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

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

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Transcript of Proceedings  
Public Inquiry Hearing,  
held at Eaton Hall, Marlborough Hotel,  
331 Smith Street, Winnipeg, Manitoba

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WEDNESDAY, MAY 15, 2013

## **APPEARANCES**

**MS. S. WALSH**, Commission Counsel

**MR. D. OLSON**, Senior Associate Counsel

**MR. R. MASCARENHAS**, Associate Commission Counsel

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

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

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

**MR. S. SCARCELLO**, for First Nations of Northern Manitoba Child and Family Services Authority First Nations of Southern Manitoba Child and Family Services Authority Child and Family All Nation Coordinated Response Network

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

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

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

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

**MR. W. HAIGHT** and **MS. K. BJORNSON**, for Manitoba Métis Federation and Métis Child and Family Services Authority Inc.

**MR. T. BOCK**, for witness, Ms. Darlene McDonald

**MS. B. BOWLEY**, for witness, Ms. Diva Faria

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

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1 MAY 15, 2013

2 PROCEEDINGS CONTINUED FROM MAY 14, 2013

3

4 THE COMMISSIONER: Good morning.

5 MS. WALSH: Good morning, Mr. Commissioner.

6 THE COMMISSIONER: We have Dr. Wright this  
7 morning, do we?

8 MS. WALSH: Yes.

9 THE COMMISSIONER: Good morning, Dr. Wright.

10 THE WITNESS: Yes, good morning.

11 THE COMMISSIONER: Thank you for being available  
12 to complete your evidence and you're ready to proceed,  
13 Ms. Walsh?

14 THE WITNESS: You're welcome.

15 MS. WALSH: I am. I'm finished with my questions  
16 and so I just wanted to make sure, before Mr. Gindin starts  
17 his cross-examination, Dr. Wright, can you see us?

18 THE WITNESS: Yes.

19 MS. WALSH: You can see us. Can you see my  
20 colleague, Mr. Gindin?

21 THE WITNESS: Yes.

22 MS. WALSH: Okay, good, because that's where the  
23 questions are going to come from for the most part. All  
24 right, thank you.

25 THE COMMISSIONER: All right. Thank you,

26

1 Dr. Wright, for being available. And, Mr. Gindin, you're  
2 on.

3 MR. GINDIN: Thank you.

4

5 **ALEXANDRA SHARON COLLEEN WRIGHT,**  
6 previously affirmed, testified as  
7 follows:

8

9 CROSS-EXAMINATION BY MR. GINDIN:

10 Q Good morning, Ms. Wright. My name is Jeff  
11 Gindin. I represent Kim Edwards and Steve Sinclair. I  
12 have some questions for you. Can you hear me okay? Can  
13 you hear me all right?

14 A Yes, yes. Maybe just a little, if you speak just  
15 a little more loudly.

16 Q All right. Last time you were here, of course  
17 you testified, and I just want to quote to you part of your  
18 testimony which appears at 22, page 22 of your transcript  
19 which I'm not sure everybody has but I don't think it's  
20 that's significant that they have it in front of them. And  
21 here's what you said:

22

23 "... there are some who would say  
24 that the two (that is the  
25 Protection Branch and the

1                   Prevention Branch) should be  
2                   separated and that debate has been  
3                   going on for a long time, too."

4

5 Do you have a transcript of your testimony in front of you?

6 Is that what you're looking at?

7           A     Yes.

8           Q     Okay. So at page 22 --

9           A     Yes.

10          Q     -- the first answer on that page, about halfway  
11 through that, you were discussing this debate that's been  
12 going on between perhaps separating the two aspects of the  
13 child welfare system, protection and prevention, and you  
14 referred to a debate that's been going on for a long time.

15          A     Yes.

16          Q     Can you tell us about that debate a bit?

17          A     I think what's happened historically is there  
18 would be one side of the debate that would say that child  
19 protection, and by that I mean really managing a case of a  
20 child maltreatment where there are allegations or  
21 substantiation of abuse or neglect should be kept separate  
22 from family support type services in that -- and one of the  
23 reasons is that there is a belief that families may be  
24 better able to trust an organization that can provide just  
25 supportive intervention and that doesn't have to deal with

1 the child protection per se in terms of child abuse. Does  
2 that help?

3 Q Yes. So that the, if we can call it the policing  
4 function, sometimes affects the way people react to the  
5 family prevention and family enhancement portion of their  
6 services; is that what you mean?

7 A Well, I personally wouldn't use the term policing  
8 function. From my perspective and experience, good child  
9 welfare work should be able to provide protection and  
10 support and I think that's a key issue in terms of the  
11 relationship building that goes on between a social worker  
12 and the family. So I guess for me, I think why I stated  
13 what I stated in terms of my own perception, Mr. Gindin, is  
14 because, is sometimes when you're working with families  
15 it's very difficult to separate out just the protection  
16 issue and just a support issue. And often you're working  
17 with families where there is complex cases and you know  
18 that whole building of relationships is really important.  
19 That doesn't mean that you might not have other service  
20 providers involved. For example, there might be a family  
21 support worker, you know, who helps the family services  
22 worker in terms of meeting the family's needs. But to be  
23 fair, the debate is out there. Some would argue that it's  
24 better to separate the two functions and provide those two  
25 services very separately.

1 Q And one of the problems, I presume, is that it's  
2 necessary for the client, if I can use that phrase, to  
3 trust the workers that are either, that are trying to help  
4 them.

5 A I'm sorry, can you just speak up a bit, please?

6 Q Yes, sorry, sorry. In order to --

7 A You're cutting in and out.

8 Q Okay. In order to build a relationship between  
9 the families and the workers, which you've told us is very,  
10 very important, an element of trust is clearly a  
11 prerequisite, correct?

12 A Yes.

13 Q And that's one of the problems really that --

14 A Yes.

15 Q -- the image out there by some people is that  
16 they don't trust the social workers or the system. You've  
17 come across that?

18 A The image out there is which?

19 Q Is that very often people don't trust the system  
20 or the social workers.

21 A Yes, yes, that's correct.

22 Q And based on your readings and your research, are  
23 there ways that you can suggest that that image can be  
24 improved so that the relationship between families and  
25 social workers can be a better one?

1           A     I think the relationships focus between social  
2 workers who provide child welfare services even if it's  
3 only protection services but under the purview of giving  
4 protection and support.     But even in the case of just  
5 protection can be improved and there has to be a focus on  
6 trying to build some sense of trust.     I think there are  
7 cases where it's really difficult to build trust but even  
8 then you can provide services in a professional and honest  
9 way with families.

10          Q     We've heard evidence that clients can be  
11 resistant to getting help or seeking help.     Is there any  
12 research that can assist us in ways to deal with resistant  
13 clients that you've come across?

14          A     I think -- I referenced Rooney's book on Working  
15 with the Involuntary Client.     I think that's the title of  
16 it.     I'd have to double check to confirm.     And you know  
17 that text is really helpful in terms of working with  
18 service users who don't want to be involved with the system  
19 whatsoever and I think what's key is being able to work  
20 ethically, being honest in what you can do as a worker and  
21 what you can't do and being clear on consequences to  
22 choices that are made.

23          Q     We've also heard from at least some people who  
24 didn't seem to know, for example, that if they contacted  
25 CFS with a referral or essentially to report an issue with

1 a family that they've observed, that they weren't aware  
2 that that call could be anonymous. Do you think that more  
3 could be done in terms of educating the public to ensure  
4 that they do report more and do know what the procedures  
5 are like?

6 A That's a hard question for me to answer just  
7 because I don't know the specifics there but I think public  
8 education and a focus on looking after our children in the  
9 community is a good step in terms of healthy communities  
10 and wellbeing for children and families.

11 Q All right. I'm going to refer to just a few  
12 portions of the article that you wrote which I think is  
13 Exhibit 42, if I have that correctly. If we can get that  
14 up, I'm going to refer you to certain pages. If we can go  
15 to page 5 of that article and about halfway down the page  
16 it says:

17

18 "Evaluations can be skewed to  
19 support --"

20

21 A What page?

22 Q This would be page 5. Do you have that in front  
23 of you?

24 A Yeah, I do.

25 Q And that's part of your section dealing with

1 Best Practices in Child Welfare, that's the previous  
2 heading, and about halfway down that page or perhaps a  
3 third of the way in the middle of that big paragraph, you  
4 say:

5

6 "Evaluations can be skewed to  
7 support outcomes that are likely  
8 to be funded."

9

10 And I'm curious as to what exactly you meant by that.

11 A I think what I was trying to say in that section  
12 was simply that caution with any kind of, you know,  
13 research or evidence based approach and evaluation need to  
14 be taken and people need to read the process of the  
15 evaluation to be certain that there may be wasn't a bias or  
16 any kind of skewing either in the presentation of the data  
17 that was found or perhaps in the method of sampling, for  
18 example.

19 Q So one has to be careful --

20 A An example though of that, an example might be  
21 though to highlight the numbers of people receiving  
22 services but maybe not looking at whether there were  
23 positive outcomes.

24 Q I see.

25 A So it's just being cautious in terms of how

1 someone is reading an evaluation.

2 Q So cautious in terms of how the evaluation is  
3 interpreted and analyzed.

4 A Yes.

5 Q Um-hum, okay. Now let me just take you back one  
6 page to page 4 and if we can scroll up a little bit, or  
7 scroll down, yes. Towards the bottom of that page you're  
8 talking about the "Child Welfare Outcome Indicator Matrix",  
9 as you put it, "a tool used to measure child welfare  
10 outcomes in four areas". Do you see that in front of you?  
11 Have you got that?

12 A Yes.

13 Q And the last one of those mentions the phrase, if  
14 you read it, "parenting capacity". Correct? You can see  
15 that there?

16 A Yes.

17 Q And what did you mean by that phrase there?

18 A Okay. So this comes directly from the Child  
19 Welfare Outcome Indicator Matrix as quoted from Trocmé,  
20 MacLaurin and Fallon.

21 Q Right.

22 A I don't have their exact definition of parenting  
23 capacity and they will have a very specific one, but  
24 essentially it means the -- I mean it refers to the ability  
25 of the parent to care for a child.

1 Q Is there research that would inform us as to how  
2 that is best to be assessed, that you're aware of at least?

3 A Yes, I think there is some research out there  
4 that can provide guidance on that issue.

5 Q Are you able to tell us a bit of a précis there  
6 as to how you feel, based on the research parental capacity  
7 ought to be assessed? In other words, can it be assessed  
8 by a social worker? Is a psychologist necessary to do it?  
9 Things of that nature.

10 A Well I think, you know, even when you look at  
11 risk assessment tools, they generally have one component  
12 that tries to assess some element of parental capacity to  
13 care for a child. Do you want me just to speak generally  
14 or do I need to be referring --

15 Q No, no.

16 A -- specifically to specific --

17 Q You can begin speaking --

18 A Pardon me?

19 Q You can begin speaking generally and then we'll  
20 see where it goes.

21 A Okay, okay. So I mean I think anything -- I  
22 think there's research that clearly demonstrates issues  
23 such as substance abuse, cruelty or violent behaviour, an  
24 inability to put the child's needs before the parent's  
25 needs. I guess any kind of sexual exploitation of a child.

1 I mean those are all examples of where the parental  
2 capacity is severely limited, you know, if not unable.

3 Q Um-hum. Now --

4 A Does that help in your --

5 Q Yes, yes, yes. Thank you, it does. In this  
6 case --

7 A There's also ...

8 Q Um-hum, go ahead.

9 A Just one other thing I'd like to add on the  
10 parenting capacity and I can't quote the specific research  
11 right now but there is a, I know, a finding that has shown  
12 that inconsistent parenting is also very damaging to  
13 children. So where one day might be providing good  
14 parenting and the next day chaotic parenting.

15 Q All right. And in this inquiry there was  
16 evidence that the mother of Phoenix Sinclair, at the time  
17 of the birth, appeared to be emotionally ambivalent,  
18 emotionally flat towards the child and that's certainly  
19 something that would be reflective of a parental capacity  
20 or a lack thereof, correct?

21 A Yeah, when, when I referred later on to family  
22 centered practice in child welfare in the paper, I did  
23 speak of the emotional bond --

24 Q Right.

25 A -- that needs to be an assessment, assessed

1 between the parent and the child and an emotional bond or  
2 attachment really refers to that emotional bond that allows  
3 for a secure relationship to develop so that the child can  
4 develop in a, sort of meeting the developmental needs of  
5 the child and the wellbeing and functioning positively. So  
6 that emotional bond or attachment is an important area for  
7 assessment, yes.

8 Q It's an important part of parental capacity to be  
9 able to emotionally bond with your child obviously,  
10 correct?

11 A Um-hum.

12 Q Yes.

13 A Yes.

14 Q I'll take you to page 25 of your article and this  
15 is towards the bottom of that page. Now what you're  
16 talking about there, according to the, that last paragraph:  
17 "Factors considered impediments to good practice are  
18 paraphrased" and then you list a number of things, correct?  
19 Do you see that there?

20 A Yes.

21 Q Now towards the bottom it says --

22 A Yes.

23 Q -- "Inadequate and badly timed training" that's a  
24 phrase that is used by you. Fourth bullet from the bottom,  
25 do you see that?

1 A Yes.

2 Q And when you say "badly timed training" what do  
3 you mean by that?

4 A Well that could have, sort of a situation where,  
5 for example, there may be a newly hired social worker and  
6 there is a planned orientation training component, however  
7 the person, the individual may not receive the training  
8 maybe until a year into the work. So what may have been an  
9 adequate training module wasn't provided though in a timely  
10 manner when it is most helpful for the worker.

11 Q And what --

12 A That would be an example.

13 Q And it would be most helpful, I take it, as early  
14 on as possible, correct?

15 A Yes.

16 Q Yes.

17 A Yes. Another example is when, I think the other  
18 example on the training issue though is also when workers  
19 are expected to attend training, however there's no  
20 recognition of workload pressure, or to alleviate those  
21 pressures in order for them to attend and benefit from the  
22 training.

23 Q And at page 26, I think that's the next page,  
24 about halfway through that big paragraph, you used the  
25 phrase "a positive public profile". I think you can see

1 that about halfway through the paragraph. It says, "Social  
2 workers having -- "

3 A Yes.

4 Q "-- a sense of pride in their work --"

5 A Yes.

6 Q "-- with a positive public profile." And are you  
7 talking there about the image and the perception of the  
8 social worker in society; is that what you're referring to  
9 there?

10 A Yes, I think -- yes, and particularly child  
11 welfare workers, yes.

12 Q Um-hum. And just to complete what we were  
13 talking about before, it was page 35 where you mentioned  
14 the attachment between the child and parental figure as an  
15 important element of the assessment process and I think  
16 that's what you were referring to earlier when we talked  
17 about parental capacity; is that right?

18 A Yes, and I think when you're assessing the  
19 attachment or emotional bond, the concept is, is that it  
20 could be resulting in a nurturing relationship, you know,  
21 that when you see positive family functioning and the child  
22 feels secure in the family context.

23 Q And also I believe last time when you were here  
24 there was a discussion about the benefits of workers being  
25 advised about either good outcomes or adverse outcomes from

1 the work they've done. Do you recall that?

2 A Yes.

3 Q And one of the benefits of course is that the  
4 work is discussed and analyzed and hopefully people learn  
5 from the mistakes that were made and change their  
6 behaviour, right, and that's a good process?

7 A Yes.

8 Q And that's a much better process than having to  
9 wait for an inquiry like this to find out about what might  
10 have gone wrong, correct?

11 A I think having a process in place to look at ways  
12 to improve policies or practices for children and their  
13 families is a real benefit and would be considered a best  
14 practice approach.

15 Q And the sooner that can happen the better, that  
16 you find out about the outcomes and what may have gone  
17 wrong, correct?

18 A Yeah, and I think, I think there's a natural,  
19 there's a natural fit with good supervision that allows for  
20 that process to occur on a more micro level and then on an  
21 organizational level it could be more broad too but, you  
22 know, talking about case issues should be occurring on the  
23 supervisory level.

24 Q And not only after there's been adverse outcome  
25 if that's the result, but also during the handling of the

1 file supervision can be very, very important, right?

2 A Yes.

3 Q And you would agree that the role of a supervisor  
4 goes well beyond simply signing off on the closing of a  
5 file?

6 A Yes.

7 MR. GINDIN: Those are my questions. Thank you.

8 THE COMMISSIONER: Thank you, Mr. Gindin.

9 There will be another counsel coming to the  
10 table. Ms. Bowley?

11 MS. BOWLEY: Good morning, Mr. Commissioner.  
12 It's Bernice Bowley representing Diva Faria. I have some  
13 questions of this witness that are of relevance and  
14 interest to Ms. Faria and as per the protocol we've been  
15 working under I'd like your permission to ask those  
16 questions.

17 THE COMMISSIONER: Granted.

18

19 CROSS-EXAMINATION BY MS. BOWLEY:

20 Q Dr. Wright, you can hear me all right?

21 A Yes, thank you.

22 Q I don't know about you but this is my first time  
23 asking questions of a witness via teleconference.

24 A My first time too.

25 Q I thought it might be.

1 THE COMMISSIONER: Well you're both performing  
2 well.

3 MS. BOWLEY: So far.

4

5 BY MS. BOWLEY:

6 Q Dr. Wright, is there a bit of a time lag between  
7 when you see me speaking versus when you hear my voice?

8 A I think a little bit, yes.

9 Q All right. And vice versa so we'll have to work  
10 with that. Do you have available to you a screen where  
11 commission disclosure documents can be pulled up for you?

12 A No, but I have my paper and a transcript in front  
13 of me here.

14 Q All right, thank you. This may pose a little bit  
15 of a problem because I do have some other documents to ask  
16 you about but I'll try to give you as much description and  
17 help as possible when I'm referring to a document and if  
18 there's context that you think you want to hear, please let  
19 me know.

20 MS. BOWLEY: Madam Clerk, could you pull up, for  
21 the rest of the crowd, document, or page number 11904?

22

23 BY MS. BOWLEY:

24 Q All right, now, Dr. Wright, this is a letter from  
25 Billie Schibler dated April 26th, 2006. It's addressed to

1 a number of people including Elsie Flette, the Chief  
2 Executive Officer of the Southern Authority; Dennis  
3 Schellenberg, Chief Executive Officer as he then was of the  
4 General Authority; and Jay Rodgers as he then was Executive  
5 Director of the Child Protection Branch and in this letter  
6 Billie Schibler sets out the scope of the review that she  
7 is going to be undertaking. Have you -- do you recall ever  
8 seeing a letter from Billie Schibler dated April 26th,  
9 2006?

10 A No.

11 Q All right. On page 2 of that letter Billie  
12 Schibler writes that:

13

14 The review will be conducted in  
15 three separate phases as follows.

16

17 And number one is best practices review. She writes:

18

19 A best practices review will be  
20 undertaken to determine what the  
21 optimum standards in child welfare  
22 are against which the existing  
23 standards and practices can be  
24 measured.

25

1 Is that what you understood your mandate to be in creating  
2 the paper dated June of 2006?

3 A My understanding, from what I recall, is that I  
4 was writing, doing a literature review within a very  
5 specified timeline to provide them with some, to provide  
6 the committee, and that was Irene Hamilton, Billie and  
7 Michael, I've forgotten his last name.

8 Q Michael Hardy?

9 A Anyways, with an -- pardon me?

10 Q Sorry, was it Michael Hardy?

11 A Yeah. And to provide them with an overview of  
12 best practices in child welfare but it was very, it was a  
13 brief overview, a lit review.

14 Q Right. And so then the paper --

15 A That's my understanding.

16 Q Thank you. The paper of June 2006, which starts  
17 at page 3335 in the commission disclosure documents was, as  
18 you set out in the introduction, a brief overview of the  
19 child welfare system in Manitoba current as of June of  
20 2006; is that right?

21 A Yes.

22 THE COMMISSIONER: Is that Exhibit 42 you're  
23 talking about?

24 MS. BOWLEY: No, sir, that is the June of 2006  
25 report --

1 THE COMMISSIONER: Oh, oh.

2 MS. BOWLEY: -- or article that was attached --

3 THE COMMISSIONER: Yes.

4 MS. BOWLEY: -- to the Strengthen the Commitment  
5 report.

6 THE COMMISSIONER: I understand.

7

8 BY MS. BOWLEY:

9 Q And then, Dr. Wright, Exhibit 42, your recent  
10 report, was requested by commission counsel to provide a  
11 more comprehensive report of best practices; is that right?

12 A Yes.

13 Q And the --

14 A And I guess, I was just going to add that certain  
15 areas were really updated and revised. There was a greater  
16 inclusion, for example, of community approaches. I think I  
17 really reduced the kind of best practice in terms of direct  
18 practice approach. So it was modified significantly.

19 Q Right. And I was going to ask you that. Some  
20 things were elaborated upon and some things were omitted;  
21 is that right?

22 A Yes.

23 Q Sorry?

24 A Yes, yeah. I don't know, did I -- oh I'm not  
25 sure if I omitted things or just really reduced things.

1 Q All right.

2 A You know what I mean?

3 Q Yes, I do. And, Dr. Wright, if you could turn to  
4 page 13 of your June 2006 report and that is page 348 of  
5 the commission disclosure documents. Do you have it,  
6 Dr. Wright?

7 Do you have it, Dr. Wright?

8 Hello? Can you hear me?

9 A I don't have the 2006 report.

10 Q Okay. Well let me see if I can test your memory  
11 then.

12 THE COMMISSIONER: What exhibit number are we  
13 talking about?

14 MS. BOWLEY: It's not an exhibit, sir. It's --  
15 all I can give you is the commission disclosure page number  
16 348.

17 THE COMMISSIONER: What is the document?

18 MS. BOWLEY: It is the June 2006 Best Practices  
19 paper by Dr. Wright that was attached to the Strengthen the  
20 Commitment report.

21 THE COMMISSIONER: Oh was that never marked as an  
22 exhibit?

23 MS. WALSH: No, Mr. Commissioner, because it's  
24 part of our disclosure. It's commission disclosure number  
25 3. You have a hard copy of each of the reports and so it's

1 an appendix to disclosure number 3 and the page --

2 THE COMMISSIONER: I know what, I know what the  
3 document is. Well is Exhibit 42 an update of it?

4 MS. WALSH: Exhibit 42 is an update and -- yes,  
5 an expansion of --

6 THE COMMISSIONER: Of, of the original assignment?

7 MS. WALSH: Yes.

8 THE COMMISSIONER: And that Best Practices report  
9 in 2006 was commissioned by Schibler and Hardy and who was  
10 the third person?

11 MS. BOWLEY: Hamilton.

12 THE COMMISSIONER: Hamilton, yes.

13 MS. WALSH: The ombudsman, that's right.

14 THE COMMISSIONER: Okay, okay.

15 MS. WALSH: And Ms. Schibler testified about  
16 requesting that.

17 THE COMMISSIONER: That's, that's the document  
18 we're talking about now, is it?

19 MS. BOWLEY: Yes.

20 THE COMMISSIONER: Okay, I didn't get that.

21 MS. BOWLEY: Thank you, Ms. Walsh.

22 THE COMMISSIONER: Okay, just a minute. Now I  
23 might have that with me. No, no, I don't. I only have 42.  
24 So I know what the document is so carry, carry on.

25 MS. BOWLEY: Thank you.

1 BY MS. BOWLEY:

2 Q And I just want a clarification, Dr. Wright.  
3 Midway down that page you write:

4

5 "In their examination of ..."

6

7 And you put in quotation marks,

8

9 "... 'good practice' in child  
10 welfare, the CASW ..."

11

12 Which is the Canadian Association of Social Workers; is  
13 that right?

14 THE COMMISSIONER: Did you hear that question,  
15 Dr. Wright?

16

17 BY MS. BOWLEY:

18 Q Do I have the acronym right that CAS --

19 A I'm sorry.

20 Q Can you not hear me?

21 A Can you repeat that? It was cutting out.

22 Q In your June of 2006 report, Dr. Wright, on page  
23 13 -- can you hear me so far?

24 A Yeah.

25 Q All right. In that report on page 13 you wrote:

1                    "In their examination of 'good  
2                    practice' ..."

3

4    And "good practice" was in quotation marks,

5

6                    "... in child welfare, the  
7                    CASW ..."

8

9    And that acronym means the Canadian Association of Social  
10    Workers, is that right?    Yes?

11            A     Yeah.

12            Q

13                    "... identified key organizational  
14                    factors considered necessary to  
15                    enhance good practice ..."

16

17    And all I want to know is whether in this phraseology good  
18    practice is akin to best practices.

19            A     Yes.    I think in that context the idea is that  
20    really the most desirable practices or policies necessary  
21    or approaches that can be used to improve services and  
22    planning of child welfare approaches for children and  
23    families.    And the idea is that best practices or good  
24    practices there will result in positive outcomes for  
25    children and families.

1 Q And to the extent that the factors listed there  
2 are not contained in your new 2012 report, would you agree  
3 that they still hold true?

4 A Yes, yes.

5 Q Dr. Wright, when you last appeared here on  
6 April 24 of 2013, you said, and if you want to follow along  
7 it's in your transcript at pages 29 to 30. You said that  
8 there is -- it's at the bottom of page 29:

9

10 "... there isn't necessarily a  
11 conflict between minimal standards  
12 and best practices. ... some  
13 minimum standards may reflect best  
14 practices already, right, so  
15 there's not an automatic tension  
16 there or conflict."

17

18 Do you see that?

19 THE COMMISSIONER: You've got to answer, Witness.

20 THE WITNESS: Yes, I read that.

21

22 BY MS. BOWLEY:

23 Q And what I would suggest to you, Dr. Wright, is  
24 that that tension is not there if the foundational or the  
25 minimum standards are also current with best practices. Is

1 that what you mean?

2 A I guess, I guess what I, what my perception is of  
3 that is that depending on how minimal standards are defined  
4 and set, there really isn't a conflict necessarily with  
5 best practices. If you approach best practices from the  
6 perspective of child welfare service planning and practice  
7 approaches that are considered the most desirable, given  
8 the evidence available and the information available that  
9 result in positive outcomes for families and children, I  
10 think minimal standards can reflect best practices.

11 Q Right. But that is only if the minimal standards  
12 actually do reflect best practices. That's not always the  
13 case, is it?

14 A In terms of an organizational or legislative  
15 standards?

16 Q Yes.

17 A I guess so.

18 Q Well look at it this --

19 A I'm -- you know I'll tell you why I'm hesitating.  
20 I'm hesitating because it's hard for me to answer that  
21 without looking specifically at an organizational practice  
22 or standard, you know, or policy that I'm referring to.  
23 That's why it's difficult for me.

24 Q I understand that. But as a general concept, in  
25 order for there to be a lack of tension between minimal

1 standards and current best practices of the day, we have to  
2 be satisfied that those minimal standards actually meet  
3 best practices of the day; is that right?

4 A I think what is really important is that there is  
5 a culture, an organizational culture of best practices. So  
6 that means even if a standard isn't meeting what the view  
7 is of a best practice there's a process or system there  
8 then to assess that and to look at gaps and to try to meet  
9 those gaps from a best practice approach.

10 Q All right. I actually think we're talking about  
11 the same thing, we may be just coming at it a little bit  
12 differently.

13 A Okay.

14 Q My point is, is that best practices, whether it's  
15 an organization culture or whether it's ongoing research  
16 and evaluation, it's an ongoing striving to improve; is  
17 that right?

18 A Yes, yes.

19 Q It's not static; is that right?

20 A Yes.

21 Q Sorry?

22 A Yes.

23 Q And --

24 A Yes.

25 Q -- the approach to best practices is continually

1 evolving and moving forward?

2 A Yes.

3 Q And then sometimes the minimum standards of an  
4 organization have to catch up?

5 A Yes. And sometimes an organization may be  
6 finding that their approach is really a best practice  
7 approach so the focus is maintaining it.

8 Q Right. And sometimes an organization finds that  
9 its approach is not meeting best practices; is that right?

10 A Yes, that's right.

11 Q And akin to what Mr. Gindin asked you, the sooner  
12 minimal standards are modified to catch up with best  
13 practices, the better for social worker's ability to  
14 deliver services; is that right?

15 A Yes. I would argue that, yes.

16 Q Would you agree that an organization standards  
17 should be evaluated regularly and updated so as to minimize  
18 the lag time between minimal standards and best practices?

19 A Yes.

20 Q Dr. Wright, go now to Exhibit 42. This is your,  
21 what we've been calling your new report. Is there a date  
22 for that report?

23 A Is there a which?

24 Q A date. Was it January of 2012? Was it later?  
25 I just, I don't see a date on it and so I'm trying to just

1 clarify when this was produced.

2 A I think we talked about that when I was last  
3 there and there is a date. I think -- did we say -- I'm  
4 going to have to refer to Sherri on this one.

5 Q Well just give me a minute.

6 A January, January 2013?

7 MS. WALSH: I don't recall that there's an actual  
8 date on the report, but I think January '13 is around the  
9 time that it was provided. I can look at and see if your  
10 transcript addressed that but I think that's, that's around  
11 the time. Whenever everybody received it from our  
12 disclosure that's consistent with when you provided it to  
13 us.

14

15 BY MS. BOWLEY:

16 Q All right. So then we'll work with January of  
17 2013, Dr. Wright; is that acceptable?

18 A Sure.

19 Q Could you please turn to page 26 of Exhibit 42?

20 A Okay.

21 Q This page falls under the heading of "The  
22 Organization Level", is that correct, the heading going  
23 back to page 23?

24 A Yes.

25 Q And on page 26 you talk about organizational

1 factors necessary to support best practice, that's the  
2 first full paragraph at the top of the page. Do you see  
3 that?

4 A Yes.

5 Q And then toward the bottom you quote from a  
6 number of authors saying that:

7

8 "[Best Practice] also requires a  
9 commitment from organizational  
10 leadership."

11

12 Do you see that?

13 A Yes.

14 Q And that's essentially saying that best practices  
15 is not only for frontline workers and their supervisors to  
16 meet, it's for those above them in the change, or in the  
17 chain of command as well?

18 A Yes, yes.

19 Q And in terms of those above frontline workers and  
20 their supervisors, those people also need to have a strong  
21 personal commitment?

22 A Yes.

23 Q And all elements of the organization should be  
24 striving for best practices in service delivery?

25 A Yes.

1 Q And, Dr. Wright, if you could look at page 29 of  
2 your transcript again, line 4. Do you see it?

3 A Sorry, I just got the wrong one.

4 Q That's fine.

5 A Yeah, I've got it.

6 Q And you speak there about best practices being  
7 important because it provides accountability to a variety  
8 of entities; is that right?

9 A Yes.

10 Q And you agree with me that personnel above  
11 frontline workers and supervisors should also be  
12 accountable to service recipients and funders?

13 A Yes.

14 Q And those people as well should be applying their  
15 clinical judgment to improve service planning and programs?

16 A They should be applying their judgment.

17 Q Now if you could turn to page 75 of your  
18 transcript from April 24 of 2013. And if you could just  
19 read to yourself the last paragraph, beginning at line 17  
20 and then let me know when you're finished please.

21 A Yes.

22 THE COMMISSIONER: This is her transcript?

23 MS. BOWLEY: Yes, it is, sir. Do you have it in  
24 front of you, Mr. Commissioner, because otherwise we can --

25 THE COMMISSIONER: No, but that's all right.

1 MS. BOWLEY: Okay.

2

3 BY MS. BOWLEY:

4 Q I'm sorry, Dr. Wright, did you say you were  
5 finished? I might have missed that.

6 THE COMMISSIONER: No, I don't think she  
7 answered.

8 THE WITNESS: Yes.

9

10 BY MS. BOWLEY:

11 Q And so what you're --

12 A Yes, I'm finished.

13 Q Okay, thank you. What you are saying there is  
14 that where there are unexpected outcomes it's important  
15 for, in terms of best practices, an organization to learn  
16 from that; is that right?

17 A Yes.

18 Q Would you agree with me that best practices on an  
19 organizational level is more than that, it includes efforts  
20 by the organization to improve the service delivery on an  
21 ongoing basis separate from unexpected outcomes?

22 A Yes, I think best practices on an organizational  
23 level really sets a culture, an organizational culture that  
24 focuses on instilling best practices as an approach within,  
25 whether it's a direct practice, relationship stuff or

1 supervisory or management or recruitment and hiring and the  
2 training. It really -- it views it on a broad  
3 organizational level and when things work well you learn  
4 from those and when things don't work well you learn from  
5 those experiences and then there's an evaluative component  
6 where the organization has a process to then improve  
7 services or maintain, you know, good services --

8 Q So everybody --

9 A -- and policies.

10 Q Everyone needs to be working together to improve  
11 things, higher-ups and frontline people; is that right?

12 A Yes, and I think that's very critical that things  
13 aren't just limited to focusing on a direct practice level.

14 Q Meaning the frontline workers and supervisors?

15 A Yes, and that people need to be -- the work that  
16 people produce is within the context of their organization.

17 Q And I think you mentioned this and I just want to  
18 highlight it a bit, it's also important for the  
19 organization to evaluate programs and determine whether  
20 they are achieving desired outcomes; is that right?

21 A Yes.

22 Q And as part of that evaluation process, improving  
23 them, if necessary.

24 A Yes.

25 Q And getting back to this all working together

1 idea within the organization, the organization needs to  
2 provide resources and tools before it can expect what you  
3 call the direct service people to successfully apply a best  
4 practices approach in their work; is that correct?

5 A Well I think, I think a solid organizational  
6 approach can really enhance and sustain best practice, best  
7 practices on a direct service level. It doesn't mean that  
8 direct service can't reflect best practices even if they  
9 aren't always getting as much support as they need or a  
10 culture of best practices. Having said that, I think it's  
11 very difficult for direct service practice to be best  
12 practice when you don't have the organizational support.

13 Q I'm going to move on now, Dr. Wright. You refer  
14 in your report and your evidence to the importance of  
15 regular plan supervision. Do you recall that?

16 A Um-hum.

17 Q Sorry?

18 A Yes.

19 Q Thank you. And I take it based on the things  
20 that we've just discussed that you'd agree that supervisory  
21 positions need to be structured so that time and priorities  
22 would allow for that regular plan supervision; is that  
23 correct?

24 A Yes.

25 Q And similarly, in order for the supervision to be

1 meaningful, the supervisor must be given tools including  
2 training on standards and manuals and best practices; is  
3 that right?

4 A Yes. And should be given training on how to be a  
5 good supervisor.

6 Q I want to move on again to another area and  
7 that's with respect to some evidence that you gave on  
8 April 24 of 2013 and I think it's going to take me just a  
9 minute to find it, so please bear with me. It was with  
10 respect to what social workers ought to do when they find  
11 themselves in a situation where, because of workload issues  
12 and workplace issues, they are unable to meet standards or  
13 best practices and you suggested -- this is now at page 82  
14 of your transcript. You said at the very least that social  
15 workers have a responsibility to raise issues; you recall  
16 that?

17 A Yes.

18 Q And they have a responsibility to discuss these  
19 issues with their supervisors, correct?

20 A Yes.

21 Q And going forward, then supervisors have a  
22 responsibility to address this with managers. You agree  
23 with that?

24 A Yes.

25 Q Yes. And I hear what you're saying, I think, in

1 that social workers and their supervisors can advocate for  
2 change; is that right?

3 A Yes.

4 Q But you'd also agree with me that given the  
5 hierarchy and the chain of command and authority, that they  
6 don't have the ability to force these things to change; is  
7 that right?

8 A I guess. I think, you know, they also have --  
9 and it's a -- if the social worker has options in terms of  
10 union support, I don't know -- I know all agencies don't  
11 have a union, that might be another option, or a  
12 professional association may help too. But generally, yes,  
13 I don't think it's in the power of the social worker to  
14 change things.

15 Q Do I understand you to say that one of the things  
16 social workers might do when they're struggling to meet  
17 their mandate is to make the Institute of Registered  
18 Manitoba Social Workers aware?

19 A I think from a professional body, I think the  
20 institute may provide support services or advocacy for  
21 workers. That's not (inaudible) real area of focus but I  
22 think there's potential there.

23 Q But again, you'd agree that the institute does  
24 not have the power to force this change, it can only  
25 advocate; is that right?

1           A     Yes, that's right.

2           Q     I want to turn now to something that may be  
3 picayune but I just want some clarification and we're  
4 hindered a bit in that you don't have your old report with  
5 you but I'll try and give you as much context as possible.  
6 In your old report on page 34 of that June 2006 or page 369  
7 of the commission disclosure documents.

8           THE COMMISSIONER: Page what of the report?

9           MS. BOWLEY: Thirty-four of the hard copy of the  
10 report.

11          THE COMMISSIONER: Yeah, that's what I'm working  
12 with, yeah.

13          MS. BOWLEY: Okay.

14

15 BY MS. BOWLEY:

16          Q     The first -- and sorry, this is under the heading  
17 of "Best Practice in Child Welfare: Concluding Points" in  
18 your old report and I'll give it to you because you don't  
19 have it in front of you. The first bullet point said:

20

21                   "On a direct service level [best  
22 practice] can only occur if  
23 caseloads and workloads are  
24 manageable and allow the worker to  
25 implement BP [best practice]

1                    approaches such as meeting face to  
2                    face with children, families and  
3                    collaterals ... and developing a  
4                    relationship with families."

5

6    You see that? Oh sorry, you don't see that. You heard me  
7    say it though?

8            A    I hear it.

9            Q    Yes, thank you.

10          A    Yes.

11          Q    And then if we go to your new report, page 43,  
12    the final recommendations, do you have it there?

13          A    Yes.

14          Q    I'm sorry, I didn't hear you.

15          A    Yes.

16          Q    Okay, thank you. Would you agree with me that  
17    those bullet points are not ranked in order of priority?

18          A    Yes.

19          Q    And so now the comment that I read to you in your  
20    old report does not appear there in total but further down,  
21    the eighth bullet point, you say:

22

23

24                    "On a direct service level [best  
25                    practices] can only occur if

1                   workloads are manageable and allow  
2                   the worker to implement [best  
3                   practices] approaches ..."

4

5   Et cetera, et cetera. And I just want to confirm for you  
6   because you've omitted the word caseload, was that  
7   deliberate?

8           A     Yes, that was deliberate.

9           Q     And why was that?

10          A     Well really to clarify as I did indicate from,  
11   but really to clarify that workload is a, is a very  
12   important consideration because it doesn't just take into  
13   consideration one sort of the active case per se, but it  
14   looks at time required to provide support to that family,  
15   it may be working with collaterals, it may be travel time,  
16   but it is much, I think a more fair way to look at  
17   workload, of service providers.

18          Q     Right. So workload is a meaningful tool for you,  
19   or a meaningful term?

20          A     Yes.

21          Q     And do you agree that workload measurement within  
22   an organization is helpful?

23          A     Yes.

24          Q     Do you have more to say on that?

25          A     Oh I just think another example that I think

1 often gets sort of overlooked with direct practice or  
2 social workers working with families is if you have a  
3 family where there may be five kids involved and one of  
4 them is, there have been allegations or substantiations  
5 perhaps of abuse and if the other four still require a lot  
6 of family support, it's important to be able to look at  
7 that worker providing services to the five as opposed to  
8 just the one. That's an example of one family though.

9 Q All right, thank you. And in your new January of  
10 2013 report, you cited a book by Peter Reder, Sylvia  
11 Duncan, Moira Gray. It's called "Beyond Blame: Child Abuse  
12 Tragedies Revisited".

13 A Yes.

14 Q And that book was published in 1993; is that  
15 right?

16 A Yeah.

17 Q And that book resulted from three social work  
18 academics, that is professors, studying 35 fatal child  
19 abuse inquiry reports published between 1973 and 1989 in  
20 the United Kingdom?

21 A Yes.

22 Q And they reanalyzed these cases using systemic  
23 theories and other applicable theories?

24 In case you're struggling with that, I read it  
25 from a book review. If that's not something you're

1 familiar with, that's fine.

2 A Okay.

3 Q In a general sense though would you agree with me  
4 that these professors analyzed these cases using various  
5 theories and then put forward their findings in this book?

6 A Yes.

7 Q And that book was not cited in your 2006 report,  
8 correct?

9 A I don't know.

10 Q Well I don't see it in your bibliography. If  
11 you're of a different conclusion you can review report and  
12 let commission counsel know and we can correct that on the  
13 record.

14 A Okay.

15 Q And in your evidence last time on April 24 of  
16 2013, you gave evidence that you didn't know if this book  
17 was widely available to people with BSWs; is that right?

18 A I think what I said is I'm not sure if it's  
19 taught in, if it's used in classrooms or BSW.

20 Q All right. And it was not required reading?

21 A Right. Yes, that's correct, it's not required  
22 reading.

23 Q Thank you. You were also asked if the concepts  
24 in this book with respect to assessment process and meeting  
25 with family members were new and you answered no, do you

1 recall that?

2 A Yes, I recall that.

3 Q Would you agree with me that the age of a concept  
4 in terms of workers' knowledge has less to do with age and  
5 more to do with dissemination?

6 A Are you talking about the concept of meeting with  
7 family members?

8 Q No, I'm talking about generally concepts, their  
9 age has little to do with how widely they're known and  
10 applied, it has more to do with dissemination and training.

11 A Generally they might?

12 Q Yes.

13 A I'm struggling with this one. I don't know how  
14 to answer that, I'm sorry.

15 Q That's fine.

16 A But I think the concept of meeting with families  
17 isn't a new one and is, is a known one, that's an important  
18 thing to do. Even though I know I quote Reder, et cetera,  
19 but I think even in classes where that text may not, might  
20 not be used, that concept is a known concept.

21 Q Right. And you meet with families in order to  
22 build a relationship so that you can effect change for  
23 these families?

24 A Building a relationship is one piece but really  
25 in cases where there are safety concerns, to assess the

1 safety of the family members, as well as build a  
2 relationship --

3 Q Right.

4 A -- they go together.

5 MS. BOWLEY: Mr. Commissioner, I think that I'm  
6 nearly finished. This might be a good time for the morning  
7 break and I may be able to come back and say that I have no  
8 more.

9 THE COMMISSIONER: Well, I'm just thinking about  
10 the teleconferencing. Are there going to be any other  
11 witnesses, any other counsel have questions for this  
12 witness?

13 MS. BOWLEY: Yes, I see one nod in the  
14 background, oh two nods.

15 THE COMMISSIONER: Well why don't you go to your  
16 table and see if there's further questions you want and we  
17 take Mr. Ray, I believe it is, right?

18 MS. BOWLEY: That, that works. Thank you.

19 THE COMMISSIONER: Have you got questions,  
20 Mr. Ray?

21 MR. RAY: Not very many in light of many of the  
22 questions that Ms. Bowley has asked. I may have very  
23 little once I'm, once I'm finished so.

24 THE COMMISSIONER: Well, and Mr. Scarcello, have  
25 you got questions?

1 MR. SCARCELLO: Yes, I will have.

2 THE COMMISSIONER: Well, what are we going to do  
3 about an adjournment with a teleconferencing, can we put it  
4 on hold for 15 minutes?

5 MS. WALSH: I don't know that we've ever done  
6 that, Mr. Commissioner. I mean I suppose we can ask  
7 Dr. Wright just to go and take a walk for 15 minutes, but I  
8 mean I think the ideal thing would be just to proceed and  
9 finish with her evidence.

10 THE COMMISSIONER: I think --

11 MS. WALSH: She's nodding.

12 THE COMMISSIONER: I think we'll do that. We'll  
13 let you back if there's something else you want.

14 MS. BOWLEY: That certainly works for me. Thank  
15 you.

16 THE COMMISSIONER: Okay. Do you want to come,  
17 Mr. Scarcello?

18 MR. SCARCELLO: Yes, thank you.

19 THE COMMISSIONER: We're going to carry on,  
20 Witness.

21 THE WITNESS: Okay, thank you.

22

23 CROSS-EXAMINATION BY MR. SCARCELLO:

24 Q Good morning, Dr. Wright.

25 A Good morning.

1 Q My name is Shawn Scarcello. I'm counsel for the  
2 Northern Authority, Southern Authority and ANCR in this  
3 proceeding. I just have a few questions for you. Now your  
4 paper obviously focuses on best practices and in your prior  
5 testimony you had spoken about some possible impediments to  
6 achieving best practice, do you recall that?

7 A Yes.

8 Q And one of them you had brought up was, as a  
9 possible impediment, was support from management for social  
10 workers --

11 A Yes.

12 Q -- and you had spoken about that a bit this  
13 morning as well. Now perhaps you can clarify, really what  
14 you're saying here is that if there isn't the appropriate  
15 support from management that that can be an impediment to  
16 achieving best practices. Do you agree with that?

17 A Yes.

18 Q And when you're talking about support from  
19 management, you're talking about management, for example,  
20 providing appropriate training, appropriate tools and  
21 organizational structure that best allows the achievement  
22 of best practices to occur.

23 A Yes.

24 Q So if you have an organizational structure that  
25 is, for example, providing comprehensive training, you'll

1 agree that that would be management working to remove one  
2 possible impediment to the achievement of best practices?

3 A Yes.

4 Q And that would be, for example, training the  
5 frontline staff or the supervisors on standards,  
6 legislation, best practices and other social work  
7 techniques and so on?

8 A Yes.

9 Q Now you'll agree with me that if management has  
10 social workers communicating to them that they feel that  
11 they are adequately trained and that they are trained  
12 sufficiently that they feel that they can perform their  
13 duties, it's reasonable to conclude that management has  
14 effectively removed training as a possible impediment to  
15 best practices being achieved?

16 A I guess I sort of see it as an ongoing process  
17 but yet after a certain training period the worker is  
18 saying I can do the job appropriately or I feel competent  
19 and I get the support I need then, yes, I think that's  
20 correct.

21 Q And if there's no other evidence to suggest  
22 otherwise?

23 A Yes.

24 Q Now just talking about the organizational  
25 structure and the issue of workload as being an impediment,

1 you had mentioned that as well?

