The Legacy of Phoenix Sinclair

Achieving the Best for All Our Children

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

Volume 1

December 2013

Phoenix Victoria Hope Sinclair
(2000-2005)

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

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Commission of Inquiry into the Circumstances Surrounding the Death of Phoenix Sinclair

COMMISSIONER: E.N. (TED) HUGHES, OC, QC, LL.D (HON)

December 15th, 2013

The Honourable Andrew Swan
Minister of Justice and Attorney General
Room 104 Legislative Building
450 Broadway
Winnipeg, Manitoba R3C 0V8

Pursuant to the Order In Council of March 23, 2011 and subsequent Orders extending the reporting timeline, I now submit to you my Report containing:

(1) My findings pertaining to the Inquiry into the circumstances surrounding the death of Phoenix Sinclair including:
  (a) the child welfare services provided or not provided to Phoenix Sinclair and her family under The Child and Family Services Act;
  (b) other circumstances, apart from the delivery of child welfare services, directly related to the death of Phoenix Sinclair; and
  (c) why the death of Phoenix Sinclair remained undiscovered for several months.

(2) My recommendations to better protect Manitoba children.

Respectfully,

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

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PREFACE AND ACKNOWLEDGMENT

It was in March of 2011 that Attorney General Andrew Swan invited my participation in this Inquiry as its Commissioner. In the course of my acceptance of that invitation we met in Winnipeg during that month. It seemed reasonable to both of us that the Order In Council establishing the Commission provide for the completion of its work and delivery of my findings and recommendations by March 31, 2012.

That delivery is now made approximately 21 months after the original due date. The Commission first sat in public session on June 28, 2011 and concluded its hearings on July 30, 2013. A reading of the Process chapter will reveal the step-by-step proceedings of the work of the Commission. Before the first witness was called on September 5, 2012, Commission Counsel had interviewed and often re-interviewed 177 potential witnesses. More than 70,000 pages of documents were processed and distributed to the parties participating at the hearing. In total the Commission was in session for 92 days and heard from 126 of the witnesses who had been interviewed by Commission Counsel.

All applicants with a legitimate basis to request standing or intervenor status received a positive response. As the work of the Commission was centered around the death of a little Aboriginal girl, I was alert to the assistance that participants from the Aboriginal community could give. Several of the grants of standing brought that assistance to the table and I am grateful that it was available to me.

Funding of participants was not my responsibility. I do not know the details of funding arrangements made by the Government of Manitoba with participants in the Inquiry. I do know, however, that the funding that was made available allowed for the full participation of those who wanted to be heard and from whom I wanted to hear. Without that contribution it would have been impossible for some to participate. For that I am also grateful, as should be all residents of Manitoba.

I have many to thank for their participation and assistance. At the top of the list is Commission Counsel Sherri Walsh, a partner in the Winnipeg law firm of Hill, Sokalski, Walsh and Trippier LLP and the team of lawyers from that firm who lent their knowledge and expertise to the work of the Commission. The names of the participants to whom I refer, including Senior Associate Commission Counsel Derek Olson, who was so ably at Ms. Walsh's side throughout, are recorded in Appendix 2. The dedication that Ms. Walsh and her team brought to the proceedings and to the report preparation was exceptional in every sense and without their support and constant availability to me, I would not have arrived at this day with the attached document. I thank them all sincerely, especially Ms. Walsh whose commitment and leadership was exemplary.

A report of this magnitude takes organization, planning, and expertise of a very special nature. To edit my work I was fortunate to have Kathleen Keating of Vancouver available to me. She is a colleague of long standing with whom I have worked over the years on many public assignments. She is a professional in every

sense of the word, in the rare combination of law and journalism. The advice and assistance she has given me in the production of this report, with respect to both content and form, has been invaluable. She has worked diligently with Commission Counsel and with me, to put the thoughts and message I want to convey in an organized and readable format. My sincere thanks to her.

My appreciation is also extended to the Administrative staff, who carried out their responsibilities in the Commission office in an organized and efficient manner. Reference to Chief Administrative Officer Marcia Ewatski, and Office Manager Cindy Pearson is made in Appendix 2. Other members of the administrative staff are identified there as well. I thank them all for their cooperation and support, particularly Ms. Ewatski and Ms. Pearson.

Many lawyers participated at the hearings. Those representing parties with standing were present each day. Others made appearances at appropriate times. I thank them all for their participation, contribution, and cooperation. They and their clients are each identified in Appendix 5 to this report.

A hearing room does not run smoothly without an exceptional guiding hand. Fulfilling that role was Diane DeLaRonde, who was made available to the Commission by the Department of Justice. Ms. DeLaRonde has had many years of experience in the administrative side of court proceedings in Manitoba and I am thankful that she so ably fulfilled the role of clerk of proceedings.

Finally I want to make special mention of the participation of the two universities located in Winnipeg, The University of Manitoba and the University of Winnipeg. The former participated with intervenor status and witnesses from its faculty of Social Work, including the Dean, were called to testify. Faculty members from the University of Winnipeg also gave evidence. This participation is an example of the public role that universities can fulfill on relevant public policy matters where they have professional expertise to contribute to the betterment of the communities they serve. I thank them both for coming forward and assisting me as I carried out my assignment.

1 EXECUTIVE SUMMARY

Phoenix Victoria Hope Sinclair was born a healthy baby with a lifetime of possibilities ahead of her. But she entered life in circumstances that were fraught with risk and it was clear from the start that her parents would need significant support if they were to make a safe and nurturing home for her.

Phoenix's parents, Samantha Kematch and Steve Sinclair, were teenagers. They themselves had suffered abuse and neglect as children and had come of age as wards of the child welfare system. Neither had much in the way of a parental role model in their lives. They were Aboriginal; neither had completed high school; they were unemployed and living on social assistance; and both had substance abuse issues. Kematch had already had a baby, when she was 16; he was taken into care and she had shown no interest in him. Neither parent had made any preparation at all for Phoenix's birth, though Sinclair said that on the day she was born he fell in love with her and he chose her name.

