of that document the Government affirmed its commitment to the Aboriginal Justice Inquiry – Child Welfare Initiative (AJI-CWI): "The Government of Manitoba is prepared to continue the agenda of restructuring, renewal and innovation that began with the AJI-CWI."[1009] Rodgers repeated this commitment during his testimony as current CEO of the General Authority, saying, "The transfer of powers and the gains that have been made under devolution are too important . . . to take any steps backwards on that, I think that's critical that those powers and duties that have been devolved remain and we even look at ways of further devolution, so our Aboriginal colleagues can get even, perhaps, more control over the services they offer."[1010]

The $42 million, Rodgers said, was unprecedented in the history of child welfare in Manitoba, in terms of a government's financial response to a report. Significantly, that sum included allocations for certain areas such as workload relief and differential response that had been identified as priorities by the reviews. This too was an unusual step for government, Rodgers said: "So this was creating tremendous opportunity for new investments and approaching our work differently in the child welfare system."[1011]

Rodgers testified that the reports clearly endorsed devolution and the new structure that was by then in place. He also noted a common recognition of longstanding challenges to the child welfare system and a need for child welfare to work in a more integrated way with other systems. *Changes for Children* grouped the reports' recommendations into the following broad themes:

Keeping children safe through primary prevention programs: recognizing that the child welfare system alone cannot keep children safe, the government committed to acting on recommendations to build stronger relationships between service systems such as education and health and others; to involve communities in designing prevention strategies; to enhance education about threats to child safety; and to increasing opportunities for children and families to engage in healthy activities.

A priority emphasis on early intervention for families: the Government agreed with the recommendations for a differential response initiative and committed to immediately work towards implementation. According to *Changes for Children*, by 2008/09, $22.5 million of the Government's $42 million commitment would be invested in the implementation of that model across the province. These initiatives were to complement existing prevention and early intervention programs such as: 150 new residential placement resources in community-based partners such as as Ma Mawi WI Chi Itata Centre; Healthy Child Manitoba programs such as Family First, Health Baby, and Triple P Parenting; and Neighbourhoods Alive and Lighthouses.[1012]

Enhanced support for frontline child protection workers: the Government accepted that workers must have more time in their day-to-day work to assess situations, engage with their clients, and support children and families. It therefore targeted $15 million of its new funding over three years for a workload relief fund (hiring additional staff to reduce the load on frontline staff); information system upgrades; improved access to information after hours; new training programs; and province-wide capacity for critical incident debriefing.[1013]

Strengthening the new governance structure: agreeing that the collaborative governance relationship between the Department and the four Authorities required more resources, the Government allocated funding that made possible the creation of the Office of the Standing Committee to promote consistency across the child welfare system.

Recognizing the fiduciary obligation of the Government of Canada: the Government agreed with the review reports' identification of the vulnerabilities that often especially affect Aboriginal children and families:

> *Larger societal concerns including poverty, inadequate housing, lack of clean water, and insufficient health services contribute to the issues that bring families into contact with the child welfare system. Children, families and communities will not be able to heal themselves until the basic physical and social infrastructure has been addressed.*[1014]

Further, funding disparities and other inefficiencies arise from the sharing of responsibility for child welfare funding with the federal government, which is responsible for services on reserves.[1015] As a consequence, the Government committed to pursue immediately, with First Nations leadership, a meeting with the Minister of Indian and Northern Affairs Canada to begin discussions about a timely resolution of the identified funding inequities and related policy and jurisdictional matters.[1016]

Responsibility for child death reviews: the government committed to transferring this function, formerly carried out by the Office of the Chief Medical Examiner under Section 10 of *The Fatality Inquiries Act*, to the Office of the Children's Advocate .

When *Changes for Children* was published, the two Assistant Deputy Ministers of Family Services, Carolyn Loeppky and Peter Dubienski, met with government departments that would be affected, to review with them the report and recommendations so that they would know what to expect. Loeppky testified that once that was done, work began in inter-departmental committees to produce a fetal alcohol spectrum disorder strategy and a suicide prevention strategy, and an inter-departmental committee of senior officials was asked to develop responses to a number of recommendations. [1017]

One of the larger initiatives undertaken was the creation of 54.5 new positions for differential response and family enhancement.[1018] This was in response to the many recommendations in the reviews that supported a focus on prevention and early intervention with families, before apprehension of children becomes necessary. Loeppky explained that this was approached in 3 phases, in cooperation with the CEOs of each Authority, before a full rollout of the differential response model: first a research phase, to look at other jurisdictions where similar approaches had been implemented; then a set of initial principles and a conceptual framework were developed; and then pilot projects were used to gather information.

Changes for Children provided the framework for the changes to the child welfare system that were implemented over the ensuing years. The government is to be commended for proceeding on the recommendations in the manner it did.

9 DEVOLUTION

9.1 DEVOLUTION IN THE CONTEXT OF THIS INQUIRY

The Aboriginal Justice Inquiry – Child Welfare Initiative (AJI-CWI) was an initiative designed to transfer responsibility for child protection and family support services to the Aboriginal people of Manitoba. This meant also transferring the capacity to deliver these services throughout the province.[1019] This process became known as "devolution."

Devolution was already underway throughout the province when Winnipeg Child and Family Services closed Phoenix's file for the last time on March 9, 2005, but that agency had not yet begun to transfer its files to the Aboriginal Authorities. There is no evidence that the devolution process had any impact on the services provided or not provided to Phoenix and her family. As noted in closing submissions by the Assembly of Manitoba Chiefs (AMC) and the Southern Chiefs' Organization (SCO):

> *There was nothing in the design of the AJI-CWI that contributed to the tragedy of [Phoenix's] death, and responsibility for the failure to provide services to Phoenix and her family during the time that she was engaged with the child welfare system has been acknowledged by both Winnipeg CFS (as the agency that provided services to both Phoenix and her family) and the Department, who was solely responsible at that time to ensure that adequate services were provided. To the extent that preparations for the transition of child welfare files to First Nations agencies contributed to any failure to provide adequate services to Phoenix and her family, it must be noted that control over those processes were also entirely within the control and responsibility of Winnipeg CFS and the Department.*

In their final submissions, the Southern Authority, Northern Authority, and Child and Family All Nations Coordinated Response Network (ANCR) took the position that First Nations jurisdiction over child and family matters ought to be fully restored. They point to the unacceptable over-representation of First Nations children in the child welfare system and suggest that there are fundamental issues that need to be addressed. The restoration of First Nations jurisdiction will ensure a system that is culturally appropriate and based on First Nation values, traditions, and practices.

Furthermore, they say that the AJI-CWI devolution process was never the "end game," but was always intended to be an interim measure. The Southern Authority, Northern Authority, and ANCR refer to the evidence of Norman Bone, former Chief of the Keeseekoowenin First Nation, who testified that devolution has not yet been completed and this is the reason for the non-derogation clause at section 3 of *The Child and Family Services Authorities Act*,[1020] which reads as follows:

Aboriginal rights protected

3. This Act must not be interpreted as abrogating or derogating from

a) the pursuit of self-government by Aboriginal peoples in Manitoba through present or future negotiations or agreements; and

b) the Aboriginal and treaty rights of the Aboriginal peoples of Canada that are recognized and affirmed by section 35 of the Constitution Act, 1982.

The Department confirmed for me during final submissions that the Province recognizes that the current system is not the "end game," and does not assert that the creation of *The Child and Family Services Authorities Act* fully satisfies the ambitions of Aboriginal people for self-governance in child welfare matters. The degree of Aboriginal control over child welfare in Manitoba today is unprecedented in Canada, said counsel for the Department. What is needed now, at this interim stage, is to make the current system work as effectively as possible, and to build within the Aboriginal community "the capacity for whatever the future may hold, in terms of Aboriginal self-governance." The Department said that the next step or proposal, in terms of self-governance, must come from First Nations.[1021]

The General Authority supports the full restoration of the provision of child welfare services to Aboriginal people.[1022]

It is not within my mandate to look specifically at the issue of whether devolution has been fully realized. As Trocmé said, Manitoba has been one of the leaders in Canada, at least at a structural level, in trying to engage First Nations communities in the provision of child welfare services.[1023] Many of the witnesses who testified during Phase Two of the Inquiry support the general position that Aboriginal people should have more control over their child welfare services. I support the remaining steps to be taken on that path, remembering, as always, that in any changes to the child welfare system the safety and well-being of children must remain the paramount consideration.

9.2 CIRCLE OF CARE: TRADITIONAL VALUES IN CHILD WELFARE PRACTICE

Devolution has led to innovations in child welfare practice incorporating a variety of traditional approaches, the Commission learned.

The Nisichawayasihk Cree Nation, for example, has found a way to bring together a broad range of services and programs designed to meet the often-complex needs of its community, in an environment that promotes health and well-being. It has adopted a circle of care approach, based on the holistic teachings of the medicine wheel.

Felix Walker, who was called as a witness by the AMC and SCO, is a community member and since 2001 has been CEO of the Nisichawayasihk Cree Nation and Community Wellness Centre Inc.

He described the consultation process in his community that led to creation of a wellness centre and a change in the way services were provided. Under this integrated service delivery model, the single corporate entity provides public health, maternal health, and head start programs; daycare; fetal alcohol programming; diabetes initiatives; and child and family services, among others. The community centre offers men's groups, fitness classes, parenting groups, various youth groups, early childhood education, and other community services. A mentoring program makes elders available to young people attending programs, and at the same time engages elders in the community.

Walker testified that the Wellness Centre's mandate is to provide health and social services that meet the needs of the community and to identify those needs through consultation. It is accountable to the community through its reports to Chief and Council and to funders. "In unity we work to strive and recognize the strengths of all of our community members," he said.[1024]

The community's innovative programs include a summer adventure camp for children ages 3 to 18, with activities designed to increase children's self-esteem and their sense of identity. Older campers develop teamwork and leadership in a 10-hour canoe trip and weeklong stay at a traditional camp. The program has had a great deal of success. A Rediscovery of Families Program takes families to that same camp setting for a week or more, to learn to work together as a unit:

> *And you see a gradual change as soon as you -- as soon as those families get to the camp. You get to see what our communities were like before, prior to electricity and running water, et cetera, et cetera. You see this natural progression occur where the division of labour becomes apparent, everyone is responsible for everyone, children can be children. They get to play but they're supervised, they're always being watched. And everybody works together as a unit . . . They also get the opportunity to identify who their extended relatives are, what strengths that they have, because everyone has strengths. And we built on those strengths and we create that, that opportunity for collaboration once they come back.*[1025]

In the area of child welfare, the Wechitiwin Family Enhancement Program operates in Thompson to deliver enhanced prevention services for families who have been diverted from the conventional protection-based stream. Development of this program, like others in the community, relied heavily on traditional teachings and the life experiences of the elders, he said.

The Wellness Centre has created a planning guideline based on the circle of care concept, to guide its program planning. It is a model that is designed to provide a coordinated, multi-service plan to strengthen families who have a number of challenges and opportunities, and need a combination of services. It supports and encourages the active participation of extended family, elders and spiritual leaders.[1026]

Walker spoke of the bond that was broken when the Indian agents came to the reserves and removed children from their homes to place them in residential schools. When a child is removed from the circle, he said, it creates "disconnect, disharmony, the structures start to break down. What once was a strong community, a strong family grouping, a strong sense of identity no longer exists and you have to go through the process of trying to rebuild that structure. And by doing that you are creating a sense of self-worth, you're developing a new self-concept. You're developing a new sense of self-esteem. You're developing a new self-awareness and you're developing a new sense of self-determination."[1027]

The community has not eradicated its problems, Walker said, but the Wellness Centre has achieved its objectives "in terms of working in collaboration with the community, creating a unified approach to dealing with some of the issues that our families face," he said.[1028]

The AMC and SCO called former Chief Bone to testify about his perspectives based on his experience as a leader. Bone was involved with the development of West Region Child and Family Services, which started at the Chiefs' table at West Region Tribal Council. He believed that the program, which ran for 10 years, represented a successful service delivery model, which combined treatment and prevention. Elsie Flette, CEO of Southern Authority, described the program as a block-funded, community-based pilot project delivering culturally appropriate services.[1029] These prevention services successfully reduced demands on child and family services, keeping children safely in their homes and resulting in substantial cost savings, as reported in the Wen:De Report.[1030]

Among the challenges facing First Nations agencies is funding, said Cheryl Freeman, management consultant to the Wellness Centre and former Chief Financial Officer for the Northern Authority. She described for the Commission a number of deficiencies in the current funding model for First Nations agencies. Often these stem from the fact that many First Nations agencies service a number of communities that are spread out geographically, she said. Also, there is inadequate provision for administrative and IT costs. She acknowledged that these areas, among others, will be reviewed when the current funding model is reviewed in 2015. The funding model is discussed further in Chapter 15.

Another challenge is the difficulty of developing culturally appropriate child welfare standards in a modern context, the Commission was told. Bone testified that although early societies embraced a holistic, interdependent lifestyle with a social and political structure based on the clan system and extended families,

modern Aboriginal communities no longer all share the same connection to historical values, especially those located close to non-Aboriginal communities. As a result of colonization, many historical traditions and cultural practices have been lost, he said. Some people still adhere to traditional teachings while others gravitate towards a blend of cultures and still others are more connected to the societal values of the dominant culture. Aboriginal culture in Manitoba is diverse, he testified, with more than 60 First Nations, six or seven tribal councils and as many linguistic groups, and several numbered treaties. These complexities mean that development of culturally appropriate standards and models will require time, resources, and knowledge, Bone acknowledged.[1031]

9.3 STANDING COMMITTEE PROMOTES CO-ORDINATION

As referenced in Chapter 3, one of the changes implemented under *The Authorities Act* was the creation of the Standing Committee, to ensure consistency of service delivery across the province. Section 30 of the Act reads as follows:

> ***Standing Committee established***
>
> *30 (1) A Standing Committee is established consisting of*
>
> *a) the senior executive officer of each authority;*
>
> *b) the director; and*
>
> *c) an additional member appointed by the Metis Authority.*
>
> ***Role of the committee***
>
> *30 (2) The Standing Committee is to serve as an advisory body to the authorities and the government, and is responsible for facilitating cooperation and coordination in the provision of services under this Act.*

The Standing Committee is charged with development of minimum standards and joint protocols; investigation and analysis to ensure that best practices are applied; and research and planning to further implement the AJI-CWI.[1032]

The Department described the Standing Committee as a partnership of the four Authorities and the statutory director. The Committee itself does not report to anyone,[1033] but each Authority is accountable to its board, and the statutory director to the Deputy Minister. Collectively they are responsible for identifying areas requiring central planning and coordination and then co-ordinating implementation of such changes without encroaching upon the goals of the AJI-CWI, which is for Aboriginal Authorities to exercise a high degree of autonomy over child welfare with respect to their people.[1034]

The General Authority told the Commission that the four Authorities communicate with one another at Standing Committee. Information is shared there about initiatives or programs undertaken by an Authority and then it is up to the others to decide whether it can be tailored to its own needs, according to the General Authority's evidence. [1035] But according to Rodgers—who, as General Authority CEO is a member of the Standing Committee—the committee needs to

do a better job of sharing information amongst the Authorities and reporting that information to the Minister.[1036]

The Office of the Standing Committee has a staff of 15 who do research, prepare documents, and generally support the Standing Committee in its work.[1037] The Office was established in January 2008 by a Standing Committee resolution passed by a consensus of the four Authorities, the Child Protection Branch, and the Leadership Council. [1038]

The Standing Committee had assumed responsibility in August 2007 for *Changes for Children*, the Department's response to the recommendations of the external reviews that followed upon the discovery of Phoenix Sinclair's death. In support of that role, the Office of the Standing Committee focused on planning for the implementation of the recommendations; participating in inter-sectoral committees and initiatives; developing and delivering training; and providing technical support to the Committee.[1039] The Standing Committee was significantly involved in many of the system-wide initiatives that were implemented following the *Changes for Children* initiative, including development of the differential response model and competency-based training.

I heard evidence that the Standing Committee meets twice a year with representatives from the University of Manitoba's Faculty of Social Work to discuss labour force demands, curriculum issues, and research possibilities. I see this as a positive practice that ought to continue.

9.4 RECOMMENDATIONS

1. **Recommendation:** That the Standing Committee discuss as a regular agenda item, the programs and policies being implemented by each Authority to determine those that can be adapted more broadly, in a culturally appropriate manner.

   Reason: This will further the purpose of the committee, which was created under *The Authorities Act* to ensure consistency of services across the province.

2. **Recommendation:** That the Standing Committee issue annual reports of its work to the Minister for tabling in the legislature and for concurrent release to the public.

   Reason: This will better inform the public about the workings of the child welfare system in Manitoba.

10 DIFFERENTIAL RESPONSE: A NEW MODEL OF PRACTICE

10.1 NEGLECT AND ABUSE CALL FOR DIFFERENT RESPONSES

One of the most significant changes made to the child welfare system in Manitoba following the systemic reviews has been the introduction of a new model of practice, known as "differential response." This new approach recognizes that although an immediate threat to a child's safety requires speedy intervention, most cases call for a less urgent—but more intensive and sustained—response.

Child welfare expert Dr. Nico Trocmé, whose evidence has been referenced in Chapter 4 used this analogy to explain:

> *So, for instance, in an emergency room, people are very clear and understanding that the child who shows up with a gaping wound is an urgent case requiring immediate intervention. A child showing up with signs, perhaps, of having a form of cancer will not be seen right away by the ER physicians; they'll be sent to a specialist maybe two or three days later. We're all—we all understand that the first case is a more urgent situation, but the second one is a more severe one.*[1040]

Obviously both children in this scenario need care, but their situations call for different responses from the medical system. Similarly, a differential response model in the child welfare context recognizes that some situations do require urgent intervention to protect a child from immediate harm. But in the vast majority of cases, it is the child's development and long-term well-being that are endangered by chronic neglect, and this can have far more serious consequences.[1041] Trocmé testified:

> *You compare neglected children to any other type of child—physically abused, sexually abused, children living in poverty, children living in a range of circumstances—neglected children stand out.*
>
> *Emotionally neglected children, physically neglected children stand out. You can measure them any which way you want. You can measure their language acquisition at age three, at age four. You can measure rates of anxiety and depression as teenagers. You can look at their aggressiveness. You can look at how they do at school, at educational delay, dropout. Any which way you measure them, at any age, neglected children are the ones that have the worst outcomes, by far.*[1042]

In situations of chronic neglect or emotional maltreatment, he said, the concern is not that conditions are at risk of escalating, but that they are at risk of continuing as they are. "It's just living in an environment that is unpredictable for an infant, a young child, an adolescent, is extremely difficult and is extremely harmful."[1043]

Child welfare practice traditionally has focused on urgent threats to a child's safety but, "day-to-day exposure to a parent who doesn't have the energy, the resources, to meet the needs of that child, that is devastating to that child's long-term development . . . . The child whose sense of self, whose sense of—whose stimulation, whose sense of learning is harmed by chronic exposure to neglect—the damage can be permanent."[1044]

This incongruity between traditional child welfare practice, and the reality of children's lives, is what the differential response model of practice was designed to address.

10.2 TWO APPROACHES TO CHILD WELFARE SERVICES

Theoretically, the differential response model contemplates two streams of social work:

- the protection stream, which is a traditional child welfare approach; and
- the family enhancement stream, where workers aim to develop relationships with children and families and connect them with support services that can enhance their ability to keep children safe at home and provide stable and nurturing homes, before a crisis occurs.

Evidence showed, however, that in practice this is an artificial distinction. Child welfare services are provided on a continuum, focusing on protection in the face of an immediate threat to a child's safety but almost always working with a family enhancement approach to keep children safe at home.

Protection services use a forensic approach to focus narrowly on finding answers to specific questions in cases where there may have been reports of sexual abuse, or serious physical or emotional harm, and where criminal charges might be laid, Trocmé explained.[1045]

Where immediacy of risk is lower, family enhancement services take a different approach. In a case of general neglect, for example, a social worker would engage the family on a voluntary basis if possible, and identify community and agency supports that could help the family develop a secure and supportive home for its children.

Unfortunately the artificial distinction between the two "streams" has been embedded in the differentiated caseload ratios contained in the existing funding model.

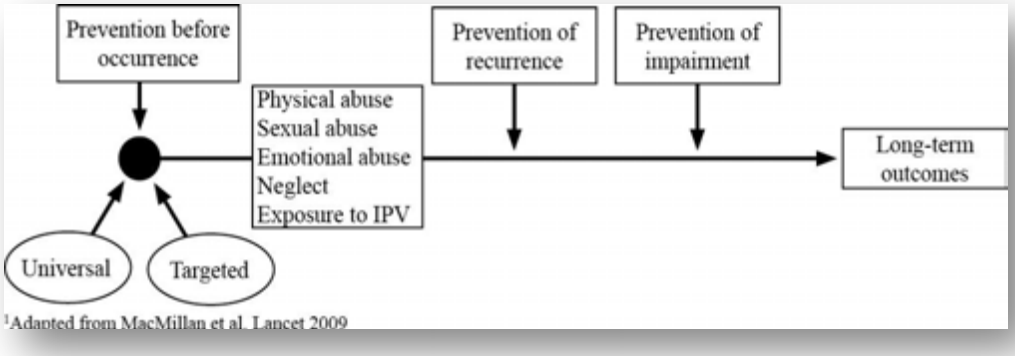
10.3 DIFFERENTIAL RESPONSE APPROACH REQUIRES SERVICES

Differential response is not itself a service, Trocmé pointed out, but rather a triage mechanism for assessing a family's needs: it relies on services being in place once the assessment has identified the family's needs. Returning to the medical analogy, he said it doesn't make sense to have emergency room triage if there is no physician to provide the needed treatment. In the child welfare context, it's important to have the tools to determine what services are needed, but then those services must be available and funding in place to ensure that they can be provided "with the intensity and the duration that's required given the complexity of the situation." [1046]

Whether addressing abuse or neglect, three types of intervention are possible, Trocmé testified:

- prevention before occurrence, also known as early intervention (before contact with the child welfare system),
- prevention of recurrence (once maltreatment has occurred and the child welfare system is involved), and
- prevention of impairment (addressing the harm that resulted from the maltreatment).[1047]

The following diagram illustrates these three opportunities to provide services:[1048]



("IPV" refers to intimate partner violence.)

The task of prevention before maltreatment generally falls to systems and agencies outside the child welfare system, such as public health and education through universal services accessible to everyone, and targeted services, typically aimed at high-risk families. Prevention of recurrence and prevention of impairment—that is, prevention or mitigation of harm resulting from abuse or neglect—fall within the mandate of the child welfare system.[1049]

10.4 IMPLEMENTATION OF DIFFERENTIAL RESPONSE IN MANITOBA

The decision to implement a differential response model in Manitoba was based on research that showed that in a large number of cases where child welfare had to become involved with a family in an intrusive way—such as by apprehending a child—there had been earlier contacts that could have been opportunities for prevention. "So the idea of differential response," according to General Authority CEO Rodgers, "is to identify those families early, who are most likely to come back later on and require a more intrusive response . . . and to provide them with supports then, as opposed to later, and by doing so keep those kids from having to come into care later on."[1050]

Successful implementation of a differential response model requires reliable assessment tools, Rodgers explained, for two reasons. First, child safety has to be assured, "So we have to effectively and appropriately assess the safety of kids, to know that we don't need to proceed down the investigation track." Second, once safety is established, it's essential to be able to predict which families are likely to need intervention later on, if supports aren't provided earlier.[1051]

To identify the assessment tools that would be used as the basis for its differential response model, the General Authority retained two recognized experts in this area: Dr. Eric Sigurdson, a child and adolescent psychiatrist; and Dr. Bradley McKenzie, a professor of social work at the University of Manitoba.

Based upon these experts' recommendations, the decision was made to adopt a set of actuarial tools known as the Structured Decision-Making Tools (SDM), which was developed by the Children's Research Centre in the United States. SDM is a set of tools to guide the gathering of information that will be critical to the management of each child welfare case. It is discussed in more detail below. Rodgers testified, "One of the real values of using the SDM approach is that, because of the research that's behind it, it has really crystallized the information that is needed to make particular decisions in the life of a case. And so it helps focus workers on the information that really matters to each decision." The SDM tools, he said, enable clear communication with families about why the agency is concerned, and what the family and the agency need to work on together, to ensure the safety of the child.[1052]

With its detailed policy and procedures manual, and training, this structured approach brings consistency to the interpretation of information from case to case, and from worker to worker, Rodgers said. It reduces the impact of bias, so that workers make decisions more objectively.

All four Authorities contracted with the Children's Research Centre and participated in the process to adapt this suite of decision-making tools for use in Manitoba, and all four agreed to use it.[1053] The first step was a set of pilot projects.

Given that SDM relies on quality information to guide decision-making, another innovation, called "Signs of Safety," was introduced as part of the pilot projects, to help ensure that the information gathered by social workers would be full and accurate. Signs of Safety is an "internationally known approach to child welfare," said Rodgers. It is a set of "strategies and practice skills to allow social workers to engage with families in a way that they feel a sense of ownership in the process, they feel that they have some influence on the process; and there are also strategies that animate the voice of children in the process."[1054]

Each Authority was allocated funds for pilot projects to test a differential response model between the latter part of 2009 and March of 2011, McKenzie testified. After evaluating the projects, he recommended continuing use of the SDM tools.[1055]

Parents and other caregivers responded overwhelmingly positively to the services that were offered to them, McKenzie reported. He attributed this to high levels of family engagement and positive working relationships. A family's willingness to engage, McKenzie reports, is the most important element in achieving a successful outcome. He also found that collateral service providers in the communities where the projects were located were unanimous in their support for the expansion of the service model. But success depends on intense services and workers spending a lot of time with families, so workloads must be manageable. And if higher risk families are taken into the program, services will need to be provided for longer periods of time. With families who are less willing to engage with the system, such as seemed to be the case with Kematch (at least towards the later period of Phoenix's life), services sometimes must be involuntary.[1056]

Workers must be trained in the proper use of the tools, but they are only tools, McKenzie cautioned: they must be supplemented with "good, sound clinical judgment and an ability to do an assessment of what's needed for families . . .and the skills to do the practice."[1057]

The Department confirmed that differential response is funded across the province. Counsel for the Department submitted that to his knowledge it is in place at every agency in the province. It's not necessary to prescribe it, he said, because with the resources there, agencies are happy to adopt this model. How it is delivered is up to the individual Authorities and their agencies.[1058]

McKenzie testified that this model will result in fewer such families being referred back again for further investigation. He said:

> *. . . . And there's some evidence in evaluations, longer-term evaluations that have been done of these kinds of programs that that does, in fact, occur. The results are a little bit mixed in that regard because you establish a fairly trustworthy working relationship with some of these families and in some cases they may voluntarily come back and ask for additional types of assistance from the agencies.*[1059]

McKenzie testified that a differential response model should be able to effectively address situations such as occurred in Phoenix's case, where files were opened and closed repeatedly, with no services delivered. Rather than close the file because no immediate threats to safety were identified, a differential response model would identify long-term risks to the child's well-being and would intervene with a range of services to support the family.[1060]

The Inquiry heard evidence that funding earmarked for family enhancement services is limited to $1,300 per family, per year. This is the amount available to provide services a family may need (beyond the work of the agency social worker), such as a family support worker, emergency food, therapy for children, summer camp, or daycare.[1061] This fund is discussed further below.

10.5 DIFFERENTIAL RESPONSE AT THE GENERAL AUTHORITY

In its final submissions, the General Authority said it expects to have fully implemented this new model by early 2014, as the most essential component of its vision for a truly functional and responsive child welfare system. Its implementation has been consistent with the evidence-based practice recommended by Wright (see Chapter 3.) The General Authority has applied current research to the daily practice of social work while continually evaluating its initiatives, whether by way of feedback from frontline workers, or formal evaluations such as that conducted by McKenzie.[1062]

The General Authority's practice model supports social workers' engagement with families—even families who are not cooperative and are receiving services involuntarily, and may not trust the child welfare system. The goal is to build trust and redirect the focus from "parent blaming" to a collaboration that can help the family function better so that children will be safer, preferably at home. The model allows workers to apply the same techniques whether they are working in collaboration with families to keep their children safe at home, or with families whose children have been apprehended. Even where there is a child protection investigation, social workers need to work with families to keep children as safe and well as possible, the Authority submitted.[1063]

10.5.1 THE SDM SUITE OF TOOLS

SDM features a set of forms to guide social workers in making their assessments, as well as training in their use. The forms include:

1. a safety assessment;
2. a probability of future harm (risk) assessment;
3. a family strengths and needs assessment, which includes assessment of both caregiver and child;
4. risk reassessment; and
5. family strengths and needs reassessment.

The General Authority also plans to introduce the SDM reunification tool, which is used to assess whether it is safe to return a child to his or her caregivers. The benefit of using the entire suite of tools, Rodgers said, is that each assessment informs and complements the other. [1064] Witnesses described the tools as follows:

> **1. SDM Safety Assessment:** This is the first tool that would be used by a social worker, to make an immediate determination as to whether a child needs to be apprehended. Based on the information that the form asks for, the worker must make one of three decisions for each child in the household:
>
> 1. The child is safe; or
> 2. The child is not currently safe, but could be made safe with supports; or
> 3. The child is unsafe and cannot be made safe in the home.
>
> The third choice results in apprehension.[1065] Every child, regardless of age, must be seen and assessed. If this is not possible, the reason must be documented.[1066]
>
> Rodgers testified that the Children's Research Centre has provided training for trainers in all four Authorities and all four have agreed to implement this safety assessment tool to replace the safety assessment in the Intake Module. Rodgers said, when he testified in May 2013, that the General Authority expected the SDM safety assessment to be in use across its system by the fall.[1067]
>
> **2. Probability of future harm (risk assessment):** This form is to be completed within the first 30 days of contact with a family. It poses a set of questions, the answers to which will guide a worker in determining the likelihood of children being harmed in the future if services are not provided. "It doesn't accurately predict which families will re-harm their kids; it only provides a classification of families that are more likely to harm their kids," Rodgers testified. The decision to keep a case open, and the intensity of services to be provided, will be informed by this tool.[1068]It also determines the frequency with which a family must be seen by the agency.[1069]
>
> All four Authorities have agreed to use this risk assessment tool.[1070]
>
> **3. Family strengths and needs assessment:** This has two components—one looking at each caregiver in the home and the other at each child. It focuses on the needs of families and caregivers and identifies strengths that can be built upon to help them meet those needs. Workers are taken through an itemized list and are asked to score particular areas as strengths or needs.[1071] Based on the information gathered at this stage, the worker collaborates with the family to identify a support network and develop a case plan. Embedded in the case plan is a safety plan: for example, a parent who is struggling with sobriety might plan to call a particular person for

support when the urge to drink threatens to become irresistible. The agency then would work with the contact person to plan for an appropriate response when that happens. A case plan is not set in stone: it is reassessed as needs and circumstances change.[1072]

4. **Probability of future harm reassessment:** This is used to re-evaluate the probability of future harm to a child after a child has been returned to the care of his or her parents for a minimum of 45 days.[1073] The assessment is used to determine whether the family still requires services, or whether the file can be closed. It can be used to amend or modify the family's case plan and to determine what services the family will require in the future. If the reassessment shows that the risk to a child has not lowered sufficiently, the worker will engage the family in a strengths and needs reassessment, which would be used to construct a new case plan.[1074]

5. **Family strengths and needs reassessment:** This is the same tool as the initial family strengths and needs assessment.

Adoption of the SDM tools required a license from the Children's Research Center, Rodgers testified. Licensing is the means the Center uses to ensure that the tools are used properly.[1075] The Center also provides training and works with users to adapt its tools to local circumstances.

Workload levels can be expected to increase at the outset, Rodgers said, but over time as workers become familiar with the assessments, their workload decreases. He acknowledged that workers had not yet been reporting a decrease in their workloads and said the General Authority is planning to look into the issue.[1076]

Rodgers emphasized, as did other witnesses,[1077] the importance of good clinical judgment in the use of these tools. The tools are an organized and structured method of collecting information, but they do not make the decisions, Rodgers said. Workers make those decisions, based on their interpretation of the information. So, for example, a worker might say to a supervisor that the tool is suggesting a particular result "but my clinical judgment, I'm seeing these other things." The information-gathering tool ensures that they can have an informed discussion about the best course of action for that family. [1078]

10.6 DIFFERENTIAL RESPONSE AT WINNIPEG CHILD AND FAMILY SERVICES

Winnipeg Child and Family Services (CFS) falls under the jurisdiction of the General Authority and is the largest agency in Manitoba. At the time it delivered services to Phoenix, Winnipeg CFS provided both intake and long-term family services. Since May 2005 the intake function is provided by ANCR.

Karen McDonald is a leading practice specialist at Winnipeg CFS and provides formalized training, teaching, and mentoring to workers and supervisors. When she testified on May 15, 2013 she said that training on the complete set of SDM tools was to be completed by the end of June.[1079]

Alana Brownlee has been CEO of the agency since 2011. She testified that while there was some reluctance when the agency first started training on the new tools, workers are becoming more comfortable with them as they see their effectiveness and share success stories. The one "resounding" criticism that she hears regularly is the impact on workload: workers complain about the volume of paperwork and are struggling with the requirement to make face-to-face contact with families as often as required, she said.[1080]

Brownlee pointed out in her testimony that social workers have always gathered information, and what is now being gathered with the use of the new assessment tools isn't necessarily different information. She said:[1081]

> *I think the biggest difference that I'm seeing regarding the tools and actually seeing them put into practice is that it gives social workers and their supervisors and people at my level a consistent framework in which to hang that information, so to speak. So you can now take a family that has those characteristics and instead of me making a subjective judgment about how does that impact risk, or how does that potentially impact what's going to happen for this child and this family, we now have the consistent way of saying okay, so this should be rated this way with these characteristics. At the end of the day, this is a medium risk case, this is a high risk case, and then that helps inform your case plan and what are the things that you really need to be focused on, as well as helping you decide the safety factors.*

This new structured approach also means that there is consistency in terminology across agencies, Brownlee said. If ANCR says it is transferring a case to Winnipeg CFS and it's a medium risk case, "I know exactly what that means," she said.[1082]

Winnipeg CFS has developed a case recording guide for use by its workers, which fully incorporates the SDM package of assessment tools.[1083] The guide begins with instructions for a worker upon receipt of a new file from Intake, with a timeline for each task. It asks for demographic and family information, and a full child welfare history.[1084] Then it suggests questions to be explored with the family so that the worker can obtain the information necessary to score the items on the Probability of Future Harm Assessment. But beyond the scoring, the worker is asked to record a brief narrative that will allow anyone who picks up the file to understand the facts and observations that underpin the assessment. For example, instead of a simple "Yes" recorded under the first category of neglect, a worker might report details such as finding no food in the house, the children dirty, chicken bones on the counter, and dog feces on the floor. A worker who answers "No" to the question about prior child protection investigations is expected to record what sources were checked.[1085]

This is significantly different from the state of file recordings prior to 2006, Brownlee said. At that time there was no specific document for a worker to use to complete an actual risk assessment. Now there is a framework and tools, ongoing training, and specific expectations, and since all workers are using the same tools, there is also a high degree of consistency.[1086]

This recording package was developed over a period of five years, specifically for Winnipeg CFS, but it has been adopted by other General Authority agencies and has been shared with agencies under other Authorities for their consideration.[1087]

Brownlee also discussed the Signs of Safety principles, which are intended to guide social workers, who need to decrease families' defensiveness so that they can have difficult conversations with them and gather the needed information.[1088]

Brownlee acknowledged that the basic expectations of a worker have not changed since the time Phoenix received services: a worker should do a case plan; should talk to the parents; should take the name and investigate the identity of a new person in a household; and should not close a file before ensuring that there are no child protection concerns. What is different now, she said, is the level of clarity as to expectations of a worker; clinical training in practical skills to allow workers to engage with families; as well as new tools to provide clarity and consistency in decision making.[1089]

When asked how the agency can ensure that staff complies with the new requirements, Brownlee testified:

> *I think first of all you need, staff need to know very clearly what the expectations are so they need to know what is expected. I think we've done that in terms of the standards are very clear. Our policies are really clear. I think then staff need to have training in terms of, okay, what does that mean on the ground? How do I actually implement this? It's fine to have a standard. What does that mean when I'm actually meeting with a family? What does that mean? And so that's the next step that's really important is the actual training. Then they need the tools and the skills to actually do that as well, so we developed the tools. That's where the SDM tools come in. The practice model training comes in terms of actually how do you have those interviews, how do you come up with a case plan that a family's likely to follow through with. The last piece is they have to have the supervision and the support and the resources to then be able to do the job. So they need regular supervision that is geared to focusing on those same aspects. They need to be able to readily access the resources they need to support the families and ultimately they also need to have a reasonable enough caseload. I can tell you with my staff right now, a worker with a caseload of 40 is not going to be able to have this done on every case and they're not going to be able to meet the standards on every case.*[1090]

Not all of her workers have manageable caseloads, she said. The average for her workers was about 30 cases. For workers in a specialized perinatal program for young mothers it ranged from 18 to 24; permanency planning workers, who work only with permanent wards, averaged 35 to 44 cases; and family service workers, which include the new differential response/family enhancement files, had from 24 to more than 40 cases. When asked if she was concerned that the workload was such that her staff is not able to comply with standards she testified:

> *I think the level of engagement isn't where I would like to see it with all cases and our ability to meet the standards in terms of being able to complete all the required assessments in a timely manner isn't consistent either.*[1091]

She was asked about the level of engagement required of workers, to meaningfully complete the new SDM tools:

> *MS. BROWNLEE: If you could meet the standards with weekly contacts or even biweekly contact, that would be meaningful engagement and you would be able to, I think, easily and readily complete the assessment information and have a real relationship with the families you're working with.*
>
> *MS. WALSH: And are you saying that's not happening in every case?*
>
> *MS. BROWNLEE: Yes.*
>
> *MS. WALSH: And is it happening in 50 percent of the cases?*
>
> *MS. BROWNLEE: What we do is we use our family support program is critical to helping us meet those standards. So the social worker will not necessarily have time to meet with the family and we're very, very reliant on being able to have our family support staff spend that time, so we will have support workers in the home once or twice a week. Right now we have about 2000 families and on average last year I believe we had services provided to about 1500 of our families.*
>
> *MS. WALSH: So family support workers are a part of your solution for managing workload?*
>
> *MS. BROWNLEE: Part of our solution for ensuring that we have consistent, regular contact with, with our families and that we have knowledge and information about the family circumstances. They're certainly a critical part of the case plan in terms of, as we've said earlier, identifying kind of what are the risk factors and how are we meeting them and who's going to help the family support in doing, doing these steps.*
>
> *MS. WALSH: What is your solution? What would you like to see, what do you need to see in order for these tools to be properly filled out?*
>
> *MS. BROWNLEE: To be honest, I think we need to, we need to follow the funding model guidelines that we've established, if we stuck to the one to 20 and the one to 25 and funded agencies with that, but also funded services that you require to deliver services that are outside of protection and the prevention. My critical piece is our resource staff. I have 50 staff members that I've had to take from the protection stream of funding to provide support and services to our foster care. . . . .*

The other piece of that is we have about 19 positions that are dedicated to family support or resources support children, either at home or families with children at home. So we have the $1300 per family but that doesn't cover kind of the level of support services that you really need to put into work with families, so …

MS. WALSH: So you need something more than what we've heard the funding model provides?