2 A Yes.

3 Q And you'd agree with me that if management was  
4 working in collaboration with its employees in making  
5 genuine efforts to make changes in adding funding and  
6 adding positions in attempting to reduce workload and in  
7 fact to some extent actually reducing the workload, you  
8 would agree that that would be an example of management  
9 removing or at least helping to partly remove the  
10 impediment that workload can have on achieving best  
11 practices?

12 A Yes, yes.

13 Q Now you'll agree with me that no matter how much  
14 training is done by an organization or attempts to, you  
15 know, reduce workload, that there's always some level of  
16 judgment or application of skill and technique required by  
17 social workers in performing their duties?

18 A Yes.

19 Q Like at some point they have to analyze the  
20 situation and assess it and make a judgment call?

21 A Yes.

22 Q And there's nothing management can do to ever  
23 totally remove that from the equation, you'll agree with  
24 that?

25 A That's right. I think that's how you can define

1 frontline work and that there isn't direct supervision of  
2 work being done.

3 Q Right.

4 A That's one of the characteristics of it.

5 Q So what we're talking about here for management  
6 is, is what they can do is provide the proper tools, the  
7 proper training, the organization structure to best assist  
8 the social workers in having everything they need to  
9 properly make that analysis and assessment of the situation  
10 and make the best call in the situation.

11 A With the supervisory role included in that too.

12 Q Of course, yes. Thank you. Those are all my  
13 questions. Good morning.

14 THE COMMISSIONER: Thank you, Mr. Scarcello.

15 Mr. Ray?

16 MR. RAY: Good morning, Mr. Commissioner. Thank  
17 you.

18

19 CROSS-EXAMINATION BY MR. RAY:

20 Q Ms. Wright, my name is Trevor Ray. I'm counsel  
21 for the Manitoba Government Employees Union which is the  
22 union that acted or acts, continues to act and represent  
23 the social workers that were involved in providing services  
24 to Phoenix Sinclair and her family and I also act for many  
25 of the social workers that provided the services to Phoenix

1 and her family. I just have a few questions of  
2 clarification for you. You're able to hear me okay? I see  
3 you nodding.

4 A Yes.

5 Q Firstly, I just, I think you said this when you  
6 last testified but I just want to confirm that you  
7 communicated you were not familiar with the specific facts  
8 involved in Phoenix's case, you had not heard the evidence,  
9 that's correct?

10 A Right.

11 Q Okay. And do I take it from that that you have  
12 not conducted a review of the provincial foundational  
13 standards that existed either at the time services were  
14 provided or any of the changes to the foundational  
15 standards that have resulted since that point in time?

16 A Are those the standards that are online?

17 Q There's a set of provincial foundational  
18 standards that existed -- oh I don't want to open this can  
19 of worms if we don't have to. There's standards that  
20 existed in 1988 and they were modified and they now  
21 currently exist as of 2005 they were placed on line but  
22 they have been modified again since 2005.

23 A I think I've looked at them briefly but not in  
24 any level of detail to be able to comment on the specifics.

25 Q And when you say you've looked at them you mean

1 the ones that are online?

2 A Yeah.

3 Q And so those would be the 2005 and going forward  
4 standards, just for your information.

5 A I did work -- I worked in child welfare years ago  
6 so I was aware of what we had then but nothing since.

7 Q Okay, thank you. So you're not in a --  
8 Ms. Bowley asked you some questions. You're not in a  
9 position to say whether particular provincial foundational  
10 standards as they exist either today or as they existed at  
11 the time service was provided to Phoenix's family, you're  
12 not in a position to say whether those standards as written  
13 did or did not meet best practice or what you would  
14 consider best practice?

15 A I'm not in a position to say that.

16 Q Thank you. You gave some evidence about -- I'm  
17 looking for the terminology here if you'll give me a moment  
18 -- of the case management approach to providing social work  
19 services versus the family assessment approach and your,  
20 your evidence was that if social workers are expected to  
21 engage and build trust and enable changes they need time  
22 and resources in order to do that. Do you recall that  
23 evidence? Okay. You're nodding yes.

24 A Yes.

25 Q And you then said if caseloads are too high then

1 it becomes very difficult to provide those services and  
2 what that results in is the social worker then providing  
3 services in a case management approach as opposed to a  
4 family support approach. And if I understand what you're  
5 saying is a case management approach is really more of a  
6 putting out fires, attending to emergencies approach or  
7 providing services, whereas a family support approach would  
8 be a much more in depth, more detailed assessment in  
9 working with the family in the way that you've described  
10 would meet the best practice that we would want to achieve;  
11 is that correct?

12 A Well, and I think a case management approach  
13 really would be more sort of ensuring that, or trying to  
14 get other collateral service providers to be providing  
15 whatever necessary family support services are needing.

16 Q Okay, thank you. And would a case management  
17 approach possibly lead to social workers -- I'm sorry, I'll  
18 withdraw that question. Thank you.

19 You were, had described when Ms. Bowley asked you  
20 some questions about what you would expect or hope a social  
21 workers would do when confronted with high workloads and an  
22 inability to meet standards and you testified that you  
23 would hope that they would tell the supervisors and so on.  
24 Today in your evidence you also mentioned perhaps advocacy  
25 on behalf of their union and I assume you would agree with

1 me that if a union was writing to perhaps the director or  
2 leader of an organization or perhaps going beyond that and  
3 writing to the minister responsible for Child and Family  
4 Services and identifying concerns that were brought to the  
5 union's attention by its membership and by its supervisors  
6 and that the union felt were not being addressed, that that  
7 would be the type of thing that you would hope that social  
8 workers and the union would do when they were unable to  
9 meet certain standards or unable to address issues as they  
10 wanted to in light of their caseload. And you're nodding,  
11 correct?

12 A Yes.

13 Q You mentioned also there are times when  
14 notwithstanding the social workers attempt to work with the  
15 family and to form a relationship with the family that the  
16 family may not be willing to engage with the social worker  
17 and may be either attempting to avoid services, for  
18 example, or not cooperating and I think what you said in  
19 your evidence when you last testified was at that point the  
20 social worker needs to take an authoritative and decisive  
21 stance with respect to the services they're providing to  
22 the family. You would agree with me that the ability of a  
23 social worker to do that would depend upon their, their  
24 experience and their training and their knowledge in terms  
25 of how to address that difficult situation with the family?

1           A     And I think critically their, their supervisor's  
2 direction too.

3           Q     Yes.        And the supervisor's training and  
4 experience as well in terms of dealing with those difficult  
5 situations?

6           A     Yes.

7           Q     Would it also, I assume, be necessary for the  
8 social worker to have the experience to recognize when a  
9 family is being, is deliberate avoiding the social worker  
10 or deliberately refusing to participate in services as  
11 opposed to perhaps a situation where they're not, they're  
12 just not home or perhaps a situation where we've heard  
13 evidence about cultural practices in particular with  
14 aboriginals where a child may be raised by more than one  
15 family or friends of a family and that's a common thing  
16 that happens.    So the worker would have to be able to  
17 recognize that as a legitimate cultural approach versus a  
18 situation where the family is really trying to deliberately  
19 avoid the social worker.    That was a bit of a long  
20 question, but ...

21          A     I think, I think the key there is ensuring that  
22 whatever the situation is, is the worker, if they are  
23 questions or concerns the worker has the opportunity to  
24 raise those issues with their supervisor and, you know, get  
25 some feedback and direction in terms of next steps.

1           Q     And that -- I assume what you're saying then is,  
2     and that would really apply to providing any type of  
3     service in the course of providing social work services.

4           A     Yes.

5           MR. RAY:       I think I'm nearly finished,  
6     Mr. Commissioner, if I could just have a moment --

7           THE COMMISSIONER:   Yes, yes.

8           MR. RAY:   -- to review my notes.

9           THE COMMISSIONER:   Fine.

10          Counsel is just checking his notes, Witness, to  
11     see if there's anything else, so we won't be long.

12          THE WITNESS:   Okay, thank you.

13

14     BY MR. RAY:

15          Q     With respect to the death reviews that were  
16     discussed by Ms. Bowley and that are referred to in your  
17     paper, one of the factors that you said can impact, or not  
18     that you said but that you cited as impacting services was  
19     a situation where there was constant organizational change  
20     within the provision of services. Would you agree with me  
21     that that would include a situation where we changed the  
22     model of providing services from which was centralized to  
23     one which was then decentralized to one which then became a  
24     situation where social workers would first provide specific  
25     types of services to one where they would provide all types

1 of services from one to where we went through the concept  
2 of devolution and including changing provincial standards.  
3 Are those the types of constant change that you would find  
4 that would impact services?

5 A I think organizational change can absolutely have  
6 an impact, a negative impact on direct practice and the  
7 smoothness of the transition to organizational change can  
8 make a difference.

9 Q And of course I'm not suggesting we shouldn't  
10 make good changes but however well intended those changes  
11 are, the fact that those changes are occurring is, is,  
12 makes it more difficult; is that correct?

13 A If they're -- if the transitions aren't smooth,  
14 yes, I think that is correct.

15 Q Thank you.

16 MR. RAY: Thank you, Ms. Wright. Those are my  
17 questions. Thank you for reattending with us today.

18 Thank you, Mr. Commissioner.

19 THE COMMISSIONER: Thank you, Mr. Ray.

20 Now is there anyone other than Ms. Bowley?

21 MR. PAUL: No questions, Mr. Commissioner.

22 THE COMMISSIONER: Anything else, Ms. Bowley?

23 MS. BOWLEY: I'm sorely tempted to ask some  
24 questions, Mr. Commissioner, but I thought better of it and  
25 I'll stand down.

1 THE COMMISSIONER: Well if there's something  
2 you ...

3 MS. BOWLEY: I'm just teasing, there are no more  
4 questions.

5 THE COMMISSIONER: Oh okay. Go back to your  
6 chair.

7 MS. BOWLEY: Thank you.

8 THE COMMISSIONER: All right. Now is there  
9 any -- do you have any questions?

10 MS. HARRIS: No, I have no questions. Thank you.

11 THE COMMISSIONER: Thank you.

12 MS. WALSH: I have no further questions. Thank  
13 you.

14 THE COMMISSIONER: Dr. Wright, you're finished.  
15 Thank you very much for making this further appearance.  
16 You've been of assistance to us.

17 THE WITNESS: Thank you.

18

19 (WITNESS EXCUSED)

20

21 THE COMMISSIONER: And that concludes -- all  
22 right. We're ready to take a 15 minute break, are we?

23 MS. WALSH: Yes.

24 THE COMMISSIONER: We'll do that and then we'll  
25 take our next witnesses.

1 MS. WALSH: Thank you.

2

3 (BRIEF RECESS)

4

5 THE COMMISSIONER: All right.

6 MR. MCKINNON: Hello, Mr. Commissioner.

7 THE COMMISSIONER: We're going to have a panel  
8 presentation, are we?

9 MR. MCKINNON: We're going to have a panel  
10 presentation. For the monitor it's Gordon McKinnon  
11 speaking. There will be two witnesses who will be speaking  
12 as a panel. They are Alana Brownlee and Karen McDonald and  
13 maybe the first thing we should do is have the witnesses  
14 sworn. Ms. Brownlee has testified twice previously,  
15 Mr. Commissioner, Ms. McDonald has not testified before.

16 THE COMMISSIONER: We'll -- Ms. Brownlee will  
17 remain under oath. I'm sure she understands that.

18 MS. BROWNLEE: Yes.

19 THE COMMISSIONER: And Ms. McDonald will be  
20 sworn.

21 MR. MCKINNON: Thank you.

22 THE COMMISSIONER: Or affirmed as she wishes.

23 THE CLERK: Can you just stand for a moment. Is  
24 it your choice to swear on the Bible or affirm without the  
25 Bible?

1 MS. MCDONALD: I can swear on the Bible.

2 THE CLERK: Okay. Just take the Bible in your  
3 right hand then. State your full name to the court.

4 MS. MCDONALD: Karen Leah, L-E-A-H, McDonald,  
5 M-C-D-O-N-A-L-D.

6 THE CLERK: And is it K-A-R-E-N?

7 MS. MCDONALD: Yes.

8 THE CLERK: Thank you.

9

10 **KAREN LEAH MCDONALD**, sworn,  
11 testified as follows:

12

13 **ALANA BROWNLEE**, previously sworn,  
14 testified as follows:

15

16 THE CLERK: Thank you. You may be seated.

17 MR. MCKINNON: Mr. Commissioner, from time to  
18 time Ms. Brownlee may need to stand as a result of a  
19 medical condition and I'm sure if she does that, that will  
20 be acceptable to the Commission.

21 THE COMMISSIONER: There's room there, is there?

22 MS. BROWNLEE: Yes.

23 THE COMMISSIONER: Don't want you falling off the  
24 platform.

25 MS. BROWNLEE: I hope not.

1 THE COMMISSIONER: It's pretty close but if  
2 there's any problem let me know.

3 MS. BROWNLEE: If there's a question I don't want  
4 to answer I'll maybe do that as an out.

5 THE COMMISSIONER: Okay.

6 MR. MCKINNON: Mr. Commissioner, the detailed  
7 summary of the evidence that these two witnesses will be  
8 touching upon can be found at the Department's phase 2  
9 summary of evidence, which is the 79 page document, now  
10 Exhibit 63 and their evidence starts at page 44 of that  
11 exhibit.

12 THE COMMISSIONER: Well let me see if I can find  
13 Exhibit 63.

14 MR. MCKINNON: I think that was the spiral bound  
15 document.

16 THE COMMISSIONER: Yes, yes. This could be it  
17 here. No, that's 75. Oh I have it, yeah.

18 THE CLERK: What's the page number?

19 MR. MCKINNON: Starting at page 44.

20 THE COMMISSIONER: All right.

21 MR. MCKINNON: And just by way of introduction,  
22 Mr. Commissioner, we're going to be talking a lot about  
23 essentially two things, training and in the course of  
24 describing to you the current training we are going to give  
25 you a bit of a sense not just about the training but what's

1 taught because that's relevant to the way in which practice  
2 is now being done at Winnipeg CS, Winnipeg CFS. So a lot  
3 about training and then later on we're going to talk how  
4 the Phoenix Sinclair case would look if it were handled  
5 today under the new GA practice model which you heard about  
6 from Mr. Rodgers yesterday. So those are the two big areas  
7 of evidence that these witnesses will be covering.

8           And one other area that we will be covering and  
9 it will probably be right at the end, and I'll ask  
10 Ms. Brownlee to comment on this at the end but that is the  
11 response of Winnipeg CFS to the recommendations contained  
12 in the internal review and I have provided commission  
13 counsel with a binder. I think there are three copies.  
14 It's a one inch binder. And I'm proposing to mark that  
15 now, Mr. Commissioner, even though we won't be referring to  
16 it for some time, because there is one exhibit in there  
17 that we may refer to during the course of the panel's  
18 evidence. So I'd like to mark the, that document entitled  
19 "The Response of Winnipeg CFS to the Internal Review" as  
20 the next exhibit.

21           THE COMMISSIONER: That will be Exhibit what,  
22 seventy ...

23           THE CLERK: Exhibit 78, Mr. Commissioner.

24           THE COMMISSIONER: Seventy-eight.

25

1                   **EXHIBIT 78:       DOCUMENT ENTITLED**  
2                   **"THE RESPONSE OF WINNIPEG CFS TO**  
3                   **THE INTERNAL REVIEW"**

4

5                   THE COMMISSIONER:   So are these witnesses in the  
6 main going to follow the pages in Exhibit 63 starting at  
7 page 44?

8                   MR. MCKINNON:   They are in the main going to do  
9 that, Mr. Commissioner.   I'm going to try -- we won't get  
10 through if I, if I follow it exactly, we won't complete  
11 today, so I'm going to try and shorten their evidence up.  
12 And then you will have this if you want to refer to it  
13 which may be more detailed than some of their evidence  
14 today.

15                  THE COMMISSIONER:       But should expect that  
16 everything they're going to tell us is contained in these  
17 pages?

18                  MR. MCKINNON:   By and large.   They may amplify  
19 with some anecdotes to make it --

20                  THE COMMISSIONER:   Yes.

21                  MR. MCKINNON:   -- easier to understand but the  
22 content should be in those pages.

23                  THE COMMISSIONER:   And is that page 44 to the end  
24 which is page 79?

25                  MR. MCKINNON:   Correct.

1 THE COMMISSIONER: All right.

2 MR. MCKINNON: Now I know you've already heard a  
3 bit about Ms. Brownlee's education and work history.

4 THE COMMISSIONER: Yes.

5 MR. MCKINNON: I'm going to just highlight a few  
6 points from that and I'll do that for both these witnesses  
7 by leading in the hope to save some time.

8 THE COMMISSIONER: And just remind me of the  
9 current positions.

10 MR. MCKINNON: Right.

11

12 DIRECT EXAMINATION BY MR. MCKINNON:

13 MR. MCKINNON: So in terms of your current  
14 position, Ms. Brownlee, you are the chief executive officer  
15 of Winnipeg CFS?

16 MS. BROWNLEE: That's correct.

17 MR. MCKINNON: And then if I go backward and  
18 start with your work history and education, you have a  
19 bachelor of social work, 1989, and a master's of social  
20 work 1998, both from the University of Manitoba?

21 MS. BROWNLEE: Yes.

22 MR. MCKINNON: And you're a family service social  
23 worker from 1989 to 1992 in one of the regions that would  
24 now be part of Winnipeg CFS?

25 MS. BROWNLEE: Yes.

1 MR. MCKINNON: And from 1992 to 1995 you were the  
2 abuse and treatment services coordinator at Winnipeg CFS?

3 MS. BROWNLEE: Yes.

4 MR. MCKINNON: And 1995 to 2000 you were a  
5 supervisor at what was then called a family reunification  
6 unit?

7 MS. BROWNLEE: Yes.

8 MR. MCKINNON: And just in a sentence or two,  
9 what's a family reunification unit do?

10 MS. BROWNLEE: That was part of the family  
11 preservation, family reunification for province-wide  
12 strategy that was implemented at that time and it was  
13 focused on, it was focused on providing intensive services  
14 to --

15 THE COMMISSIONER: Move that forward as much as  
16 you like.

17 MS. BROWNLEE: Focused on providing services as  
18 much as -- intensive services to families where children  
19 were in care and were in care of significant protection  
20 issues as a way of trying to facilitate reunification in a  
21 safe a way as possible.

22

23 BY MR. MCKINNON:

24 MR. MCKINNON: And from 2000 to 2005 you were the  
25 provincial investigations coordinator at the Child

1 Protection Branch which is part of the department. Very  
2 briefly, what was that job?

3 MS. BROWNLEE: That job was focused on conducting  
4 child abuse investigations where the allegations involved  
5 either staff members of the CFS system or people that were  
6 considered in a position of trust. So it included  
7 allegations made against agency staff, residential care  
8 staff, correctional system staff for the youth justice  
9 system and an oversight role related to agencies conducting  
10 allegations against foster parents.

11 MR. MCKINNON: Okay. And after that for a period  
12 of about two years, so this would be '05, '06, you were the  
13 manager of the, of children's resources for the department.

14 MS. BROWNLEE: Yes.

15 MR. MCKINNON: That might be less relevant to  
16 your evidence today?

17 MS. BROWNLEE: It had -- I was working at the  
18 Child and Family Services division and I had responsibility  
19 for the provincial placement desk, licencing of residential  
20 care, the child abuse registry, as well as the provincial  
21 child abuse investigations, as well as foster, the  
22 provincial foster care system.

23 MR. MCKINNON: Okay. And then from 2006 till  
24 2011, you were the executive director of the Métis CFS  
25 agency, correct?

1 MS. BROWNLEE: Yes.

2 MR. MCKINNON: And just for the record,  
3 Mr. Commissioner, she was the CEO of the Métis agency, not  
4 the Métis authority.

5

6 BY MR. MCKINNON:

7 MR. MCKINNON: Am I right in my understanding of  
8 that?

9 MS. BROWNLEE: That's, that's correct.

10 MR. MCKINNON: And we've already discussed but  
11 commencing in July of 2011 you became the CEO of Winnipeg  
12 CFS?

13 MS. BROWNLEE: Yes.

14 MR. MCKINNON: Mr. Commissioner, I'm now going to  
15 just go through Ms. McDonald's education and work history.

16 THE COMMISSIONER: Right.

17

18 BY MR. MCKINNON:

19 MR. MCKINNON: Ms. McDonald, you have a Bachelor  
20 of Social Work from the University of Manitoba, graduating  
21 in 1990?

22 MS. MCDONALD: Correct.

23 MR. MCKINNON: Now you have something called a  
24 field instructor's course in the Faculty of Graduate  
25 Studies 1995, also from the University of Manitoba.

1 Briefly what's that?

2 MS. MCDONALD: That was a course that we took if  
3 we wanted to supervise students within our agency and I was  
4 a supervisor of several students, so I was required to take  
5 that course. It is a graduate studies course and we did  
6 have to register at the university.

7 MR. MCKINNON: Okay. And you have been involved  
8 as a provincial competency based trainer since 1998, am I  
9 correct in that?

10 MS. MCDONALD: That's correct.

11 MR. MCKINNON: And what does that mean?

12 MS. MCDONALD: The Province of Manitoba has a  
13 competency based training core curriculum for social  
14 workers and I am a trainer in that and have been since  
15 1998. I trained a five day core module that was on family  
16 assessment and case planning and currently train two  
17 modules, one on family assessment and the other on  
18 investigative processes in the field.

19 MR. MCKINNON: Thank you. And point (c) on your  
20 CV is you commenced work as a family service social worker  
21 at Winnipeg CFS in 1990; am I correct in the year?

22 MS. MCDONALD: That's correct.

23 MR. MCKINNON: I'm going to skip a couple because  
24 you have a lengthy CV. At paragraph (e) you were at one  
25 point, from 1995 to 1999, a therapist at the in-home crisis

1 resolution program in the family preservations  
2 reunification unit of Winnipeg CFS. We've heard  
3 Ms. Brownlee a moment ago describe what family preservation  
4 reunification unit is. Do you have anything to add to  
5 that?

6 MS. MCDONALD: The only thing that I've had to  
7 add is that our program was somewhat different than the  
8 program that Ms. Brownlee worked in. We had families, we  
9 were considered auxiliary workers, meaning that they also  
10 had another social worker attached to them and the purpose  
11 that we were involved for was we were involved in both  
12 preservation and a reunification capacity and in the  
13 preservation stream it was families where the children were  
14 at high risk of coming into care and required intensive  
15 work. So we would work with those families as well as  
16 families where the children were in care but they needed  
17 extra support and work to get them home.

18 MR. MCKINNON: Okay. And I'm going to skip  
19 clause (f) because that's a six month term position, and  
20 move to clause (g) where you were a unit supervisor,  
21 services to children and families at Winnipeg CFS. Now  
22 we're talking from 1999 to 2003. Briefly describe that  
23 experience to the commissioner.

24 MS. MCDONALD: I supervised a family, a family  
25 service unit in the core area of Winnipeg. A family

1 service unit is comprised of social workers who are case  
2 carrying frontline social workers. I had a team of social  
3 workers that I supervised and they all worked with children  
4 that, and families that were, where there were protection  
5 issues.

6 MR. MCKINNON: Okay.

7 THE COMMISSIONER: Has that CV been filed?

8 MR. MCKINNON: No, this is just, I'm just at  
9 the --

10 THE COMMISSIONER: Okay. Well when you were  
11 skipping various things I didn't know whether --

12 MR. MCKINNON: I'm at page 47 following the --  
13 it's all in the summary.

14 THE COMMISSIONER: Oh, okay. I didn't know the  
15 CV was here, okay.

16 MR. MCKINNON: Yes.

17 THE COMMISSIONER: I see now, okay. Thank you.

18

19 BY MR. MCKINNON:

20 MR. MCKINNON: And the next position you had was  
21 also a supervisor, Ms. McDonald, and it's a unit supervisor  
22 of the permanent ward program at Winnipeg CFS, that's 2003-  
23 2005. I don't know if we have to get into that because  
24 we're not so much concerned here with the permanent ward  
25 program. I see that at page 48, clause (i) you then became

1 a unit supervisor at the permanent ward program at the  
2 Métis Child and Family Services agency for a period of two  
3 years.

4 MS. MCDONALD: That's correct.

5 MR. MCKINNON: And at that time was Ms. Brownlee  
6 the CEO of that agency?

7 MS. MCDONALD: In the beginning Ms. Brownlee was  
8 not. She came on though during that time.

9 MR. MCKINNON: Okay. And I see as well you were  
10 the acting executive director of the Métis agency for a  
11 very brief time?

12 MS. MCDONALD: Yes.

13 MR. MCKINNON: Okay. And then at paragraph (k)  
14 you became a unit supervisor of the foster care resources  
15 unit at Winnipeg CFS for a period of three years. Again  
16 very briefly what was that?

17 MS. MCDONALD: I supervised a unit that was  
18 comprised of foster care social workers who were  
19 responsible for licencing and supporting the foster homes  
20 that Winnipeg Child and Family Services had. They were  
21 responsible for ensuring that the homes met all of the  
22 standards and expectations. They were responsible for  
23 training and maintaining and supporting so that the homes  
24 provided for the children that they were carrying for in  
25 the best way they could.

1           MR. MCKINNON: At paragraph 11 we finally get to  
2 your current position -- or sorry, not paragraph 11,  
3 paragraph (1) we finally get to your current position which  
4 was the leading practice specialist and Mr. Rodgers  
5 explained a bit about this yesterday but perhaps you could  
6 just describe your job and what you do and how that will  
7 inform the evidence you're about to give today.

8           MS. MCDONALD: Sure. I am currently a leading  
9 practice specialist with Winnipeg Child and Family  
10 Services. Mr. Rodgers did, did reference that there are  
11 nine leading practice specialists throughout the general  
12 authority agencies, but I am one of the Winnipeg based  
13 leading practice specialists. So my responsibilities lie  
14 solely at this point with Winnipeg Child and Family  
15 Services.

16           THE COMMISSIONER: But you're one of the nine?

17           THE WITNESS: I'm one of the nine.

18

19 BY MR. MCKINNON:

20           MR. MCKINNON: And in terms of the services you  
21 provide to Winnipeg Child and Family Services, are you the  
22 only leading practice specialist or do you have colleagues  
23 that are also providing similar type of service?

24           MS. MCDONALD: I have colleagues. There are two  
25 other leading practice specialists within Winnipeg Child

1 and Family Services as of this date that also provide  
2 services.

3 MR. MCKINNON: And my understanding is that as a  
4 leading practice specialist you're expected to do a number  
5 of things. One of them is training?

6 MS. MCDONALD: Yes.

7 MR. MCKINNON: And you do that in the sense of  
8 formalized training where you do PowerPoint presentations  
9 and you actually teach?

10 MS. MCDONALD: Yes.

11 MR. MCKINNON: And we'll talk about that in a  
12 minute.

13 MS. MCDONALD: Okay, yes.

14 MR. MCKINNON: You do mentoring?

15 MS. MCDONALD: Yes.

16 MR. MCKINNON: Just again, how does the mentoring  
17 fit with the training?

18 MS. MCDONALD: Mentoring is actually one of  
19 probably the most foundational pieces of my work.  
20 Mentoring is when we, when we train something in a  
21 classroom type setting we know that people, when they leave  
22 that room they don't retain about 80 percent of what  
23 they've learned unless they practice it right away. I'm in  
24 the position to be able to take that training and then go  
25 out to and sit individually with workers or supervisors and

1 help make that training real for them in their real day to  
2 day jobs.

3 MR. MCKINNON: Okay. Now you went over an  
4 important point there. You gave this figure of 80 percent.

5 MS. MCDONALD: Um-hum.

6 MR. MCKINNON: What was your point of the 80  
7 percent?

8 MS. MCDONALD: What was -- oh, my point was  
9 simply that the transfer of learning process is really  
10 important for people to, to have the ability to access when  
11 they go to training because when people sit in a training  
12 room or any kind of seminar or any kind of teaching, they  
13 do lots of tuning in and out to things and they also do  
14 lots of feeling that they've just taken pieces of  
15 information and can't remember or know how to put into  
16 practice what they have learned when they're actually at  
17 their desk or meeting with families.

18 MR. MCKINNON: So we're talking about application  
19 of knowledge?

20 MS. MCDONALD: Yes.

21 MR. MCKINNON: And, and so when you said 80  
22 percent, was it 80 percent was not retained, is that what  
23 your point was?

24 MS. MCDONALD: Oh sorry. Yes, 80 percent is not  
25 retained, 80 percent gets left in the room with them when

1 they leave.

2 MR. MCKINNON: And if it's followed up by  
3 mentoring do you have any information as to whether that  
4 improves?

5 MS. MCDONALD: It improves immensely because  
6 they're then able to learn -- take what they have learned,  
7 take that information with them, practice it immediately  
8 and that's how they retain it. They're able then to work  
9 through the information that they have learned and  
10 received, apply it and figure out how to use it on a  
11 regular basis.

12 MR. MCKINNON: And when you talk about applying  
13 it and using it on a regular basis, you're talking about on  
14 their actual cases?

15 MS. MCDONALD: On their actual cases or with  
16 their actual workers if we're referring to supervisors.

17 MR. MCKINNON: And does that relate at all to the  
18 concept of continuous quality improvement?

19 MS. MCDONALD: Absolutely because with one of --  
20 one of the things that we're able to do is that we're able  
21 to help ensure that what we are in fact teaching or hope,  
22 expecting workers and supervisors to do, is really being  
23 done and we're able to then see if it's being demonstrated  
24 and if it's meeting the targets that we hope it will meet  
25 and if it isn't, we're able to then adapt our teaching or

1 bring people back or do things different so that we can  
2 then try again.

3 MR. MCKINNON: Okay. Now I'm going to move on to  
4 the topic of training, Mr. Commissioner. We're at page 49  
5 of the summary of evidence and I'm going to ask both these  
6 witnesses to talk about the training issues, starting with  
7 Ms. Brownlee.

8

9 BY MR. MCKINNON:

10 MR. MCKINNON: Let's talk about orientation.  
11 We've heard a lot about orientation at this inquiry. Could  
12 you describe to us what orientation is like now at Winnipeg  
13 CFS?

14 MS. BROWNLEE: Okay. Well initially, just to  
15 build on kind of what Karen was saying and for an overview,  
16 Winnipeg CFS really prioritized because we know in child  
17 welfare that there is --

18 MR. MCKINNON: Can you take the microphone a  
19 little bit closer?

20 MS. BROWNLEE: Okay. Usually I'm so loud. We  
21 know in child welfare that retention is always an issue  
22 regardless of the agency just because the work is very  
23 difficult. So it was identified by Winnipeg CFS that it  
24 was really critical how we brought staff into the  
25 organization and how we supported them in understanding and

1 learning the job. Delivering Child and Family Services  
2 work is very complex. It's not easy. We generally usually  
3 say it takes about two years of doing the actual work to  
4 be, to be fully trained and fully competent and to  
5 experience all the different possible scenarios. So based  
6 on that, once our leading practice specialist or our LPS's  
7 were in place in 2010, one of the first tasks for them was  
8 to develop a comprehensive orientation program that would  
9 give an overview and give a better start for staff starting  
10 in the job. So the idea was that it should clearly what  
11 expectations of work are which would include standards as  
12 well as agency policies, would give them an overview in  
13 orientation to the agency philosophy values, the programs  
14 that are available both within the agency as well as  
15 external and would start to train them on the expectations  
16 related to how to make decisions related to case work and  
17 Karen will speak in more detail about some of that but it  
18 included structures for how do you do assessments, what is  
19 the documentation required, how do you casements, those  
20 kind of things that, that we knew were not necessarily  
21 consistently being trained on. We wanted to make sure that  
22 staff are coming in and that everyone has the same  
23 foundation or same baseline, so that it's not reliant on an  
24 individual supervisor to orient the staff in the way that  
25 that supervisor is. So now workers will get a standard

1 orientation as well as the support and ongoing supervision  
2 from their supervisors.

3 MR. MCKINNON: And, and if I can ask you --

4 THE COMMISSIONER: Just a minute. I'm looking  
5 through this evidence, this book. Under number 3 where you  
6 start your training --

7 MR. MCKINNON: Right.

8 THE COMMISSIONER: -- and you described that as  
9 (a) --

10 MR. MCKINNON: Yes.

11 THE COMMISSIONER: -- (a) training. I don't see  
12 there's any (b). I'm just trying to see what, what it is  
13 because you go to page number 4 on page 54. So from page 3  
14 to page 54, does that all relate to, to training?

15 MS. BROWNLEE: It relates to the orientation,  
16 like orientation and then when you go to page 50 and it  
17 goes (a), (b), (c), (d) --

18 THE COMMISSIONER: But, but --

19 MS. BROWNLEE: -- that's giving you an overview  
20 of each module.

21 THE COMMISSIONER: But before you get to -- oh at  
22 page 50.

23 MS. BROWNLEE: Oh sorry.

24 THE COMMISSIONER: But that's not the same kind  
25 of a (d) because that ...

1 MS. BROWNLEE: Oh I see.

2 MR. MCKINNON: Mr. Commissioner, that may be  
3 my --

4 MS. BROWNLEE: Yes, I actually I see as you're  
5 going forward --

6 THE COMMISSIONER: Yeah.

7 MS. BROWNLEE: -- it's not following.

8 THE COMMISSIONER: Well then where does  
9 orientation end in the book?

10 MS. MCDONALD: Orientation ends at the middle of  
11 page 52.

12 THE COMMISSIONER: Okay.

13 MS. BROWNLEE: Yeah.

14 MR. MCKINNON: Yes, that's a numbering problem.  
15 It probably -- the (a) is the misnomer. Orientation is the  
16 little (i) and the next comp is competency based training  
17 at 52 which is (ii), so the (a) is the problem.

18 THE COMMISSIONER: We don't need that (a).

19 MR. MCKINNON: The (a) is the problem, yes.

20 THE COMMISSIONER: Okay.

21 MR. MCKINNON: Sorry about that.

22 THE COMMISSIONER: All right. I follow now.

23

24 BY MR. MCKINNON:

25 MR. MCKINNON: Just back to Alana Brownlee for a

1 moment. You were talking about this, a comprehensive  
2 orientation program being created in 2010. Can you compare  
3 what's in existence now with orientation with the way it  
4 was in 2006? Again, not going through all the detail but  
5 just some sort of qualitative and quantitative comparison.

6 MS. BROWNLEE: In 2006 the orientation for new  
7 staff starting would have been very -- it would have been  
8 ad hoc. The agency did ask social workers to meet with  
9 identified critical piece people, so meet with someone from  
10 the resource program. They would bring people in to do a  
11 brief overview of different program areas, but there was  
12 nothing that was very structured and consistent that would  
13 walk you through everything from standards and policies up  
14 to how to do case notes, how to do assessments. That was  
15 very reliant on the individual supervisor and the  
16 expectation was that the worker would learn those things on  
17 the job.

18 MR. MCKINNON: So the point is that this is  
19 effectively, this formal orientation program that's been  
20 structured and designed is effectively new.

21 MS. BROWNLEE: It is. It started in 2010 and it  
22 was originally 8.5 days and it is now up to 10.5 days as  
23 we've continued to tweak and modify it based on feedback  
24 from staff as well as supervisors.

25 MR. MCKINNON: Okay.

1 MS. BROWNLEE: We also had it evaluated in 2011  
2 which was very positive in terms of how staff were feeling  
3 and feedback from the supervisors as well in terms of how  
4 better prepared staff were in starting.

5 MR. MCKINNON: Yes. So that -- and that  
6 evaluation was done by whom?

7 MS. BROWNLEE: The General Authority.

8 MR. MCKINNON: Okay. And the next question I  
9 have in terms of orientation, you said it's now at 10.5  
10 days. Was that all delivered at once, like a consecutive  
11 10.5 days of training?

12 MS. BROWNLEE: No. We found it was really  
13 important to do it non-sequentially. If you do all the  
14 training at one time as Karen's already indicated, the  
15 retention is very limited so we do them in structured  
16 components and we found out that it's more effective, and  
17 Karen can speak to this, more effective for them to be able  
18 to bring actual cases. So when we're actually doing the  
19 risk assessment they're expected to bring actual cases.  
20 They bring their actual case notes and get feedback on them  
21 from the LPSS so we found that it facilitates their  
22 learning and their comprehension and understanding better  
23 if it's not delivered all at the same time and if it's over  
24 the course of three months when they first start.

25 MR. MCKINNON: Okay. And we've heard comment at

1 this inquiry about whether or not training and orientation  
2 should occur prior to workers assuming a caseload. Can you  
3 comment -- you've commented I think on that just a moment  
4 ago, but can you comment on your sense as to whether that's  
5 a good thing, that is that it all be done before they get a  
6 caseload, and then secondly comment on how Winnipeg phases  
7 workers into their caseload.

8 MS. BROWNLEE: We haven't found that it's helpful  
9 to do it all prior to them starting, although we do have  
10 our students go through the orientation and we have found  
11 that that's helpful because they are working with, you  
12 know, one or two or three or four families and they can  
13 still apply it. We found that it is really critically that  
14 they actually have the actual cases they're working with to  
15 actually take your training and actually implement it. I  
16 forgot the other piece of your question, sorry.

17 MR. MCKINNON: Just, just in terms of -- we heard  
18 some evidence from Mr. Rodgers about no cases, less cases,  
19 full cases.

20 MS. BROWNLEE: Oh yes, sorry.

21 MR. MCKINNON: How, how do you structure that?

22 MS. BROWNLEE: We have structured it where we  
23 tried to have the first week where they're not assigned a  
24 case where it's really trying to do the orientation,  
25 building some facilitation with the team, familiarizing

1 themselves with the cases that they will be getting  
2 although they're not responsible for them and then to try  
3 as best we can to do a gradual case build up. We have made  
4 the internal policy that workers that are new to the agency  
5 or, I should clarify that, new to child welfare don't get  
6 caseloads above 20 in their first year. We also limit the  
7 number of intakes that they can accept to one a month if  
8 they are getting new intakes for the first year as well.

9 MR. MCKINNON: Okay. So if I can summarize then,  
10 the first week no cases and it's training. For the first  
11 year it's limited to 20 cases in total and no more than one  
12 new case a month and that's to accommodate the less  
13 experienced workers.

14 MS. BROWNLEE: Yes.

15 MR. MCKINNON: Now I understand that orientation  
16 is supposed to be a very high level and we're going to get  
17 into the contents of that in a minute but subsequent  
18 training I understand will drill down into each of these  
19 concepts in more detail. Are you able to just explain how  
20 that works in terms of both the orientation at the start  
21 and then more focused training later on?

22 MS. BROWNLEE: Yes. The orientation is really  
23 the overview. So it gives you an overview of expectations,  
24 an overview of the resources that are available, an  
25 overview of the tools that are available in your work. The

1 subsequent training is really developing your clinical  
2 skills and is based on further developing assessment  
3 abilities, your ability to engage with families, your  
4 ability to do effective case plans, your interviewing  
5 skills, your motivational interview or solution focused  
6 skills. So that's the subsequent training that's then  
7 provided.

8 MR. MCKINNON: That's the subsequent training,  
9 okay.

10 MS. BROWNLEE: And it's -- and beyond that  
11 there's also -- we try to, we believe it's really important  
12 that the first two, three years are really focused on child  
13 welfare specific training and then once people are very  
14 grounded in that then they move towards more specialized  
15 training such as attachment training, fetal alcohol  
16 syndrome, FASD training, sexual exploitation and then  
17 people start developing those specializations based on kind  
18 of the cases they work with or families as well as interest  
19 level.

20 MR. MCKINNON: Thank you.

21 Mr. Commissioner, we're going to move essentially  
22 to page 50 now and I'm going to ask Karen McDonald to speak  
23 to this and obviously Alana if you want to elaborate on any  
24 point that Karen makes.

25

1 BY MR. MCKINNON:

2 MR. MCKINNON: But if we look at page 50 and  
3 there's the first three, day one, day two, day three, my  
4 understanding is that those first three days of orientation  
5 are offered to all staff, social work staff and other  
6 staff, like administrative staff, people that might be  
7 providing family supports, those kinds of people. Everyone  
8 takes the first three days of training; am I correct in  
9 that?

10 MS. MCDONALD: That's correct.

11 MR. MCKINNON: And could you tell the  
12 commissioner what is involved in those first three days of  
13 training?

14 MS. MCDONALD: When we design the training we  
15 specifically wanted to be inclusive of and build upon our  
16 orientation to start from what you would need to know to  
17 just be an employee of our agency. So day one and day two  
18 and day three are very much based -- we talk about the  
19 history of child welfare, we talk about how Winnipeg Child  
20 and Family Services came to be today as it is. We talk  
21 about some very basic policies and expectations such as  
22 like hours of work, dress code, things that you need to  
23 make sure you acquire on your job. We then begin to talk  
24 about things that again are, are about our agency. We go  
25 through all of the programs that are in our agency. We

1 describe each program at some length and how to access the  
2 programs and how those programs would be helpful to all the  
3 families and children we work with.

4 MR. MCKINNON: So would you explain, for example,  
5 what ANCR is and some of these --

6 MS. MCDONALD: Yes.

7 MR. MCKINNON: -- collateral or partners of --

8 MS. MCDONALD: Yes, exactly. And we also talk  
9 about our partner agencies and the ones, particularly ANCR  
10 we talk quite a bit about because we do partner with them  
11 all the time, for many of our services.

12 MR. MCKINNON: And when you talk about programs,  
13 that would be things like what a family service unit is,  
14 what a perinatal unit is, what a foster care program is.

15 MS. MCDONALD: Yes.

16 MR. MCKINNON: That kind of detail.

17 MS. MCDONALD: Yes.

18 MR. MCKINNON: So you're just -- and a lot of  
19 this the commissioner has heard throughout the course of  
20 this --

21 MS. MCDONALD: Yes.

22 MR. MCKINNON: -- inquiry but you're orienting  
23 them to the actual services --

24 MS. MCDONALD: Yeah.

25 MR. MCKINNON: -- at Winnipeg CFS.

1 MS. MCDONALD: Yes.

2 MR. MCKINNON: And how they relate to one  
3 another?

4 MS. MCDONALD: That's correct.

5 MR. MCKINNON: Is there anything else about those  
6 first three days --

7 MS. MCDONALD: Yes.

8 MR. MCKINNON: -- you want to tell us?

9 MS. MCDONALD: There is. We also talk about  
10 worker and staff safety. That's being safe in your office  
11 as well as being safe when you're out with families and  
12 children. We talk about supervision. We talk about what  
13 you can expect from supervision, what you bring to  
14 supervision and how you would prepare for supervision and  
15 we also talk about the act, the Child Welfare Act and begin  
16 to introduce the legislation and then we get into some of  
17 the cases. Can I add one other thing --

18 MS. MCDONALD: Sure.

19 MR. MCKINNON: -- that's fairly unique about our  
20 orientation because I'm explaining that we talk about this  
21 but really our orientation is very interactive. When staff  
22 and social workers come to our orientation the first thing  
23 they're given is a large binder with many dividers. All of  
24 our orientation we build upon so we will use handouts, we  
25 use small group activities, large group activities and

1 interactive discussions to facilitate all of the learning.  
2 We also walk through things and have them do them with us  
3 so, for example, this may sound basic but we would have  
4 them fill in a mileage sheet with us together so they would  
5 have what one should look like when they leave. We then  
6 will fill in, as we go along with social workers, we would  
7 fill in other documents such as a voluntary placement  
8 agreement. So that they would know how to do those things  
9 and they would have a reference point when they go back.  
10 If they complete the 10 and a half days they have a very  
11 large binder full of all of the information, all of the  
12 activities and all of the discussion materials relevant.

13 THE COMMISSIONER: Now are these all new hires  
14 you're discussing?

15 MS. MCDONALD: All new employees are expected to  
16 attend orientation but honestly we have had people who have  
17 worked with the agency before, have been out on a  
18 secondment and have come back and have attended orientation  
19 and have wanted to, so we have -- we certainly are  
20 inclusive to everybody and it's open to anybody who wants  
21 to do that and can do that and the agency supports that.

22 THE COMMISSIONER: And this program started in  
23 2010?

24 MS. MCDONALD: Myself and my co-worker started  
25 working on it in 2010. I believe the first one we

1 delivered was in 2011.

2 THE COMMISSIONER: And how many employees did you  
3 bring up who had been longstanding in the, in the  
4 organization? I'm thinking people that were there in 2005-  
5 '06.

6 MS. MCDONALD: I believe we've had only three or  
7 four people who have returned to the agency from either  
8 secondment or have gone on to it, like have worked, one of  
9 them worked in children's special services and then came  
10 back to the agency and came through it. I believe we've  
11 only had about three or four of those people come through  
12 orientation.

13 THE COMMISSIONER: So the rest are new hires?

14 MS. MCDONALD: The rest are new, yes.

15 THE COMMISSIONER: Thank you.

16 MR. MCKINNON: Thank you.

17

18 BY MR. MCKINNON:

19 MR. MCKINNON: And just for the benefit of the  
20 commissioner, Ms. Brownlee, could you indicate how many of  
21 the individuals who were witnesses at this inquiry are  
22 still in the employ of Winnipeg CFS? Or currently employed  
23 is probably the better way to put it.

24 MS. BROWNLEE: We have --

25 MR. MCKINNON: Do you remember off the top of

1 your head?

2 MS. BROWNLEE: We have six staff that are  
3 currently employed and working at Winnipeg CFS but there  
4 are a number of staff that are Winnipeg CFS employees who  
5 are seconded to ANCR.

6 MR. MCKINNON: Seconded to another agency?

7 MS. BROWNLEE: Yes.

8 MR. MCKINNON: Okay.

9 THE COMMISSIONER: And there's six employees who  
10 what?

11 MS. BROWNLEE: Who continue to be employees of  
12 Winnipeg that testified at the inquiry.

13 THE COMMISSIONER: Oh, who are involved in the  
14 Phoenix case.

15 MS. BROWNLEE: Yes.

16 MR. MCKINNON: Yes.

17 THE COMMISSIONER: Six and how many at Winnipeg  
18 Child and Family Services and how many at ANCR?

19 MS. BROWNLEE: At ANCR there would -- I'm going  
20 to have to guesstimate.

21 MR. MCKINNON: You can estimate, yes.

22 MS. BROWNLEE: But I think there would be  
23 approximately 15.

24 THE COMMISSIONER: And did they undergo this  
25 orientation once you got it up and running?

1           MS. BROWNLEE: They wouldn't have because, well  
2 the ANCR secondments wouldn't have because this is unique  
3 and specific to Winnipeg Child and Family Services.