This report examines the ways in which Manitoba's child welfare system failed Phoenix and her family, from the day of her birth until she was killed at age five. Years have passed since those events. Lessons have been learned and changes made. This report considers those changes and finds that the child welfare system is on the right path, though it has more distance to cover. But the social and economic conditions that render children vulnerable to abuse and neglect are well beyond the scope of the child welfare system. In particular, the circumstances that bring Aboriginal children to the child welfare system in such high numbers are deeply rooted in this country's history and call out for special attention. This is a responsibility shared by us all.

1.1 PHOENIX AND THE CHILD WELFARE SYSTEM

Throughout her five years, Phoenix was in the care of the child welfare system for the first few months of her life, and again, for a time, at age three. She was shuffled between the homes of Kematch, Sinclair, his sisters, and his friends Kim Edwards and Rohan Stephenson, never attending daycare, nursery school, or any community programs. When Kematch and her new partner, Wesley Mackay, moved her from Winnipeg to Fisher River and then killed her, nobody knew she was missing, except the boy who saw her die.

Meanwhile, at least 13 times throughout her life, Winnipeg Child and Family Services received notice of concerns for Phoenix's safety and well-being from various sources, the last one coming three months before her death. Throughout, files were opened and closed, often without a social worker ever laying eyes on Phoenix.

I recognize that the professional responsibilities of child welfare workers are complex, difficult, and often stressful. They work with vulnerable children and families with daunting problems. They are often unwelcome in the homes of those families, yet their presence there is essential to the discharge of their duties.

Despite these taxing conditions, some good work was done on this file. An example was the case plan prepared by supervisor Andrew Orobko after Phoenix was apprehended at her birth. He met with Phoenix's parents and prepared a case plan calling for ongoing involvement by a social worker, and offering guidance for that worker in providing services and long-term planning for this family. He astutely observed:

> *The assigned worker shall have two primary issues to sort through in the coming months. Firstly, the question of parental motivation and commitment will need to be assessed and weighed on an on-going basis. Secondly, it will be necessary to determine Samantha's parental capacity.*

Though these words were there to be seen each time the file was opened—from May 2000, when they were written, until March 2005 when Phoenix's file was closed for the last time—they were never acted upon.

Phoenix's parents' lack of motivation and commitment was identified repeatedly, yet nothing was done. Kematch's parental capacity was questioned, but never measured. Her "flat affect" and her indifference towards Phoenix were frequently observed, but never addressed. Time and again, the focus was on the short term. A worker would find no immediate safety concerns, the file would be closed, and the agency's involvement would end until the next referral. No consideration was given to the potential long-term harmful effects of leaving Phoenix in the care of parents who had significant unresolved issues of their own.

When Phoenix was a year old, her parents had another baby. Then they separated, and the baby died soon after. Sinclair made efforts to parent Phoenix, but he was struggling with grief and with substance abuse. Phoenix was apprehended from his home, at age three.

Further good work on this file was done by social worker Laura Forrest during this period. She clearly grasped the dynamics of the interaction between this family and the child welfare system when she wrote this caution against returning Phoenix to her parents before they proved their commitment and capacity to care for her:

> *Steven and Samantha have clearly indicated their mistrust and unwillingness to be involved with a child welfare agency however they have not demonstrated a capacity and commitment to ensure their child's wellbeing enough for the agency not to be involved. Unfortunately, because of their past involvement as wards of a child welfare agency they are not receptive to services from the agency and they deny or minimize any issues presented in an effort to keep the agency away from them. They would do anything, or nothing, to keep the agency at bay. It is this worker's opinion that it is this attitude and disregard for the agency that has probably resulted*

in this agency's previous termination of services, and not a lack of child welfare issues.

If one looks back in previous recording the identified and unresolved problems are still very much present in the family's current situation. The problems haven't gone away, and now neither can the agency. The obvious struggle in commitment, questionable parenting capacity, along with an unstable home environment, substance abuse issues, and lack of positive support system all lend to a situation that poses a high level of risk to this child, for maltreatment and / or placement in agency care. Phoenix is in agency care now, and it would probably not be in her best interests to be returned to either parent at this time or until they can show something to indicate that they can and will be more responsible and protective of her.

Despite this warning, and with the issues of motivation, commitment, and parental capacity still unresolved, Phoenix was returned to her father and six weeks later his file was closed. Limited efforts were made to provide the supports he would need to succeed as a father to Phoenix. At times he had nowhere to live. Phoenix was staying with Sinclair's friends, Edwards and Stephenson, who provided a safe and loving home for her during much of her young life. But in the spring of 2004, after she had entered a relationship with McKay, Kematch took Phoenix from their home and placed her on the social assistance budget that she and McKay shared. Edwards and Stephenson never saw Phoenix again. From that day, Phoenix was defenseless against her mother's cruelty and neglect, and the sadistic violence of McKay, whose identity was never researched by the agency but about whom it had ample disturbing information.

By not accessing and acting on the information it had, and by not following the roadmaps offered by clear-thinking workers, the child welfare system failed to protect Phoenix and support her family.

1.2 MISSED OPPORTUNITIES

This report's chronology of child welfare's involvement with Phoenix and her family reveals many instances of such failures, of which these are only examples:

- The family support worker who was placed in the home when Phoenix was returned as a baby in September 2000, should not have been discontinued. Her help was desperately needed, especially when Sinclair found himself the single parent of two babies. Then, after the infant's death, the agency failed to offer him the support services he needed at this stressful time of his life.
- Although it was widely recognized as a requirement, the agency repeatedly failed to make face-to-face contact with Phoenix, or to keep current in its understanding of her home situation. Case plans were prepared but not followed. Files were closed when further investigation was warranted.

- Both parents at times relied on various community-based programs, including the Winnipeg Boys and Girls Club where they found an advocate and mentor, but the child welfare agency failed to capitalize on these connections.
- Sinclair's friends seemed to genuinely care for Phoenix and tried to make a safe home for her, but because the agency did not formalize their arrangement, Phoenix fell into the custody of her mother, whose parenting ability, according to the agency's own information, was questionable at best and disastrous at worst.
- When the agency became aware that Phoenix was in the care of her mother or grandmother, its investigation of a report that 'rock' was being smoked in her presence was inadequate.
- Most significant was the failure to recognize McKay's identity and background. He was Kematch's partner from early 2004 and his violent past would have been revealed by a search of the agency's own files. He was a dangerous man, from whom the agency could have, and should have, saved Phoenix.