MS. BROWNLEE: Yes.[1092]

Brownlee testified about the practical impact of funding limitations for family enhancement services. Many teams use service assistants or family support workers who will coordinate with various outside service partners and agencies to support families and will attend appointments with those families, but the $1,300 allowed per family annually doesn't go very far, she said: [1093]

Our average length of service for family support contracts is just a little bit over a year and that's less to do with ideal and more to do with just trying to ensure that we can spread the services around. Our average length of service per families is 36 months. So if you look at two and a half years, ideally you would want a big chunk of that to involve some level of support services. If you had someone, a support worker working with someone for six hours a week for 20 weeks I think was the math I had my finance person do, that costs approximately $5,000. So that's more than the $1,300. That also doesn't include the other uses that we use for that money. That's the money we use for emergency food for families. Lots of times our families run short. We regularly provide emergency food to get people over. I don't want anyone to have any beliefs that we apprehend kids because they're short of food. We absolutely do not, but we will provide assistance. We provide transportation assistance and bus tickets or cabs. That . . . also includes if a child is living at home and they need therapy or you want, say, the parent needs therapy, if you wanted to do some attachment work. All of those costs come out of the family support budget. Also we cover camp for kids that are at home, the parental contribution. We cover the parental contribution for day care out of that family support budget.[1094]

Brownlee agreed that it is frustrating to have such a limited fund available for prevention measures aimed at keeping children safe in their homes.[1095]

I commend Brownlee for her candour. It was obvious from her testimony that she is committed to following best practice in providing services to children and families. Her frustration in not being able to provide the level of services she believes necessary was apparent. Trocmé testified that without the services to support children and families, assessments are of little value. Based on Brownlee's testimony it appears that the agency has insufficient resources to provide the necessary services or even—in a significant proportion of its cases—to complete the full assessments that are essential to the differential response model of practice.

As Brownlee identified, due to workload demands, in many cases the agency relies on family support workers rather than social workers to comply with contact requirements and to identify risk factors. But the $1,300 available to fund those support workers has to be stretched to cover other prevention services as well, as discussed earlier. Both McKenzie and Trocmé testified that to be effective, services to families must be intense. McKenzie said workload must be manageable and Trocmé said that funding must be commensurate with the complexity of the situation.[1096]

10.7 DIFFERENTIAL RESPONSE AT THE SOUTHERN AUTHORITY

CEO Elsie Flette testified that the Southern Authority has also adopted differential response as its service model. This innovation, together with the introduction of the SDM tools, is one of the major changes to the child welfare system that resulted from lessons learned from Phoenix Sinclair's story she said. This new approach, with templates and forms to guide decision making, mean that social workers no longer have to rely on gut feelings in deciding what to do in a case.[1097]

At the time of her testimony the Authority was close to a full rollout, she said: a number of pilot projects had been completed and training had been done on the structured decision-making tool.[1098]

The Southern Authority has produced posters and pamphlets and a video called "Changing the Face of CFS" to promote community awareness of this new approach to child welfare and to show people what they can expect from their agency. Working with its agencies, it has identified partners and has entered into partnership agreements in certain program areas.[1099]

These partnerships, Flette said, are key to finding "different ways of working with families that are perhaps less threatening or less stigmatizing than the child welfare agency itself."[1100] Services such as addictions counseling or parenting support can be provided by community partners while the caseworker manages the case and maintains responsibility to ensure that the family is actually receiving the services and is benefitting from them.[1101]

Not all cases can be sent to the family enhancement stream, she said. If a matter is before the courts or if children have been apprehended, or if there is an active abuse investigation, that case must go to the protection stream. But even so, the agency can use a family enhancement approach in working with the family, she said. This new service model changes how work is done in both streams.[1102]

As did others, Flette testified that the $1,300 available for family enhancement services is insufficient. The limit is the same, regardless of how complex the family's needs or how many children, although if one family doesn't require the full amount, any remaining funds can be pooled and used for a family with greater needs, she said.[1103]

10.8 DIFFERENTIAL RESPONSE AT ANCR

As described in Chapter 3, All Nations Coordinated Response Network (ANCR) provides a coordinated intake service and after-hours coverage for the 20 child welfare agencies operating in Winnipeg. Outside of normal business hours, ANCR is the only child welfare agency operating in Winnipeg and the nearby rural region.[1104]

Executive Director Sandra Stoker testified that ANCR has been using the SDM tools across all of its programs since July 2012.[1105] This means that for every allegation of abuse or neglect received by ANCR, whether through its crisis response unit, or after hours unit, or any other program, a safety assessment must be done, which requires that every child be seen. A file cannot be closed without a safety assessment and risk assessment. [1106]

The SDM Probability of Future Harm tool is the tool workers use to assess the probability that a child may be harmed in the future. It requires the worker to do a thorough history check, counting the number of allegations that have been made against each caregiver in the home. "(Y)ou run through the questions and it automatically scores it for you. And then based upon the score, it tells you the risk level," Stoker testified. There are some overrides that can be made for policy or discretionary reasons, but these can be used only to increase the risk level, never to lower it, she said.[1107]

The two primary criteria for sending a case to the family enhancement stream, Stoker said, are these: can the child be safely maintained in the home; and is the family willing to engage with the agency?[1108]

In ANCR's family enhancement stream, an intake worker has a short-term and a longer-term option: if it seems that the family can be successfully supported and risk factors resolved within 90 days, the file may be kept at ANCR. But 90 days is the limit for a file in ANCR's family enhancement stream, so if it seems that the family's issues will take longer to resolve, it will be referred for ongoing services at a family services unit.[1109] After ensuring that a thorough strengths and needs assessment has been done, Intake would complete the process to determine the family's choice of Authority, and then refer the family for ongoing services under that Authority. ANCR can recommend that the family receive either protection or family enhancement services.[1110]

ANCR's family enhancement program is not a stepping-stone to ongoing services at one of the Authorities, Stoker said. A file that looks as if it will require longer than 90 days to resolve can be referred directly to the appropriate Authority, so that families don't have to deal with a change in workers. About 50 to 60 percent of the family enhancement files opened at ANCR are closed there, and are not transferred to an Authority, Stoker said.[1111]

One of the services that ANCR offers to families is a family support worker who can teach parenting skills or can provide respite—for example, by looking after children while a single mother goes grocery shopping on a winter day. Other supports include bus tickets to allow parents to attend programs, and emergency food or clothing supplies. Of ANCR's $540,000 annual budget for family enhancement services, about $300,000 goes to hiring in-home supports; $100,000 to emergency supplies; and $60,000 to transportation for families.[1112]

Stoker testified that at present, 22 percent of ANCR's workers are family enhancement workers, but over time, the goal is to shift personnel to this prevention stream as the need for protection services decreases.[1113]

In his evaluation report, McKenzie recommends a review of the strengths and weaknesses of maintaining a family enhancement program at ANCR, suggesting that all family enhancement services be shifted to the appropriate agencies.[1114] In spite of Stoker's comment that ANCR's services were not to be seen as a stepping-stone to ongoing services at an agency, McKenzie testified that during his review period—up to March 2011—32 percent of the cases that were referred to Winnipeg CFS came from ANCR's family enhancement program. This means that a large number of families needed services for longer than the 90 days that was first predicted for them. Disrupting services in this way, often with a resulting delay, flies in the face of a best practice approach to delivering intensive services and building a relationship between worker and family, McKenzie said. [1115]

Rodgers was asked to comment on McKenzie's recommendation that every effort be made to transfer cases as soon as possible to an agency's family enhancement program, rather than keep them at ANCR for short-term services. He agreed that this is a recommendation worth pursuing. Families who had to be transferred to Winnipeg's family enhancement program after ANCR had been unsuccessful in resolving their issues within 90 days found this confusing, he said. And although family enhancement services can improve a situation within 90 days, it typically takes longer to reduce the probability of harm to a level where an agency can be comfortable closing the file.[1116]

10.9 SDM AND CULTURAL BIAS

The Inquiry heard from Dr. Cindy Blackstock, executive director of the First Nations Child and Family Caring Society of Canada, and a recognized expert in the field of First Nations child welfare issues. She expressed concern about possible cultural bias in the SDM assessment tools. She cautioned about the wholesale application of tools that were developed for another population, without accounting for the different context of First Nations children.[1117]

Issues such as poverty are often conflated with neglect, she said. Most structured decision-making tools she has reviewed have codified structural issues such as poverty, and treated them as parental deficits. And answers to other questions will often disadvantage First Nations families, she said. For example, many of these tools ask about previous history of abuse: many First Nations families will tick that

box because of residential school experiences, which are no fault of their own. It is important that those who use the tool are aware of its limitations and are given proper training, she said, because misapplication could result in the removal of a child from a parent.[1118]

Rodgers testified that if there is cultural bias built into the SDM it will be corrected when the General Authority asks the Children's Resource Center to do a validation study, which can be done only after three to five years' experience with the tools in the jurisdiction. The study will help determine whether there is any cultural bias built into the SDM tools as they are being used in Manitoba. He said that in Minnesota a validation study suggested an anomaly with regard to Native Americans in that state and correction was made.[1119]

Representatives of AMC and SCO expressed the view that the tools should not be used before they are validated to correct for cultural bias. The General Authority responded that although the tools are developed for a particular jurisdiction, it is only after they have been used in enough cases that a validation study can done. At that time, any cultural bias can be detected and eliminated if found.[1120]

10.10 THE ROLE OF COMMUNITY AGENCIES

Manitoba needs a more comprehensive prevention and early intervention strategy for child welfare services, McKenzie testified. By this, he means a broad range of well-coordinated universal programs and specially targeted services that are available to families both inside and outside of the child welfare system.[1121]

Such a strategy should be designed, funded, and implemented by the Department in conjunction with the four Authorities, McKenzie recommended in his evaluation of the General Authority's differential response/family enhancement pilot projects. The strategy would identify the steps to be taken to achieve a continuum of prevention and early intervention services, including increased partnerships with other government services and with community-based organizations that operate outside of the formal child welfare system but have essential roles to play in promoting the well-being of children and families in Manitoba.[1122] Rodgers testified that he accepts McKenzie's recommendation and agrees that more work needs to be done in that regard.[1123]

Carolyn Loeppky is the Statutory Director of Child and Family Services for Manitoba and Assistant Deputy Minister of Family Services. She agreed with the importance of strong community-based agencies and programs and that they must have strong relationships with child welfare agencies and Authorities. To improve the capacity of community partners, the department has provided a level of stability to some organizations that deliver programming in certain areas, by converting project-based funding to ongoing funding. Some community organizations receive program funding from other government departments, such as Education and Justice, she said.[1124]

Loeppky acknowledged, however, that there is no identifiable policy or legislation that places responsibility on a particular government department for coordinating the funding of community agencies to ensure that those agencies have the capacity necessary to support a successful differential response model. She agreed that such a policy or legislation would be worthwhile.[1125]

10.11 ADDRESSING CHRONIC NEGLECT

Both Rodgers and Trocmé testified that most Aboriginal children who come to the attention of the child welfare system do so as a result of issues related to chronic neglect, as opposed to abuse. "(L)imited income, low educational attainment, combined with social isolation are the combination of factors that increase the likelihood of families coming into contact with the child welfare system," Rodgers testified.[1126]

Rodgers said the differential response model is designed to meet these chronic needs of families in a number of ways, including the annual $1,300 family support funding, though he acknowledged that the amount may be insufficient and "we may not be able to use it quite as creatively as we would like." He said perhaps more should be done to address that. He also spoke of working with families to create safety networks and connect families with community services that can ensure they are not neglecting their children to the point they are being harmed.[1127]

10.12 WORKERS' COMMENTS ON DIFFERENTIAL RESPONSE

Workers who had been involved in delivering services to Phoenix and her family were asked at the Inquiry about their experience using the SDM tools. Most of those witnesses who continue to work in the system are now employed with ANCR. Given how recently those tools had been implemented, their responses were limited but their evidence generally was that tools provide a more consistent approach to carrying out their assessments. However, they also said that so far, the tools have increased their workload. At the time of their testimony not all workers had received training on the tools and not all were using them.[1128] I expect that this will have been remedied by now, and if not, should be seen as a priority.

10.13 CHALLENGES TO BUILDING TRUSTING RELATIONSHIPS

Rodgers testified that the foundation of a successful child welfare intervention is the worker's ability to build a relationship of trust with the family. Many other witnesses echoed that belief. Acknowledging that Phoenix and her family received services over the course of five years from a number of different workers, each having limited involvement, he said this makes it difficult to build a relationship.[1129]

Another challenge to building trust, Rodgers said, is the dual mandate of the child welfare system. By this, he meant that the initial involvement with the family is in an investigative role, about child protection concerns; but once the children are found to be safe, the worker needs to act in a collaborative role with the family. It's difficult for social workers to do both, but he said that workers are trained in techniques they can use to help them engage with families even in the initial, adversarial period.[1130]

One other aspect of relationship building that ought to be considered is the manner in which agencies share information with caregivers. *The Child and Family Services Act* restricts a caregiver's access to information about a child who is the subject of protection services.[1131] While I recognize the importance of confidentiality in this context, a trusting relationship requires as much transparency as possible between the caregiver and the agency. Without this, it is doubtful a family will truly engage with the worker as they must do, for the benefit of the child. For example, it would be important for the agency to share, as far as possible, the agency's concerns and plans for the child and family. As always, safety concerns remain paramount.

10.14 WHO SHOULD DELIVER PREVENTION SERVICES?

The emphasis on the significance of prevention services and the need to establish trust so that a family is open to receiving those services, led to the question of whether child and family services should be limited to its traditional protection role, leaving prevention services to be delivered by some other entity. In other words, should child welfare be delivering prevention services at all?

This was the position taken by Edwards and Sinclair. In his final submission, their counsel recommended:

> *That the CFS Act be changed to reflect child protection as the only purpose of the mandated child protection agencies. Family preservation and support services should be delivered by a separate government agency or non-governmental organizations with a special emphasis on a child's well-being as opposed to immediate safety.*[1132]

The General Authority acknowledged that trust is a major issue but said there is no evidence to suggest that the reason people do not trust agencies is that they have the power to investigate and to apprehend children. Trust, it argues, is being built through the new practice model's collaborative approach between families and workers. It is important that the same agency provides both protection and prevention services. Whether the agency is working with a family and children safely in their home to prevent the need for greater intervention in the future; or whether it is necessary to apprehend the children with a view to eventually reuniting the family—whichever stream the case falls into, it is nevertheless child protection work. [1133]

The AMC and SCO do not support an amendment of the Act to limit the purpose of mandated child welfare agencies to child protection alone. They point to the legislative review envisioned by the AJI/CWI process and say that no such amendment should be considered outside the context of that review. The AMC and SCO also make the point that prevention and protection services are closely interwoven. Separating the two would be difficult and could lead to gaps in service, in part because transition between prevention and protection can be a gradual process. For example, a family might be first identified as requiring prevention services but over time, failure to respond to interventions may result in the child requiring protection services. There is value to having continuity of service from the same social worker.[1134]

The Department submits that the child welfare system should be responsible for providing the bulk of prevention services. It accepts that non-mandated community-based agencies provide valuable services and support to struggling families. But it urges caution in accepting community-based agencies as a viable alternative to the family enhancement services now provided by mandated agencies.[1135] Relying on the evidence of McKenzie, the Department argues that:

1. Since 2006, CFS has been concentrating on building capacity within its system to provide an alternative approach;
2. Manitoba does not have a well-developed sector of community-based organizations;
3. Those organizations and programs that do exist in Manitoba are generally unavailable outside of Winnipeg, so Aboriginal communities and smaller remote communities do not have access to those services; and
4. Community-based organizations see themselves as having an advocacy or therapeutic role, which is important. But it means that they do not want to support CFS and do not want to disclose information to CFS because it would destroy their relationship with the client.[1136]

The Department suggests that community-based organizations have an important role to play in delivering prevention services before maltreatment occurs (Trocmé's "prevention before occurrence"). This would include "universal" programs such as early childhood education and Healthy Baby programs that are available to everyone and aim to reduce the probability of maltreatment of children. There are also program such as addictions counseling, teen mother programs, and youth justice programs that are targeted at addressing identified risk factors.[1137]

Once a family comes to the attention of the child welfare system, the first job of CFS is to prevent recurrence of maltreatment, the Department submitted. The second is to prevent impairment, or harm, resulting from maltreatment. Here, community-based, non-mandated agencies can help. They can provide programming and counseling to ameliorate long-term impairment. The Department argues that it is critical that CFS be involved at this point to act as a "quarterback," ensuring that the child is safe and that services are being provided. The Department underlined that in protection matters, CFS has the power to require that services be received, which non-mandated agencies do not.[1138]

Trocmé testified that there is no research comparing the efficacy of services provided by child welfare agencies to those provided by community agencies or others. But there is research on the level of service required to make a difference. Unless a service provider has the resources and the mandate to provide the level of outreach necessary to work with families who are difficult to engage with, there is a risk that these families will fall by the wayside, he said. That is why services must be provided by an agency that has both the resources and the mandate to work with complex families, including workers—whether public health nurses, or social workers, or other professionals— with the time and ability to engage with children and families in their homes. Further, their caseloads must be reasonable. Typically, he said that would vary from 10 to 20 cases per worker for intensive in-home services.[1139]

Regardless of who delivers the services, intensity and duration is critical, Trocmé said. These are not services that are effective over a short period of time. It is also important, he said, that the services be supported by a training manual specific to the type of intervention, and effective training on how to deliver that service. [1140]

Evidence heard by the Inquiry clearly demonstrates that early intervention and prevention should be the central focus of services aimed at supporting families and protecting children.

The significance of the role to be played by community-based organizations and other government departments, such as Health and Education, in providing early intervention supports to families before maltreatment occurs, cannot be overstated. I make a recommendation respecting coordination of funding for these organizations later in this report.

On the other hand, the child welfare system must have primary responsibility for services aimed at preventing recurrence of maltreatment and preventing impairment resulting from maltreatment because these interventions occur after the threshold for intervention by the child welfare system has been met.

The differential response model is the Department's primary response to problems with the child welfare system that became apparent from this tragedy. I accept that it is an effective approach to delivering child welfare services. Its goal—to keep children safe at home, with appropriate supports—is laudable. Strengthening families and reducing the number of children in care will result in better outcomes for children.

For family service workers, there is no distinction between protection and family enhancement services. They are delivered by the same workers, who need the same training and skill set, as they work with families along a continuum of services. Training and funding should reflect this.

An effective differential response model involves decision-making and assessment through the use of tools that promote consistency in service delivery, and the exercise of sound clinical judgment. It is essential as well to have services available to support families and children once those assessments have been made. These services can often best be provided by community-based organizations or other government departments. What is important, as Trocmé pointed out, is that the services be adequately resourced to provide for the required intensity and duration, and that whoever delivers the services has a clear understanding of what it takes to make them effective. This includes coordinating services delivered by others. Once the child welfare system is involved, prevention services may best be delivered by a community-based organization, but it will still be up to the CFS worker to ensure that families are in fact engaged with the service provider.

10.15 RECOMMENDATIONS

1. **Recommendation:** That the Province and the four child welfare Authorities, who are responsible for the delivery of child welfare services, adhere to the following principles:

    a) The key to supporting families and protecting children is offering early intervention through both universal and targeted services, to prevent the vulnerability that leads to contact with the child welfare system.

    b) Child welfare services are provided on a continuum, focusing on protection in the face of an immediate threat to a child's safety but almost always working with a family enhancement approach to keep children safe at home.

    c) Once a family comes to the attention of the child welfare system, the children's safety and well-being must be assessed; this means assessing both immediate and long-term risk of harm, including chronic neglect, and it requires face-to-face contact.

    d) Assessment tools must be used as an aid to, and not as a substitute for, the exercise of a worker's clinical judgment.

e) Assessment tools must be used in a way that takes into account a family's cultural, social, and economic circumstances.

f) After an assessment of the child's safety and well-being, and of the family's strengths and needs, the necessary and appropriate services, as determined by the assessment, must be available.

g) When a child has been found to be in need of protection, the goal of the child welfare system is to prevent recurrence of maltreatment and resulting impairment. This should be done by child welfare agencies acting on their own or in partnership with community-based organizations and other government departments.

h) The goal of the child welfare system is to keep as many children safe at home as is possible.

Reason: These principles promote the protection of children, their safety and well-being, within the context of the differential response practice model that has been adopted by Manitoba's child welfare system. They start by recognizing that children are best protected when they and their families receive services that prevent their vulnerability to coming into contact with the child welfare system.

2. **Recommendation:** That the Province ensure that the family enhancement services required to support the differential response practice model are developed, coordinated, and made accessible, through partnerships and collaboration among the child welfare system, and other departments, and community-based organizations.

   Reason: The differential response model holds great promise for the better protection of children, but its success will depend on the availability of services, once the assessment tools have identified a family's needs.

3. **Recommendation:** That All Nations Coordinated Response Network (ANCR)—whose role is triage and delivery of short-term services—no longer provide family enhancement services but should transfer families who need those services to a family services unit as soon as possible.

   Reason: This will avoid disruptions in service for families whose needs cannot be effectively met within ANCR's limited time frame.

4. **Recommendation:** That every effort be made to provide continuity of service by ensuring that, to the extent reasonably possible, the same worker provides services to a family throughout its involvement with the child welfare system.

   Reason: Switching workers unnecessarily can interfere with the building of trusting relationships between family and worker.

5. **Recommendation:** That when responsibility for delivering services to a family is transferred from one worker to another, those workers communicate orally with each other, to the extent possible, and either record the conversation in the file, or document the reason why a conversation was not possible.

   Reason: When it is necessary to change workers, the quality of information shared about the family is usually enhanced in a personal conversation, rather than in writing; recording the conversation allows for accountability and continuity of service.

6. **Recommendation:** That agencies strive for greater transparency and information sharing with caregivers, which may require changes to legislation.

   Reason: Building trust between a worker and a family is imperative to provision of effective family enhancement services.

7. **Recommendation:** That the Authorities enhance availability of voluntary early intervention services by placing workers in schools, community centres, housing developments, and any other community facilities where they would be easily accessible.

   Reason: These workers will raise the profile of the agency and build trust within the community, gain an understanding of the community's needs, and increase accessibility of voluntary supports and resources to individuals and groups, for the better prevention of child maltreatment.

8. **Recommendation:** That all child welfare workers who are expected to make use of the SDM assessment tools be trained on their proper use without delay.

   Reason: These new tools are essential to the new practice model, but they require specialized training if they are to be used effectively for the protection of children.

9. **Recommendation:** That *The Child and Family Services Act*, *Personal Health Information Act, Freedom of Information and Protection of Privacy Act* and any other legislation as may be necessary be amended to allow service providers to share relevant information with each other and with parents (or caregivers) when necessary for the protection, safety, or best interests of a child.

   Reason: Protection of children sometimes requires that information be shared among service providers such as police, social workers, educators and health professionals.

11 STANDARDS

The Department has the responsibility to develop foundational standards to ensure a level of consistency of practice across the province. Assistant Deputy Minister Loeppky testified that:

> *. . . the provincial foundational standards are the primary tool that child welfare looks to, to articulate what the minimum requirements are for the delivery of service. Provincial foundational standards apply on and off reserve."*[1141]

The issue of standards became relevant to this Inquiry primarily because of testimony from workers and supervisors who delivered services to Phoenix and her family. I repeatedly heard that there was confusion as to which standards were in effect when they performed their work. Various versions of these standards were in effect during those years. They included documents known as the "1988 Standards,"[1142] the "1999 Standards,"[1143] the "2000 Remnants Package,"[1144] and the "2004 Draft Standards."[1145] Which version was in effect at various times is the subject of some debate.

It was not necessary for me to determine which standard governed at any particular time because the testimony from the majority of social workers was that for the most part, specific standards did not govern their practice.[1146]

Winnipeg CFS acknowledged that during those years it was not training workers and supervisors on standards, but its policies and procedures, which governed practice, were based on those standards. The agency submitted that standards were not, and still are not, intended to instruct workers or supervisors on how to manage cases day-to-day. They provide a framework, and policies describe how work is to be conducted.[1147]

The Department's evidence was that during the relevant time, two manuals governed service delivery: the Intake Program Description Manual,[1148] in effect in July 2001; and the Orientation Manual[1149] in effect May, 2004.[1150] Some workers testified that they were familiar with and read these manuals from time to time,[1151] while others did not recall the manuals.[1152]

The Department acknowledges that there was no articulated standard in place at the time services were delivered to Phoenix and her family that required a child who was the subject of a protection investigation to be seen before the file was closed. That level of detail would be found, not in standards, but in policy and procedure manuals.[1153] However, as I discussed in Phase One, regardless of any confusion as to which version of the standards applied, there was never any doubt that a child who was the subject of a protection investigation had to be seen, to determine her safety.

11.1 CHANGES THAT FOLLOWED THE 2006 REPORTS

11.1.1 THE DEPARTMENT

Provincial standards were the subject of a number of recommendations in the reports that followed upon the discovery of Phoenix's death. The Section 4 Report[1154] recommended that the Child Protection Branch work in partnership with the Authorities to develop a set of provincial standards to apply to all mandated agencies, and that it complete a standards manual on a priority basis. The report, titled "*Honouring Their Spirits*," recommended that the Child Protection Branch prioritize the timely completion of the Provincial Standards Manual. In her internal report, Rhonda Warren recommended that the Province, the Authorities, and the agencies give priority to resolving case management standards and their expectations.

A set of provincial foundational standards had been released to all agencies and the Authorities in January 2005. Their development is ongoing and the current standards are posted online.[1155] These standards apply across the system, both on and off reserve.[1156] One of the new standards stipulates the frequency of face-to-face contact with a child that is required, depending on the assessed level of risk.[1157]

Loeppky, who has represented the Department on the Standing Committee, testified that its members work collaboratively as much as possible to develop standards but when agreement cannot be achieved, the director of Child and Family Services has authority to approve and implement a Provincial Foundational Standard.[1158] She also said that under *The Child and Family Services Authorities Act*, the Authorities may develop their own standards provided that they are consistent with provincial standards.[1159]

11.1.2 THE AUTHORITIES

General Authority CEO Rodgers testified that his Authority decided to clarify the provincial foundational standards in response to the findings of the reviews that followed Phoenix's death, that there was confusion around standards. According to Rodgers, in 2008 the General Authority combined all existing standards in a binder, a copy of which was sent to every frontline staff person in the Authority. All frontline staff were trained on these standards.[1160]

Rodgers also told of initiatives by the Authority to present the standards in formats that may be more useful for frontline staff. For example, case management standards were also presented in the form of a flow chart[1161] and the standards for face-to-face contact with children and families are summarized in a four-page fact sheet. A copy has been provided to all frontline staff and is distributed as part of its case management standards training.[1162]

CEO Flette testified that the Southern Authority offers standards training twice a year at its training centre[1163] and is in the process of creating Authority-specific case management standards to enhance the provincial standards.[1164]

11.2 THE CURRENT SITUATION

It does appear that work has been done by the Department and the Authorities to clarify standards, policies, and procedures and to ensure that staff is made aware of these standards. I learned from the testimony of MGEU representative Janet Kehler that in 2006 things began to change. She said workers now have a greater knowledge of standards than ever before. She did caution, though, that workers continue to feel that not all the standards are achievable.[1165] This is an issue of workload, which is addressed in Chapter 12.

12 WORKLOAD AND ITS IMPACT ON SERVICES

Without exception, each witness who commented on the issue of workload, from frontline workers to management, testified that workload is a significant challenge to the provision of effective child welfare services in Manitoba. In Phase One I concluded that organizational challenges, including workload, did not have a direct impact on the services that were or were not delivered to Phoenix and her family. I accept, however, that it was and is a widespread problem. According to the Department, workload is a problem across Canada and perhaps worldwide.[1166]

(There was general agreement that "workload" is a better indicator than "caseload" of the burden on workers. "Caseload" identifies the number of a worker's active cases, but "workload" takes into account that some cases are more complex and require more of a worker's time than others.)

The General Authority submitted that workload reduction remains one of the most important—if not the most important—factor in ensuring the safety of children.[1167] In its updated responses to the 2006 case specific reviews, The Authority said, "Workload demands in child welfare are often described in research and review reports as being the single most significant barrier to effective practice in child welfare."[1168]

I heard throughout the Inquiry that the new differential response model offers potential for better outcomes for children and economic savings down the road, but that family enhancement services in particular require investment of resources and a commitment of time by social workers, if that potential is to be achieved. This means that workers must not be burdened with unreasonable workloads.

Rodgers testified that as CEO of Winnipeg CFS in 2004 and 2005 he was aware that workload was a pervasive issue. It was raised in discussions at the agency and identified in feedback from staff in the fall of 2004 when they were asked to comment on what were then draft standards. A dominant theme from that consultation was the difficulty of meeting those standards under existing workload demands.[1169]

The Department's evidence was that since 2006 it has significantly increased funding and staffing: for example, Winnipeg CFS has seen a 32.8% increase in frontline positions, with only an 8.6% increase in cases.[1170]

Loeppky referenced the government's provision of $15 million for workload relief, announced in its 2006 *Changes for Children* report. She said workload was one of the first issues the government wanted to address in its response to the reports that followed the discovery of Phoenix's death. It began with an immediate $5 million, which created 63.5 new positions across Manitoba. The next infusion of staff was a foster care initiative that created 16 new positions in the four Authorities; then 5 positions for fetal alcohol spectrum disorder; 10 positions for continuous quality improvement services in the four Authorities; and a further 54.5 new positions for differential response and family enhancement.[1171] These are positive and significant steps taken by the government, but despite these efforts, workload has remained a concern.

Schibler, former Children's Advocate and current CEO of the Metis Authority, believes that caseloads are still too heavy. She testified:

> *You know, you can't expect a child welfare system to be able to provide those good assessments, those good therapeutic supports to families if they are just running from putting out fire and fire and fire. There has to be the ability to be able to step back and look at the family, get to know them, assess where they're going on an ongoing basis in a good way and develop those relationships with families. You can't do that when you're overworked with your caseload.*[1172]

The 2009-2010 Annual Report of the Children's Advocate included this caution:

> *The areas of funding, caseload size, staffing and staffing resources jointly speak to stress within a system that expects more than can possibly be delivered with its current resource base. Caseload size continues to be a barrier to best practice service delivery and we can see the impact in case management and accountability as noted above.*[1173]

The University of Manitoba supports additional funding for reduced workloads, to allow staff to spend more time building relationships with families.[1174]

One of the recommendations made in the Section 4 Report was that Winnipeg CFS work towards meeting caseload standards set by the Child Welfare League of America. These standards call for the following caseload ratios:

> *CRU/Intake: 12 active cases per month per worker;*
>
> *Family Services: 17 active cases per month per worker with no more than 1 new case for every 6 open cases; and*
>
> *Supervisors: 5 workers to each supervisor*[1175].

Loeppky testified that those ratios are difficult to apply to Manitoba, in part because of differences in the way cases are counted. In Manitoba, each child in a family might count as a "case," whereas the American standards sometimes count a family as one case. These inconsistencies also make cross-Canada comparisons of workload ratios difficult, she said.[1176]

Brownlee, who was put forward as a witness by the Department, quite candidly testified that Winnipeg Child and Family Services does not have the resources to deliver all the services it determines necessary to meet the needs of children and families. I appreciated her testimony, which has assisted me in formulating my recommendations in this area.

As discussed in Chapter 10 (Differential Response), Brownlee testified that her family service workers sometimes carry more than 40 cases and a worker with that number of cases cannot meet the practice standards on every case. She said her agency has prioritized the need for face-to-face contact with families and she is confident that this is happening, but workers don't always have the level of engagement with families that she would like to see, and are not able to consistently meet the standard for timely completion of assessments. She would like to be able to meet the caseload standards set out in the new funding model: 20 cases per worker for family enhancement services; and 25 for protection services. Funding for ongoing services to children in need of protection is being diverted to foster care and other services that are not being funded, she said.[1177]

The caseload ratios prescribed by the funding model, as I have said in Chapter 10, reflect an artificial distinction and should not be maintained.

McKenzie, who did the evaluation of the differential response pilot projects, testified that even 20 cases per worker is too many, to realize the full benefit of the differential response service model. He suggested a maximum of 12 to 15 active family enhancement cases. If this differential model is to be successful, McKenzie said, workers have to spend a lot of time with families.[1178]

MGEU's evidence was that it began trying in 1996, through collective bargaining, to bring workload levels into line with the Child Welfare League of America standards. In 2003, an agreement covering the entire civil service did include a provision for the employer to meet with the union to discuss workload concerns, but the obligation extended no further than discussions. In 2006 and again in 2010, the union attempted to include in the collective agreement a provision that it is the employer's responsibility to re-assign work if workloads become unmanageable. The areas of work specified were child and family services and other areas, mainly in the field of social work: the aim was to have a joint committee to work through issues, and failing resolution, binding arbitration. The union pointed to such provisions that have been agreed upon in other jurisdictions. [1179]

The union says its reasons for proposing these terms go beyond working conditions for social workers:

> *Representatives at every level of the child welfare system want to succeed in providing good services and outcomes for families and also want accountability. Those two concepts go hand in hand. Unless and until social workers have reasonable caseloads, workloads and working conditions, an*

employer will have difficulty holding individuals accountable for not achieving Standards or best practice.[1180]

MGEU representative Janet Kehler testified that excessive workload causes workers to make decisions based strictly on risk, in a reactive manner, sometimes compromising best practice. For example, she said that if a child in care is in the agency office for a visit with a parent, it is good practice for a worker to spend time with them, to gain an understanding of the relationship between parent and child. But a worker who is under pressure may decide that this child is not at risk at the moment, and so will take that time to attend to other tasks that seem to have higher priority.[1181]

In its submissions the union adopted Kehler's testimony that, "While social workers certainly want fair working conditions, in the experience of the MGEU it has been of far greater importance for social workers to be able to feel good about the type of work that they do to ensure that they have the ability to do good work for the clients that they service."[1182]

Kehler acknowledged that workload is more manageable today than it has been for many years. She also said that workers enjoy the work of prevention because they have the chance to effect long-term change. But they have not been able to maintain the stipulated 20-case maximum for family enhancement services and so "they haven't yet fully realized what that prevention model ought to bring."[1183]

This is consistent with Wright's testimony that when workload becomes excessive, social workers are reduced to responding to crises, and "just really scrambling to get anything done." This means that preventive services, which are key to keeping children safe and reducing workload overall, do not occur regularly, or at all.[1184]

I understand the MGEU's position. There clearly is a duty upon the employer to provide a work environment that allows workers to achieve best practices. That being said, I am reluctant to participate in what is essentially a labour relations matter by recommending wording in a collective agreement. But it is crucial that agencies have sufficient staff to deliver their services. Implicit in that is that workloads allow staff to perform according to best practice.

So much of the evidence I heard during Phase Two of the Inquiry focused on the assessment tools and forms that workers are required to use, but I am reminded of Trocmé's caution that without services, the tools are of little value. Effective services can be delivered only if workers have the time they need to engage with families and meet their needs. As was the case with Phoenix and her family, those needs are often complex.

Increasing staff is not the only strategy that can reduce workload. It is possible that advances in practice delivery models could enhance efficiency and thus ease workload burdens. For example, Loeppky testified that current standards require four family visits to prepare an assessment, but as experience is gained with the new SDM tools, they may yield better information in fewer visits, and that requirement could change.[1185]

And if prevention services are applied effectively and begin to stem the tide of families needing child welfare services in the first place, this will have a positive impact on workloads. When fewer families need services, workers can take more time to do better work with the cases they have.

Each of the individuals who served as CEO of Winnipeg CFS during the years of involvement with Phoenix and her family testified about the significance of early intervention and prevention as a means to lessen workload.[1186] The importance of such early intervention measures was apparent throughout the evidence heard in all three phases of this Inquiry and will be discussed more fully in the chapters dealing with Phase Three.

12.1 RECOMMENDATIONS

1. **Recommendation:** That all ongoing services to families should be delivered on the basis of 20 cases per worker.