4           THE COMMISSIONER: Yes, yes.

5           MS. BROWNLEE: And the other staff wouldn't have  
6 attended because -- they would have attended components of  
7 the training as part of the overall Winnipeg Child and  
8 Family Services training but not the specific orientation.  
9 So, for example, all of Winnipeg CFS staff have attended  
10 standards training. All Winnipeg CFS staff have attended  
11 training related to the structured decision making tools as  
12 well as how they're incorporated into the Winnipeg Child  
13 and Family Services recording package. So everyone has had  
14 that including the staff that have testified or were  
15 involved in the case, but not in the format of this  
16 orientation because we were really gearing this to new  
17 staff.

18           THE COMMISSIONER: But that was subsequent to  
19 their involvement in the Phoenix case?

20           MS. BROWNLEE: Absolutely.

21           THE COMMISSIONER: Yeah.

22           MS. BROWNLEE: Yeah.

23           THE COMMISSIONER: Thank you.

24           MR. MCKINNON: Thank you, Mr. Commissioner.

25

1 BY MR. MCKINNON:

2 MR. MCKINNON: I'm now going to ask Karen  
3 McDonald if she'll take us to days four to nine and we're  
4 at paragraph (d) on page 50, Mr. Commissioner, going on to  
5 page 51. This is days four to nine and my understanding is  
6 that this content now is designed exclusively for child  
7 welfare workers, social workers?

8 MS. MCDONALD: Correct.

9 MR. MCKINNON: Frontline social workers, not the  
10 administrative people, not the family service people, what  
11 we would, we've been calling frontline workers in this  
12 inquiry?

13 MS. MCDONALD: That's correct. We have had a few  
14 service assistants go through the entire 10 and a half days  
15 as well based on their job responsibility.

16 MR. MCKINNON: Okay. But by and large this is  
17 designed for social workers?

18 MS. MCDONALD: Yeah.

19 MR. MCKINNON: So we're getting more into the  
20 social worker --

21 MS. MCDONALD: Yes.

22 MR. MCKINNON: -- practice in days four to nine.  
23 Can you briefly tell us what's taught in these five days of  
24 orientation?

25 MS. MCDONALD: Sure. As we, as we start going

1 into days four to nine, we are truly looking at what is  
2 involved in working through a case in Child and Family  
3 Services. So we begin to -- we call it looking through the  
4 cycle of a case and we begin starting a case coming to our  
5 agency, what services are involved and what would be  
6 required of you. We break things out into specific forms,  
7 specific programs that you might access and what they can  
8 do but we also spend quite a bit of time talking about  
9 things like case notes, contact notes and what --

10 MR. MCKINNON: Okay. And just, just -- because  
11 that's been an issue at this inquiry --

12 MS. MCDONALD: Okay.

13 MR. MCKINNON: What are you teaching about  
14 contact notes?

15 MS. MCDONALD: We spend quite a bit of time on  
16 contact notes. We teach, we teach social workers what a  
17 contact note must include, what it should look like, how it  
18 needs to be written. We review -- we do an exercise on  
19 contact notes where we review it and have them review it  
20 for content and for things that they need to do  
21 differently. We give them out some written work on what --  
22 written, written pages to take away with them on everything  
23 they need to know about contact notes essentially so that  
24 they have that to refer back to and we, we stress  
25 repeatedly the importance of contact notes as being

1 fundamental and foundational to the work that they do.

2 MR. MCKINNON: Okay. And another topic, I  
3 understand, is there's an introduction, and these are my  
4 words --

5 MS. MCDONALD: Um-hum.

6 MR. MCKINNON: -- an introduction to assessment.

7 MS. MCDONALD: Yes.

8 MR. MCKINNON: I know you go into that lot more  
9 in subsequent training but just at the orientation what do  
10 you teach about assessments?

11 MS. MCDONALD: Well the orientation -- what we  
12 begin to teach at the orientation is how assessments are  
13 foundational to all of our work, that we work with  
14 families. We need to know how to assess them. We need to  
15 know the importance of assessment and we need to have the  
16 tools and the ability to make very good assessments on our  
17 families. We do then during the orientation actually teach  
18 them the structured decision making tools, the probability  
19 of future harm, the family strengths and needs assessment  
20 and which includes the child and the caregiver's strengths  
21 and needs and the probability of future harm reassessment.  
22 We do the full two day training as part of our orientation.

23 MR. MCKINNON: And there's two days of training  
24 on structured decision making?

25 MS. MCDONALD: Yes.

1           MR. MCKINNON:    But that's not all the training  
2 that will follow subsequently; am I correct in that?

3           MS. MCDONALD:   That is correct.

4           MR. MCKINNON:   So that would be a high level  
5 review of structured decision making?

6           MS. MCDONALD:   That is, that is the structured  
7 decision making training that all staff receive. We just  
8 make sure that staff will receive it within their  
9 orientation so that they are able to begin to use the tools  
10 with some confidence and really as they are intended to be  
11 used in their job. We also introduced the Winnipeg file  
12 recording package to them and teach them how, during  
13 orientation, how they need to be, how they need to record  
14 all of their work with their families in an assessment  
15 manner.

16          MR. MCKINNON:   Okay, and we'll come back to the  
17 file recording package later. Just on the structured  
18 decision making then, am I correct that it's two days of  
19 training on that?

20          MS. MCDONALD:   Yes.

21          MR. MCKINNON:   And what about follow up after  
22 they leave that training?

23          MS. MCDONALD:   Well, again, this is the part of  
24 orientation that is, I think, quite powerful, for lack of a  
25 better word, for workers is that because myself and my

1 co-worker are the ones that deliver all of the orientation,  
2 we meet all of the students and new employees right away  
3 and we start to develop a relationship and a comfort with  
4 them and they with us, so that we're able to be able to  
5 mentor them very easily. So when we train them on anything  
6 from how to write a case note to how to use a structured  
7 decision making tools, we offer them the same mentoring  
8 that we, and coaching behind them that we would for  
9 anybody.

10 MR. MCKINNON: And just so the commissioner's  
11 clear, when you say coaching behind, what does that mean?

12 MS. MCDONALD: Okay. One of the things that I --  
13 I often explain my job is that in the beginning I will  
14 train, I will be in front of you. I will teach you and I  
15 will deliver material and curriculum to you. I then will  
16 walk beside you and I will mentor and help you be able to  
17 do what you need to do on your real cases, on the -- with  
18 the families and children that you work with, whether that  
19 be needing paperwork requirements, I will help you figure  
20 out what needs to be in your recording but I will also help  
21 you figure out how to ask those hard questions and how to  
22 get the information and make sense of the information with  
23 a family. At some point later, I will stand behind you and  
24 I will support you in whatever you need to be able to do  
25 your job, but it's really I'm in front, beside, behind

1 approach to teaching and to helping support our workers and  
2 supervisors.

3 MR. MCKINNON: If we look at page 51 of the  
4 summary of evidence, there are six references to tools  
5 there, probability of future harm, et cetera. Could you  
6 briefly describe -- these are the tools then that you're  
7 now teaching at orientation.

8 MS. MCDONALD: Correct.

9 MR. MCKINNON: And could you briefly describe to  
10 the commissioner what those tools are. You heard  
11 Mr. Rodgers' evidence so you don't have to repeat sort that  
12 theoretical, but at a very practical level --

13 MS. MCDONALD: Sure.

14 MR. MCKINNON: -- what are these tools?

15 MS. MCDONALD: The probability of future harm  
16 tool is our risk tool. So we train our social workers how  
17 to use that tool to determine the risk level in the  
18 families that they're working with and how to take that  
19 risk level and understand what the frequency of contact  
20 that they must have with their children and their families.

21 MR. MCKINNON: And just stop right there.

22 MS. MCDONALD: Okay.

23 MR. MCKINNON: Risk determines frequency of  
24 contact?

25 MS. MCDONALD: Correct.

1           MR. MCKINNON:       And could you tell the  
2 commissioner how that relates?

3           MS. MCDONALD:       Okay.     The standards are --  
4 provincial standards say that if we have a high risk  
5 family, a medium risk family or a low risk family, we must  
6 see, see the family and the children at a certain frequency  
7 or a certain amount of times.   For example, if a family is  
8 high risk the standards state that there must be contact  
9 with the family once a week.   One of those contacts per  
10 month must be with the social worker and one must be in the  
11 family home.   It further states in a high risk situation or  
12 a high risk family, that we need to have contact as a  
13 social worker with the vulnerable children in the home once  
14 every -- or not in the home, with the vulnerable children  
15 once every two weeks.

16           MR. MCKINNON:       Okay.   And that, the example you  
17 just gave was high risk and thank you for that.

18           MS. MCDONALD:       Yes.

19           MR. MCKINNON:       I lost my train of thought.  
20 Ms. Brownlee, do you have anything to add to that in terms  
21 of the risk factors and how it, how it relates to the  
22 contact with the family?

23           MS. BROWNLEE:       Not related to that.   I mean  
24 there's, I think, several points I'd like to eventually  
25 make related to the tools so I don't know if this is the

1 right time or not.

2 MR. MCKINNON: Maybe you'll do that at a high  
3 level and then I'll get Ms. McDonald to follow up. Do you  
4 want --

5 THE COMMISSIONER: You said one of the weekly  
6 contacts must be by a social worker.

7 MS. MCDONALD: Yes.

8 THE COMMISSIONER: Who are the other contacts by?

9 MS. MCDONALD: They can be by like a family  
10 support worker, but somebody employed by the agency, so not  
11 a community person but an agency staff person. It may be a  
12 service assistant who is working with a family.

13 THE COMMISSIONER: Okay, thank you.

14

15 BY MR. MCKINNON:

16 MR. MCKINNON: Ms. Brownlee, you wanted to add  
17 something about the tools in general?

18 MS. BROWNLEE: Yeah, because I think the, I think  
19 that's probably one of the things that is most critical in  
20 terms of changes that have been made to our system. Social  
21 workers have always gathered assessment information and the  
22 information that we're gathering as part of the tools isn't  
23 necessarily different information. We're still, you know,  
24 looking for information related substance abuse, family  
25 violence, parent's history of an involvement or their own

1 family of origin history. I think the biggest difference  
2 that, that I'm seeing regarding the tools and actually  
3 seeing them put into practice is that it gives social  
4 workers and their supervisors and people at my level a  
5 consistent framework in which to hang that information, so  
6 to speak. So you can now take a family that has those  
7 characteristics and instead of me making, you know,  
8 subjective judgment about how does that impact risk or how  
9 does that potentially impact what's going to happen for  
10 this child and this family, we now have the consistent way  
11 of saying, okay, so this should be rated this way with  
12 these characteristics. At the end of the day this is a  
13 medium risk case, this is a high risk case and then that  
14 helps inform your case plan and what are the things that  
15 you really need to be focused on, as well as helping you  
16 decide the safety factors.

17 I think the other piece that is really, really  
18 critical is that as a system we've adopted this so we're  
19 all now speaking the same language and we all now mean the  
20 same thing. So if ANCR says they're transferring a case to  
21 us and they've now said it's a medium risk case, I know  
22 exactly what that means. I know what factors they've taken  
23 into consideration when they've come to that medium risk  
24 assessment.

25 The re-assessment piece is also really critical

1 because when we're able to say that we've done a risk  
2 re-assessment and that the risk has changed, that it's  
3 lower, I think we can feel a lot more confident that our  
4 services are successful, they are having an impact and  
5 they're really assisting us in having a clearer, more  
6 structured way of making decisions about when we're ready  
7 to end our involvement with families.

8 MR. MCKINNON: Okay. And we're going to get into  
9 that a little bit more as well as we go through the  
10 details, but --

11 MS. BROWNLEE: Yeah, that's why I wasn't sure if  
12 now was the right time or not.

13 MR. MCKINNON: We'll come back to that. In terms  
14 of the evidence that Ms. McDonald just gave about the  
15 requirement and the standard and seeing the child and how  
16 risk plays into that, I'm going to ask you to look at, and  
17 I don't know if you have the standards, I think they're in  
18 the box on the floor beside you. One of them is the  
19 current printout of the online standards manual. For the  
20 monitor, the best way to find it might be to go to page  
21 42313 of the commission disclosure.

22 Mr. Commissioner, you have this as well.

23 MS. WALSH: Exhibit 63.

24 MR. MCKINNON: It's Exhibit --

25 MS. WALSH: Sixty-six.

1           MR. MCKINNON: Sixty-six, in one of those binders  
2 in front of you.

3

4 BY MR. MCKINNON:

5           MR. MCKINNON: Can you see it in the monitor in  
6 front of you?

7           MS. MCDONALD: Oh, yeah.

8           MR. MCKINNON: Have I got the right standard up,  
9 first of all, 1.1.4?

10          MS. MCDONALD: Yes.

11          MR. MCKINNON: And is that the one you were  
12 referring to about seeing high risk child, seeing the child  
13 once a week, once a month in the home, once a month by the  
14 social worker, et cetera?

15          MS. MCDONALD: Correct.

16          MS. BROWNLEE: The standards also highlight  
17 different points of case activities that require direct  
18 face to face contact with children as well.

19          MR. MCKINNON: And --

20          MS. BROWNLEE: So things like if you're doing  
21 abuse investigation, if you're returning a child, if you're  
22 doing a placement change are just some of the examples that  
23 are highlighted.

24          MR. MCKINNON: So your point is that this  
25 standard, as I understand it, would be the standard that

1 would apply to a normal protection file in Manitoba?

2 MS. MCDONALD: Correct.

3 MR. MCKINNON: And your point, Ms. Brownlee, is  
4 that there are other standards, for example, I know there's  
5 a different standard for children in care, correct?

6 MS. BROWNLEE: I was talking about services to  
7 families. So this standard gives you a base line of if my  
8 family is considered high risk or medium risk it tells me I  
9 need to structure my time in such a way that I will see the  
10 children this often and I will see the family this often.  
11 The other standard that I was referring to is talking about  
12 very specific activities that you will do during the course  
13 of your work with a family that also reinforces that when  
14 you do that specific activity over and above these  
15 standards, you must also include ensuring that the child is  
16 seen.

17 MR. MCKINNON: So even --

18 MS. BROWNLEE: So they're blended.

19 MR. MCKINNON: Okay. And, and if there was a  
20 specific activity that might count as one of the four  
21 required attendances; is that what you're saying?

22 MS. BROWNLEE: It could but it could also be over  
23 and above that. For example --

24 MR. MCKINNON: So if you've had the four required  
25 attendances and then you had to do a particular type of --

1 MS. BROWNLEE: Yes.

2 MR. MCKINNON: -- assessment, that would also  
3 require an attendance?

4 MS. BROWNLEE: Yes.

5 MR. MCKINNON: Okay, thank you.

6 Now we were talking about the probability of  
7 future harm tool. I don't know if you were finished. I  
8 stopped you because you mentioned the word risk and I  
9 wanted to relate to the standard. Were you finished  
10 talking about the probability of future harm tool?

11 MS. MCDONALD: Yes, because the only thing I  
12 would have added is what Ms. Brownlee did say is about  
13 consistent tool now that we have, that we will -- when we  
14 look at it we will all be able to understand what that risk  
15 level means.

16 MR. MCKINNON: What's the family's strengths and  
17 needs assessment -- and I understand from Mr. Rodgers  
18 there's two components which is the caregiver strengths and  
19 needs and the child's strengths and needs. Briefly tell us  
20 what do you teach about those tools?

21 MS. MCDONALD: What we teach about those tools is  
22 that, again, in order to fully understand what is going on  
23 for a family, what we're worried about, what's working well  
24 and where we need to go with that, we need to be able to  
25 assess the family and understand what their needs and their

1 strengths are. And a family is not complete if we only  
2 look at the caregivers. We need to have an in depth look  
3 at each and every child that is in their home, that they  
4 are caring for, providing care for. So workers have a tool  
5 that will give them key factors that they can look at to  
6 come up with their assessment, their full and complete  
7 assessment on both the child and both of the caregivers.  
8 Or I need to say all of the caregivers because the tool has  
9 room that if the -- if there's more than two caregivers you  
10 need to assess everybody who is providing care to that  
11 child.

12 MR. MCKINNON: And what if there's more than one  
13 child?

14 MS. MCDONALD: You need to assess every child  
15 individually. We don't clump children together or assume  
16 needs or strengths of children. They're individuals and we  
17 need to assess each one as an individual. With that, they  
18 take that information. They get -- this is -- we help our  
19 workers understand that the tool is just a tool and it will  
20 guide them in the information that they need to get on some  
21 of the factors that will have the greatest impact for a  
22 family and for a child, but they need to be able to get  
23 lots of information from everybody in order to make  
24 decisions about how they apply that to the tool. We, we  
25 need to teach them and stress over and over and over that

1 it is all of that information that they will then take and,  
2 and use that to inform their tool. So we give them further  
3 training on how to get all of that information that they're  
4 going to need to get.

5 MR. MCKINNON: There was a question put to  
6 Mr. Rodgers yesterday about children under the age of six.  
7 What are these tools? How do they relate to children under  
8 the age of six? Are they expected to be assessed as well?

9 MS. MCDONALD: Absolutely. And I need to start  
10 that part of one of our first assessments, an assessment we  
11 do regularly throughout the course of our work is a safety  
12 assessment and it does look at a child being more  
13 vulnerable if they're under five. That is only one place  
14 that we look at. The safety assessment also requires that  
15 we see every child, no exception. If we cannot see them,  
16 it needs to be documented why and the reason isn't because  
17 they're at the neighbours or because they're sleeping. It  
18 would need to be that they are in Thompson, Manitoba and  
19 we're in Winnipeg, like it's not -- if they're sleeping we  
20 still are required to see them --

21 MR. MCKINNON: Okay.

22 MS. MCDONALD: -- before we leave.

23 MR. MCKINNON: That's on the safety assessment?

24 MS. MCDONALD: That's on the safety.

25 MR. MCKINNON: Okay.

1           MS. MCDONALD: But the other piece and probably  
2 the piece that for me is remarkably different for our  
3 social workers today is that there is now a huge emphasis  
4 on including children as a key and central part of any case  
5 planning and involving the children in the plan. In order  
6 to do a child strengths and needs assessment, we need to  
7 see, and not just see, we need to ask questions, we need to  
8 talk to all of the children involved, regardless of their  
9 age.

10           We also have specific tools that we train our  
11 workers on to help get information from children that are  
12 younger than we might normally have thought we could get --  
13 or that are younger. Like a child at five certainly we can  
14 talk to but we also, and I can explain later or now, we  
15 also teach them a tool called the three houses and a safety  
16 house that's specifically designed for children who are  
17 struggling to articulate themselves at whatever age and  
18 they do it better in, sort of in drawing pictures than in  
19 words.

20           MR. MCKINNON: Well you opened that door up so  
21 why don't we enter that, no put intended.

22           MS. MCDONALD: Sure.

23           MR. MCKINNON: We'll enter that room. Tell us  
24 what you mean by that.

25           MS. MCDONALD: As part of our GA practice model,

1 there is one particular module that we spend, well it's a  
2 half a day training and it's specifically on something we  
3 call the three houses and a safety house. And these are  
4 tools that are specifically designed to get the voice of a  
5 child and to have a child be heard because we know all too  
6 often that -- or we know that children know lots and lots  
7 and lots about what's going on for them and we need to  
8 ensure that we really have heard what they have to say  
9 about what's going on in their family and for them in their  
10 life.

11 So one of the tools is simply, it's called the  
12 three houses and it simply, in child's language, asking  
13 them what they are worried about, what's working well and  
14 what's their next steps are, but we do it through drawing  
15 three houses, through drawing three iPods, three trucks,  
16 through whatever their interest is and then begin a  
17 conversation as what would you -- can you help us figure  
18 out what you're worried about in your house.

19 The safety house is another tool that really  
20 talks -- it's an excellent reunification tool or a tool  
21 used to help us understand when we're thinking about visits  
22 or visiting home as to what would need to be in the child's  
23 house for them to feel safe and what would not need to be  
24 there.

25 MR. MCKINNON: So you ask the child that

1 question?

2 MS. MCDONALD: Yes, we would ask the child that  
3 question and they, in fact it's a child-led not a worker-  
4 led conversation, we follow their lead. But the other  
5 thing that we stress in training and in our coaching and  
6 mentoring after is we still need to ask more questions. So  
7 a child may say something, for example, my dad hurts me. I  
8 need to then ask that child what hurt means and I need to  
9 make sure I fully and completely understand what they mean  
10 by that because there's a vast difference between he hurt  
11 me when he combed my hair and there were tangles to he's  
12 doing something that hurts me.

13 MR. MCKINNON: Okay. And we've jumped ahead a  
14 little bit now.

15 MS. MCDONALD: Okay.

16 MR. MCKINNON: This, this three houses is after  
17 orientation --

18 MS. MCDONALD: Yes.

19 MR. MCKINNON: -- when we're drilling down into  
20 the --

21 MS. MCDONALD: Yes.

22 MR. MCKINNON: -- the subsequent training. So  
23 but you mentioned it so I just wanted to clarify for the  
24 commissioner.

25 MS. MCDONALD: Sorry.

1           MR. MCKINNON: No, don't apologize, we'll jump  
2 around a bit. But back to the strengths and needs and  
3 maybe, I don't know if this is a good point to raise this  
4 point, but again the question that's been raised by  
5 Ms. Walsh and asked of other witnesses, is the question of  
6 whether one child can be a proxy for another.

7           MS. MCDONALD: No.

8           MR. MCKINNON: The answer is unequivocal?

9           MS. MCDONALD: The answer is no. Every child  
10 needs to be assessed as their own child and we need, a  
11 worker needs to feel confident that they have gotten all of  
12 the information they can get that's feasibly possible in  
13 order to make their assessment.

14          MR. MCKINNON: The third point on page 51 in  
15 terms of the tools is case planning. I don't know if  
16 that's a tool or that's just a term, but --

17          MS. BROWNLEE: Can I just jump in the proxy?

18          MR. MCKINNON: Sure.

19          MS. BROWNLEE: I'd also just like to add, because  
20 I think, I think the piece is that a tool in and of itself  
21 is not necessarily going to change things and I think the  
22 biggest change that we've made is that we've really  
23 embedded with the practice, the engagement and philosophy  
24 is how you work with families and with the tools. So part  
25 of the structure of the tools creates a lot more checks and

1 balances and ensures safety but we've also given staff the  
2 skill set and the interviewing ability to both engage  
3 better with children and get more information with  
4 children, feed that information from the children back to  
5 the parents so the parents know how they're impacting their  
6 child in the behaviour and to really engage and develop the  
7 relationship with the parents so you're not coming in and  
8 seeing a family for 15 minutes, making a really quick  
9 assessment. You're actually spending the kind of time you  
10 need to do the relationship. So it's important that the  
11 tools need to be embedded with the practice and the skills  
12 set and the clinical skills as well to really create that  
13 full safety network.

14 MR. MCKINNON: Okay. And I'm going to try to  
15 move you to the next point which is the case planning and  
16 how does that then relate to what you've done? You've done  
17 your probability of future harm, you've done your strengths  
18 and needs. What's case planning involve?

19 MS. MCDONALD: Case planning is really -- you  
20 can't case plan without first understanding what the needs  
21 and the strengths are with the family. So you need a full  
22 and complete assessment of the children and the families to  
23 be able to know how to case plan. The case plan then is  
24 formulated strategically from the strengths and the needs  
25 that the family has but is targeted to meet the needs, so

1 we would --

2 MR. MCKINNON: Okay. And I want to ask you just  
3 to comment to the Commissioner, because we use these  
4 phrases strengths and needs.

5 MS. MCDONALD: Okay.

6 MR. MCKINNON: I kind of know what they mean  
7 because I've spent so much time talking to you and  
8 interviewing you. But for the Commissioner, when we're  
9 talking about strengths, give us some concrete examples.  
10 What are the strengths that you might identify as a  
11 strength and a strengths needs assessment?

12 MS. MCDONALD: Okay. A strength of a caregiver  
13 might be the fact that they do not have mental health  
14 issues and they have demonstrated good coping abilities in  
15 the face of sort of adversity or -- and when I say  
16 demonstrated, because it's not enough to just say we think  
17 they have. We need to understand in our interviewing what  
18 in fact they have done and they need to be able to describe  
19 and show us what they have done when they have been faced  
20 in situations where maybe one might not cope as well, what  
21 have they done to cope in those situations.

22 MR. MCKINNON: So demonstrated acts where they  
23 are showing some resilience and ability to cope?

24 MS. MCDONALD: Right.

25 MR. MCKINNON: Okay. Are there are any other

1 sort of examples you might give to the Commissioner so he  
2 understands what we're talking about?

3 MS. MCDONALD: Okay. Well good resource  
4 management. All of the factors that we assess can be a  
5 strength or a need but if we took resource management, for  
6 example, in fact it might be a strength that a family is  
7 living on income assistance but are paying their rent --  
8 well not might be, it is a strength, that they're paying  
9 their rent, that they're managing to have food and adequate  
10 clothing for their children. That is absolutely a  
11 strength.

12 MR. MCKINNON: Okay. And take the other side of  
13 the equation, the needs. What are typically, when you're  
14 doing this assessment, what are you identifying as needs?

15 MS. MCDONALD: So the reverse might be on  
16 resource management. They may -- that may be a need for  
17 the family if in fact -- they, they may be employed and  
18 making a reasonable income but are not able to because of  
19 other issues. They may have whatever but they are not  
20 able --

21 MR. MCKINNON: Don't say whatever. Are we  
22 talking --

23 MS. MCDONALD: Okay.

24 MR. MCKINNON: -- drugs or alcohol or?

25 MS. MCDONALD: They may have drug or gambling or

1 they may, they may have substance abuse issues but they are  
2 at risk of losing their home. They, there's very limited  
3 food, their children are poorly clothed. They're not able  
4 to manage the resources that they have. Reverse a need,  
5 might be a substance abuse. In fact, if substance abuse is  
6 interfering and impacting on the care of their children, so  
7 they are using substances that are preventing them from  
8 being able to provide the care to their children that they  
9 need, that the children require and desire, that would be a  
10 need.

11 MR. MCKINNON: Okay. So that all goes into the  
12 strengths, needs assessment. Now we're looking at the case  
13 plan. What's -- how do you, how do you deal with these  
14 issues?

15 MS. MCDONALD: So we take the needs of the family  
16 and the needs of all of the children and we sit down with  
17 the family and we talk about what they think needs to  
18 happen and what we think needs to happen to be able to  
19 begin to address those needs. The family is, the family  
20 and the children are key to being involved in that process,  
21 because they often have very creative and unique ideas of  
22 what they need to do to address their needs. They in fact  
23 do know themselves best. So we have had some workers come  
24 up with their families with some very creative case plans  
25 that in fact will address needs and are not just service

1 based and that's very important because services don't  
2 equal safety and we teach workers that somebody can attend  
3 a service a hundred times over and never achieve safety for  
4 their children. We need to see them have demonstrated acts  
5 of protection that the caregiver takes and they need to be  
6 able to do that over time to so us that they've achieved  
7 safety.

8 MR. MCKINNON: And --

9 MS. BROWNLEE: So just as a concrete example --

10 MR. MCKINNON: Sorry, I was just going to say,  
11 Mr. Commissioner, I might just try and finish these tools  
12 and then take the lunch break if that's acceptable.

13

14 BY MR. MCKINNON:

15 MR. MCKINNON: Ms. Brownlee?

16 MS. BROWNLEE: I think the case planning and the  
17 training that were given related, that we're now delivering  
18 to staff in terms of how to do case planning is  
19 significantly different. It's really driven by the  
20 collaboration, specifically with the family, the  
21 collaboration with the children and it also involves  
22 identifying who is in the family support network. So the  
23 plans that you're coming up with now, the families clearly  
24 -- so it's not the workers sitting at the office with a  
25 supervisor saying okay, we want you to go to an addiction

1 program, we want you to go to a parenting program, here's  
2 your plan and the family feels very judged and  
3 authoritarian, they don't feel that the plan is actually  
4 addressing their needs or that they've even been part of it  
5 or that they've been heard or listened to. These plans are  
6 much more concrete. So it may, it may involve some of the  
7 same things.

8           So it may involve, in Karen's example, substance  
9 abuse. So if it's substance abuse so the family maybe  
10 agrees that, yeah, you know what, I need to go to a 28 day  
11 program. So then the plan changes when they're finished  
12 the program, okay, so what are we going to do to help you  
13 maintain sobriety in the community? You've been through a  
14 28 day program before, where did it break down? Do you  
15 have any ideas? So then they may come up with, you know  
16 what, if I'm feeling stressed and I feel like I need to  
17 drink, I'm going to call my mom and then we spend time  
18 working with the mom, okay, so what are you going to do  
19 when she calls you. So that is then built into the actual  
20 case plan, so it actually becomes very, very tangible and  
21 very concrete in terms of how you actually implement it and  
22 then from a social worker perspective and from our  
23 perspective, we can actually then measure the success. So  
24 you can follow up with grandma and say so how many times  
25 this month did they call you? And you can also, I think

1 it's again building trust. So we're not saying we don't  
2 think you're going to ever slip or that you're not ever  
3 going to have the desire to drink, but we're going to build  
4 the networks to help you do that and that allows you to  
5 then have that, that transparent and open discussion about,  
6 yeah, I really did want to drink. This is what was going  
7 on at that time. So then we can then say, okay, so we see  
8 that this is a real big stressor for you, what else do we  
9 need to do? And you can also then give families a lot of  
10 encouragement for the successes, great, you didn't drink,  
11 you did reach out. We know this is a safety plan that's  
12 actually really working. And it's then a plan that we can  
13 continue that we don't need to be involved in after we've  
14 seen this succeed for a period of time, they should then be  
15 able to continue to do that when the agency is no longer  
16 involved.

17 MR. MCKINNON: And you're talking about involving  
18 others. Is that the same as the safety network that  
19 Mr. Rodgers spoke about yesterday or is that something  
20 different again?

21 MS. BROWNLEE: No, that's a critical, the safety  
22 planning is a critical piece of it and it's linked with the  
23 case planning.

24 MR. MCKINNON: And, and am I using the correct  
25 phrase, the safety network?

1 MS. BROWNLEE: Yes.

2 MR. MCKINNON: Is that part of a case plan as  
3 well?

4 MS. BROWNLEE: Yes. It's a separate safety plan.  
5 We have it as a separate plan and a separate document. But  
6 it's embedded in the case plan and it would be similar,  
7 other agencies and other jurisdictions are doing similar  
8 things. They just use different names. It's really, the  
9 concept of it is really not working with the family in  
10 isolation but building in community, building in extended  
11 family, building in friendship networks to create safety  
12 around a family and support. So --

13 MR. MCKINNON: We've heard other witnesses talk  
14 about circle of care --

15 MS. BROWNLEE: Yes.

16 MR. MCKINNON: -- in aboriginal agencies. Is  
17 this similar in a non-aboriginal context? Would a, would a  
18 safety network be something like a circle of care?

19 MS. BROWNLEE: Yes, it's very similar. Like the  
20 equivalent, when I was at Métis Child and Family Services,  
21 was we did sharing circles and we used an elder as, as a  
22 component. This would be similar without the concept of  
23 sharing circle and without using an elder, but we're still,  
24 you know, bringing a circle of people around the family  
25 that are going to then participate in helping keep the

1 child safe or the children safe.

2 MR. MCKINNON: Okay.

3 THE COMMISSIONER: Mr. McKinnon, once we're  
4 through case planning, I think we might as well break  
5 because if the other three tools are going to take the time  
6 the first three have, we'll be long past lunch hour.

7 MR. MCKINNON: I, I agree, Mr. Commissioner. I  
8 was going to suggest it's a good time to break.

9 THE COMMISSIONER: So finish number 3 and then  
10 we'll break.

11

12 BY MR. MCKINNON:

13 MR. MCKINNON: Is there anything more you want to  
14 add on the case plan before, before we take out break?

15 MS. MCDONALD: The only thing, the only thing I  
16 would want to add would be that the case plan is ever  
17 changing and not necessarily static. It's the starting  
18 point that we would work with the family and we reassess  
19 our case plan all along the way and but we do sort of pick  
20 where the family is at, they help us determine that, and  
21 where the children are at because it's equally important  
22 that again the children's needs are all addressed. So if  
23 they come up with needs, any case plan we set must address  
24 all of the children's needs as well.

25 MR. MCKINNON: Okay. That would be a good time

1 to take our break.

2 THE COMMISSIONER: All right. We'll adjourn now  
3 till two o'clock.

4

5 (LUNCHEON RECESS)

6

7 THE COMMISSIONER: All right, Mr. McKinnon,  
8 please.

9 MR. MCKINNON: Thank you, Mr. Commissioner. Just  
10 to orient you, Mr. Commissioner, to where we are, we appear  
11 to have been bogged down on page 51.

12 THE COMMISSIONER: Yes.

13 MR. MCKINNON: I wanted to give you some  
14 assurance that we are covering a lot of the material that  
15 is in the subsequent pages. We're just rearranging the  
16 order somewhat because it seemed to make sense to put it in  
17 there.

18 THE COMMISSIONER: They fit in under those  
19 headings or those --

20 MR. MCKINNON: That's right. So when we come to  
21 the GA practice model in a moment we won't go over all of  
22 this again.

23 THE COMMISSIONER: Thank you.

24 MR. MCKINNON: Okay.

25

1 BY MR. MCKINNON:

2 MR. MCKINNON: Before the break we were talking  
3 about, I think we had completed discussing the case  
4 planning concept and I was going to take perhaps Karen to  
5 talk about a probability of future harm reassessment and I  
6 think the commissioner is starting to get an idea of the  
7 extent of the way in which these tools have changed our  
8 practice model, so I'm going to invite you just to give him  
9 a very general explanation as to what the probability of  
10 future harm reassessment is and when it's used.

11 MS. MCDONALD: Sure. The probability of future  
12 harm reassessment is really an opportunity for us to look  
13 at the family and reassess any changes in risk, which would  
14 then, like I said with the risk, it would then also dictate  
15 or help us determine what our service contact would be if  
16 there was a change. But most importantly, we come up with  
17 a reassessment of risk but it also helps us then to really  
18 look at if change is being made in the family and to what  
19 degree it is because our hope would be that any change that  
20 occur -- that we would see change and that the change would  
21 in fact be in passing on lowering the risk to the children.

22 MR. MCKINNON: Okay. And when do you do a  
23 probability of future harm reassessment, what points in the  
24 file?

25 MS. MCDONALD: You would do a reassessment at the

1 point in time about 90 days after a case plan, so the  
2 family has time to really be working on the plan that  
3 you've established together. So that's when you would  
4 begin to look. You certainly could do reassessment sooner  
5 if something substantial has changed, if we've seen lots of  
6 progress or really, really no progress and we need to sort  
7 of make some other decisions.

8 MR. MCKINNON: Okay. And I'm going to direct  
9 this one to then Alana --

10 MS. MCDONALD: Can I add -- sorry.

11 MR. MCKINNON: Sorry, go ahead.

12 MS. MCDONALD: The only other thing I wanted to  
13 add about the reassessment that is, I'm not sure if it was  
14 said in other testimony but the one unique thing to the  
15 probability of harm reassessment is there is an ability for  
16 social workers with supervisory approval to override the  
17 risk down one level. And that's important because there  
18 are certain factors, in fact the first four factors on the  
19 probability of harm reassessment that we call something,  
20 that we call static factors. They're really things in a  
21 family's life that they can't change. Were they abused as  
22 a child? We can't change that. Have they had lots of  
23 other contact with the agency? They can't change that. So  
24 the reassessment recognizes that some of those factors are  
25 beyond a parent's or caregiver's control and may in fact

1 not be impacting on their children today.

2 MR. MCKINNON: Okay. And this is what I  
3 understand is called a discretionary override.

4 MS. MCDONALD: It is the discretionary override  
5 and it gives the ability to override up one level and down  
6 one level with an explanation and with supervisory  
7 approval.

8 MR. MCKINNON: Okay. And could you just explain  
9 to the commissioner how clinical judgment comes into that  
10 piece, the --

11 MS. MCDONALD: Yes.

12 MR. MCKINNON: -- discretionary override?

13 MS. MCDONALD: Clinical judgment would weigh into  
14 that because you would need to look at the family and say,  
15 taking into account those four particular areas and based  
16 on their progress towards meeting a case plan and based on  
17 the current circumstances in our assessment, those  
18 particular factors are not, are not impacting on the  
19 child's safety today or in our opinion in the future. So,  
20 for example, if a parent has done -- they were abused as a  
21 child but the fact that they were abused as a child is not  
22 impacting on how they parent today and in fact they, you  
23 maybe receive lots of -- they've, they've done a lot of  
24 work with themselves and for themselves to overcome any  
25 issues that might in fact impede on their ability to

1 parent. We would want to write that in the probability of  
2 harm reassessment, explaining why that factor or the other  
3 factors were not at play in our assessment and that would  
4 be our clinical judgment.

5 MS. BROWNLEE: I just, I'm just going to add in a  
6 piece with that.

7 MS. MCDONALD: Um-hum.

8 MS. BROWNLEE: As a, another example if you're  
9 working with a family and the initial probability risk,  
10 probability of future harm tool had identified substance  
11 abuse and family violence as issues that were as well as  
12 the static factors Karen's referring to, and then after  
13 you've worked with the family for a period of time and  
14 based on the strength needs assessments, implementation of  
15 the case plan and the reassessment where we're seeing this  
16 is. So the substance abuse issue is now addressed  
17 satisfactorily, the family violence issue is now addressed  
18 satisfactorily, that would reduce the risk. But you have  
19 these four other factors that aren't going to change  
20 because you can't change someone's history or age or things  
21 like that. So that's really where the clinical judgment  
22 comes in. So the two present factors that were a  
23 significant issue were substance abuse and family violence,  
24 the worker and the supervisor, in their consultation and  
25 through the strength needs assessment, the clinical

1 judgment, the implementation of the plan, the fact that  
2 we've seen behavioural changes are resulting in us saying  
3 well we think we can close this file safely. We think  
4 these children are safe at home. That's where you'd be  
5 using the override.

6 In addition, Winnipeg CFS has also identified  
7 that to make extra checks and balances we feel it's also  
8 important that the service manager reviews ones like that  
9 where there is an override based on static factors just so  
10 again, so there's a shared accountability between the  
11 worker and the supervisor and the service manager.

12 MR. MCKINNON: So the point you're making is  
13 where there's a discretionary override it goes up one level  
14 higher in the management structure at Winnipeg CFS?

15 MS. BROWNLEE: Yes.

16 MR. MCKINNON: And the next question I wanted to  
17 ask you, and you kind of alluded to it but I want to make  
18 sure that we emphasize this point. When you talk about it  
19 being address satisfactorily, we've seen some evidence on  
20 the Phoenix Sinclair case, for example, where someone went  
21 to a program and completed a program. Alana, would that be  
22 considered having been addressed satisfactorily?

23 MS. BROWNLEE: No. I think that's -- one of the  
24 reasons I spent so much talking about the case plan because  
25 I think how we make decisions about when we're able to

1 close a case is significantly different. In 2006, as an  
2 example, it was commonly used to, in our system to say no  
3 identified protection concerns or that was kind of the  
4 common language and that was kind of the common deciding  
5 factors that workers and supervisors would discuss. Now  
6 what you would be looking at his you would be looking at  
7 three key things, starting with the probability of future  
8 harm risk reassessment and then the strength, caregiver  
9 strength needs, child strength needs, reassessment. So  
10 you're taking your clear assessment information, your plan,  
11 your case plan that you've worked on with the family, and  
12 then you're assessing all three of those things in  
13 conjunction with the clinical judgment of the workers. So  
14 you're looking at has the family demonstrated behavioural  
15 changes. So if they went to a program, you want to see  
16 them take the information from that program and actually  
17 implement it. Very much similar to what Karen's talking  
18 about we require from workers of mentoring is if I'm  
19 trained on something I need to actually be able to  
20 implement it in my work. We want families to take the  
21 information that we're giving them or the planning and show  
22 us that they're able to not only do it once but sustain it  
23 over a period of time and that they've made significant  
24 behavioural changes. We also want to look at ensuring that  
25 their network is following through the way we've asked them

1 to and the family's asked them to. So we want to see if,  
2 for example, I keep going back to grandmas but that's a lot  
3 of our extended family networks is relying on aunties and  
4 grandmas and grandpas. So if grandma is part of the safety  
5 plan we want to know that grandma actually is following  
6 through and that the parent is actually reaching out or  
7 that the child is reaching out or that the steps we've put  
8 in are actually being implemented.

9 MR. MCKINNON: Okay.

10 MS. BROWNLEE: So that's part of what the  
11 decision making that has to occur now for us to be  
12 satisfied that there has been a change in the family.

13 MR. MCKINNON: And one of the things you  
14 mentioned in terms of, you know, whether something had been  
15 addressed satisfactorily, you mentioned the family  
16 strengths and needs reassessment and I'm going to maybe ask  
17 Karen just to briefly describe what that is and when it's  
18 used and I understand it's quite similar to the original  
19 assessment.

20 MS. MCDONALD: It's in fact the same tool. So  
21 really when we're working with a family we would -- and  
22 where we would complete a probability of future harm  
23 reassessment, and based on what the outcome was, if risk  
24 had not changed or had increased or had not lowered enough  
25 for us to feel confident, we would then engage in a family

1 strengths needs reassessment because -- and that would be  
2 taking that exact same tool, going through it again and  
3 looking at have any of the needs changed, have the  
4 strengths changed on again all of the members of the  
5 family. All of the caregivers and all of the children and  
6 then from there we would construct our new case plan.

7 THE COMMISSIONER: You're on number 5 now?

8 MR. MCKINNON: We're on number 5 now, Mr.  
9 Commissioner.

10 MS. MCDONALD: Yes.

11

12 BY MR. MCKINNON:

13 MR. MCKINNON: And just in terms of the suite of  
14 tools, I think that there's often a perception that these  
15 tools, the probability of future harm and the strengths,  
16 needs and the, and the reassessments, I think there's a  
17 perception that those are being used to apprehend children.  
18 You're shaking your head saying no, that's not, that's not  
19 correct.

20 MS. MCDONALD: Correct.

21 MR. MCKINNON: They're used to determine what  
22 services are required; is that correct?

23 MS. MCDONALD: I don't even want to say what  
24 services are required. What steps need to happen because  
25 again safety doesn't equal services so --

1 MR. MCKINNON: Right.

2 MS. MCDONALD: -- what needs to happen for the  
3 family to make the change necessary to be able to keep  
4 their children safe in their own homes.

5 MR. MCKINNON: And in terms of, again the issue  
6 of closing files, what do you have to see to close a file  
7 in today's practice model?

8 MS. MCDONALD: We would have to have a safety  
9 assessment completed which would come up with the children  
10 being safe.

11 MR. MCKINNON: Right.

12 MS. MCDONALD: The determination of safe.

13 THE COMMISSIONER: Then just let me ask you. You  
14 talked about what was required to closing a file when  
15 you're dealing with number 4.

16 MR. MCKINNON: Yes.

17 THE COMMISSIONER: And you now --

18 MR. MCKINNON: I'm doing it in a very general way  
19 now because when I think I was talking about number 4,  
20 that's one of the tools you used but I'm saying, the  
21 question I'm putting to the witness now is if there's a  
22 decision to be addressed about closing a file, what's the  
23 full procedure that you would expect to see and the tools  
24 that you would expect to see on the file so that your  
25 worker could make that decision?

1 THE COMMISSIONER: Well what's the difference  
2 from what you answered a few minutes ago about closing a  
3 file. What's different about that than the question Mr.  
4 McKinnon has put to you now?

5 MS. MCDONALD: I think the only difference is,  
6 and maybe I can clarify is that before we would ever make a  
7 distinction to close a file, we would also do a safety  
8 assessment as well as a probability of future harm risk  
9 assessment. They are two very different tools and they  
10 come up with two very different decisions and sometimes,  
11 and we certainly with workers have to reinforce their  
12 difference so that they're clearly not interchangeable.  
13 Because the safety assessment determines safety here and  
14 now immediate. It's are you safe today in this next very  
15 brief period of time and it only determines that. The  
16 probability of future harm is our risk and our risk is  
17 over, what is the likelihood that a child will be abused or  
18 neglected over the next 18 to 24 months. So the  
19 maltreatment of any kind will occur over the next -- so  
20 it's risk and safety really that will complete or satisfy  
21 us that we can potentially close a case.

22 MS. BROWNLEE: So if you're following this  
23 document, essentially when the worker and the supervisor  
24 would sit down to make a determination about whether or not  
25 they could close a case, they would be looking at the case

1 plan, the probability of future harm reassessment, the  
2 family strength and needs reassessment and the safety  
3 assessment, so three, four, five and six.

4 MR. MCKINNON: And just on point number 6, in  
5 this document it says:

6

7 The safety assessment and the  
8 reunification assessment are not  
9 currently being taught but they  
10 may be by the time evidence is  
11 given.

12

13 We heard from Mr. Rodgers, if memory serves me, that the  
14 reunification assessment is not ruled out yet.

15 MS. MCDONALD: Correct.

16 MR. MCKINNON: What about the structured decision  
17 making safety assessments?

18 MS. MCDONALD: We begin training the safety  
19 assessment. Our supervisors will be trained on May 31st  
20 and all of our staff will have completed training by the  
21 end of June of this, of 2013.

22 MR. MCKINNON: And in the absence of the SDM  
23 safety assessment, when you're talking about safety  
24 assessment in your evidence, what are you currently using?