These failings were the result of work carried out by social workers who were assigned to files as they were opened. What must be appreciated is that this work was carried out under the guidance of supervisors who oversaw that work and recorded their approval each time a file was closed.

I also note that during the five years of Phoenix's life, 27 workers and supervisors played a role in relation to this family, none of them for long enough to form a relationship with Phoenix or her parents.

The agency's last opportunity to intervene to protect Phoenix came in March 2005 when it received a report that she was being abused by her mother. A file was opened, an investigation done, and the file closed within five days, all without anyone having laid eyes on Phoenix, and despite the history of this dysfunctional family—including details of McKay's violent past—all easily available in the agency's own files to any worker who took the time to look.

1.3 HOW DID THIS TRAGEDY HAPPEN?

How did such a tragedy happen? Various answers were offered. The Department acknowledged that Winnipeg CFS was the responsible agency and that the evidence demonstrated failure by that agency in the delivery of services to Phoenix and her family. What went wrong, it submitted, was that workers and supervisors did not ask the right questions, and focused solely on immediate safety concerns rather than on long-term risks to Phoenix's safety and well-being.

I agree. But even when the agency asked the right questions and did an appropriate assessment, it failed to follow through on providing the services that it had identified as necessary.

On behalf of individual workers and supervisors I was pointed to systemic failings including excessive workload, lack of staff training, and confusion about standards.

I agree that the evidence disclosed a child welfare system challenged by heavy workloads, and staff whose training and knowledge of standards was limited. These were failures by the organization to meet best practices.

But I do not find evidence that these organizational challenges had a direct impact on the services that were, or were not, delivered to Phoenix and her family.

I believe that the social workers who testified at this Inquiry wanted to do their best for the children and families they served, and that they wanted to protect children, but their actions and resulting failures so often did not reflect those good intentions.

What was missing was a fundamental understanding by staff of the mandate of the child welfare system and of their own role in fulfilling that mandate. For the most part, workers and supervisors lacked an awareness of the reasons why families come into contact with the child welfare system and of the steps they needed to take to support those families. The focus on short-term safety concerns to the exclusion of long-term risk is an example of this lack of understanding.

From the day of her birth, the signs were clear that Phoenix and her parents would need intensive long-term support. It was up to the system to identify their needs and strengths and provide the services necessary to protect Phoenix and support her family.

A number of witnesses testified that at the time, there was nothing extraordinary about this file. I appreciate that a great many of the families they deal with are struggling with poverty, addictions, and with their own troubled histories. But if these issues are common among families who come in contact with the system, they must be understood as needing attention.

Child welfare workers cannot be expected to solve the problems of poverty and other social and economic conditions, but they can be expected to identify how these affect the families they work with, and to take what steps are available. For example, Phoenix's father wanted to find daycare for her and work for himself. It was known that he needed help with substance abuse. Sadly, throughout the five years the agency was involved with this family, it never made an attempt to provide these practical supports.

Responsibility to protect children is a shared responsibility—shared within the agency and child welfare system itself, and with other arms of government and with the community as a whole. I will return to this subject in a moment.

For now, I address the question: how did Phoenix's death go undiscovered for so long?

The only witness to the killing was McKay's 12-year-old son who, understandably, feared for his own safety. When Kematch and McKay told anyone who asked that Phoenix had gone to live with her father, they were believed. Being not yet school age and not enrolled in nursery school or daycare, or any programs of any kind, Phoenix didn't have a profile in the community and had no other adults who might come looking for her.

When a relative did go looking it was too late, but her phone calls to child welfare agencies might have led to an earlier discovery of the death, had her calls been considered in the context of this family's child welfare history and its serious unresolved issues. Ultimately, the young boy did come forward. Otherwise, the circumstances of Phoenix's death might never have been known.

1.4 HAS WHAT WENT WRONG BEEN FIXED?

Having identified the failings in the services that were delivered to Phoenix and her family, and having considered the reasons for them, I considered this question: "Has what went wrong, been fixed?"

A major response to this tragedy has been the adoption by the child welfare system of a new practice model. Called a differential response model, it aims to identify families that need help in the early stages, before children come to harm; assess their needs and their strengths; and provide the services that will enable them to keep their children safe at home.

This approach depends on skilled social workers who can spend the time to develop a relationship with the family. A set of assessment tools is designed to guide the worker through the process of gathering the information that evidence has proved to be critical to the decisions that need to be made. The standardized risk assessment tool now in use by all four child welfare Authorities requires a worker to thoroughly check the family's history. When the form is completed, it automatically generates a preliminary calculation of the risk level, which may be adjusted upwards by the worker, but not down.

This new practice model provides much more thorough, ongoing assessments of safety and risk, and of strengths and needs. It also promotes better engagement with families by social workers who build working relationships based on trust.

Once assessments are made, however, the next step is to provide the services and supports that those assessments indicate are needed. That is what I find missing. Winnipeg CFS developed a hypothetical scenario to explain how the agency would have responded to Phoenix and her family according to today's practice and training. But neither in the evidence as a whole nor in the hypothetical scenario, is there mention of the services the agency would have delivered, once risks and needs had been assessed.

For example, when the decision was made to return three-year-old Phoenix to Sinclair's care, the agency says that—by today's standards—there would have been a clear case plan indicating what Sinclair was to work on, and requiring that he demonstrate behavioural change before he would be considered ready to resume care of Phoenix. I was disappointed to see no mention of what services and supports would be provided to help him address his issues of substance abuse and his own childhood trauma; his unemployment; and his lack of parenting skills and experience. Nor was there a suggestion of involvement of the community-based agencies with which Sinclair had been connected.

One of the practical services that was extended to Phoenix's family early on, was a family support worker who visited the home twice a week. She had a dual role, both teaching Phoenix's mother and father the basic skills they needed as parents, and also making observations so that if there were any concerns for Phoenix's safety she could alert the responsible social worker. Phoenix's parents accepted her help and seemed glad to have it. Inexplicably, that service was discontinued while it was still needed.