   Reason: This ratio has been agreed to for family enhancement services and the family enhancement approach should be embedded in all ongoing services to families. Over time, greater investment in family enhancement services will lead to a reduction in demands for protection services.

2. **Recommendation:** That the Authorities and agencies explore ways to reduce administrative burdens on social workers through the better use of technology and administrative staff.

   Reason: Professional social workers are a valuable and scarce resource; they require appropriate tools and support to make most effective use of their time and their skills.

3. **Recommendation:** That each Authority designate staff who are available both during the day and after hours, to support the work of social workers by locating individuals through investigative means, and serving court documents as necessary.

   Reason: These staff members will allow for more efficient use of the time of social workers, and can be used to serve court documents where that could interfere with the relationship between social worker and family.

13 QUALITY ASSURANCE AND SUPERVISION

13.1 SUPERVISION IS KEY

Supervision is key to best practices in an organization, the Inquiry was told. Supervisors can set the tone of an organization and ensure accountability to the organization itself, to funders, and to the families and children being served. Indeed, during Phase One of the Inquiry it became apparent that it is only the social worker and the worker's direct supervisor who have any knowledge of the facts of a family's file. Wright confirmed that this is typical, and underlines the supervisor's role in ensuring compliance with the agency's mandate.[1187]

No formal quality assurance program was in place at Winnipeg CFS during the time services were delivered to Phoenix and her family, the agency acknowledged. It relied primarily upon supervisors for quality assurance.[1188]

In the units where files were maintained for only brief periods—After Hours, Crisis Response, and Intake—workers' reports were immediately reviewed by supervisors and signed off. Brownlee testified that in many ways this provided continuous quality improvement opportunities as the supervisor gained a sense of workers' strengths and areas that required improvement. She testified: "They would know whether the reports are well written, whether they're comprehensive, whether the actions taken were appropriate, and whether their planning and recommendations were appropriate."[1189]

At Family Services, where files were kept open for longer periods, quality assurance relied on a worker identifying and describing case developments to the supervisor. Supervisors would also review documents in the file, including social histories, assessments, and legal documents.

Another opportunity for quality assurance in any unit occurred every time a case was either transferred or closed. At that point, the supervisor was required to sign off on the entire file and so would have an opportunity to review the worker's notes and all documentation related to the case plan.[1190]

Before 2004, Winnipeg CFS had no formal supervision policy, Brownlee testified. That year a policy was created for family services supervisors, but some Intake and Crisis Response Unit supervisors also were guided by it to an extent, the Inquiry heard.[1191] The new policy was intended to highlight the importance of regular supervision, ensuring that responsibility for decision-making is shared between worker and supervisor.[1192]

13.2 RECORD KEEPING

Throughout the course of the Inquiry I heard evidence about the importance of record keeping to the delivery of appropriate and consistent child welfare services.

Yet, I also heard from workers that record keeping was time consuming and often not a priority, given the gravity of the issues that occupy them. Some workers just were not good note takers.[1193] There was inconsistency in note-taking practices also among supervisors. Of great concern is the fact that almost none of the notes that supervisors testified to having made about services delivered to Phoenix and her family could be located; nor could their notes of supervision sessions with workers delivering those services. Similarly, the Department admitted that it could not locate notes made by the family support worker who was involved with the family in 2000.[1194] This was so, notwithstanding efforts made to find them once they were identified as missing from the documents provided by the Department and Winnipeg CFS.

The supervision policy that was implemented in 2004 and updated most recently in December 2012[1195] pays particular attention to the notes that supervisors must make and retain. It clarifies that whenever a case is transferred or closed, the supervision notes must be placed with the file. These notes articulate what information was discussed and how decisions were made. Brownlee testified that this Inquiry made it significantly clearer to her management team at Winnipeg CFS that supervisor notes need to be kept in the case file to reflect the fact that responsibility for most decisions is shared between worker and supervisor.[1196]

From my review of the evidence in Phase One, it is clear that supervisors, for the most part, did not adequately supervise the work of their social workers and did not enforce compliance with best practice. Generally speaking, the deficiencies I have identified in the delivery of services to Phoenix and her family were sanctioned by supervisors who demonstrated a casual approach to their role.

The importance of the supervisor's role in enforcing compliance cannot be overemphasized. As I heard repeatedly, the individuals in the child welfare system who are knowledgeable about a given child are the child's worker and the worker's supervisor. As Wright has pointed out, if supervision is to be meaningful, adequate time must be allowed, and supervisors must be trained on standards and best practices, and on how to be a good supervisor.[1197]

13.3 THE AUDITOR GENERAL'S 2006 REVIEW

Before devolution, no effective accountability framework was in place to ensure that the mandated agencies were performing as expected by the Department, according to the Auditor General's 2006 review.[1198] For example, two of the four mandated agencies reviewed were using out-of-date case management standards; no quality assurance reviews had been performed since October 2001; and as at March 31, 2004, reviews of mandated agencies had not been performed for an average of 5.5 years. I find this lack of consistent quality assurance to be a matter of concern.

A recommendation by the Auditor General—that the Department conduct quality assurance reviews of each of the Authorities—had not yet been met by the time of her follow-up report in 2012. Bellringer testified that she had been told that two reviews had been started, a financial review had been completed on one Authority, and progress had been made on another, but six years after her 2006 audit she would have expected this recommendation to be fully implemented.[1199]

The 2006 report also found that 79% of the sampled child in care files lacked evidence that quarterly supervisory reviews had been conducted. At two mandated agencies, standard forms were in place, but were not used.[1200]

The Auditor General recommended that the Department help the Authorities develop a standard supervisory review process and form. The 2012 follow up found that a new process was introduced through training rather than a form. Bellringer testified that although this may be sufficient, her office was still urging that the information be put in a checklist that would be available in the file to anyone at any time.[1201]

13.4 THE CURRENT SITUATION

The situation with respect to quality assurance appears to have improved somewhat, but progress is uneven. The new funding model requires all four Authorities to maintain a quality assurance program, and each agency to have a quality assurance specialist. These certainly are positive steps. On the other hand, despite the Department's responsibility to conduct its own quality assurance reviews of the Authorities,[1202] there was no evidence of if, or when, these reviews were last conducted.

The General Authority conducts regular audits to ensure that its agencies are complying with various standards, Rodgers testified.[1203] He also said that the General Authority has introduced a tool to track outcomes system-wide. Referred to as an "outcomes matrix" it tracks five areas: family and community support; permanency for children; safety; service effectiveness and satisfaction; and child well-being. With data gleaned from a variety of identified indicators, over time the Authority can prepare outcome reports for every agency twice a year, "so they have a sense of how they're doing in relation to what we've all agreed are positive outcome trends."[1204]

As an example, two of the indicators used for tracking the well-being of children in care are education and behaviour management. Data is gathered from several sources: CFSIS; annual child in care forms, completed by agencies for every child who has been in care for 12 continuous months; and surveys completed by families receiving services.[1205] The General Authority says this information allows it to determine what is, or is not, helping families.

This matrix does not track how well the agencies are doing with children who are not in care, although they are a majority of the General Authority's cases. Rodgers acknowledged the need for a better way to track these children.[1206] I note that during the five years over which services were provided to Phoenix, she was in care for only about seven months in total.

The Southern Authority has a quality assurance team and a goal of reviewing agencies every four years, although this goal is not yet being met, apparently due in part to a lack of resources.[1207]

Flette testified to a number of other means by which the Southern Authority monitors its agencies, including program reviews; operational reviews, sometimes in connection with a child death; and file audits. She said her Authority has found that by working alongside the agencies and involving them in designing review processes, they encounter few compliance issues. She contrasted her experience in earlier years with the emphasis that now is being placed on quality assurance.[1208]

The Southern Authority, Northern Authority and ANCR argue that funding allocations for quality assurance functions at the agencies and Authorities should take into account a range of relevant factors including agency size, geographic area, and caseload. For example, the single quality assurance expert that is provided for in the funding model might not be enough in larger agencies, they submitted.[1209]

The Department and Winnipeg CFS submitted that significant steps have been taken to improve and enhance quality assurance across the system: the quality assurance requirements built into the new funding model are an example. The General Authority conducts formal quality assurance reviews on Winnipeg CFS, but it is the leading practice specialists, who provide day-to-day quality assurance by actively looking at files as workers are working on them, who are the most effective means of ensuring quality of service, it was submitted.[1210]

The Department submitted that the SDM tools provide a means of quality assurance within agencies because they allow supervisors to see the work being done on a file. The recording package requires explanations for decisions and there are specific timelines in place. These help the supervisor understand what is happening on the file, and whether the right decision has been made.[1211]

13.5 RECOMMENDATIONS

1. **Recommendation:** That CFS supervisors, social workers, and family support workers be required to keep complete and accurate records of all involvement with children and families, including records of all services they deliver, copies of any communications related to their involvement, and notes related to all contacts.

   Reason: Effective quality assurance and supervision requires that a complete record be kept of all work done on a file.

2. **Recommendation:** That when an agency engages a consultant, such as a medical professional, in the course of delivering services to a family, it must obtain a written report from the consultant and retain it in the relevant file.

   Reason: To ensure quality of service and continuity of care, it is important to have a comprehensive record of the advice received.

3. **Recommendation:** That ANCR and all designated intake agencies throughout the province ensure that records are made and retained with respect to every telephone call received by the agency, regardless of whether a file is already open.

   Reason: The potential relevance of a call to a child welfare matter is not always apparent at the time of the call; a complete record of calls received is essential for the protection of children.

4. **Recommendation:** That an appropriate policy be developed by the Authorities to govern the retention of records made by agency personnel.

   Reason: Many files are opened and closed over extended periods of time; continuity of service and the protection of children requires that all records be available whenever the family comes to the attention of an agency.

5. **Recommendation:** That the Authorities each develop and implement a supervision policy including provisions that:

   a) articulate that the primary function of supervision is to ensure compliance with best practice;
   b) require that supervisors prepare written reports of supervision meetings with workers, with copies retained in the appropriate case file;
   c) stipulate that before approving the transfer or closing of a file, the supervisor must document the reason for approving the decision; and
   d) require annual performance reviews to be conducted by a worker's direct supervisor using an objective set of articulated criteria, developed in consultation with agency staff.

   Reason: The responsibility for decision-making about delivery of services to children and families is shared between supervisors and workers. These recommendations are aimed at quality assurance, accountability and compliance.

6. **Recommendation:** That the Authorities each perform and publish annual composite reviews of the well-being of children who are receiving services from their agencies, or have received services within the past 12 months, whether in or out of care.

   Reason: These annual reports will enhance accountability and quality assurance and will help to instill public confidence in the workings of the child welfare system while providing the Authorities with valuable information about the effectiveness of their services. With all the Authorities now using electronic tools to collect information about children, this is not an onerous requirement.

14 INFORMATION SYSTEMS

14.1 LIMITATIONS

Information management is critical to a child welfare system's ability to keep children safe. A reliable, robust, and accessible database is indispensible. With turnover in social workers and mobility of families, there is no other way to record, track, and retrieve essential information about children and families.

Manitoba's child welfare system uses an electronic database referred to as "CFSIS" (Child and Family Services Information System). This is the system that was in place during the period of Phoenix's involvement with child welfare and it is where workers document day-to-day activity in a case.[1212]

The only significant update to CFSIS since its inception in 1993 was the introduction of the Intake Module, which came into use at Winnipeg CFS in May 2005. This module is linked to CFSIS and is the first point of entry into the system. It is used to log all new referrals and whenever a child is, or might be, in need of protection. It also logs non-child welfare contacts, such as calls for information.

Flette testified that CFSIS has become more user-friendly and current than it was 10 years ago. For example, staff can now run reports themselves that previously had to be requested from the Child Protection Branch. But the system is old and it has serious limitations, she said.[1213]

14.1.1 OLD TECHNOLOGY

I heard widespread support for development of a new information system to replace the existing system that is now 20 years old. At the same time, it is acknowledged that this will be a costly undertaking.

Loeppky testified about some improvements that have been made to CFSIS, including the capacity to upload digital photos. The safety assessment and SDM risk assessment forms are now embedded in the system. A "face-to-face screen" has been added, to allow a worker or supervisor to quickly identify when a child was last seen, and to allow an agency to measure compliance with standards.[1214]

But the changes that can be made to CFSIS are limited because it is an old platform, Flette testified. A completely new system is needed.[1215]

The Northern and Southern Authorities and ANCR jointly recommended that the Province and all stakeholders develop a new information system for use by all mandated agencies. The current information systems are no longer efficient or effective and a change is required, they submitted.[1216]

The 2006 Auditor General's Report recommended that the Authorities collaborate with the Department to determine the future use of CFSIS or the potential for development of a new case management system. A possible solution was being considered and funding was requested from Treasury Board to complete the "solution-scoping phase" but the funding request was denied in December 2009.

The Auditor General was informed only that alternatives were being considered.[1217] Her 2012 follow up review identified this initiative as being "in progress."

Loeppky testified that this is now being looked at again, though a new system would cost probably in the range of $30 million.[1218] The solution-scoping phase is expected to be undertaken in the current fiscal year.[1219]

14.1.2 CONNECTIVITY

For some rural and remote agencies, the problem is internet connectivity. Flette testified that steps have been taken to address these problems. Around the end of 2010 the Southern Authority received federal funding to support a project that is intended to bring high-speed connectivity to every agency. This also gives these remote agencies the capacity to use internet phones, and to teleconference.[1220]

Loeppky testified that a provincial government broadband initiative will eventually bring high-speed internet access to communities that don't have it, with fiber optic cable.[1221] The number of communities with connectivity issues has decreased significantly, she said.[1222]

As submitted jointly by the Authorities and ANCR, full connectivity would also give agencies the ability to use a distance education model for training, saving on travel and reducing the time that trainees are away from their work. It will facilitate recording and immediate transmission of information between agencies for better tracking of situations such as a licensing application for a foster home after it has been closed by another agency; and it will enhance agencies' ready access to "Alert" information.[1223]

14.1.3 INCOMPLETE DATA

A data bank is only as good as the information that goes in: its value depends on workers keeping the information current, and on all agencies using the system.

The 2006 Auditor General's report found that CFSIS information was not always accurate or complete.[1224] The auditors found children in care information that did not match agency information, and foster home information that was not accurate or complete. That report recommended that the Department clarify and confirm its expectations of how CFSIS is to be used by the Authorities and agencies, and Bellringer testified that her 2012 follow up found that this had been done.[1225] Flette testified that use of CFSIS by the agencies has been made a condition of the new funding model.[1226]

There remains the problem of workers not keeping current with their entries. If the system were easier to use, it would be used more consistently, Flette said.[1227]

14.1.4 GAPS IN TRACKING OF CHILD CONTACTS

Flette testified about the large number of children who are receiving protection services but are not in care. There is a requirement that these children be seen face-to-face but CFSIS does not track these contacts, as it does for children in care. She said, "I know we had flagged that for CFSIS, that they really need to figure out a way for us to be able to enter that information very quickly, and be able to see at a quick glance whether these children have been seen or not." She emphasized that the concern for these children is arguably greater than for children in care because they are still living in families where there is an element of risk. A professional decision has been made to leave them there and provide services, but "you would really want to make sure that those kids continue to stay safe."[1228] I am reminded that Phoenix was actually in care for only about seven months in total.

14.1.5 OUT OF DATE AND DUPLICATE DATA

There are still a number of files on CFSIS that are marked as open but have no activity recorded on them. In some cases children have actually been returned home and that information has not been recorded on CFSIS. Flette said, " . . . this leaves the feeling that you cannot rely on the CFSIS as a system that will give you the information you need."[1229]

The Auditor General's 2006 report found many duplicate records on children, and recommended that these be reduced. At its 2012 follow up, it found that the number of duplicate records had improved somewhat but continued to be a significant problem. It urged the Department to periodically and systematically eliminate duplicate records. It also urged the Authorities to ensure that caseworkers properly use the search function before creating a new child record.[1230]

14.2 PROPRIETARY INTEREST IN INFORMATION

AMC and SCO led evidence to support their position that First Nations have a proprietary interest in information about their members. They submitted that any information system used by the child welfare system ought to recognize that information about First Nations families on reserve belongs to the First Nation, and remains under its control. First Nations leaders see themselves as responsible for decisions about security of data, confidentiality, storage, data sharing agreements, and terms of use.

In their final submission, AMC and SCO suggested that this issue can be addressed by adoption of a new information management system that could interface with databases maintained by First Nations.

14.3 A MODERN INFORMATION SYSTEM IS ESSENTIAL

The information system on which Manitoba's child welfare system relies is outdated and not easy to use. The intake module, while an improvement, seems a stopgap measure. The fundamental issue with CFSIS is that it is an old platform that cannot readily respond to changing needs. As an old system, it lacks a user-friendly interface so it is not used as consistently as needed to keep records current and complete. Its search functions can be awkward, resulting in many duplicate records.

Such a system should ensure that a search done on the system for a child should provide all relevant information about that child and his or her family and collaterals, irrespective of how the file was actually opened. The evidence revealed that this was a problem in Phoenix's case when workers failed to consider relevant information contained in a file that had been opened under another name.

Additionally, connectivity issues in parts of the province mean that not all agencies are able to make proper use of the system. This too creates gaps in the CFSIS database that can pose a risk to children.

Manitoba's child welfare system needs an information system that is reliable, current, accurate, and complete. This is not to say that First Nations should not retain ownership over their members' information. I understand their purpose in asserting this right and responsibility, and if it can be achieved without risk to children's safety, priority should be given to a system that will recognize this right.

14.4 RECOMMENDATIONS

1. **Recommendation:** That the Department complete its solution-scoping phase for the replacement of CFSIS within the current fiscal year and proceed with implementation without delay.
2. **Recommendation:** That the new information management system be capable of:
    a) interfacing with other government systems including Employment Insurance, Education, and Health;
    b) keeping track of all children receiving protection services, as well all children in care;
    c) using alert features to flag those known by the system to pose a significant risk to children; and,
    d) efficient file recording, for example through the use of electronic dictation equipment and voice recognition, or direct entry using a computer, tablet, or other portable device.

Reason: Protection of children requires a reliable and up-to-date information management system that tracks not only children in care, but all children receiving protection services; provides comprehensive information about individuals in the system; and allows access to relevant data from other government systems. A new information system will improve the efficiency and effectiveness of workers by providing accurate information, and will reduce administrative workload. It will also allow the Authorities to compile statistical information, which can be used to measure outcomes for children and families.

3. **Recommendation:** All agencies must be required to use whatever information system is adopted.

   Reason: Families are mobile and unless all agencies are using the same information system, there may be gaps in information that can leave children vulnerable.

4. **Recommendation:** The Department must ensure that all agencies have access to its information system, either through direct connectivity, or where that is not possible, through alternative means such as telephone access to an agency that has that capability.

   Reason: All agencies require immediate access to all available information, if children are to be protected. I recognize that in some remote communities reliable connectivity may be a challenge.

15 FUNDING

15.1 CHALLENGES

Across Canada, the provinces and territories have statutory authority and responsibility for delivery of child welfare services, but funding for these services to First Nations people is shared with the federal government.

Child welfare funding issues are neither new nor simple. With the disproportionate representation of First Nations children in the child welfare system, come questions about the extent of funding responsibility carried by each level of government. And when resources are scarce there is heightened tension between competing claims: are those scarce dollars better spent on prevention? Or on protection services?

The Manitoba Government Employees Union and many of the social workers and supervisors who provided services to Phoenix argued that the child welfare system at that time lacked the funding, resources, and training that social workers required to do their jobs effectively.[1231]

Blackstock testified that child welfare is a public service and investing in children is sound economic policy. She said:

> *We know from good research that for every dollar you invest in a child you save six to seven down the line, as a government . . . And the reason for that is that you maximize the opportunities of raising a generation of children who not only are proud of their traditions and their peoples, but are also best prepared to be able to implement the career of their dreams and take full advantage of the opportunities that are presented to them.*[1232]

She cautioned against allowing jurisdictional disputes between the federal and provincial government to compromise the safety and well-being of children. The child's interests are paramount, as confirmed by Jordan's Principle.[1233] This principle states that if a First Nations child qualifies for a service that is available to all other Canadian children, then the government of first contact must pay and then later seek reimbursement from the other level of government.[1234]

I wholeheartedly agree with these statements. If we get it right, we will have many more healthy, productive members of society down the line.

In her Best Practices paper,[1235] discussed in Chapter 4, Wright refers to the 1992 Aboriginal Justice Inquiry report, which echoed earlier calls for increased funding for provision of protection and prevention services by Aboriginal agencies. She testified that funding of these services remains a major issue. She referred to data provided by Blackstock showing that Aboriginal children are funded at a much lower level than non-Aboriginal children. She also acknowledged the challenges posed by the sharing of funding responsibilities between levels of government.[1236] These are issues that come up time and again and must be addressed.

I heard evidence that services to Aboriginal children and families can be more expensive than others because they tend to have greater needs. Trocmé testified that:

> *. . . a typical case involving a First Nations child is overall going to be a more complex one compared to a non-aboriginal case. It's going to be one where there are more difficulties in the home, fewer supports available to those parents, and the high rate of removal represents the, the high risk factors in those, in those families and in those communities.*[1237]

Blackstock made the point that it will cost more to provide services to Aboriginal children and families if real equality is to be achieved:

. . . if you were to take a non-aboriginal child who typically has lesser needs and compare them with a First Nations child and we say that our standard is the same in the statute, if safety and well-being of the child is a paramount consideration, it's reasonable to assume it may take more money to bring the First Nations child up to that standard because they suffered a greater level of disadvantage. That to me is substantive equity. That's what we should be going for. The standard in the legislation says that the safety and well-being of the child is of paramount consideration, thus the investment in children with higher needs to bring them to that standard should necessarily just be a part of the fabric of the way that we understand the equality rights of children involved in the child welfare system.[1238]

15.2 CHANGES TO THE FUNDING MODEL

The two funders of child welfare in Manitoba are the Province of Manitoba (through the Department of Family Services), and the Government of Canada (through Aboriginal Affairs and Northern Development). The same applied during the years that services were delivered to Phoenix and her family.

Before introduction of *The Child and Family Services Authorities Act* in 2003, First Nations agencies were funded directly by the Federal Government and had jurisdiction to provide child welfare services only to First Nations children with treaty status who resided on reserve. The *Authorities Act* introduced the concept of "concurrent jurisdiction," which allowed First Nations agencies to provide services both on and off reserve.

The Order in Council appointing this Inquiry instructed me to consider the 2006 Auditor General's report. In that report, the Auditor General set out to consider the appropriateness of the funding model for children in care as of March 31, 2004 but found the funding model in place at the time could not be fully explained.[1239] The auditors were unable to determine whether it was adequate to ensure that the expected quantity and quality of services could be consistently delivered.[1240]

In 2008, representatives of the Department, the Standing Committee, the Assembly of Manitoba Chiefs, and Canada began negotiations and in July 2010 a new funding model[1241] was agreed to, according to the evidence given by the Department to this Inquiry. It substantially increased funding from both governments to mandated child welfare agencies in Manitoba: between 2001 and 2012, provincial funding for child welfare has increased by 155% and federal funding by 145%. Approximately 431 new child welfare positions have been created as a result of the new model.[1242]

The new funding model is based on these principles:

- equitable funding, whether on or off reserve, and whether the source is federal or provincial;
- adequate funding to the Authorities, to meet their mandate; and
- offering a differential response model to provide a family enhancement stream of service in addition to protection services.[1243]

The Department has undertaken to review the model after five years. The challenge will be the competing priorities and availability of resources from the Province in difficult financial times, according to the Department's closing submissions.[1244] Before concluding this new funding model the governments consulted the CEOs from each Authority; Manitoba Keewatinowi Okimakanak (MKO), representing the Northern First Nations; Assembly of Manitoba Chiefs (AMC), representing the Southern First Nations; and Manitoba Metis Federation (MMF).[1245] It was known at the time that certain items could not be accommodated and that those would be on the agenda for review in the next round of negotiations.[1246]

This funding model is unique in part because Manitoba permits mandated Aboriginal child welfare agencies to provide services both on and off reserve. Agencies are funded according to the following caseload ratios:

- in the protection stream, 25 active cases per worker; and
- in the prevention, or family enhancement stream, 20 active cases per worker.

The difference is explained by the more time consuming and intensive nature of family enhancement work.[1247] As I have said in Chapter 10, the distinction between protection and prevention streams is not borne out in practice, nor should it be. Child welfare services are delivered on a continuum, always with the goal of keeping children safe at home wherever possible.

The model provides for a 60-40 split between the Province and Canada, except the agencies in the Métis Authority and the General Authority, which are funded 100% by the province.

The two governments take different approaches to calculating their respective contributions to the shared funding. The provincial government uses actual counts of children who have come into contact with the child welfare system, based on the previous years' experience. But the federal government uses what is known as an "assumption model." It assumes that a certain percentage of First Nations children living on reserve will have contact with child welfare, and bases its funding on that percentage of the reserve population.[1248]

15.3 CORE FUNDING

Core funding finances the essential operations of each agency, including support staff and the five mandatory positions of executive director, chief financial officer, human resources manager, child abuse coordinator, and quality assurance specialist. [1249] The balance of funding is for the hiring of social workers.

The calculation of Canada's 40% contribution, based on the assumption that 7% of children are in care, can result in under- or over-funding of an agency. For example, Flette testified that the Southern Authority has one agency where 14% of children are in care, and two others that are also above 7%. During the first 3 years of the agreement the federal government has been prepared to make adjustments, but adjustments are not guaranteed.[1250]

The result is that an agency may have to divert money from family enhancement or prevention programs to protection services because, Flette said, " . . . these children are in care and these families are at risk and they have to serve them." This is unfortunate, she said, because these may be the very agencies that could most benefit from prevention services, and yet they are restricted by funding that is based on an assumption that may not be true for that agency.[1251]

By contrast, the provincial model is based on actual case counts and funding is adjusted annually, using established criteria.[1252]

The new model also provides funding for certain community-based organizations that deliver specific services, Loeppky said. For example, Ma Mawi Wi Chi Itata Centre provides men's groups, youth programs and residential care facilities.[1253] More will be said about the government's funding and use of community-based organizations in chapters relating to Phase Three.

15.4 FAMILY ENHANCEMENT FUNDING

There are two components to family enhancement services: first is the $1,300 per family that is allocated annually for the purchase of a range of services and benefits; and second, the agency social workers who work with families.

The Inquiry heard evidence that $1,300 per family is not sufficient to provide the intense service that is often necessary, even though funds not required by one family can be pooled to be available for others.[1254] I heard over and over these services are essential. Schibler said they are "the critical pieces," saying:[1255]

> *If we want to do something to make a difference, we have to be able to intervene with those kinds of services, and the grass roots services that are out in the community that provide those outside of the child welfare system. Every year they're vying for their funding dollars and they never really know where they're going to be from one year to the next and that, in itself, is really unacceptable.*

The reality is that $1,300 per family simply cannot meet the funding model's objective of providing family enhancement services. Significantly more resources continue to be spent on protection services because of the cost of out-of-home care. This limited funding for family enhancement is a step in the right direction, but there must be more if we are to see meaningful change. If the money isn't available, the services necessary to support families won't be available. And without those services, change is unlikely. Family enhancement must move beyond a concept, into something meaningful, and that will take more money.

The Inquiry heard testimony that if the family enhancement stream is to be truly effective, workers should carry no more than 20 active cases, and that is the ratio established in the new funding model. Rodgers emphasized that workers must have the time to practise in a way that engages with the family.[1256] But Brownlee testified that Winnipeg CFS is not staffed according to the ratios set by the funding model and more staff is needed for prevention services. Brownlee further testified that the General Authority's practice model sees family enhancement as an approach that is embedded in all of its services and these supports should be available to all of the families it serves.[1257]

The funding model, in my view, should reflect this practice model. All workers should have workloads that allow them to provide the services necessary to prevent further maltreatment or impairment, and agencies must have the additional resources they need, to obtain prevention services for families. All of these services, whether provided by the agency or by others, are aimed at supporting families and keeping children safe in their own homes.

I have heard compelling testimony during this Inquiry that a greater investment in early intervention ultimately saves children from coming into care and not only benefits those children, but results in savings to the public purse.

Testifying on behalf of the Department, Leoppky compared the high cost of keeping children in care compared to supporting them in their own homes, and emphasized the long-term savings generated by investments in early childhood programs and other prevention services.[1258]

Flette painted a vivid picture of the limitations on resources available to keep children in their homes, contrasted with what is available once a child is removed from the home. Speaking of a West Region Tribal Council pilot project[1259] that focused on prevention and community-based programing, she said:

> *For example, we could have a single mom who was, you know, raising four kids, very stressed out, whose kids would come into care because she just couldn't cope with it anymore. But we, we were very limited in what we could give that single mom in terms of respite or daycare or support services in the home. However, once we removed those kids we could give the foster parents all of that at big cost. We could send the kids to camp, we could send them to hockey, we could pay for their daycare, we could put a support worker in the home, we could pay the foster parent a fee for service. And we'd look (inaudible) that, you know, sometimes this is pretty crazy. Like, if we had just a piece of that money to give to the mom, she could have done it. Like, now we've got these kids in care, because there were risk factors but our way of addressing them just seemed to be not making sense. So that was kind of our argument with trying to get into different rules around maintenance.*[1260]

McKenzie evaluated that West Region program and found that prevention measures resulted in millions of dollars in savings and better outcomes for children and families. He found "plenty of tangible evidence that the monetary cost savings and cost avoidance from prevention are substantial." The study noted that not all agencies have the capacity to carry out such preventive initiatives within their existing funding. "Nevertheless, the calculations demonstrate a critical need to re-direct policy costs in favor of primary and secondary preventive services as a principal component of the casework model, while still adequately reacting to more complex cases of high-risk family conflicts."[1261]

Brownlee testified that:

> *(In the child welfare system) there's a huge belief that the most effective place for kids is with their parents if we can keep them safe and I think social workers all believe that we can keep kids safe at home but we need to have some of the tools to do it. It can't only just be the caseworker popping in. And we think that that is ultimately, ultimately cheaper for the system than the costs of bringing children into care.*[1262]

It seems obvious that keeping children at home, supported in the main by parents with whatever supports are necessary, is less costly than bringing children into care, and better for the children. The West Region pilot program has clearly demonstrated the social and economic success of this approach. As a society we ought to support this as good public policy.

Unfortunately, the new funding model has had a negative impact on the West Region program. Flette testified that under the earlier arrangement with the Province, the Region received block funding for maintenance (out-of-home care), which it diverted to prevention services thereby keeping children at home, saving maintenance money, and making more money available for prevention services. Under the new model, prevention funds come from family enhancement funding, which is not enough to provide the same level of prevention services. As a result, West Region has had to scale back its prevention programming.[1263]

The Department acknowledged that it would look at the adequacy of family enhancement funding when the new funding model is up for review, beginning in 2014.[1264]

15.5 RECOMMENDATIONS

1. **Recommendation:** That the Authorities be funded to a level that supports the differential response approach, including:

    a) Funding to allow agencies to meet the caseload ratio of 20 cases per worker for all family services workers;

    b) Increasing the $1,300 fund for family enhancement services to a reasonable level, especially for families who are particularly vulnerable, many of whom are Aboriginal; and

    c) Determination of the amount of necessary funding after meaningful consultation between agencies and the Authorities, and between the Authorities and government, after agencies have reasonably assessed their needs.

    Reason: If the new differential response practice model is to achieve its goal, the agencies must have adequate staff and resources:

    - The funding model's caseload ratios should no longer be based on an artificial distinction between protection and prevention services. Family enhancement is an approach that should be embedded in all ongoing services. The cost of keeping children safe at home is far less than the cost of maintaining children in care; directing resources towards prevention and family enhancement will reduce the high number of Manitoba children currently in care.
    - Many families have complex needs and require considerably more services than can be purchased within the current limit of $1,300 if they are to be supported so that their children can be kept safe at home
    - Funding decisions must take into account the complexity of some families' needs, and the added cost of providing services to particularly vulnerable families, many of whom are Aboriginal.

16 EDUCATION AND TRAINING OF CHILD WELFARE WORKERS

16.1 EDUCATION

Although most of the social workers who provided services to Phoenix and her family had Bachelor of Social Work (BSW) degrees, this was not then, nor is it now, a requirement for the practice of social work in Manitoba. (More about will be said on this subject in Chapter 19.)

I heard evidence that the current entry-level requirement for social workers at the General Authority is a BSW or equivalent degree but not all workers currently on staff meet that requirement. An equivalent degree includes a certificate from any accredited faculty of social work. Certain defined equivalencies also are accepted.[1265]

The University of Manitoba's Faculty of Social Work is the only accredited social work program in Manitoba.[1266] Dean of Social Work, Dr. Harvey Frankel, testified that most BSW graduates go into frontline work, and about 40% of these enter the child welfare field. These graduates need to have knowledge of child development; crisis intervention techniques; how to work with families with difficulties; and knowledge of legislation, policies and procedures, Frankel said. In his view, the faculty does prepare students for practice in the child welfare field, keeping mind that an undergraduate degree is a generalist degree.[1267]

Frankel's view is that although every frontline social worker should have a BSW, given current workloads, he did not oppose the current acceptance of workers who lack the degree but have years of experience.[1268]

Wright, who was Associate Dean of the undergraduate program at U of M Faculty of Social Work between 2008 and 2010, and an associate professor at that faculty from 2009 to the time of her testimony, was of the view that any worker practising child protection should have a BSW degree from an accredited program. In her best practices paper for the Inquiry, she noted that the need for improvement in the education and training of child welfare staff has been identified in previous reviews and inquiries going back to 1975. "Given the complexity of the work, the requirement of a BSW degree is one means to ensure a minimal level of knowledge and abilities, which include the development of critical judgment and analysis, knowledge, and practice skills," she wrote.[1269]

I agree with Wright's statement. Child welfare workers work with one of the most vulnerable segments of our population. Theirs is important and demanding work that requires a range of skills. It calls for the requirement of educational credentials.

One of the main concerns I heard from witnesses was that requirement of a BSW degree might pose a barrier to recruiting Aboriginal workers to the profession. I am sympathetic to this argument. Discouraging the hiring and retention of Aboriginal social workers is the last thing I would wish my recommendations to do.

Frankel testified that "child welfare in Manitoba is predominately Aboriginal child welfare . . . and if we're expecting to see changes in the child welfare system we have to develop leaders who really have a different paradigm, who come with a different basis for practice."[1270]

There has in fact been an increase in the number of Aboriginal social workers who have obtained degrees and practise in their communities, according to Wright.[1271] Part of this increase, I suspect, is the result of concerted efforts by the University of Manitoba to increase opportunities for Aboriginal students to obtain a degree or equivalent, and to remove the barriers to the profession that they may have faced.

At the time of Frankel's testimony, 979 students were enrolled in the Faculty of Social Work, making it the largest social work faculty in the country. A BSW degree is a four-year degree, of which three are spent in the Faculty of Social Work. Students are required to take child welfare-related courses such as child development, and a course in human behavior that applies social science theory to working with people.

Frankel testified that over the previous two years the faculty had developed a program leading to a BSW degree with a concentration in child and family services. Students who choose this program spend a minimum of two 450-hour blocks in supervised practice. This gives them the opportunity to apply theory to practice in a protected environment, under the supervision and mentorship of a social worker. This new program, however, is optional: it is not a requirement for practice in the child welfare field.

Initiatives the faculty has taken to facilitate access to the profession for students who face geographic or other barriers to higher education were described by Frankel:

- Non-traditional students, the majority of whom are Aboriginal, or students who might not qualify under the regular admissions criteria, may gain entry to the faculty through one of its access programs, at the Fort Garry campus or in northern Manitoba. Upon graduation they will receive a BSW with no designation that they attended through an access program.
- The faculty also offers two versions of a distance education program. One is completely online, for rural students and northern Manitobans. The other is delivered face-to-face, with groups throughout the province.
- A diploma in Aboriginal child welfare or in community health is available through a 60 credit-hour program that generally takes up to a year to complete.

These initiatives by the University of Manitoba are steps in the right direction and allay my fears about the challenge of recruiting Aboriginal social workers. The demands of the profession call for a requirement of a BSW degree, so I am heartened to see the university removing barriers that have historically stood in the way of Aboriginal students. Positive steps of this kind are to be encouraged.

However, before prospective students even think of applying to a university program, they must be persuaded that the practice of social work is a valuable and valued profession. Frankel testified about the demands of child welfare work: the emotional stress; less than optimal working conditions; heavy caseloads; and sometimes lack of supervision. Added to those conditions is a level of public scrutiny that can leave workers feeling vulnerable. Frankel spoke of a need to change the work environment, and enhance mentorship, supervision, and support for workers so that child protection work will be more appealing, particularly to Aboriginal people.

Frankel also suggested financial support for current workers in the system who are not already degree holders, so that they can obtain a BSW degree. This is certainly a recommendation I endorse.