25 MS. MCDONALD: It would be the intake module.

1 MR. MCKINNON: And the commissioner may not know  
2 what that means.

3 MS. MCDONALD: Oh sorry. The safety assessment  
4 that would be on, on CFSIS.

5 MS. BROWNLEE: Contained in the intake module.

6 MS. MCDONALD: Contained in the intake module,  
7 sorry.

8 MR. MCKINNON: So it's -- and, and I think that's  
9 enough. I don't have to go further than that. So those  
10 are the two things that have yet to be trained where staff  
11 get to be trained at which point there will be a full  
12 complement of SDM --

13 MS. MCDONALD: Yes.

14 MR. MCKINNON: -- a full suite of SDM tools  
15 available.

16 MS. MCDONALD: And with that said though, workers  
17 are very aware of the safety assessment of what the  
18 decision points that are coming down. So they're, they're  
19 all -- that language will not be new to them and that idea  
20 will not be new to workers.

21 MR. MCKINNON: And I'm thinking who's the best  
22 person to answer this question. Maybe I'll start with  
23 you, Ms. McDonald, as the trainer. What's the feedback  
24 from the staff that you're training, the staff that you're  
25 coaching, the staff that you're mentoring, what's the

1 feedback to the, the reaction to the use of their tools and  
2 their attitude towards whether they're improving their  
3 ability to practice?

4 MS. MCDONALD: I think that feedback has  
5 generally very positive. I think workers, as they become  
6 more comfortable with the tools are finding them to be a  
7 real value to their work. We've had reports from workers  
8 where they have talked about how they have had a highly  
9 resistant family that they've been working with, or more  
10 particularly in this one case it was a highly resistant  
11 mother who they tried everything that they could. But when  
12 they were able to actually say, look it, this is what I'm  
13 using to assess you with and this is what, what I, the  
14 questions I need -- or not questions, the categories, the  
15 items that I'm looking at, the mother actually came to the  
16 table, sat with them and has been trying over a number of  
17 meetings now to really say oh by the way I also want to  
18 tell you more about this, so that I really want you to  
19 understand now how, how my coping skills are or are not so  
20 great. And has really -- because they found, workers have  
21 found now that families -- they can, if they're much more  
22 transparent with families, families understand what they  
23 are being, I don't like to use this word, but measured  
24 against. Workers have also felt that it's been very good  
25 to have consistent tools coming right to them from ANCR so

1 that now when they get a file transferred to them from  
2 ANCR, they're able to pick up where ANCR left off and  
3 understand what ANCR has also done to come up with their  
4 decisions and have a conversation based on that starting  
5 point. So that consistency was something that we didn't  
6 have before.

7 MR. MCKINNON: And that's because ANCR is using  
8 these same tools?

9 MS. MCDONALD: Right. They've also expressed,  
10 and I think this is -- well it's for me something that I  
11 find -- they had a higher level of confidence in the work  
12 that they're doing because the tools are able to give them  
13 a feeling that they -- although we've always done work  
14 based on clinical judgment, it's not about their gut, it's  
15 supported by their tools, their judgment is supported by  
16 the tools that they use.

17 MR. MCKINNON: And Alana Brownlee, if you could  
18 comment as a senior manager at Winnipeg CFS what your  
19 impression is as to the confidence you have in the way in  
20 which staff are now executing their duties.

21 MS. BROWNLEE: I see it as a, it's been two years  
22 of building. I think any time you implement something  
23 that's as a large a change as this it takes a while. We  
24 made a really conscious decision that we wanted to make  
25 sure that, that this was implemented in a way that would

1 allow staff to buy in and that would be implemented in a  
2 way that had a lot of the mentoring, the coaching, and to  
3 make sure that we were training teams as teams, so that the  
4 team could really build around how are implementing this  
5 practice as individual workers and as, as a functioning  
6 team in a unit.

7           What I have seen is there is some initial  
8 reluctance to the tools when we first started training.  
9 Some of that is comfort. So as they've gotten more  
10 comfortable with it, as they become more knowledgeable, as  
11 they started actually using the tools, they're certainly  
12 buying in much more, they're seeing the use of them,  
13 they're seeing the effectiveness. The other piece that's  
14 been really helpful is Karen and all their training, and we  
15 do that as a supervisor group and as all staff meetings,  
16 talking and sharing success stories. So as people have  
17 started sharing the success stories about actually taking  
18 the tools out in their work with families and actually  
19 being very transparent with the tools, we've had some  
20 tremendous success stories and feedback from families and  
21 that's really reinforced. So part of it has been building  
22 the connection that these tools are not compliance tools.  
23 These tools are about doing your job better and helping you  
24 provide better quality of service and as we've really been  
25 able to continue reinforcing that message and as their

1 practice use reinforces that message, we've started to see  
2 a lot of increase in workers feeling like this is a good  
3 change.

4 That being said, the one kind of resounding  
5 criticism that we're hearing regularly is staff are clearly  
6 saying this is really impacting workload in terms of the  
7 volume, the paperwork and that they're struggling with the  
8 face to face contact and the requirement to be seeing  
9 families that often and the paperwork demands and are  
10 struggling with how are they suppose to prioritize that.

11 MR. MCKINNON: Okay, and we'll come back to that  
12 later. I now want to move on, we're on page 51 of the  
13 summary of evidence and I see the next few boxes or the  
14 next few days of orientation training as being less  
15 relevant to this inquiry, so I'll just touch on them  
16 briefly. Day 7 is forms and procedures when a child comes  
17 into care. That would be more technical training on that  
18 kind of issue and stop me if you think there's anything the  
19 commissioner needs to hear.

20 Day 8 you talk about specific topics like  
21 attachment and separation, placement for children and  
22 reunification, those kinds of things. I'm not diminishing  
23 the importance of those but I think they're more self-  
24 explanatory. The one question I could ask perhaps is was  
25 something like attachment being specifically taught in 2006

1 as part of orientation?

2 MS. MCDONALD: No, but in 2006 we didn't have a  
3 structured orientation with this either. So again,  
4 orientation has, in 2006 would have been very much  
5 dependant on your supervisor.

6 MR. MCKINNON: And maybe I could rephrase it.  
7 Was it being taught anywhere in your experience in --

8 MS. MCDONALD: To my knowledge, no. Can I also  
9 add though in day 7 and 8 we also do talk about and share  
10 the designated safe living arrangement policy and practice  
11 at the general authority.

12 MR. MCKINNON: Okay, and that's of importance to  
13 this inquiry.

14 MS. MCDONALD: Yes. Everybody's --

15 MR. MCKINNON: And just so the commissioner  
16 understands, the designated safe living arrangement would  
17 be a situation where there are concerns about child safety  
18 or risk to a child and the child is placed in an informal  
19 placement?

20 MS. MCDONALD: Correct.

21 MR. MCKINNON: And what do you train now as to  
22 that, the correct procedure?

23 MS. MCDONALD: We've trained since orientation  
24 began, even as the policy was written, we trained that if  
25 there was any reason that a parent could not pick up their

1 child from that home and if we would have any concern  
2 whatsoever that child was to be apprehended and we were to  
3 give that child status and do, and initiate a place of  
4 safety with the caregiver, that there were to be nothing  
5 considered like a private arrangement, unless we had  
6 absolutely no reason to feel the child would be unsafe if  
7 the parent picked him up.

8 MR. MCKINNON: And when you talk about status,  
9 you're talking about legal guardianship?

10 MS. MCDONALD: Apprehension and initial legal  
11 guardianship.

12 MR. MCKINNON: And the problem with the informal  
13 arrangements in the absence of an apprehension is that the  
14 parent can come back and pick up that child --

15 MS. MCDONALD: Correct.

16 MR. MCKINNON: -- at any time?

17 MS. MCDONALD: That is correct.

18 MR. MCKINNON: And the person who is caring for  
19 that child has no legal status?

20 MS. MCDONALD: Correct. And --

21 MR. MCKINNON: And with an apprehension could  
22 they still be placed with a friend of the family?

23 MS. MCDONALD: Absolutely. But we would initiate  
24 a place of safety with the person which would formalize the  
25 arrangement.

1           MR. MCKINNON:   Okay.   Day 10 is case management  
2 standards so that's now --

3           MS. MCDONALD:   Can I --

4           MR. MCKINNON:   Sorry?

5           MS. MCDONALD:   Day 9 we spend time talking about  
6 developmental milestones and abuse or neglect indicators  
7 and we do also spend quite a bit of time talking about how  
8 to interview children, just even in a beginning stage on  
9 trying to determine if we have any abuse or neglect  
10 concerns.

11          MR. MCKINNON:   Thank you for that.   And day 10,  
12 I'm moving to because of the standards manual and standards  
13 training and we've again heard a lot about that.   This is  
14 the first time that we've talked about training on those.  
15 We heard a little bit from Jay Rodgers yesterday.   Is there  
16 anything you feel you should add to what he said?

17          MS. MCDONALD:   The only thing I'm going to add is  
18 that we have specifically added the one day training on  
19 case management standards directly to the orientation  
20 because that's our way at Winnipeg Child and Family  
21 Services to ensure that each and every staff continues to  
22 get trained on very soon into their employment on  
23 standards.   So we, myself and my coworker trained all of  
24 the staff in -- I can't remember.   I think it was 2011 on  
25 case management standards and completed like, well trained

1 all of Winnipeg Child and Family Services and --

2 MR. MCKINNON: And when you say all of Winnipeg,  
3 you're not talking just new hires?

4 MS. MCDONALD: No. All of the staff from program  
5 managers to, to service assistants on case management  
6 standards and we run another three, three training sessions  
7 and when I say training session, they include like up to 25  
8 people per training. But the way we upkeep and ensure that  
9 new staff don't have to wait for six months to receive it  
10 is we're adding it into orientation, that way they will get  
11 it very soon into their employment and anybody, like  
12 students or, more like students can also join in at that  
13 point in time. So it's not closed for people at  
14 orientation but it's closed -- it's open then, we'll offer  
15 that training and just say it's for the orientation people  
16 plus anybody else who may still require it.

17 MR. MCKINNON: Okay. I'm going to direct the  
18 next question to Ms. Brownlee. The last half day of the  
19 orientation is, is, from Winnipeg CFS, is staff lawyer, Ms.  
20 Poskar. We've heard evidence from her at this inquiry. I  
21 understand that's where things like PHIA and FIPPA and the  
22 technical requirements for court appearances, that's where  
23 that training is provided?

24 MS. BROWNLEE: Yes, she, she does an overview,  
25 helping them understand the legal aspects of the Child and

1 Family Services Act, the authority that they hold with the  
2 act, and specifically how our act interfaces with other  
3 legislation such as PHIA, FIPPA. She'll walk through the  
4 various stages of court such as docket court if you do an  
5 apprehension, what court information is required to be  
6 filed, the time deadlines related to that, the next step of  
7 pre-trial and those kind of steps. She also talks about  
8 evidentiary processes. So if you are filing an  
9 apprehension, what does it mean to be able to demonstrate  
10 that a child is in need of protection, what kind of  
11 information you need. So she walks them through that kind  
12 of information. She also highlights that as a statutory  
13 worker as well, you have the same responsibility as anyone  
14 else and a higher level of responsibility if you become  
15 aware of information you also have the duty to report as  
16 well. So if you find out something, I don't know, you're  
17 coaching in the community, you have a duty to report. If  
18 you're out doing work with a family and they report  
19 something else, you have a duty to report and we have even  
20 included to make sure that they're aware that, you know, if  
21 I become aware of a concern with Karen as a colleague I  
22 still have a duty to report. So just making sure that  
23 people are aware of all aspect of our duty and that we're  
24 held to a higher standard because we are CFS workers.

25 MR. MCKINNON: Thank you for that.

1           Mr. Commissioner, I'm now moving to competency  
2 based training which is --

3           THE COMMISSIONER: Yes.

4           MR. MCKINNON: -- page 52.

5           MS. MCDONALD: Can I just -- sorry.

6           MR. MCKINNON: Oh sorry.

7           MS. MCDONALD: No, I'm sorry.

8           MR. MCKINNON: If you have something you need to  
9 add --

10           MS. MCDONALD: I just wanted to add as we end  
11 orientation that the other piece, and the evaluation  
12 somewhat spoke to it, but the other piece at the end of it  
13 all, myself and my coworker, who run the orientation, have,  
14 I had said earlier, developed a relationship with some of  
15 the workers but we also with that are able to get a sense  
16 of some of the worker's strengths and maybe some of the  
17 areas that the worker requires more learning or more  
18 training and we're able to feed that back to supervisors as  
19 they, as we go along so that they're able to be able in  
20 their supervisor to target certain areas that may be --

21           MR. MCKINNON: To follow up with your --

22           MS. MCDONALD: Yes.

23           MS. BROWNLEE: Um-hum.

24           MR. MCKINNON: -- identified concerns.

25           MS. MCDONALD: May be tricky. So I sort of --

1 there's a piece that we find, that supervisors have found  
2 very valuable for us to be able to say and those workers  
3 then also have a comfort to come back to us and ask us for  
4 feedback on other topics as well, not just the structured  
5 tools that we train on.

6 MR. MCKINNON: Okay.

7 Now moving to the next completely new topic, Mr.  
8 Commissioner, on competency based training, I'm going to  
9 start with Ms. Brownlee and we might put a much less  
10 emphasis on this than we did on the orientation, but let me  
11 start with the basics.

12

13 BY MR. MCKINNON:

14 MR. MCKINNON: The orientation that we've just  
15 been through for over, well over an hour, that's all a  
16 Winnipeg CFS specific orientation and training program?

17 MS. BROWNLEE: Yes.

18 MR. MCKINNON: Competency based training, I  
19 understand, is not. That is a department wide training  
20 program --

21 MS. BROWNLEE: Yes.

22 MR. MCKINNON: -- am I correct?

23 MS. BROWNLEE: Yes.

24 MR. MCKINNON: Thank you. I'm never sure. And I  
25 want, again realizing that it's departmental and therefore

1 much broader than Winnipeg CFS, I'm not going to ask you to  
2 go into that as much detail, but perhaps you could,  
3 Ms. Brownlee, give us a sense of the, you know, the extent  
4 to which this -- how broad it is, what kinds of things it  
5 covers and how that integrates with what your staff may  
6 have learned in orientation.

7 MS. BROWNLEE: Competency based training is, I  
8 think, the original province wide foundational training  
9 that was developed specifically for child welfare workers  
10 across the province. It's been delivered since 1999. It's  
11 been mandatory at Winnipeg CFS since 2000 and the training  
12 was originally broken down into four modules. It's now up  
13 to six modules, I believe. Yes. Eight.

14 MS. MCDONALD: Eight.

15 MS. BROWNLEE: Okay. Six and eight look the same  
16 without glasses. And it's really built on identifying what  
17 are the core foundational competencies that all social  
18 workers should learn within the first two years on the job  
19 in order to adequately fulfill their roles and  
20 responsibilities. It's not specific to any service  
21 delivery model. It's based on what is known as the best  
22 kind of skill set, clinical skill set and tools and  
23 theories that, that social workers should get. So it's  
24 been a mandatory training delivered by the province and  
25 Karen's one of the facilitators for a number of years. The

1 program has been updated and modified. As I said it went  
2 from four to eight modules and it's --

3 MR. MCKINNON: And just if I could stop you  
4 there. It was four -- how many modules were there in 2006?

5 MS. BROWNLEE: I believe there would have been  
6 four which would vary from two days to five days, depending  
7 on which module it was. So it was still a comprehensive  
8 training.

9 MR. MCKINNON: It was fairly extensive but not as  
10 extensive as it is today?

11 MS. BROWNLEE: No. It's now 20 days and I think  
12 the feature that's been added that's very beneficial is it  
13 now has what they're calling learning labs.

14 THE COMMISSIONER: And how many days was it in  
15 2006?

16 MS. BROWNLEE: Was it 15?

17 MS. MCDONALD: Fourteen.

18 MS. BROWNLEE: Fourteen.

19

20 BY MR. MCKINNON:

21 MR. MCKINNON: And how many days is it now?

22 MS. BROWNLEE: Twenty.

23 MR. MCKINNON: Twenty. And just before you get  
24 into the detail of learning labs and that sort of thing, in  
25 my summary of evidence, Mr. Commissioner, I said at the

1 bottom of page 52, that there were six modules. That is,  
2 that is incorrect, that is my mistake. I, I understand  
3 there's a new document which I, which I didn't have at the  
4 time I prepared this which the witness has provided to me  
5 on the weekend. I sent a copy to Ms. Ewatski. I don't  
6 know if it's been put on a stick.

7 THE COMMISSIONER: Well I thought they just said  
8 there were now six modules.

9 MR. MCKINNON: No, they said there were eight.

10 MS. BROWNLEE: There's now eight. I said six and  
11 was corrected to eight.

12 THE COMMISSIONER: Oh yeah, you did say six.

13 MS. BROWNLEE: I did say six.

14 THE COMMISSIONER: Thank you for correcting that,  
15 otherwise I would have been wondering what I was hearing.

16 MR. MCKINNON: Okay. And what I was hoping to do  
17 is mark as an exhibit a new document and it's entitled  
18 "Case Worker Core Competency Based Training 2012".

19 THE COMMISSIONER: Give me that again.

20 MR. MCKINNON: "Case Worker Core Competency Based  
21 Training 2012".

22 THE COMMISSIONER: And we're marking that?

23 THE CLERK: Exhibit 79.

24 THE COMMISSIONER: Exhibit 79.

25

1                   **EXHIBIT 79:       DOCUMENT ENTITLED**  
2                   **CASE WORKER CORE COMPETENCY BASED**  
3                   **TRAINING 2012**

4

5   BY MR. MCKINNON:

6                   MR. MCKINNON:   And I want to try and abbreviate  
7 this portion of the evidence because, as I say, it's  
8 departmental evidence not specific to Winnipeg.

9                   If I could get perhaps Ms. McDonald to just  
10 outline to the best of your recollection, what's been added  
11 since 2006 to this training and just a brief description of  
12 it. I don't think the Commissioner needs the details but I  
13 think he is interested in knowing how the system has  
14 improved since 2006.

15                  THE COMMISSIONER:       And are the additions  
16 identified by the module number?

17                  MS. MCDONALD:   Yes and no. One of the additions  
18 that is identified is a module that was never offered  
19 before and that's module 5 which is the investigative  
20 process in family centered child welfare. That was not  
21 offered in the original competency based training series.  
22 And another addition that is not identified specifically by  
23 module is what Ms. Brownlee referred to as learning labs.  
24 Basically the modules have been spread out and they have  
25 been, they have taken a part of each -- or many of the

1 modules and added an opportunity to practice what you have  
2 learned in the days. So, for example, in the investigative  
3 process module, it is a three day module, or it's a two day  
4 module. One day is on learning what is required to do an  
5 investigation and the second day is practicing through  
6 various techniques to actually perform an investigation.

7

8 BY MR. MCKINNON:

9 MR. MCKINNON: And is there anything else that  
10 has been added since 2006?

11 MS. MCDONALD: Substantially on that? No, it's a  
12 reconfiguration with, with some potentially different  
13 content in certain areas, different methods of learning,  
14 different videos, but --

15 MR. MCKINNON: Yeah, we don't need that level of  
16 detail.

17 MS. MCDONALD: No.

18 MR. MCKINNON: Just what's been added.

19 MS. MCDONALD: But those are the specific  
20 changes.

21 MR. MCKINNON: Okay. And is there anything else  
22 about competency based training that the commissioner  
23 should hear about that's new or different from 2006?

24 MS. MCDONALD: Again, I'm not sure if it has been  
25 brought up but there's also, there was also a

1 reconfiguration of the supervisor's competency based  
2 training core curriculum, so you may have already spoken  
3 about that.

4 MR. MCKINNON: I don't think we've heard much  
5 about that. Could you mention that to the Commissioner?

6 MS. MCDONALD: There, there's also a supervisors  
7 -- the one that we just talked about --

8 THE COMMISSIONER: This was not in place in '06?

9 MS. MCDONALD: There was one but it was again  
10 much smaller with no learning labs attached. So what they  
11 did and the supervisor competency based training since '06  
12 is they again revised all of the modules, expanded and I  
13 believe it was four and they now have six modules for  
14 supervisory core. And they have also added additional  
15 learning labs to those modules to give supervisors  
16 opportunities to practice what they have learned.

17 MR. MCKINNON: And, Ms. Brownlee, if I can get  
18 you to go the binder of documents.

19 Mr. Commissioner, we're at Exhibit 64.

20 THE COMMISSIONER: Yes.

21 MR. MCKINNON: At tab 23.

22

23 BY MR. MCKINNON:

24 MR. MCKINNON: This is just an index, it's not  
25 the full training program, but in that index at the bottom

1 of page 41692 -- are you able to find it? There it is.  
2 It's on the screen.

3 MS. BROWNLEE: Yeah.

4 MR. MCKINNON: At that bottom of that --

5 THE COMMISSIONER: What tab number is it? It's -

6 -

7 MR. MCKINNON: Sorry.

8 THE COMMISSIONER: -- in Exhibit 64?

9 MR. MCKINNON: Sixty-four, tab 23. And it's the  
10 bottom of the page, Madam Clerk, that you're now on.

11

12 BY MR. MCKINNON:

13 MR. MCKINNON: Under heading "C. Supervisor Core  
14 Module." Is that what Ms. McDonald was just describing?

15 MS. BROWNLEE: Yes.

16 MR. MCKINNON: Okay. And how many days is that  
17 now, how many days of training is that now?

18 MS. BROWNLEE: It's now six modules. I'm not  
19 sure, do you know how many days it is? I'm sorry, I can't  
20 remember.

21 MR. MCKINNON: I'm cheating by looking at our  
22 summary at page 54. It says 10 days. Does that sound  
23 right? And four days of Tony Morrison training?

24 MS. BROWNLEE: The 10 days I think is the  
25 leadership and supervisory training through OSD.

1           MR. MCKINNON:   Okay.   So that's a different type  
2 of training?

3           MS. BROWNLEE:   Yes.

4           MR. MCKINNON:   Thank you for correcting me.   So  
5 in terms of the supervisor competency based training,  
6 that's one component of training for supervisors?

7           MS. BROWNLEE:   Yeah, the Winnipeg CFS has three  
8 supervisory training components.

9           MR. MCKINNON:   That's what I'm looking for.   If  
10 you could give those three to the commissioner.

11          MS. BROWNLEE:    So we expect all of our  
12 supervisors to complete these three trainings for different  
13 reasons.   One, we expect our supervisors to all complete  
14 the core competency based training for supervisors which is  
15 the six modules we were just discussing.   As an agency, we  
16 regularly deliver the Tony Morrison training on supervision  
17 in social services agencies and that's been a longstanding  
18 practice because we feel it fits philosophically with our  
19 agency service delivery model.   So we periodically redo  
20 that training.   We just did it in 2011 and we do that  
21 training as a management group.

22          MR. MCKINNON:   Okay.

23          MS. BROWNLEE:    The -- once, once supervisors have  
24 finished those two trainings we then ask that they go  
25 through what's called the organizational staff development

1 training curriculum and attend a leadership and supervisory  
2 training that's offered through that and it's 10 days and  
3 it's not specific to child welfare. It is a generic  
4 leadership and management training but we find that it  
5 still has obviously useful specifics that are helpful for  
6 supervisors in, in leading and managing a team.

7 MR. MCKINNON: And how much of that is new since  
8 2006? Some of the core competency we've already talked  
9 about that.

10 MS. BROWNLEE: Yes.

11 MR. MCKINNON: Tony Morrison, is that new since  
12 2006?

13 MS. BROWNLEE: It's been redone. It had been  
14 done in 2004 at Winnipeg CFS. So the fact that we've just  
15 held that -- it's a five day training. The fact that we  
16 just went through it again as a management team would be an  
17 update.

18 MR. MCKINNON: So 2004 was the first time and now  
19 it's become, if I can put it, part of the regular  
20 expectations of management that they, from time to time,  
21 will challenge this training.

22 MS. BROWNLEE: Yes, we feel it's, it's a good  
23 opportunity to bring the management team together and just,  
24 I think ensure consistency, ensure consistent values,  
25 ensure that we're all practicing from the same point of

1 view. So we've agreed that we should do it at least every  
2 second or third year as a management team.

3 The other piece that's new is any time we have a  
4 new supervisor we've developed a learning plan that's  
5 devised specifically with a supervisor and it has the  
6 components of they must attend the competency based  
7 training but we also include pairing them up with a mentor,  
8 so they're paired up with a senior supervisor and this is a  
9 formal pairing. So the senior person knows and that they  
10 have regular contact and that's for mentoring and the  
11 service manager is expected to provided biweekly  
12 supervision to the supervisor for the first six months to  
13 be reevaluated at the end of the first six month period of  
14 time.

15 MR. MCKINNON: Okay.

16 Mr. Commissioner, I'm about to move to a new area  
17 and we're in the middle of page 54 and we're talking here  
18 about the GA practice model and you heard a fair bit about  
19 this yesterday from Mr. Rodgers and I'm going to lead a  
20 little bit here, witnesses.

21

22 BY MR. MCKINNON:

23 MR. MCKINNON: There are three components to the  
24 GA practice model. (A) is structured decision making; (B)  
25 is signs of safety principles; and (C) is training. And

1 we've essentially covered the structured decision making in  
2 our long-winded description of the orientation training, so  
3 I won't take you through that in any detail. We've  
4 essentially gone through training and we'll come back to  
5 that in a bit in terms of the practice model specific  
6 training but in terms of signs of safety, that may be where  
7 we're going to spend most of our time in the next ten  
8 minutes or so.

9           And you've told us what a safety assessment is,  
10 you've told us what a probability of future harm assessment  
11 is, you've told us, and I'm going through pages 56, 57.  
12 You've talked about things like discretionary overrides and  
13 how clinical judgment comes into there, into play there.  
14 I'm at page 58 of our summary of evidence and I'm at point  
15 18 and I think I'm going to ask Ms. Brownlee to address the  
16 question of the file recording package that accompanies  
17 this tool. If you could introduce that and then if there's  
18 anything in terms of the detail that needs to be elaborated  
19 on, Ms. McDonald can provide that. But would you tell the  
20 commissioner -- and I know you've referred to this  
21 previously --

22           MS. BROWNLEE: Um-hum.

23           MR. MCKINNON: -- about there being a file  
24 recording package, but I suspect the Commissioner won't  
25 know what that means and the significance of it. So if you

1 could describe that to the commissioner.

2 MS. BROWNLEE: Okay. The --

3 THE COMMISSIONER: Now which one of the three  
4 components is this under?

5 MR. MCKINNON: We are still under the structured  
6 decision making, Mr. Commissioner, and this is one of the  
7 points that we didn't cover off earlier when we were  
8 talking about the training on structured decision making.  
9 So it's page 58, bullet 18 and I'm asking the witness how  
10 the recording package relates to the structured decision  
11 making tools.

12

13 BY MR. MCKINNON:

14 MR. MCKINNON: Have I phrased that question  
15 correctly?

16 MS. BROWNLEE: Yes and no. The file recording  
17 package is broader than the structured decision making  
18 tools. The Winnipeg CFS has had a committee of people  
19 working on the recording package actually since 2008 which  
20 I know probably seems like a crazy amount of time but  
21 they've had to continuously revamp it and, and Winnipeg CFS  
22 has piloted different versions of it. It is now, since  
23 2012, it's fully integrated with the SDM package so that  
24 there is complete consistency and continuity and it  
25 actually we just, just finished the child in care recording

1 component of it to make sure that it's consistent with the  
2 child strength needs assessment. So it is broader than  
3 just the tools. It is something that's also unique to  
4 Winnipeg CFS, although it has been adopted by other GA  
5 agencies and it has actually been shared with other  
6 agencies under other authorities for their consideration.

7 But just so you have an idea, the, the recording  
8 package starts with what a worker is supposed to do when  
9 they get a new file from intake, so it includes what we  
10 call a demographic and family information section which  
11 outlines what information they should be gathering based on  
12 the intake information as well as the history. So it  
13 includes categories such as an alert section where you  
14 could put something where, you know, that it needs to be  
15 flagged for, you know, specific safety issues. It includes  
16 the worker to be required to do a full review of the file  
17 and document the child welfare history. That's important  
18 because one of the assessment components of the risk  
19 assessment or the probability of future harm tool requires  
20 you to know the child welfare history and the involvement.  
21 The family of origin history or as much as you know,  
22 caregiver criminal involvement as well as anything that's  
23 specifically identified from the intake that's safety  
24 considerations. So that's kind of the first part of the  
25 recording package.

1           Then the package looks at the recording tools,  
2 the SDM tools that we have and the recording committee and  
3 the agency did not feel, as well as the LPS's did not feel  
4 that simply checking the box on the tool was sufficient  
5 information, so we have built in a narrative component  
6 where you have to explain under each component in the  
7 probability of future harm or the safety assessment or the  
8 family strength needs specifically what you're basing your  
9 scoring on. So, for example, if you were scoring someone  
10 on substance abuse, you have to look at what the definition  
11 is, that they also have to document that it's scored in a  
12 specific way either because you have clear information that  
13 says it's not a problem or what your clear information is  
14 that suggests it. That's something that's again unique to  
15 us because we felt two things, one, it helps the worker  
16 again clarify how am I taking my actual information and  
17 applying it to the tools. It assists anyone else picking  
18 up the file such as the supervisor in knowing how did you  
19 achieve this rating. So it really helps us with  
20 consistency and it assists anyone if the file is closed  
21 they're not going to just know that say a rating was  
22 medium, they're going to know the rating was medium because  
23 of the specific concerns and it's all very clear in the  
24 tool.

25           The other piece that Karen's already referred to

1 that's part of the recording package is some clear  
2 structure around how case notes should be done and also how  
3 they apply, like how these things all flow together,  
4 because otherwise it may seem to work in filling out this  
5 form, this form, this form, when, you know, when am I  
6 supposed to put in my contact notes. So part of the  
7 training is to really help them understand why the document  
8 was important and how it fits into your actual case work,  
9 into your decision making and how it fits together. So  
10 when we train on the SDM tools, we actually train  
11 completely on the tools and the recording package as a  
12 whole.

13 MR. MCKINNON: Okay. That was going to be my  
14 next question about training. I don't know that we need to  
15 go into that more. Maybe, maybe the best way to phrase the  
16 next question is, and it may be self evident, but just the  
17 extent to which the current training and expectations of  
18 Winnipeg CFS with respect to recording compared to what was  
19 in effect in 2006.

20 MS. BROWNLEE: Okay. There are -- there's  
21 differences. In 2006 there, there was a recording policy  
22 that outlined, that outlined a requirement related to  
23 completing assessments with a timeline and completing  
24 recording such as case notes and also completing risk  
25 assessments. The difference today is that we still have

1 the same requirements that are based in standards, we now  
2 actually have a framework for staff to use. So before it  
3 would be you need to an assessment but there wasn't  
4 actually a framework in terms of how they should do it. A  
5 lot of staff would come back from competency based training  
6 and take narrative and have narrative headings, but there  
7 was not a specific document that allowed you to do an  
8 actual risk assessment. So I think the biggest difference  
9 is we have a framework. We have tools. We have ongoing  
10 training, specific to all of those expectations and I think  
11 probably the bigger piece or a significantly different  
12 piece is the ongoing coaching and mentoring. Our three  
13 LPSs, and I'm not sure if you've said this or not, they're  
14 attached to specific teams so each of them has, just as a  
15 random number, six teams that they're responsible for.  
16 Those teams and those workers know that Karen is their LPS  
17 or Bev is their LPS. So they know that's who their go to  
18 person is. They have a structured schedule for the whole  
19 year where they're coming out to, to do team training and  
20 that's really reinforcing on an ongoing, continuous basis  
21 beyond just their supervisor that this information is  
22 important. We need to know, we need to have written  
23 assessments. We need, we need to know what your assessment  
24 is, how you're making decisions. So they're regularly  
25 bringing cases in, they're regularly sitting down and

1 helping the staff do the tools. They do a combination of  
2 individual and team training and we have really found  
3 training in the teams is really self reinforcing so that  
4 they say anytime you interview someone knew you have the  
5 leaders that charge ahead and get excited and jump on board  
6 and then you kind of have the stragglers that have to be  
7 prodded a little bit. And the team, the collegial pressure  
8 of I'm doing this, it's exciting, it's working well, seems  
9 to have a stronger influence on say the stragglers than a  
10 directive from me or those kind of things. So we're really  
11 finding, I think, the structure is really helpful.

12 MR. MCKINNON: Can you just comment a bit more on  
13 the consistency of recording and how it might assist if  
14 there is a new social worker that has to come and pick up a  
15 case from someone who's been working on that file?

16 MS. BROWNLEE: Well I think the consistency in  
17 what you should expect to find. It's also, I think, hugely  
18 reinforcing that other agencies are using the same tools.  
19 So when we get an intake case, now it doesn't matter which  
20 intake worker is doing it, we expect to see a safety  
21 assessment or probability of future harm and a strength  
22 needs. So we're all using the same tools and the same  
23 assessment framework. So we're all looking through the  
24 same lens at a family. So when a worker picks it up so  
25 they're familiar that these things should be on, they know

1 that those are your go to things in a file because a lot of  
2 our files can be quite arduous. Some of our families are  
3 open with us for significant periods of time. So if, say  
4 for example if I'm covering for a worker because they're  
5 off on a leave for a week, it may be very difficult for me  
6 to go through a file that that's big but if I know these  
7 documents are what I need to look for and they're the  
8 critical ones, I'll look for the most recent assessment,  
9 I'll look for the most recent probability of future harm or  
10 reassessment and then I should have some very good  
11 information based on looking at only one or two documents.  
12 Not to say if I was going to be responsible for this file  
13 on an ongoing basis you would want to read the whole file,  
14 but in short order, in a covering way or a way to get a  
15 really quick snapshot of what's going on for a family, this  
16 certainly streamlines and focuses you on what you should be  
17 looking at.

18 MR. MCKINNON: You wanted to add something to  
19 that, Mr. McDonald.

20 MS. MCDONALD: What I wanted to add was that when  
21 we train social workers on the file recording package we're  
22 really trying to train them to get away from jargon and  
23 this is a big stress that we use because, because  
24 historically our field is very laden with jargon and  
25 terminology like, for example, would say mom's parenting is

1 adequate. What was adequate to me and what's adequate to  
2 somebody else could be very different. So we really expect  
3 workers in the file recording to break that down into  
4 exactly what they saw, heard, were told, found out and  
5 describe it in behavioural terms. So describe what the  
6 parenting practice is. Or if we use Alana's example of  
7 substance abuse versus just saying, you know, has a  
8 substance abuse problem, Dad admitted to drinking this  
9 amount, or Dad described drinking this amount per day and  
10 the children said that when Dad drinks his five beers he  
11 falls asleep on the couch and a criminal check showed Dad  
12 has a DUI on this date. So that when the next worker picks  
13 that up, they don't have to guess what adequate means or  
14 what that substance abuse issue looks like, they're very  
15 clear based on those descriptors as to what that worker saw  
16 or was told or heard.

17 MR. MCKINNON: And that's how you're training  
18 now?

19 MS. MCDONALD: Yes. And what we also do is, as  
20 leading practice specialist or what I would do is often  
21 workers are saying can you look at this to see if we're  
22 doing this the way we're expected to. So by virtue of us  
23 being able to read their narratives, if we can understand  
24 what they're saying, then we know they're hitting the mark.  
25 So that's a piece of our, our sort of double checking

1 system or continuous quality improvement, that we're  
2 looking at them, saying yeah, you know what, or I'm not  
3 totally sure about this, can you give me some more, get it  
4 out of your head and onto the paper.

5 MR. MCKINNON: Okay.

6 Mr. Commissioner, at page 59 you'll see there's a  
7 reference to SDM family strengths and needs assessment.  
8 We've covered that. I won't ask these witnesses to go over  
9 that again, but it's there if you want to refresh your  
10 memory.

11 At page 62 there's the SDM family reunification  
12 tool. We've covered that. It's not yet in, in practice.  
13 Also at the bottom of page 62 is the probability of future  
14 harm reassessment. We've talked about that. And I'm  
15 moving then on to page 64, there's the family strengths and  
16 needs reassessment. We've talked about that. And to some  
17 extent, when we're getting to the next topic, this is part  
18 B, this is -- and it's really B and C combined, Mr.  
19 Commissioner, which is signs of safety and training on  
20 signs of safety. And this is the other two components of  
21 the GA practice model.

22 THE COMMISSIONER: Yes.

23 MR. MCKINNON: And to some extent we covered this  
24 in the evidence of the witnesses earlier when they were  
25 talking about things like the three houses and the voices

1 of children and how you assess children. So some of this  
2 has been covered by these witnesses already.

3 THE COMMISSIONER: Yes.

4

5 BY MR. MCKINNON:

6 MR. MCKINNON: I'm going to ask some fairly broad  
7 questions rather than get into those details again and I  
8 think you did an excellent job but just some, some high  
9 level questions and maybe, Ms. Brownlee, can you talk about  
10 the difference between, and I think the terms, I've got  
11 them correct, danger and safety, are those the right terms  
12 that I should be referencing in this, signs of safety  
13 concept, this technique?

14 MS. BROWNLEE: It is. It's a combination of a  
15 technique as well as -- like the practice model overall is  
16 a combination of clinical skills and then the tools.

17 MR. MCKINNON: Right.

18 MS. BROWNLEE: So it's the clinical --

19 THE COMMISSIONER: Just let me ask, is this (b)  
20 and (c) combined? I'm looking at page 54, the three  
21 components --

22 MR. MCKINNON: Yes, this is (b) and (c) combined.

23 THE COMMISSIONER: This is (b) and (c) combined?

24 MR. MCKINNON: Yes.

25 MS. BROWNLEE: Yeah. So to get back to how I

1 think, the reason why I'm pointing that out is because a  
2 lot of the signs of safety practice principles are about  
3 how do you, how do you do the work with a family? How do  
4 you gather this information? How do you have these  
5 conversations with families about protection issues about  
6 harm that they may have caused to their child in a way that  
7 will allow them to enter into your home and do the work  
8 with them? How do you not -- how do you decrease their  
9 defensiveness? So the signs of safety was developed in  
10 Australia and I don't want to go into lots of this but I  
11 think the critical piece and why I think it's so useful is  
12 it was designed from the ground floor up based on the  
13 practice experiences of child welfare workers in  
14 consultation and in direction with therapists. So it  
15 wasn't coming, you know, from my level down to workers  
16 telling you this is how, it was based on the actual  
17 practices of when I do this work, this helps. If I do  
18 this, this helps, you know, and it was gradually built from  
19 there. One of the critical components of it that we  
20 haven't talked about is what we call a mapping process and  
21 that's centering the practice around three kind of key  
22 questions: What are we worried about? What is working  
23 well? And what are the next steps? And we've tried to  
24 incorporate that agency wide, so we try to use that when  
25 we're making decisions as management and strategic

1 planning. So when you're looking at what you're worried  
2 about, you're working with a family around harm and danger  
3 and separating out the concepts of harm and danger is, is  
4 unique to this process in the sense that harm is what has  
5 actually happened to the child, so the child has been left  
6 alone overnight and they're five years old because the  
7 parent went drinking. That would be harm. Danger is what  
8 are we worried will happen if nothing else changes? So if  
9 we do not change -- Karen's example of Dad with five beer -  
10 - if we do not change Dad's pattern of drinking to the  
11 point of passing out and leaving the children unattended,  
12 what are we worried is going to continue to happen?

13 So those are the conversations that you have and  
14 you do it mapping with the family so you're really clear.  
15 Like here's, here's what the impact is, here's what we're  
16 worried about, what are you worried about? And, and just  
17 even framing it as this is what I'm worried about and this  
18 is why I'm worried about in terms of outlining the harm to  
19 the child really has a different feel for families. Like  
20 obviously not all families will respond to this but we  
21 really found that a lot of families just feel less judged.  
22 They are able to see that, okay, yes, that's a legitimate  
23 concern when you start saying what are our next steps, how  
24 are we going to change this, it just creates a different  
25 dialogue than we've been having with families when we come

1 in saying we've had a report of abuse or we've had a report  
2 of neglect. It just is a different style of interaction.

3           When you're looking at what is working well,  
4 you're really trying to pull from the family not just what  
5 their strengths are, but what are their acts of protection?  
6 All families do some, provide some quality of care to their  
7 children, even families that are abusive and neglectful,  
8 have strengths and provide some positive aspects. So it's  
9 really getting families to really identify, getting the  
10 kids to identify what are the positive things. And it's  
11 not -- some of the strengths are things that are not going  
12 to mitigate safety, but it's still really important to  
13 identify them. We've had, you know, a parent, when we have  
14 identified as strengths, said you know I didn't think you  
15 saw anything good about me, you know. So again, it really  
16 has an impact on the relationship that you can build on.  
17 And again, what, what happens next is, is moving into the  
18 case planning.

19           So this is kind of how we, you know, we have the  
20 tools that we need the information on, so the mapping  
21 process is the types of questions, how you ask it. It's  
22 bringing out flip chart paper to the family home where  
23 you're writing, writing things out. It's using, as Karen  
24 said, animating the voice of children. I think that we  
25 haven't always been good at incorporating. We know when we

1 need to interview a child related to a specific allegation,  
2 but we haven't as a system always been very good at  
3 ensuring that we talk to kids, just about what are the  
4 things that are good at home, what are the things that  
5 aren't good at home. A good example of that is family with  
6 family violence issues who the mom and dad are positive the  
7 child is in bed when they're fighting and the child doesn't  
8 hear so there's no impact. So you do the three houses with  
9 the child and you find out well no, when mom and dad are  
10 fighting I hear everything and I'm really scared and I go  
11 into the closet and I hide in the corner, I shut the door.  
12 So that's new information for the parents and it has a lot  
13 more power when that comes from the voice of the child  
14 than, you know, me as a worker trying to convince you that  
15 you know I'm sure your child is hearing you. So it's those  
16 kind of tools that we now are training staff to be able to  
17 use and are training them that these are critical  
18 components of the case plan and we're really seeing a  
19 difference in terms of how families are responding to that.

20

21 BY MR. MCKINNON:

22 MR. MCKINNON: I'm going to, just in terms of the  
23 training component, you used the word training, if you  
24 look, Ms. McDonald, at pages 64, 65 and 66 of our summary  
25 of evidence, there's reference there to 12 more modules.

1 MS. MCDONALD: Correct.

2 MR. MCKINNON: This is the training on the GA  
3 practice module or practice model, sorry. This is the  
4 training on the GA practice model?

5 MS. MCDONALD: This combined with the structured  
6 decision making training.

7 MR. MCKINNON: Right.

8 MS. MCDONALD: This completes the model.

9 MR. MCKINNON: So I'm not going to ask you to go  
10 through each one of them but how is this delivered, who  
11 delivers it, what follow up? Just at a very big level.

12 MS. MCDONALD: Yeah.

13 MR. MCKINNON: Is this something that you do as  
14 part of your work as a leading practice specialist?

15 MS. MCDONALD: Yes, I do. So I would deliver  
16 this training or myself and my coworker deliver this  
17 training. Teams come to us, we deliver it in our training  
18 centre and we would go through with the module one at a  
19 time. Essentially, how we structured the training is teams  
20 will come and they will be trained about every six weeks on  
21 a new module and that's strategically done because each  
22 module is a half to a full day in length and at the  
23 completion of each module we ask individuals to -- they're  
24 given a sheet. We call it things to try or opportunities  
25 for practice and we ask them to share with their team and

1 their group what they plan to practice over the next four  
2 to six weeks and that's how we begin our transfer of  
3 learning. So they come and learn a new concept with us,  
4 everything that Alana had talked about is sort of broken  
5 down into specific components and then they will share and  
6 then they'll go back and in that, between that four to six  
7 week period, so it's really actually six weeks for  
8 Winnipeg, that six week period we would be able to mentor  
9 them on those. So we might go out to their team, we might  
10 meet with them individually, we might do a phone call, but  
11 ask them how they're using them, talk to them about what  
12 their struggles are and when they come back together again  
13 with their team they report out at the beginning of every  
14 training what they tried and how it worked for them so that  
15 we can talk about, talk about that as a group, as a  
16 collective.

17 MR. MCKINNON: And just to give a visual picture  
18 of this because we've been talking about, I'm sure, the  
19 Commissioner is trying to understand how all these training  
20 programs relate to one another, if we look at Exhibit 64,  
21 tab 24, this is something that you prepared, Ms. McDonald.

22 MS. MCDONALD: Yes.

23 MR. MCKINNON: I'm going to sort of lead you  
24 through it to try and speed it up. But the -- my  
25 understanding is that the line at the top is orientation.

1 It's a very wide body of information but you're not getting  
2 a great deal of depth at orientation?

3 MS. MCDONALD: Correct.

4 MR. MCKINNON: Below that is competency based  
5 training which is also a broad learning experience. You're  
6 getting into more depth but you're not drilling down to the  
7 bottom of the, of the pool. Then we get into something  
8 like the practice model and the 12 modules and we're into  
9 the details of structured decision making. Then we're  
10 drilling down into a lot more information about narrower  
11 topics.

12 MS. MCDONALD: That's correct.

13 MR. MCKINNON: And the case management standards  
14 is another example where we drill down?

15 MS. MCDONALD: Right.

16 MR. MCKINNON: And then those purple boxes are  
17 what are -- they're showing standalone so those are  
18 specialized training programs that are being offered.  
19 There's three listed there but I understand there are  
20 others as well.

21 MS. MCDONALD: Yes. Those, those would be sort  
22 of specialized or related skills training that would help,  
23 that are definitely a much more specific area and  
24 definitely drilled down but may not be directly related to  
25 everybody's current practice.

1           MR. MCKINNON: I'm going to ask Ms. Brownlee if  
2 she can comment on how the new practice model, the new  
3 recording package, the SDM tools, and CFSIS, how you use  
4 those collectively to -- how they've impacted the way in  
5 which your supervisors do quality insurance and how they've  
6 impacted the way you review what your supervisors are  
7 doing.