The services of a family support worker are purchased from the $1,300 fund that is now available to the agency for each family each year, for what are termed family enhancement services. This sum is meant to cover the whole range of services a family may need beyond the involvement of the social worker, from bus passes for getting children to medical appointments, to therapy or summer camp for children. For many families, the amount is simply not sufficient.

Most of the services that Phoenix and her family received were delivered at an intake stage, with the file never being transferred for ongoing services. Those intake services are now delivered in Winnipeg by All Nations Coordinated Response Network (ANCR). Executive Director Sandra Stoker testified about innovations at that agency that would have made a difference in Phoenix's case.

There is a new computer application for logging referrals. One of its features is an automatic "prior contact check," activated when a new person is added to a file. For example, if a worker had added Mackay's name to Phoenix's file, the history of his prior involvement with the child welfare system would have immediately appeared on the screen. Another feature is a built-in safety assessment tool that poses a set of questions. A single affirmative answer requires the worker to outline the steps taken to ensure the child's safety.

A province-wide standard for face-to-face contact has been established, the Commission learned. Whenever there is an allegation of abuse or neglect, a worker must see all children in the household and if possible, interview them in a safe environment. The worker must also see the primary caregiver in the home and must see and interview the person who is reported to have caused the child to be in need of protection. There were many instances where a worker should have seen Phoenix and spent time with her, out of the presence of her mother.

Private arrangements are no longer entered into so casually. For example, when Sinclair arranged to have his friends care for Phoenix, there was nothing to prevent Kematch from taking her from their home. Private arrangements can be good for a child if it means staying in a familiar home. But now, such arrangements can be considered as an alternative to apprehension only in situations of low to medium risk, and with safeguards. Importantly, the file may not be closed as long as the private arrangement is in place.

Record keeping is much improved, the Commission was told, both in terms of the records made, and how they are kept. Training is approached in a more thorough and systematic manner.

These are all positive changes, and I accept that improvements to the system should result in better services, but the real issue in this case was one of compliance. Deficiencies in the delivery of services to Phoenix did not result from a lack of understanding of policies, procedures and provincial standards, or from confusion about which standards applied. Rather, they resulted from a lack of compliance with existing policies and best practice.

Another cause for concern is the evidence I heard that in 2012, ANCR apprehended 660 children, compared with 550 the year before. This increase was attributed to better risk assessments, and increases in hard drug abuse, domestic violence, gang-related violence, and mental health issues for both caregivers and children. Whatever the reasons may turn out to be, this apparent upward trend in apprehensions at ANCR should be closely monitored, with attention paid to what impact, if any, is being registered as a result of the innovations that have been undertaken.

The General Authority is the child welfare Authority under which the Winnipeg Child and Family Services operates. It took the position that what went wrong has been fixed, while acknowledging that more work remains. I heard of improved risk assessments; better file recording practices; more engagement of workers with families; improvements to training; and efforts to reduce caseloads and add resources to the system. It is acknowledged that caseloads need to be further reduced, because safety and well-being of children is enhanced when workers are able to work intensively with families.

Workload has been an area of continuing concern. Current resources, it seems clear, do not allow for caseload ratios that have been agreed are necessary to deliver the family enhancement services that are called for under the differential response model of service delivery.

General Authority CEO Jay Rodgers speaks positively about the potential for primary prevention through integration of systems working together to battle the chronic problems that bring families into contact with the child welfare system in the first place. I agree that improvements have responded to the recommendations set out in the 2006 reviews of the services delivered to Phoenix and her family. I remain convinced, however, that while there has been a good start, more must be done to better protect Manitoba children.

This means compliance by all child welfare workers with best practices; it means effective training and supervision; and it means partnerships with other government departments and with community-based organizations that have been mentioned.

I find that the Department and the Authorities have made improvements towards ensuring compliance with best practices. Standards and policies have been clarified. Improvements have been made to training. New tools and strategies have been devised and are in the process of being implemented. It is still early with respect to assessing many of these improvements, not all of which have been implemented to their full extent across all Authorities.

I acknowledge the significant increase in resources injected into the system since 2006, and appreciate the funding challenges that Manitoba will continue to face as it pursues its commitment to achieve positive outcomes for children. This is particularly so, in light of increasingly complex needs experienced by families.

Organizational support offered to workers through professional development, regular and constructive supervision, and a manageable workload will have a positive impact on quality of service and will contribute to maintaining a stable workforce, with clear benefits for families and children.

Over the long term, prevention strategies, the use of other resources such as family support workers, and participation by other governmental and community agencies and organizations will reduce the burden on the child welfare system.

In the interim, it is imperative that agencies have the necessary resources to deliver effective services to protect children and support their families. At the end of each workday, each child welfare worker must be able to answer affirmatively these questions posed by former Children's Advocate Billie Schibler:

> *As a worker within the system, as a service provider, do I feel confident with the work that I did today and would I feel confident having received services from the system that I work for?*

More remains to be done, but the improvements to the system about which I heard, and the further changes recommended by this report should go a long way towards enhancing the ability of child welfare staff to comply with best practices in delivering their services to children and families, so that each one, each day, can answer that question affirmatively.

1.5 ABORIGINAL CHILDREN

The fact that Phoenix was Aboriginal is not irrelevant to this Inquiry. More than 80% of Manitoba children in care are Aboriginal. The picture is similar across Canada, and the numbers are growing. There isn't much difference in the rates of serious abuse among Aboriginal and non-Aboriginal families but the substantiated reports of neglect are many times higher, the Commission learned.

Cross-Canada research shows that Aboriginal children are taken from their homes in far greater numbers, not because they are Aboriginal, but because they are living in far worse circumstances than other children. They are poor because their parents are poor. They live in substandard housing; their parents are struggling with addictions; and they don't have the family and other supports they need.

The reasons for these conditions that afflict so many Aboriginal families, witnesses told the Commission, are rooted in the legacy of colonialization and residential schools, the conditions on reserves, cultural dislocation and loss of identity.

And poverty becomes entrenched: when a child grows up knowing no one who has finished school or held a steady job, it's difficult to envision another kind of life.