16.2 TRAINING

A new BSW graduate, with no experience in the field, needs supervision and mentorship and field-specific training before being ready to take on a full caseload at an agency, Frankel testified, and the faculty expects the employer to provide this training.[1272]

On the other hand, Southern Authority CEO Elsie Flette testified that university graduates should be better prepared than they are, to begin work in the field. She said that the Authorities are shouldering too great a training burden and child welfare agencies have had to become "quasi-educational institutions." New graduates, she said, should know the basics of their job, such as how to do a safety assessment and a risk assessment, but instead, they have to receive that training on the job. She suggested that employers should work with the university to improve the education provided there so that BSW graduates are ready to go to work.[1273]

Wright testified about the positive impact on quality of service when social workers are supported by their employer through orientation, professional development, and regular supervision. Ongoing training and support for career advancement contribute to maintaining a stable workforce, with clear benefits for families and children. She said:

> *If, if there's a stable workforce -- really, the focus of all of this is on improved services for children and their families, and the benefits to children and their families, so stable workforces result in the, in the capacity for social workers to develop relationships and maintain ongoing relationships. It allows for smooth transitions, whether it's between workers or even case closures. But where it's done in a planned and deliberate manner as opposed to just sort of, suddenly there's a new worker on the scene.*[1274]

Supervisors too must have not only the capacity to take on a supervisory role, but sufficient education and training, including continuing professional development, and their own regular supervision, Wright said.[1275]

The Department and Winnipeg CFS acknowledged that there was insufficient training for workers and supervisors during the time that services were delivered to Phoenix and her family. Before 2005, training consisted primarily of core competency training offered by the Department, and Winnipeg CFS did not provide consistent orientation to new employees. Various initiatives were undertaken, but there was a lack of funding for a permanent team of professional trainers. Core competency training was mandatory for workers and supervisors before 2006. The goal was to have new workers complete that training within six months, but the Department conceded that this was not always achieved.[1276]

After receipt of the 2006 external reviews following Phoenix's death, the Department began work to support the Authorities in developing training programs for their agencies. First, the Department introduced funding for a joint training team: five individuals were assigned to the four Authorities to provide a more formalized system of training. This allowed the Authorities' own specialists to work with their agencies to accommodate their unique training needs, while maintaining the ability to implement province-wide initiatives such as Structured Decision Making (SDM). In addition, the Department has funded 10 quality assurance specialists, shared among the four Authorities. Authorities can use this funding to provide training, mentoring, and quality assurance, as was done by the General Authority.[1277]

Though most of the evidence I heard about training concerned the General Authority and specifically Winnipeg CFS, I understand that training throughout Manitoba has much improved since services were delivered to Phoenix and her family. As Rodgers testified, there is no comparison between the training available today and what was available in 2000 to 2005. I commend those responsible for funding and implementing these significant enhancements to training.

16.2.1 TRAINING AT THE GENERAL AUTHORITY

Training at the General Authority and Winnipeg CFS is centered around "leading practice specialists," it was submitted. There are nine such specialists at the General Authority, three of whom are assigned to Winnipeg CFS. Karen McDonald is one of those three. She said her role is to begin training in a classroom setting but then to work with social workers and supervisors as they put their new skills into action on the job. She explained it this way:[1278]

> *I often explain my job is that in the beginning I will train, I will be in front of you. I will teach you and I will deliver material and curriculum to you. I then will walk beside you and I will mentor and help you be able to do what you need to do on your real cases, on the -- with the families and children that you work with, whether that be needing paperwork requirements, I will help you figure out what needs to be in your recording but I will also help you figure out how to ask those hard questions and how to get the information and make sense of the information with the family. At some point later, I will stand behind you and I will support you in whatever you need to be able to do your job, but it's really I'm in front, beside, behind approach to teaching and to help and support workers and supervisors.*

CEO Alana Brownlee said the coaching and mentoring provided by leading practice specialists is the most significant component of the training program at Winnipeg CFS.[1279] In 2010 the agency introduced its own orientation training for new employees, developed by the leading practice specialists. It began as an 8.5-day program and expanded to 10.5 days, after feedback from staff and supervisors. Brownlee contrasted this comprehensive program with the "ad hoc" orientation that was available in 2006.[1280]

New employees do not take all orientation training days at once. They receive an initial orientation, but then training is done in increments as they begin working on actual files so that they can begin applying what they have learned, with the expectation that this will ingrain good practices into their work. Winnipeg CFS also has a policy of easing new hires into actual casework, with limited new intakes each month and a maximum of 20 cases at any one time during the first year on the job.[1281]

The first three days of training is basic orientation for all employees. It delivers information about the history of child welfare; basic policies and expectations; agency programs and how to access them; worker and staff safety; supervision; and legislation. Frontline child welfare workers attend days four to nine. Here they receive instruction on case-related activities including note taking, assessments, SDM tools, and using the Winnipeg file-recording package. (This recording package is discussed in Chapter 10.) McDonald said she meets students and new employees right away to begin to develop a level of comfort so that she can mentor them. Day 10 of orientation is for training on case management standards. This training is delivered to all staff at various times but it was added to the orientation program so that new workers are trained on these standards early in their employment.[1282] The last half-day of orientation is delivered by the staff lawyer and is devoted to legal issues including the requirements of privacy legislation, court appearances, pre-trial procedures, and time deadlines.

The Department's core competency training is also available for workers who have not yet taken it. This training is much more general; it is not specific to a particular practice model or Authority.[1283]

More specialized training is available in 12 modules being taught as part of the General Authority practice model. These modules teach social workers how to apply the SDM tools to their cases, and offer training in clinical skills, including interviewing children to ensure that they have a voice during assessment and planning. A focus is on helping workers learn how to engage with families.[1284]

There is training specific to supervisors as well. Core competency training for supervisors is offered by the Department; 10 days of leadership and supervisory training is offered through the Government's Organization and Staff Development office; and four days of training in supervision in social service agencies is provided, using the Tony Morrison supervision model. Supervisors also take the 12 training modules in the General Authority practice model twice: first with a group of supervisors and then again with their workers.[1285]

16.2.2 TRAINING AT THE SOUTHERN AUTHORITY

Flette confirmed that agencies in the Southern Authority have also done extensive training on the use of the SDM tools.[1286] She estimated that 500 staff have been trained, but they have also trained their own trainers so that each agency now has capacity to train new staff on these assessment tools. They have also trained supervisors in how to supervise a case.

The Southern Authority has also trained hundreds of staff in the use of CFSIS and has a computer lab in its Winnipeg training centre for this purpose. The response has been very positive, Flette said.

The Southern Authority offers standards training twice a year at its training centre and is working towards establishing an Authority-wide standard that every worker must take standards training within six months of beginning work. Many agencies now run their own standards training, Flette said. Finally, the Southern Authority has developed templates and training around case documentation.

16.2.3 TRAINING AT ANCR

ANCR has mandatory training requirements for front-line social workers. Executive Director Sandra Stoker testified that a new worker receives both operational and program-specific orientation, including a review of *The Child and Family Services Act* and regulations. There is a job-shadowing program for new graduates without field experience. All workers are trained on provincial standards, CFSIS, the Intake Module, caseworker core competency, Structured Decision Making, nonviolent crisis intervention, and suicide assessment.[1287]

16.3 MORE WORK IS STILL NEEDED

The evidence was that many training developments are very recent. For example, the case recording package, which is meant to assist workers in using the SDM tools, is dated March 25, 2013.[1288] Although training is much improved it is my belief that there is still a ways to go. I note that in her 2009-2010 Annual Report, the acting Children's Advocate identified three main themes in her recommendations to the child welfare system: case management, accountability and training. On the subject of training, she acknowledged the efforts that had been made but said:[1289]

> *However, the breadth and depth of knowledge demanded in the current service delivery milieu is remarkable. Workers need to master the core competencies but that foundational piece is only the beginning. In addition to keeping up-to-date in areas of expanding knowledge such as post-traumatic stress and fetal alcohol spectrum disorder, agencies and service providers are stretched to learn better ways of delivering service to children and families increasingly troubled by addictions, gang involvement, and sexual exploitation. Increasing numbers of agency workers and service providers further increases the pressure on training resources as new untrained people enter the field.*

Even though that report is now three years old, former Children's Advocate Billie Schibler in her testimony underlined the necessity of more and better training for workers, supervisors, and service providers, acknowledging that it takes time to ensure that everyone is receiving the necessary training.[1290]

Most of the workers who delivered services to Phoenix and her family testified that they received no training before beginning work with Winnipeg CFS and did not receive core competency training until several months later.

Until 2006, lack of appropriate training was such a significant issue for workers that union negotiations for Winnipeg CFS included bargaining for training dollars rather than money in workers' pockets, said MGEU representative Janet Kehler. But in 2006, things began to change and by now there has been a dramatic improvement. Last year, she said, when she was negotiating a collective agreement for ANCR she was told not to include training proposals because workers felt they were getting the training they need.[1291]

However, there are areas where many social workers still do not receive enough training, according to Blackstock. As examples, she listed the multi-generational impact of residential schools; and the role of poverty, poor housing, and substance misuse in assessments of child neglect.[1292] She testified that without such training social workers may, for example, mistake poverty for neglect and fail to address the poverty issues that threaten a child's well-being. Workers also need training in assessing substance misuse, its impacts on parenting, and how to really help families be able to mediate these issues, she said.[1293]

16.4 RECOMMENDATIONS

1. **Recommendation:** That a Bachelor of Social Work or equivalent degree, as recognized by the proposed Manitoba College of Social Workers, be required of all social workers hired by agencies to deliver services under the Act.

   Reason: Child welfare workers do complex, demanding work that requires a high level of knowledge, skills, and analytical abilities.

2. **Recommendation:** That a concerted effort be made to encourage Aboriginal people to enter the social work profession, by promoting social work as a career choice and supporting educational institutions in removing barriers to education through access programs and other initiatives.

   Reason: The child welfare system, which serves an overwhelmingly Aboriginal population, needs the unique insights and perspectives that Aboriginal social workers can bring to their practice.

3. **Recommendation:** That the four Authorities share information about their training programs, and share materials so that successful training tools, techniques, and programs can be adapted and implemented more broadly.

Reason: Sharing of high-quality materials developed by an Authority will promote consistency of training across the province.

4. That workers be specifically trained on the multi-generational impacts of residential schools and on the role of poverty, poor housing, substance abuse and other social and economic factors in assessments of child neglect.

   Reason: Child welfare workers cannot adequately support families to protect their children unless they understand the underlying causes of the conditions that can lead to maltreatment.

17 SHARING INVESTIGATIVE REPORTS WITH WORKERS

Two of the reports that were commissioned upon the discovery of Phoenix's death were examinations of the specific facts of the child welfare system's involvement with her and her family. When the reports were released, none of the workers or supervisors who had been involved in providing services to Phoenix or her family were shown the reports. They first encountered the reports through their participation in this Inquiry.

These fact-specific reports, "*A Special Case Review In Regard to the Death of Phoenix Sinclair*" (the Section 4 Report)[1294] and "*Investigation into the Services Provided to Phoenix Victoria Hope Sinclair*" (Section 10 Report),[1295] are summarized in Chapter 1 of this report. Rodgers, in his testimony, acknowledged that workers and supervisors may have had a general familiarity with the reports' recommendations, but that was all.[1296]

Workers and supervisors testified that they had been unaware, both of the contents of the reports and of their involvement with Phoenix and her family as detailed there.[1297] Several testified that they would like to have known what was written about them and have had an opportunity to respond to, and learn from, the reviews.[1298]

Darlene MacDonald, then CEO of Winnipeg CFS, testified that the decision not to share the reports with workers and supervisors was made by individuals above her. When asked whether she agreed with that decision, she said she realized that the purpose of the reports was not to examine individual performance, but to see whether standards were met, to examine the circumstances at the time, and to prevent such a thing from happening again.[1299] To her knowledge, no employee was disciplined, censured, or required to undergo remedial training as a result of the findings in the reviews.[1300] Rodgers confirmed this.[1301]

MacDonald testified that she was first sent a copy of the Section 10 Report on October 12, 2006, by Linda Burnside, Director of Authority Relations with the Department of Family Services and Housing. The letter enclosing the report was addressed to Dennis Schellenberg, who was CEO of the General Authority at the time. MacDonald was copied on the letter, which read, in part:

> *Given the sensitive nature of the report, we ask that you not make copies of the report nor share its contents without the written permission of the Executive Director of the Child Protection Branch. However, a copy of the CME's report may be shared with staff of the Winnipeg, Rural and Northern Child and Family Services (Winnipeg regional office) (WCFS) who are directly involved with the matter for purposes of reviewing the recommendations in the CME's report.*[1302]

MacDonald testified that despite the direction in the letter about sharing with Winnipeg staff, she understood that she was permitted to review the report with program managers only. She said she asked Schellenberg for clarification because, "in order to answer any recommendations I had to be able to share the report with at least senior managers." She said Schellenberg confirmed that the report was to be shared with no one except program managers.[1303]

Schellenberg testified about the decision to not share the report with staff. He said that Burnside's direction that he not make copies of the report or share its contents without written permission was a typical instruction in relation to a Section 10 Report. He said, "but of course it could be shared with individuals who were pertinent to the case within the organization." He said he did not recall a discussion with MacDonald about the Section 10 Report, or about sharing the report with workers at Winnipeg CFS.[1304] Rodgers, in his testimony, agreed that the wording of the letter came from a template and was meant to convey that such reports were confidential because they were case-specific.[1305]

The Section 4 Report came to Schellenberg with a letter dated October 17, 2006, from Rodgers, who was then the Acting Executive Director of the Child Protection Branch. The letter, which also was copied to MacDonald, contained the following directive:

> *Given the sensitive nature of the report, we ask that you not make copies of the report nor share its contents without the written permission of the Executive Director of the Child Protection Branch.*[1306]

An email dated October 24, 2006 was sent by Pat Wawyn, whom Schellenberg described as one of his "senior program staff" at the General Authority, to three people including MacDonald, and copied to Schellenberg. The email read:

> *By now, each of you has received a copy of the confidential Section 4 Review that was undertaken by the Office of the Children's Advocate.*
>
> *We just want to remind you that given the sensitive nature of the report, that you not make copies not share its contents without the written permission of the Executive Director of the Child Protection Branch.*
>
> *Should attempts be made by another individual(s) to copy your document, Janet Wikstrom has suggested that you initial in ink each page of your copy as a security measure.*

We'll see everyone at the General Authority office on November 1, 2006 at 3 p.m.[1307]

MacDonald replied the same day, saying that the contents of the report needed to be shared with "a few select managers," as she wanted feedback about some of the recommendations. Schellenberg's email reply to MacDonald was to please get written consent from Rodgers.[1308] Schellenberg believed that MacDonald had obtained that consent by virtue of a signed note on a copy of the October 17 cover letter, which read: "permission to produce 3 copies."[1309] Rodgers, in his testimony, confirmed that the note and signature were his. He vaguely recalled authorizing MacDonald to make three copies of the report.[1310]

Rodgers testified that he left the decision as to whether to share the Section 10 Report up to MacDonald; they did not discuss it. In hindsight, Rodgers said that he now believes that parts of the report ought to have been shared with staff who were involved, as an opportunity for learning. [1311]

The confidentiality restraints on the Section 4 Report were more restrictive than the Section 10 report, Rodgers agreed. He understood that this was because the Section 4 Report contained information obtained in interviews with staff members who might have had a certain expectation of privacy and some of the information they were sharing was sensitive.[1312]

Rodgers testified that the purpose of the reports is not to "judge the competence of individual workers. It's to review the file, to make recommendations to the organization or the system about what might be done to help avoid similar tragedies in the future." He went on to say, "If this report is being used for the basis of discipline, then we're not doing our day-to-day supervision very well. That is, if there are performance issues, supervisors should know them long before these types of reports come out."[1313]

It is clear from the evidence that none of the workers involved in this file were made aware by their supervisors, or by anyone in the agency, that his or her actions were in any way lacking, despite the findings of various reports to the contrary. Nor were they made aware of the significance and impact of their involvement, to Phoenix's safety and well-being.

I agree with MacDonald and Rodgers that the purpose of these reports is not to form the basis for discipline. As Rodgers testified, deficiencies in service ought to have been noticed during supervision. But they were not. What the reports have done is highlight the importance of the supervisory process. Had that process worked as it should, perhaps the outcome for Phoenix would have been different.

The reports found that workers and supervisors made a number of errors. The Department accepted the recommendations that flowed from those reports. Given the tragic result in this case, it is certainly unfortunate that the reports and their findings were not shared in a timely manner with the staff involved, on an individual and confidential basis.

While it seems to me that the system as a whole ought to have recognized that these reports needed to be shared with the workers involved, I do not fault any one individual for not doing so. Not sharing these reports reflected a system that did not value the personal accountability of professional staff.

Rodgers testified that the report sharing process has changed somewhat. The Children's Advocate is now very open with sharing draft special investigation reports (formerly known as Section 10 reports) within the system before finalizing findings and recommendations. He finds this helpful and a significant improvement over past practice.[1314] In its final submission, the General Authority said that through the Standing Committee, all four Authorities have agreed to a protocol with the Office of the Children's Advocate to permit these draft reports to be shared with agencies before their content and recommendations are finalized. This allows agencies to provide feedback and correct facts to ensure accuracy of reporting and greater accountability among individual staff.[1315] In light of the recommendations made in Chapter 20, this protocol will need to be revisited.

Rodgers testified that the Standing Committee has created a "multiples working group," to receive and jointly respond to any recommendations from a special investigation report that are directed at more than one party.[1316] That appears to be a sound practice.

The General Authority has also implemented a protocol, termed a "leading practice guideline," setting out expectations for its agencies and regions when reviewing draft reports. This guideline applies to the sharing not only of Children's Advocate special investigations, but also reports completed by the General Authority under s. 4(2)(c) of *The Child and Family Services Act* and s. 25 of *The Child and Family Services Authority Regulation*. The guideline provides that "At minimum, the content, findings and recommendations of the draft reports will be shared with agency staff that had direct involvement in the case." The director of the agency or region, and the CEO of the General Authority, respectively, have discretion to share the findings and recommendations of a final report with staff who were directly involved and other staff as well, with a view to promoting transparency and accountability and excellence in service provision.[1317]

It was unclear from the evidence whether this leading practice guideline has been adopted by all Authorities.

The General Authority also provides an annual summary to the Ombudsman on the status of implementation of recommendations made in special investigation reports, and shares these summaries with its agencies.

The sharing of reports prepared on the death or critical injury of a child will be dealt with in Chapter 20.

17.1 RECOMMENDATIONS

1. **Recommendation:** That the Director share with the relevant Authority the findings and recommendations of the report of any investigation with respect to the welfare of any child dealt with under section 4(2)(c) of *The Child and Family Services Act* and that the Authority share those with agencies, to be shared with staff.

   Reason: These reports contain important information that can be used to improve child welfare services, promote best practice, acknowledge and encourage excellence in service, and provide ongoing learning opportunities for staff.

2. **Recommendation:** That all four Authorities ensure that the findings and recommendations in this report are shared and discussed with all child welfare staff and management.

   Reason: This will improve child welfare services, promote best practice and provide ongoing learning opportunities for staff.

18 REGISTRATION OF SOCIAL WORKERS

18.1 MANITOBA AWAITS REGULATION

Manitoba is the only province in Canada that does not have any mandatory regulation of social workers, the Inquiry was told by Miriam Browne, executive director of the Manitoba Institute of Registered Social Workers (MIRSW). In every other province, the designation of "social worker" is restricted to registered members of a statutory body.[1318]

An issue that arose repeatedly during the Inquiry was whether registration should be required for the practice of child welfare work in this province. MIRSW is the regulatory body for the profession of social work in the province of Manitoba, but registration is voluntary. Neither the Department nor any of the Authorities require child welfare workers to be registered, as a term of employment.

In fact, regulatory legislation was passed in 2009 but has not yet been proclaimed into law. *The Social Work Profession Act* has been controversial. The Inquiry heard from some who say that the Act doesn't go far enough, and from others who say it may go too far.

Browne testified that over the past 25 years there has been a Canada-wide movement in the profession towards legislation that, at the very least, protects the title "social worker," so that only registered members of the regulatory body can represent themselves as social workers. This is the approach taken in Manitoba's Act. MIRSW has lobbied for decades for this legislation, Browne said, but its position is that the government needs to go further, as a number of provinces have done, to control not just the title of "social worker," but also the actual practice of social work. This would mean that whether a person is called an addictions worker, or a probation officer, or a child welfare worker—anyone working within the scope of social work practice would have to be registered.[1319]

As the Act now stands, anyone using the title "social worker" will be required to meet minimum qualifications for registration with a body to be known as the Manitoba College of Social Workers—which is MIRSW, under a new name. It will protect the public interest by offering better assurance that the services received from social workers are coming from qualified professionals, and it will increase accountability of social workers through the College's complaints process, Browne said. The new Act also includes requirements for members to take a minimum number of hours of continuing professional development annually.[1320]

Much of the opposition to the new Act comes from disagreement over whether registration should require a Bachelor of Social Work (BSW) degree. Some support this as a minimum requirement while others see it as too restrictive, especially for those who are currently working in the field without a degree. Browne noted, however, that the Act contains a "grandparenting" clause that, for three years after enactment, would permit practising social workers without a BSW degree to apply for registration based on their skills and experience.[1321]

A transitional board of directors for the College was established by Order in Council in August 2011, and members were appointed in April 2012. Under s. 77 of the Act (the only section that has been proclaimed into law), the board is charged with doing anything necessary or advisable to bring the Act into force. Browne said that the regulations referred to in the new Act have not yet been drafted. In an attempt to speed the process, MIRSW has drafted bylaws and regulations, which were passed by its membership in May 2012 and have been given to the transitional board.[1322]

The Dean of the Faculty of Social Work at the University of Manitoba, Harvey Frankel, is one of the appointees to the transitional board. He acknowledged that there have been a number of objections to the Act and that it is awaiting proclamation pending completion of the board's work and its report to the Minister. That report was to have been made before July 2013.[1323] I am unaware whether this has occurred.

18.2 EXISTING REGISTRATION REGIME IS VOLUNTARY

Existing legislation, *The Manitoba Institute of Registered Social Workers Incorporation Act,* currently governs the voluntary MIRSW, whose mandate is to protect the public interest by regulating and supporting the profession of social work.[1324] Browne testified that the legislation was enacted in 1966 and gives MIRSW control over the title "Registered Social Worker."[1325] Registration requires an on-line application; a criminal records check; a child abuse registry check; two professional references; a university transcript; and 40 hours of professional development completed in the previous 12 months. A committee considers the application and makes a recommendation to the board of directors.[1326]

Browne testified that membership benefits include access to ongoing learning opportunities and guidance on ethical dilemmas that arise in practice. There is a complaint mechanism and disciplinary process, though disciplinary options are limited, since membership is not mandatory. Members in private practice must purchase liability insurance. Although registration isn't required, members are proud to be registered social workers, she said, and see themselves as professionals working within a code of ethics and recognized standards of practice. She testified that MIRSW has its own set of 10 core standards of best practice that apply to all sectors of social work. [1327]

MIRSW has just over 1,000 members but it is difficult to determine the number of practising social workers in Manitoba, Browne said, because at present the use of the term "social worker" is unregulated. The Institute has the power to address complaints only against its registered members.[1328]

18.3 VARYING VIEWS ON MANDATORY REGISTRATION

Various views on mandatory registration were expressed during the Inquiry. For example, Edwards and Sinclair were in support of a registration requirement. The Department and Winnipeg CFS were also in favour of registration in principle, but cautioned that it must be done in a way that is respectful to Aboriginal agencies and workers.[1329]

Intertribal Child and Family Services (ICFS) said it has no objection in principle to registration but questioned the ability of registration criteria to take into account the aptitude and personality traits that are required of a good social worker. Other concerns were raised about supports for Aboriginal workers, and the particular challenges of recruitment in rural and remote communities. Existing barriers to a university degree could compromise the ability of agencies to deliver services in those communities.[1330]

The AMC and SCO do not oppose registration, provided that there is no requirement for all case managers (front line social workers) employed by agencies to be registered social workers. This position, they say, reflects the difficulty that First Nations agencies in remote northern communities have in recruiting social workers or case managers who would meet the criteria for registration.[1331]

Southern Authority CEO, Elsie Flette, agreed with the concept of registration but had concerns about whether the College would have sufficient understanding of Aboriginal practices. She also said that it will have limited effectiveness if it merely regulates the title of "social worker," and not the actual practice: "So, you could say, 'I'm not calling my workers "social workers," I want to call them "CFS workers" and not have them registered," she suggested. She indicated agreement with the concerns raised by others, but did say, "it is important for the profession itself to be monitored and regulated."[1332]

18.4 MANDATORY REGISTRATION ENSURES ACCOUNTABILITY

Registration is an important aspect of accountability in the delivery of child welfare services. As set out in Bill 9, *The Social Work Profession Act*, the objectives of the new College would be to:

1. promote and increase the professional knowledge, skill and proficiency of its members as social workers;
2. regulate and govern the professional conduct and discipline of its members, students and professional corporations, consistent with the principles of self-regulation and the public interest;
3. promote and foster in the public a greater awareness of the importance of social work; and
4. generally advance the professional interests of its members.[1333]

In my view, mandatory registration would go a long way to the attainment of these objectives. *The Social Work Profession Act* however, does not go far enough. To better protect Manitoba children, it is necessary to regulate not only who can use the title, "social worker," but who can in fact provide social work services. It must protect not only the title, but also the practice.

Child welfare workers serve a population that is often particularly vulnerable. Because of that vulnerability, these children and families require, and are entitled to, the services of workers who have the necessary education, training, and skills to serve them effectively. Accountability requires that members of the public have a channel for complaints when necessary, and a responsive and appropriate process for addressing them. A requirement that anyone practising as a social worker—with whatever title—be registered and subject to the Act and its regulations should meet these objectives.

As to the concern that experienced people will be forced out of social work if registration is mandatory, I point to the grandparenting provision that will allow for registration of qualified people now working in the field, who do not meet the academic criteria.

For those coming into the field or considering social work as a profession, the Inquiry heard from the Dean of Social Work about programs and initiatives aimed at enhancing access to the profession generally, and for Aboriginal social workers in particular. These are discussed in Chapter 16.

18.5 RECOMMENDATIONS

1. **Recommendation:** That the transitional board established under s. 77 of *The Social Work Profession Act* complete its work and report to the Minister by no later than June 30, 2014.

   Reason: Mandatory registration is an important tool for promoting accountability of social workers and delivery of service according to best practice.

2. **Recommendation:** That *the Social Work Profession Act* be:

   a) amended to require that anyone who practises social work in Manitoba, under whatever title, be registered by the Manitoba College of Social Workers; and

   b) proclaimed into law at the earliest possible date, following receipt of the report of the transitional board.

   Reason: This amendment will protect not only the title of "social worker" but will ensure that members of the profession are truly qualified, meet a standard of competence, and are governed by a code of ethics.

19 SUPPORTING THE TRANSITION TO ADULTHOOD

About 500 Manitoban children each year reach the age of majority while in care of the child welfare system. Like any child turning 18, they become adults in the legal sense of the word, but the very reasons why they were in care mean that many are ill-prepared for this new stage in their lives. They may have been abused or neglected by their parents or by others, or their parents may have been incapable of caring for them. Many suffer from fetal alcohol syndrome or other disability. In any event, as reported in *Strengthening our Youth: Their Journey to Competence and Independence*, a 2006 report on Manitoba children transitioning from care, "without question, the majority of youth after they leave care are alone and vulnerable." The report states:

> *. . . each child has been subjected to or exposed to incidents that have left scarring and taken a toll on their sense of safety and security. Without exception, children in care bring with them memories of traumatic events, loss, and fear. Their trust in significant adults around them has been damaged.*[1334]

These are vulnerable young people who do not have family and other connections to rely on as they make the transition to adulthood. The outcomes are not surprising. *Strengthening our Youth* reviews major studies showing that young people "aging out of care" are far more likely than their peers to experience homelessness, unemployment, involvement in criminal activity, early school leaving, depression, and substance abuse. They are at high risk of exploitation, especially in the sex trade. Many have babies at a young age and become involved again with the child welfare system, this time as parents.[1335]

Phoenix's parents were examples of young people who aged out of Manitoba's child welfare system. General Authority CEO Rodgers testified:

> *. . . I remember I happened to be at the Inquiry for some of Mr. Sinclair's testimony and I remember Ms. Walsh asking Mr. Sinclair if the child welfare system had provided certain supports when he turned 18 in care. Things like emotional supports, or counseling, or job search assistance, or resume preparation, or supports for post-secondary education, and each time he was asked he said no, that the child welfare system did not provide any of those supports.*

Today, when a youth turns 18 in the care of the General Authority, Rogers testified, "all those supports will be available to them."

Through its Youth Engagement Strategy, the General Authority aims to provide services that would mirror the supports that other children receive from family. The Authority relies on partnerships in the community to deliver services in four areas:

- financial literacy, including help with basic personal banking;
- mentorship, providing a meaningful relationship with an adult;
- assistance with gaining access to employment; and,
- mental health supports.[1336]

As an example of community partnerships, the General Authority has arranged with the University of Winnipeg for a certain number of tuition waivers to permanent wards aging out of care. In September 2012, 25 current or former youth in care from all four Authorities were admitted under this arrangement. Winnipeg Technical College and Red River Community College have now joined the program and others are expected to join.

The Child and Family Services Act, however, limits the assistance that the Authorities can offer, in terms of both eligibility and the duration of services. Under s. 50 (2) of the Act:

- Any extension of services past age 18 must end at the person's 21st birthday. Manitoba's legislation in this regard lags behind other jurisdictions, Rodgers said. (By department policy, services are extended only one year at a time, to that point.)
- Services can be extended past age 18 only to those who are permanent wards at their 18th birthday. This means that there can be no extended services for children who are temporary wards at that date, or who are in care under a voluntary placement agreement.

Rodgers told of a service offered by the General Authority, called "Navigator." This is a dedicated worker, located at the Canadian Mental Health Association offices, who is available to help young people transitioning from care to find access to the range of services they may need.

The General Authority's program of services offered through community partnerships is still at the pilot project stage, Rodgers said, but through the Standing Committee the other Authorities have been made aware of it and they are interested to see the results. The General Authority receives no additional funding for its youth transition services, so it has reallocated funding from other areas, he said.

The Métis Authority has its own approach to supporting youth aging out of its care. CEO Schibler described the mission of the Métis Spirit program:

> *…if they think they're ready to venture out on their own and they leave the supports of the child welfare system, they can -- they go out and then they encounter real life situations and they know that there are struggles out there that they face, but because some of them aren't connected to family of origin, they will come back to the agency and they will come back through this program, and this program will support them and advocate for them and help them to find the resources that they need so that they don't have to fall through the cracks. So it's one of those things where, again, where youth is defined beyond the age of majority because they still are our youth and they still do need our supports, even though they're no longer attached to the child welfare system.*[1337]

The demand for this program outstrips its capacity, she said, and as reported by the General Authority, there is no funding specifically provided for it. There are long waiting lists for services to address situations that would be considered high risk, if the youth were still in care, she said. They include issues with employment, housing, poverty, gang recruitment or exploitation. These young people "need to know that there's somebody there that they can reach out to who can respond to them."[1338]

Strengthening our Youth was commissioned by Schibler when she was Children's Advocate and is one of the six reports listed in the Order in Council establishing this Inquiry. Schibler testified that it was that report that convinced her of the importance of this issue. Many of the report's recommendations were in the areas of housing and education. Housing issues are a particular challenge for young people, she said, and call for a partnership between the Departments of Housing and Family Services. On the education front, Schibler acknowledged the General Authority's work on behalf of all four Authorities with post-secondary educational institutions.[1339] As did Rodgers, she expressed support for the report's recommendation that the age of eligibility for extended care and maintenance be extended from 21 to 25 years.

From the evidence I heard, it is clear that, like most young people transitioning from their family environment, young people who have been permanent or temporary wards continue to need supports as they transition into adult life in the community. These supports can take many forms, including assistance with housing, education, and employment. They can and should be provided by Child and Family Services, other government departments, and community organizations, either alone or in partnership.

19.1 RECOMMENDATIONS

1. **Recommendation:** That *The Child and Family Services Act* be amended to allow for extension of services to any child who at the age of majority was receiving services under the Act, up to age 25.

   Reason: Many young people require support in the transition to adulthood, even past age 21, and this applies not only to those who were in care, but to those whose circumstances put them in need of services under the Act.

2. **Recommendation:** That a program be implemented to ensure that children who have been receiving services under the Act have available to them an individual social worker to coordinate services and ensure that they receive the necessary support for a successful transition into the community.

   Reason: Young people need help navigating a successful transition into adulthood.

20 CHILDREN'S ADVOCATE

20.1 CURRENT ROLE OF THE OFFICE

Manitoba's Children's Advocate is an important voice for children and youth in the province's child welfare system. But it is a role that needs greater independence, and an expanded mandate.

The Office is established under *The Child and Family Services Act*. Its duties include:

- advising the Minister on matters relating to services provided or available under the Act, and the interests of the children who receive, or are entitled to receive those services;
- Investigating complaints;
- advocating for children who are receiving, or should be receiving services under the Act;
- reviewing the circumstances surrounding the death of a child who has been involved with the child welfare system within a year of death (as discussed further below); and
- reporting annually to the Legislature.

The current occupant of the office, Darlene MacDonald, and her immediate predecessor, Billie Schibler, both testified about the functioning of the office, and about the changes they believe are needed for the sake of Manitoba's children and youth.

Schibler, who served as Children's Advocate from 2005 to 2011, explained that the office investigates concerns brought to its attention by workers, children, parents, or the community at large. In her experience, most are complaints about the services received from social workers, she said. Advocacy officers and investigators look into the complaint. They can use CFSIS to check activity on a file, and speak to the worker involved with the family. Complaints are often resolved at this stage, she said.[1340]

The Children's Advocate is also required to produce annual reports, which are tabled in the Legislature and are released publicly. Schibler testified that she used these reports as an opportunity to identify what she saw as important child welfare themes.[1341] Some recurring themes that came up during her tenure included:

- concerns about communication both within the child welfare system and with other service providers;
- lack of knowledge around standards, which were set up to be the minimum requirement (people not knowing what was expected of them in certain circumstances);
- flaws in approaches to assessments of both risk and safety; and
- a lack of services for youth aging out of the system.

Before her appointment as Children's Advocate, MacDonald was CEO of Winnipeg CFS, a position she held since 2006. She testified that most of the approximately 30 employees of the Office of the Children's Advocate are former child welfare staff. Most have Bachelor of Social Work degrees and some have Masters degrees. The Office's advocacy side has four intake officers, six advocacy officers, and a program manager. Special investigation reviews (child death reviews) are handled by 10 staff and a program manager. There is a deputy Children's Advocate, an office manager, finance manager, and four administrators.

MacDonald testified that annual reports are written for child welfare agencies, the Authorities, the public, children, and other interested parties. They are accessible on the office's website. Her 2011/2012 Annual Report[1342] reveals that there are 3,650 more children in care than in 2004—an increase from 2% of Manitoba's children to 3.5%. She said her office needs to do more research to discover the reasons for this increase.[1343]

20.2 CHILD DEATH REVIEWS

In 2008, responsibility for the special investigations that are known as "child death reviews" was transferred from the Office of the Chief Medical Examiner to the Office of the Children's Advocate. These were investigations under s. 10 of the *Fatalities Inquiry Act* into the death of any child who has been involved with the child welfare system within a year of the date of death. The focus is on the standards and quality of care and services that were provided to the family or child, or that should have been provided. With this new mandate came the jurisdiction to investigate not just the child welfare system, but any publicly funded department, such as Health or Justice, said Schibler.[1344]

This change had been recommended by *Strengthen the Commitment,* one of the external reviews commissioned as a result of Phoenix's death.

Before 2008, if the Children's Advocate learned of the death of a child in care that seemed to call for further examination, the Office would investigate and would report to the Minister.[1345] But there was no specific authority for those investigations, nor was there authority to review services that may have been provided by other government agencies.

Child death reviews have several purposes, Schibler testified. One is to discover any mistakes that might have been made so that they are not repeated; another is to identify possible improvements to services, and to consider whether there were publicly funded services that could have made life easier for that child.[1346]

The completed reviews are sent to the Chief Medical Examiner for a decision as to whether to call an inquest; to the Ombudsman; and to the Minister of Family Services, for transmission to the department and to the various agencies and Authorities. If recommendations relate to another government department, the Minister is asked to deliver the report to that department. The reviews are not made public.

Ms. Schibler said she had assumed that the reports would be shared with the workers who had been involved in providing the services under review, but she learned that sometimes they were not:

> *Well, I had hoped that they would be and I had assumed that they would be, but I discovered that no, they, they weren't. I mean, you know, in some of the staff and management that I spoke with, sometimes those reports didn't make it through to the agencies, sometimes they never made it through to the front line of the agencies where, you know, those recommendations were really, really relevant and imperative because they weren't just about government and government's decision, they were about how to deliver better services, they were about things that they needed to be aware of that was missing, maybe, in this child's life and how do you link those systems with other systems and so forth. I mean, there was so much relevance to the service providers.*[1347]

The subject of sharing of reports with workers is also discussed in Chapter 17.

20.3 INDEPENDENCE

The Children's Advocate is designated as an officer of the legislature, but unlike the Auditor General and other officers, it does not have its own legislation. Instead, the Children's Advocate is a creature of *The Child and Family Services Act.*

Under that Act, the first duty of the Children's Advocate is to advise the Minister of Family Services on matters relating to services provided under the Act and to the interests of children receiving or entitled to receive those services.

Schibler testified that the Office operates independently and at arm's length from government. The intention is that the Advocate will have unbiased opinions and represent children without influence of other bodies. But in her view, the lack of stand-alone legislation compromises the independence of the office:

> *You can't report to the people that oversee your legislation, you can't advise them, when they are responsible for your legislation.*[1348]

Schibler noted that there is no formal process requiring child and family welfare authorities to report back to the Advocate on implementation of its recommendations. It is the Ombudsman who has legislative authority to monitor the implementation of recommendations made by the Children's Advocate. Schibler expressed the view that this somewhat undermines the Office of the Children's Advocate, which should have the power to publicly report on the implementation of its own recommendations and to hold the system accountable. However, having the Ombudsman, as another independent office, overseeing and reporting on implementation of its recommendations does provide another voice echoing the concerns of the Children's Advocate, she said.[1349]

MacDonald also expressed support for independent legislation for the Office.