8           MS. BROWNLEE: Okay, just, one thing I just  
9 wanted to insert about the training because I think it  
10 speaks to the continuous quality improvement. We've tried  
11 training in the teams two different ways and gotten clear  
12 feedback from our supervisors about which way works better.  
13 Originally we were training the module so the supervisor  
14 attends with their team.

15           MR. MCKINNON: Yes.

16           MS. BROWNLEE: But they were at the same level as  
17 their workers so they're learning it the exact same time  
18 and we found supervisors are the clear leaders and really  
19 set the practice bar for their teams. So that wasn't  
20 working very well so now what we do is the supervisors are  
21 trained as a group pre their staff in the module. So  
22 supervisors essentially go through all the training twice  
23 to ensure that they're ahead of their staff. It also helps  
24 us to work with them on how they're implementing it in  
25 their supervision. So as much as the modules are, how are

1 the workers implementing it? The training that we give for  
2 the supervisors in the modules is, so how are you going to  
3 take this back in your team and they have their own kind of  
4 homework assignments as well and specific cues about what  
5 they're to do in that four to six weeks with their workers  
6 in terms of how are you using this. So when your social  
7 worker is coming in for supervision are they bringing the  
8 tools in, are you going through the tools with them. How  
9 many have you done. Like those kind of tasks.

10           So that's been a big part, I think, of what we've  
11 been trying to build at Winnipeg CFS is to make quality  
12 assurance more about a continuous learning environment and  
13 a continuous quality improvement environment. So it's not  
14 something that the general authority comes in and does once  
15 a year, that it's something that we as an organization are  
16 taking ownership for and it's something that we're building  
17 in to how supervisors supervise their staff, how staff  
18 organize themselves and think about their cases, how the  
19 service managers supervise their supervisors, how I  
20 supervise my service managers and even the types of  
21 information that's readily available for me so that I have  
22 a sense of you know what are implementing well, what are  
23 our barriers, what do we still need to work on.

24           So we've built in a few different things with  
25 that. Some of that I've talked about is about training,

1 some is I think the continuous mentoring and support so  
2 that everything we're working on is living, breathing  
3 action. It's not a policy that's up on the website that  
4 nobody refers to except when there's a review, and external  
5 review. It's something that, you know, we're talking about  
6 on a regular basis in terms of how are we implementing  
7 this. It's a regular part of -- we have supervision or  
8 meetings with all our supervisors twice a month and the  
9 first part of every agenda is, is, at this stage, dedicated  
10 to how are we doing with the practice module, model,  
11 modules, how are we implementing them, what's working well.  
12 We also share success stories of what's working well and we  
13 always identify barriers so that we can continue working on  
14 how do we facilitate this. We've done that with -- we had  
15 an all day staff day where that was a huge theme, was  
16 getting feedback from staff on what's working well, what do  
17 you like. We had -- we did videos of staff sharing  
18 vignettes of things that worked well. We've also -- one of  
19 the -- as part of that one of the feedback we got from  
20 staff really clearly early on was this is really confusing,  
21 I have 30 cases at various stages, it's very confusing to  
22 me to know when am I supposed to do a probability of future  
23 harm, when am I supposed to do this, how am I supposed to  
24 keep track of all these different dates that I'm supposed  
25 to be meeting. So as a result of that, we worked with our

1 IT person to build a database. So now available to the  
2 workers, the supervisors and the service managers is a  
3 database for each team and each individual worker that has  
4 their case. It gets entered when say a case comes in for  
5 intake, does it have the probability of future harm, the  
6 assessments on it, and then it automatically gives you the  
7 date of when your next assessment is due. So in six  
8 months, you know, you're required to do a strength needs  
9 assessment and I'll give you a day. So the supervisor,  
10 when they have supervision with them, they know if any of  
11 the assessment tools are outstanding the worker has a much  
12 better idea of where they need to focus their priorities,  
13 what's outstanding, what's caught up. So that's one of the  
14 things we've done.

15 We've also started on a monthly basis utilizing  
16 the CFSIS reports that can be run and they're given to the  
17 service manager to then follow up with given to the  
18 supervisors. So the face to face contact is run on a  
19 monthly basis and is shared with the supervisor who then  
20 goes through it with the staff. The child in care --

21 MR. MCKINNON: I'm just going to, I'm just going  
22 to stop you there because I want to make sure the  
23 Commissioner understands. The point that I was leading to  
24 and I think you've touched upon, but it's the database and  
25 that this is a new tool that's available to a supervisor to

1 know when the staff under their supervision, where they're  
2 at with their various case plans, decision points, when the  
3 tools should be done, when the assessments should be done.  
4 So that they can check electronically now where they  
5 couldn't do that in the past. Am I correct in that  
6 description?

7 MS. BROWNLEE: Yes.

8 MR. MCKINNON: And what about you as the CEO, can  
9 you check that as well?

10 MS. BROWNLEE: I can. We haven't, we haven't  
11 given it to me yet because it's large and at this stage I  
12 am just relying on the service managers. I can get it and  
13 I tend to be a hands-on person so I will, you know,  
14 regularly be reviewing it, but at this stage the service  
15 managers are regularly reviewing it.

16 MR. MCKINNON: So let me just stop you there.  
17 The supervisors review the case workers. The service  
18 managers are reviewing their supervisors and if you want to  
19 you could review what the service managers are doing; is  
20 that fair?

21 MS. BROWNLEE: Yeah. Well, it would be the same  
22 database, so I would have access to every team. So I would  
23 have access to the, the individual supervisor's team of the  
24 individual workers.

25 MR. MCKINNON: Is there anything else you want to

1 add to that? I'm thinking of moving on to the Phoenix  
2 Sinclair case specific description. Is there anything more  
3 you want to add in terms of the training, the signs of  
4 safety or structured decision making before we move to the  
5 case itself?

6 MS. BROWNLEE: The only other piece I'd want to  
7 add is that again with the LPSs, because they're spending  
8 so much contact with the teams, they provide a quarterly  
9 report to the service managers about where the teams are  
10 at. So -- and again, that's not, it's not designed to have  
11 them be kind of tattling, I guess is one of the words  
12 that's been used, but it's really designed to be  
13 identifying, okay, what, what's being implemented, what are  
14 barriers, what, you know, are there other supports we need  
15 to put in place. So it's really a trouble shooting kind of  
16 mechanism but it really assists us with having again just a  
17 broader array of information about how our individual  
18 workers and individual teams are doing in terms of their  
19 work with families.

20 MR. MCKINNON: Okay.

21 Mr. Commissioner, I'm now about to move on to the  
22 last part of the evidence of these witnesses which would be  
23 to go through some key decision points on the Phoenix  
24 Sinclair file and perhaps describe how those might be  
25 handled differently today. In my written document I think

1 there's about 24 points. I intend to cover about 10 of  
2 those because you will find there's a fair bit of  
3 repetition. So we could take our break now for 15 minutes.

4 THE COMMISSIONER: I think that's suitable.  
5 We'll adjourn for 15 minutes.

6 MR. MCKINNON: Thank you.

7

8 (BRIEF RECESS)

9

10 MR. MCKINNON: Mr. Commissioner, we're now moving  
11 on, and by way of background, Mr. Commissioner, the  
12 evidence you've heard so far from the department talked  
13 about the changes they made at a macro level from the GA,  
14 about the changes in terms of the practice model from these  
15 witnesses, how they're implementing those changes. And all  
16 of this arose out of a challenge Ms. Walsh gave to me which  
17 was to demonstrate to her and to this commission of inquiry  
18 what would happen today if the Phoenix Sinclair case were  
19 to present itself. So that's where we're going. And as I  
20 mentioned there are -- we're at page 68 of 79.

21 THE COMMISSIONER: Yes.

22 MR. MCKINNON: I, I think there's about -- and  
23 I'll just check. There's 26 points. I'm not going to go  
24 through all 26 points because what you will see is that as  
25 we get into this, the evidence would become repetitious.

1 THE COMMISSIONER: Yes.

2 MR. MCKINNON: So we're just going to try and  
3 highlight a few of the points at the early part of this  
4 case.

5 THE COMMISSIONER: That's fine.

6 MR. MCKINNON: Now the first decision point in  
7 the Phoenix Sinclair case, Mr. Commissioner, was the  
8 initial decision to apprehend and as you are aware, if that  
9 were to happen today, Winnipeg CFS would not be the agency  
10 of first contact. The hospital would be expected to have  
11 contacted ANCR, probably in the after hours program, if my  
12 recollection of the facts is correct, and ANCR would have  
13 performed the intake function, including the administration  
14 of an ADP. And you'll remember, Mr. Commissioner, an ADP  
15 is the authority determination protocol.

16 MS. MCDONALD: Protocol.

17 MR. MCKINNON: And through that would have been  
18 allowed to elect the Northern Authority, the Southern  
19 Authority, the Métis Authority or the General Authority.

20 Now of course we know that in 2003 Mr. Sinclair  
21 did an ADP and he elected the Southern Authority. If he  
22 were to do that today, this case would not come to Winnipeg  
23 CFS, so our evidence on this would be very short.

24 What I've instructed these witnesses to assume is  
25 that Mr. Sinclair and Ms. Kematch, at the time of the birth

1 of Phoenix, is that were to have happened today, that they  
2 would have elected the General Authority so that you could  
3 see how this case would have been dealt with today if it  
4 were a case that was referred to Winnipeg CFS.

5

6 BY MR. MCKINNON:

7 MR. MCKINNON: And I'm going to start by asking  
8 Karen McDonald, given what I've just said and we're  
9 assuming that this young couple with their history that you  
10 are generally aware of, elected to receive services from  
11 the GA and the GA referred this case to Winnipeg CFS. What  
12 would you expect to see as this file moved across to  
13 Winnipeg CFS from ANCR?

14 MS. MCDONALD: We would expect to see on --

15 THE COMMISSIONER: Just let me interrupt.  
16 Bearing in mind that the GA wasn't in existence at that  
17 time.

18 MR. MCKINNON: Everything in this exercise is  
19 hypothetical, Mr. Commissioner.

20 THE COMMISSIONER: Yeah, okay, okay.

21 MR. MCKINNON: It's to demonstrate the change  
22 solely. Thank you.

23 THE COMMISSIONER: I follow you.

24 MR. MCKINNON: Yeah.

25 MS. MCDONALD: So if the file was transferred

1 from ANCR to Winnipeg Child and Family Services, upon  
2 receipt of the file we would expect to see a safety  
3 assessment completed. We would expect to see a probability  
4 of future harm assessment, so we would now understand the  
5 determination of safety at the time and we would understand  
6 the determination of risk. We would also expect the file  
7 to have a caregiver's strengths and needs assessment  
8 complete and that's where we would begin. We would then  
9 take the file, we would review all of that information. We  
10 would begin to fill in our file recording, the demographic  
11 and family history information piece. From there we would  
12 want to -- we would review all of the documentation, all of  
13 the narrative that ANCR has attached as to how they derived  
14 at their assessments.

15 MR. MCKINNON: Right.

16 MS. MCDONALD: We would then go and we would want  
17 to meet with the family. So in this case Samantha and  
18 Steve, we would want to meet with them and we would want to  
19 begin to have a conversation, picking up where ANCR had  
20 left off. We would want to review what ANCR had seen as  
21 their needs and their strengths. And we would likely begin  
22 that conversation with them, what we were worried about,  
23 what we saw working well and ask them what they're worried  
24 about and what they would see as working well in their  
25 family situation.

1

2 BY MR. MCKINNON:

3 MR. MCKINNON: And when you're talking about  
4 worried about and working well, you're now demonstrating an  
5 exercise of the signs of safety training techniques that  
6 you've given to your frontline workers.

7 MS. MCDONALD: Correct.

8 MR. MCKINNON: Keep going, please.

9 MS. MCDONALD: Okay. So we would then -- we'd  
10 have that opportunity to begin that discussion and begin to  
11 review, as I said, that the needs and strengths as  
12 identified by the caregiver strengths and need done by  
13 ANCR. We would be asking to get a lot more information  
14 from them about worries, worries and, we call them worries  
15 and well, but what's working well and what they're worried  
16 about with respect to not just the things that ANCR has  
17 identified but anything else that may have been happening  
18 in between the time that ANCR saw them and the time that we  
19 received the case.

20 MR. MCKINNON: And, and what's the worker  
21 expected to do? What are, what are -- what's the Winnipeg  
22 CFS worker being tasked to in a case like this where the  
23 child is in, has been apprehended at birth, is in care.  
24 What's that worker tasked to do?

25 MS. MCDONALD: The worker's ultimate task at that

1 point is to be sitting down with the family and coming up  
2 with a case plan.

3 MR. MCKINNON: Okay.

4 MS. MCDONALD: And essentially, as I explained  
5 earlier, the case plan really is about how do we address  
6 the needs and ensure safety because everything that needs  
7 to be done would need to impact on the child in a safe  
8 manner. So ultimately we would be looking towards what  
9 needs to happen for Phoenix to be returned to their care.

10 MR. MCKINNON: Okay. And I know you've never  
11 actually read the Phoenix Sinclair case file and Alana  
12 Brownlee is more familiar.

13 MS. MCDONALD: Correct.

14 MR. MCKINNON: Alana, knowing what you do about  
15 the Phoenix Sinclair case, what would you expect to see in  
16 a case plan today?

17 MS. BROWNLEE: Well part of it, I mean we're  
18 obviously oversimplifying because you wouldn't have one  
19 only -- only one meeting with a family to do the assessment  
20 piece. But knowing what we know, you would have some  
21 dialogue discussion in connection with the parents around  
22 ambivalence towards Phoenix, an interest in parenting.  
23 Because we're moving towards much more behavioural  
24 indicators we would want then to show us some really clear  
25 behavioural indicators that there's a change in the

1 attachment and interest and commitment to parenting. So  
2 you would expect to see things like attendance of the  
3 visit. You would expect to see some very clear indicators  
4 during the course of the visit in terms of how they're  
5 actually providing care for Phoenix. So are they responding  
6 to her immediate needs? Are they cuddling with her or how  
7 are they managing feeding? So it would be some very  
8 tangible, concrete kinds of data that we would be looking  
9 at to look at say the attachment piece.

10 MR. MCKINNON: And would you expect to see that  
11 recorded on the file?

12 MS. BROWNLEE: Yes.

13 MR. MCKINNON: Okay, go on.

14 MS. BROWNLEE: The other issues that had been  
15 identified were the family of origin and the history  
16 related to Samantha's first child. So you would want to,  
17 once we had, at the point you had more information there is  
18 some indication that there was some substance abuse issues  
19 or there could have been in her past. So you'd want to get  
20 more assessment information with that. The other piece of  
21 this case plan that would look different is there was a  
22 significant person involved from boys and girls club, Nikki  
23 --

24 MR. MCKINNON: There was an advocate named  
25 Taylor, as I recall.

1 MS. BROWNLEE: Yeah, Nikki Taylor (phonetic).  
2 That person, I would expect -- I know she regularly  
3 attended meetings with the agency.

4 THE CLERK: (Inaudible).

5 MS. BROWNLEE: Are you telling me you can't hear?

6 So then I would expect that she would have been  
7 at least one component of the safety plan. That would also  
8 be part of the dialogue that we would be working instead of  
9 -- prior to this model of work with families, I think we  
10 really worked with mom, dad and unless someone was -- we  
11 would work with professional care providers but we weren't  
12 really actively identifying who was in your support  
13 network. Part of this plan, and particularly with parents  
14 as young, we would be very active in asking lots of  
15 questions and asking them to identify who helps you, who  
16 provides support, who would you go to if you had a problem,  
17 who would you go to if you needed money. Those kind of  
18 questions help kind of get information about who are your  
19 go to people. And then we would be asking, we want them  
20 part of the plan, we want to bring them in and can we get  
21 your permission to have them part of the meeting. So  
22 hopefully in this case situation we would have those Nikki  
23 identified but we would also have Ms. Edwards and Mr.  
24 Stephenson identify, I would hope through this process as  
25 these are real go to people and then they would then become

1 part of the case plan as well. How, you know what kinds of  
2 support can you provide, what would that look like, what  
3 can they rely on you for, what can the agency rely on you  
4 for and that becomes part of an overarching signed case  
5 plan and safety plan.

6 MR. MCKINNON: And when you talk about a signed  
7 case plan and safety plan, who signs it? Is it just the  
8 parents? Is it the other members of the safety network,  
9 the people like Ms. Edwards and Mr. Stephenson and Ms.  
10 Taylor, would they sign as well? Who signs this plan?

11 MS. BROWNLEE: The case plan is signed by the  
12 parents and with a social worker and it is reviewed and  
13 signed off by the supervisor. But we always want to ensure  
14 that the family has, has their own copy, that this is their  
15 living document and that as Karen said, that it's written  
16 from the parents' perspective, it's not written with our  
17 social worker jargon, it's written, you know, this is what  
18 we're agreeing to.

19 The safety plan could be signed off by anyone  
20 who's part of that safety network. So it could include  
21 having grandma sign off if she was an integral part and  
22 that's demonstrating kind of her commitment. Those copies  
23 would be, we would want them given to everyone who is part  
24 of the safety network.

25 MR. MCKINNON: Just in terms of this safety

1 network and this safety plan, does it define specific  
2 expectations of individuals other than mom and dad?

3 MS. BROWNLEE: Yes.

4 MR. MCKINNON: And what -- give me again an  
5 example of what that might be.

6 MS. BROWNLEE: It's only limited by the  
7 creativity of the people involved but an example I already  
8 used was if we know that there is substance abuse issues.  
9 So the person's been sober for a period of time. We know  
10 that people with substance abuse issues, relapse is a  
11 chronic issue and typically steps towards sobriety will  
12 involved relapse. So you want to build into the safety  
13 plan, how do you ensure that there's no harm to the child.  
14 So if you think you're going to drink you need to say call  
15 this person. This person's job then is to come and get the  
16 child, come and stay with the child, whatever it is so it's  
17 clear that there are steps then that this person will do  
18 and then the next day they need to kind of call the agency  
19 and let us know what's going on. So it would be step one -  
20 -

21 MR. MCKINNON: So there's two components, one is  
22 to actually provide safety and the other is to report to  
23 the agency, the agency knows there's been a, a problem has  
24 developed?

25 MS. BROWNLEE: Yeah, and part of the safety

1 planning process is monitoring it. So it's not a document  
2 you do and then you don't do follow ups. You would have  
3 regular meetings with the safety network where you're  
4 modifying things and talking about what's working, what's  
5 not working, because part of what we want to see is again  
6 demonstration. So we want to know that this plan worked.  
7 We want to know that grandma does follow through as grandma  
8 is committed to. Or we want to know something that didn't  
9 work and why didn't it work, so how do we change that, how  
10 do we fix that. So that we know that the support network  
11 or the safety network around the family, the family can  
12 rely on and the agency can rely on the and the child can  
13 rely on.

14 MR. MCKINNON: And you've mentioned Ms. Taylor,  
15 you've mentioned Ms. Edwards, you've mentioned Mr.  
16 Stephenson. We know factually in this case there was a  
17 family support worker involved. Would that person be part  
18 of a safety plan or a safety network?

19 MS. BROWNLEE: I would see them probably more  
20 typically involved in the actual case plan. They would  
21 attend certainly the safety planning meetings. So, for  
22 example, in this case the case plan would have very  
23 specific things that the family support worker would be  
24 working with the family around and then reporting back to  
25 the safety network. So, you know, she's in the home this

1 many days a week, working with the parents on and reporting  
2 back on what the attachment looks like, what the routine  
3 looks like, what the feeding looks like during the course  
4 of visits and then further identifying either what other  
5 needs were identifying from her involvement, identifying  
6 strengths, identifying behaviours we're seeing that are  
7 positive and continuing to identify needs.

8 MR. MCKINNON: I'm going to skip over numbers 4  
9 and 5, Mr. Commissioner, because I don't think they would  
10 change.

11 Number 6, and I'm going to address this to Karen  
12 McDonald. Phoenix, in September 1st of 2000 Phoenix was  
13 returned to her parents. There was no formal written  
14 reassessment on the file before returning Phoenix to her  
15 family. Can you describe what would happen today? What  
16 would be the expectation that would accompany that kind of  
17 a decision?

18 MS. MCDONALD: Sure. Prior to even considering  
19 whether a child should be returned, you would need to be  
20 reviewing the case plan and you would need to be reviewing  
21 whether or not there were demonstrated acts on the part of  
22 the caregivers that the parents had made significant  
23 changes to their behaviours then their child would no  
24 longer be impacted. You would also need to do a new safety  
25 assessment and you would need to be able to do that safety

1 assessment and come up with a determination of safe and you  
2 would need to -- and then you would need to do a  
3 probability of future harm, reassessment once the child was  
4 returned and no sooner than 45 days.

5 MR. MCKINNON: Thank you. And the 45 days from  
6 when?

7 MS. MCDONALD: From the point of the child being  
8 returned.

9 MR. MCKINNON: So that would impact as well in  
10 terms of the next question which is the ability to close a  
11 file upon return of a child.

12 MS. MCDONALD: That cannot be done because we  
13 need to give at least 45 days where the child was in the  
14 home where we have been able to monitor and assess the  
15 caregiver's abilities to meet the needs of the child so  
16 that when we our probability of future harm reassessment we  
17 have all of that relevant information.

18 MR. MCKINNON: If the probability of future harm  
19 reassessment came out high, what does that mean  
20 in connection with the agency's obligations to that  
21 family?

22 MS. MCDONALD: It would certainly mean that we  
23 need to -- well, first we need to know why it came up high  
24 because it can come up high for static factors --

25 MR. MCKINNON: Right.

1 MS. MCDONALD: -- if it met all of the static  
2 factors and we did talk about that this morning with  
3 respect to how our clinical judgment could interplay with  
4 that. But if there had been no progress towards meeting  
5 the case plan or if there were other incidences of  
6 substance abuse or violence between the caregivers, that  
7 would also impact on the rating. So we would need to know  
8 what, what was scoring and why it was scoring in that way  
9 to determine what the high meant to us.

10 MR. MCKINNON: Okay. And once you've determined  
11 what the high means, let's assume you're satisfied that  
12 this is still a high risk case, there's no discretionary  
13 overrides, what do you then do? You've still got a high  
14 risk case.

15 MS. MCDONALD: Yes.

16 MR. MCKINNON: What do you do?

17 MS. MCDONALD: Then we need to continue to work  
18 with the family. We need to revisit through the family's  
19 strengths and needs and child's strengths and needs,  
20 reassessment. So we need to redo that. We need to go  
21 through that with the family, identify what the existing  
22 means are at that point in time and what the strengths are.  
23 We need to then revise our case plan because something is  
24 not working for the family. To make the changes they need  
25 to change. Something isn't, is not working, so we need to

1 look at what that might be.

2 MR. MCKINNON: And, Mr. Commissioner, we're on  
3 point 7 at pages 71 and 72.

4 THE COMMISSIONER: Yes, I'm with you.

5

6 BY MR. MCKINNON:

7 MR. MCKINNON: And I think I've got an error here  
8 so I'm going to ask the witness to correct it. The first  
9 full paragraph at the top of page 72 says:

10

11 "... the case plan will dictate  
12 the frequency of contact with the  
13 family."

14

15 I understand that's incorrect.

16 MS. MCDONALD: That is incorrect.

17 MS. BROWNLEE: Yeah.

18 MS. MCDONALD: It would be the probability of  
19 future harm reassessment that will dictate the frequency of  
20 further contact with the family.

21 MR. MCKINNON: And that's --

22 THE COMMISSIONER: What will?

23 MS. MCDONALD: The probability of future harm  
24 reassessment.

25

1 BY MR. MCKINNON:

2 MR. MCKINNON: And that reassessment could come  
3 up with a rating of high or medium or low?

4 MS. MCDONALD: Correct.

5 MR. MCKINNON: And --

6 MS. MCDONALD: Or very high.

7 MR. MCKINNON: Or very high. High and very high  
8 are, for all practical purposes, the same.

9 MS. MCDONALD: Yes.

10 MR. MCKINNON: Yes. And if the rating on that  
11 probability of future harm reassessment is high, that would  
12 dictate, and you spoke about this, I can't remember if it  
13 was this morning or this afternoon, but that would relate  
14 to the standard 1.1.4 regarding the frequency of contact?

15 MS. MCDONALD: That would be correct.

16 MR. MCKINNON: So if there was a high probability  
17 of future harm assessment, there would be an expectation as  
18 you described earlier --

19 MS. MCDONALD: Once.

20 MR. MCKINNON: -- once a week by someone in the  
21 agency, once a month by the social worker, once a month in  
22 the home as a minimum?

23 MS. MCDONALD: And once every two weeks with  
24 vulnerable children.

25 MR. MCKINNON: Thank you. So in this case it

1 would be that because --

2 MS. MCDONALD: Yes.

3 MR. MCKINNON: -- Phoenix would be defined as a  
4 vulnerable child?

5 MS. MCDONALD: Correct.

6 MR. MCKINNON: Thank you.

7 MS. BROWNLEE: Just, I just want to add, because  
8 I think the tools are meant to be examined as a package.  
9 So when you're looking at making decisions about has a  
10 family made sufficient progress, in this example after  
11 reunification, you wouldn't look at the probability of  
12 future harm reassessment in isolation. You would be  
13 looking at the probability of future harm reassessment.  
14 You would be looking at the strength, caregiver strength  
15 needs assessment, you would be looking at the child's  
16 strength needs assessment and looking at the case plan and  
17 you'd be looking at the integration of those. The tools  
18 are designed to have continuity and consistency amongst all  
19 of the assessment information and the case plan and what  
20 you're working towards. So it's really important to  
21 realize that, you know, you don't just take one tool and  
22 make a decision. You're looking at kind of how the tools  
23 overlap and the information they give you and looking at,  
24 okay, so what, what are the next steps we have to do, what  
25 are the worries that we've, that we've resolved, what

1 continues to be outstanding and then you're constantly  
2 updating and modifying based on all of that information.

3 MR. MCKINNON: Alana, I'm going to, Ms. Brownlee,  
4 I'm going to address this next one to you at number 9, Mr.  
5 Commissioner.

6 On the Phoenix Sinclair case we saw a period from  
7 late 2000 to early 2001, a three or four month period,  
8 where there was no contact with the family by a social  
9 worker. The file was still an open protection file. Are  
10 there safeguards in place to prevent that from happening  
11 today?

12 MS. BROWNLEE: There's a few safeguards that  
13 we've put in that are different. Supervisors are required  
14 to have at minimum monthly supervision. In addition to  
15 that, they're also having generally monthly training with,  
16 with the LPSs. We've added that supervisors are required  
17 at minimum on a quarterly basis to ensure that they do a  
18 complete case review because not necessarily does every  
19 case get discussed in every supervision session. So that's  
20 one way of ensuring that at minimum on a quarterly basis we  
21 would be able to flag if there had been no contact.  
22 Supervisors, as part of the process of supervision, is  
23 really clear that one of the questions they always have to  
24 be asking is when was the last time you saw this family,  
25 when was the last time you saw the children.

1           The other piece that will help is the, again the  
2 database that I referred to that both workers and  
3 supervisors can use that documents the assessment tools and  
4 their frequency and when they're supposed to be completed.  
5 So in supervision a supervision can pull up this database  
6 and identify if an assessment is outstanding and you can't  
7 complete any of the assessment information without having  
8 actual contact with the family. So it's just another  
9 check-in balance. It's not designed specifically to look  
10 at contact, but certainly you can't do your work if you're  
11 not doing it. So the supervisor will be able to have a  
12 better sense of is that worker behind because it's a  
13 paperwork issue or is the worker behind because they're not  
14 seeing the family.

15           MR. MCKINNON: And in this case, in the Phoenix  
16 Sinclair case, we saw Ms. Balan was the supervisor during  
17 this period of time. My understanding from the evidence is  
18 she would have been totally dependant upon the advice she  
19 received from the worker as to whether this case was not  
20 receiving the frequency of contact that it required. This  
21 database would give the supervisor an independent source of  
22 information; is that correct?

23           MS. BROWNLEE: Yeah, the database as well as the  
24 tools. The tools are all required to be signed off by the  
25 supervisor. Because we now have a structured way for

1 social workers to do their risk assessment and their family  
2 assessment, they're going to be handing these documents in.  
3 Before the assessments were considered to be part of the  
4 case no process and we didn't give staff a specific way of  
5 documenting assessments they were doing. So it was much  
6 less likely that a supervisor would actually have been  
7 given a handed assessment document. They relied heavily on  
8 the workers telling them verbally what their assessment of  
9 the family was. So now that they have a clear framework,  
10 they have a database that says this is due, they can do  
11 reminders. The admins, we haven't a hundred percent got  
12 this up and running yet but the intent is that each of the  
13 team administrative staff will also be doing reminders much  
14 the same way as we do when a voluntary placement agreement  
15 is lapsing so that workers know as well that things are  
16 due.

17 MR. MCKINNON: So there's, there's some reminders  
18 to the worker, there's some access to data, to the  
19 supervisor, and the supervisor would also be seeing these  
20 tools as they come in because there's a regular schedule --

21 MS. BROWNLEE: Yes.

22 MR. MCKINNON: -- of expectation on these tools  
23 being completed.

24 MS. BROWNLEE: Yes. And there's an expectation  
25 on the service managers that they're monitoring this for

1 patterns. So if we see, again, if we see someone who's two  
2 or three weeks behind, that is likely a workload issue. If  
3 we see someone who is, I'm going to go to the worse case  
4 scenario, I guess, someone who has done none, then that's  
5 certainly a flag of there's some compliance issue and we  
6 need to do that, need to get a better assessment of what's  
7 going on.

8           So it's a flag both for the supervisor in terms  
9 of performance management as well as quality of services  
10 and it gives the service manager a much better sense of  
11 what's going on in the routine, not just what the  
12 supervisor is telling hem as well, so it flags for the  
13 areas that they need to follow up.

14           MR. MCKINNON: I'm going to move to point number  
15 10 and I'll address this one to Ms. McDonald. We know in  
16 the Phoenix Sinclair case, in April of 2001, a second child  
17 was born. Assuming there was an open protection file, what  
18 would be the birth of a second child trigger in terms,  
19 today, in terms of expected case worker?

20           MS. MCDONALD: It would trigger an automatic new  
21 safety assessment.

22           MR. MCKINNON: And why is that?

23           MS. MCDONALD: Because a safety assessment is  
24 triggered whenever there is a change in family  
25 circumstances which would be the birth of a new child,

1 would be a new person entering into a home or any major  
2 decision points. So --

3 MR. MCKINNON: So that's triggered. What else?

4 MS. MCDONALD: That would --

5 MR. MCKINNON: What else?

6 MS. MCDONALD: That would automatically be  
7 triggered. It would also require a family strength and needs  
8 reassessment to be done. So whether or not on our timeline  
9 a reassessment was due we would be required to reassess  
10 because now we would have to factor in another child and  
11 would that impact or change any of the needs that the  
12 family may encounter or anything. And we'd also need to  
13 look at the child and that particular child, although they  
14 may be newborn, may also have some needs that need to be  
15 factored in.

16 MR. MCKINNON: And just so that I'm clear, the  
17 reassessment has to be done at regular intervals. What  
18 you're saying is that if this was before that regular  
19 interval it would move it up.

20 MS. MCDONALD: Yes, that's correct. So it just  
21 moves up the timeline and then, then that's another  
22 discussion with family and again in all of our discussions  
23 with the families where we're having those conversations  
24 with them and where we're identifying what we might be  
25 worried about with respect to this new child entering into

1 their home or what might they be worried about, again we  
2 would also then be talking about their network, what else  
3 might they need and that would trigger potentially a new  
4 case plan or a revision of the case plan that exists.

5 MR. MCKINNON: Okay.

6 MS. MCDONALD: Can I add one thing about the  
7 safety network?

8 MR. MCKINNON: Sure.

9 MS. MCDONALD: When we're involving a safety  
10 network, the other really key piece that we tell people to  
11 do now is anybody that's included in our network needs to  
12 be aware of our danger and what we're worried about. So  
13 they need to share that worry with us. They need to  
14 understand the worry as fully and completely as we do  
15 because that way they -- if they don't have the information  
16 they can't know what they need to pay attention to.

17 MR. MCKINNON: And that's, you're talking about  
18 sharing information with people in the safety network?

19 MS. MCDONALD: With everybody. Otherwise if they  
20 don't have that information they shouldn't be part of the  
21 network.

22 MR. MCKINNON: And we've heard some criticism of  
23 that in this case from, in particular, Steve Sinclair.

24 MS. BROWNLEE: Just in terms of the safety  
25 assessment as well, the safety assessment would require you

1 to see every child. So it wouldn't be sufficient say to go  
2 to the hospital when [redacted] was born and just assess  
3 Mom, Dad and [redacted]. You would have to make sure that  
4 you had saw Phoenix as well and that's a requirement when  
5 you're completing the safety assessment. You have to  
6 specifically talk about each individual child and having  
7 face to face contact with each individual child.

8 MR. MCKINNON: Thank you. If I can move to  
9 number 11, and I'll address this to Ms. McDonald. In July  
10 of 2001 there was some concern and factually it doesn't  
11 really matter whether it happened or didn't happen but  
12 there was a concern about family violence. Winnipeg Police  
13 Service was involved. Upon receiving a report like that,  
14 again we're assuming an open protection file now, what  
15 investigations would that trigger today?

16 MS. MCDONALD: As soon as there's an incident of  
17 an allegation of abuse or neglect, then we would do, again,  
18 do a safety assessment and, and like Alana said the safety  
19 assessment means that we need to see every child in the  
20 home and assess the safety for each individual child. But  
21 it would also spur another probability of future harm  
22 assessment, not a reassessment this time --

23 MR. MCKINNON: And you're pointing out that I've  
24 got another typographical error in my report, Mr.  
25 Commissioner, at page 73, number 11, third line in the

1 answer. It says probability of future harm reassessment.  
2 It's not a reassessment, it's a new --

3 MS. MCDONALD: It's a brand new assessment.

4 MR. MCKINNON: -- new assessment.

5 MS. MCDONALD: Yes.

6 MR. MCKINNON: And it's a brand new assessment  
7 why?

8 MS. MCDONALD: Because there was another incident  
9 or an alleged incident of abuse or neglect. So we have to  
10 look at that and redo all of the items in the neglect  
11 indicators and the abuse indicators and assess each  
12 individually again based on the information available to us  
13 at that time, the new information, and anything else we've  
14 had.

15 THE COMMISSIONER: Mr. McKinnon --

16 MS. MCDONALD: Because we're -- oh sorry.

17 THE COMMISSIONER: Addressing points 10 and 11 --

18 MR. MCKINNON: Right.

19 THE COMMISSIONER: You've said assuming there was  
20 an open file. Now I haven't checked my notes on whether  
21 there was or there wasn't in the Phoenix case. If, if  
22 there wasn't, are you saying that based upon the facts as  
23 they have been related here there would be an open  
24 protection file?

25 MR. MCKINNON: I think that it's reasonable to

1 assume there would be an open protection file because the  
2 evidence that we've heard would suggest this remained a  
3 relatively high risk family. But --

4 THE COMMISSIONER: Yeah.

5 MR. MCKINNON: -- the reason I state it as an  
6 assumption, because I'm not sure off the top of my head if  
7 it was still open at that time.

8 MS. BROWNLEE: It was still open.

9 MR. MCKINNON: It was?

10 MS. BROWNLEE: Yeah.

11 MR. MCKINNON: Okay.

12 THE COMMISSIONER: Okay, that answers that then,  
13 yes.

14 MR. MCKINNON: But the other point that I'll make  
15 and maybe through the witness, if for any reason the file  
16 was closed and this incident arose, would it come to  
17 Winnipeg CFS?

18 MS. MCDONALD: If the file was closed it would go  
19 back to ANCR.

20 MR. MCKINNON: Thank you, that's --

21 MS. MCDONALD: Yes.

22 MR. MCKINNON: -- that's helpful.

23 MS. MCDONALD: Can I just -- what I also wanted  
24 to say with respect to that is that the other reason we  
25 would do a new probability of future harm assessment is we

1 do need to determine whether or not the new allegation  
2 affects risk, the information changes the risk level,  
3 because remember our safety is only the immediate safety  
4 and the probability of future harm is determining our risk  
5 to, or the likelihood of something --

6 MR. MCKINNON: And if there is an act of family  
7 violence, that would change the risk factors?

8 MS. MCDONALD: That very well may change it.

9 MR. MCKINNON: Thank you. And that mistake I  
10 made about the probability of future harm, reassessment is  
11 repeated again at paragraph, or not paragraph but at number  
12 12 in the fifth line down. The same point is with respect  
13 to the death of the second child. The death of the second  
14 child would be another incident that would give rise to a  
15 safety assessment?

16 MS. MCDONALD: Yes.

17 MR. MCKINNON: And it would give rise to a new  
18 probability of future harm assessment?

19 MS. MCDONALD: Um-hum. And from there again, we  
20 would be bumping up our family strengths in these  
21 reassessment if we were remaining or we were open with them  
22 because, again, based on a new probability of future harm  
23 and a new safety, we need to take a look at what's  
24 happening in the family.

25 MR. MCKINNON: And still around this same time we

1 know factually that Samantha Kematch left the home and  
2 Steven Sinclair became the sole parent. What would that  
3 trigger by way of investigation?

4 MS. MCDONALD: Now again, because it's still on  
5 the same incident, we would have done a safety assessment  
6 and a new probability of future harm so the caregiver would  
7 have changed there from being both of them to just one, but  
8 that, the importance of that now is that we absolutely  
9 would need to redo the family strengths and needs  
10 assessment because we would now need to reflect that  
11 Samantha is no longer in the home. We would need to know,  
12 we would need to have Steven as the primary care provider  
13 and we would need to be assessing what his needs were to be  
14 able to meet the needs of the children.

15 MR. MCKINNON: Because you got a new, a new  
16 household --

17 MS. MCDONALD: A new household, quite frankly --

18 MR. MCKINNON: A new household.

19 MS. MCDONALD: -- by the definition of the tools.

20 MR. MCKINNON: If we jump ahead to number 14:

21

22 "On March 1, 2002, Steven  
23 Sinclair's protection file was  
24 awaiting closure. The file closed  
25 due to a lack of any request for

1 services from the agency. What  
2 would happen today?"

3

4 MS. MCDONALD: Today, before any file can be  
5 closed we would do -- again, we would do a safety  
6 assessment and a probability of future harm reassessment  
7 because again we're not --

8 MR. MCKINNON: That's where the reassessment  
9 comes in --

10 MS. MCDONALD: Yes.

11 MR. MCKINNON: -- it's when you're considering  
12 the closure?

13 MS. MCDONALD: Correct.

14 MR. MCKINNON: Thank you.

15 MS. BROWNLEE: And also just to add that a file  
16 could no longer be closed with that as the rationale for  
17 why it was being closed. Because we now have the tools  
18 files can be closed based on we've assessed that the child  
19 is safe at home or safe with a plan with a safety network  
20 that we have tracked and are confident that they can  
21 continue to function without the agency and that the  
22 probability of future harm has been mitigated enough for us  
23 to confidently close. So you wouldn't be able to close for  
24 that reason.

25 MR. MCKINNON: So under no circumstances could a

1 file be closed because there haven't been any requests for  
2 services?

3 MS. BROWNLEE: No.

4 MR. MCKINNON: Thank you.

5 Mr. Commissioner, I think you're probably getting  
6 a pretty good sense from these examples, so I'm going to be  
7 skipping large chunks now because I don't want you to hear  
8 how many times we would have done these different tools. I  
9 don't think you're learning anything new.

10 THE COMMISSIONER: The picture is unfolding.

11 MR. MCKINNON: Thank you.

12

13 BY MR. MCKINNON:

14 MR. MCKINNON: I'm going to just highlight a  
15 couple of details. On page 77, Ms. Brownlee, at paragraph  
16 21 we talk about the informal arrangement that was where  
17 Phoenix was placed with Kim Edwards and Ron Stephenson.  
18 Can you talk about, and you've alluded to this earlier  
19 today about the new policy, but what would you expect to  
20 see happen today if that was being contemplated?

21 MS. BROWNLEE: Well, I would expect, I guess, two  
22 pieces, one is a practice piece and one is a policy piece.  
23 Practice wise, because we now are really training staff  
24 that you need to really build the support network or safety  
25 network around families and you need to include them in

1 case planning, I would expect from a practice point of view  
2 that Ms. Edwards and Mr. Stephenson would have been in  
3 participation in meetings with us, with Steven, about  
4 Phoenix and we would be identifying them as part of his  
5 safety network and that would then, policy wise then, would  
6 include, clearly identifying what does that mean and  
7 working with Kim, Ms. Edwards, and Mr. Stephenson related  
8 to what our expectations would be on them in terms of  
9 keeping Phoenix safe. The other piece would be if we felt  
10 that she was unsafe and that she could not be returned to  
11 Steven, we would not enter into an informal arrangement.

12 MR. MCKINNON: And in fact, the evidence here is  
13 there was a letter written saying effectively, I'm  
14 simplifying it, but that the agency would have concerns if  
15 Phoenix was returned to either parent so --

16 MS. BROWNLEE: Yes.

17 MR. MCKINNON: -- again, how would that fit into  
18 your planning?

19 MS. BROWNLEE: So that is -- it's not acceptable  
20 to do that. We've, prior to the general authority standard  
21 or practice guideline and the agency or Winnipeg Child and  
22 Family Services had been working on a, a policy with a  
23 supervisor. So we've been really clear for probably almost  
24 two years that if there is a protection concern you can't  
25 do an informal arrangement, you must, you must look at

1 doing a place of safety.

2 MR. MCKINNON: And that, that would involve an  
3 apprehension.

4 MS. BROWNLEE: Yes.

5 MR. MCKINNON: And that would -- could you then  
6 place with Ms. Edwards and Mr. Stephenson as a place of  
7 safety if, if all the other checks were acceptable?

8 MS. BROWNLEE: Yes. You could do a voluntary  
9 placement agreement with a parent where they're consenting  
10 and agreeing to it or you could do an apprehension and seek  
11 a temporary order, but you would then look at having them  
12 licenced as either a place of safety, we like to call them  
13 kinship care homes where you're trying at minimum to try  
14 and find a placement for the child that's still keeping  
15 them connected to their family and their community but in a  
16 safe way and it gives the alternative care provider a legal  
17 grounding and foundation for providing care. So they then  
18 have the right to say tell Mr. Sinclair, no, you can't take  
19 Phoenix, you have to contact the agency, I can't give her  
20 to you.

21 MR. MCKINNON: They would have had the legal  
22 right to keep Phoenix --

23 MS. BROWNLEE: Yes.

24 MR. MCKINNON: -- they would have had the legal  
25 right to phone the agency and the right to phone the police

1 if need be, if they were concerned?

2 MS. BROWNLEE: Yes, they would have an obligation  
3 to phone the agency and they would have the legal right to  
4 contact the police.

5 MR. MCKINNON: Thank you. One final point that  
6 I'm going to address to Ms. McDonald, and we're at  
7 paragraph 23 on page 78. And this is the May 2004 incident  
8 where a social worker fielded to the door, a male answered  
9 the door and identified himself as Wes and that full  
10 identity was not obtained. How would that be handled  
11 today?

12 MS. MCDONALD: When, when we learned that this  
13 male named Wes was a central figure in the family home, not  
14 just somebody who popped in to borrow some milk, that he  
15 would be around the children, we would need to do a safety  
16 assessment and we would need to obtain his new, his full  
17 name for that purpose of the assessment, the safety  
18 assessment which would then also involve a CFS check, et  
19 cetera.

20 MR. MCKINNON: Okay. And, and are there any  
21 practice changes that make it easier or -- two questions.  
22 One is easier to get that information, and two is to ensure  
23 it's obtained.

24 MS. MCDONALD: We couldn't --

25 MR. MCKINNON: And maybe Alana can help with

1 that --

2 MS. MCDONALD: Well we could --

3 MR. MCKINNON: -- because I know --

4 MS. MCDONALD: Well in order to do the safety  
5 assessment or even complete it, we would have to have that  
6 part filled in. So if we didn't obtain the name, a worker  
7 wouldn't be able to come to their supervisor for any kind  
8 of signature or any follow up to say we have any  
9 reasonable, or we're ready to sign this offer, say that  
10 we've even done a safety assessment in this situation.  
11 There's a missing gap of information and we would need to  
12 go back out and get it again or try it again.

13 MR. MCKINNON: So essentially in the absence of,  
14 of a lack of integrity on the part of the worker who might  
15 represent information, it would be mandatory today?

16 MS. MCDONALD: It would be mandatory to have it.  
17 And again, because, because this person is then obviously  
18 having some kind of, or some kind of -- they're part of the  
19 household, so we would then need to do a family strength  
20 needs assessment and now assess them as a new individual  
21 living in that household.

22 MR. MCKINNON: Okay.

23 MS. BROWNLEE: And I just want to reiterate again  
24 that these are not, these are not things that are involving  
25 one contact with the family. So you may still, the worker

1 may still go out to meet with the family and only get Wes  
2 as the first name. They would then know that they don't  
3 have enough information. There may have been circumstances  
4 that resulted in a not being a good opportunity for them to  
5 explore that further. They would still then know that they  
6 need to go back out. So part of it is this isn't stuff  
7 that you're going to go spend 15 minutes with a family and  
8 gather. All of this information really requires you to be  
9 able to spend time and have regular contact with the family  
10 and that you're then following up. So part of the form is  
11 it demonstrates -- the follow ups you can't lose sight of,  
12 you know, we found out there's a Wes, I don't know his last  
13 name. He's someone new. He seems to be there a lot, you  
14 know, we need to get more information, great. We can't --  
15 the form can't be completed until the information is full  
16 so you just -- again, it's another check and balance for  
17 ensuring that we don't lose track of the need to do that.