These are large challenges, beyond the reach of the child welfare system. The responsibility to keep children safe cannot be borne by any single arm of government, or even by a single government. It's a responsibility that belongs to the entire community.

It is also a problem that extends beyond the boundaries of Manitoba. It is a serious national problem and it needs to be tackled at a national level. For that reason I am recommending that the Premier take this issue to the next meeting of the Council of the Federation and that he take the lead in urging his colleagues from the Provinces and Territories in a national dialogue to find solutions.

1.6 A SHARED RESPONSIBILITY

The root causes of neglect—including poverty, poor housing, food insecurity, and substance abuse—lie beyond the scope of the child welfare system to resolve. But a collaborative approach, working with parents and harnessing the collective resources of child welfare and other provincial government departments, other levels of government, and the province's many community-based organizations, can make a difference for vulnerable families.

The first principle of *the Child and Family Services Act* is this:

> *"The safety, security and well-being of children and their best interests are fundamental responsibilities of society."*

We all must play our part.

In Phases One and Two of the Inquiry the Commission heard repeatedly that mistrust of the child welfare system is a barrier that prevents many families from engaging with that system in a productive way. In Phases Two and Three I learned of the valuable role played by community-based organizations that are trusted by families and can contribute to efforts to prevent child maltreatment.

These lessons were certainly borne out in the case of Phoenix and her family. Kematch and Sinclair had their own histories with child welfare that had left them ill-disposed to welcoming the system back into their lives, now that they were parents. The fact that their assigned social workers constantly changed and they had little face-to-face contact with any of them, did little to alter that fact.

On the other hand, they willingly involved themselves with organizations in their community, and one in particular—the Winnipeg Boys and Girls Club. It was at this organization's Aberdeen drop-in centre where Sinclair and Kematch connected with supervisor Nikki Humenchuk before Phoenix was born. They dropped in several times a week and came to trust and rely on her. When Phoenix was born and they learned she would be apprehended, they turned to her for advice and support because, as Sinclair said, "she was already in our lives."

This person had more opportunities than did any agency social worker to observe the two as individuals and as a couple, and to assess their capacities and limitations. I note that she was one of the few professionals involved with the couple who were able to testify about them from memory.

The involvement of that club, and Humenchuk in particular, with these young parents is commendable. *The Child and Family Services Act* recognizes the importance of promoting the family's capacity to care for its children. The services offered by community-based organizations, such as the Boys and Girls Club and others, can play a pivotal role in achieving that goal. Immediately after Phoenix's birth, one CFS worker was ready to involve Humenchuk in the plan to reunite the family, but the agency never took advantage of services that could have been offered by any of the community-based organizations with which the couple was involved.

Communication and collaboration between the agency and these organizations might have led to enrolment in a daycare program for Phoenix. Sinclair could have been supported in his wish to find employment and he could have been helped to overcome his substance abuse issues so that he might have been the father to Phoenix that he wanted to be. These were missed opportunities to make a substantial difference in Phoenix's life.

1.7 PREVENTION IS THE FIRST STEP IN PROTECTION

Historically, the child welfare system has focused on investigating and then addressing parental shortcomings or misconduct, with little emphasis on prevention. In Phase Two of this Inquiry I learned that the child welfare system has acknowledged that attention to prevention and building on a family's strengths will better protect children.

There are good reasons to look to what has been termed a "public health" approach to protect and enhance the well-being of all children. First, it is not sustainable to keep bringing more and more children into care, needing safe and nurturing alternative homes. And second, because child maltreatment is often unreported and unnoticed, only a universal approach can ensure that supports are provided to all who need them.

It follows that we need to look to an approach to prevention that will offer protection to all children and reduce the need to remove children from their homes by decreasing the risks that maltreatment will occur or reoccur.

Just as we extend medical care and public education to everyone, we should be offering universal services that will enhance outcomes for all children and reduce the risk of children needing to be taken into care, the Commission heard. Examples include quality low-cost childcare and other early learning environments.

Other prevention strategies need to focus on particular vulnerabilities: programs for youth with substance abuse issues, or for women who are at risk of a pregnancy affected by alcohol are examples.

1.8 RECOGNIZING CHILDREN'S RIGHTS

An analysis based on internationally recognized rights of the child provides another way of looking at prevention of harm to children.

The Universal Declaration of Human Rights declares that childhood is entitled to special care and assistance. The United Nations Convention on the Rights of the Child, ratified by Canada in 1991, recognizes that children have rights of their own.

It was suggested to the Commission that the Convention can be seen as supporting a public health response to child welfare by providing a legal instrument for implementing policy, accountability, and social justice. A witness emphasized that by virtue of the Convention, our moral obligation as a nation to protect children now is also a legal obligation.

1.9 EARLY INTERVENTION IS KEY

I heard throughout the Inquiry, and particularly in Phase Three, that early intervention offers the best chance of protecting vulnerable children. I heard evidence about early childhood as a period of both opportunity and vulnerability, with big payoffs for wise investment of resources at this stage.

I learned of the importance of integrating the delivery of services beginning with the prenatal period through to school age, in neighborhood centres where all families feel welcome. These can be housed in schools, or in other community facilities. The important thing is that they would give young children and their families a safe place where they feel they belong, and where they know they can gain access to the services they need.

These centres would provide not only childcare and early learning opportunities, but a range of services that families now have to seek out in various locations. For example, providing the services of a pediatrician on site at a centre where families already gather is more effective and efficient than requiring each family to find transportation to visit a doctor elsewhere.

Parents can find respite from the difficult job of parenting, and take the opportunity while their children are being cared for, to address their own issues such as unemployment, or participate in programs to improve their parenting skills. They can make friends. As one witness put it, such centres promote social cohesion and break through the social isolation that so many families experience, and which is a breeding ground for neglect, abuse, and violence.

The Commission was told of persuasive research showing that all children from the age of two should have access to good quality early childhood education, based on social, scientific, and economic rationales. I heard ample evidence throughout the Inquiry that the period from birth to school age is a period of particular vulnerability because these children often are unseen in the community. Early childhood centres that offer a range of services have been shown to reduce the need to remove children from their homes, the Commission was told, because daily attendance at a centre allows for regular monitoring of young children.