20.4 SCOPE OF THE MANDATE

The mandate of the Children's Advocate is specific to the child welfare system. Its duties are confined to matters relating to children who are receiving, or are entitled to receive, services under *The Child and Family Services Act*.[1350] Schibler sees this as "a huge limitation" for the office:

> *. . . if you say you're the Children's Advocate in the province of Manitoba that would suggest you have the ability and the mandate to be able to advocate for all children and youth in the province who are receiving any type of publicly funded services.*[1351]

Schibler contrasted this limited mandate with the more expansive powers of British Columbia's Representative for Children and Youth.[1352]

MacDonald echoed Schibler's concerns that her office is not able to advocate for children outside of the child welfare system. She shared the view that the Children's Advocate should be an office for all children receiving government services.

A second limitation on the Children's Advocate's mandate is the restriction of special investigations to cases where a child has died. Schibler testified that this should be extended to allow for reviews of cases where the child did not die but was critically injured:

> *. . . being able to review critical injuries as well as the child deaths I think is really, really important. There are critical injuries that occur out there and I think that those are important to review, so that we can see how we can improve the system and the supports to families so that those don't occur again.*

20.5 LEGISLATIVE CHANGE IS REQUIRED

20.5.1 INDEPENDENCE, EXPANSION OF MANDATE, AND NAME CHANGE

To be truly independent, the Office of the Children's Advocate must come out from its place under *The Child and Family Services Act* and be established under its own legislation. It should be accorded the same degree of independence as the Ombudsman and the Auditor General. This will remove the responsibility of the Advocate to advise the Minister. The Minister has a Deputy Minister and Director of Family Services to fulfill that role. It should not be the role of the Advocate. This proposal has the support of the current Advocate and her predecessor. Their reasons are sound. The Ombudsman should cease to have any responsibility under the Act.

Further, an expansion of the mandate of the Office of the Children's Advocate is overdue. Many children, youth, and families who need the services of the Children's Advocate now have no access to that office. The authority of the Office should extend beyond the child welfare system, to include services by any government department or publicly funded organization to children and youth. In

British Columbia the legislation gives the Representative responsibility with respect to a range of "designated" services, which include services under *The Adoption Act*, *Youth Justice Act,* and other enactments, as well as a range of publicly funded services in areas such as early childhood development, addictions services, and others that may be prescribed.

Some seven years ago, at the request of the Government of British Columbia, I had the responsibility to recommend changes to the child protection system in that province. I draw on the success of the implementation of those changes in advancing the recommendations I now make to the Government of Manitoba.

The broadening of the scope and responsibility of the child advocate's role has been successfully implemented in British Columbia, and based on the evidence I heard in this Inquiry, I believe it will meet with similar success in Manitoba.

I recommend, as I did in British Columbia, a new statute, with widened responsibilities. To emphasize the enhanced independence and broadened powers of the office, I recommend a new name for the occupant of the position: the Representative for Children and Youth, and I recommend that the new legislation be titled the "*Representative for Children and Youth Act.*"

As to the functions of the Representative, I recommend that the new Act include provisions similar to those in Section 6(1) of the *Representative for Children and Youth Act of British Columbia*, which are set out in the recommendations section of this chapter.

20.5.2 SPECIAL REPORTS

Particularly important is the expansion of the Representative's advocacy role beyond responding to individual complaints, to include systemic advocacy to bring about needed change. The Representative does not have the authority to impose its views on government. Its influence lies in the power of reason, not coercion.

I have been impressed by the many special reports issued by the Representative in British Columbia since establishment of the office in 2006. I mention some of them here to illustrate the scope and depth of the issues that have been addressed:

1. An investigation into the life of a young Aboriginal girl who was neglected and abused after moving from the care of the BC government to the care of her grandfather in Saskatchewan.
2. A report on youth mental health services in BC, with focus on 16- to 18-year-olds.
3. An aggregate review examining the life circumstances of 15 youth who died as a result of suicide and 74 youth who engaged in self-injury.
4. An investigation into the lives and deaths of three BC children killed by their father, showing that actions called for two years earlier, to address domestic violence, were still needed.

5. An investigation into the life and unexpected death of a four-month-old First Nations infant, making recommendations to address gaps in how government and delegated Aboriginal agencies work together, and how courts assess potential caregivers.
6. An examination of services provided to a 15-year-old girl with Down syndrome, who was found alone with the body of her deceased mother.
7. A review of an intervention program for children and youth who have been sexually abused and for young children with sexual behaviour disorders.
8. An examination of how a coordinated system linking criminal law, child welfare, and family justice information might have prevented the murder of a child and his mother.

All special reports by the Representative have been made public and are in addition to annual reports, service plans, and critical injury and death review reports. My observation is that significant improvements in services to children have resulted from the discussion that has followed release of these reports.

I recommend adoption in Manitoba of the British Columbia provision specifically authorizing the Representative to make special reports to the Legislative Assembly, and to report on compliance with recommendations made in those reports. Special reports, like the Representative's other reports, go to the Speaker of the legislature and then to the Standing Committee on Children and Youth, and are to be made public.

20.5.3 CRITICAL INJURY REPORTS

The authority that the Advocate now has to investigate child deaths should be expanded to include critical injuries. The purpose of death reviews, as stated in the Act, is to "identify ways in which the programs and services under the review may be improved to enhance the safety and well-being of children and prevent deaths in similar circumstances." Common sense suggests that reviews of critical injuries would yield the same benefit.

The British Columbia legislation defines a critical injury as an injury to a child that may result in the child's death, or may cause serious or long-term impairment of the child's health.

Subject to the confidentiality provisions of the Act, and protecting the identity and privacy of the children and families involved, all death and critical injury reports are to be sent to the Minister, the Chief Medical Examiner, and the public body responsible for the services that are the subject of the review, and are to be made public.

20.5.4 STANDING COMMITTEE ON CHILDREN AND YOUTH

Another recommendation I made in British Columbia in 2006 that I believe should be implemented in Manitoba is establishment of a new Standing Committee of the Legislature, on Children and Youth. The Representative should be required to report at least annually to the Committee and to meet with the

Committee to discuss special reports. The comments I made in support of that earlier recommendation apply equally today:

> *I believe that the establishment of this Standing Committee will help Members of the Legislative Assembly to understand that their relationship with the Representative should be a collaborative one. It should also help to develop a greater awareness and understanding among legislators and the public, of the child welfare system in our province. It is my fervent hope that it will encourage Government and the Opposition to work together to address some of the very real challenges facing the child welfare system now and in the near future.*

I appreciate that the Advocate's annual report in Manitoba requires consideration by the Standing Committee of Legislative Affairs but my proposal calls for much more specific attention to the work of the Representative, which I believe will be to the benefit of both legislators and the public, as the many challenges faced by Manitoba's child welfare system become better known and understood.

The British Columbia legislation fosters a level of accountability that is warranted by the importance of the office, through a process that I recommend for Manitoba. The Representative is required to prepare an annual service plan that includes a statement of goals and specific objectives for the year, and performance measures. The plan is delivered to the Speaker who lays it before the Legislative Assembly and the Standing Committee on Children and Youth. The Representative is expected to speak to it before the Committee.

20.5.5 APPOINTMENT OF THE REPRESENTATIVE

I recommend that appointment of a Representative be by resolution of the Legislative Assembly upon the unanimous recommendation of the Standing Committee on Children and Youth. Before making that recommendation, the Committee should be required by the Act to consider the candidates' skills, qualifications, and experience, including understanding of the lives of Aboriginal children and their families in Manitoba. This is critical because until the over-representation of which I have spoken is remedied, much of the Representative's work will be among Aboriginal children and families. Of course, the Office of the Representative must also be alert to the needs and perspectives of the many other communities that make up Manitoba's population.

I make the same recommendation with respect to appointment by the Representative of a Deputy, a position that should be provided for by statute. I go further and recommend that understanding of the lives of Aboriginal children and their families in Manitoba be a requirement for appointment to all positions in the Office of the Representative that require direct involvement with children served by the office. To be clear, of the approximate 30 positions currently in the Advocate's office, this should be a requirement for any new hires in all but the six clerical positions, after enactment of the new legislation.

The most suitable candidate for Representative may well be a child welfare worker but that need not be the case. For instance, in British Columbia, after a wide search, the first representative appointed had a background of academic, legal, and judicial experience. It is inevitable that many hires in the office, including the Representative and the Deputy Representative, may previously have been employed by agencies delivering services to children and youth. I do not recommend that a "cooling off" period be required, but rather that discretion be exercised in the assignment of duties where a conflict could exist.

The current Advocate is in office until April 2014. I recommend that at that time an acting Children's Advocate be appointed pending enactment of legislation to create a Representative for Children and Youth in Manitoba. If amendment to existing legislation is required to make that possible, it should be proceeded with now. If the current Advocate has an interest, I know of no reason why she could not be a candidate for consideration in filling the interim position.

20.6 RECOMMENDATIONS

1. **Recommendation:** That the position of a Manitoba Representative for Children and Youth be established under its own legislation, titled *The Representative for Children and Youth Act*, with these features:

    a) status as an Officer of the Legislature, with the same independence afforded to the Ombudsman and Auditor General;

    b) a mandate to advocate not only for children in the child welfare system, but for all children and youth in the province who are receiving or are eligible to receive any publicly funded service;

    c) responsibility to review not only deaths, but also critical injuries to any child in care and any child who had been involved with child welfare during the previous year; and

    d) authority to make special reports to the Legislative Assembly where considered necessary, including reports on compliance with recommendations made previously by the Representative under the Act, such special reports to be delivered to the Speaker and the Standing Committee on Children and Youth.

    Reason: Manitoba needs a truly independent officer of the legislature, with authority to advocate for all Manitoba children who receive, or are entitled to receive publicly funded services, and to report on matters that concern them.

2. **Recommendation:** That the Representative be appointed by a resolution of the Legislative Assembly, on the unanimous recommendation of the Standing Committee on Children and Youth following a search for a suitable candidate. In making its recommendation, the Committee must be required by the Act to consider the skills, qualifications, and experience of the candidate, including the candidate's understanding of the lives of Aboriginal children and families in Manitoba.

   Reason: This is an important position that requires the support of the child welfare system; and because of the large numbers of Aboriginal children to be served, it requires a person with understanding of their varied concerns and circumstances.

3. **Recommendation:** That the Representative for Children and Youth be appointed for a five-year term with an option for a second term, but no one should serve in the position beyond 10 years.

   Reason: A term in office of between five and ten years offers a balance between the need for experience in the position, and the advantages of fresh energy and insights that a new office holder can bring.

4. **Recommendation:** That a Deputy Representative be appointed by the Representative for Children and Youth.

   Reason: This will be a close working relationship and it will be important that the Representative be free to choose a person who complements the Representative's own strengths and areas of expertise.

5. **Recommendation:** That a Standing Committee on Children and Youth be established as a standing committee of the Legislature, and the Representative be required to report to it at least annually and to discuss special reports, and on other appropriate occasions.

   Reason: This committee will be a forum for collaboration between the Representative and the Legislature and it will promote greater understanding, both in the Legislature and in the public, of the workings of the child welfare system.

6. **Recommendation:** That the Representative be required to prepare:
   a) an annual service plan, with a statement of goals and specific objectives and performance measures, and
   b) an annual report including a report on the Representative's work with Aboriginal children and families and with others, and comparing results for the preceding year with the expected results set out in the service plan.

   Reason: This is a mechanism for ensuring accountability of the Representative to the people of Manitoba.

6. **Recommendation:** That all annual reports, special reports, and service plans are to be made public, following delivery to the Speaker for placement before the Legislative Assembly and the Standing Committee on Children and Youth.

   Reason: These will enhance public understanding of the child welfare system, and of the challenges facing other children in the province who are receiving, or are entitled to receive other publicly funded services.

8. **Recommendation:** That in the hiring of all new staff for the Office of the Representative, except those filling clerical roles, consideration be given to an applicant's understanding of the lives of Aboriginal children and families in Manitoba.

   Reason: A great deal of the work of this office will be with Aboriginal children and youth and their families: it is important not only that staff have an understanding of their concerns and life circumstances, but also that the people who need its services feel comfortable approaching the office.

9. **Recommendation:** That at the end of the term of the current Children's Advocate, an acting Children's Advocate be appointed, pending enactment of new legislation to create a Representative for Children and Youth. If any amendment to existing legislation is required to make that possible, that should be done now.

   Reason: This will ensure a smooth transition to the new position of Representative for Children and Youth.

10. **Recommendation:** That the new Act contain provisions similar to the following, which are contained in Section 6(1) of the *Representative for Children and Youth Act of British Columbia*:[1353]

    6(1) The Representative is responsible for performing the following functions in accordance with this Act:

    (a) support, assist, inform and advise children and their families respecting designated services, which activities include, without limitation,

    (i) providing information and advice to children and their families about how to effectively access designated services and how to become effective self-advocates with respect to those services,

    (ii) advocating on behalf of a child receiving or eligible to receive a designated service, and

    (iii) supporting, promoting in communities and commenting publicly on advocacy services for children and their families with respect to designated services;

(a.1) support, assist, inform and advise young adults and their families respecting prescribed services and programs, which activities include, without limitation,

(i) providing information and advice to young adults and their families about how to effectively access prescribed services and programs and how to become effective self-advocates with respect to those services and programs,

(ii) advocating on behalf of a young adult receiving or eligible to receive a prescribed service or program, and

(iii) supporting, promoting in communities and commenting publicly on advocacy services for young adults and their families with respect to prescribed services and programs;

(b) review, investigate, and report on the critical injuries and deaths of children as set out in Part 4;

(c) perform any other prescribed functions;

Reason: These provisions have worked to the benefit of children and youth in British Columbia and I have every reason to believe that they will bring similar benefits in Manitoba.

11. **Recommendation:** That in drafting the new legislation, reference be made to British Columbia's *Representative for Children and Youth Act* to ascertain whether provisions other than those addressed in the above recommendations are suitable for inclusion.

    Reason: These provisions have worked to the benefit of children and youth in British Columbia and I have every reason to believe that they will bring similar benefits in Manitoba.

12. **Recommendation:** That the responsibility of the Ombudsman with respect to special investigation reports be removed.

    Reason: This responsibility will be assumed by the Representative for Children and Youth.

13. **Recommendation:** That a public awareness campaign be undertaken to inform the public about the expanded mandate and role of the Representative for Children and Youth.

    Reason: If this new position is to offer support and protection to vulnerable members of society, it is essential that there be a broad public understanding of the office, and its role, and the extent of its authority.

21 HAS WHAT WENT WRONG BEEN FIXED?

In Phase One of this Inquiry I heard evidence of the errors that were made and opportunities that were missed in the provision of child welfare services to Phoenix and her family. In Phase Two I heard of the changes to the child welfare system since that tragedy. Many of those changes were made in direct response to the recommendations of the six reviews listed in the Order in Council that established this Inquiry. Others were more general in nature.

The major responses to this tragedy, I have learned, have included the infusion of significant resources by the provincial government, and the adoption by the child welfare system of a new practice model. The new differential response model is still in the implementation phase, and other changes are also quite recent, so evidence as to their impact is limited. That said, there certainly was unanimous agreement on the benefit of early intervention and prevention in a concerted effort to support families and keep children safe in their own homes wherever possible. This is a positive development.

Now, looking specifically at the services that were delivered to Phoenix and her family, I turn to this question: "Has what went wrong, been fixed?"

My findings as to what did go wrong are set out in preceding chapters and need not be detailed here. But in general terms, the system failed Phoenix and her family from the moment she was born, until she died.

Phoenix was born a healthy baby, but she entered life in circumstances that were fraught with risk for her well-being. Her parents, Samantha Kematch and Steve Sinclair, were teenagers. They themselves had suffered abuse and neglect as children and had come of age as wards of the child welfare system. Neither had much in the way of a parental role model in their lives. They were Aboriginal, living in an urban setting. Neither had completed high school. They were unemployed and living on social assistance. Both had substance abuse issues. Kematch had given birth to her first child at age 16 and had shown no interest in that baby, who was taken into care at birth. Neither of Phoenix's parents had made any preparation at all for her birth. On the day she was born, both expressed uncertainty about whether they were ready to be parents.

Winnipeg CFS recognized immediately that Phoenix would be at risk with her parents and she was taken into care. Within a short time, the agency was aware of all of the risk factors listed above, and what would be needed to support the family so that they could care for Phoenix. Unfortunately, it failed to act on what it knew.

The evidence was that early on, Sinclair wanted to find employment for himself and daycare for Phoenix, but he received no support in either endeavour. According to Child and Family Services files, Sinclair was certainly the more dedicated of the two parents. Also, he had some support from his family and from his friend Kim Edwards and her partner, Rohan Stephenson.

Both parents had contact at various times with community-based programs at Ma Mawi, Andrew's Street Family Centre, and at the Winnipeg Boys and Girls Club, where they had found an advocate and mentor, but the child welfare system failed to capitalize on these connections. Kematch also participated in the Healthy Baby Program before and after the birth of her fourth child, but ended her contact with the public health nurse who was associated with that program when that nurse told her that Child and Family Services was seeking information about her.

Throughout her five years, Phoenix changed addresses many times, moving between the homes of Kematch, Sinclair, Sinclair's sisters, and Edwards and Stephenson, from Winnipeg to Fisher River, never attending daycare, nursery school, or any community programs. She was a child who became invisible.

Counsel for the Department and Winnipeg CFS, and counsel for the Authorities and ANCR were asked to assist the Commission by identifying how the changes made since the death of Phoenix could have influenced the services delivered to her and her family, had they been in effect at the time.

21.1 THE RESPONSE OF ANCR

Most of the services that Phoenix and her family received were delivered by intake units, whether the After Hours Unit (AHU), Crisis Response Unit (CRU) or Intake. Those services are now delivered in Winnipeg by All Nations Coordinated Response Network (ANCR). Executive Director Stoker testified about what would have been different, if the concerns that were expressed for Phoenix had been addressed under ANCR's current service model.

The first significant change she pointed to is the 2005 implementation of the Intake Module to log all new referrals. This is a computer application that is linked to the system's electronic database referred to as CFSIS (Child and Family Services Information System). This module has a number of features that are intended to enhance child welfare's ability to protect children:

- It is a "live" system: workers input information as they open a file. Previously, referrals often would be logged on paper and then entered into CFSIS later by an administrative assistant. Now the information enters CFSIS contemporaneously.
- It forces a prior contact check for any new family member, or any person added to a file. If the person has had prior contact with the child welfare system, that information will immediately show on the screen. Previously, a worker could add a new person to a file without doing a prior contact check.
- The module offers the worker a choice from a set of pre-defined issues and it automatically generates the appropriate response time for that issue: a worker may change the response time only with supervisor approval.

- A safety assessment tool is built in: it poses a set of questions to the worker, to elicit information about the child's immediate safety. A "Yes" answer to any of the questions requires the worker to complete a safety plan, outlining what steps have been taken to ensure the child's safety. [1354]

The Structured Decision Making (SDM) set of assessment tools that I have discussed earlier is another major change that could have affected how services were delivered to Phoenix and her family, Stoker said. The "probability of future harm" form is the standardized risk assessment tool that all four Authorities now use. Importantly, a worker has to thoroughly check the family's history to complete the form. When the form is completed, it automatically generates a preliminary calculation of the risk level, which may be adjusted upwards by the worker, but not down.[1355]

The intake agency's current client contact policy requires a worker—whenever there is an allegation of abuse or neglect—to see all children in the household and, where possible, interview them in a safe environment. The worker must also see the primary caregiver in the residence, and must see and interview the person alleged to have caused the child to be in need of protection. Stoker testified that this policy is consistent with a province-wide foundational standard established since the Phoenix Sinclair case, which articulates the requirement of face-to-face contact as part of any child protection investigation. [1356]

Criteria for private arrangements have also changed in accordance with recommendations from the reports that followed Phoenix's death. Now, a private arrangement—as was made between Sinclair and the Stephensons—may be considered as an alternative to apprehension only in situations of low to medium risk. It may only be done with the consent of the primary caregiver. There is a signed agreement and the same criminal record and other checks are done, as if it were a formal placement. A worker is expected to stay in touch with the people who have care of the child, and no file may be closed while a private arrangement is in place. She stressed that, as an intake agency, ANCR has only short-term involvement with families, and so these are intended as short-term arrangements.[1357]

With respect to record keeping, Ms. Stoker testified that the current case recording policy essentially says that any record that is obtained or created as part of the service a worker provides must be stored and must be kept. So any handwritten note and any piece of any documentation received from any collateral must be kept on the file. Workers often take brief notes while they are meeting with a family, for example. They are encouraged to record that meeting in the intake module as soon as possible: this record will be more detailed, but the handwritten notes must still be kept in the physical file. [1358]

These are all positive changes that should improve the delivery of intake services, if properly and consistently applied. It is too soon to know the real impact they will have on the system's stated goal of keeping children safe in their own homes, but it is to be hoped that evaluations in the not too distant future will answer that question.

I am concerned, however, by Stoker's evidence that in 2012 ANCR apprehended 660 children, compared with 550 the year before. She attributed this increase to better risk assessments; and to the increasing complexity of societal issues in families, including more frequent escalation from alcohol abuse to hard drug abuse, and an increase in domestic violence. She also noted an increase in gang-related violence, and mental health issues for both caregivers and children.[1359]

Whatever the reasons may turn out to be, this apparent upward trend in apprehensions at ANCR should be closely monitored, with attention paid to what impact, if any, is being registered as a result of the changes noted above.

To illustrate how the outcome for Phoenix might have been different, given today's tools, and focusing on the services delivered between January 14, 2004 and March 9, 2005, Stoker conducted hypothetical assessments of Phoenix's situation, applying today's tools to the facts that were known at the time.

To begin, Stoker said the new assessment tools would require a more comprehensive appraisal of Phoenix's immediate safety and risk of future harm, both with respect to abuse and neglect. The worker would have focused on both Sinclair and Kematch and would have met face-to-face with Phoenix each time the file was opened. The assessment forms would also have required a complete assessment of McKay as a secondary caregiver. In each instance, rather than closing the file at Intake or CRU, the worker would have transferred it to an agency for ongoing service.

I find that, if applied as Stoker has indicated they would be, these assessment tools and services could have better protected Phoenix. Physical contact with her at various points would have revealed changes in her development and well-being, which, as many witnesses identified, was noticeably deteriorating by the end of 2004. Identification of Wes McKay as a dangerous man would have led to a decision not to allow Phoenix to be in his care.

At the May 2004 intervention, prompted by the call from Employment and Income Assistance (EIA), it was learned that Kematch was living with McKay. Stoker said that the safety assessment form would have revealed no immediate safety concerns based on the information from EIA, so on that basis, she would have determined that there was no risk to Phoenix's immediate safety. But McKay would have been listed as the secondary caregiver on the probability of future harm form, so at that point the worker would have had to review his history as a parent. With that information, today's risk assessment tool would lead to an assessment of high probability of future harm to Phoenix and on that basis the matter would have been transferred for ongoing services. At that stage there would

have been a strengths and needs assessment, involving a meeting with McKay and with Kematch, and a conversation with Phoenix. Stoker testified that Phoenix would not have been apprehended based on the information they had at Intake at that time.[1360]

Given McKay's history, I have trouble understanding how the agency could determine that Phoenix's immediately safety was not at risk in a home with McKay as a caregiver. The Intake Module's requirement of a prior contact check before adding him as a person in Phoenix's file should have revealed the risk he posed to Phoenix's immediate safety. Of course, this assumes that the prior contact check would have been properly performed and analysed, including a thorough review of the case history.

I note that Stoker's evidence was at odds with that of Parsons, who testified that based on McKay's history there would have been grounds to require McKay to leave the home while the file was transferred to ongoing services for further investigation.[1361] I acknowledge however, that Stoker's evidence was given as part of a hypothetical exercise and she did elaborate that workers would ultimately meet with each of McKay, Kematch, and Phoenix in person. Perhaps those interviews would have yielded a different result than what initial tools identified. Again, I caution that standardized tools cannot substitute for the exercise of professional judgment.

21.2 RESPONSE OF WINNIPEG CHILD AND FAMILY SERVICES

As the preceding chapters outline, the evidence of Winnipeg CFS showed that significant changes have been made to its practices and procedures, including improvements to training and case management. Winnipeg CFS also provided the Inquiry with its own hypothetical scenario to explain how services delivered to Phoenix and her family would have differed if delivered according to today's practice and training.

Clearly, the new practice model provides much more thorough and comprehensive ongoing assessments of safety, and risk, and of strengths and needs. It also promotes better engagement with families, as social workers build trust and establish good working relationships.

But once assessments are made, the next step is provision of the services and supports that those assessments indicate are needed. That is what I find missing. Neither in the evidence as a whole nor in the hypothetical scenario, is there any mention of the services that the agency would deliver to support Phoenix and her family, once they had been assessed. For example, when the decision was made to return Phoenix to Sinclair's care on October 2, 2003, the agency says that today there would have been a clear case plan indicating what Sinclair was to work on, and that he would need to demonstrate progress and behavioural change before being deemed ready to assume care of Phoenix. I was disappointed to see no mention of what services and supports would be provided to Sinclair to help him address his issues of substance abuse and his own childhood trauma; his

unemployment; and his lack of parenting skills and experience. Nor was there any mention of working with the community-based agencies with which Sinclair had been connected.

The majority of the evidence about how the agency would do things differently if services were delivered to Phoenix and her family today focused on assessment of risk, and family strengths and needs. Clearly it would be important to understand the underlying reasons Phoenix and her family were coming to the attention of the child welfare system to determine what services the agency needed to provide to protect and support Phoenix and her family. Unfortunately, that is where the evidence of the agency was lacking, both generally in the evidence I heard about how the agency functions today and in the specific hypothetical scenario created to respond to the particular needs of Phoenix and her family.

As I have commented repeatedly, agencies must be in a position to provide services either directly or in collaboration with other governmental and community-based entities to effectively protect children and support their families. Dr. Nico Trocmé's testimony about the importance of services to back up assessments and case plans, cannot be overemphasized.

21.3 IMPACT OF TRAINING ON SERVICES

Winnipeg CFS contends that if current training had been in effect between 2000 and 2005, social workers and supervisors would have had access to better training and tools; their assessments would have been better; and there would have been better case planning before reuniting Phoenix with her family. McDonald testified that before Phoenix was returned to them, the parents would have had to demonstrate significant changes to their behaviours and there would have been a formal reassessment to confirm that they were ready to assume care of their child. Then there would have been a follow-up assessment 45 days later. It is likely that the case would have been identified as high risk and family services would have continued working with the family for a longer period of time, she said.[1362]

I note however, that while Winnipeg CFS accepts responsibility for failing to provide appropriate training, it submits that this was not a critical factor impacting the delivery of services to Phoenix and her family. The agency's position is that the deficiencies identified in the delivery of those services were not related to a lack of understanding of policies, procedures, and provincial standards, or any confusion about which standards were in effect.[1363]

I accept that improvements to a system should result in better services, but the real issue in this case is not knowledge, but compliance. In that regard, I agree with the agency's submission that the deficiencies identified in the delivery of services to Phoenix did not result from a lack of understanding of policies, procedures and provincial standards or from confusion about which standards applied. Rather, I find that they resulted from a lack of compliance with existing policies and with best practice.

I am optimistic that the extensive enhancements to training throughout the child welfare system will have a beneficial impact on the delivery of services, though these changes are too recent to allow for concrete evidence yet. But I must emphasize that even in today's much-improved training regime, compliance is key. However great the workers' knowledge and understanding, if they do not follow policies, procedures, and provincial standards, whether because workload demands make compliance difficult or for any other reason, the same problems that plagued the handling of Phoenix's file could very well occur again.

21.4 IMPACT OF CHANGES RELATING TO STANDARDS

The Department acknowledged in its submissions that there was confusion around standards during the years when services were delivered to Phoenix and her family, and it accepted responsibility for the confusion. It argued, however, that lack of clarity around standards does not appear to have had a significant impact in this case.[1364]

The workers and supervisors who delivered services to Phoenix and her family appeared to have been aware of what was required of them. But clearly, awareness of expectations is not enough to ensure best practices.

For example, there is no question that staff knew or ought to have known that McKay needed to be investigated as a new partner in Phoenix's home, and Phoenix needed to be seen when concerns were raised. This was the case, regardless of which version of the standards was in effect at the time. Further, the evidence from a number of witnesses was that there was never any doubt that a child who was the subject of a child protection investigation needed to be seen.[1365] I recall the evidence of supervisor Faria from the March 2005 intake, who testified that according to the existing intake manual, a worker would need to complete an assessment and investigation, including seeing the child, to determine whether there were child protection concerns before a file could be closed.[1366] I also recall Zalevich's acknowledgment that he understood at the time that it would have been best to see Phoenix; he confirmed that he was present at a CRU meeting a year earlier where the need to see children was discussed.[1367] The minutes of that meeting record instructions that "as much as is possible, when there is a concern about a child in the home, the home and the child should be seen by a worker."[1368]

Standards and manuals aside, every social worker ought to have known, as a matter of common sense, that a child who was the subject of a child protection investigation, had to be seen by that worker.

21.5 SO, HAS WHAT WENT WRONG BEEN FIXED?

To answer this question, having considered all of the above, I look now to the evidence of General Authority CEO Rodgers. He answers positively, referring to the significant improvements to risk assessments; better file recording practices; and more engagement of workers with families. He identified improvements to training and knowledge of standards. He also talked about the efforts made to reduce workloads and add resources to the system, acknowledging that while much has been done, more work remains.[1369]

As for future improvements, Rodgers spoke of the need to further reduce workloads because "safety and well-being of children is enhanced greatly by the ability to work intensively with families . . ."[1370] He also spoke positively about the potential for primary prevention through integration of systems working together to battle the chronic problems that bring families into contact with the child welfare system in the first place.

I do agree with Rodgers that improvements have been made to the delivery of child welfare services and that they respond to the recommendations set out in the fact-specific reviews of the services delivered to Phoenix and her family.[1371] But the evidence was clear that while there has been a good start, more must be done to better protect Manitoba children.

That is to say, and at the risk of being repetitive, the system must develop, coordinate, and make accessible services necessary to support families and keep children safe at home. The child welfare system cannot accomplish this alone: it must partner with other government departments and with community-based organizations and other service providers, as I have said earlier in this report.

Finally, the other point that cannot be over emphasized is the need for individual child welfare workers to comply with best practices. This means, going back to the evidence of Alana Brownlee, CEO of Winnipeg CFS, that staff need to know clearly what is expected of them: standards and policies must be clear. Staff need training as to what that means in practice. They need the tools and skills to fulfill what is expected of them. In addition to resources, they need the supervision and support to ensure they perform their job appropriately. Ultimately, they need to have a reasonable caseload to enable them to comply with expectations.

Based on the all evidence I heard at the Inquiry I find that the Department and the Authorities have made improvements towards ensuring compliance with best practices. Standards and policies have been clarified. Improvements have been made to training. New tools and strategies have been devised and are in the process of being implemented. It is still early with respect to assessing many of these improvements, not all of which have been implemented to their full extent across all Authorities. But I think there is reason for optimism based on what is being done, combined with the expectation that the recommendations I make in this report will be implemented to enhance and further the positive path Manitoba's child welfare system is taking.

I acknowledge the significant increase in resources injected into the system since 2006, and the new tools incorporated into practice. I also appreciate the funding challenges that Manitoba will continue to face as it pursues its commitment to achieve positive outcomes for its children. This is particularly so, in light of increasingly complex needs experienced by families.

One area that remains of concern, however, is the issue of workload. The evidence from Brownlee and from Southern Authority CEO Flett, gave clear examples of how current resources do not allow for the staffing levels necessary to deliver effective services, particularly having regard to the family enhancement services that are called for under the differential response practice model.

There are many ways in which workload can be addressed and I have discussed those strategies earlier. They include not only the obvious—funding additional social work positions—but also use of other resources such as family support workers, and collaborating with community-based organizations and other government departments to provide necessary supports. Over the long term the focus on early intervention and prevention, which has clearly been identified by the system and which many of my recommendations address, will reduce workload. Investments in early intervention and prevention measures, however, may not yield immediate returns. In the interim, it is imperative that agencies have the resources they identify as being necessary, based on informed and reasonable assessment, to deliver effective services to protect children and support their families.

The system must foster recruitment and retention of a stable workforce in this important profession.

At the end of each day, in my view, each worker must be able to provide an affirmative answer to these questions posed by Billie Schibler:

> *As a worker within the system, as a service provider, do I feel confident with the work that I did today and would I feel confident having received services from the system that I work for?*[1372]

More remains to be done, but the improvements to the system about which I heard, and the further changes recommended by this report should go a long way towards enhancing the ability of child welfare staff to comply with best practices in delivering their services to children and families, so that each one, each day, can answer that question affirmatively.

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[1062] Final Submissions of The General Child and Family Services Authority, paras. 57 and 75
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PHASE THREE - THE COMMUNITY: ITS NEEDS AND RESPONSIBILITIES, PROTECTING AND PROMOTING CHILDREN AND FAMILIES

The responsibility to protect children cannot fall solely on the shoulders of the child welfare system. The evidence heard throughout this Inquiry leads to a clear conclusion: this is a responsibility that belongs to the entire community.

I have heard from expert witnesses that Aboriginal children, who are disproportionately represented in child welfare systems across Canada, are more often taken into care for reasons of neglect than abuse, and child neglect is commonly associated with factors that are largely out of the parents' control: poverty, poor housing, and often, the parents' own troubled histories.

Poverty, homelessness, limited opportunities, and substance abuse place stresses on families that can leave children at risk. Not only are these conditions often beyond the ability of individual families to prevent, they are beyond the scope of the child welfare system itself. These social and economic conditions call for a comprehensive approach that harnesses the resources of government and communities to engage with families and provide the services they need, for the better protection of Manitoba's children.

Phase Three of this Inquiry is devoted to this subject: to the community, and to the social context in which families live, recognizing that the child welfare system plays but one part, significant though it may be. These are the questions I have chosen to address:

1. What are the circumstances that bring vulnerable families and in particular, Aboriginal families in Winnipeg, into contact with the child welfare system?
2. Beyond the child welfare system, what prevention services, programs, and departments, whether government or community-based, are available or ought to be available, to support families and children?[1373]

I address the first question in Chapter 21 and the second in the chapters that follow.

The Inquiry heard from witnesses whose experience ranged from local to international, and from personal to professional. All of them were helpful to me in formulating my recommendations.

22 WHAT BRINGS FAMILIES TO THE CHILD WELFARE SYSTEM?

22.1 HOW MANY CHILDREN?

Before considering how and why children and families come into contact with the child welfare system, it's important to understand the dimensions of the problem and whether the numbers are growing or declining. The Inquiry heard some facts that demonstrate the gravity of the situation here in Manitoba, and across Canada.

- Canadian children are taken into care at a rate far in excess of children in other countries—10 times as often as in Western Australia, for example. [1374]
- Manitoba children are taken into care more often than in most other parts of Canada. [1375]
- More than 80% of the children in care in Manitoba are Aboriginal. [1376]
- 3% of infants in Manitoba are placed in care. [1377]
- 7.5% of all Manitoba children have been in care by the time they are 7 years old. [1378]

It is troubling to see the upward trend in the numbers of Manitoba children being taken from their homes and placed in the care of the child welfare system, as illustrated by this chart:

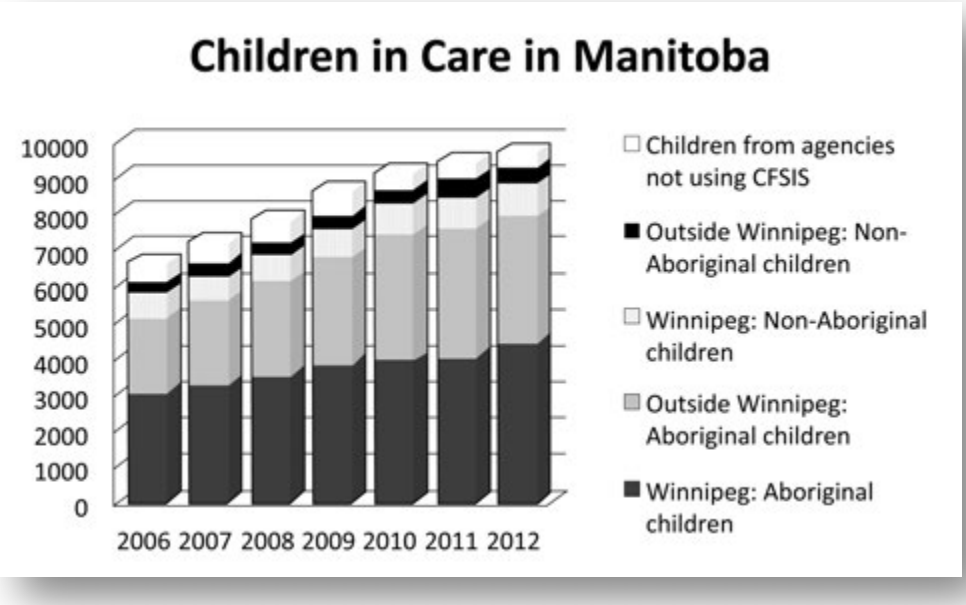

FIGURE 1: Number of children in care in Manitoba, 2006-2012
(Data source: Exhibit 39)

22.2 HOW MANY ABORIGINAL CHILDREN?

Aboriginal children are involved with Manitoba's child welfare system at a much higher rate than non-Aboriginal children. Of the more than 9,700 children in care of child welfare agencies in Manitoba, more than 80% are Aboriginal, and the numbers have been steadily increasing since 1997.[1379] In Winnipeg alone, 83% of the 5,291 children in care in 2012 were Aboriginal. These numbers are reflected in the following chart:[1380]

FIGURE 2: Number of children in care in Winnipeg per CFSIS, 2006-2012.
(Data source: Exhibit 39)

Dr. Nico Trocmé, a leading Canadian academic in the field of child welfare, was asked by the Commission to address the subject of this over-representation. He was Principal Investigator for the three most recent cycles of the Canadian Incidence Study on Abuse and Neglect, which for the first time, in 2008, included First Nations child welfare agencies in its sampling.[1381] The findings from the most recent study are published in the 2011 report, *Kiskisik Awasisak: Remember the Children, Understanding the Overrepresentation of First Nations Children in the Child Welfare System*.[1382]

It is beyond question that the number of Aboriginal children coming into contact with the child welfare system is far out of proportion to the size of the Aboriginal population. That is particularly true in Manitoba, and even more so in Winnipeg, as the above charts make abundantly clear.