18 MR. MCKINNON: Okay.

19 MS. MCDONALD: And sorry, and I should add too  
20 that again, maybe when I'm painting the picture, like even  
21 in doing the family strengths and needs assessment, that  
22 would involve then working with Wes and Samantha or  
23 whoever --

24 MR. MCKINNON: Whoever the caregivers.

25 MS. MCDONALD: -- the caregivers are and getting

1 to know them. That isn't just a single meeting of just  
2 going out and saying -- the safety assessment can be done  
3 very quickly and is to be done in -- able to be information  
4 that we can gather right away, if at all possible, unless  
5 they're not giving it to us. But the family strengths and  
6 needs and the probability of future harm are tools that  
7 require us to have more than one contact with them and  
8 engage them and get to know them and gain more information.  
9 We have to feel confident that we have all of the  
10 information we can possible get on any of the individuals  
11 before we're able to complete the tools.

12 MR. MCKINNON: Mr. Commissioner, that's really as  
13 far as I think I wanted to take -- we could go on but I  
14 think you get the picture.

15 THE COMMISSIONER: No, I think the picture is  
16 there.

17 MR. MCKINNON: And the other document, which I  
18 marked at the outset and you have in front of you,  
19 Ms. Brownlee, is the response to the internal review. When  
20 we were preparing for this case, the exhibit number is ...

21 MS. WALSH: Seventy-eight.

22 THE COMMISSIONER: What number?

23 MS. WALSH: Seventy-eight.

24 THE COMMISSIONER: Seventy-eight.

25 MR. MCKINNON: When we were preparing for this

1 review, Mr. Commissioner, we were anticipating that Rhonda  
2 Warren would be a witness and we would file this so that we  
3 would have a complete response to her report.

4 THE COMMISSIONER: Yes.

5 MR. MCKINNON: I think it's highly repetitious of  
6 what we've already been through. I don't intend to take  
7 the witness through all these responses but they are there  
8 for your review if you would find it helpful.

9 When we were rehearsing your evidence,  
10 Ms. Brownlee, we talked about possibly asking you to  
11 comment on question number 2 but I think you've covered  
12 that in your testimony earlier. This is at page 2, this  
13 question about supervisors determining the level of contact  
14 between the social worker and the family and to whether  
15 that level of contact is appropriate to the stated needs,  
16 in brackets, risk of the case.

17 Madam Clerk, we are at -- I don't think this  
18 document is in the, on the pin.

19 MS. BROWNLEE: In just looking at it, I think, I  
20 mean I think I've covered off --

21 MR. MCKINNON: If you have covered it I'm not  
22 going to ask you to repeat it. It's my perception that you  
23 have but I just want to make sure you're in agreement that  
24 we've covered off that second recommendation to your  
25 satisfaction.

1 MS. BROWNLEE: Yes.

2 MR. MCKINNON: Thank you.

3 Mr. Commissioner, those are my questions in  
4 direct examination.

5 THE COMMISSIONER: Thank you, Mr. McKinnon.

6 Ms. Walsh?

7 MS. WALSH: Thank you.

8

9 CROSS-EXAMINATION BY MS. WALSH:

10 MS. WALSH: Well thank you for that very detailed  
11 presentation. I'll tell you in a nutshell my main concern  
12 and I'm hoping that you can reassure me. First of all, all  
13 of the assumptions that you set out in the document are all  
14 predicated on the file being transferred to Winnipeg CFS  
15 for ongoing family services; is that right?

16 MS. MCDONALD: Correct.

17 MS. WALSH: In other words, not being closed at  
18 the intake level?

19 MS. MCDONALD: Correct.

20 MS. WALSH: So that's the first assumption, okay.  
21 You've gone on at great detail about the expectations of  
22 what a worker should do. A worker should do a case plan, a  
23 worker should sit down and talk to the parents. A worker  
24 should take the name, when they find out there's a new man  
25 in the household, they should investigate who he is. A

1 worker should not close the file before the ensure that  
2 there are no child protection concerns. Is it fair to say  
3 that those expectation were all expectations that existed  
4 during the time that Phoenix received services?

5 MS. BROWNLEE: I would say they are to some  
6 extent, but I think the difference is the level of clarity,  
7 as well as the tools in which we're using to make the  
8 decision.

9 MS. WALSH: So I think the tools, from my  
10 listening at this end, to me when I want to answer the  
11 question what's different, it seems that the tools are the  
12 biggest difference; is that a fair statement?

13 MS. BROWNLEE: Not in isolation because I'm not  
14 sure that the tools without the, the philosophical change  
15 and the practice clinical skills to really engage the  
16 families changes a lot. The tools are a huge difference  
17 and I think in terms of consistency, consistency in  
18 decision making. We have never had anything that clearly  
19 tells us when it's safe to close a case. So in my  
20 experience people typically err on the side of sometimes  
21 keeping cases open too long where we're not actively doing  
22 anything, but just because, and it's called monitoring, or  
23 we close too early because we don't have anything readily  
24 identifiable which we're working on. Now I think there's  
25 really -- it's really of assistance to really clearly tell

1 both the family this is what has to be worked on. Here --  
2 you can give the tools to the family. Here's what I need  
3 to know before I can close this case. Here's what will  
4 keep your child safe. So I think those are different but  
5 the other philosophical changes, that is not effective to  
6 just walk in to a family and use your authority. That's  
7 not going to get you very far with families, it doesn't  
8 help with the engagement. And I think workers have always  
9 known that but we've not ever given them really specific  
10 tools and skill sets that help them have what I call those  
11 hard, hard conversations with families. You can have a lot  
12 of clinical training. That doesn't necessarily train you  
13 to talk to someone about neglecting their child or abusing  
14 their child. Those are, those are not -- those are  
15 different skills. So I think the clinical training really  
16 assists that and, and gives the workers the ability to  
17 really engage.

18 I think the system is really, in a lot of ways,  
19 is still going to very predicated on frequency of contact  
20 that staff can have with families and that's embedded in  
21 the standards as a critical component. The tools reinforce  
22 that in terms of now being to have it consistently across  
23 the agents or across the whole province. Everyone is using  
24 SDM so everyone --

25 MS. WALSH: Are they? I'm sorry, I didn't hear

1 that yesterday that in fact SDM is being used by everyone.

2 MS. BROWNLEE: My understanding, I can say with  
3 confidence that the Southern Authority and the Métis  
4 Authority are all using the probability of future harm for  
5 sure and the strength needs. I can't, with confidence, say  
6 if the Northern is or not. But that means when we're  
7 looking at cases we can all say and mean the same thing,  
8 this case is medium risk. This case is high risk.

9 MS. WALSH: I still have concerns about  
10 compliance because we heard evidence from workers, yes, I  
11 know that I must assess a new person in the household and  
12 the new person's identified in the case notes and the  
13 supervisor's aware of the existence of the new person and  
14 nonetheless the new person is not assessed. How do the new  
15 tools, if at all, change compliance?

16 MS. BROWNLEE: Compliance is not -- the tools  
17 give you an avenue to measure compliance. I think what  
18 we're doing at Winnipeg CFS and how we are trying to  
19 improve compliance is by making it about quality of  
20 services and making it about a share responsibility again  
21 for a learning environment and continuous growth in our  
22 practices and what we're doing, as opposed to directives  
23 and compliance. In my experience, saying here's your  
24 standard, here's your policy, you must do this, without  
25 ensuring that there are other structures in place don't

1 ensure compliance, so ...

2 MS. WALSH: So can you give me a concrete  
3 example?

4 MS. BROWNLEE: Well I'll tell you what  
5 environment I think you need, which I think we're creating.  
6 I think first of all you need, staff need to know very  
7 clearly what the expectations are so they need to know what  
8 is expected. I think we've done that in terms of the  
9 standards are very clear. Our policies are really clear.  
10 I think then staff need to have training in terms of, okay,  
11 what does that mean on the ground? How do I actually  
12 implement this? It's fine to have a standard. What does  
13 that mean when I'm actually meeting with a family? What  
14 does that mean? And so that's the next step that's really  
15 important is the actual training.

16 Then they need the tools and the skills to  
17 actually do that as well, so we developed the tools.  
18 That's where the SDM tools come in. The practice model  
19 training comes in in terms of actually how do you have  
20 those interviews, how do you come up with a case plan that  
21 a family's likely to follow through with. The last piece  
22 is they have to have the supervision and the support and  
23 the resources to then be able to do the job. So they need  
24 regular supervision that is geared to focusing on those  
25 same aspects. They need to be able to readily access the

1 resources they need to support the families and ultimately  
2 they also need to have a reasonable enough caseload. I can  
3 tell you with my staff right now, a worker with a caseload  
4 of 40 is not going to be able to have this done on every  
5 case and they're not going to be able to meet the standards  
6 on every case.

7 MS. WALSH: So what, what is the average caseload  
8 that your workers are carrying right now?

9 MS. BROWNLEE: Well, stats, like anything else,  
10 can be manipulated so I will tell you in a few different  
11 ways to try and be as transparent as possible. If I do the  
12 straight numbers with what our caseload is as of the end of  
13 March of 2013 and divided by the number of case carrying  
14 workers, it's an average of 30. If I separate it out to  
15 try and give you a little bit more detail and look at it  
16 more specifically, my 18 social workers who would be in  
17 what we call our family enhancement program have a case  
18 range from 18 to 24. My permanency planning workers, who  
19 work with just permanent wards, have caseloads between 35  
20 and 44, and my family service workers have caseloads that  
21 range between 24 and in the forties.

22 MS. WALSH: Do your workers have manageable  
23 workloads?

24 MS. BROWNLEE: All of them do not. Some of them  
25 do.

1 MS. WALSH: And when you say some of them, does  
2 it depend on the unit that they're in or just a happy  
3 coincidence of having a lighter workload because of the  
4 files that had come their way?

5 MS. BROWNLEE: There's a variety of reasons for  
6 the difference. Some of the people that have the lower  
7 cases are new staff with our commitment to have them have  
8 lower caseloads and the teams strive to, to keep that so  
9 that then in turn results in the senior people and that  
10 specific team having higher cases. Sometimes the senior  
11 staff end up with the more complex cases which then result  
12 in them having cases that are open for a longer period of  
13 time, so their caseload gradually builds up. We also have  
14 specific teams. We on average get 60 to 80 new intake  
15 cases a month, but that's not spread out throughout all the  
16 teams.

17 MS. WALSH: So is the workload manageable? Some,  
18 you're saying some, some have a manageable workload but  
19 others do not?

20 MS. BROWNLEE: Yes, I have some teams and some  
21 pockets that have cases of 24, 25. I think they are able  
22 to do a tremendous job and they are able to come as close  
23 as possible to meeting standards and when they're not  
24 meeting them, it's more like they're, you know, a week  
25 behind which to me I think is, is close to meeting the

1 standards. Then I have some where they would have cases  
2 where they're clearly meeting standards. They would be  
3 identifying and prioritizing their work so they would be  
4 identifying either families where there is an immediate  
5 crisis and immediate safety and all of their energy is  
6 going into those eight to ten cases and they're providing  
7 less attention to the medium ones and even less attention  
8 to families that are identified as low risk until it  
9 becomes more of a crisis.

10 MS. WALSH: Let me ask you this. Are you  
11 concerned that the workload is such that your staff is not  
12 able to comply with standards?

13 MS. BROWNLEE: Yes, I am concerned that we  
14 continue not to --

15 MS. WALSH: To what extent?

16 MS. BROWNLEE: We have a high level of compliance  
17 with what we've talked about within Winnipeg CFS as  
18 priority standards, so we have prioritized ensuring face to  
19 face contact. I'm confident that I don't have any or very  
20 many. Virtually all of our cases are having a regular  
21 contact and by face to face I don't just mean children in  
22 care. We've really prioritized that it's critical that  
23 you're going out to see the families on a regular basis, so  
24 I don't believe we have any families that would have no  
25 contact. I think the level of engagement isn't where I

1 would like to see it with all cases and our ability to meet  
2 the standards in terms of being able to complete all the  
3 required assessments in a timely manner isn't consistent  
4 either.

5 MS. WALSH: So when you talk about the level of  
6 engagement, these new tools that you've described, in order  
7 for them to be meaningfully filled out, that requires a  
8 fairly intense level of engagement, doesn't it, or a high  
9 level of engagement?

10 MS. BROWNLEE: If you could meet the standards  
11 with weekly contacts or even biweekly contact, that would  
12 be meaningful engagement and you would be able to, I think,  
13 easily and readily complete the assessment information and  
14 have a real relationship with the families you're working  
15 with.

16 MS. WALSH: And are you saying that's not  
17 happening in every case?

18 MS. BROWNLEE: Yes.

19 MS. WALSH: And is it happening in 50 percent of  
20 the cases?

21 MS. BROWNLEE: What we do is we use our family  
22 support program is critical to helping us meet those  
23 standards. So the social worker will not necessarily have  
24 time to meet with the family and we're very, very reliant  
25 on being able to have our family support staff spend that

1 time, so we will have support workers in the home once or  
2 twice a week. Right now we have about 2000 families and on  
3 average last year I believe we had services provided to  
4 about 1500 of our families.

5 MS. WALSH: So family support workers are a part  
6 of your solution for managing workload?

7 MS. BROWNLEE: Part of our solution for ensuring  
8 that we have consistent, regular contact with, with our  
9 families and that we have knowledge and information about  
10 the family circumstances. They're certainly a critical  
11 part of the case plan in terms of, as we've said earlier,  
12 identifying kind of what are the risk factors and how are  
13 we meeting them and who's going to help the family support  
14 in doing, doing these steps.

15 MS. WALSH: What is your solution? What would  
16 you like to see, what do you need to see in order for these  
17 tools to be properly filled out?

18 MS. BROWNLEE: To be honest, I think we need to,  
19 we need to follow the funding model guidelines that we've  
20 established, if we stuck to the one to 20 and the one to 25  
21 and funded agencies with that, but also funded services  
22 that you require to deliver services that are outside of  
23 protection and the prevention. My critical piece is our  
24 resource staff. I have 50 staff members that I've had to  
25 take from the protection stream of funding to provide

1 support and services to our foster care. So they oversee  
2 our kinship care homes, they oversee our foster homes. We  
3 have approximately, I want to say 700 foster homes so I'm  
4 hoping that's accurate. And --

5 MS. WALSH: And you don't have adequate funding  
6 to support those homes?

7 MS. BROWNLEE: We don't have any funding for  
8 those homes.

9 MS. WALSH: So you say --

10 MS. BROWNLEE: It's not part of the funding  
11 model. The other piece of that is we have about 19  
12 positions that are dedicated to family support or resources  
13 support children, either at home or families with children  
14 at home. So we have the \$1300 per family but that doesn't  
15 cover kind of the level of support services that you really  
16 need to put into work with families, so ...

17 MS. WALSH: So you need something more than what  
18 we've heard the funding model provides?

19 MS. BROWNLEE: Yes.

20 MS. WALSH: Something significant it sounds like  
21 to me.

22 MS. BROWNLEE: Well I would like 50 staff.

23 THE COMMISSIONER: You're talking more money, do  
24 I hear you correctly?

25 MS. BROWNLEE: I'm talking about -- the original

1 funding model that was proposed had resource staff  
2 positions attached to it.

3 MS. WALSH: Is that foster -- just so I  
4 understand the term resource staff, does that mean or does  
5 that include staff for foster homes?

6 MS. BROWNLEE: That's, that's -- it's the foster  
7 care and the kinship care.

8 MS. WALSH: Okay.

9 MS. BROWNLEE: Or place of safety. And we think  
10 those are critical. We have 25 percent of our children who  
11 are in care are residing with family members as kinship  
12 care or place of safety and we think that that's very  
13 positive for children to be safely maintained not with  
14 their parents but at least within their extended family  
15 network. But licencing aside, I mean those staff members  
16 meet regularly with, with care providers around managing  
17 the children, supporting family contact, ensuring the  
18 safety of children, ensuring that their special needs are  
19 being met, ensuring they have good school programming, that  
20 they have recreational programming. So it's a really  
21 critical component to the quality of care.

22 MS. WALSH: They need to be funded.

23 MS. BROWNLEE: Yes.

24 MS. WALSH: What about family enhancement? Do  
25 you have workers, you talked about a family enhancement

1 stream. Do you have workers who do just family  
2 enhancement?

3 MS. BROWNLEE: We do. I just, I want to be clear  
4 because from all the evidence I've heard, it seems to me,  
5 at least listening to it, that people are using terms  
6 differently.

7 MS. WALSH: Okay.

8 MS. BROWNLEE: The family enhancement programming  
9 that we have is our staff that are able to do the one to 20  
10 and they're specialized programming. So it is our  
11 perinatal program, so it's working specifically -- we  
12 believe it's really important to work as intensively as  
13 possible with young moms. It is our program that was  
14 originally the differential response program, which is  
15 working intensively with families right from intake to try  
16 and prevent them from becoming more embedded and entrenched  
17 in the child welfare system and to try and address issues  
18 immediately and then we have a newcomer program so try --  
19 and again, that's a population we feel that needs a more  
20 intensive component. That being said, within those  
21 programs there was some evidence that was presented,  
22 suggesting that those are families with low risk or no risk  
23 or where it's kind of really straight prevention. That's  
24 not the case for us. We're really -- there's still, you  
25 know, medium, high risk situations. What we're finding,

1 and I think Mr. McKenzie or Dr. McKenzie's evaluation  
2 speaks to that as well, family enhancement has less to do  
3 with the level of risk and more to do with the family's  
4 ability to engage and participate in the planning. So  
5 families that are open and willing and want some  
6 assistance, even if they're high risk are quite successful.  
7 You could have a family that's low to medium risk that  
8 really doesn't want any service and we're going to be less  
9 successful with that family. So our programs are really  
10 entrenched around that.

11 MS. WALSH: So I'm really struggling with what  
12 does family enhancement look like? Is it something  
13 different or is it just that the funding model now has a  
14 different category for how it delivers funds but the work  
15 that you're doing is essentially what you've always been  
16 doing?

17 MS. BROWNLEE: I think -- this is my own  
18 perspective. I think what happened was family enhancement  
19 was originally designed, and it goes back to when it was  
20 differential responses, it was going to be a different  
21 service because it is a function of something that should  
22 be strained from intake. The intent with all the pilot  
23 project was to identify how, because our system is  
24 complicated, how will these pilot projects, how could they  
25 be embedded. And if you look at the literature and the

1 jurisdictions that have implemented differential response,  
2 they identified some critical components, one being  
3 family's willingness to a level of intensity of service, an  
4 effort to try and have services be more time limited, and  
5 an attempt to have families or work with families be less  
6 intrusive. So instead of needing to always do a full  
7 maltreatment investigation, you should be able to do a  
8 comprehensive assessment with a family and take a little  
9 bit longer getting all the information if you could ensure  
10 safety versus doing an authoritarian investigation. So  
11 that's kind of the premise behind that. I think that --

12 MS. WALSH: That's the practice. What does it  
13 look like today?

14 MS. BROWNLEE: Well what I think we found was  
15 that we went this is really effective period, so --

16 MS. WALSH: Right.

17 MS. BROWNLEE: -- this shouldn't be a program,  
18 this should be a model. This should be how we are doing  
19 our work. So I think that's where it's become confused.  
20 It started with it was going to be a program, it was going  
21 to be a diversion from intake and because (a) it's really  
22 effective, (b) it fits with everyone's philosophy and  
23 belief that we should try and keep and work with kids at  
24 home and it really fits with where we want to go as a  
25 provincial system. So it has now become more a model of

1 how we do service and the general authority practice model  
2 is really based on all of those premises that you know  
3 what, we shouldn't, we shouldn't be doing this in this  
4 program for these 150 families. We should be doing this  
5 for all 2000 of our families.

6 MS. WALSH: So in terms of, setting aside the  
7 term in the funding model, in terms of practically how  
8 family enhancement looks at your agency, it's really a  
9 philosophical approach that is embedded in all of the  
10 services you're delivering; is that fair?

11 MS. BROWNLEE: Yes.

12 MS. WALSH: Okay. That's very helpful, thank  
13 you, because I'd be looking for the family enhancement  
14 worker and the family enhancement manual and I haven't seen  
15 it. So that, that is very helpful.

16 Do you still need though in an agency, if you're  
17 going to collaborate more, pursuant to this philosophical  
18 approach, if you're going to collaborate more with  
19 community based agencies, do you still need a coordinator  
20 in your agency? Do you have such a person? Or is it more  
21 that the worker, each worker needs to do that much more  
22 work to make sure that somebody isn't just given the phone  
23 number of an addictions treatment program but gets into the  
24 program, make sure that their child has day care while  
25 they're attending a program? So is it, is it a matter

1 of -- sorry, it's a long question -- is it a matter of the  
2 worker, each individual worker having that responsibility?

3 MS. BROWNLEE: I think it's a combination of  
4 things. I think what we found is what works really, really  
5 effective, effectively, and you can come at it from a few  
6 different ways, our family enhancement team that was  
7 originally the DR team, has two service assistants attached  
8 to six social workers. So those service assistants do a  
9 lot of the stuff you're talking about, the practical  
10 supports. The other teams, some have service assistants,  
11 some don't, but we then rely on the family support worker  
12 to do a lot of that. That kind of concrete level of  
13 support is really, really critical with our families. A  
14 lot of our families are intimidated by different  
15 organizations. They're not comfortable in group settings,  
16 they're not comfortable reaching out. They haven't  
17 necessarily had good experiences with CFS or other systems,  
18 so accompanying them to appointments and doing that just  
19 extra level of support is really, really important, which  
20 is one of the reasons we believe that the dual team of  
21 social workers, family support worker or a paraprofessional  
22 such as a service assistant is a really good blend. What's  
23 really important is that that person is part of the team.

24 MS. WALSH: And do you have funding for those  
25 support people?

1 MS. BROWNLEE: We have the \$1300 per family case  
2 funding.

3 MS. WALSH: That's, that's where you would get  
4 the funding --

5 MS. BROWNLEE: Yes.

6 MS. WALSH: -- for a staff person to, for  
7 instance accompany someone to an appointment?

8 MS. BROWNLEE: Yes.

9 MS. WALSH: How far would that go?

10 MS. BROWNLEE: It doesn't go very far. I think  
11 we cost it out. Our average length of service for family  
12 support contracts is just a little bit over a year and  
13 that's less to do with ideal and more to do with just  
14 trying to ensure that we can spread the services around.  
15 Our average length of service per families is 36 months.  
16 So if you look at two and a half years, ideally you would  
17 want a big chunk of that to involve some level of support  
18 services. If you had someone, a support worker working  
19 with someone for six hours a week for 20 weeks I think was  
20 the math I had my finance person do, that costs  
21 approximately \$5,000. So that's more than the 1300. That  
22 also doesn't include the other uses that we use for that  
23 money. That's the money we use for emergency food for  
24 families. Lots of times our families run short. We  
25 regularly provide emergency food to get people over. I

1 don't want anyone to have any beliefs that we apprehend  
2 kids because they're short of food. We absolutely do not,  
3 but we will provide assistance. We provide transportation  
4 assistance and bus tickets or cabs. That --

5 MS. WALSH: So all of that has to come out of the  
6 \$1300?

7 MS. BROWNLEE: Yes. The -- that also includes if  
8 a child is living at home and they need therapy or you  
9 want, say, the parent needs therapy, if you wanted to do  
10 some attachment work. All of those costs come out of the  
11 family support budget. Also we cover camp for kids that  
12 are at home, the parental contribution. We cover the  
13 parental contribution for day care out of that family  
14 support budget.

15 MS. WALSH: Wow. That's my response, I'm sorry.  
16 It sounds frustrating.

17 MS. BROWNLEE: It is because I think there's --  
18 as a system I think there's a huge belief that the most  
19 effective place for kids is with their parents if we can  
20 keep them safe and I think social workers all believe that  
21 we can keep kids safe at home but we need to have some of  
22 the tools to do it. It can't only just be the case worker  
23 popping in. And we think that that is ultimately,  
24 ultimately cheaper for the system than the costs of  
25 bringing children into care. Unfortunately one is kind of

1 a set pot of money and one is based on your actual volume  
2 and your actual costs of children in care. So I don't  
3 think provincially, and this isn't a unique problem to us  
4 and certainly, you know, a problem that's been readily  
5 identified in Ontario or other provinces, the U.K., the  
6 U.S.

7 MS. WALSH: But all of these, I mean things that  
8 you're describing -- we spent a lot of time, we saw in  
9 changes for children, we've seen it throughout the  
10 documents, prevention is key, early intervention is key and  
11 all these things that you're describing to us as coming out  
12 of that same \$1300 pot, aren't all those prevention  
13 measures?

14 MS. BROWNLEE: It depends how you define --

15 MS. WALSH: Or early intervention measures?

16 MS. BROWNLEE: Early intervention, I think  
17 absolutely. I think that's absolutely how we're using the  
18 money. I mean Mr. Rodgers certainly talked about the trend  
19 in the General Authority for keeping children at home, so I  
20 think we're demonstrating some success in that.

21 MS. WALSH: Training. Is there any requirement  
22 for workers under the General Authority to have ongoing  
23 continuous training? Like as lawyers we have to do a  
24 certain number of hours of professional development. Do  
25 social workers under the General Authority have to do that?

1           MS. BROWNLEE:    We have the mandatory minimum  
2 training that's required, that's set out for the first  
3 several years that outlines the different training that has  
4 to happen.    Then staff have the opportunity to attend  
5 individual training.    We regularly have what I'm calling  
6 agency training that becomes mandatory because we're saying  
7 it's an agency priority and that varies over the years for  
8 the past -- well right now it's clearly the practice model  
9 training.    We've also done vicarious trauma training as a  
10 priority, attachment training has been a priority in the  
11 past.

12           MS. WALSH:       But so are you saying that your  
13 workers from your agency, do they have mandatory training  
14 requirements on an ongoing basis?

15           MS. BROWNLEE:    Yes.    We, on a regular basis, at  
16 management we identify what our training priorities are and  
17 then we deliver or generally with the support of the  
18 General Authority deliver specific training that we've  
19 identified as a priority for us.    Over and above that,  
20 workers and supervisors should be identifying kind of key  
21 learning plans and identifying based on, you know, interest  
22 and regular supervision in terms of need, caseload, what  
23 extra training workers should be attending.    We've actually  
24 just revamped our training policy, kind of reflecting that.  
25 But staff have a, staff have a lot of training

1 opportunities. That's a huge difference from 2006.

2 MS. WALSH: But opportunities and requirements  
3 are not the same thing?

4 MS. BROWNLEE: They're not the same, no.

5 MS. WALSH: So you're saying there are certain  
6 areas that are required?

7 MS. BROWNLEE: Yes.

8 MS. WALSH: And you talked about the competency  
9 based training now being much more extensive than it was  
10 originally. So our workers, existing workers who took  
11 their training when it was perhaps less extensive, have  
12 they been required to take the additional training?

13 MS. BROWNLEE: We haven't decided that yet. The  
14 -- we wanted to -- this is a job actually that we've  
15 assigned to our LPSS is to evaluate the curriculum and  
16 evaluate it against the practice model curriculum and  
17 identify for us what's, what's different and identify and  
18 then we're hoping then we can have some discussions with  
19 the Province about can we have staff opt in to specific,  
20 and instead of redoing all 20 days can they opt in to some  
21 specific ones. So we are looking at that. We also have  
22 been having some debate and discussion as a management team  
23 or supervisor group about some stuff. Like, for example, I  
24 went through competency based training in like, I don't  
25 know, a really long time ago, so would there be any benefit

1 to just saying, you know, periodically everyone needs to go  
2 through it because I mean it has changed.

3 MS. WALSH: Okay.

4 MS. BROWNLEE: So should we do this -- so I mean  
5 it's areas we're discussing --

6 MS. WALSH: You're looking at.

7 MS. BROWNLEE: Yeah.

8 MS. WALSH: Okay. Can you just do us a favour,  
9 and perhaps your counsel will assist, and point out where  
10 in the disclosure the various tools that you've been  
11 referring to are? Because it's still a little abstract.

12 MR. MCKINNON: The tools are at Exhibit 74,  
13 tab M, which was filed by Ms. Harris yesterday. That is --

14 MS. WALSH: Maybe we could pull that up and you  
15 could just identify which is which.

16 MS. BROWNLEE: Sure. And there should be a  
17 different filing for the safety assessment.

18 MS. WALSH: Yes, the safety assessment, I'm a  
19 little confused about that too because you talk about --

20 THE COMMISSIONER: That's this document?

21 MS. WALSH: -- the safety assessment that ANCR  
22 does and then the safety assessment that's done at your  
23 agency, so if you can clarify that, that would be terrific.

24 MR. MCKINNON: Mr. Commissioner, did we file  
25 this --

1 THE COMMISSIONER: Yes.

2 MR. MCKINNON: -- a colour copy as well? I see  
3 you've got what is -- is there an exhibit number on it?

4 THE COMMISSIONER: Mine says Exhibit 74, tab M.

5 MR. MCKINNON: Okay.

6 THE COMMISSIONER: So it's part of Exhibit 74 and  
7 it's the M tab.

8 MR. MCKINNON: I can indicate, Mr. Commissioner,  
9 we did deliver colour copies, 33, to Ms. Ewatski because it  
10 does, it is easier to read in colour than it is in black  
11 and white.

12

13 BY MS. WALSH:

14 MS. WALSH: So can you take us through and --

15 MS. MCDONALD: Yes, absolutely.

16 MS. WALSH: -- tell me exactly what's what with  
17 reference to your testimony today?

18 MS. MCDONALD: Sure. So if we're looking on  
19 page 4, that is the probability of future harm tool,  
20 otherwise known as a risk assessment and the subsequent  
21 pages that follow, 6 to page 16, are all of the definitions  
22 that are required to score that particular tool. And page  
23 17 and 18 are the policy for the probability of future harm  
24 tool.

25 MS. WALSH: Okay.

1 MS. MCDONALD: Okay. Then if we go to page 24  
2 and 25, that's the caregiver's strengths and needs  
3 assessment or reassessment, because it's one in the same as  
4 I explained, the same tool. And that is just for the  
5 caregiver so it makes up one component of our family  
6 strengths and needs assessment. That's the caregiver  
7 piece. And page 26 to 30 are the definitions for that tool  
8 and 31 and 32 is the policy and procedure. On page 33 and  
9 34, that is the child's strengths and needs assessment or  
10 reassessment and that is done on every child in the home,  
11 or out of -- like if one is in care you would still do  
12 every child in the family and I should say.

13 MS. WALSH: Every child in the family?

14 MS. MCDONALD: Yes.

15 MS. WALSH: What if somebody wants to fill out  
16 more information than this form indicates?

17 MS. MCDONALD: Okay, that's where we have our  
18 supplementary document, the Winnipeg file recording package  
19 and that's where not -- can I just clarify -- it's not  
20 should they want to, they must fill out more information,  
21 because these are just going to give you a number. The  
22 file recording that accompanies it, it's the accompanied  
23 document, it will give you the reasons why that number is  
24 chosen.

25 MS. WALSH: Is that package unique to Winnipeg

1 CFS?

2 MS. MCDONALD: It is. It was developed by  
3 Winnipeg Child and Family Services but it has been adopted  
4 by rural and northern as well.

5 MS. WALSH: What about agencies under  
6 authorities, do you know?

7 MS. MCDONALD: Under authorities, I'm not, I'm  
8 not sure if it has. I know that within the General  
9 Authority it's been shared to all of their of their  
10 agencies and I would imagine, although Mr. Rodgers would be  
11 in a better position, I would imagine he is willing to  
12 share with, and Alana are willing to share it with whoever  
13 would like it should they want it.

14 MS. WALSH: Okay.

15 MS. BROWNLEE: I have shared it. We have had a  
16 request from other agencies so it has been shared with, and  
17 I may not be a hundred percent accurate with who we've sent  
18 it to, but it has been shared with Métis Child and Family  
19 Services, Dakota-Ojibway Child and Family Services. I'm  
20 not remembering which one, but one of the northern, I think  
21 it was Cree Nation had a request in for it and Southeast  
22 Child and Family Services and ANCR.

23 MS. WALSH: I'm sorry, carry on.

24 MS. MCDONALD: Okay. So the definition for the  
25 child strengths and needs assessment and reassessment are

1 page 35 to 38 and then the policy and procedures follows  
2 that. And the probability of future harm reassessment is  
3 found on page 41 and the definitions are on 42 to 46 and  
4 then the policy on 47.

5 MS. WALSH: And the safety assessment you talked  
6 about?

7 MS. MCDONALD: The safety assessment is not in  
8 this. It's a separate, it's a separate bound book. Mr.  
9 McKinnon, do you ... I have my copy, I can ...

10 MR. MCKINNON: It would take me a minute to find  
11 that, Mr. Commissioner. I can, I believe it's in the  
12 commission disclosure --

13 MS. WALSH: So long as you can advise us.

14 MR. MCKINNON: -- but it would take me a minute  
15 to find it.

16 MS. WALSH: Also the risk -- not the risk, the  
17 recording package.

18 MS. MCDONALD: The recording package I know you  
19 had it.

20 MR. MCKINNON: The recording package is appendix  
21 A or appendix 1 to the response to the internal review that  
22 was just filed this afternoon.

23 MS. WALSH: So Exhibit 78? Appendix A, okay,  
24 what's called the case recording guide?

25 MR. MCKINNON: I'm going to, just to make sure

1 I'm correct, I'm going to ask the witness to --

2 MS. WALSH: Yeah.

3 MR. MCKINNON: -- identify that for the record.

4 MS. WALSH: Good.

5 MS. BROWNLEE: And just to clarify, we have,  
6 we've actually updated since this was filed. I think I  
7 mentioned earlier that this was, everyone was trained, but  
8 this was specific to focusing on family service files and  
9 we actually now have a specific package related to children  
10 in care files.

11 MS. MCDONALD: This is only, this is a piece but  
12 only a small piece of the recording package. The recording  
13 package includes a guide which is, gives workers ideas of  
14 what is expected. Certainly you can have my copy, if you  
15 want. This is the full and complete package which includes  
16 the guide but I only have one to offer up right now.

17 MS. WALSH: Can we make this an exhibit then?

18 MS. MCDONALD: Yes.

19 THE COMMISSIONER: I think we should. That would  
20 be exhibit, is it 80 now?

21 MR. MCKINNON: That's fine. I thought I had I  
22 produced the whole thing. I apologize.

23 THE CLERK: We're at 80.

24 MS. WALSH: So we'll get copies --

25 MS. MCDONALD: This is yours though.

1 MS. WALSH: That's mine?

2 MS. BROWNLEE: That's Gord's.

3 MS. MCDONALD: No, that wasn't.

4 MR. MCKINNON: Do you want to mark it and I'll --

5 MS. WALSH: We'll mark it, yes.

6 THE COMMISSIONER: Is that Exhibit 80?

7 THE CLERK: It is.

8 THE COMMISSIONER: Yes.

9

10 **EXHIBIT 80: WINNIPEG CFS CASE**  
11 **RECORDING PACKAGE**

12

13 MS. MCDONALD: Can I just make sure I haven't  
14 slipped any of my own papers in there? Thank you.

15 MS. WALSH: So, Mr. McKinnon, you will provide us  
16 with an electronic copy and then we can distribute it --

17 MR. MCKINNON: I'll get a fresh copy and  
18 distribute it to the usual list.

19 MS. WALSH: Wonderful, thank you.

20 THE COMMISSIONER: So that's the full package?

21 MS. WALSH: Yes.

22 MS. MCDONALD: Of the narrative that would, you  
23 will take the tool -- the tool will be shown in there too,  
24 you'll take the tool and the narrative and that becomes  
25 what needs to be produced.

1 THE COMMISSIONER: And that's, that's appendix A  
2 in Exhibit 78?

3 MS. WALSH: No, we've determined that Exhibit 80  
4 is the full package.

5 THE COMMISSIONER: Oh, oh.

6 MS. WALSH: Appendix A was only a portion of it.

7 MS. WALSH: Oh, I thought she said it wasn't the  
8 full package. This is the full package?

9 MS. MCDONALD: That is the full package.

10 MS. BROWNLEE: That is the full package.

11 THE COMMISSIONER: Oh okay.

12 MS. WALSH: The new exhibit is.

13 MS. MCDONALD: Yes, I'm sorry.

14 MS. WALSH: The new exhibit is.

15 MS. MCDONALD: Yes.

16 MS. WALSH: That's very helpful. Thank you for  
17 that.

18 MS. MCDONALD: You're welcome.

19

20 BY MS. WALSH:

21 MS. WALSH: The safety assessment that ANCR fills  
22 out is a different document?

23 MS. MCDONALD: Currently the safety assessment  
24 that ANCR is using I believe is the safety assessment on  
25 the intake module.

1 MS. WALSH: Okay.

2 MS. MCDONALD: But ANCR, it's my understanding --

3 MS. WALSH: Right.

4 MS. MCDONALD: -- that ANCR will be adopting the  
5 structured decision making safety assessment basically  
6 almost as we speak. I believe they're expected to roll out  
7 almost the same time as Winnipeg is.

8 MS. WALSH: And when we heard evidence about  
9 safety assessments being filled out and we saw actual  
10 documents filled out --

11 MS. MCDONALD: Um-hum.

12 MS. WALSH: -- at the intake level, they were  
13 directed to a large extent at response time, or certainly  
14 had a component that was directed at response time. Is  
15 there a document that identifies that currently?

16 MS. MCDONALD: In the, in the structured decision  
17 making?

18 MS. WALSH: Well is --

19 MS. MCDONALD: If they --

20 MS. WALSH: That's, I assume that's still part of  
21 the intake module.

22 MS. MCDONALD: That is part of the intake module.  
23 The structured decision making tool is not part of the  
24 intake module.

25 MS. WALSH: Right.

1 MS. MCDONALD: And that does not dictate response  
2 time.

3 MS. WALSH: Okay. Just one other question, again  
4 it's not that I'm cynical but I want to make sure that we  
5 understand really how things have changed. You've  
6 identified in the, in the assumptions that you made for us  
7 about, you know, if the file, if Phoenix's file were being  
8 looked at today, you identified that when the new, when  
9 there was a new baby there would be a new assessment done.  
10 What is it that would prompt a worker to do that today that  
11 didn't prompt any other work in 2001 or 2004, both  
12 occasions when there were new babies, when the workers were  
13 aware that there were new babies in the household?

14 MS. MCDONALD: I mean I, I -- back in 2004 we  
15 didn't have this particular safety assessment --

16 MS. WALSH: Right.

17 MS. MCDONALD: -- which the policy would now  
18 suggest we must because there's been a change in family  
19 circumstance. So I mean that would be one significant  
20 thing that I would say would prompt, because a new baby is  
21 born into a family that we're working with. If we're  
22 staying true to our, to our practice we would be assessment  
23 safety.

24 MS. WALSH: But so how does that work? Is it  
25 because -- I mean doesn't it still require a worker to

1 identify the new concern and fill out a new form?

2 MS. MCDONALD: Sorry?

3 MS. WALSH: Identify that, that the fact of the  
4 new baby --

5 MS. MCDONALD: Right.

6 MS. WALSH: -- requires some further assessment.  
7 So what will prompt them now that wouldn't have prompted  
8 that before?

9 MS. BROWNLEE: I think there's two pieces to  
10 that. I think before they knew they needed to go out and  
11 assess how mom's doing with the new baby. They knew they  
12 needed to do an assessment. Now the training is not just  
13 you need to do a generic assessment, now the training is  
14 you need to do a safety assessment, you need to ensure that  
15 that child is safe. You need to ensure that any other  
16 children in the home are safe as well. So there's -- it's  
17 more specified about what type of assessment you need to do  
18 and it's almost much clearer that this is a change in  
19 circumstance. So I think clinical judgment wise I think  
20 that a lot of social workers in the past would have known  
21 that they needed to do those kinds of assessments. Now  
22 you've got a really clear structure that tells you not just  
23 what tool you have to do but also why. Like here's the  
24 tool, here's how it links to clinical practice, here's how  
25 it links to the decision making points. In that situation

1 the supervisor and the worker were both well aware of the  
2 birth of the baby, so you would also have the supervisor  
3 saying, okay, so now we need to do the safety assessment  
4 because this is new information, this is going to change  
5 the dynamics.

6 MS. WALSH: So what's changed in a very general  
7 way is new tools and new training together?

8 MS. BROWNLEE: Yeah.

9 MS. WALSH: And a new emphasis on prevention and  
10 early intervention; is that fair?

11 MS. BROWNLEE: And, and with safety as a  
12 component that's really important. I think embedded  
13 throughout all of this is how does this impact the child,  
14 what is the harm to the child, is, is kind of important. I  
15 think that's one of the areas that again child welfare, in  
16 a more general sense, has struggled with how do you, how do  
17 you do family centered strength based and ensure you're  
18 protecting the children? I really feel that this training  
19 curriculum and these tools really has achieved a balance  
20 between those things, a balance of engaging families but  
21 also still ensuring safety.

22 MS. WALSH: And which prompts one final question.  
23 We've heard a lot of evidence about the debate or the sort  
24 of dialogue between focusing on protection and focusing on  
25 prevention and that one should not be at the expense of the

1 other. And so, Ms. Brownlee, when in answer to my question  
2 which, what's new and I listed new tools, new training and  
3 a focus on prevention, you nodded and then you added and  
4 safety. So is there a greater emphasis on protection now  
5 than prevention in fact?

6 MS. BROWNLEE: In my experience, and maybe Karen  
7 can speak to this, in my over 20 years I think that there's  
8 always been pendulum shifts in terms of what is the  
9 priority. I think what I've seen in the last six years,  
10 eight years, is that we have, we are trying to achieve  
11 balance. We are trying to ensure safety while still  
12 ensuring that kids can stay at home wherever possible with  
13 an added emphasis of if they can't stay at home with their  
14 parents is there another family member they can stay home  
15 with? And we haven't done that -- you know the system has  
16 been criticized for apprehending too many kids in the past  
17 and removing them from their families and then there's been  
18 criticism of we're trying to keep kids with the families  
19 too much and we're ignoring protection. So it is trying to  
20 find that balance. I think this, this model and this  
21 training does achieve that balance. I think it's -- you  
22 need both. I would be really concerned if, I know that  
23 there's been comments about CFS is just a policing  
24 function. I think we would be doing a real disservice to  
25 children and families if we went only with protection and

1 we didn't engage families and we didn't try and build  
2 relationships and we didn't try to provide, as Dr. Wright  
3 said, the family support services or the family centered  
4 services. I think the balance is really, really important  
5 and I think we've -- different agencies have clearly been  
6 able to demonstrate that you can safely keep kids at home  
7 and kids don't have to be in care if they don't need to be.

8 MS. WALSH: And would you agree that the more  
9 early intervention services you can provide, or if not you  
10 someone, the more that early intervention is provided to a  
11 family, what's sometimes called upstream work, the greater  
12 likelihood that children will be able to be safe in their  
13 homes?

14 MS. BROWNLEE: I agree with that, with a caveat.  
15 In my experience -- I'm trying to figure out how to say  
16 this without sounding rude. In my experience, people like  
17 doing programming that's generic that helps families that  
18 may be experiencing a glitch. So families that are overall  
19 functioning quite well, but are maybe having some minor  
20 bumps in the road and the support services help them get  
21 through it. The families that I've spent 20 years working  
22 with, families are less or community prevention services  
23 seem less able to meet the needs of those families and  
24 they're not, they don't tend to be as targeted for those  
25 kind of families. And if the program is, is geared to

1 those families, you need to build in outreach components.  
2 These are not the families that are going to come to your  
3 door. So I'm always, I'm always reluctant to, to a hundred  
4 percent endorse prevention services without having there be  
5 some clear connection to how will this impact and how will  
6 our families access them because I think our families  
7 really need those services and they can, they can achieve  
8 tremendous results. We've seen families being hugely, have  
9 huge issues, huge protection issues and be able to make  
10 great strides if they're able to access the correct  
11 services and the correct support.

12 MS. WALSH: And so outreach is a critical  
13 component of early intervention services.

14 MS. BROWNLEE: Um-hum.

15 MS. WALSH: Sorry, was that -- did you say yes?

16 MS. BROWNLEE: Yes, sorry.

17 MS. WALSH: Okay, thank you. Those are my  
18 questions. Thank you very much.

19 THE COMMISSIONER: Thank you, Ms. Walsh.

20 Well now do counsel want to adjourn for an hour  
21 now or do their cross-examinations?

22 MR. MCKINNON: My suggestion is we just do a  
23 canvass of the counsel and see how much cross-examination  
24 there is. I do have two other witnesses that Ms. Walsh has  
25 asked me to direct they're scheduled for six o'clock to

1 appear here but they can obviously wait. But if I could  
2 get some sense --

3 THE COMMISSIONER: See if you can get a time  
4 estimate.

5 MR. MCKINNON: Mr. Ray has indicated about five  
6 minutes. Ms. Dunn, who is representing an intervenor, has  
7 asked for about five minutes, I believe, and that's it.

8 MS. DUNN: (Inaudible) Mr. Commissioner, have to  
9 do that through Ms. Walsh.

10 THE COMMISSIONER: What did she say?

11 MR. MCKINNON: She's saying something about doing  
12 that through Ms. Walsh according to protocol.

13 THE COMMISSIONER: Well, I know -- I think you're  
14 leaving, are you? Mr. Olson will be in charge.

15 MS. WALSH: Yes, if that's all right?

16 THE COMMISSIONER: Yes, well that's understood.  
17 People have had to come and go.

18 MS. WALSH: Thank you. Ms. Dunn, in the past,  
19 has sought your permission to ask a question here and there  
20 and so I think she could be free to do that.

21 THE COMMISSIONER: All right. So what you're  
22 saying we should take them now since they're not long?

23 MR. MCKINNON: Well, if, if counsel are true to  
24 their words, we'll be ten minutes and that might be a good  
25 time to take the break.

1 THE COMMISSIONER: Well, I --

2 MR. MCKINNON: I don't have anything in re-  
3 examination and I assume Ms. Walsh --

4 THE COMMISSIONER: She won't have anything --

5 MR. MCKINNON: If she's leaving, she's not going  
6 to have anything.

7 MS. WALSH: I'll be very quiet.

8 THE COMMISSIONER: Yes, all right. Well then  
9 let's take Mr. Ray then.

10 MR. MCKINNON: Thank you.

11 MR. RAY: Sorry about the miscommunication, Mr.  
12 Commissioner. I had indicated to Mr. McKinnon that I just  
13 wanted about five minutes to review my notes to determine  
14 whether I needed anything.