An integrated early childhood program is already being piloted in Manitoba: the Lord Selkirk Park Childcare Centre. This is a facility for 47 children beginning in infancy. The community where these children live is known for a high crime rate. Most families are on social assistance and most are Aboriginal. The Centre's program was developed in consultation with, and is funded by, Healthy Child Manitoba, to meet the early education needs of children living in poverty. Higher-than-average staff-to-child ratios allow for more adult-child interactions, and children are given healthy snacks and a hot lunch. The facility also serves as a drop-in centre for families. Importantly, a home visitor works closely with the 19 families whose children attend the Centre. Many of these families are involved with the child welfare system. The outreach worker sees parents every day when they drop off and pick up their children, and she meets with them at home at least weekly. She helps them problem-solve; she advocates for them, and helps them navigate through their crises, the Commission was told.

1.10 PARTNERSHIPS

Integrated service delivery centres as described above require a network of partnerships of entities both inside and outside government. The Government of Manitoba has already recognized that no single government department or service can successfully promote the well-being of children and youth, nor can government be successful without community participation. *The Healthy Child Manitoba Act* is government's long-term, cross-departmental prevention strategy with an emphasis on early childhood development.

I find the evidence in favour of a rights-based approach to child well-being compelling, and *The Healthy Child Act* is a step in the right direction. It provides for collaboration among government departments and between government and the community. But what is needed is a legislative framework that protects children's rights and that can be used as a benchmark for evaluating any public policy, legislation, or program that affects the well being of children.

Canada and Manitoba have long accepted education and health care as universal rights. This new approach would also recognize children's rights to quality care in the pre-school years and access to resources and services that will give them their best chance to succeed in life.

This new approach means tackling the root causes that put children at risk, before they come to harm. It means creating networks of government departments and programs, and harnessing the wisdom, capacity, and energy of community-based organizations, to provide a coordinated response to the needs shared by all children and families, as well as to the particular needs of vulnerable populations. It means building on the strengths of children and families and collaborating among partners for better results.

Winnipeg has a network of well-established community-based organizations that have earned the trust of their clients, often by providing for their most basic needs, such as access to telephones or laundry. Gradually, relationships are built and clients may eventually participate in programs such as violence prevention, employment readiness, or any of a wide array that are made available as needs arise. Many of these organizations are Aboriginal-led and many recruit their staff and volunteers from their communities.

Their challenge, often, is funding. Even if they are successful in procuring the resources they need from year to year, their situations are precarious and too much time and energy is diverted from their important work. Also, there is no coordination among various government departments that fund many of these programs, so there is no way to ensure against gaps in service.

These organizations are effective vehicles for delivering early intervention services to families and children. They can be valuable partners with the child welfare system in the delivery of family enhancement services; and in some cases they can be the setting for integrated early childhood centres described above.

What is needed is a legislated body to coordinate government funding to these organizations, so it is directed where it can do the most good, and organizations can put their energies into their work.

The ability of community-based organizations to build trusting relationships with the families they support is invaluable in the protection of children in the broadest sense, and they deserve to be supported.

I have emphasized here the importance of early intervention with young children. But older children cannot be forgotten. About 500 Manitoba children each year become of age while in the care of the child welfare system. Sinclair and Kematch were among them. The very reasons why these children were in care can leave them poorly prepared for this new stage in their lives, and yet the child welfare system has limited ability to extend services to youths beyond age 18. The consequences are severe, both for the young people themselves, and for society, in terms of unemployment, criminal activity, and often the continuation of a cycle that was described by one witness:

> *So it almost is this vicious cycle that those kids who were born to teen moms, or those kids who live in extreme poverty, or those kids involved in child welfare services, go on to be more likely to be on income assistance themselves, they're more likely to be young parents themselves, and the whole cycle starts again because then their children are experiencing those same risks.*

These young people should be supported by Child and Family Services, other government departments, and community-based organizations for a successful transition into early adulthood.

1.11 ACTING ON WHAT WE KNOW

Everything we know tells us that from the moment of her birth, Phoenix was at high risk for maltreatment. The child welfare system knew it too, and apprehended her immediately. Unfortunately, the system failed to act on what it knew, with tragic results.

The same gap between knowledge and action can be seen in our response as a society to the needs of families and young children. We know the factors that can lead to abuse and neglect of children and we heard over and over that there are many children in circumstances no better than Phoenix was. And yet, so far we have failed to take the steps necessary to fully protect our children.

What is needed is a coherent and collaborative approach to supporting families and preventing maltreatment of children before they ever come into contact with child welfare.

This means intervening in children's lives early, and making programs available to all children, to give them the best start in life. These programs need to be offered from centres based in schools or other community facilities, to help children and parents receive the services they need.

Many steps have been taken in the right direction, Healthy Child Manitoba being one, and it seems that Manitoba is well placed to continue the journey. A report presented to the Commission says:

> *Nationally and internationally, Manitoba is recognized as being unique in its scientific and intersectoral policy potential to close the gap between what we know and what we do in the everyday lives of children and families. This is the potential to "give every child the best start in life," to address and redress inequalities in children's developmental opportunities, reduce inequities in their developmental outcomes, and "close the gap in a generation."*

New approaches are being taken in the child welfare system, emphasizing the importance of prevention. Many community-based organizations provide critical services to vulnerable individuals and families. Steps are being taken within government to bring sectors together. A great deal of money is being spent to finance programs and services both inside and outside government. What is needed now is a major collaborative effort to harness the resources, expertise, and wisdom of all of these sectors, to optimize results for children.

The benefits of full integration of services for children and families were described in a 2009 report prepared for a committee established by the Child and Family Services Standing Committee. The report finds:

> *The arguments for full system integration for children are profound, not only in terms of human rights principles of fairness and equity, but also in the potential economic gain for society. . . . A society that envelopes its children in an integrated system that leaves no room for the most vulnerable to fall through the cracks will ensure a stronger and healthier society in the future."*

Full integration has not yet been achieved in Manitoba, but progress has been made since that paper was prepared in 2009, and this remains a Provincial goal, the Commission learned. But integration will only be as successful as the components of the system. The evidence of expert witnesses reinforces the need for ongoing research and evaluation.