Trocmé testified about the "dramatic" over-representation of First Nations children in the Canadian welfare system. That description was adopted by Blackstock as well. McKenzie acknowledged that the proportion of Manitoba children in care who are Aboriginal—more than 80%--is quite high by comparison with other jurisdictions, but said the general trend of over-representation is similar across Canada. Indeed, the fact of this dramatic over-representation is incontrovertible

when it is appreciated that Aboriginal people represent just over 4% of the Canadian population. Even in Winnipeg, where the figure is about 10% and in Manitoba, where it is about 16%, this disproportionate number of children in care is unconscionable. In Manitoba and across our country, the horrors of life that cause children to be taken into care and away from their moms and dads are visited in gross disproportion on Aboriginal children.

Moreover, the rate of over-representation is amplified at each stage of the protection process, beginning with reports of maltreatment, according to Trocmé:[1383]

- Aboriginal families are investigated for abuse or neglect at a rate 4 times higher than non-Aboriginal families.
- Allegations are substantiated 5 times as often for Aboriginal children.
- Court applications result 8 times more often in cases involving Aboriginal children.
- Aboriginal children are taken into care at a rate 12 times higher than non-Aboriginal children.

The most glaring over-representation of Aboriginal families is found in the number of cases of neglect, as opposed to abuse. Neglect, for these purposes, is defined as a failure to supervise or to adequately meet a child's physical needs. The Canada-wide study mentioned above found that the difference between Aboriginal and non-Aboriginal families when it comes to serious physical abuse is negligible, but substantiated reports of neglect are eight times higher for Aboriginal children.[1384]

To Canada, a country that purports to be a leader in the advancement of human rights, both at home and abroad, the foregoing facts have to be a significant national embarrassment. The problem cannot be solved by Manitoba acting alone.

With these statistics staring me in the face, I am most uncomfortable being confined to the boundaries of a provincial public inquiry. Included in the recommendations at the end of this chapter will be one addressing the inequity of which I speak. I believe that this is as far as I am empowered to go in the search for a solution to this unacceptable state of affairs. That solution will not be simple and will not be quickly accomplished. But for a multitude of reasons, and especially for the sake of the future of generations of Aboriginal children, that solution must be found.

22.3 WHAT ACCOUNTS FOR SUCH OVER-REPRESENTATION?

Research shows that Aboriginal children are taken from their homes in disproportionate numbers, not because they are Aboriginal but because they are living in far worse circumstances than other children. Many live in poor housing conditions, with parents who are struggling with alcoholism and substance abuse and lack the supports they need.[1385]

When Aboriginal families are compared with other families in the same circumstances, there is no significant difference in rates of apprehension.

Many of the reasons why Aboriginal children and families are more vulnerable and more likely to come into contact with the child welfare system, according to several witnesses, have to do with the legacy of colonization and residential schools. In a paper she prepared for the Commission, Dr. Alexandra Wright says:

> *The negative effects of colonization on the Aboriginal community, through government sanctioned practices such as residential schools and the apprehension of children, continue to permeate the health and well-being of Aboriginal families . . . Issues such as high levels of substance abuse, suicide, family violence, mental health issues and parenting are considered to result from "long-term social and economic impacts of colonization on Indigenous family life".*[1386]

Billie Schibler appeared before the Inquiry in various capacities. Testifying as former Children's Advocate, she was asked about the factors that result in families and children needing the child welfare system. Schibler replied:

> *I would say that those families or those children don't have a solid support network around them and they might not have access to the resources that are needed to build capacity, build strength. And, and then they may not be visible in their communities for, for services or, or community people to reach out to them. There's many things that are combined, like poverty, historical involvement, generational involvement in a system, child welfare system.*[1387]

In her role as CEO of the Métis Authority, Schibler identified these reasons for over-representation of Métis families in the child welfare system:

> *I think just the social barriers, the limited education, the poor housing, the poverty issues, the families that have come in from some of the rural communities to try and find a way of life here and have struggled and have needed those additional supports. Our teen pregnancies, being involved with them and, and finding that they don't have those natural supports around them, for many of them. So it's having to re-establish that and develop that all over again.*

When asked why these are the experiences of so many Métis families, she said:

> *Well, I think that a large portion of it has to do with I think what we've consistently heard around our populations where there is that loss of culture, where there is that loss of identity. Again, things that have happened through the residential school and the day schools. That's why our emphasis in our programs is so much about re-establishing that pride in that culture. That's why that whole piece around Métis pride is so important because it's about helping people to know that we can become each other's natural resource and support and, and feel a lot of pride when people can step out and come to the services that are being offered in a way where they're not afraid of the*

> *services, where they see it as a support rather than just a huge intrusion in their life. . . . I believe that it's an over-representation of, of people who have struggled with all of these pieces of history and have to now re-establish themselves."* [1388]

As a member of the Kookum Council, Schibler spoke movingly about the lasting impact that residential schools have had on the families and communities who were left behind, after the children were taken:

> *In our traditional teachings about our communities, the children are seen to be the spirit of the community . . . . The children are seen as the sacred fire. They are the spirit. And when you don't have the spirit in your community anymore, all sacredness is gone. . . . When you have communities where your children are taken and placed in residential school, you've taken the spirit from those communities. You've taken the sacredness from those communities. You've taken everything that has given those communities purpose. Our teachings say as long as you have a child in your life, you will always have purpose and meaning for life. So when you take that away from your communities, your communities suffer.*[1389]

Together, these findings and observations lead me to conclude that only by addressing underlying factors, including poverty, homelessness, and substance abuse, will we ever begin to address the vulnerabilities that bring families to need the intervention of the child welfare system.

22.4 NEGLECT CAN BE MORE SERIOUS THAN ABUSE

It became clear from Trocmé's presentation that those underlying factors lead much more often to child neglect, than to abuse. This much higher rate of neglect is significant because chronic neglect has such serious consequences for children. Trocmé testified:

> *You compare neglected children to any other type of child—physically abused, sexually abused, children living in poverty, children living in a range of circumstances—neglected children stand out.*
>
> *Emotionally neglected children, physically neglected children stand out. You can measure them any which way you want. You can measure their language acquisition at age three, at age four. You can measure rates of anxiety and depression as teenagers. You can look at their aggressiveness. You can look at how they do at school, at educational delay, dropout. Any which way you measure them, at any age, neglected children are the ones that have the worst outcomes, by far.*[1390]

The impact of neglect on the development of the human brain was explained by Dr. Rob Santos, Executive Director of Science and Policy for the Healthy Child Office and the Department of Children and Youth Opportunities, whose testimony is discussed later in this report. He told the Commission that the fundamental experience that shapes early brain development is the "serve-and-return" of interactions with "caring, wise adults" who surround the developing child. He said neglect is "one of the most pernicious and invisible forms of child maltreatment" because in the absence of that serve-and-return interaction, "the developing brain simply doesn't have the opportunities to develop in the ways that it needs to in order to be healthy and successful in life."[1391]

The concept of neglect is complex for a family living in extreme poverty, Trocmé said. While it is a matter of debate as to whether responsibility should be attributed to the parents or the community in which the parents live, it is clear that children's needs are not being met. He gave as an example a child who comes home from school to an empty house and is found to be suffering from lack of supervision amounting to neglect. The parent may be working all afternoon and evening, trying to make ends meet for the family, but:

> *For whatever reason, we've decided to attribute responsibility for that to the parent, as opposed to the principal of the school who sends the child home, knowing that there is no one there to look after the child.*[1392]

As discussed in previous chapters, Trocmé testified that a long term, sustained response is required for families living with chronic challenges and who are at highest risk.[1393] I am told that this is what Manitoba's child welfare system intends to deliver through its differential response approach to prevention.

22.5 COMPLEX FACTORS LEAD TO VULNERABILITY FOR FAMILIES

22.5.1 POVERTY AND ECONOMIC DISADVANTAGE

Part of the goal of this phase of the Inquiry was to shine a light on the factors that make children and families vulnerable and lead them into contact with the child welfare system. To make recommendations for the better protection of Manitoba children, I needed a better understanding of these factors, beginning with the most significant: poverty.

Poverty can be defined in many ways. Dr. Shauna MacKinnon, former Director of the Manitoba Office of the Canadian Centre for Policy Alternatives, suggested that an appropriate definition looks not simply to income level, but to what she referred to as social exclusion. She spoke about the sense of hopelessness and helplessness that sets in when people feel no engagement with their community; when they feel they have no ability to make choices because they have to accept whatever charity is given to them; and when they don't have access to opportunities that many people take for granted. "The less you have access to, the further disengaged you become," she said.[1394]

Two dimensions of poverty are important to measure, MacKinnon said. First is its depth: life is much more difficult for families living far below the poverty threshold than for those who are closer to it. The second dimension is time: the longer people live in poverty, the harder it is to escape. Children of families that have been living in poverty for generations don't see the possibility of a different life. Many have never known anybody who has worked for a living, so they don't know what that means, she said. [1395]

The poverty that is found in Winnipeg's inner city is complex, deep, and multigenerational, and it calls for multi-pronged approaches, MacKinnon testified. Income supports are important, but education, employability, health and well-being, nutrition and housing, all need to be addressed as well. "Children are poor because their parents are poor, so we need to look at how we address poverty more generally," she said.[1396]

Attacking one issue at a time is ineffective, she testified. For example, a quick training program for a person who is lacking education may lead to a job, but in low-wage work that leaves the person still living in poverty and possibly worse off, if they have no access to affordable, reliable childcare. So, employment is important, MacKinnon said, "but just because somebody has employment doesn't mean that they don't have all the other issues still complicating their lives."[1397]

By contrast, and to illustrate that with longer term investment these cycles can be broken, MacKinnon gave the example of an Aboriginal woman who participated in a cultural program that taught her to be proud of her history and her identity. Then she began taking courses at the Urban Circle Training Centre and eventually completed Grade 12. From there, she entered the University of Manitoba Access program (mentioned in Chapter 16) in the inner city and obtained her BSW degree. As a result of her success, other family members returned to school, her children went to university, and her grandchildren now look forward to university. It took that woman seven years to go back and complete Grade 12, MacKinnon said, "but there's a whole family now for whom the cycle of poverty has likely been broken."[1398]

The enormous impact that poverty has on well-being was emphasized by Santos, who referred the Commission to calls by authorities such as the Canadian Medical Association to treat poverty as a causal agent for disease because of its "enormous negative effect on human health and illness."[1399] His testimony about the effect of poverty as a stressor affecting children's early brain development is referred to later in this report.

A 2009 report by the Canadian Centre for Policy Alternatives called for a poverty reduction plan for Manitoba. It made recommendations in the areas of health, education, housing supports, income security, and others.[1400] Since then, Manitoba has passed the *Poverty Reduction Strategy Act*, effective 2011. Lissa Donner, Executive Director of the Policy and Planning Branch of the Department of Family Services and Labour, testified about the development, implementation, and monitoring of

this government-wide strategy, also known as *All Aboard: Manitoba's Poverty Reduction and Social Inclusion Strategy.*[1401]

Donner explained that there are various approaches to measuring poverty or defining "low income," but, according to the measurement typically used by the provincial government, 101,000 Manitobans met the low-income threshold in 2010. This includes some 15,000 Manitobans who identified themselves as Aboriginal and living off reserve (there were no on-reserve numbers), and it includes 28,000 children. Single parents, Aboriginals, and children are among the groups disproportionately represented among the poor. [1402]

What is more, the level of poverty is deep and has improved little in a decade. In 2000, on average, low-income Manitobans were living 33.9% below the low-income threshold; by 2010, that number was almost unchanged, at 32.6%.[1403]

Donner echoed MacKinnon's evidence about the social exclusion that is an element of poverty. The All Aboard strategy addresses this:

> *Social exclusion happens when people are discouraged or blocked from fully participating in society because of barriers such as unemployment, poor housing, lack of accessible options, family breakdown, addictions, mental illness, outdated beliefs about their capabilities and discrimination. These barriers can keep people from accessing the benefits, resources and opportunities they need to participate more fully in their communities and reach their full potential.*[1404]

Any discussion of poverty has to include considerations of food security. I understand the principle of food security to mean that everyone has access to food to meet his or her nutritional needs.[1405] According to Olivier De Schutter, United Nations Special Rapporteur on the Right to Food, 55% of Canadian households relying on social assistance are "food insecure" as the result of "a huge discrepancy between social assistance levels and the rising costs of living."[1406] He confirmed that housing costs are a key reason why people suffer from hunger and have to resort to food banks.

Lyna Hart, board member and volunteer with Winnipeg Harvest, the province's largest food bank, was instrumental in arranging De Schutter's visit to a number of First Nations in Manitoba in May 2012, and to Winnipeg Harvest.[1407] Following his visit, he reported that in Canada:

> *The reliance on food banks is symptomatic of a broken social protection system and the failure of the State to meet its obligations to its people. In the view of the Special Rapporteur, social assistance levels need to be increased immediately to correspond to the costs of basic necessities; it should be regularly indexed to real living costs; and a housing benefit paid outside the social assistance system should be guaranteed, to ensure that the poorest families are not obliged to sacrifice food in order to pay for the non-compressible and non-divisible costs of housing.*[1408]

These conclusions are consistent with the testimony of other witnesses including Donner [1409] and MacKinnon.[1410]

More than 63,000 Manitobans use food banks every month and nearly half of those are children, according to Hart. Manitoba has the highest percentage of children requiring the assistance of food banks in Canada, she said, referring to a 2012 report by Food Banks Canada.[1411]

22.5.2 HOUSING AND HOMELESSNESS

Closely linked to poverty are the issues of housing and homelessness. MacKinnon testified that "if we want to look at reducing poverty and increasing inclusion, housing has to be on the top of the list of things we address."[1412] Not having enough money for basic necessities or for activities that encourage social inclusion is a primary factor in creating a cycle of homelessness that has touched generations of people living in Winnipeg, says a report titled, *A More Inclusive and Generous Canada: The 2012 Acceptable Living Level*.[1413] The dearth of available, affordable housing in Manitoba, and in Winnipeg in particular was a theme often repeated in the testimony of witnesses in Phase Three.

In Winnipeg, poverty is concentrated within the geographic boundaries of the inner city, and among its Aboriginal inhabitants, MacKinnon said. Of those Aboriginal people who move to Winnipeg from other communities, 85% end up living in this inner city area, according to Dr. Jino Distasio, Director of the University of Winnipeg's Institute of Urban Studies.[1414]

Distasio defined homelessness in terms of permanency, control, and the right to tenure. "Anybody who lacks permanent, safe, affordable housing falls into that definition of homelessness." The "hidden homeless" are those living in volatile housing, whether rooming houses or couch-surfing with friends and family, he said. In addition to those "hidden homeless," Distasio estimates that another 100,000 Winnipeg residents are at risk of becoming homeless because they are barely scraping by.[1415]

Social assistance housing allowances have not increased substantially since 1992, McKinnon said. Organizations have been calling for an increase to 75% of the median market rental rate, which isn't enough, she said, but would be an improvement.[1416]

Besides poverty, there are other reasons for the housing challenges facing Aboriginal families. Mobility is one. Aboriginal people move back and forth between Winnipeg and their home communities in large numbers, Distasio said. They tend to come to the city for better jobs and for the same reasons anyone does, but they have serious difficulty finding housing in the city. Faced with homelessness, the challenge of accessing services in an urban setting, and a difficult labour market, they often move back home, only to try returning to the city again later. In addition, Distasio spoke of family and spiritual ties that keep drawing Aboriginal people back to their traditional homes. These frequent moves complicate access to acceptable and affordable housing.

Racism is another factor that can shut people out of the housing market, Distasio said, although it is difficult to quantify.[1417] McKinnon made similar observations.[1418]

The supply of housing is another challenge. Distastio said that Winnipeg vacancy rates are low and the market is not adding enough new units to meet demand. Low vacancy rates make it especially difficult for first-time renters and those relying on EIA to come up with a damage deposit and the quality references they need, to secure rental accommodation.[1419]

Despite the shortage of housing units and the many inner city homes that are in need of major repairs, Distasio was optimistic about the capacity in Winnipeg to address housing needs, if the existing network of Aboriginal-based housing providers were given the resources they need. Both provincial and municipal governments need to "step up," he said. He did give credit to the Province for its rent supplement program that helps non-profit housing agencies to provide more affordable housing. Still, he pointed to studies done as far back as 1969 and the waiting lists for quality housing and queried whether meaningful progress has been made.[1420]

22.5.3 SUBSTANCE ABUSE

Addictions and substance abuse issues are often a concern in families involved with the child welfare system, the Inquiry heard from social workers. There was evidence about the role that drugs and alcohol played in the lives of Phoenix's parents and their ability to care for her.

Addiction, it seems, is almost never the sole issue an individual is facing. The Inquiry heard from a number of witnesses in this Phase about the constellation of needs that must be addressed in treating addictions. Jean Doucha, executive director of the Behavioural Health Foundation, testified about the foundation's work in addressing addictions through residential treatment in Manitoba. She noted that:

> *. . . individuals rarely only have a substance abuse issue. Our clients have issues in, in all areas of their lives and so if we don't address the issues in the areas of their lives in addition to the substance use and the mental health issues, then they're going to relapse. Those problems need to be addressed. So the substance use is really a secondary issue, the primary issues are those of family dysfunction, neglect in their childhoods, that they experience low levels of education and failure within their education systems. A lack of employment opportunities. Just a lack of work skill and work knowledge. And many, many other issues. Trauma, certainly.*[1421]

Residents of the foundation's facility include men, women, and children and just over one-third have co-occurring mental health problems. They typically come from dysfunctional families and many began their substance use early in life, often between the ages of 10 and 12. Only about 5% were employed before arrival in

treatment and most earn less than $15,000 annually, often through social assistance. Approximately 80% of the residents are Aboriginal, she said.[1422]

The Behavioural Health Foundation addresses each of the issues experienced by its residents. It is unique in Manitoba, Doucha said, in providing treatment to the whole family. One of the benefits of this approach is that treatment is then available to single parents who would not enter treatment if it meant leaving their children in the care of others. [1423]

The Commission heard that addiction treatment facilities are not adequate to meet the demand. Doucha testified that her facility has waiting lists and she knew of no addictions centre in the province that doesn't. Further evidence was that treatment facilities providing culturally appropriate services for Aboriginal clients are in even greater demand.[1424]

22.5.4 SOCIAL EXCLUSION AND ISOLATION

Here I return to a theme that arose throughout this phase of the Inquiry—social exclusion, or isolation. Poverty, mental illness, homelessness, and addictions are conditions that isolate people from their communities. Parents who suffer these conditions are less likely to take advantage of voluntary programs that could benefit themselves and their children, according to Kerry McCuaig, an expert in early childhood development. [1425] Social isolation of families is a breeding ground for neglect, she said.[1426]

For children, isolation is often a function of their family's housing issues, according to McCuaig. Families who can't find suitable, affordable housing tend to move often, and children who are constantly moving don't connect with their schools or peer group. Eventually they become "invisible" at school and drop out as soon as they can.[1427]

22.6 RECOMMENDATIONS

1. **Recommendation:** That the Province take the lead to work in concert with the federal and municipal governments, First Nations, and the private sector to develop further strategies to increase availability of a variety of affordable housing, including incentives and supports for landlords, developers, and community-based housing associations.

   Reason: Bringing appropriate housing within reach will help alleviate a major stressor for many families living in poverty.

2. **Recommendation:** That the Province closely examine the 2009 report, *The View From Here: Manitobans Call for a Poverty Reduction Plan*, with a view to implementing the outstanding recommendations, paying particular attention to the area of adult education.

   Reason: Over the long term, education offers one of the best means of breaking the cycle of poverty, which is one of the major risk factors for children.

3. **Recommendation:** That social assistance housing allowances be increased to at least 75% of the median market rate.

   Reason: Increasing housing allowances will address the poverty-related issues that make families vulnerable and can lead them into contact with the child welfare system.

4. **Recommendation:** That supports for families transitioning from First Nation communities to urban centres be expanded and enhanced. To this end, Manitoba should collaborate with First Nations and other levels of government.

   Reason: Many families make this move and are ill equipped to navigate among the services they need to make a successful transition.

5. **Recommendation:** That at the next meeting of the Council of the Federation (the Premiers of Canada's ten provinces and three territories), the Premier of Manitoba request placement on the agenda and the opportunity to speak to the unacceptably disproportionate number of Aboriginal children taken into care by child welfare authorities across Canada in comparison to non-Aboriginal children. Further, that if given the opportunity to speak to the matter, the Premier of Manitoba outline the severity and seriousness of the problem and the consequences for all of us, but particularly for Aboriginal children and families, if allowed to continue unabated; and that he explore whether collectively his colleagues are of a mind to take steps in search of a solution and a process for implementation of that solution over time.

   Reason: The over-representation of Aboriginal children in Canadian child welfare systems is a serious national problem for which a solution must be found for the benefit of Aboriginal children, and all Canadians.

23 PROTECTION BEGINS WITH PREVENTION: A PUBLIC HEALTH APPROACH

23.1 NEW FOCUS ON PREVENTION IS NEEDED

Having addressed the circumstances that bring families and particularly Aboriginal families into contact with the child welfare system, I now turn to the second question posed in this phase:

> Beyond the child welfare system, what services, programs, and departments, whether government or community-based, are available or ought to be available, to support families and children?

I recognized early in this report that protection of children is a shared responsibility. In Phase Two, the Inquiry heard of the ways in which the child welfare system has recognized the importance of prevention in the protection of

children. This and subsequent chapters look at prevention strategies and services, outside the formal child welfare system.

The ever-increasing number of children coming into the care of the child welfare system attests to the fact that at least until very recently, efforts have failed to address the many vulnerabilities among Manitoba children and families in any meaningful way.

Historically, the child welfare system has focused on investigating and then addressing parental shortcomings or misconduct, with little emphasis on prevention and empowerment. In Phase Two of this Inquiry I learned that the child welfare system has acknowledged that a new focus on prevention and building on a family's strengths will better protect children.

In looking beyond the child welfare system for recommendations to support this approach, I am mindful of this observation from Dr. Marni Brownell, Senior Research Scientist with the Manitoba Centre for Health Policy:

> *The knee-jerk response to severe child abuse and individual deaths, like the case of Phoenix Sinclair, is moral outrage and a need to punish not only the perpetrators of the abuse, but also "the system" that allowed the abuse to occur. Policy responses often revolve around detection and punishment rather than focusing on developing and implementing interventions to improve conditions for children . . . . But such interventions are necessary in order to reduce and prevent child maltreatment.*[1428]

Preventive measures that will improve conditions for all children are especially critical for two reasons, argues Brownell in the paper she prepared at the Commission's request, *Children in Care and Child Maltreatment in Manitoba: What Does Research from the Manitoba Centre for Health Policy Tell Us, and Where do we Go from Here?* First, the number of children currently being taken into care throws into question the system's ability to provide high quality foster care on a sustainable basis. Second, it is likely that only a fraction of children who are subject to maltreatment ever come to the attention of the child welfare system.[1429]

A public health approach would involve preventive strategies at multiple levels, from upstream approaches such as social policies affecting all children and their families, to midstream, targeted approaches for families and children at risk, through to downstream approaches involving child protection in cases of severe maltreatment.[1430]

23.2 THE SHIFT TO EARLIER INTERVENTION

Throughout the Inquiry, I heard loud and clear that prevention is key to protecting children. Jan Sanderson, Deputy Minister of the Department of Children and Youth Opportunities, summed up the message delivered by so many witnesses:

> *Prevention is, in fact, the first step on a continuum of protection.*[1431]

For the reasons I have discussed, we need to look to a public health approach to prevention that will offer protection to all children and reduce the need to remove children from their homes by decreasing the risks that child maltreatment will occur or reoccur.

A useful analogy was provided by Brownell. Public health education uses this example of a treacherous highway where cars keeping driving off a cliff:

> *A downstream approach would suggest building a hospital at the bottom of the cliff to treat the victims; a midstream approach may involve erecting a sign on the highway to warn drivers about the upcoming cliff; whereas an upstream approach would change the environment (in this case the highway) so that drivers are no longer placed at risk (e.g., re-route the highway away from the cliff).*[1432]

All three approaches have their place, she says, but in the child welfare context there has been a disproportionate emphasis on child protection (the downstream approach) and not enough on prevention (the upstream approach).

Early interventions can be offered on a universal basis, or they can be targeted to particular populations. Universal services can cost more, but targeted programs cannot deliver large-scale benefits and often miss the very people who need them most.

23.3 UNIVERSALLY AVAILABLE INTERVENTIONS

Prime examples of universal supports that benefit all children are healthcare and public education. Public awareness campaigns are another.

Kerry McCuaig, Atkinson Fellow in Early Childhood Development with the Ontario Institute of Studies in Education at the University of Toronto, commented on the importance of providing universal supports to families:

> *If we want to change outcomes on a population level, then we need a universal approach to reaching all children with services . . . [aimed at] supporting the development of the child and that are linked to supporting parents in their roles as both parents and as, as earners. And what we have tended to do, particularly in the Anglo-American context is to identify vulnerable kids and target them for treatment. What we know is that when we do that, we miss all sorts of kids and that we don't see those big population change differences that we need to see . . . if we want to reach our social goals. So if our social goals are actually reducing vulnerability amongst children, helping all children to succeed to be the best that they can be . . . that can't happen by identifying and treating one child at a time. We have to catch children before they fall into a situation where they are made wards of the state.*[1433]

Brownell made a similar point, emphasizing that because child maltreatment is often unreported and unnoticed, only a universal approach can ensure that supports are provided to all who need them. She gave examples of universal interventions that are shown by research to reduce child abuse:

> *. . . extended parental leave programs, so parents have time to spend with their kids; ensuring that they have access to, to quality low-cost childcare and other early learning environments; and also, as I talked about, trying to reduce that gap between the rich and the poor because it's not just about those living in poverty but it's the differences between those living in poverty and those who are very, very wealthy. So reducing that gap.*[1434]

23.4 TARGETED INTERVENTIONS

While providing universal programs and services are essential to prevention, some prevention strategies do need to focus on particularly vulnerable populations. Examples include programs for youth with substance abuse issues, or for women who are at risk of a pregnancy affected by alcohol. These are sometimes described as secondary or "mid-stream" prevention.

A challenge in providing targeted interventions lies in tailoring services to the specific needs of the community being served, according to Santos.[1435] For example, it is important that Aboriginal people receive services developed and delivered by Aboriginal-led organizations, said Leslie Spillett, executive director of Ka Ni Kanichihk, an Aboriginal community-based organization. She testified that, in her view, this is most often not the case and she advocated for building capacity within Aboriginal-led organizations.[1436]

24 PREVENTION BASED ON CHILDREN'S RIGHTS

24.1 INTERNATIONAL RECOGNITION OF CHILDREN'S RIGHTS

An analysis based on internationally recognized children's rights provides another way of looking at prevention of harm to children.

The Universal Declaration of Human Rights, which Canada was instrumental in drafting, declares that childhood is entitled to special care and assistance.[1437]

The United Nations Convention on the Rights of the Child, ratified by Canada in 1991, recognizes that children have rights of their own, separate from parental rights. In the paper she prepared for the Commission, Wright references three key principles of the Convention:

- anti-discrimination guarantees (Article 2);
- the requirement that the best interests of the child must be a primary consideration in any action concerning that child, whether by public or private social welfare institutions, courts of law, or other bodies, (Article 3); and
- in matters affecting a child, the views of the child must be heard (Article 12).[1438]

Wright also points out the support for parents contained in Article 18.2 of the Convention which requires that, for the purpose of promoting children's rights, governments must assist parents and guardians in the performance of their child-rearing responsibilities and "ensure the development of institutions, facilities and services for the care of children."[1439]

The Convention can be seen as supporting a public health response to child welfare by providing a legal instrument for implementing policy, accountability, and social justice.[1440]

Brownell, in her paper and in her testimony, suggested using the Convention as a framework for preventing child maltreatment. She emphasized that our moral obligation as a nation to protect children now is also a legal obligation, by virtue of the Convention.[1441]

The Convention has influenced a shift towards seeing a children's rights agenda as "the firmest platform for developing public policy," according to the paper McCuaig prepared for the Commission.

Basing early childhood policy on children's rights fully recognizes children as human beings with capacities to communicate and contribute. While still a relatively new concept, this rights-based approach, she says, "challenges the deficit model of early interventions where children are identified by their problems and singled out for treatment. Instead, the focus is on children's assets. Parents are integrated into programs out of respect for the intimate knowledge they bring of their child. Communities are involved and celebrated for their values, traditions, and sustainability."[1442]

The Convention's protections for children and parents were also cited with approval by Blackstock. However, its principles have not yet been embedded in all legislation that touches on the lives of children and families, Blackstock said. She recommended that leaders at all levels of government, including provincial, federal, and First Nations, familiarize themselves with the Convention's principles and use them as a benchmark for evaluating any public policy that affects the well-being of children.[1443]

24.2 HEALTHY CHILD MANITOBA: A COLLABORATION STRATEGY

The Government of Manitoba has already recognized that no single government department or service can successfully promote the well-being of children and youth, nor can government be successful without community partnerships.

In the mid-1990s the government became interested in research being done in the area of child development, and responded to concerns about gaps in services for children and youth by establishing a Children and Youth Secretariat.[1444] Over time, the Healthy Child Manitoba Strategy evolved, eventually becoming law in *The Healthy Child Manitoba Act*.[1445] This is Manitoba's "long-term, cross-departmental prevention strategy for putting children and families first."[1446] This legislation is a positive step towards better protecting Manitoba children.

Responsibility for this *Act* rests with the Department of Children and Youth Opportunities. Sanderson said the Act aims to achieve the best outcomes for Manitoba's children, with a policy emphasis on early childhood development.[1447] According to s. 3(1) of the Act:

> *The Healthy Child Manitoba strategy is the government's prevention and early intervention strategy to achieve the best possible outcomes for Manitoba's children with respect to their*
>
> *a) physical and emotional health;*
>
> *b) safety and security;*
>
> *c) learning success; and*
>
> *d) social engagement and responsibility.*

The expectation of collaboration is clearly stated in the Act: government is to collaborate with community partners, governments, and others, with respect to research, policy and program development, implementation, and evaluation of the strategy.[1448]

Responsibility for the strategy and for making recommendations to cabinet, including financial priorities and resource allocation, rests with the Healthy Child Committee of Cabinet.[1449] That Committee is made up of ministers who are responsible for policies, programs, or services that directly impact the lives of children.[1450] At the time Sanderson testified, the Committee was chaired by the Minister of Children and Youth Opportunities and also included the Ministers of the following departments:

- Aboriginal and Northern Affairs
- Culture, Heritage and Tourism
- Education
- Family Services and Labour (now Family Services)
- Health
- Healthy Living, Seniors and Consumer Affairs
- Immigration and Multiculturalism
- Justice[1451]

The Healthy Child Manitoba Office supports the work of the Committee. Deputy Minister Sanderson is CEO. The Office has a staff of 35 and reports to government through the Department of Children and Youth Opportunities.[1452]

The *Act* provides for parent-child coalitions, which receive modest funding for local investment in early childhood. Sanderson used as an example the Central Region, which receives about $80,000 a year from Healthy Child Manitoba. The major sectors in the region—the health authority, school division, Aboriginal organizations, child welfare, parents, sometimes the faith community, and recreation—come together to decide how the funds will be spent. Often they choose to hire a coordinator to provide services through a family resources centre, such as a mom and tot program, lending libraries, or whatever the particular region needs. This is a powerful tool at the local level, Sanderson said, "and it gets those sectors talking to each other."[1453]

The *Act* also permits collection and linkage of data across sectors, enabling the research that Brownell, Santos, and others rely on to assess how Manitoba children are doing. The *Act* requires periodic public reporting on progress in child and youth development. The first such report, prepared in 2012, was submitted into evidence at the Inquiry.[1454]

The vision of Healthy Child Manitoba encompasses much more than just physical health, Sanderson said. Its intention is that:

> *To their fullest potentials kids will be physically and emotionally healthy, safe and secure, successful at learning and socially engaged and responsible.*[1455]

24.3 BUILDING ON THE HEALTHY CHILD MANITOBA STRATEGY

I find the evidence in favour of a rights based approach to child well-being compelling. *The Healthy Child Act* is a step in the right direction towards protecting the rights of children, but it is not sufficient in its current state. The Act provides for collaboration among government departments and between government and the community. It needs to go further to protect children's rights by providing a benchmark for evaluating any public policy, legislation, or program that affects the well-being of children.

A new model for promoting the well-being of children, based on internationally recognized rights, would focus not on parental deficits, but on providing adequate supports to children and families to ensure that all children can thrive and reach their potential.

Canada and Manitoba have long accepted education and health care as universal rights. This new approach would also recognize children's rights to quality care in the pre-school years and access to resources and services that will give them their best chance to succeed in life. At the core is respect for the dignity of the child and true recognition of children's best interests as paramount.

This new approach means tackling the root causes that put children at risk, before they come to harm. It means creating networks of government departments and programs, and harnessing the wisdom, capacity, and energy of communities, to provide a coordinated response to the needs shared by all children and families, as well as to the particular needs of vulnerable populations. It means building on the strengths of children and families and collaborating for better results.

An example of legislation that offers a rights-based approach to promoting children's well-being is Alberta's recently proclaimed *Children First Act.*[1456] This Act requires the creation of a "Children's Charter" to guide the Government of Alberta and its various departments in the development of policies, programs, and services affecting children. It is also intended to guide collaboration among departments and agencies, service providers, and all Albertans.

The Government of Alberta is now engaged in consultation with citizens about the content of the Charter. By virtue of s. 2(2) of the Act, it must recognize the following principles:

- that all children are to be treated with dignity and respect regardless of their circumstances;
- that a child's familial, cultural, social and religious heritage is to be recognized and respected;
- that the needs of children are a central focus in the design and delivery of programs and services affecting children;
- that prevention and early intervention are fundamental in addressing social challenges affecting children; and
- that while parents have primary responsibility for their children, individuals, families, communities, and governments have a shared responsibility for the well-being, safety, security, education and health of children.

I believe that Manitoba requires legislation similar to the *Children First Act*. *The Healthy Child Manitoba Act*, if amended, could meet that need. It would put the well-being of children at the forefront, not only of the child welfare system, but of all government departments and service providers. It would provide a collaborative platform upon which government departments and service providers could develop policies and programs to truly keep the best interests of children at the forefront of decision making and service delivery.

24.4 RECOMMENDATIONS

1. **Recommendation:** That the Province amend *The Healthy Child Manitoba Act* to reflect the rights entrenched in the United Nations Convention on the Rights of the Child, in a manner similar to Alberta's *Children First Act*, stipulating that the well-being of children is paramount in the provision of all government services affecting children.

   Reason: The well-being, safety, security, education, and health of children must be at the forefront, not just of the child welfare system, but throughout government. This statement of children's rights must be entrenched in legislation: *Healthy Child Manitoba Act* is the perfect home.

25 BUILDING COMMUNITY CAPACITY

There was no dispute among witnesses at the Inquiry that responsibility for protecting Manitoba children is one that is shared by all of us. Child welfare agencies alone cannot bear this burden. They must be supported by individuals, families, and communities.[1457]

In her testimony as a member of the Kookum Council, Schibler gave her view:

> *Everybody has to know that we are responsible, within our own families, within our own communities, to help one another and to know that we have a role, all of us, to keep those, those sacred children protected. That's everybody's responsibility.*[1458]

In Wright's paper for the Commission, she writes:

> *A community building approach recognizes that the welfare of children is the responsibility of the community in which the child resides or to which the child belongs and that child welfare services and the professionals who provide the services and implement policy cannot have the sole responsibility or authority for the protection of children.*[1459]

The witnesses in Phase Three testified about the importance of healthy communities. McKenzie spoke of community capacity building as developing the community's strengths so it can work collaboratively with child welfare and other institutions that are responsible for education and development of young people. He emphasized the importance of economic development that puts people to work, and noted the link between capacity building and self-determination. Communities need to be able to establish their own priorities, and manage their own services and resources.[1460]

Wright also underlined the long-term benefits of working towards "a community that is empowered to be able to make positive choices and develop programs or activities, . . . with that goal of providing the community the control and responsibility and authority for their children."[1461]

The Commission heard evidence about supports and programs already in place across Manitoba that strengthen families and communities. These include services provided by community-based organizations, government programs under the umbrella of Healthy Child Manitoba, and First Nations programs. Through all of these programs and supports runs the common thread of shared responsibility for the health and well-being of Manitoba children.

25.1 COMMUNITY-BASED ORGANIZATIONS

The Commission heard from a number of community-based organizations that serve families through early intervention programs and supports for children and their families. Some are universally available and some are targeted at particular needs.