15 THE COMMISSIONER: Oh, okay.

16 MR. RAY: If other counsel have questions that  
17 you're going to be allowing, while we have those questions  
18 asked I could review my notes and perhaps I'll have  
19 nothing.

20 THE COMMISSIONER: Well I think there is -- you  
21 have a question --

22 MR. RAY: Perhaps we could deal with those first  
23 and then --

24 THE COMMISSIONER: Yes, you can come forward.  
25 All right, Ms. Dunn.

1 MS. DUNN: Thank you, Mr. Commissioner.

2

3 CROSS-EXAMINATION BY MS. DUNN:

4 MS. DUNN: Ms. McDonald and Ms. Brownlee, my name  
5 is Catherine Dunn and I'm appearing this afternoon on  
6 behalf of Ka Ni Kanichihk and as well with respect to best  
7 interests of aboriginal children. Sorry. Did you hear  
8 that?

9 MS. MCDONALD: Yes.

10 MS. DUNN: Okay. I just have a few questions and  
11 it's in connection with exhibit, which I believe is 76  
12 which is the big flowchart, right -- yes.

13 Now I don't care at all who answers the  
14 questions, so whoever feels like it, feel free. I'm going  
15 to suggest to both of you highly skilled women that the job  
16 of social work today is much more complicated than it was  
17 in 2006. And let me just clarify that because that's kind  
18 of a general question. The reason that I say that is  
19 because in 2006 social workers were not expected to do the  
20 amount of paperwork that you have described over the course  
21 of today. They were not expected to do the training  
22 modules that they are expected to do today. They were not  
23 expected to see the children on a 30 day turnaround, every  
24 child in the family, if necessary, that wasn't an order.  
25 They're not expected, for example, in a high risk case to

1 see the family at least once a week. So the pressures on a  
2 social worker today are much more complex than they were in  
3 2006.

4 MS. BROWNLEE: Okay, I'm just thinking of what,  
5 the points. I think there are a lot of pressure on social  
6 workers and I would not ever want to minimize that. I  
7 think social workers -- unfortunately, you can only, you  
8 can only gauge success in hindsight with the kind of work  
9 that we do. So you only know if you had a positive impact  
10 on a family down the road based on how they continue to  
11 function with their children. That has not changed, that's  
12 always been a pressure point for social workers in terms of  
13 balancing and decision making and did you get the decision  
14 right. I think that the changes that we've made in the  
15 system don't make the job, don't increase the pressure. I  
16 think it helps clarify expectations and I think it helps  
17 give them the skills they need to meet those expectations.  
18 I think the fact that, you know, for a really long period  
19 of time social workers started a job and were handed a  
20 caseload and got mentored by colleagues in their team and  
21 their individual supervisor without clarity on how often  
22 should you see a family, how do you know how to do risk,  
23 how do you know if this family is high risk or that family  
24 is medium risk without having those objective tools. So I  
25 think the tools and the training, I think help compliment

1 and assist them in doing their job. Does it decrease the  
2 pressure on them or the pressure that they put on  
3 themselves, quite frankly, to do their job, do it well. It  
4 doesn't but I think it assists them in being able to, at  
5 the end of the day, say okay, I think, I think I did good  
6 work. I think I have a solid foundation for the decisions  
7 I'm making.

8 MS. DUNN: So I'm hearing from you that these  
9 tools assist social workers, but I'm going to suggest to  
10 you that these are new tools, that you're in the upload  
11 learning situation and that the skill level of social  
12 workers at this point in history, child welfare history,  
13 makes this job very complicated.

14 MS. BROWNLEE: Absolutely, there is absolutely no  
15 doubt that the tools require training. There is no doubt  
16 that, and I want to reiterate again, the tools, the tools  
17 need to go with a good solid practice model training around  
18 how to engage with families. They are not something that I  
19 think are effective in isolation or on their own. That's  
20 why, that's why the General Authority in Winnipeg Child and  
21 Family Services has adopted both the training and the  
22 coaching and the mentoring, because we know that sending  
23 someone for, for example, the structured decision making  
24 tools is a two day training. Sending them for the training  
25 and expecting them to just go then back and implement the

1 tools without anything else isn't going to work. So I  
2 think the mentoring and the coaching is really important.

3 MS. DUNN: On top of that complexity, we have the  
4 still existing problem of notwithstanding the funding model  
5 suggestion of one to 25 for CP, child protection cases, and  
6 one to 20 for family enhancement cases, on a day to day  
7 basis social workers are often dealing with more than that  
8 number of caseload.

9 MS. BROWNLEE: Yes, absolutely.

10 MS. DUNN: That increases the complexity that the  
11 social workers have to deal with.

12 MS. BROWNLEE: That increases the complexity of  
13 their ability to meet all the standards, absolutely.

14 MS. DUNN: Right. And they are the bottom line  
15 to protecting children, are they not? They are the person  
16 who is ultimately responsible or held responsible by  
17 society or whatever if something terrible happens to a  
18 child in care or a child associated with the child welfare  
19 system.

20 THE COMMISSIONER: Well their the frontline  
21 workers.

22 MS. DUNN: The frontline workers, the people who  
23 have the day to day contact with people like Phoenix  
24 Sinclair.

25 THE COMMISSIONER: Mr. McKinnon?

1           MR. MCKINNON:   Mr. Commissioner, I just rise on  
2 an objection --

3           MS. DUNN:   I'm sorry?

4           MR. MCKINNON:   -- and maybe seek a ruling from  
5 you --

6           MS. DUNN:   Sorry?

7           MR. MCKINNON:   -- as to whether or not counsel  
8 for an intervenor is entitled to cross-examine on issues  
9 that don't affect her client.

10          THE COMMISSIONER:   Well, I had assumed that those  
11 questions must in some way affect her client.

12          MR. MCKINNON:   Her client is a non-mandated  
13 agency that doesn't deliver child protection services, so I  
14 fail to see how they could affect her client. So I rise to  
15 object on the grounds that it's -- I'm not saying it's not  
16 relevant, I'm saying it's not relevant to this counsel's  
17 client.

18          THE COMMISSIONER:   Well I've allowed her to ask  
19 the questions but I've assumed that they're relevant to her  
20 client.

21          MS. DUNN:   They are indeed relevant to Ka Ni  
22 Kanichihk. The --

23          THE COMMISSIONER:   Explain how to Mr. McKinnon --

24          MS. DUNN:   All right.

25          THE COMMISSIONER:   -- or to us.

1 MS. DUNN: I have two, two comments to make, Mr.  
2 Commissioner. At the time that we made application on  
3 behalf of Ka Ni Kanichihk, we had two roles. One is to  
4 have an interest in community based organizations.  
5 Secondly, to look at the interests of aboriginal children  
6 in the child welfare system in general, our role being not  
7 because Ka Ni Kanichihk is the best community based  
8 organization in the world, it is the only community based  
9 aboriginal organization that is seeing fit to come to this  
10 inquiry to make inquiries on behalf of aboriginal children.  
11 So we have two roles here today. So to answer my learned  
12 friend who's rising again, so ...

13 THE COMMISSIONER: Well --

14 MS. DUNN: I just wanted -- this isn't going to  
15 be that long.

16 THE COMMISSIONER: Well what I'm going to do is  
17 I'm going to ask Mr. Olson to sort this out --

18 MS. DUNN: Okay.

19 THE COMMISSIONER: -- over the supper hour. Is  
20 there anyone else other than the -- Mr. Ray, you have  
21 questions?

22 MR. RAY: I have -- I'll be very brief, Mr.  
23 Commissioner. I have two or three questions and then if,  
24 it may or may not be able to be sorted out --

25 THE COMMISSIONER: Well, Mr. Funke, what have you

1 got to say?

2 MR. FUNKE: Just a very brief comment, Mr.  
3 Commissioner, in response to Ms. Dunn's last comment. I  
4 take no issue with respect to the appropriateness of her  
5 question. I do take some issue, however, with the  
6 characterization that her client is the only First Nation  
7 organization that has a vested interest in --

8 MS. DUNN: No, no, I --

9 MR. FUNKE: -- the welfare of First Nations  
10 children. I think she simply misstated her position.

11 MS. DUNN: If that's what I said I did misstate  
12 it --

13 THE COMMISSIONER: All right.

14 MS. DUNN: -- completely.

15 THE COMMISSIONER: Mr. Olson, I'm going to ask  
16 you to straighten this matter out over the dinner hour with  
17 counsel because I know there was a -- it was left  
18 indefinite as to what the role was in one of her  
19 applications.

20 MR. OLSON: Certainly.

21 THE COMMISSIONER: So we'll take Mr. Ray and then  
22 we'll adjourn for a short while and you and Ms. Dunn and  
23 Mr. McKinnon can perhaps confer and see if we can't resolve  
24 this.

25 MR. OLSON: That sounds good.

1 THE COMMISSIONER: Mr. Ray?

2 MR. RAY: Yes, thank you, Mr. Commissioner. As I  
3 stated I'll be quite brief.

4

5 CROSS-EXAMINATION BY MR. RAY:

6 MR. RAY: Good late afternoon. Trevor Ray for  
7 the record on behalf of social workers and the MGEU. You  
8 were discussing the tool and you had made mention of the  
9 fact that the tool assists a supervisor in kind of doing  
10 checks and balances with respect to the social workers that  
11 that supervisor is supervising, right. Is it fair for me  
12 to say that it's an improvement, in addition to the ways  
13 you've described, that the tool is also an improvement in  
14 that before supervision was primarily conducted on a face  
15 to face meeting with the social worker and so the  
16 supervisor would be interacting with the social worker and  
17 asking them did you do this, did you do that, and did you  
18 do various things that are required to be done on the file.  
19 As I understand the new tool, of course it doesn't  
20 eliminate the need for supervision, but the supervisor is  
21 able to do certain checks and balances without the need of  
22 having to meet face to face with the social worker and the  
23 supervisor will know whether certain things have been done  
24 by the social worker. So that may expedite and may shorten  
25 supervision meetings and may assist in that supervision

1 being ongoing as opposed to monthly schedule, would that be  
2 fair to say?

3 MS. BROWNLEE: I think it would assist with  
4 streamlining and focusing the supervision and would  
5 hopefully assist them in maybe getting to the point where  
6 they could actually cover off all of the cases on a more  
7 regular basis. The other thing that supervisors are doing  
8 that workers at least are finding very helpful is they're  
9 actually using the tool in supervision and completing the  
10 tool jointly with our staff as a way both of managing  
11 workload and ensuring that workers are really understanding  
12 how to do the tool and how they're applying the narrative  
13 to the scoring of the tool. So staff have been quite  
14 creative and supervisors in the use of it.

15 MR. RAY: And just to put it in context, Mr.  
16 Commissioner, some of the evidence we heard in phase one,  
17 both from social workers and supervisors, was that given  
18 caseloads and workloads of social workers, it was often  
19 difficult to conduct supervision or to conduct thorough  
20 supervision. And also given the number of social workers,  
21 that supervisors had to supervise. So I think it would be  
22 fair to say that this tool would, would enhance and make  
23 that supervision easier to a greater extent.

24 MS. BROWNLEE: It does and I'm just going to add  
25 a point that you made me think of with your example. It

1 also assists the worker and the supervisor with taking that  
2 step back from the crisis and doing a more thoughtful and  
3 planfull assessment and that's, I think, something that's  
4 really important in our system because we're very crisis  
5 driven. A lot of supervision, I know people have testified  
6 to ad hoc supervision because there's an immediate crisis,  
7 you're doing an immediate safety assessment. When the  
8 documents are being completed, it's taking that step back  
9 and making sure that in the crisis you haven't missed  
10 pieces of information, that you haven't failed to integrate  
11 information that's really important.

12 MR. RAY: And I just want to clarify your  
13 evidence. You were asked a question by Ms. Walsh. She  
14 indicated she needed some assistance with respect to her  
15 concerns about compliance because she suggested that social  
16 workers, at the time they were dealing with Phoenix's file,  
17 knew they ought to be doing certain things, but didn't do  
18 them and they've had given their reasons for that and one  
19 of your answers was this helps enforce compliance.

20 THE COMMISSIONER: This helps what?

21 MR. RAY: Enforce compliance with meeting these  
22 day to day duties.

23

24 BY MR. RAY:

25 MR. RAY: That you'd agree with me that the

1 tool --

2 MS. BROWNLEE: I'm not sure I said it helps  
3 enforce.

4 MR. RAY: Okay. Measure compliance maybe was --

5 MS. BROWNLEE: Measure, yeah.

6 MR. RAY: Sorry.

7 MS. BROWNLEE: Yeah.

8 MR. RAY: What, what you mean by that is, and I  
9 guess, I think what I got from your evidence at the end as  
10 you were explaining it, was that the tool works in  
11 conjunction with lower caseloads and lower workloads that  
12 have been, you've been able to achieve through the funding,  
13 the tool works in conjunction with the more training you've  
14 provided, the tool works in conjunction with more clarity  
15 on standards and all of those things together are going to  
16 assist in avoiding a situation that we had with respect to  
17 Ms. Phoenix Sinclair's file; is that correct?

18 MS. BROWNLEE: Yes, and I think it's important  
19 that you continue highlighting that it's all of those  
20 things together, because I think that is really, really  
21 important. I really see -- my job is ensuring that as an  
22 organization that we have all those pieces and that I am,  
23 when you talk about the compliance piece, I feel my job is  
24 to regularly be on top of what are our barriers, what are  
25 the things that are preventing us from achieving that state

1 of practice and that I'm continually supporting staff to do  
2 that because staff will always do the best job they can.  
3 They can't make changes if we have systemic issues that are  
4 putting barriers from them doing best practices or meeting  
5 standards or doing the best job possible. So that's,  
6 that's my job.

7 MR. RAY: Thank you. Those are my only  
8 questions. Thank you, Mr. Commissioner.

9 THE COMMISSIONER: Thank you, Mr. Ray.

10 Well now unfortunately I think you're going to  
11 have to stay because we've got to sort out this matter.

12 How long do you want to break for, for -- can you  
13 get a consensus, Mr. Olson, from your colleagues?

14 MR. OLSON: I think seven o'clock is the  
15 consensus.

16 THE COMMISSIONER: Seven o'clock is the desired  
17 time? Yes. I hate to keep these witnesses available for  
18 that period of time but I guess we have no other choice, I  
19 guess, because you have to sort that thing out and so we'll  
20 have to ask you to be back at seven o'clock.

21 MR. OLSON: Okay, now I'm being told 6:30 might  
22 be better.

23 THE COMMISSIONER: Well is there anyone that  
24 can't make it at 6:30? All right --

25 MR. MCKINNON: I'm happy with either time.

1 THE COMMISSIONER: We'll go with 6:30.

2 MR. OLSON: 6:30.

3 THE COMMISSIONER: All right.

4

5 (SUPPER RECESS)

6

7 MR. OLSON: I believe we were able to  
8 successfully resolve the issue over the break. Ms. Dunn  
9 had a couple of more areas of questioning. I think there  
10 were two more areas she wanted to cover and that was  
11 satisfactory to everybody.

12 THE COMMISSIONER: All right. Ms. Dunn?

13 MS. DUNN: Thank you, Mr. Commissioner.

14

15 CROSS-EXAMINATION BY MS. DUNN:

16 MS. DUNN: You had mentioned in your testimonies  
17 that networking with other organizations is beneficial in  
18 case planning.

19 MS. BROWNLEE: Yes.

20 MS. DUNN: All right. I'm going to suggest that  
21 because of the number of things that are going on in the  
22 child welfare system right now in terms of extra learning,  
23 extra things that are being put on the table that it is a  
24 crucial element of reuniting families with their children  
25 and I say this because social workers are, have a lot on

1 their plate at this particular point in time, that they  
2 have \$130 a family to deal with extra expenses and they  
3 need and desire or should need and should desire the  
4 expertise of community based organizations and do use  
5 community based organizations to help them with their  
6 mandate with returning children home.

7 THE COMMISSIONER: So what's your question?'

8

9 BY MS. DUNN:

10 MS. DUNN: My question is do you think that it's  
11 important to have an advocate at the table from community  
12 based organizations for families, (a) because it would  
13 increase --

14 THE COMMISSIONER: What table?

15 MS. DUNN: The case planning table, the initial  
16 sit down meeting with the family that was discussed  
17 initially in terms of bringing people to the table for the  
18 plan.

19 MS. BROWNLEE: I think that that is very  
20 important. I wouldn't limit it to I'm just community  
21 service providers but I think our system and our social  
22 workers are very reliant on our community partners to  
23 support families and to be part of the intervention plan.  
24 I'm not sure that we've always been as a system as  
25 effective including them in the case planning but that is

1 definitely our emphasis for a couple of reasons, one being  
2 families need as many supports as possible from different  
3 avenues and the second part of that is our ultimate goal is  
4 to be able to have families be self-sustaining which means  
5 that we want to develop networks for families that include  
6 their extended family, friends, community members and  
7 community service agencies so that progress that they made  
8 related to keeping their kids at home or reunifying their  
9 children allow them to continue to keep their children safe  
10 in the long term.

11 MS. DUNN: And when you've indicated that your  
12 average time with the families about two and a half to  
13 three years, community partnerships become all the more  
14 important in terms of developing that reunification.

15 MS. BROWNLEE: Yes, that number wasn't specific  
16 to families with children in care.

17 MS. DUNN: Okay.

18 MS. BROWNLEE: The 36 months, like the -- 70  
19 percent of the families in Winnipeg CFS works with the  
20 children are at home. So a huge proportion of our families  
21 we're working not for reunification purposes but we're  
22 working towards trying to maintain the children in the  
23 family setting in a safe way.

24 MS. DUNN: Keeping the -- in a safe way, okay.  
25 Thank you.

1 MS. BROWNLEE: I just also wanted to clarify,  
2 just for the record, that it's \$1300 per family, not \$130.

3 MS. DUNN: Thank you. That is a significant  
4 difference.

5 Thank you, Mr. Commissioner.

6 THE COMMISSIONER: Thank you, Ms. Dunn.

7 All right. Anything else, Mr. McKinnon?

8 MR. MCKINNON: Nothing further, Mr. Commissioner.  
9 Thank you.

10 THE COMMISSIONER: Mr. Olson?

11 MR. OLSON: Nothing further.

12 THE COMMISSIONER: Witnesses, thank you very  
13 much.

14 MS. BROWNLEE: Can I -- I know this is  
15 probably --

16 THE COMMISSIONER: Yes.

17 MS. BROWNLEE: -- everyone's tired of me and  
18 everything at this point.

19 THE COMMISSIONER: No.

20 MS. BROWNLEE: I just wanted to highlight just  
21 one thing that I don't think anyone else has talked about.  
22 Jay got to, or Mr. Rodgers got to do his wish list, so if I  
23 could just add one piece to my wish list, would that be  
24 okay?

25 THE COMMISSIONER: Yes, you certainly can. You

1 may have questions on it but go ahead.

2 MS. BROWNLEE: Okay, yeah, my lawyer's probably  
3 going to kill me now. But the only thing would be that I  
4 think that this inquiry has been focused on a tragedy and  
5 most of our oversight related to our case work as a system  
6 is always related to tragedies or child deaths. I would  
7 like an equal emphasis placed on our successes. We have  
8 lots of families that we are very successful with and I  
9 think that we can learn just as much, if not more, if we  
10 had the same level of evaluation related to what are the  
11 factors that contributed to that success. So if anything  
12 came out of this towards getting us to look at our success  
13 stories as well, that would be wonderful.

14 THE COMMISSIONER: Well have you got any  
15 suggestion as to what a recommendation might look like to  
16 bring that to the place you would like it to be?

17 MS. BROWNLEE: If there could be a focus on an  
18 evaluation that was based on success, and I don't mean just  
19 outcomes because I think outcomes indicate success but it  
20 doesn't necessarily speak to how you got there. So if we  
21 could do regular evaluations with families that were  
22 successful with where children are safe, where we're able  
23 to keep kids safe at home or where we've been able to make  
24 a successful reunification, if we were able to evaluate  
25 from the family's perspective what did that look like, what

1 helped change that and do that on a regular and consistent  
2 basis versus only looking at the cases where we've not been  
3 successful.

4 THE COMMISSIONER: And the, the good that would  
5 come from that would be what?

6 MS. BROWNLEE: I think we did then learn what we  
7 need to be replicating. We would be in real, real sense  
8 instead of saying well we think these would be good  
9 recommendations or we think these would be good standards  
10 or we think this practice works. We would be able to  
11 legitimately say we've now looked at 100 families where  
12 this was the type of engagement, these were the types of  
13 services, this was the frequency of the contact, these are  
14 the tools that were used, this is -- those kinds of things  
15 would then help us to know that, that's good work, that's  
16 what good work looks like, that's the work that will have a  
17 positive outcome.

18 THE COMMISSIONER: I follow you. Well I don't  
19 think -- that will be added to the list for our  
20 consideration and my consideration.

21 MS. BROWNLEE: All right, thank you.

22 THE COMMISSIONER: And I don't think there's any  
23 questions arising out of that. I hear you and I understand  
24 you.

25 MS. BROWNLEE: Yes.

1 THE COMMISSIONER: Thank you both very much.

2 MS. BROWNLEE: Thank you.

3

4 (WITNESSES EXCUSED)

5

6 THE COMMISSIONER: Mr. McKinnon?

7 MR. MCKINNON: Maybe we'll just take one moment  
8 to set up the --

9 THE COMMISSIONER: Yes, to rearrange.

10 MR. MCKINNON: -- the one witness and then I'll  
11 call Mr. Dennis Schellenberg.

12 THE COMMISSIONER: The role for associate  
13 counsel.

14 MR. MCKINNON: Mr. Schellenberg, do you prefer to  
15 be sworn or do you affirm?

16 THE WITNESS: Affirm.

17 THE CLERK: State your full name for the court,  
18 please.

19 THE WITNESS: My full name is Dennis Herbert  
20 Schellenberg.

21 THE CLERK: And spell us your first name.

22 THE WITNESS: Spell the first name?

23 THE CLERK: Yes.

24 THE WITNESS: D-E-N-N-I-S.

25 THE CLERK: And your middle name?

1 THE WITNESS: H-E-R-B-E-R-T.

2 THE CLERK: And your last name, please?

3 THE WITNESS: Schellenberg, S-C-H-E-L-L-E-N-B-E-  
4 R-G.

5 THE CLERK: Thank you.

6

7 **DENNIS HERBERT SCHELLENBERG,**

8 affirmed, testified as follows:

9

10 THE CLERK: Thank you. You may be seated. I'll  
11 get you some fresh water.

12 MR. MCKINNON: Mr. Commissioner, Mr. Schellenberg  
13 is being called at the request of commission counsel and  
14 she has requested that I take his direct. He'll be  
15 speaking to two issues. One is what we've been calling the  
16 report sharing issue and the --

17 THE COMMISSIONER: The what?

18 MR. MCKINNON: Report sharing.

19 THE COMMISSIONER: Oh yes, yes.

20 MR. MCKINNON: And the other is the standards  
21 issue.

22 THE COMMISSIONER: Right.

23 MR. MCKINNON: And I propose to take him through  
24 both of those topics at the request of Ms. Walsh.

25

1 DIRECT EXAMINATION BY MR. MCKINNON:

2 Q Just for the record, you're currently not working  
3 in any capacity related to the child welfare system?

4 A That is correct.

5 Q Okay. And let me then take you through -- and,  
6 Mr. Commissioner, I'll take you through his background.

7 I understand you have a bachelor of theology, a  
8 bachelor of history, a master of -- an MA in historical  
9 theology and a master's in social work.

10 A That's correct.

11 Q And you started your involvement or attachment to  
12 the CFS system, started as a volunteer, as a board member  
13 at the old Children's Aid Society of Eastern Manitoba?

14 A Yes.

15 Q And you eventually became president of that  
16 board, a position that you held for five years?

17 A Yes.

18 Q And that was as a volunteer?

19 A Yes.

20 Q In 1985 you became the executive director of the  
21 Children's Aid Society of Central Manitoba which is around  
22 Portage la Prairie, Manitoba?

23 A That's correct.

24 Q And then you were at that point an employee of  
25 the system?

1 A Yes.

2 Q And you held that position for 14 years?

3 A Yes.

4 Q Now you were asked to assume the position of the  
5 director of family conciliation in Winnipeg which I  
6 understand you held for two years, that is from 1999 to  
7 January 15th of 2001.

8 A Correct.

9 Q And that position, director of family  
10 conciliation, is outside of the CFS system as well?

11 A Yes.

12 THE COMMISSIONER: Outside of what?

13 MR. MCKINNON: The CFS system.

14

15 BY MR. MCKINNON:

16 Q So you had your 14 years as executive director of  
17 the Children's Aid Society of Central Manitoba, then you  
18 were absent for two years when you were with the family  
19 conciliation. Following that you became the director of  
20 the child welfare branch?

21 A Right.

22 Q The statutory director and at that point you were  
23 an employee of the Province of Manitoba?

24 A That's correct.

25 Q Now my understanding is you held that position

1 from January 15th, 2001 until March 17th, 2003.

2 A That's correct.

3 Q And following that you were asked to take on the  
4 job of being the first CEO of what we've been referring to  
5 in this proceeding as the General Authority.

6 A That's correct.

7 Q And that was right during the period of the  
8 transition into devolution.

9 A Right.

10 Q And --

11 THE COMMISSIONER: And that was in March of '03?

12

13 BY MR. MCKINNON:

14 Q That was March 1st of '03 according to my notes;  
15 does that sound right?

16 A That's correct.

17 Q And you held that position until April 30th,  
18 2007?

19 A That's correct.

20 Q And then in April 30th of 2007 you left the  
21 position of the CEO of the General Authority and you  
22 assumed a position unrelated to child welfare where you  
23 remain today?

24 A That's correct.

25 Q Okay. The -- in terms of the issue then of the

1 sharing of these reports, I'm going to start by asking you  
2 if you recall receiving a copy of what we've been referring  
3 to in these proceedings and I suspect you would be familiar  
4 with this label, the Section 10 report in connection with  
5 the death of Phoenix Sinclair.

6 A I recall receiving that, correct.

7 Q And at that time it would have been in the, about  
8 September of 2006 you were CEO of the General Authority?

9 A Correct.

10 Q And if I could take the witness to commission  
11 disclosure 835 at page 18031.

12 THE COMMISSIONER: And what exhibit number is  
13 this?

14 MR. MCKINNON: Commission disclosure 835.

15 THE COMMISSIONER: Oh, it's not a -- where will I  
16 find that, Mr. Olson?

17 MR. OLSON: You should have a copy.

18 THE COMMISSIONER: Where, in the exhibits? I've  
19 seen the letter before, but ...

20 MR. OLSON: Is there a copy on your desk?

21 THE COMMISSIONER: Well, we'll -- no, there's not  
22 a copy on my desk, I don't think. We'll --

23 MR. MCKINNON: I did not prepare copies of these  
24 various exhibits for you, Mr. Commissioner.

25 THE COMMISSIONER: Carry on with your question.

1 I'll follow it on the screen.

2 MR. MCKINNON: Okay.

3

4 BY MR. MCKINNON:

5 Q You've seen this letter recently, Mr.  
6 Schellenberg, I think it's been provided to you by my  
7 office and others?

8 A That's correct.

9 Q And this letter pertains to the section 10 report  
10 that we're all familiar with at this proceeding. My  
11 understanding is that this is a letter that you received  
12 from Linda Burnside, the director of authority relations.  
13 Who is Linda Burnside? How does she relate to -- who does  
14 she work for?

15 A Linda Burnside at that time was the director of  
16 authority of relations, positioned at the executive  
17 director of the Child Protection Branch's office.

18 Q Okay.

19 A So she was one of the senior staff there who was  
20 our primary conduit into the department.

21 Q Now do you recall who the executive director of  
22 child protection was at this time?

23 A I know Joy Cramer took over from me, so I'm  
24 assuming it was Joy Cramer.

25 Q This would have been -- my understanding is this

1 was Jay Rodgers?

2 A That was Jay -- it's very possible that it was  
3 Jay Rodgers.

4 Q Okay. So this letter from Linda Burnside would  
5 have been presumably on behalf of Jay Rodgers?

6 A Or whoever the executive director was, yes.

7 Q Okay. Now there's been some discussion at this  
8 inquiry about the first paragraph of this letter, which  
9 deals with -- I won't read it verbatim but the reference to  
10 not making copies of the report nor share its contents  
11 without the written permission of the executive director of  
12 the Child Protection Branch. However, it goes on to say in  
13 certain circumstances it can be shared. You've had an  
14 opportunity to review that recently?

15 A That's correct.

16 Q Now can you comment on whether or not this COMS  
17 concept, this what I'll call a confidentiality warning, is  
18 that typical of the letters you would receive with section  
19 10 reports?

20 A Specific to section 10 reports, these, this  
21 letter was not inconsistent with a template letter type  
22 that we would receive, typically from the director of child  
23 welfare or the executive director of the Child Protection  
24 Branch, kind of identifying that they didn't want copies  
25 made but of course it could be shared with individuals who

1 were pertinent to the case within the organization.

2 Q Okay. And there will be some discussion, I'm  
3 sort of anticipating that, so I'm going to ask you the  
4 question. It says:

5

6 May be shared with staff of  
7 Winnipeg, rural and northern Child  
8 and Family Services, Winnipeg  
9 regional office.

10

11 In simple language that's Winnipeg CFS?

12 A That's correct.

13 Q And then it goes on to say:

14

15 ... who are directly involved in  
16 the matter for the purposes of  
17 reviewing the recommendations in  
18 the CME's report.

19

20 So was -- again, can you comment on that last phrase in  
21 terms of for the purposes of reviewing the recommendations  
22 in the CME's report, what was your understanding of what  
23 that meant?

24 A Again, this letter was template language for  
25 section 10 reports that we had received and for the

1 purposes of reviewing the recommendations, clearly the  
2 staff involved in the case, because we would get a number  
3 of these kind of letters every year. With a number of  
4 children in care we periodically had kind of deaths of  
5 children in care and the CME was always involved in the  
6 review of those cases and while they were tragedies, we  
7 needed to review the participation of the, of the agency,  
8 that is Winnipeg Child and Family Services or any other  
9 agency where the child was receiving, child or family was  
10 receiving services to determine kind of what services the  
11 Child and Family were receiving and whether or not there  
12 was anything that we could do better.

13 Q Okay. And I see, if we look at the second page  
14 of this letter, there's a carbon copy to Darlene McDonald,  
15 the acting executive director of Winnipeg CFS with the  
16 report attached. So your understanding, I assume, was that  
17 at the same time you received this, Ms. McDonald would have  
18 received this.

19 A Along with the others who were CC'd and again  
20 that was typically the list of CCs or section 10 reports.

21 Q Okay. Did you -- do you recall having any  
22 discussions with Darlene McDonald about this letter or  
23 sharing the section 10 report with the individual CFS  
24 workers at Winnipeg CFS?

25 A I don't recall any conversation. It doesn't mean

1 it didn't happen but I don't recall any conversations with  
2 Darlene McDonald or any senior staff at Winnipeg Child and  
3 Family pertaining to this letter.

4 Q Okay. Now I'm going to take you to another  
5 letter. It's CD 838. This is -- again, you've seen this  
6 letter recently, I've provided you with a copy?

7 MR. MCKINNON: Madam Clerk, if you could just --  
8 oh, I'm sorry, you need the page number. Do you need the  
9 page number, Madam Clerk?

10 THE CLERK: I'm not sure.

11 MR. MCKINNON: 18039. This is a letter dated  
12 October 17th, 2006. It is also addressed to you and I  
13 understand this letter enclosed a copy of the section 10  
14 report --

15 THE WITNESS: Section 4.

16

17 BY MR. MCKINNON:

18 Q Sorry section 4, report.

19 A Section 4 report, yes, correct.

20 Q And this was also carbon copied to Darlene  
21 McDonald, correct?

22 A That's correct.

23 Q And again this report has a slightly different  
24 phrase in it in terms of describing the confidentiality  
25 issue. It says:

1                   Given the sensitive nature of the  
2                   report, we ask that you not make  
3                   copies of the report nor share its  
4                   contents without the written  
5                   permission of the executive  
6                   director of the Child Protection  
7                   Branch.

8  
9                   Again, that was sent to you, this time the letter  
10                  is signed by Jay Rodgers himself, the acting executive  
11                  director?

12                 A     That's correct.

13                 Q     And your understanding is Ms. Darlene McDonald  
14                  would have received a copy of the report at the same time  
15                  you did?

16                 A     Correct.

17                 Q     Now page 18014. Page 18014 -- or sorry, 041, my  
18                  mistake. And if you could scroll down a bit on this  
19                  document. My understanding is this is a series of emails.  
20                  You've been provided with a copy of this to refresh your  
21                  memory?

22                 A     That's right.

23                 Q     And reading them, we have to read them from  
24                  bottom to top to get them in chronological order; is that  
25                  correct?

1           A     That's right.

2           Q     So the first email is from someone named  
3 Pat Wawyn. Who was that?

4           A     Pam Wawyn was staff at the General Authority.  
5 She was my staff at the time and she was responsible for,  
6 for all community complaints and was one of the senior  
7 program staff.

8           Q     And if you could just either read or summarize  
9 for the commissioner what the message was contained in this  
10 three or four paragraph email?

11          A     Essentially what Pat is suggesting to the, the  
12 three people, Darlene McDonald, Patrick Harrison and  
13 Janet Wikstrom and copied me that in order for the  
14 section 4 report to be shared, Mr. Rodgers' consent would  
15 have to be received. Again, back to the previous letter,  
16 it was very clear that because it was a section 4 or a  
17 report generated as a result of a section, of section 4 of  
18 the Child and Family Services Act, and contained very, very  
19 sensitive material that in order for it to be shared even  
20 internally, Mr. Rodgers would have to give consent for  
21 that.

22          Q     Now, and I know you probably have no actual  
23 recollection of this but again I've shown you some  
24 documents and if we could go back to page 18039 and scroll  
25 down to the bottom of that page. There's a handwritten

1 note at the bottom of that page and can you tell the  
2 Commissioner your belief as to how that relates to the  
3 issue that we're now discussing.

4 A Well, I believe that to be Mr. Rodgers'  
5 signature, first of all. I can only speculate how it got  
6 there, but I believe what occurred is that Ms. McDonald,  
7 the executive director of Winnipeg Child and Family  
8 Services, upon direction from myself and Pat Wawyn, asked  
9 Jay Rodgers for permission to produce or reproduce and it  
10 was granted in that form.

11 Q And, and based upon your previous email where you  
12 were saying if you want permission get it from the  
13 executive director of child protection, that's what you  
14 would have expected to see?

15 A Yeah, some form of permission. This is, this is  
16 fairly informal permission but it is signed by Jay Rodgers,  
17 unfortunately not dated but, yeah, this is permission.

18 Q Okay. And do you know anything more about this  
19 issue in terms of the report sharing that you've shared  
20 with us by looking at these documents or is that, is that  
21 the sum total of what you recall about this?

22 A That's the sum total.

23 Q Okay.

24 A And Ms. McDonald was asking us to reproduce the  
25 document for certain people internal to organization. We

1 were sympathetic but we directed her to Jay Rodgers for  
2 permission.

3 Q Okay. I'm going to move to another area.

4 THE COMMISSIONER: How do you know it was  
5 McDonald who sought the permission?

6 THE WITNESS: I don't know that. I, I know she  
7 was asking for permission.

8 THE COMMISSIONER: How do you know that?

9 THE WITNESS: She was asking us.

10 THE COMMISSIONER: Was that in the email?

11 THE WITNESS: That's right.

12 THE COMMISSIONER: I don't think we saw that  
13 email.

14 THE WITNESS: We didn't receive an email from  
15 Darlene McDonald but we received two responses from us. So  
16 Darlene was asking us verbally in meetings for these and we  
17 were responding to her in email form, saying receive  
18 permission from Jay Rodgers.

19

20 BY MR. MCKINNON:

21 Q And I should have taken you to that and that's  
22 probably why the commissioner is confused. Let me go back  
23 to page 18041. So the first of these emails is the one  
24 from Pat Wawyn to Darlene McDonald reminding her of the  
25 confidentiality issue and the second one back, it says:

1           The contents need to be shared  
2           with a few select managers, for  
3           instance I want feedback from  
4           Ellen with respect to the foster  
5           care recommendations. I need to  
6           discuss with Rob and Dan feedback,  
7           re recommendations.

8

9           That's what you're referring to as the request?

10          A     Right.

11          Q     I'm sorry, I meant to take you to that,  
12                Mr. Commissioner. I've overlooked it. And then the third  
13                in the string of emails is, is the one that goes back to,  
14                it's from Dennis Schellenberg, back to Darlene McDonald:

15

16                        Please ensure you get Jay's  
17                        written consent to share with  
18                        specific people, Dennis.

19

20           That's the string of three emails?

21          A     And, and -- that is the string of the three  
22                emails and if you look at the dates, two of them are on the  
23                same date, the 24th of October, the response from Pat  
24                Wawyn. So that's why I was suggesting that it was raised  
25                in a meeting. She emailed Pat with the specific request

1 and the next day I responded by saying get Jay Rodgers'  
2 consent.

3 Q And when you see that note at the document that I  
4 subsequently took you to, page 18039, you're assuming that  
5 was the consent that you had suggested that she get?

6 A That's correct. And unfortunately that, that  
7 signature is not dated but I'm assuming it happened shortly  
8 after the 26th of October 2006.

9 Q Okay. And that's the sum total of your  
10 recollection of this issue?

11 A That's correct.

12 Q I'm next going to take you to page 36186, it's  
13 commission disclosure 1766. It does not look like it's  
14 supposed to look, 36186 -- sorry, 36187.

15 Now I'm hoping that this is the document I  
16 emailed to you yesterday. Did I get that right yesterday?

17 A I don't believe so.

18 Q Okay. So let's scroll through this document and  
19 see if you recall what it is.

20 A I obviously know this document.

21 Q Okay. It is an eight page document and at the  
22 last page -- sorry, seven page document. At the last page  
23 36193, your name appears. Do you recall what this document  
24 was and what it was requesting?

25 A If we could scroll back to the first page of the

1 document, this is the request for an internal review that  
2 was done very shortly after we became aware of the death of  
3 Phoenix Sinclair and this is not an unusual request for an  
4 authority CEO, whether it be the General Authority or any  
5 other authority, for the agency to have a look at itself  
6 first.

7 Q Okay.

8 A And this is the request for an internal review  
9 and the -- it was given a timeframe for completion of April  
10 17th of 2006 and it contains a number of questions that,  
11 that we're concerned about immediately in looking at this  
12 very tragic situation.

13 Q Okay. And my understanding is this internal  
14 review was subsequently conducted by Rhonda Warren; is that  
15 correct?

16 A That is correct.

17 Q And my understanding is that questions that were  
18 to be answered in this review were formulated by you and  
19 your staff?

20 A That's correct.

21 Q And can you tell me why you did that? You said  
22 it was routine but what's the purpose of doing this kind of  
23 a --

24 A Well it's routine, it was routine but this was  
25 clearly a very, very tragic situation that had been in the

1 news for a number of months and, and we were aware that  
2 Winnipeg Child and Family Services, one of the agencies  
3 under the umbrella of the General Authority had a, had an  
4 intimate involvement with the case and we wanted to know  
5 from their review, internally to begin with, what exactly  
6 their involvement was with the case. So the questions in  
7 my view were very, very preliminary questions to start the  
8 review going. We knew that this would be a matter for some  
9 internal, and when I say internal I mean internal to the  
10 Manitoba Government, the General Authority and, and as we  
11 subsequently learned, the public, wanted to know what went  
12 on here. So I wanted to know as the CEO of the General  
13 Authority from the perspective of one of my agencies what  
14 kind of services and what kind of activities had gone on in  
15 this case.

16 Q Okay. And if I can take you to CD 843, page  
17 18066. Have you had a chance to see this document  
18 recently?

19 A Yes.

20 Q And can you tell the Commissioner what that is?

21 A This is the recommendation, the recommendations  
22 that came out of the, out of the internal review and the  
23 response from Winnipeg Child and Family Services. The  
24 recommendation is in bold and the responses are in non-bold  
25 script.

1 Q And you would have -- did you also receive the  
2 internal review report prepared by Rhonda Warren?

3 A Yes.

4 Q Okay. And as CEO of the General Authority, what  
5 role, if any, did you play in terms of making decisions,  
6 personnel decisions in respect to staff at Winnipeg CFS  
7 upon receipt of this report from Ms. Warren and this  
8 response to recommendations?

9 A The role of the CEO of the General Authority was  
10 not as a hiring authority for its agencies. The agencies  
11 were the hiring authority. So in terms of, in terms of my  
12 role in seeking a discipline or anything like that or any  
13 labour relation type activity with staff, that would have  
14 been the role of the executive director or the CEOs of the  
15 agencies. I wasn't the hiring authority so I would have no  
16 labour relations involvement and that's codified in the  
17 collective agreement and that sort of thing.

18 Q Okay.

19 A I wasn't their boss.

20 Q That's -- thank you for that.

21 MR. MCKINNON: Mr. Commissioner, I'm going to  
22 move to another entirely different area and at this point  
23 I'm asking the witness to put on other hats as well because  
24 I'm going to ask him about standards and they cover a  
25 longer period of time.

1 BY MR. MCKINNON:

2 Q Mr. Schellenberg, we've heard a fair bit at this  
3 inquiry about what are sometimes called provincial  
4 standards, they're sometimes called program standards,  
5 they're sometimes called the 1988 standards, they're  
6 sometimes called the foundational standards. Are you  
7 generally familiar with what we're talking about?

8 A I am.

9 Q And just at the highest possible level, what are  
10 they?

11 A The standards that are sometimes called the blue  
12 book standards as well, they're the standards for the Child  
13 and Family Services system that were finalized in 1988 and  
14 it's a series of standards that follow fairly closely to  
15 the Child and Family Services Act, for instance section 3  
16 of that act is the section that deals with child  
17 protection. And the child protection section, of course,  
18 talks about all kinds of authorities and it talks about  
19 things like abuse and neglect and the, or the duty to  
20 report and those kinds of things. So those are the kinds  
21 of things that are contained in the act. The standards  
22 also parallel the Child and Family Services. So section 3  
23 of the 1989 standards would be a section on standards  
24 related to child abuse and neglect.

25 Q Okay.

1           A     So it would be the operationalization (sic) of,  
2 of legislation, regulation and policy for the specific  
3 purposes of, of informing services to children and families  
4 per the Child and Family Services Act.

5           Q     And if we follow along, for example, part 2 of  
6 the Child and Family Services Act deals with voluntary  
7 services. We've heard some discussion about that as well.  
8 Are you suggesting that part 2 of the standards manual  
9 would deal with voluntary services?

10          A     That's correct.

11          Q     And we can follow all the way through?

12          A     That's right.

13          Q     Foster care, et cetera?

14          A     Adoption, everything, post-adoption.

15               MR. MCKINNON:   Now I'm just going to, for the  
16 record, Mr. Commissioner, get this witness to identify the  
17 1988 standards. It's commission disclosure 983 and if we  
18 start at page 18662 and this is a very lengthy document,  
19 Mr. Commissioner. I've got it at 450 pages. Obviously I  
20 don't want to ask the witness to go through it, other than  
21 to identify it.

22

23 BY MR. MCKINNON:

24          Q     Are you able to, as we just scroll through the  
25 index, for example, if we go to page, for example, 18665, a

1 couple of pages in, part 1 is program administration. That  
2 would conform with part 1 of the act, is that what you're  
3 saying?

4 A That's correct.

5 Q And part 2 is services to family, families,  
6 that's voluntary services?

7 A That's right.

8 Q And the next page, part 3, is child protection,  
9 et cetera. So that's what you were just describing?

10 A That's right.

11 Q And these are -- have I correctly shown you what  
12 you recollect to be the 1988 --

13 A That's right.

14 Q -- program standards.

15 A And if you read the scripts beside each one of  
16 the section numbers, we're now on child in care, for  
17 instance, that's one up, but just to take, for example,  
18 451, health and personal care, care provider. That would  
19 be the standard around health and care of children in care  
20 which wouldn't be contained in an act or regulation but it  
21 would be contained in a standard of service and the  
22 expectation of care providers around things like health and  
23 personal care.

24 Q Okay.

25 A So those are the kinds of things that I was

1 referring to.

2 Q Thank you, that's helpful. Now my understanding  
3 is the 1988 standards did not contain a section that was  
4 specifically entitled "case management standards".

5 A That's correct.

6 Q They would have been, this is my word, let's  
7 sprinkle throughout wherever there was an issue that might  
8 involve case management that corresponded with a provision  
9 in the act you might find something there.

10 A Again using my example, health and personal care.  
11 The standard of care would be that the worker would ensure  
12 that the care provider, often a foster parent, would be  
13 complying with the health and personal care requirements of  
14 the standard, you know bathing and those kinds of things  
15 that you would do for any child in your care.

16 Q Now my understanding, and I'm going to ask the  
17 clerk to take us to commission disclosure 1884 at page  
18 39654. And I've just called this up, Mr. Schellenberg, to  
19 help refresh your memory. You pointed this out to me when  
20 we met. This is talking about a 1997 review of standards  
21 that was undertaken and there in front of you on the screen  
22 are some of the objectives. Could you please explain to  
23 the commissioner why was it in 1997 that a review of  
24 standards was undertaken, what were the objectives?

25 A Well, the objectives are there in the bullets.

1 To present the standards in a logical and user friendly  
2 way, to eliminate duplication and the presentation of the  
3 standards, to differentiate between those issues which will  
4 be defined by required standards and those which will be  
5 subject to recommended procedures to right the standards in  
6 a way which would facilitate quality assurance review, for  
7 example, measurable review, to present the standards in a  
8 way that could be adapted to the Child and Family Services  
9 information system, that is CFSIS, and/or be incorporated  
10 into an electronic integrated case management system. So  
11 there was some very, very positive reasons why the 1998  
12 standards would be reviewed in 1997.