Strong leadership will be needed, to effect a shift in culture and in our perspective on the way to best fulfill our moral and legal obligations to our children.

Even strong leadership, however, needs broad public support. This is what creates and bolsters political will and drives change. It can be much easier to arouse public outrage in the wake of the death of a child than to stimulate public demand for significant and long-term reform aimed at prevention.

A witness elaborated on our shared responsibility to protect children:

> *. . . the question as to who is in charge necessarily I think has to fall back to each of us in terms of what do we expect from our governments and our public institutions and our community agencies. And more importantly, what do we expect from ourselves in the roles that each of us have, day to day, in the lives of children. And once we are able to do those things, I think you'll see the kinds of outcomes that we all aspire to.*

The director of an Aboriginal-led community-based organization urged us to act now:

> *I think we, we need to take those brave steps now because we don't want to be back here in 20 years, [saying] "There's 20,000 Aboriginal children in the child welfare system," and we're still asking "What the heck is going on?" I can—I am here to say that we believe that, that the answers are within our collective, and they have to be within our collective if we're going to change the dynamic and the relationship that, that, that has caused this in the first place. You can't fix a vehicle that's broken by putting another broken wheel on it; it's just not going to happen.*

It is not possible to entirely prevent violent acts against children. But the conditions that put Phoenix at risk the day she was born are within our power to address, and it is our collective responsibility to do so.

Protection of Manitoba children will take a concerted and collaborative effort and true commitment from the child welfare system, other government departments, community-based organizations, and the general public.

Despite all the steps that have already been taken in Manitoba, the number of children coming into the child welfare system, particularly Aboriginal children, continues to rise.

To truly honour Phoenix, we need to provide all of Manitoba's children with a good start start in life, and offer to the most vulnerable an escape from the cycle of poverty and vulnerability that trapped Phoenix and her family.

My hope is that the heart wrenching evidence I heard in Phase One of this inquiry will serve as a catalyst to ensure that the recommendations that emerge from this report are wholeheartedly embraced and implemented. The protection of children is a shared value of the whole community. The public interest that this Inquiry has received encourages me in the belief that achievement of the better protection of all Manitoba's children, and especially the most vulnerable, will be the true legacy of Phoenix Sinclair.

RECOMMENDATIONS SUMMARY

1. **Recommendation:** That the Province and the four child welfare Authorities, who are responsible for the delivery of child welfare services, adhere to the following principles:

    a) The key to supporting families and protecting children is offering early intervention through both universal and targeted services, to prevent the vulnerability that leads to contact with the child welfare system.

    b) Child welfare services are provided on a continuum, focusing on protection in the face of an immediate threat to a child's safety but almost always working with a family enhancement approach to keep children safe at home.

    c) Once a family comes to the attention of the child welfare system, the children's safety and well-being must be assessed; this means assessing both immediate and long-term risk of harm, including chronic neglect, and it requires face-to-face contact.

    d) Assessment tools must be used as an aid to, and not as a substitute for, the exercise of a worker's clinical judgment.

    e) Assessment tools must be used in a way that takes into account a family's cultural, social, and economic circumstances.

    f) After an assessment of the child's safety and well-being, and of the family's strengths and needs, the necessary and appropriate services, as determined by the assessment, must be available.

    g) When a child has been found to be in need of protection, the goal of the child welfare system is to prevent recurrence of maltreatment and resulting impairment. This should be done by child welfare agencies acting on their own or in partnership with community-based organizations and other government departments.

    h) The goal of the child welfare system is to keep as many children safe at home as is possible.

    Reason: These principles promote the protection of children, their safety and well-being, within the context of the differential response practice model that has been adopted by Manitoba's child welfare system. They start by recognizing that children are best protected when they and their families receive services that prevent their vulnerability to coming into contact with the child welfare system.

2. **Recommendation:** That the Province ensure that the family enhancement services required to support the differential response practice model are developed, coordinated, and made accessible, through partnerships and collaboration among the child welfare system and other departments, and community-based organizations.

Reason: The differential response model holds great promise for the better protection of children, but its success will depend on the availability of services, once the assessment tools have identified a family's needs.

3. **Recommendation:** That All Nations Coordinated Response Network (ANCR)—whose role is triage and delivery of short-term services—no longer provide family enhancement services but should transfer families who need those services to a family services unit as soon as possible.

   Reason: This will avoid disruptions in service for families whose needs cannot be effectively met within ANCR's limited time frame.

4. **Recommendation:** That every effort be made to provide continuity of service by ensuring that, to the extent reasonably possible, the same worker provides services to a family throughout its involvement with the child welfare system.

   Reason: Switching workers unnecessarily can interfere with the building of trusting relationships between family and worker.

5. **Recommendation:** That when responsibility for delivering services to a family is transferred from one worker to another, those workers communicate orally with each other, to the extent possible, and either record the conversation in the file, or document the reason why a conversation was not possible.

   Reason: When it is necessary to change workers, the quality of information shared about the family is usually enhanced in a personal conversation, rather than in writing; recording the conversation allows for accountability and continuity of service.

6. **Recommendation:** That agencies strive for greater transparency and information sharing with caregivers, which may require changes to legislation.

   Reason: Building trust between a worker and a family is imperative to provision of effective family enhancement services.

7. **Recommendation:** That the Authorities enhance availability of voluntary early intervention services by placing workers in schools, community centres, housing developments, and any other community facilities where they would be easily accessible.

   Reason: These workers will raise the profile of the agency and build trust within the community, gain an understanding of the community's needs, and increase accessibility of voluntary supports and resources to individuals and groups, for the better prevention of child maltreatment.

8. **Recommendation:** That all child welfare workers who are expected to make use of the SDM assessment tools be trained on their proper use without delay.

   Reason: These new tools are essential to the new practice model, but they require specialized training if they are to be used effectively for the protection of children.