I was informed in particular by a panel of executive directors from four community-based organizations: Dilly Knol, of Andrews Street Family Centre; Diane Roussin, of Ma Mawi Chi Itata; Sharon Taylor, of Wolseley Family Centre; and Bernice Cyr, of Native Women's Transition Centre. I also heard about services provided by three other community-based organizations: Ka Ni Kanichihk, Eagle Urban Transition Centre, and Manidoo Gi Miini Gonaan.

The panelists spoke about their common approach to community development. They talked about building relationships with members of their communities and responding directly and in a holistic way to the needs that their clients express to them. Those needs may be as basic as access to a telephone, or as complex as prevention of family violence.

These witnesses discussed the difficulties their communities face, including systemic discrimination, poverty, housing issues, addictions, and violence. They spoke of the challenges of working within a system that is focused on addressing deficits in individuals on an isolated, and often short-term, basis. They identified the need for sustained core funding of their agencies' work to allow for provision of long-term, holistic services. They also identified the need to have Aboriginal-led agencies serve the needs of an Aboriginal population.

Representatives of these organizations confirmed that they collaborate with each other to provide a continuum of services to their clients. That collaboration is facilitated by their participation in a coalition referred to as CLOUT—Community-Led Organizations United Together. But the four panelists were unanimous in saying that no one from government or from child welfare had consulted with them or their agencies about enhancing their capacity to respond to families that might be diverted to community organizations through child welfare's new differential response, family enhancement stream.

The rest of this chapter will discuss in greater detail the services provided by each of these agencies.

25.1.1 ANDREWS STREET FAMILY CENTRE

Andrews Street Family Centre serves families in Winnipeg's North End. It was here that Sinclair and Kematch completed an eight-week parenting program during the period of Phoenix's first apprehension, the Inquiry was told. Knol testified:

> *We have programs for all ages. We have an Aboriginal preschool program for 40 children in total, and also work with the parents of those children. We also have a Pritchard Place program, which is a program for after school and weekend and seven-day-a-week program for kids six to seventeen-year-old. It's a drop-in program that is mostly unstructured but we do have some structured programming there.*
>
> *We have a parenting helping parents program, which supports parents in the community with home visits. They help them at appointments. They basically support parents wherever parents need support. It could be helping them find some shoes, housing, those kind of things, whatever they need to do. They also run parenting programs all throughout the year . . . .* [1462]

Andrews Street Family Centre also offers an addictions support worker, food security programs, and a drop-in centre where community members can do laundry, have a snack and meet one another in a safe place.[1463] Parents attending the Centre can use the onsite drop-in children's program:

> *. . . we always have a children's program area also so if people are in parenting we have a place where their kids can be watched while families are coming for resources, so it's not a hindrance for them to get there.*[1464]

25.1.2 MA MAWI WI CHI ITATA CENTRE

Roussin testified about Ma Mawi's work to support and strengthen Aboriginal families in Winnipeg. In existence for 29 years, it is indigenous-led and the largest urban Aboriginal organization in Winnipeg.[1465] She summarized the broad range of services provided by Ma Mawi:

> *We deliver over 50 different programs and services and resources. We operate out of 11 different sites throughout the city. We do have one healing lodge out, out of town. We deliver youth leadership mentorship programs, we have three resource centres very similar to Wolseley and to Andrews Street. We have family violence programming, we recruit and train Aboriginal foster families to provide foster care for kids who are in care of CFS, both long term and short term foster families. We have five group homes and each group home has a different specialty and focus.*[1466]

The three family resource centres provide practical supports to families, including toast and coffee for drop-in visitors, access to laundry and internet, and a place to make community connections.[1467] The nature of these supports is based upon the needs identified by the families it serves. Roussin said:

> *Families will walk in and either they're already involved with CFS and so how can they -- they'll sometimes need some advocacy to keep their kids.*

Sometimes they will need to do things to get their kids back, and sometimes they're just struggling, you know, and so they can come to us and we can figure out what it is that's creating the stress, you know, before we get to that protection stage, right. So sometimes people just need help with how are they going to drag five kids around to do laundry, you know, or sometimes they just need transportation. Sometimes they need someone to just look after their kids so they can go grocery shopping. I mean, you know, sometimes parents just need a break. Like, I mean, there's all kinds of things that come up.

. . . . So again, you know, we try to -- whatever the family is coming in the door with, we try to respond to that as best as we can with the resources we have. We work, obviously, with our sister organizations as much as possible and we'll refer if we can. So we, we try not to turn anybody away as much as possible. If we don't have it, then we try to figure out who's got it and how can we get it.[1468]

Roussin spoke about the importance of building a foundation of trusting relationships:

At the core of all of our programs and services we're in the business of building relationships and, you know, in order to have a really good service under any banner you really have to have good trusting relationships with your families in order for the service to work, and so that's really important to us and we try really hard to, to do that and build that foundation.[1469]

Ma Mawi also administers a number of early childhood development programs, including Little Red Spirit, an Aboriginal head start program; and it coordinates parent-child centres in community schools.[1470]

25.1.3 WOLSELEY FAMILY PLACE

Wolseley Family Place supports families in the West Broadway area of Winnipeg. It offers a wide range of services, Taylor testified, including a preschool with spots allocated for respite, as well as:

. . . parenting classes . . . prenatal and postnatal classes. We have health services which involves having a doctor come once a week, and we have a health educator that will do various workshops on current issues that the families might be talking about, about immunization, various things, diabetes, whatever the families sort of express to us that they would need.[1471]

In addition to these services focused on early interventions for children and families, Wolseley Family Place meets basic needs by providing access to phones and computers, laundry services, a food bank, addictions and violence counseling, and assistance with EIA and housing. It also operates as a community drop-in centre.[1472]

Taylor described the approach taken by Wolseley Family Place to program development and delivery:

We try to do holistic services and we try to provide services according to what the families tell us what they need.

When I first started, it felt like a good feel place that you would just do a parenting class. As time went on, you realized that people's lives are very complex and then how do we be able to assist and work with them in many ways. And so we just keep expanding in areas, with a limited budget, to be able to provide whatever the families need.[1473]

She likened this approach to a harm reduction model, so that staff work with families "where they're at, and going along with them in the journey."[1474]

25.1.4 NATIVE WOMEN'S TRANSITION CENTRE

The Native Women's Transition Centre is Manitoba's only Aboriginal-led long-term transitional facility for Aboriginal women, Cyr said. It has served more than 20,000 women in its 34 years of operation. Its mandate is to support women who are escaping violence, and their needs are complex. Often they arrive with what Cyr termed the "holy trinity" of problems: addictions, and parenting and anger management issues. She expressed frustration that CFS sends mothers to the transition centre to be prepared for having their children returned to them, but then fails to follow up with them. "They often view us as addictions treatment, which we are not," she said, though the centre does support these mothers:

We recognize that women need supports prior to getting their children back and there needs to be good reunification plans and safety networks developed around them. Oftentimes women are set up for failure when they do receive their children back and services and supports are cut off. Oftentimes, because there's medically complex situations that they don't have resources elsewhere so CFS is one of their only resources. Because we, because we serve province-wide they may not be from an urban centre, they may be from a rural or remote community, so oftentimes there will be CFS involved because that's the only way they're going to get health services for their child.[1475]

The centre offers a variety of services including family violence prevention programs, gang prevention programs, and healing ceremonies. It works with a network of other women's resources to offer both short-term shelter and long-term placements. Women can stay with the centre for up to three years, she said. Operating from three sites with 25 employees, the centre has beds for up to 60 women. It receives funding from the Department of Family Services but also charges per diems to other systems using its services, such as Corrections (34 of its beds are mandated for women leaving Corrections), or child welfare. For example, there are children at the centre who are in care of CFS.

Cyr described a major shift in the centre's practices, from a "risk model" to a "safety model." Risk isolates people, she said. She explained that if the focus is on risk, "you arrest them, you apprehend their children." On the other hand, "if you build safety, it means you have to build a network around them," providing for better long-term outcomes.[1476]

Another shift is towards creating economic sustainability for families. She explained:

> *You can have communities or families surrounded with supports and services; if they cannot feed their children, if they cannot find work, if they cannot find a means of income, you're setting them up for failure. And so our goal, certainly, we're starting up the Violet Nelson classroom, we have a number of economic development initiatives for women that they can attend to, and one of the number one conditions for women exiting Corrections, even if they have children, is to work, and so we try to meet those, those conditions as well.*

25.1.5 KA NI KANICHIHK

Ka Ni Kanichihk is a community-based Aboriginal organization in existence since 2002. Executive Director Leslie Spillet described its wide range of community-building programs and projects, which are outlined in the organization's 2011-2012 annual report.[1477] Programs include a daycare for 16 infants and pre-schoolers, and an after-school program for Aboriginal girls aged 9 to 13 years, called the Butterflies Club. Spillet said:

> *The Butterflies Club is, is specifically for girls . . . they learn about their culture, they learn about bullying, they learn how to build, build the skills that they would -- that would make them more resilient to bullying, to racism, to the difficulties that they might, might have, and it also gives them the opportunity to, to do recreation, to have opportunities to go to -- like, for example, they go to the ballet once in a while, so that they engage in, in, in a range of activities. And the idea there is to, is to just build girls that . . . have a place of belonging, that they, that they, that they're empowered, that they feel that, that they have a place in this society.*[1478]

As a grassroots community organization, Ka Ni Kanichihk responds to the needs identified by its community as best it can. Spillet said:

> *It's natural that our community comes to us because we are there . . . we're known for our work. And then people come to us but we don't have a lot of structural support to be able to provide the services that they really deserve.*[1479]

But the needs of these communities extend well beyond what can be provided through parenting and other therapeutic supports, she said. The organization works with people who have nothing—they may not know where they are going to sleep at night, or they may be living in social housing with bedbugs. So even if they can access counseling services, for example, "you can't do therapy on bedbugs to leave the house," she said. These people "need resources."[1480]

She also said that what is needed now is building leadership and indigenous-led organizations to serve indigenous people: "We know what we need." [1481]

25.1.6 EAGLE URBAN TRANSITION CENTRE

Distasio told the Commission about the study he did almost 10 years ago of the experiences of Aboriginal people moving into Winnipeg and adjusting to city living. He described how hard it was for people to get access to the services they needed:[1482]

> *If you live in a small community or on reserve and you've got a centralized approach to your service supports and network, and then you're thrust into a city of 700,000 where, you know, you have to go to Broadway for one type of support, you've got to go here for another, and you've got to go across town, you've got to go onto third floor, fifth floor, and you're running around, the complexity was overwhelming for people.*

What people needed, he found, was a "one-stop shop" to connect them to the complex network of services they needed to succeed in their new life in the city. The Eagle Urban Transition Centre was developed by the AMC in response to that research. It became a single access point for a mobile Aboriginal population.[1483]

Program manager Jason Whitford testified to a drastic increase in use of the Centre's services. In the last year, there were 6,900 client contacts, including young mothers and youth involved in the child welfare system. They sought help with a wide range of challenges including poverty, addictions, housing, mental health issues, literacy, and education. Some were arriving in Winnipeg for the first time, but some have been in the city for 10 years and are still struggling to be self-sufficient, "to get a roof over their head," and to find a job. Some clients will come into the Centre for up to a year, he said, because it can take them that long to get into training, or deal with their addictions, or find a place to stay. [1484]

Whitford said that it would be helpful to have the resources to provide transition support for families before they leave their First Nations communities to help them learn to navigate the city. But jurisdictional funding issues mean there is a gap between services provided on reserve and those provided in urban centres.[1485]

Transition services for Aboriginal people, Whitford said, could pay the same dividends that governments have seen from their investment in settlement programs for immigrants to Canada:

> *Immigrants are obtaining employment, they're getting educated, their children are healthy, they're well, they're, they're healthy and like if a similar kind of an investment and a similar approach was taken for First Nations people and look at the, the benefits, I think that would be, that would be tremendous.* [1486]

He also spoke about discrimination and the "culture shock" Aboriginal people experience on transitioning to urban life:

> *The discrimination is an added, an added challenge . . . . Applying for a job, going to school, walking in a mall, walking down the street. Like security will, will target an Aboriginal person, they'll follow, they'll follow an*

Aboriginal person through the mall because of the stereotype attached to that.[1487]

He told of a client who came into the Centre because he had seen a woman on the street look at him and clutch her purse as he approached her, and "he needed somebody to talk to about that because that hurt him."

On the employment front, Whitford spoke of the limitations on the Centre's capacity to work with employers on hiring programs. There has been short-term funding in the past that supported an agreement with the Canadian Manufacturers Association through which several manufacturing businesses had committed to hiring Aboriginal employees, but that funding came to an end. The business community has shown a willingness to offer jobs to young Aboriginal workers, he said, but the Centre needs the resources to make it happen.[1488]

He described a program run by the Centre for Aboriginal youth who are out of school and unemployed. Called "The Eagle's Nest," it's an all-day, three-month-long program for 25 youth at a time. It promotes pride in their identity by teaching about colonization, treaties, and traditional ceremonies, and it offers training in practical skills. Whitford said there has been an overwhelming response and the program has a long waiting list. All participation is voluntary, he said, but 30% of participants are referrals from child and family service agencies and 30% come from probation or the justice system. The remainder come from other organizations or word-of-mouth.[1489]

The Eagles Nest curriculum is based on the medicine wheel philosophy. It includes life skills, first aid, suicide prevention, driver's education, and literacy skills and offers one-on-one counseling as well. An elder is available one day a week to teach about traditional practices and values and Whitford said that the youth are eager to learn. When asked why they choose to come to Eagles Nest, participants typically give one of three responses, Whitford said:

I'm tired of, of doing nothing with my life. That's one response. And the second response is I'm here because I want to get a job and the Eagle's Nest will . . . help me become more employable. And the third response is I want to learn who I am. I want to learn my Aboriginal identity and I know the Eagle's Nest provides that. [1490]

Although the Eagle's Nest Program lasts only 14 weeks, the connection it makes with youths can be lifelong, Whitford said.

The greatest need for the Transition Centre services and the Eagle's Nest program is in Winnipeg, he said, but he is often asked why these can't be available in Brandon, and Thompson, and other urban areas. He also sees a need for four or five Centres in other areas of Winnipeg itself.[1491]

25.1.7 MANIDOO GI MIINI GONAAN

Manidoo Gi Miini Gonaan operates three childcare programs in Winnipeg's Lord Selkirk community. Childcare allows parents to find work or finish high school, deal with family crises, or take treatment they may need, executive director Carolyn Young said.[1492] But Manidoo offers more than just childcare. Young testified about the importance of providing a range of supports to the whole family, including food, employment counseling, and addictions services.

Manidoo began in 1991 with an infant centre for use by young parents attending R.B. Russell High School so they could complete their high school education. Still operating, the infant centre is funded by the Province and demand always exceeds the 16 spots available.[1493]

Lord Selkirk Park Childcare Centre is a relatively new facility for 47 children from infancy to 12 years of age who live in the Lord Selkirk Park housing units. Young described this as a complex community with a high crime rate, where the majority of families are on social assistance and most are Aboriginal. The Centre's program was developed in consultation with Healthy Child Manitoba, which funds the program as a pilot project to test a curriculum known as the Abecedarian approach. The curriculum aims to meet the early education needs of children living in poverty. Higher-than-average staff-to-child ratios allow for more adult-child interactions, and children are given healthy snacks and a hot lunch. Importantly, a home visitor works closely with the 19 families whose children attend the Centre. Many of these families are involved with the child welfare system. The outreach worker sees parents every day when they drop off and pick up their children, and she schedules time to meet with them at least weekly, and more often if needed. "Her role is to help them navigate through their crises," Young said. She helps them problem-solve; she advocates for them and accompanies them to appointments with Child and Family Services, or lawyers. "She has a close relationship with them," she said.[1494]

I note the contrast between this evidence and the evidence I heard in Phases One and Two, from workers who said that they had difficulty connecting with families because of trust issues or workload demands. This reinforces the fact that community-based organizations, who often can have much more frequent contact, play a significant role in protecting children and supporting their families.

Research has shown that for children living in extreme poverty, the Abecedarian approach in the early years can yield benefits that last throughout a child's school career, Young said:

> *"The evidence has shown that there were lower teen pregnancies. There was high school completion, was at a high rate . . .. They didn't engage in criminal activity as much as those that hadn't been part of the approach. And it's just a general wellbeing of a family or for the participants and their families to, to be successful in life.*[1495]

Preliminary results of the pilot project indicate that the children in the Abecedarian group at Lord Selkirk Park are doing significantly better than the control group. Young also reports anecdotal evidence of improvement: [1496]

> *We see children that are engaged with adults. We see children that are reaching their milestones on target, which is something that we have never seen before in Lord Selkirk Park . . . .The feedback is really positive. The families, they're just in awe and amazed at what's happening because they're comparing a lot of the children that are in our program to their older children that have never seen it . . . They're thriving and, yeah, it's quite an amazing thing to see.*[1497]

The success of the Lord Selkirk Park program is due to the strong relationships that have been built with families and the community, Young said. She would like to see the program expanded to benefit more children.[1498]

The childcare centre operates out of the first floor of the housing complex's high-rise tower. At the same location, Manidoo operates a family resource centre that serves as a drop-in centre, often for those who aren't yet ready for a program of any kind. "It's sort of a stepping stone," she said.[1499] The centre operates with three staff:

> *We have a family support worker who provides any kind of assistance as all three of our staff do, and then one of our staff also does outreach. So outreach is a huge component of the success of our organization, we do it regularly. And building relationships with the community is a, is a big part and it's very community led. The services and the programs that we provide in the resource centre are led by what the community is saying that they would like to see. Some things we can help with and some things are sort of out of our scope, but we continue to work on it. If we can't meet the needs of the issues that they're coming to us with, we will refer them to other agencies, work with other agencies.*[1500]

Manidoo's approach to developing resources is based on identified strengths within the community. Young said:

> *We work on an asset based, strength based model. There are a lot of assets in the community . . . they know that their voice will be heard through, through the services that we provide through the resource centre and the relationship that we have. It's taken a long time to build that trust but they know that when they have a need or an opinion or a recommendation, that we will hear it and try to actualize it and that's what I see my role as. I listen to what their needs are and I try to remove any barriers and then help them actualize it.*[1501]

25.2 HOW COMMUNITY-BASED ORGANIZATIONS SUCCEED

25.2.1 BUILDING TRUST TO SERVE FAMILIES

Some common threads run through the work of each of the organizations mentioned above. Their approach to serving and supporting families is holistic—they look at the whole family and all of its needs; they are community-led; and they focus on meeting the needs identified by those seeking their help.

All of the community leaders I heard from emphasized the need to establish relationships between their organizations and the communities they serve. Some of the strategies they use to build trust with members of the community are: declining the authority to apprehend children; recruiting staff and volunteers from within their own communities; and focusing on relationship building. I will comment on each of them.

25.2.2 DECLINING THE AUTHORITY TO APPREHEND CHILDREN

At the time of its formation, Ma Mawi chose not to take on the full mandate of a child welfare agency, which would have included the authority to apprehend children. Roussin said:

> *In order to build very trusting relationships with families you can't have the power to take away their kids, and that was the thinking back then and that's the thinking today. . . . And so that conversation does come up every now and then and we're still firm, you know, we don't want the legal -- we don't want the power to take away kids, we want to work with the families in supportive preventative way.* [1502]

25.2.3 FINDING STAFF AND VOLUNTEERS IN THE COMMUNITY

Clients can more readily trust an organization when they are receiving services from someone within their own community who has similar life experience.[1503] A number of witnesses testified that Aboriginal staff members, counselors, and elders can offer positive role models to clients, and create a welcoming environment.[1504]

Relationships are strengthened when an organization recruits its volunteers from its own community, and even from among its clients. Roussin said:

> *There is such a large job to do out there that we need to really rely on the community to get that job done. So it's a reciprocal kind of relationship in that, you know, there's some things we can do but there's a lot more that the community can do. And s that's really what grounds our service philosophy . . . . People need help; the services are there for them to access some of that help. But every one of our services also needs to have the other side of it where . . . if people want to participate in a different way, not from the deficits model but from a strengths model, that we provide that opportunity as well. . . .We have such a large volunteer base, because people want to participate and give, more than they want to receive . . ..*[1505]

Winnipeg Harvest also relies heavily upon volunteers, many of whom are current or former clients of the food bank, Hart said, and she is one of them. She said that the food bank offers "hope that has touched countless people and explains why so many of our current and former recipients are fiercely loyal volunteers and that's, you know, where I fit in as well."[1506]

25.2.4 RELATIONSHIP BUILDING

Relationships begin with looking for strengths and building on those. Knol said:

> *We know that building the relationship and the trust is how people will talk to you. And we go on strength base, so we look at what they do well and make them feel better and then they start working on the places where they're lacking resources, and then they'll look for those tools.*[1507]

The importance of relationship building was also reviewed in the evidence of Wanda Phillips-Beck. She is a nurse program advisor who testified about a First Nations-based program called Strengthening Families, which is administered by the Assembly of Manitoba Chiefs and funded through the federal Maternal Child Health Program. She testified about this home visiting program that supports families from the prenatal period through age six. [1508] If a referral to child welfare becomes necessary, in the course of providing services through the home visiting program, that can be done in a way that preserves the trust relationship that has been established between the home visitor and the family, she said.[1509]

Phillips-Beck also said:

> *It's not just about that relationship with that home visitor, but it's also about building relationships with other available supports and linking them up to other services that could be available in that community.* [1510]

The ability of community-based organizations to build trusting relationships with the families they support is invaluable in the protection of children in the broadest sense.

25.3 COMMUNITY ORGANIZATIONS WORKING WITH THE CHILD WELFARE SYSTEM

Through the new differential response approach, it is to be hoped that child welfare workers will be able to develop closer relationships with the families they serve. I recall the words of worker Forrest who wrote that Sinclair and Kematch had such distrust of the child welfare system that "they would do anything, or nothing, to keep the agency at bay."[1511] By contrast, the example of the Boys and Girls Club's relationship with the couple illustrates what can be achieved when an organization strives to meet the needs of its clients, understand their life circumstances, and has the opportunity to spend time with them.

In Phase One of the Inquiry the Commission heard from Boys and Girls Club supervisor Nikki Humenchuk about the services this organization provided at its Aberdeen drop-in centre where Sinclair and Kematch attended before Phoenix was

born. Her evidence illustrates how such organizations build relationships with their clients by meeting their real needs.

Sinclair and Kematch were dropping in several times a week before Phoenix was born and had formed a bond with Humenchuk. When Phoenix was born and they learned she would be apprehended, they turned to Humenchuk for advice and support because, as Sinclair said, "she was already in our lives."

Humenchuk had more opportunities than did any agency social worker to observe the two as individuals and as a couple, and to assess their capacities and limitations. She was one of the few professionals involved with the couple who were able to testify about them from memory.

Humenchuk testified about the nature of her involvement with the young couple before and after Phoenix's birth. She had transported them home from a medical appointment. She had facilitated Sinclair's participation in a discussion group for young people who had been in care. She visited them and their baby at the hospital and contacted CFS for them. She took them to their first visit with Phoenix at the CFS offices, and attended their meeting with the supervisor who was taking over the file. At the couple's invitation, she joined them for subsequent visits with Phoenix, and also for meetings with CFS. Sinclair and Kematch didn't have a telephone at the time, so CFS arranged to contact them through the Boys and Girls Club, where Kematch and Sinclair were attending daily to participate in a summer employment program. Humenchuk was contacted by the agency about setting up a psychiatric assessment for Kematch and tried, unsuccessfully, to find a female psychiatrist for Kematch. After Phoenix was returned to them, Sinclair and Kematch continued to visit the club, though less frequently, and Humenchuk had the opportunity to see them as a family. Eventually, they shared with her that they were expecting another baby (a fact that was unknown to CFS), and later Humenchuk saw them at the club with both their children. Then she saw them on occasion during the volatile period of their separation. After the death of new baby, Kematch turned to the club for support.

Humenchuk testified that she saw the role of an organization like the Boys and Girls Club as offering young people a safe place to be, with recreational and learning opportunities, and adult role models they could trust. She felt that Sinclair and Kematch were able to share personal information with her because the club was a non-threatening environment for them. It also must be said that she spent time with them.

The involvement of that club, and Humenchuk in particular, with these young parents is commendable. Their services likely contributed to protecting Phoenix's life, health, and emotional well-being for a time. *The Child and Family Services Act* recognizes that the protection of children by an agency includes the promotion of the family's capacity to care for its children. The *Act* also recognizes that every agency has the duty to "work with other human service systems to resolve problems in the social and community environment likely to place children and

families at risk."[1512] The services offered by community-based organizations, such as the Boys and Girls Club and Andrews Street Centre, were and are critically important to the fulfillment of this obligation.

Immediately after Phoenix's birth, one CFS worker was ready to involve Humenchuk in the plan to reunite the family, but workers changed and full advantage was never taken of the relationships that had been built between this couple and Humenchuk and her organization. There is limited evidence that the agency made any attempts to work with the Boys and Girls Club, or any of the community-based organizations with which the couple was involved.

Communication and collaboration between the agency and these organizations might have led to enrolment in a daycare program for Phoenix, with opportunities for learning and for nurturing by other adults and enhancing her visibility in the community. At the same time, Sinclair could have been supported in his wish to find employment. Steady work could have helped him towards a more stable lifestyle, so that he could have been the father to Phoenix that he wanted to be. These were missed opportunities to make a substantial difference in Phoenix's life.

Collaboration with community-based organizations that are trusted by families will be essential if the child welfare system is to ensure that families receive the supports they need, under a differential response approach to prevention. An example of efforts to promote such a collaboration came from Young, of Manidoo:

> *We're trying to educate Child and Family into participating with us, to help, like to help us to be part of the intervention when children are apprehended. We have had some children apprehended and we, we try to work with the social workers to help them to return to the centre so that they're receiving the treatment and come up with a plan.*[1513]

25.4 CHALLENGES FACING COMMUNITY-BASED ORGANIZATIONS

25.4.1 CONFIDENTIALITY

One of the challenges to collaborative relationships will be around confidentiality and information-sharing. At Manidoo, staff take care to be open with the families they work with, and always let parents know when the organization needs to share information with child welfare, Young testified. They also provide a support worker who has the trust of the parents, to attend meetings with the family and help them understand the information coming from the agency. Young said:

> *So if they have issues with CFS, often our home visitor or our staff from the resource centre will accompany them to some of these visits and help navigate everything that is being discussed. Often our families will come out of meetings and they have no idea what has occurred or it's just too overwhelming or they're in crisis and they don't hear everything. So we always have somebody to support them and attend those meetings with them and then decipher the information afterwards. And we're very open about if we need to share any information with the social worker, for example, we'll*

share it with the family as well so that we always have that trust, we're not doing anything behind their back.[1514]

25.4.2 COORDINATION

McKenzie sees the need to strengthen capacity not only of the formal child welfare agencies, but also the community-based sector, and to coordinate services from both, to provide better services to families. Agency social workers have a dual role, he said: they provide important direct services to the families in their caseload and they co-ordinate other services that may be provided by other government departments or by community-based organizations. What is important, he said, "is that we have to find a better mechanism to coordinate those services, and that needs to be thought about carefully because I don't think that kind of coordination is fully in place in our current system."[1515]

The critical need for a coordinated approach was also identified by MacKinnon. This has been accomplished in other places through the use of a "backbone organization" to serve an administrative function. She explained:

> *The way it's been done in other places that have had some success . . . they identify what they call a backbone organization. That is identified and resourced, again, it's being resourced—it can't be something that already exists—that's resourced to do that coordination, to bring people, organizations regularly to the table. Because the reality is, if you don't have that, it's not going to happen, because everybody's busy. They're all doing, you know, what they do. So unless you have an organization that's resourced and tasked with bringing everybody together, it's not going to happen. So you do have to invest resources into something like that as well.*[1516]

25.4.3 FUNDING

Community-based organizations face a common challenge in securing the resources needed to offer their services on an ongoing basis. Witnesses testified that a lack of operational, or core, funding leaves them vulnerable and unable to sustain a stable employee base. They cited inter-jurisdictional issues, and the need to shift funding towards Aboriginal-led organizations. "Organizations shouldn't have to struggle," Spillet said. "They should be given the supports to do the job that they're being tasked to do."[1517]

Eagle Urban's Whitford described himself as "a boardroom panhandler," pleading with government or corporate boards. "It's been tiresome," he said, and a challenge.[1518]

25.5 RECOMMENDATIONS

1. **Recommendation:** That the capacity of community-based organizations be enhanced by provision of sustained long-term funding to allow for delivery of holistic services, with particular emphasis on support for Aboriginal-led organizations and programs that promote cultural identity within Aboriginal communities.

Reason: The evidence was clear that community-based organizations are effective in providing prevention services, both before and after involvement with the child welfare system. These organizations need consistent and sustained long-term funding to effectively plan for the delivery of those services.

2. **Recommendation:** That a legislated committee, functioning under the provisions of *The Healthy Child Manitoba Act* (in its present or amended form) be charged with:

   a) coordinating the services provided for children and families, between community-based organizations and government departments; and

   b) allocating government funding to those community-based organizations, following meaningful and inclusive consultation. It is understood that funding from the private sector and other levels of government will continue to play an important role, as it has done, in supporting these organizations;

   and that the composition of this committee mirror the committee described by s. 21(3) of *The Healthy Child Manitoba Act*, which reflects Manitoba's various regions and cultural diversity and includes representatives of the community and recognized experts.

   Reason: Having recognized the role that these organizations can play in supporting families and protecting children, it is important that a formalized process be put in place to ensure that services are provided and accessible in a coordinated and fiscally responsible manner.

3. **Recommendation:** That child welfare agencies accommodate reasonable requests by parents or other caregivers and children and youth for participation of an individual they identify as a support in their dealings with the child welfare system.

   Reason: Community-based organizations and others can play an important role in supporting children and families in their interactions with the child welfare system. Their involvement can contribute to the building of more trusting relationships between agency workers and families.

4. **Recommendation:** That child welfare agencies meet regularly with community-based organizations that serve their clients, to discuss how they can best work together to meet the community's needs.

   Reason: Effective collaboration between child welfare agencies and community-based organizations who serve the same families is imperative to avoid gaps in provision of services. The agencies and community-based organizations need to be aware of the services each offers to work towards their common goal of supporting families and children.

26 IMPORTANCE OF EARLY CHILDHOOD INTERVENTION

26.1 THE BEST INVESTMENT IS MADE EARLY

As I have heard throughout this Inquiry, and particularly in Phase Three, early intervention offers the most effective means of protecting vulnerable children. This chapter considers the evidence heard about early childhood as a period of both opportunity and vulnerability, and how investment in early childhood development education and care (early childhood development programs) can better protect Manitoba children.

Considerable evidence points to early childhood as the best time to intervene to reduce the risks of poor outcomes for youth. Brownell explained:

> *You're more likely to have better outcomes if you implement interventions much earlier in a child's life. Kids are much more malleable at that point. Brain development is still going on, social development, all these things, and it's much easier to, I think, circumvent these problems if you put your interventions or supports early on rather than waiting till the problems show up.*[1519]

The benefits of early intervention were the focus of much of the testimony of Santos. He testified that:

> *The lifelong benefits, not just to children but to all of society, in terms of lifelong health, lifelong educational attainment, investment in children is, is fundamental to developing communities. It happens to be the most effective approach to crime prevention in the literature. It's the foundations of economic productivity and prosperity because of the nature of, of the modern economy depends heavily on the knowledge and skills of, of people, of human beings and so human capital development is the economic angle to early childhood development.*[1520]

26.2 HUMAN BRAIN DEVELOPMENT

The most active time of brain development in a person's lifetime is in the early years. A brain scan of a child's brain shows that it is twice as active as an adult's, Santos said. He explained why this matters:

> *That's important because that rapid pace of development is both an opportunity and a period of vulnerability in terms of what experiences and environments we make available to young children in the early years.*[1521]

Young brains are affected by their environment and by stressful events, "experiences building the architecture of the brain," he said. If stress is ongoing, as in an abusive or neglectful home, the child's stress response remains activated, overloading the brain and weakening neural connections that should be building up. He referred to this as "toxic stress."[1522]

Children under the age of 5, like Phoenix, are the most vulnerable to the effects of neglect and toxic stress. McCuaig testified that:

> *What we know is that it's those years before, from conception to five, is when the brain is the most plastic. That is really when, when our neuro-roots are being set down and that becomes our foundation for who you and I are.*[1523]

One in every four babies born in Manitoba each year is born into an environment of toxic stress, Santos testified, with that being defined as three or more risk factors operating at the time of birth. Poverty is one of those risk factors. Two out of three Aboriginal babies born off reserve in Manitoba each year, or about 2,000 babies, are born into toxic stress. The prevalence on many reserves is higher he said.

These effects carry through as a child ages. When children are tested for school readiness at age five, results show that about one in four of all kindergarten children are vulnerable when they start school. Among Aboriginal children tested, the ratio is two in every four. [1524] Looking at particular risk factors, or stressors, Santos testified:

> *The toxic stressors faced by our Aboriginal newborns are largely socio-economic. The top one is poverty, financial difficulties, and then things associated with that like mom not completing high school.*[1525]

Fortunately, early trajectories for children are not fixed. McCuaig testified:

> *In terms of changing trajectories for children in learning and social and emotional challenges, it's not that you can't do anything after, after children reach school age. In fact we have huge special education budgets to show the efforts that schools are putting in to changing outcomes for these, for these kids. But if you want to intervene where it's most effective, least damaging for the child, least problematic for the, for the family, intervening in the earliest years is the most effective.*[1526]

One finding of the EDI study that seems to have broad-based support is that the three factors that put children most at risk for poor academic and social outcomes are:[1527]

- teen mothers;
- families living on income assistance; and
- contact with the child welfare system.[1528]

I note that all three of these were factors in Phoenix's life.

26.3 SUPPORTING ALL CHILDREN TO REACH THE MOST VULNERABLE

One of the most valuable resources the Commission turned to for assistance in its work was Kerry McCuaig. Her work focuses on transferring knowledge gained from extensive research in the areas of early childhood development, education, and care, into public policy. She advises eight foundations whose main focus is early childhood, and five provinces regarding their early childhood policy. Her expertise

is informed by research in Canada and around the world. The principal recommendation made in her paper is:

> *Implement strategies that support integrated early childhood service delivery from prenatal through the school system at the policy, governance and delivery level.*[1529]

In support of that recommendation, she writes:

> *Families with young children need public, non-stigmatizing spaces within their neighbourhoods to call their own. Rather than a place separating children from the world, schools as community learning centres celebrate children, giving them a sense of grounded identity from birth. This promotes social cohesion and breaks down the isolation, which is a breeding ground for neglect, abuse and violence.*

She emphasized to the Commission the advantages of a universal approach to early childhood education. The key recommendation of a 2011 study, *Early Years Study 3*, of which McCuaig was a co-author along with Margaret McCain and the late Dr. Fraser Mustard, was that all children from the age of two should have access to good quality early childhood education.[1530] This study updates the social, scientific, and economic rationales for public investments in early childhood and advocates for publicly-funded early childhood education for every child in Canada. Santos also supports a proposal for a universal early childhood program.[1531]

The tendency in Canada has been to identify vulnerable children and target them for treatment, McCuaig testified. As a result, the system misses many other children and fails to achieve effective change at the larger population level.[1532] This message explains the significance of the title of the report she prepared at the Commission's request: *Supporting All Children to Reach the Most Vulnerable*.[1533]

In that report, she states:

> *The research is unambiguous – high quality early education is advantageous for all children as it delivers benefits for society. For children living in disadvantaged circumstances, quality early education can inoculate against adversity and is capable of changing life outcomes. Yet this most influential period of human development is also the most neglected by public policy . . . there is no systematic intersection between public programs and preschool-aged children. Programs exist, but they are poorly resourced and lack coherent delivery and oversight.*[1534]

She goes on to discuss the transformative influence of quality early education programs:

> *The most important influence on human development is the family. The best outcomes are found for children born to nurturing parents with the means to support them. Children's health, their parents' – particularly the mother's – educational attainment and the family's socioeconomic status are the primary influencers. The most significant non-family variables are participation in quality preschool education and the quality of primary*

education. Of these two variables, the effects of preschool are most enduring. Quality early education appears to compensate for poor primary education.[1535]

Preschool education takes many forms, McCuaig said, including kindergarten, childcare programs, and nursery school. Its main characteristic is that it offers a place where children regularly attend with other children, where they learn from one another, and where they are taught by trained educators who follow a prescribed curriculum. The longer children attend such programs, the greater the advantage they experience.[1536]

Another important characteristic of early childhood education is the involvement of parents, she said. Parents need to be seen not as "the product of their deficits, which you rescue kids from for the time they spend in programs," but rather as partners in their children's early learning.[1537] In this way, quality early childhood education programs not only benefit children directly, but by involving and educating the parents, they have the potential to improve parenting skills for the long-term.

McCuaig's evidence supports that of Santos and Brownell and others in concluding that the preschool years offer the most significant opportunity to influence children's capacity to learn throughout their lifetime. Quality preschool experiences for children can be a "life changer," she said, particularly for children from disadvantaged families.[1538]

A universal approach to early childhood education is consistent with a children's rights agenda, according to her report. She reasons that, while poverty does increase children's chances of delayed development, it is not the only factor. In fact, vulnerabilities also exist within middle and upper income households, where the majority of children reside. Poor children do face a string of disadvantages that middle class children may not encounter, but the learning gap between children from middle income families and those born to affluent families is just as big as the gap that separates middle and lower income groups, she reports.[1539]

Ultimately, quality early childhood education results in cost savings to the entire community by preventing mental health problems, problems with the criminal justice system, and poverty. [1540] But these benefits can be realized only if there is participation by a critical mass. Targeted approaches will never reach enough children to produce these effects. Also, smaller programs targeted at particular at-risk groups are inevitably under-funded and vulnerable to shifting political priorities, she reports.[1541]

More will be said about the economic benefits of such programs shortly.