13 As time went by, just to kind of give you one  
14 more point on that, Mr. McKinnon. Because the blue book,  
15 the standards manual of 1988, was a three ringed binder,  
16 when standards changed or standards were added, pages were  
17 replaced, pages were added. So over time the manual itself  
18 became somewhat less than user friendly. Too many pages,  
19 sometimes contradictory pages. So that's why, in 1997  
20 there was an impetus on behalf of the department to review  
21 the standards.

22 Q Okay. And it's my understanding that a decision  
23 was made to develop the standards in three themes. Do you  
24 recall that?

25 A Yes.

1 Q And do you recall what three themes are? I mean  
2 it's not a memory test. I'll help you if you need it.

3 A Yeah, you should help me.

4 Q Okay. I understand one was case management  
5 standards.

6 A Correct.

7 Q One was service provider standards?

8 A Um-hum.

9 Q And one was administrative standards?

10 A Right.

11 Q That makes sense?

12 A That makes sense. The first one would be related  
13 to agency provision of service. The second one would be  
14 primarily related to foster residential care children and  
15 the third one would be general administrative requirements  
16 for conducting work under the act.

17 Q Okay. And we may all have different views about  
18 what's the most important, but certainly for the purposes  
19 of this inquiry, the case management standards are what  
20 we're interested in.

21 A Right.

22 Q Can you tell us why there was a decision made to  
23 put them all together, group them as one?

24 A Put all three of them together?

25 Q No, group all the case management standards

1 together as opposed to, you know, as we've seen here,  
2 they're all over the 1988 standards. I think you're -- you  
3 agreed with me, I suggested they were sprinkled in there.

4 A They were sprinkled together and I think there  
5 was, again, an impetus within the department and within the  
6 Child Protection Branch itself to pull those as you  
7 suggest, Mr. McKinnon, together as a discrete bundle, so  
8 that it would have a different look and feel for standards  
9 and make it more user friendly, make it more consistent  
10 with CFSIS and make it more explainable and user friendly  
11 in terms of training.

12 Q And the balance of these standards in 1988 that  
13 were not case management standards would have been the, as  
14 we've just identified, the service provision standards and  
15 the administrative standards, correct?

16 A That's correct.

17 Q And we've heard various witnesses talk about  
18 remnants, is that a term you're familiar with?

19 A It is a term I'm familiar with.

20 Q In relation to standards, do you recall what,  
21 what the remnants were?

22 A I'm not exactly sure I do recall that. I, I took  
23 a two year hiatus from child protection between 1999 and  
24 2001, during which time I believe the full discussion of  
25 the remnants package, as it was then called, was going to

1 roll out to the agencies and I wasn't included in that list  
2 for the memo.

3 Q Because you were out of the system at that time?

4 A Because I was out of the system at the time.  
5 However, when I reassumed my role in the system, I became  
6 aware of the remnants package and the remnants were a piece  
7 of the 1988 standards that were going to be continuing to  
8 be in use while the new standards were piloted in certain  
9 agencies.

10 Q Okay.

11 A That's my recollection.

12 Q Thank you for that.

13 A It may be, it may be inaccurate because, like I  
14 say, I missed a number of memos in that two year period.

15 Q I'm going to -- and with that caveat in mind  
16 because there's no one, I think, who can cover the entire  
17 span of this period that we're talking about. You drew the  
18 short straw so I'm going to ask you a couple of questions.  
19 You've made reference to case management standards being  
20 piloted or tested. We've heard reference to the 1999 draft  
21 case management standards. Is that you're talking about?

22 A That's correct.

23 Q And if we look, Madam Clerk, at commission  
24 disclosure 991, page 19622.

25 THE COMMISSIONER: What's that page again?

1 MR. MCKINNON: 19622.

2

3 BY MR. MCKINNON:

4 Q And I'm trying to recall from your CV whether in  
5 -- this letter was written May 11th, 2001. Were you still  
6 out of the system at that point or had you --

7 A I think I --

8 Q You had just returned?

9 A I had just returned.

10 Q Okay.

11 THE CLERK: Sorry, I can't -- for some reason I  
12 can't hear -- on some I can't hear the mic.

13 THE COMMISSIONER: You can't hear the recording?

14 THE CLERK: No. I don't know why things changed.  
15 The clock stopped. No, my clock has stopped but that  
16 one's ...

17 THE COMMISSIONER: That one's going.

18 THE CLERK: Okay, it's back now.

19 MR. MCKINNON: Can you hear, can you hear me  
20 and --

21 THE CLERK: Yeah, yeah, it's good now.

22 MR. MCKINNON: Okay.

23 THE CLERK: I don't know why ...

24 MR. MCKINNON: Stop us if you can't hear --

25 THE COMMISSIONER: And who's this letter from?

1           MR. MCKINNON:    Could you, Madam Clerk, scroll  
2 down.  Next page.

3

4 BY MR. MCKINNON:

5           Q    This is a letter signed by you, Mr. Schellenberg,  
6 correct?

7           A    Correct.

8           Q    And I've shown you a copy of this recently to  
9 refresh your memory, I hope?

10          A    That's correct.

11          Q    And could you tell the commissioner, just very  
12 briefly, what this letter is about?

13                THE COMMISSIONER:  Well just a minute.  Go back  
14 to who it was to.  I wanted to know who it was from first.  
15 All right.

16                THE WITNESS:  So essentially, Mr. McKinnon, this  
17 was a letter to or a memo to, to the system, the  
18 operational side of the system, identifying where the,  
19 where the new standards were going to be piloted in those  
20 seven agencies.

21

22 BY MR. MCKINNON:

23          Q    And I'll just stop you there.  When you say where  
24 they were going to be piloted, it looks to me like it's a  
25 thank you for having piloted it.

1           A     Yeah, that's correct.  Yes, that's more accurate.  
2     And thanking Richard Voss who took the lead in this and  
3     identified a number of issues that came out of the pilot.

4           Q     Now one of the pilots, one of the organizations  
5     that's referred to as part of the pilot project was  
6     Winnipeg CFS and if you can't recall this obviously don't,  
7     I'm not expecting an answer, but can you recall whether  
8     that was the entire Winnipeg CFS or whether it was selected  
9     units?

10          A     It was selected units.

11          Q     And do you recall whether intake was one of the  
12     selected units?

13          A     I don't recall.

14          Q     Okay.  And I've called this letter up somewhat  
15     out of order, Mr. Commissioner, because it's the only  
16     letter that I could see which gave any indication of where  
17     these were piloted.  So I'm going to ask the witness to go  
18     back now to 1999.

19          A     When I wasn't involved in the Child and Family  
20     Services?

21          Q     Yes, when you were not involved.  Now at page  
22     19152, this is a letter of May 26th, '99.  It's signed by  
23     Richard Voss.  I think you know who he is.

24          A     I do.

25          Q     Who is he?

1           A     Richard Voss at that time was, I believe, working  
2 for the Child Protection Branch and I believe he was taking  
3 the lead on the, on the pilot of the new, of the new  
4 standards.

5           Q     Okay. And this letter, I understand, sets out to  
6 agencies. It enclosed a copy of the 1999 draft case  
7 management package and explained how the pilot sites were  
8 going to be chosen. Is that your understanding?

9           A     If that's what the letter says. Again, I wasn't,  
10 I was not a recipient of this letter and --

11          Q     I know I'm being somewhat -- I'm asking you to  
12 just actually read the letter and --

13          A     Okay.

14          Q     -- give evidence to the Commissioner based on  
15 what you've read.

16          A     So my evidence will be based on reading a letter  
17 that I didn't receive originally?

18          Q     Yes.

19          A     Okay.

20          Q     Is that your understanding that --

21          A     If that's what the letter says and I've read the  
22 letter and that's what I believe it says.

23          Q     Thank you, that's all I'm asking you. And it's  
24 my understanding that if we go to the next page, Madam  
25 Clerk, which will be the next commission disclosure. Keep

1 scrolling. If we look at this document, my understanding  
2 is this is the case management standards, the draft  
3 standards, the 1999 standards that were enclosed with Mr.,  
4 is it Voss?

5 A Voss, yes.

6 Q Mr. Voss's letter. Are you able to confirm that  
7 or not?

8 And perhaps, Madam Clerk, just scroll through a  
9 couple of the pages so ...

10 I know you wouldn't have been there at the time  
11 but when you came back in 2001, did you get a sense as to  
12 which, which standards had been drafted and what they  
13 looked like?

14 A These, these appear to be those draft standards,  
15 however they look remarkably like the 1988 standards in  
16 terms of they're parallel to the act. But I believe that  
17 this was the document that was rolled out. They may have  
18 just framed it that way so that there wasn't too much of a  
19 change shock for the system.

20 Q I see your point in terms of the headings still -  
21 -

22 A Yeah.

23 Q -- section 3, children in care -- or sorry,  
24 section 3, child protection, section 4, children in care.  
25 That's what you're referring to?

1           A     That's right.

2           Q     Okay.           But     nonetheless,     this     is     your  
3 understanding is these were the 1999 draft standards that  
4 were piloted?

5           A     That's right, because they are different than the  
6 1988 standard index that you showed me before.

7           Q     Right.     And I'm also advised that in addition to  
8 these -- I'm just going to check to see the number of  
9 pages.     There's about 54 pages of draft standards.     In  
10 addition to those 54 pages, there was a series of forms  
11 that accompanied the 1999 draft standards.     Are you  
12 familiar with that level of detail, that there were forms  
13 attached or forming part of the standards?

14          A     I believe there were forms.     Again, I didn't  
15 receive this memo because I wasn't in the system but it  
16 wouldn't surprise me that with draft standards there would  
17 be new forms.

18          Q     And if you're unable to do, I'll understand.     My  
19 understanding is it's commission disclosure 1884 and the  
20 page number is 39652 and there's a number of pages, about  
21 90 pages of forms.     Have you seen these before, after you  
22 assumed your job in 2001?

23          A     I would have seen them after 2001 but I did not  
24 see them at the time of course.

25          Q     Okay.     And just so that the commissioner knows

1 what I'm talking about, are you able to say that you're  
2 comfortable these, the 1999 draft standards and the forms  
3 together form the, the 1999 draft standards?

4 A I'm comfortable to say that.

5 Q Thank you. Now I'm still in areas where you  
6 learned about this after you returned to the system, but if  
7 we look at commission disclosure 987, page 19211. Now is  
8 this a letter that I hope I sent you a copy of to look at  
9 when, when you were preparing your evidence?

10 A I recall, I recall reading this recently.

11 Q Thank you. My understanding is that this letter  
12 went to the field and it refers to the revised remnants  
13 package and although you weren't in the CFS system at the  
14 time and you wouldn't have received this at the time, are  
15 you able to tell us generally what was in the remnants  
16 package?

17 THE COMMISSIONER: Well, who authored the letter?

18 MR. MCKINNON: The author of this letter was Mr.  
19 Phil Goodman.

20

21 BY MR. MCKINNON:

22 Q Are you able to tell the Commissioner who that  
23 was?

24 A Phil Goodman was the executive director of the  
25 Child Protection Branch at the time, the director of child

1 welfare.

2 Q The director of child welfare. And just in a  
3 very general way, we talked about remnants a moment ago.  
4 Are you able to say what the intent of this was and who it  
5 would have applied to?

6 A Yeah, it would apply to, to everyone in the  
7 system at the time if you look at who it was directed to.  
8 Beyond that, maybe you could frame your question  
9 differently.

10 Q My understanding is this memo may have created  
11 some confusion later on and I'm not holding your  
12 responsible for that confusion, but it would be helpful, I  
13 think, to the Commissioner, if we talked about what this --  
14 who would you have expected then to receive this letter in  
15 terms of the remnants package? How does it relate to the  
16 1999 draft standards?

17 A My recollection, not being in the system at this  
18 time but having it explained to me when I finally reentered  
19 the system, was that the remnants package, it was called  
20 remnants because it was the remnants of the 1988 program  
21 standards.

22 Q Yes.

23 A So there were certain aspects of the '88  
24 standards that were going to continue to be in place as  
25 program standards. Beyond that, I don't recall any more

1 detail.

2 Q And the issue that I think creates some confusion  
3 is the draft case management standards were being piloted  
4 in some but not all agencies?

5 A That's correct.

6 Q And they remnants are being sent out to all  
7 agencies?

8 A That's correct.

9 Q And that created some confusion?

10 A I'm imagining that did.

11 Q Okay. And we're going to add to that confusion,  
12 Mr. Commissioner, again not the responsibility of this  
13 witness -- sorry, I'm just having trouble finding the  
14 document. Yes, it's at commission disclosure 991, page  
15 19622. Now, sorry, this letter you did send out and we've  
16 talked about that a minute ago.

17 A Right.

18 Q This is the letter that's thanking the  
19 individuals for participating in the pilot and it's the  
20 second page of that letter I now want to draw your  
21 attention to, the third last paragraph. Next page, where  
22 it says:

23

24 "It is expected that all agencies  
25 will be using the new case

1 management standards by January  
2 1st, 2002."

3

4 Now I think we're getting to an area where you  
5 had some involvement --

6 A Right.

7 Q -- and you're able to speak from your own  
8 information as opposed to what others have told you. What  
9 were you intending at that time?

10 A At that time, and I believe this letter's dated  
11 May of 2001, correct?

12 Q May 11th, 2001.

13 A And it's signed by me and written by me probably.  
14 My intention at that point, given the pilot had occurred  
15 and what I believe was a reasonably good remnants package  
16 had been framed, that we would be implementing the new case  
17 management standards on January 1st, 2002, some eight  
18 months later.

19 Q Okay. And do you recall what those standards  
20 looked like? Because again, we have heard some reference  
21 to the 2001 standards in this. I'm going to take you to a  
22 document and see if that helps you. If you look at  
23 commission disclosure at page 25276. Do those look  
24 familiar to you? Are those the standards that you were  
25 contemplating bringing into effect when you wrote that

1 letter in May of 2001?

2 A Can we scroll down a little bit?

3 Q Going to scroll down a bit more. Keep scrolling.

4 A Yes, to answer your question.

5 Q Okay, thank you.

6 THE COMMISSIONER: Did they go out with that  
7 letter?

8 THE WITNESS: I don't believe so.

9 MR. MCKINNON: But this was --

10 THE WITNESS: This was the package that was  
11 intended to be implemented.

12 MR. MCKINNON: And we're going to take you to the  
13 next point, which they never were, Mr. Commissioner, so I'm  
14 going to take the witness through that step by step.

15

16 BY MR. MCKINNON:

17 Q I understand that shortly after your May letter,  
18 proposing that these new standards were going to come into  
19 force, you made a decision to withdraw the 2001 case  
20 management standards and that's at commission disclosure  
21 993. Madam Clerk, that is at page 19699. This letter is  
22 July 12th, 2001, a couple of months later.

23 A That's correct.

24 Q And tell the commissioner what this letter was  
25 and why you sent it.

1           A       This is a letter stating that the, the new  
2 standards would be delayed in their implementation for the  
3 authorities to --

4           THE COMMISSIONER: Speak into the microphone.

5           THE WITNESS: I'm sorry.

6           THE COMMISSIONER: No, that's fine but just move  
7 it over in front of you, yeah.

8           THE WITNESS: Okay.

9           THE COMMISSIONER: Yeah.

10          THE WITNESS: To enable the four authorities to  
11 deliver training necessary to support their use. So there  
12 was some good thinking about how these, how these standards  
13 would be implemented and it was pretty clear to us that  
14 with, without a training package that was parallel to the  
15 standards, implementation would be near impossible. In  
16 addition to that, Mr. McKinnon, at the time the AJI-CWI  
17 implementation process was well underway and we were aware  
18 that this was creating a fair amount of animation, shall I  
19 say, in the system, that people were experiencing some  
20 anxiety about that. People were experiencing anxiety  
21 around the quantity and quality of change that the AJI-CWI  
22 and child welfare sections implied. They were correct, it  
23 was a very, very big move and I became aware, in my role as  
24 director of child welfare, that in order to keep a system  
25 operational while everything around it changed, we had to

1 prioritize the number of changes we could put in place. We  
2 became aware that, we became aware that, of the belief that  
3 there was a kind of a change volume maximum that we could  
4 be asking the system to incorporate. So it was decided  
5 that with the changes around the recommendations of the  
6 aboriginal justice inquiry, child welfare initiative, that  
7 we would postpone the implementation of the new case  
8 management standards until we were farther along down the  
9 road of implementation of the four authorities.

10

11 BY MR. MCKINNON:

12 Q So your judgment at that time as the statutory  
13 director was you didn't want to impose change upon change.

14 A That's correct. Like I say, I think there is a,  
15 there is a change volume maximum that any organization or  
16 system can handle and in order for everything not to fail  
17 you have to phase in some of these changes.

18 Q And with your letter of July 12th, 2001, what was  
19 your understanding as to what standards were in effect at  
20 that point going forward?

21 A The 1988 standards.

22 Q Now I'm going to take you now to December of 2003  
23 when you were the CEO of the General Authority and you  
24 received a memorandum from Darlene McDonald who was then a  
25 program manager at Winnipeg CFS and that's commission

1 disclosure 1002, page 20101. And that is a memorandum from  
2 Darlene McDonald to yourself and to Joy Cramer and at that  
3 point you would have been the CEO of the General Authority  
4 and who was Joy Cramer?

5 A Joy Cramer was -- I know she, she succeeded me as  
6 acting director of child welfare and I'm not sure if she  
7 was in that role as of that date, December 17th, 2003.

8 Q It's my information that she was.

9 A Well that's probably correct information.

10 Q Okay. And so if that's correct, this is a  
11 memorandum from Darlene McDonald who is then a program  
12 manager to the CEO of the General Authority, to the  
13 statutory director and she's seeking clarification with  
14 respect to the expectations of the Child Protection Branch  
15 and the General Authority with respect to the use of the  
16 draft standards. Correct?

17 A That's correct.

18 Q The next in this chain, Mr. Commissioner, is CD  
19 1006, page 20263. And this is a memorandum from Joy Cramer  
20 to Darlene McDonald dated February 4, 2004 and it states  
21 that agencies are supposed to be using the administrative  
22 standards provided in place of the program standards  
23 manual. What was -- can you comment on this letter? I see  
24 it was copied to you.

25 A My only comment on this letter relates to a

1 couple of things. In my July 2001 letter, I identified  
2 that the program standards of 1988 would be in use until  
3 the new standards were put in place. However, I also said  
4 in that same letter that if people found using the new  
5 standards helpful, that they should go ahead and do that  
6 and clearly that phraseology did create some confusion. My  
7 intent there was to create a, kind of a cultural best  
8 practice. So even though the 1988 standards were in place,  
9 that the new piloted standards also had some new things  
10 that didn't contradict the 1988 standards but might be  
11 helpful in terms of service provision. In this particular  
12 letter, it seems that -- I'm not sure that Joy Cramer had  
13 a, had a good recollection of my July 2001 letter and, and  
14 because she seems to be saying something different.

15 Q And this creates in the field some confusion that  
16 you have been made aware of?

17 A That's correct.

18 Q Now if I can take you to commission disclosure  
19 1818, page 38215. Now at this point you were still the CEO  
20 of the General Authority and my understanding is that this  
21 is dated November 5, 2004 and it's a message introducing  
22 the Child and Family Services standards manual immediately  
23 prior to it going online. Correct?

24 A That is correct.

25 Q That's your understanding as well?

1           A     That's my understanding.  It also identifies when  
2  it's to be put in place, January 1st, 2005.

3           Q     And it says, "starting with the implementation of  
4  the case management standards".  So not all of the  
5  standards were coming into effect on January 1st, 2005,  
6  rather it was the case management standards?

7           A     Right.  Because it, it identifies that the --  
8  come into effect in stages --

9           Q     Right.

10          A     -- beginning January 1st, 2005.

11          Q     And if we look at the -- Madam Clerk, if you  
12  could scroll through the next few pages.  Can you go  
13  through perhaps a page at a time so the witness can see the  
14  headings?  There, just stop there.

15                   This is a document that I understand was the  
16  2005, January 1st standards that would have been posted  
17  online and become effective at that point.  Are you able to  
18  comment on that or confirm that?

19          A     Yes.  They were to be phased in, starting January  
20  1st, 2005, that's correct.

21          Q     So right up until these new standards became  
22  effective, your evidence is that the standards that were  
23  operative were what?

24          A     The 1988 standards.

25                   THE COMMISSIONER:  Was there a phase in schedule?

1 THE WITNESS: For the 2005 --

2 THE COMMISSIONER: Yes.

3 THE WITNESS: -- phase in? I'm not sure if this  
4 document identifies what the phase in schedule would be.

5 MR. MCKINNON: It does not and it's all that I  
6 have, Mr. Commissioner.

7

8 BY MR. MCKINNON:

9 Q Can you comment on -- we've heard evidence that  
10 there was no training immediately given on these 2005  
11 standards when they were posted online. Can you comment  
12 on, as CEO of the GA, what did you expect your staff to do  
13 to make sure they were meeting expectations after January  
14 1st, 2005? What were they to have regard to?

15 A At that time in 2005, by January 1st, 2005, we  
16 were in the final phases, if my recollection is correct, of  
17 what was then called devolution. I call it, in my own  
18 personal way, evolution into a different child and family  
19 services system. It was the change of, of services  
20 assigned to the four authorities, three aboriginal  
21 authorities and, and the General Authority, and we had gone  
22 through a very, very long process to get to that point.  
23 The four CEOs and certain other senior government staff sat  
24 together on a regular basis, almost every week, sometimes  
25 for one or two days in length and that was called the

1 standing committee.

2           The standing committee was struck with the  
3 responsibility of taking all issues pertaining to service  
4 delivery and finding ways of working together to implement.  
5 This 2005 training, the standards package, was clearly high  
6 on the agenda, but it was also clear to us that as it  
7 rolled out we needed to develop some consistent training  
8 between the four authorities so that it would roll out in a  
9 consistent way. That's not to say that each authority  
10 would necessary implement in exactly the same way. I mean  
11 that's the nature of having four authorities with their own  
12 kind of cultural, kind of priorities, but some consistent  
13 training in the, in the standards as they rolled out.

14           So if my recollection is correct, and I believe  
15 it is, they weren't implemented as of that date, as of  
16 January 1st, 2005.

17           Q     And when you say they weren't implemented, they  
18 were, they were online and they were public but what were  
19 you expecting staff to do on their day to day practice?

20           THE COMMISSIONER:   Just a minute.   What did you  
21 say about consistent training?

22           THE WITNESS:       Consistent training between the  
23 four authorities, Mr. Commissioner.

24           THE COMMISSIONER:   Was there to be some?

25           THE WITNESS:       Well that was the discussion at the

1 standing committee.

2 THE COMMISSIONER: But only a discussion.

3 THE WITNESS: At that point. We weren't at the  
4 point of putting in a training package as of January 1st,  
5 2005.

6 THE COMMISSIONER: So on January 1st, 2005 then  
7 what happened to the, to the standards?

8 THE WITNESS: Oh there was conversation with Joy  
9 Cramer and the Child Protection Branch around the need to  
10 have some consistent training before they rolled out. So  
11 we received the messages about the roll out as of January  
12 1st, 2005, but we received that message in November 2004.

13 THE COMMISSIONER: Yes.

14 THE WITNESS: So that gave us a little more than  
15 a month and at that point in the process of the devolution  
16 of the Child and Family Services, a month was not going to  
17 be nearly enough time to give us a reasonable training  
18 package that all four authorities could embrace.

19 THE COMMISSIONER: So what did you do?

20 THE WITNESS: We -- if I recall correctly we had  
21 conversations with the branch and we postponed the  
22 implementation of the standards until a training package  
23 could be put in place.

24

25 BY MR. MCKINNON:

1 Q And, and other people may have other  
2 recollections and I'm not here to cross-examine because  
3 that's not my role. What I, what I would ask though is if  
4 you're postponing the actual training and roll out of  
5 these, what are you telling staff to do? What would you  
6 expect your staff, your CEOs of your agencies, what were  
7 they to look for by way of direction and standard?

8 A The standards of 1988 would apply until there was  
9 a kind of a training that we could say now, now is the  
10 time, this is the day. We've all been trained, we all know  
11 what we're supposed to be doing based on the framework of  
12 the new standards and now we're moving forward with those  
13 new standards.

14 MR. MCKINNON: And, Mr. Commissioner, I've  
15 earlier referred you to the current, and when I say current  
16 the 2012 version of the online standards and that's at  
17 commission disclosure 2036, page 42278.

18 THE COMMISSIONER: 42278.

19

20 BY MR. MCKINNON:

21 Q Now I know you've been out of the system for  
22 several years by 2012 when we printed these out, but just  
23 because you were there at least till '07, if my memory  
24 serves me correct, my understanding, and I'm going to ask  
25 you to confirm this if it's your understanding for the

1 benefit of the commissioner, is what started with a small,  
2 relatively small package in January of 2005, grew and grew  
3 and grew as various standards were approved by standard,  
4 standing committee and they would have been added to the  
5 online directory and it continued to grow in '06 and '07  
6 and all the way to the present and I know you can't talk  
7 about all the way to the present but can you describe to  
8 the commissioner the process by which new standards got  
9 added to the 2005 standards?

10 THE COMMISSIONER: But the -- does the witness  
11 know whether the 2005 standards ever became operative?

12

13 BY MR. MCKINNON:

14 Q Can you answer that question, Mr. Schellenberg?

15 A They weren't operative in my time,  
16 Mr. Commissioner. I left in April of 2007 and at that  
17 point the suggested January 2005 standard had not been  
18 fully implemented for the reasons I've given before. And  
19 as Mr. McKinnon is intimating that over the time from 2007  
20 to 2012, that that standards package has changed and grown.  
21 And as you've heard evidence, I believe this afternoon,  
22 training has been put in place around those standards.

23 THE COMMISSIONER: But how could it, how, how  
24 could it be changed if it had never become operative in the  
25 first place?

1           MR. MCKINNON: I'm in a difficult position here,  
2 Mr. Commissioner. I can only do the best I can do.

3           THE COMMISSIONER: Yeah, I realize that.

4           MR. MCKINNON: And accept that I'm representing  
5 this client --

6           THE COMMISSIONER: Yes.

7           MR. MCKINNON: -- the department, and I can only  
8 do the best I can do.

9           THE COMMISSIONER: I understand that and you're  
10 not cross-examining. I understand that.

11          MR. MCKINNON: And I'm not -- I think different  
12 people have different views and I'm just trying to do my  
13 best to give you a picture of what various people  
14 understood and the consequences of that my client has to  
15 accept.

16          THE COMMISSIONER: Yes. I'm just raising my  
17 concerns as the chronological sequence unfolds.

18          MR. MCKINNON: No, and I'm doing my best to paint  
19 the picture --

20          THE COMMISSIONER: Yes.

21          MR. MCKINNON: -- and I think you've got the  
22 picture, Mr. Commissioner, you've identified the issue.  
23 Those are the questions I have for this witness.

24          Mr. Olson?

25          MR. OLSON: If we could pull up page number

1 18031. This is just on the report sharing issue.

2 THE COMMISSIONER: This is what page number?

3 MR. OLSON: This is 18031. This is a letter you  
4 wrote to Ms. Burnside.

5 THE COMMISSIONER: Yes.

6

7 CROSS-EXAMINATION BY MR. OLSON:

8 Q The wording in this letter suggests that

9

10 "... (the) report may be shared  
11 with staff of the Winnipeg, Rural  
12 and Northern Child and Family  
13 Services (Winnipeg regional  
14 office) (WCFS) who are directly  
15 involved with the matter for  
16 purposes of reviewing the  
17 recommendations in the CME's  
18 report."

19

20 First of all, I understand that none of your staff were  
21 involved in the Phoenix Sinclair matter; is that right?

22 A Not directly, no.

23 Q Okay. Were they involved, would you have shared  
24 the report with those staff members?

25 A Well there was certain -- you're asking me if my

1 staff were involved would I share, would I have shared  
2 that?

3 Q Right, had they been involved.

4 A This is the section 10 report we're referring to,  
5 correct?

6 Q Right.

7 A The section 10 report, again, has a number of  
8 recommendations that, that involved direct service staff  
9 and clearly I think it was -- it's always the intention in  
10 section 10 reports under the Fatality Inquiries Act that  
11 not only the system but individuals, supervisors, program  
12 managers have an understanding of what the review of the  
13 chief medical examiner's office was in this case and what  
14 they found to be strengths and what they found to be  
15 weaknesses in the service provisions, so yes.

16 Q And do you understand why that is or what's your  
17 understanding as to why that would be?

18 A Why that would be?

19 Q Why, why it's important to share the report with  
20 the staff involved?

21 A For enhancement of best practices. I mean for  
22 every -- as Ms. Brownlee said before in her wish list, her  
23 one point wish list, for every time you have an incident  
24 like this, you have a learning opportunity and you have a  
25 professional service enhancement opportunity.

1 Q So the staff can learn from what happened in the  
2 particular case and improve, or improve the services to the  
3 --

4 A Correct.

5 Q -- client in that case.

6 A And not every section 10 report had  
7 recommendations for the system. I mean we would have  
8 children in care who passed away tragically as a result of  
9 illness and those would be reviewed and a section 10 report  
10 would be written and sometimes there were no  
11 recommendations because service provision was fine and the  
12 child became ill and passed away.

13 Q If we put page 18039 on the monitor, please.  
14 This is a similar letter but with respect to the section 4  
15 report, this one has a bit different language in it where  
16 it requires permission to share the report.

17 A That's correct.

18 Q What's your understanding as to the reason why  
19 the language is somewhat more restrictive?

20 A The language is more restrictive, first of all  
21 you had understand the section 4 reports, while I wouldn't  
22 categorize them as rare in the Child and Family Services,  
23 we're not nearly as prevalent of section 10 reports. The  
24 director of child welfare had the opportunity to call  
25 section 4 reports on anything he or she wishes, but didn't

1 do that that often. In this particular case, with Mr.  
2 Koster writing the section 4 report, he interviewed staff  
3 and identified, I think, some sensitive staffing issues  
4 that were contained in that report and as a result of that,  
5 typically section 4 reports were not shared widely without  
6 permission.

7 Q Were they typically shared with the staff  
8 involved?

9 A Not without permission.

10 Q Not without permission. Was permission typically  
11 sought in these cases to share with the staff involved?

12 A I'm not sure I can answer that question.

13 Q Because you haven't had that experience or?

14 A Because I haven't had that experience.

15 Q I want to ask you about, I'll move on to the  
16 standards at this point. If we can take a look at, it's  
17 commission disclosure page number 19699, this is a letter  
18 where you indicate you decided to lay the implementation of  
19 the 2001 draft standards?

20 A That's correct.

21 Q And you indicated to Mr. McKinnon that was partly  
22 the result of so much change going on with the AJI process?

23 A That's correct.

24 Q The second paragraph you say:  
25

1           "During the implementation of the  
2           AJI-CWI it is essential that there  
3           continue to be clear direction as  
4           to what is expected in Manitoba to  
5           keep children safe and protected.  
6           This direction is currently  
7           provided under the Child and  
8           Family Services Act and the  
9           Adoptions Act and their  
10          accompanying Regulations and the  
11          attached administrative standards.  
12          I will continue to keep you  
13          informed of any changes as they  
14          occur."

15

16       Why do you mention the Child and Family Services Act in  
17       that context in terms of providing direction?

18           A     I'm not sure I understand your question, Mr.  
19       Olson.

20           Q     Is it -- you don't mention the current standards,  
21       for example, the 1988 standards as providing direction.  
22       You say the Child and Family Services Act is --

23           A     Oh, I see. I'm not sure why I framed it that  
24       way. In retrospect, I should have been more clear that the  
25       1988 standards were in place. I should have put that in

1 bold letters, saying that the 1998 piloted standards were  
2 not in place, the 1988 standards were in place probably  
3 would have eliminated some confusion for those who actually  
4 read this letter.

5 Q Okay. What, in your view, at the time ultimately  
6 guided social work practice, was it the standards, was it  
7 the act, was it the regulations?

8 A Oh, I think it was all, all of those. We  
9 expected all our program and senior service people and  
10 direct service workers to be aware of all those documents.  
11 The Child and Family Services Act, its regulation, any  
12 policies that were written as a result of the act and  
13 regulations, as well as the service standards. So all of  
14 those things guided, guided, guided delivery of service and  
15 guide delivery of service to this day.

16 Q Were there standards on -- Mr. McKinnon talked  
17 about case management standards and how they were sort of  
18 interspersed throughout the 1988 standards. Were there --  
19 were these standards comprehensive, did they cover every  
20 situation?

21 A I want to say no because every situation had its  
22 own matrix of variables but that's why we had systems in  
23 place such as supervisory authority, program manager  
24 authority and CEO authority, kind of to review those  
25 situations that were not clear cut. That's also why we

1 have the courts. For apprehending we have to explain  
2 ourselves before a judge and present evidence as to why  
3 this child was in need, and remains in need of protection.

4 Q Ultimately, I take it, the social worker wants to  
5 keep the child safe, that would be the ultimate goal.

6 A That should be the prime directive.

7 Q Would it be necessary in your view that there be  
8 a specific standard that would tell a social worker that he  
9 or she would need to see a child who's the subject of a  
10 protection concern?

11 A It would seem to me that that's, without wanting  
12 to be flippant in response, Mr. Olson at all, that's  
13 professional common sense.

14 Q Right.

15 A So unfortunately I think the reality of this  
16 particular situation with Phoenix Sinclair has brought us  
17 to a conclusion that perhaps we need to say it.

18 Q Would you agree that, when you look at the facts  
19 of this case, when you look at the facts of a case such as  
20 this, that would be something you would expect of a social  
21 worker in these circumstances, to see a child who is the  
22 subject of a protection concern?

23 A It's very difficult for me to put myself in the  
24 place of the social worker standing at the front door and  
25 trying to exercise discretion as to whether or not this

1 particular child needs to be seen and running through the  
2 history, running through the protection concerns in the  
3 past and those sorts of things. But we did as the four  
4 authority CEOs, immediately after we became aware of the  
5 death of Phoenix Sinclair and some of the circumstances  
6 surrounding the service provided to that family put a  
7 project in place whereby every child in care receiving  
8 service needed to be seen in a very abbreviated timeframe,  
9 so that we were assured that every child was safe.

10 Q That's something you determined fairly quickly  
11 after this --

12 A That's correct.

13 Q -- this review, the review of this case?

14 A And I believe that review was done, that whole  
15 project was done by the end of June 2006.

16 Q When it came to the standards, from the review  
17 that Mr. McKinnon did with you, it's fairly clear there was  
18 some confusion in the, in CFS during your tenure as to  
19 which standards applied?

20 A That's my understanding.

21 Q Why didn't you issue some directive or some clear  
22 letter indicating, you know, it's the 1988 standards that  
23 apply?

24 A I thought that's what I was doing in my July 2001  
25 letter. That's all I can say, Mr. Olson.

1           MR. OLSON:     Those are my questions for you.  
2 Thank you.

3           THE COMMISSIONER:   Now we've been sitting for an  
4 hour and three-quarters.   If we can finish the cross-  
5 examination of this witness by nine o'clock, we'll take a  
6 10 minute break and do that.   So that would give us 35  
7 minutes or 40 minutes.   If not, we'll adjourn till 9:30 in  
8 the morning.   So can you just take a poll of your counsel  
9 and see how long they're each going to be?

10          MR. OLSON:     I'm told that if we take a break we  
11 should be able to finish this witness by 9:30.

12          THE COMMISSIONER:   All right.   We'll limit it to  
13 10 minutes and then we'll carry on.

14          MR. OLSON:     Very good.

15

16                         (BRIEF RECESS)

17

18          THE CLERK:     We're back on the record.

19          THE COMMISSIONER:   Who's first up?   Mr. Bock?

20          MR. BOCK:     Mr. Commissioner, my name is Ted Bock.

21          THE COMMISSIONER:   Yes.

22          MR. BOCK:     I act for the Office of the Children's  
23 Advocate and am here today representing Darlene McDonald  
24 because Mr. McKinnon is constrained to some extent in his  
25 ability, obviously, to cross-examine Mr. Schellenberg on

1 behalf of Ms. McDonald, even though he represents her too,  
2 qua CFS CEO. If I may have your leave?

3 THE COMMISSIONER: Yes.

4 MR. BOCK: I have a few questions for  
5 Mr. Schellenberg on Ms. McDonald's behalf.

6 THE COMMISSIONER: You may.

7

8 CROSS-EXAMINATION BY MR. BOCK:

9 Q Mr. Schellenberg, I'd just like to direct your  
10 attention very briefly to commission disclosure 0835, page  
11 18031 and that was the letter of October 12, 2006,  
12 addressed to you by Ms. Burnside and I think you have that  
13 before you now too on the screen.

14 A It's related to the section 10 report.

15 Q That's right, thanks. Yeah, it's the transmittal  
16 letter by which that report was sent to you, correct?

17 A That's correct.

18 Q Sent to you for your information and then for the  
19 other stated purposes set out in the letter. You mentioned  
20 in your direct testimony that this was very, very sensitive  
21 and the covering letter too says that given the sensitive  
22 nature of the report that we ask that you not make copies  
23 of the report and were shared as contents

24

25 "Given the sensitive nature of the

1                   report, we ask that you not make  
2                   copies of the report nor share its  
3                   contents without the written  
4                   permission of the Executive  
5                   Director ..."

6

7   The executive director was Mr. Rodgers then, correct?

8

          As regards to that reference to the sensitive  
9   nature of the report, of course the subject matter of the  
10   report dealt with a very tragic event. In addition to  
11   that, as I understand it, October 12th, 2006, at that time  
12   this was the subject of much media attention; is that your  
13   recollection as well?

14

      A   That's my recollection as well.

15

      Q   As a result of the media attention it was the  
16   subject of a lot of public attention. Is that your  
17   recollection as well?

18

      A   That's my recollection.

19

      Q   In addition to that, as I understand it, there  
20   were criminal charges that had been laid arising out of the  
21   Phoenix Sinclair matter; is that your recollection?

22

      A   That's my recollection.

23

      Q   So that was occurring at this time too and my --

24

      A   To be, to be clear, criminal charges against the  
25   mother and the stepfather.

1 Q Yes, thank you for that clarification. And then  
2 as well, if I'm not mistaken, I think this very inquiry was  
3 called October 11, 2006 or thereabouts.

4 A You're right. Things were happening in a very  
5 compressed timeframe.

6 Q They were, all of which I would suggest would  
7 have contributed to the sensitivity surrounding this  
8 matter; is that fair?

9 A There was sensitivity, Mr. Bock, around this  
10 matter but I also said, I think in my direct testimony,  
11 that the letter that was transmittal letter for the section  
12 10 report, was fairly template letter that said it could  
13 not be reproduced and all -- except for sharing with the  
14 staff involved.

15 Q Yes. And --

16 A And that's template language for the section 10  
17 reports, as opposed to the section 4 report that had more  
18 restrictive language. But I didn't find this language  
19 necessarily unusual or resonating with the public attention  
20 attached to the case.

21 Q Understood. These -- this, in other words, was  
22 the standard letter that you often saw in connection with a  
23 section 10 report emanating from the office of --

24 A The chief medical examiner, that's right.

25 Q The chief medical examiner.

1           A     Yeah.

2           Q     And it simply informed you of the nature of the  
3 report and what you could do with it?

4           A     Well, that's correct and also attached the  
5 recommendations that pertained to my organization.

6           Q     And the second page of this letter in fact tasks  
7 you with responding to the recommendations; is that  
8 correct?

9           A     That's correct.

10          Q     And as I understand it, you actually did respond  
11 to the recommendations?

12          A     I believe so. I don't think we've seen that  
13 document in my direct evidence.

14          Q     And I must tell you, Mr. Schellenberg, there is  
15 no way that I would be able to provide you with a copy of  
16 that document, but as I understand it, and it's your  
17 recollection as well, it was actually you who ended up  
18 responding to those recommendations as contemplated by this  
19 letter.

20          A     I would have signed the letter but they, they  
21 would have been a collective effort on my office.

22          Q     Quite so.

23                 MR. BOCK: Thank you, Mr. Schellenberg. Those  
24 are my questions.

25                 THE COMMISSIONER: Thank you, Mr. Bock.

1 Ms. Bowley?

2 MS. BOWLEY: Good evening, Mr. Commissioner. For  
3 the record, it's Bernice Bowley, representing Diva Faria.  
4 I have one area on which I would like to ask this witness  
5 some questions with your permission.

6 THE COMMISSIONER: You may proceed.

7 MS. BOWLEY: Thank you.

8 Madam Clerk, could you please pull up page 35762.

9

10 CROSS-EXAMINATION BY MS. BOWLEY:

11 Q This is the letter from Richard Voss, Team  
12 Leader, Services to Public and Community, to Darlene  
13 McDonald. Do you see that, Mr. Schellenberg?

14 A I do, May 26th, 1999.

15 Q Yes. And I appreciate that you're not a  
16 recipient of this letter but I'd like to ask you some  
17 questions about Richard Voss. With what entity was he  
18 affiliated?

19 A I believe he was assigned to the Child Protection  
20 Branch at that point.

21 Q And it was part of his work to assist in dealing  
22 with this case management standards; is that right?

23 A That's correct, the ones that were to be piloted.

24 Q And did you have awareness of Mr. Voss's desire  
25 to implement a workload measurement process to go with the

1 standards?

2 A I'm not recalling anything like that. However,  
3 just to remind you again that it was during this period of  
4 time that I wasn't in the system, so memos may have been  
5 exchanged that I never got.

6 Q I know, Mr. Schellenberg, and I don't fault you  
7 for not being able to remember things when you weren't  
8 there, I was just hoping to gather some further information  
9 about this idea of workload measures. So let me ask it  
10 this way then, when you returned to the system were you  
11 aware or did you become aware of any workload measures that  
12 were implemented with respect to these case management  
13 standards?

14 A I recall a great deal of discussion about  
15 workload and treasury board submissions and those sorts of  
16 things to, to enhance the system in terms of new staff and  
17 the work, the phraseology of workload measures was bandied  
18 about but I don't recall anything specific that measured  
19 work, that I think you're suggesting, if I might --

20 Q You don't recall that any workload measurement  
21 took place with respect to these case management standards;  
22 is that right?

23 A I don't recall that.

24 Q Okay, thank you.

25 A That's not to say that it didn't happen, I just

1 don't recall it.

2 MS. BOWLEY: Thank you very much. Those are my  
3 questions.

4 THE COMMISSIONER: Thank you, Ms. Bowley.  
5 Mr. Ray?

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

7

8 CROSS-EXAMINATION BY MR. RAY:

9 Q Good evening, Mr. Schellenberg. Ray for the  
10 monitor. I'm counsel for the MGEU and a number of the  
11 social workers that provided services to Phoenix Sinclair.  
12 And thank you for your evidence respecting the status of  
13 the standards. I understand that notwithstanding your good  
14 intentions, that you acknowledge that there was obviously  
15 some confusion respecting the status of the standards of  
16 various times.

17 A That's my understanding.

18 Q And we've heard evidence from social workers,  
19 supervisors, assistant program managers, program managers  
20 and various leaders of the agencies as well as from the  
21 report writers, in particular Mr. Koster, all of whom  
22 either testified or in the case of Mr. Koster, found that  
23 there was a great amount of confusion respecting the status  
24 of the foundational standards, in particular amongst social  
25 workers. You're not in a position obviously to dispute

1 that evidence and in fact, if I understand your evidence,  
2 you'd agree with me that that level of confusion existed?

3 A That's correct.

4 Q And we've also heard evidence with respect to  
5 training on these standards. The clear evidence is that  
6 people did not start receiving training on standards until  
7 after the creation of the 2005 standards and I believe the  
8 evidence is it didn't start until at least until 2006, and  
9 are you in a position to deny or affirm that?

10 A Let me say that the 1988 standards were there to  
11 be read, so everybody could read them. And reading the  
12 standards is a form of training. It's probably not the  
13 best form of training but it is a form of training. There  
14 was also competency based training that was in place in the  
15 1990s. So just to clarify your question, is that where you  
16 wanted this to go in terms of my response or did you have  
17 something more specific?

18 Q My point is with respect to the new 2005  
19 standards --

20 A Yes.

21 Q -- that were created, nobody received training,  
22 standards training on those standards until, until 2006 or  
23 later, correct?

24 A That's correct.

25 Q Okay.

1 THE COMMISSIONER: You're being asked if you know  
2 that.

3 THE WITNESS: I, I believe I know that. I know  
4 that they weren't trained as of January 1st, 2005.

5 MR. RAY: Correct.

6 THE WITNESS: I left in April of 2006 and there  
7 was still lots of discussion about training but nothing  
8 specific apart from the training that was already in place,  
9 around, competency based training was in place around the  
10 new standards.

11

12 BY MR. RAY:

13 Q Correct. And the evidence has been that  
14 respecting core competency training there was no standards  
15 training component of core competency training, you'd agree  
16 with that?

17 A That's right.

18 Q And you'd agree that until that point in time  
19 there was no formal training until 2006. There was no  
20 other formal training respecting core foundational  
21 standards, correct?

22 A That's correct.

23 MR. RAY: Thank you, Mr. Schellenberg. That's  
24 all my questions. Thank you, Mr. Commissioner.

25 THE COMMISSIONER: Thank you, Mr. Ray.

1 Anybody else?

2 All right. Mr. McKinnon?

3 MR. MCKINNON: Nothing more, Mr. Commissioner.

4 Thank you.

5 THE COMMISSIONER: Mr. Olson?

6 MR. OLSON: Nothing more.

7 THE COMMISSIONER: All right. We'll stand  
8 adjourned until 9:30 tomorrow morning.

9 MR. OLSON: Thank you, Mr. Commissioner.

10 THE COMMISSIONER: Thank you very much,  
11 Mr. Schellenberg.

12

13 (WITNESS EXCUSED)

14 (PROCEEDINGS ADJOURNED TO MAY 16, 2013)