26.4 THE CHALLENGE OF LEADERSHIP

Lack of leadership is the main challenge to developing a cohesive early childhood system, said McCuaig. She acknowledged the excellent programs for Manitoba children, many of which are delivered through Healthy Child Manitoba, often in partnership with community-based organizations. But as in other jurisdictions, what happens in Manitoba is: "everybody involved and nobody in charge."[1542]

Many programs aim to support families and children, but differing mandates, funding, and legislative frameworks lead to discontinuity in services and confusion for parents looking for the range of services they need, whether prenatal care, places to meet other parents, or childcare to enable them to return to work. The result is that even when services are available and parents have the appropriate referrals, participation rates are low, because parents can't easily navigate the various service locations and schedules.[1543]

Lack of leadership and a cohesive legislative framework are also acutely felt by community-based organizations, who are given responsibility for providing services to children and families but not the powers or resources they need to be effective. Neither do they control the legislation and funding to create a coherent and comprehensive early childhood system.[1544]

This disorganized "system" is contrasted with what is available once children reach school age. Every community has a school that all children attend, but before school age, "where do kids go?" she asked.[1545]

The solution, McCuaig said, is to merge responsibility for education, early childhood, and family supports under one lead government ministry. This trend is being seen both internationally and in other jurisdictions in Canada, including Saskatchewan, Ontario, Prince Edward Island, and New Brunswick. Ms. McCuaig testified that these jurisdictions are moving early childhood programs from a "service patchwork into something coherent." She described it as a vision that is captured in a policy framework, with legislation and funding to back it up.[1546]

As an example, she discussed the recent implementation in PEI of a legislative framework that integrates responsibility for early childhood programs with the public education system. The initiative was led by the Premier and involved consultation with school boards, teachers unions, operators of early childhood centres, and the community.[1547]

In Manitoba, responsibility for early learning and childcare programming is housed under the Department of Family Services, while the education system is housed separately under the Department of Education.

26.5 INTEGRATED CENTRES FOR EARLY CHILDHOOD PROGRAMS

Establishing integrated service delivery centres to meet the continuum of needs that families face is the major recommendation of McCuaig's report. These centres, she says, will expand opportunities for children and families and create places of social cohesion in the neighbourhood. [1548]

This recommendation follows from the main recommendation from the Early Years Study 3 for better use of schools to provide a complete range of programming for families. Schools are an underutilized public asset taking up about a third of provincial funding yet operating only from 9 to 5, for 10 months of the year. Schools are located in every neighbourhood and can be the centre of their communities. Transforming schools into community centres can bring families into the school community earlier, thereby increasing visibility of preschool-aged children, McCuaig said.[1549]

I heard ample evidence throughout the Inquiry that this period from birth until children enter the public school system is a period of particular vulnerability because they often are unseen in the community. McCuaig's recommendation, therefore, responds directly to the facts that led to this Inquiry. If Phoenix had been connected to an early childhood program, whether preschool or daycare, from the time of her birth, she would have been much more visible to others outside of her family. That visibility could have led to better protection for her safety and well-being.

Integrated early childhood centres have been shown to reduce the need to remove children from their homes, McCuaig testified, because daily attendance at the centre allows for regular monitoring of children and also offers opportunity for parents to participate in intervention programs.[1550]

Further, integrated centres can function to neutralize the conditions that make families vulnerable and put children at risk of abuse or neglect. They offer parents respite from the difficult job of parenting, and give them the opportunity to address their own issues of unemployment or addictions; they also combat isolation by giving parents the opportunity to connect with others and to make friends.[1551]

An important feature of the recommended early childhood programs, McCuaig said, is that they would be voluntary. She recognized the public sensitivity to requiring parents to place young children in programming. But she predicts a high take-up rate if programs are not seen to be stigmatizing. Kindergarten, for example, is such a universally available and non-stigmatizing program that it is attended by 98% of children, even though attendance is voluntary. Outreach would be important, she said, to ensure that parents who might be reluctant are encouraged to bring their children. Once integrated centres are available and have a presence in a community—as they do in Montreal, for example—they become known by everyone, much as neighborhood schools are, she said. [1552]

Another benefit of delivering a variety of services from a single platform is enhanced communication across sectors. A common theme throughout this Inquiry has been that communication amongst service providers, whether government or community-based, leaves much to be desired. Ineffective communication leaves children at risk, as the facts of Phoenix's life bear tragic reminder. Although Phoenix and her parents had contact with a variety of community-based and government service providers, including Public Health, and Employment and Income Assistance, none of these programs effectively communicated with each other, or with the child welfare system, to support Phoenix and her family.

Delivering a variety of services from a single site is an effective way to reach families. For example, providing the services of a pediatrician on site at the school where families already gather is more effective and efficient than requiring families to visit their doctor at another location.[1553]

McCuaig's evidence is consistent with the evidence I heard in Phase One from Angeline Ramkissoon, the principal of the school where Phoenix was registered for preschool. During her tenure at Wellington School, a variety of programs and services were provided from within the school, including preschool and early literacy programs for children, as well as a family resource centre offering courses for parents in computers, resume writing, parenting, and cooking. Also, a community worker was available to help parents plan and coordinate medical appointments for themselves and their children. The school also operated a limited food and clothing depot, as well as a book and toy library for families.[1554]

Ramkissoon testified that she had to seek funding for these programs from a variety of sources, both inside and outside government. Sometimes she had to discontinue programs because of a lack of resources.[1555]

She told of the practical benefit of having these services housed within the school:

> *I think if you have a variety of programs, then parents are more encouraged to come into the school. Having a family room is very valuable because they come into the school and the barriers are broken and they get used and comfortable to coming to the school in an informal way.*[1556]

The importance of bringing parents into the school was highlighted by McCuaig, who testified that:

> *It's why integrating parents into early childhood settings is so very important, because it's difficult to integrate them, really integrate them into the setting successfully if they're just a problem and you're trying to separate them from their kids to inoculate . . . the kids from their home life. When you actually bring parents in as if they are part of the solution, you begin to get very different results. Well, the residential schools were an example of taking kids away to inoculate them from their families. So it's the opposite of that.*[1557]

In Manitoba, integrated early childhood programs have already been successfully implemented in the Francophone School Division, where programs are provided to Francophone families through school-based hubs. Funding comes from Healthy Child Manitoba and the federal government. These hubs (known as "Centres de la petite enfance et de la famille") are a made-in-Manitoba model of delivering early childhood development programs, including Healthy Child Manitoba programs such as Healthy Baby. The first two centres opened in 2003, and since then, two new centres have opened throughout the school division each year.[1558]

This model of service delivery was described in the 2009 document, *The Challenge of Integrated Children's Services in Manitoba,*[1559] provided to the Commission by the Department of Family Services. The document sets out the rationale for this model as follows:

> *The Manitoba model is based on the understanding that integrating early childhood resources for parents within a school setting ensures similar learning outcomes for francophone students in minority settings, compared to anglophone students in majority communities. Pre-school learning in French appears to be an optimal area of investment in early child development . . . .The model combines the building of community capacity and parental involvement with the universal established and sustained structure of the francophone school system.*[1560]

Another example of a successful integrated early childhood program already being piloted in Manitoba is the Lord Selkirk Park childcare program that was discussed earlier in this report. McCuaig commented on that project with approval but cautioned that unless it is expanded and made available for all, it will have limited value:

> *. . . what that program offers is what any good early education program should offer. And what you have at Lord Selkirk is, I think, 24 very lucky little kids and their families who have, you know, who are able to take advantage of it and what about the children attending the other 20 child care programs in the north end of Winnipeg and what about all those families that don't get anything. So it's -- again if the, if this program is being used to inform public policy, then it probably has some value. If it's another boutique program then it's in the same state as any other boutique program that has come and gone.*[1561]

I am reminded also of a broad-based integrated program that delivers a wide range of services on reserve. Felix Walker testified in Phase Two about the Nisichawayasihk Cree Nation and Community Wellness Centre, which was developed through a community-based consultation process. It provides public health, maternal health, and head start programs; daycare; fetal alcohol programing; diabetes initiatives; and child and family services, among others. The community centre offers men's groups, fitness classes, parenting groups, various youth groups, early childhood education, and other community services. A

mentoring program makes elders available to young people attending programs, and at the same time engages elders in the community.

The community has not eradicated its problems, Walker said, but the Wellness Centre has achieved its objectives "in terms of working in collaboration with the community, creating a unified approach to dealing with some of the issues that our families face."[1562]

26.6 EARLY CHILDHOOD EDUCATION PAYS HIGH RETURNS

The evidence before the Commission establishes convincingly that the biggest impact in terms of human development will come from investment in the early years.[1563] Brownell recalled the axiom that "an ounce of prevention is worth a pound of cure," saying:

> *We know that if we can prevent things from happening in the first place, it's going to pay off in the long run. And although the interventions to, to prevent things may seem costly, they really end up saving much more than they cost.*[1564]

She referenced a long-term study of disadvantaged children who had been enrolled in a two-year program of high quality preschool and home visits. Many years later the study found that:

> *. . . for every dollar spent on that program, they've saved $16 in terms of future incarcerations, unemployment, people on income assistance, involvement with child welfare. So it pays off big time.*[1565]

The research on cost effectiveness of a number of early childhood education programs was reviewed in the paper McCuaig prepared for the Commission:[1566]

> *Early childhood education is economic development, and the research shows it is economic development with a very high public return. The economic rationale for investing in early childhood programming is gathered from three types of analyses: longitudinal data quantifying the human capital benefits and reduced health and social costs for children who attend preschool; economic modelling forecasting the payback from the enhanced labour productivity of working mothers; and studies examining the early childhood sector itself and its multiplier effects on economies.*[1567]

McCuaig spoke of the economic benefits of Quebec's program of universal, low-cost, early childhood education, initiated in 1999:

> *Poverty rates, family, child poverty rates have been cut in half since the program was put in place. The number of lone parents on social assistance has been halved. It's gone from 90,000 on the rolls to 45,000 on the rolls.*[1568]

According to McCuaig, a review of the Quebec program by economist Yves Fortin found that:

> *. . . in 2008, 70,000 more Quebec women were at work and their presence could be attributed to low-cost preschool. This meant a 3.8 percent boost in women's employment and a 1.8 percent increase in total provincial employment. Adjusting for hours of work and the productivity of the new entrants, he calculated their labour added 1.7 percent to Quebec's GDP. Quebec mothers paid $1.5-billion annually in taxes, and because their earnings raised their family income, they drew lower levels of income-tested government transfers and credits, with both the federal and Quebec governments benefitting.*[1569]

In her paper, McCuaig also refers to a 2004 study of Winnipeg's 620 childcare facilities showing that every $1 invested in childcare brought an immediate return of $1.38 to the Winnipeg economy and $1.45 to Canada's economy.[1570]

These findings all are consistent with the evidence I heard in Phase Two about the cost effectiveness of prevention measures in delivering child welfare services. The evidence I heard in Phase Three supports early intervention as both an effective and cost-efficient means to ensure positive outcomes for Manitoba children. It is imperative that steps be taken to go where this evidence leads.

26.7 ABORIGINAL CURRICULUM

McCuaig also recommended integration of Aboriginal knowledge into the early childhood education curriculum.[1571]

In much of Canada, the Aboriginal content that does exist in school and preschool curriculum is targeted to Aboriginal children. But so much more could be achieved if this content were fully integrated into the mainstream curriculum, according to McCuaig:

> *It is one thing to know and value one's own culture; it is another to have others know and value it.*

In support of her recommendation, she writes:

> *Winnipeg is home to most Manitobans, and Winnipeg has the highest population of Aboriginal peoples of any Canadian urban centre. Promoting a shared understanding of Manitoba's founding peoples—Aboriginal and colonists—and their history traditions and values is essential to social cohesion. The optimal place to build cross-cultural understanding is in early childhood settings. . . .*

In Canada we have limited knowledge of Aboriginal history or culture and how this affects our lives, she says. Her paper points to examples of integrated curriculum. In New Zealand a "blended curriculum" is mandated for all preschool settings, in recognition of the country's two founding peoples—the Maori and the colonists—and their need for a common understanding of their history, traditions, and values. In Canada, the Northwest Territories is leading an initiative to create an integrated early learning curriculum incorporating Aboriginal and European cultures.[1572]

I accept McCuaig's observations and her recommendation but I would go further. There is no reason to limit this curriculum to early childhood settings: it should be extended throughout elementary and secondary education. I heard evidence that the lack of Aboriginal content and teaching methods contributes to low rates of high school completion among Aboriginal students.[1573] MacKinnon elaborated on this in the 2011 State of the Inner City Report as follows:

> *For many Aboriginal people the experience of residential schools left grandparents and/or parents psychologically and spiritually damaged; they have passed their distrust of schools on to their children. Further, the continued use of Eurocentric content and teaching styles, a shortage of Aboriginal teachers, and a lack of trust in the promise that education equates with a better life leads many Aboriginal youth to leave school at an early age. The effect has been high levels of illiteracy, absence of hope for a better future, and a perpetuation of poverty.*[1574]

The importance of expanding Aboriginal content and teaching methods throughout school curricula was emphasized by Spillet. She testified that this should be fundamental to every curriculum regardless of whether the students are Aboriginal or non-Aboriginal.[1575]

26.8 RECOMMENDATIONS

1. **Recommendation:** That the Healthy Child Committee of Cabinet consider and recommend for legislative action a framework for the delivery of early childhood development programs with the following characteristics:
    a) voluntary but universally available;
    b) offering a place where children regularly attend to learn with other children;
    c) staffed by trained educators who follow a defined curriculum; and
    d) involving parents.

Reason: Early childhood education programs, whether kindergarten, childcare, or other pre-school programs, can significantly benefit children and their parents. Pre-school years offer the most significant opportunity to influence children's capacity to learn throughout their lifetime. Universal access to quality early childhood programs supports parents by allowing them to address their own health issues including substance misuse and mental health; to seek employment; and to further their education. Ultimately, quality early childhood education results in cost savings to health and justice and other systems and combats poverty. Establishment of such a legislative framework is in line with developments in other jurisdictions in Canada and elsewhere.

2. **Recommendation:** The legislative framework for delivery of early childhood development programs should also provide for establishment of integrated service delivery centres to provide a range of services in addition to early childhood education, including public health, employment and income assistance, housing, child welfare, and adult education. These integrated service centers should be located in existing infrastructures such as schools or facilities that house community-based organizations.

   Reason: Combining a range of services that children and families need in community-based locations makes those services more accessible. It also combats social isolation by giving parents and children the opportunity to connect with others, and promotes visibility of vulnerable children.

3. **Recommendation:** That government funding to support integrated service delivery centres be allocated, following meaningful and inclusive consultation, by a committee that mirrors the committee described by s. 21(3) of *The Healthy Child Manitoba Act* and reflects Manitoba's various regions and cultural diversity, including representatives of the community and recognized experts.

   Reason: There is compelling evidence that these centres promote social cohesion in neighbourhoods, combat poverty by enhancing families' capacity to be self-sustaining; increase the visibility of young children in their community; and neutralize the conditions that make families vulnerable and put children at risk of abuse or neglect.

4. **Recommendation:** That Aboriginal culture and history, including the history of colonization and the impact of residential schools, be integrated into the provincial curriculum, including early childhood education and extending through elementary and secondary school.

   Reason: A shared understanding of Manitoba's founding people will promote social cohesion, reduce the isolation felt by many Aboriginal families, and encourage school completion by Aboriginal students.

27 ACTING ON WHAT WE KNOW

In Phase One of the Inquiry, I learned that Phoenix Victoria Hope Sinclair was born into poverty. Her parents were teenagers who had themselves been abused and neglected as children and had been in care until they aged out of the child welfare system. They were Aboriginal, living in Winnipeg. Neither parent had completed high school. They were unemployed and relied on social assistance. They both had issues with substance abuse. At least one of their parents had attended a residential school. Phoenix's mother, at 16, had already had one child who had been apprehended at birth. Phoenix was caught up in a cycle that is all too familiar. As Brownell put it:

> *So it almost is this vicious cycle that those kids who were born to teen moms, or those kids who live in extreme poverty, or those kids involved in child welfare services, go on to be more likely to be on income assistance themselves, they're more likely to be young parents themselves, and the whole cycle starts again because then their children are experiencing those same risks.*[1576]

Everything we know tells us that Phoenix was at high risk for maltreatment. The child welfare system knew it too, and apprehended her at birth. Unfortunately, the system failed to act on what it knew, with tragic results.

The same gap between knowledge and action can be seen in our response as a society to the needs of families and young children.

We know the factors that can lead to maltreatment of children and we heard over and over that Phoenix's situation was not unique. In fact, we heard that there are many children in just such circumstances, if not worse. And yet, so far we have failed to take the steps necessary to fully protect our children.

Having listened to academic experts and those with on-the-ground experience, it is clear to me that what is needed is a coherent and collaborative approach to supporting families and preventing maltreatment of children before they ever come into contact with child welfare.

This means intervening in children's lives early, for best results. It means making programs available to all children, to give them the best start in life. These programs need to be offered from centres such as schools, to help their parents integrate into the community in a setting where they can receive the supports they need.

Many steps have been taken in the right direction. Healthy Child Manitoba is one. It seems that Manitoba is well placed to continue the journey. The Early Development Instrument report[1577], co-authored by Santos and Brownell says:

> *Nationally and internationally, Manitoba is recognized as being unique in its scientific and intersectoral policy potential to close the gap between what we know and what we do in the everyday lives of children and families. This is the potential to "give every child the best start in life," to address and redress inequalities in children's developmental opportunities, reduce inequities in their developmental outcomes, and "close the gap in a generation."*[1578] *(Research references omitted.)*

I heard about the many community-based organizations providing critical services to vulnerable individuals and families. Steps are being taken within government to bring together various sectors that provide services to children. A great deal of money is being spent to finance programs and services both inside and outside government. What is needed now is a major collaborative effort to harness the resources, expertise, and wisdom of all of these sectors, to optimize results for children.

Manitoba's efforts to date have been successful, Santos said, because they reflect shared values. He pointed to the value of bringing together diverse perspectives as the Province moves forward:

> *There is huge value in bringing science together with traditional knowledge, with practitioner wisdom, with the values of parents. And, in fact, if you look at the literature that's actually what constitutes evidence-based practice is the bringing together, the integration of those different perspectives.*[1579]

The benefits of full integration of services for children and families were described in a 2009 report prepared for a child welfare intersectoral committee established by the Child and Family Services Standing committee. The report finds:

> *The arguments for full system integration for children are profound, not only in terms of human rights principles of fairness and equity, but also in the potential economic gain for society. . . . A society that envelopes its children in an integrated system that leaves no room for the most vulnerable to fall through the cracks will ensure a stronger and healthier society in the future."*[1580]

Sanderson confirmed that although full integration has not yet been achieved in Manitoba, progress has been made since that paper was prepared in 2009, and this remains the goal that the Province is striving for.[1581]

Santos cautions that, as important as integration of programs and services is, a successful result depends on having effective components within the system:

> *In other words, if the components or the pieces of the puzzle, themselves, are not optimally effective, there is no reason to believe that integrating them will make things more effective, necessarily, and so part of the challenge and this–we've heard this from our community partners and our own government departments—is that most of what we do in terms of programs and services for our children, our best efforts with the information that we have, what we*

don't -- because of resources and other challenges, don't know how effective they are. [1582]

These comments reinforce the need for ongoing research, evaluation, and in moving forward.

Strong leadership is needed to effect a significant shift in culture and in our perspective on the way to best fulfill our moral and legal obligations to our children. McCuaig testified about an initiative in PEI that succeeded at least in part because of strong leadership by the Premier:

> *Where we found significant change happen, the premier had to be behind it, the premier had to want it, they had to lead it and it's because when you go to turn chaos into coherence it goes across ministries. So there has to be leadership at that level which can say "make it so" in order for it to happen. Obviously you need, you need, you know, a strong, a strong minister and a strong set of officials in order to develop, you know, the kind of change that's required.*[1583]

Even strong leadership, however, needs broad public support. This is what creates and bolsters political will and drives change. It can be much easier to arouse public outrage in the wake of the death of a child than to stimulate public demand for significant and long-term reform aimed at prevention. Sanderson testified:

> *We don't have as many people talking about prevention as we do about the tragedy of Phoenix Sinclair and it's very important that we're shining a light on the tragedy but the, the media coverage, the general interest in phase three, is important to consider because it's also what we have to work with all the time, and that is how do you build the same level of public interest and support on the prevention end of the continuum so we don't have to deal with the tragic end of the continuum. And our political leaders will say that, as well, is we live in a democracy, we respond to what we hear from the public. We need the public putting more pressure, demand, emphasis on the importance of the early years . . . .* [1584]

Santos elaborated on the shared responsibility to protect children and the need for strong public support:

> *. . . the question as to who is in charge necessarily I think has to fall back to each of us in terms of what do we expect from our governments and our public institutions and our community agencies. And more importantly, what do we expect from ourselves in the roles that each of us have, day to day, in the lives of children. And once we are able to do those things, I think you'll see the kinds of outcomes that we all aspire to.*[1585]

Ka Ni Kanichihk's director urged us to act now:

> *I think we, we need to take those brave steps now because we don't want to be back here in 20 years, [saying] "There's 20,000 Aboriginal children in child welfare system," and we're still asking "What the heck is going on?" I can—I am here to say that we believe that, that the answers are within our collective, and they have to be within our collective if we're going to change the dynamic and the relationship that, that, that has caused this in the first place. You can't fix a vehicle that's broken by putting another broken wheel on it; it's just not going to happen.*[1586]

27.1 CONCLUSION

Phoenix was at risk from the day she was born. Her father loved her, but he lacked the skills to parent her and was struggling with addiction, unemployment, and his own troubled past. It will never be possible to prevent every tragic outcome for a child, but many of the interrelated factors that put Phoenix at risk are within our power to address and this is our collective responsibility.

Protection of Manitoba children will take a concerted and collaborative effort from the child welfare system, other government departments, community-based organizations, and the general public.

Despite all the steps that have already been taken in Manitoba, the number of children coming into the child welfare system, particularly Aboriginal children, continues to rise.

To truly honour Phoenix, we need to provide all of Manitoba's children with a good start start in life, and offer to the most vulnerable an escape from the cycle of poverty and vulnerability that trapped Phoenix and her family.

My hope is that the heart wrenching evidence I heard in Phase One of this inquiry, about Phoenix's life and death, will serve as a catalyst to ensure that the recommendations that emerge from this report are wholeheartedly embraced and implemented. The protection of children is a shared value of the whole community. The public interest that this Inquiry has received encourages me in the belief that achievement of the better protection of all Manitoba's children, and especially the most vulnerable, will be the true legacy of Phoenix Sinclair.

[1373] Transcript, March 6, 2012, p. 12, l. 8-22
[1374] Exhibit 143
[1375] Appendix 19, p.8
[1376] Exhibit 39
[1377] Exhibit 143, p. 10.
[1378] Transcript, June 5, 2013, p. 39, l. 12-16; Exhibit 143, p. 13
[1379] Exhibit 64, Tab 9
[1380] Exhibit 39
[1381] Transcript, May 28, 2013, p. 153, l. 18 – p. 154, l. 20
[1382] Exhibit 107
[1383] Exhibit 111
[1384] Transcript, May 28, 2013, p. 161, l. 11 – p. 168, l. 2
[1385] Transcript, May 28, 2013, p. 177, l. 10-17
[1386] Exhibit 42, p. 10
[1387] Transcript, April 25, 2013, p. 165, l. 25 – p. 166, l. 9
[1388] Transcript, June 4th, 2013, p. 195, l. 6 – p. 196, l. 11
[1389] Transcript, May 27, 2013, p. 37, l. 5-24
[1390] Transcript, May 28, 2013, p. 198, l. 17 – p. 199, l. 4
[1391] Transcript, June 6, 2013, p, 36, l. 14-24
[1392] Transcript, May 28, 2013, p. 168, l. 4—p 169, l. 2
[1393] Transcript, May 28, 2013, p. 202, l. 1-13
[1394] Transcript, May 27, 2013, p. 117, l. 5—p. 120, l. 5
[1395] Transcript, May 27, 2013, p. 118, l. 23 – p. 124, l. 25
[1396] Transcript, May 27, 2013, p. 171, l. 6-8
[1397] Transcript, May 27, 2013, p. 123, l. 20 – p. 124, l. 14
[1398] Transcript, May 27, 2013, p. 174, l. 1—p. 175, l. 6
[1399] Transcript, June 6, 2013, p. 37, l. 20-25
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[1401] Exhibit 95
[1402] Transcript, May 28, 2013, p. 12, l. 21—p. 13, l. 7; Exhibit 95, p. 1
[1403] Exhibit 97, p. 22
[1404] Exhibit 95, p. 1
[1405] Transcript, May 27, 2013, p. 187, l. 21 – p. 188, l. 12
[1406] Exhibit 93. p. 2
[1407] Transcript, May 27, 2013, p. 206, l. 23 – p. 207, l. 6
[1408] Exhibit 93, p. 5
[1409] Transcript, May 28, 2013, p. 68, l. 16-25
[1410] Transcript, May 27, 2013, p. 137, l. 2-15
[1411] Transcript, May 27, 2013, p. 190, l. 2-14; Exhibit 94
[1412] Transcript, May 27, 2013, p. 135, l. 22-25
[1413] Exhibit 92
[1414] Transcript, May 28, 2013, p. 103, l. 2—p. 122, l. 25
[1415] Transcript, May 28, 2013, p. 90, l. 24—p. 116, l. 18
[1416] Transcript, May 27, 2013, p. 136, l. 7 – p. 140, l. 6
[1417] Transcript, May 28, 2013, p. 128, l. 9-21
[1418] Transcript, May 27, 2013, p. 134, l. 17 – p. 135, l. 2
[1419] Transcript, May 28, 2013, p. 118, l. 16 – p. 127, l. 21
[1420] Transcript, May 28, 2013, p. 108, l. 19 – p. 138, l. 15
[1421] Transcript, May 29, 2013, p. 58, l. 6-18

[1422] Transcript, May 29, 2013, p. p. 61, l. 17—p. 63, l. 11
[1423] Transcript, May 29, 2013, p. 58, l. 20 – p. 69, l.21
[1424] Transcript, May 29, 2013, p. 34, l. 12—p. 76, l. 5
[1425] Transcript, May 30, 2013, p. 126, l. 10-22
[1426] Transcript, May 30, 2013, p. 68, l. 14-24
[1427] Transcript, May 27, 2013, p. 135, l. 13-20
[1428] Appendix [X], p. 15
[1429] Appendix [X], p. 9
[1430] Appendix [X], p. 15
[1431] Transcript, June 6, 2013, p. 10, l. 23 – p. 11, l. 4
[1432] Appendix [X], p. 10
[1433] Transcript, May 30, 2013, p. 11, l. 15 – p. 12, l. 18
[1434] Transcript, June 5, 2013, p. 91, l. 25 – p. 92, l. 14
[1435] Transcript, June 6, 2013, p. 57, l. 18 – 25
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[1437] Article 25, 2
[1438] Exhibit 42, p. 8
[1439] Exhibit 42, p. 8
[1440] Exhibit 139, p. 13-14
[1441] Transcript, June 5, 2013, p. 57, l. 22 – p. 58, l. 7
[1442] Exhibit 121, p. 3-4
[1443] Transcript, April 29, 2013, p. 268-269
[1444] Transcript, p. 18, l. 16 – p. 19, l. 10
[1445] C.C.S.M. c. H37
[1446] Exhibit 155, p. 9
[1447] Transcript, June 6, 2013, p. 73, line 24- p. 74, line 2.
[1448] The Healthy Child Manitoba Act, s. 3(2)
[1449] The Healthy Child Manitoba Act, s. 5(2)
[1450] The Healthy Child Manitoba Act, s. 6(1)
[1451] Transcript, June 6, 2013, p. 80, l. 17 – p. 81, l. 5
[1452] Transcript, June 6, 2013, p. 15, l. 12-24
[1453] Transcript, June 6, 2013, p. 82, l. 25 – p. 83, l. 25
[1454] Transcript, June 6, 2013, p. 74, l. 8-23; Exhibit 152
[1455] Transcript, June 6, 2013, p. 76, l. 21 – p. 77, l. 5
[1456] SA 2013, c. C-12.5
[1457] For example: Transcript, April 29, 2013, p. 269, l. 10-23; June 6, 2013, p. 12, l. 3-12
[1458] Transcript, May 27, 2013, p. 50, l. 1-14
[1459] Exhibit 42, p. 15
[1460] Transcript, May 31, 2013, p. 16, l. 14 – p. 18, l. 19
[1461] Transcript, April 24, 2013, p. 68, l. 3-11
[1462] Transcript, May 31, 2013, p. 121, l. 6-20
[1463] Transcript, May 31, 2013, p. 122, l. 2-22
[1464] Transcript, May 31, 2013, p. 123, l. 13-16
[1465] Transcript, May 31, 2013, p. 133, l. 24—p. 134, l. 14
[1466] Transcript, May 31, 2013, p. 134, l. 14-24
[1467] Transcript, May 31, 2013, p. 137, l. 1-4
[1468] Transcript, May 31, 2013, p. 140, l. 22 – p. 141, l. 21
[1469] Transcript, May 31, 2013, p. 137, l. 5-11
[1470] Transcript, May 31, 2013, p. 138, l. 17 – p.139, l. 1
[1471] Transcript, May 31, 2013, p. 129, l. 11-24

[1472] Transcript, May 31, 2013, p. 130, l. 1-18
[1473] Transcript, May 31, 2013, p. 132, l. 6-15
[1474] Transcript, May 31, 2013, p. 133, l. 12-15
[1475] Transcript, May 31, 2013, p. 148, l. 10-21
[1476] Transcript, May 31, p. 149, l. 2-10
[1477] Exhibit 147
[1478] Transcript, June 5, 2013, p. 136, l. 12-25
[1479] Transcript, June 5, 2013, p. 141, l. 5-14
[1480] Transcript, June 5, 2013, p. 148, l. 14—p. 149, l. 3
[1481] Transcript, June 5, 2013, p. 153, l. 17 – p. 154, l. 4
[1482] Transcript, May 28, 2013, p. 94 l. 14-22
[1483] Transcript, May 28, 2013, p. 97, l. 4-12
[1484] Transcript, May 29, 2013, p. 25, l. 14 – p. 39, l. 22
[1485] Transcript, May 29, 2013, p. 16, l. 6-15; p. 47, l. 13 – p. 52, l. 15
[1486] Transcript, May 29, 2013, p. 41, l. 20 – p. 42, l. 8
[1487] Transcript, May 29, 2013, p. 21, line 2 – p. 22, line 1.
[1488] Transcript, May 29, 2013, p. 44, l. 21 – p. 47, l. 8
[1489] Transcript, May 29, 2013, p. 27, l. 5 – p. 29, l. 5
[1490] Transcript, May 29, 2013, p. 29, l. 9 – p. 30, l. 3
[1491] Transcript, May 29, 2013, p. 37, l. 9 – p. 38, l.19
[1492] Transcript, May 30, 2013, p. 161, l. 4-10
[1493] Transcript, May 30, 2013, p. 139, l. 2-10
[1494] Transcript, May 30, 2013, p. 140, l. 3 – p. 146, l. 17
[1495] Transcript, May 30, 2013, p. 141, l. 17 – p. 142, l. 7
[1496] Transcript, May 30, 2013, p. 149, l. 18 – p. 151, l. 14
[1497] Transcript, May 30, 2013, p. 150, l. 19-22; p. 151, l. 1-14
[1498] Transcript, May 30, 2013, p. 152, l. 17 – p. 153, l. 3
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[1500] Transcript, May 30, 2013, p. 154, l. 18 – p. 155, l. 6
[1501] Transcript, May 30, 2013, p. 157, l. 15 – p. 158, l. 4
[1502] Transcript, May 31, 2013, p. 142, l. 15 – p. 143, l. 2
[1503] Transcript, May 31, 2013, p. 204, l. 6-10
[1504] Transcript, May 29, 2013, p. 23, l. 3-6
[1505] Transcript, May 31, 2013, p. 135, l. 22 – p. 136, l. 15
[1506] Transcript, May 27, 2013, p. 188, l. 13 – p. 189, l. 1
[1507] Transcript, May 31, 2013, p. 202, l. 17-21
[1508] Exhibit 135, p. 1
[1509] Transcript, June 4, 2013, p. 69, l. 2-14
[1510] Transcript, June 4, 2013, p. 61, l. 16-25
[1511] Commission Disclosure 1796, p. 37373
[1512] s. 7(1)(a)
[1513] Transcript, May 30, 2013, p. 151, l. 18 – p. 52, l.3
[1514] Transcript, May 30, 2013, p. 158, l. 20 – p. 59, l. 10
[1515] Transcript, May 31, 2013, p. 109, l. 17 – p. 113, l. 4
[1516] Transcript, May 27, 2013, p. 128, l. 15 – p. 129, l. 7
[1517] Transcript, May 30, 2013, p. 156, l. 16-24; p. 162, l. 11-12; June 5, 2013, p. 193, l. 22 – p. 198, l. 7
[1518] Transcript, May 29, 2013, p. 17, l. 22 – p. 18, l. 4
[1519] Transcript, June 5, 2013, p. 34, l. 3-9
[1520] Transcript, June 6, 2013, p. 23, l. 15-24
[1521] Transcript, June 6, 2013, p. 25, l. 14-23

[1522] Transcript, June 6, 2013, p. 36, l. 25 – p. 37, l. 19
[1523] Transcript, May 30, 2013, p. 15, l. 19-23
[1524] Transcript, June 6, 2013, p. 46, l. 10 – p. 52, l. 12
[1525] Transcript, June 6, 2013, p. 48, l. 17 – p. 49, line 5; Exhibit 151, p. 32
[1526] Transcript, May 30, 2013, p. 60, l. 7-15
[1527] Exhibit 140
[1528] Exhibit 144, p. xvi
[1529] Appendix 20, p. 13 (Exhibit 121)
[1530] Exhibit 123
[1531] Transcript, June 6, 2013, p. 171, l. 3-8
[1532] Transcript, May 30, p. 11, l. 22 – p. 12, l. 18
[1533] Appendix 20
[1534] Appendix 20, p. 1
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[1536] Transcript, May 30, 2013, p. 19, l. 16 – p. 20, l. 17
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[1538] Transcript, May 30, 2013, p. 25, l. 22 - 25
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[1540] Transcript, May 30, 2013, p. 32, l.22 – p. 33, l. 20
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[1542] Transcript, May 30, 2013, p. 35, l. 1-24
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[1545] Transcript, May 30, 2013, p. 38, l. 15-23
[1546] Transcript, May 30, 2013, p. 45, l. 11 - p. 89, l. 11
[1547] Transcript, May 30, 2013, p. 89, l. 12 – p. 94, l. 2
[1548] Appendix 20, p. 13
[1549] Transcript, May 30, 2013, p. 66, l. 9 – p. 70, l. 4
[1550] Transcript, May 30, 2013, p. 73, l. 4-19
[1551] Transcript, May 30, 2013, p. 73, l. 20 – p. 74, l. 21
[1552] Transcript, May 30, 2013, p. 122, l. 7 – p. 131, l. 23
[1553] Transcript, May 30, 2013, p. 70, l. 6 – p. 73, l. 3
[1554] Transcript, December 19, 2012, p. 103, l. 20 – p. 107, l. 18
[1555] Transcript, December 19, 2012, p. 104, l. 22 – p. 106, l. 6
[1556] Transcript, December 18, 2012, p. 108, l. 14-25
[1557] Transcript, May 30, 2013, p. 100, l. 6-15
[1558] Transcript, June 6, 2013, p. 112, l. 7-25; Exhibit 151, p. 72
[1559] Commission Disclosure 1397
[1560] Commission Disclosure 1397, p. 16-17
[1561] Transcript, May 30, 2013, p. 86, l. 19 – p. 87, l. 4
[1562] Transcript, May 7, 2013, p. 127, l. 14-21
[1563] For example: Transcript, June 6, 2013, p. 66, l. 3 – p. 67, l. 8; Exhibit 151, p. 48
[1564] Transcript, June 5, 2013, p. 55, l. 7-13
[1565] Transcript, June 5, 2013, p. 56, l. 3-24
[1566] Appendix 20, Appendix B
[1567] Appendix 20, p. 21
[1568] Transcript, May 30, 2013, p. 79, l. 25 – p. 80, l. 8
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[1570] Appendix 20, p. 22
[1571] Appendix 20, p. 14

[1572] Transcript, May 30, 2013, p. 50, l. 18 – p. 52, l. 1; Appendix 20 p. 6
[1573] Transcript, May 27, 2013, p. 127, l. 8-15; Exhibit 89, p. 38-39
[1574] Exhibit 89, p. 40; Transcript, May 28, 2013, p. 163, l. 15 – p. 164, l. 3
[1575] Transcript, June 5, 2013, p. 192, l. 20 – p. 193, l. 7
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[1578] Exhibit 144, p. 53
[1579] Transcript, June 6, 2013, p. 176, l. 20—p. 177, l. 3
[1580] Commission Disclosure 1397, p. 26405
[1581] Transcript, June 6, 2013, p. 148, l. 17-2
[1582] Transcript, June 6, 2013, p. 150, l. 12-25
[1583] Transcript, May 30, 2013, p. 104, l. 22 – p. 105, l. 5
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[1585] Transcript, June 6, 2013, p. 161, l. 11-19
[1586] Transcript, June 5, 2013, p. 143, l. 16-25