9. **Recommendation:** That *The Child and Family Services Act, Personal Health Information Act, Freedom of Information and Protection of Privacy Act* and any other legislation as may be necessary be amended to allow service providers to share relevant information with each other and with parents (or caregivers) when necessary for the protection, safety, or best interests of a child.

   Reason: Protection of children sometimes requires that information be shared among service providers such as police, social workers, educators and health professionals.

10. **Recommendation:** That the Standing Committee discuss as a regular agenda item, the programs and policies being implemented by each Authority to determine those that can be adapted more broadly, in a culturally appropriate manner.

    Reason: This will further the purpose of the committee, which was created under *The Authorities Act* to ensure consistency of services across the province.

11. **Recommendation:** That the Standing Committee issue annual reports of its work to the Minister for tabling in the legislature and for concurrent release to the public.

    Reason: This will better inform the public about the workings of the child welfare system in Manitoba.

12. **Recommendation:** That all ongoing services to families should be delivered on the basis of 20 cases per worker.

    Reason: This ratio has been agreed to for family enhancement services and the family enhancement approach should be embedded in all ongoing services to families. Over time, greater investment in family enhancement services will lead to a reduction in demands for protection services.

13. **Recommendation:** That the Authorities and agencies explore ways to reduce administrative burdens on social workers through the better use of technology and administrative staff.

    Reason: Professional social workers are a valuable and scarce resource; they require appropriate tools and support to make most effective use of their time and their skills.

14. **Recommendation:** That each Authority designate staff who are available both during the day and after hours, to support the work of social workers by locating individuals through investigative means, and serving court documents as necessary.

    Reason: These staff members will allow for more efficient use of the time of social workers, and can be used to serve court documents where that could interfere with the relationship between social worker and family.

15. **Recommendation:** That CFS supervisors, social workers, and family support workers be required to keep complete and accurate records of all involvement with children and families, including records of all services they deliver, copies of any communications related to their involvement, and notes related to all contacts.

    Reason: Effective quality assurance and supervision requires that a complete record be kept of all work done on a file.

16. **Recommendation:** That when an agency engages a consultant, such as a medical professional, in the course of delivering services to a family, it must obtain a written report from the consultant and retain it in the relevant file.

    Reason: To ensure quality of service and continuity of care, it is important to have a comprehensive record of the advice received.

17. **Recommendation:** That ANCR and all designated intake agencies throughout the province ensure that records are made and retained with respect to every telephone call received by the agency, regardless of whether a file is already open.

    Reason: The potential relevance of a call to a child welfare matter is not always apparent at the time of the call; a complete record of calls received is essential for the protection of children.

18. **Recommendation:** That an appropriate policy be developed by the Authorities to govern the retention of records made by agency personnel.

    Reason: Many files are opened and closed over extended periods of time; continuity of service and the protection of children requires that all records be available whenever the family comes to the attention of an agency.

19. **Recommendation:** That the Authorities each develop and implement a supervision policy including provisions that:

    a) articulate that the primary function of supervision is to ensure compliance with best practice;

    b) require that supervisors prepare written reports of supervision meetings with workers, with copies retained in the appropriate case file;

c) stipulate that before approving the transfer or closing of a file, the supervisor must document the reason for approving the decision;

d) require annual performance reviews to be conducted by a worker's direct supervisor using an objective set of articulated criteria, developed in consultation with agency staff.

Reason: The responsibility for decision-making about delivery of services to children and families is shared between supervisors and workers. These recommendations are aimed at quality assurance, accountability and compliance.

20. **Recommendation:** That the Authorities each perform and publish annual composite reviews of the well-being of children who are receiving services from their agencies, or have received services within the past 12 months, whether in or out of care.

    Reason: These annual reports will enhance accountability and quality assurance and will help to instill public confidence in the workings of the child welfare system while providing the Authorities with valuable information about the effectiveness of their services. With all the Authorities now using electronic tools to collect information about children, this is not an onerous requirement.

21. **Recommendation:** That the Department complete its solution-scoping phase for the replacement of CFSIS within the current fiscal year and proceed with implementation without delay.

22. **Recommendation:** That the new information management system be capable of:

    a) interfacing with other government systems including Employment Insurance, Education, and Health;

    b) keeping track of all children receiving protection services, as well all children in care;

    c) using alert features to flag those known by the system to pose a significant risk to children; and,

    d) efficient file recording, for example through the use of electronic dictation equipment and voice recognition, or direct entry using a computer, tablet, or other portable device.

    Reason: Protection of children requires a reliable and up-to-date information management system that tracks not only children in care, but all children receiving protection services; provides comprehensive information about individuals in the system; and allows access to relevant data from other government systems. A new information system will improve the efficiency and effectiveness of workers by providing accurate information, and will reduce administrative workload. It will also allow the

Authorities to compile statistical information, which can be used to measure outcomes for children and families.

23. **Recommendation:** All agencies must be required to use whatever information system is adopted.

    Reason: Families are mobile and unless all agencies are using the same information system, there may be gaps in information that can leave children vulnerable.

24. **Recommendation:** The Department must ensure that all agencies have access to its information system, either through direct connectivity, or where that is not possible, through alternative means such as telephone access to an agency that has that capability.

    Reason: All agencies require immediate access to all available information, if children are to be protected. I recognize that in some remote communities reliable connectivity may be a challenge.

25. **Recommendation:** That the Authorities be funded to a level that supports the differential response approach, including:

    a) Funding to allow agencies to meet the caseload ratio of 20 cases per worker for all family services workers;

    b) Increasing the $1,300 fund for family enhancement services to a reasonable level, especially for families who are particularly vulnerable, many of whom are Aboriginal;

    c) Determination of the amount of necessary funding after meaningful consultation between agencies and the Authorities, and between the Authorities and government, after agencies have reasonably assessed their needs.

    Reason: If the new differential response practice model is to achieve its goal, the agencies must have adequate staff and resources:

    - The funding model's caseload ratios should no longer be based on an artificial distinction between protection and prevention services. Family enhancement is an approach that should be embedded in all ongoing services. The cost of keeping children safe at home is far less than the cost of maintaining children in care; directing resources towards prevention and family enhancement will reduce the high number of Manitoba children currently in care.
    - Many families have complex needs and require considerably more services than can be purchased within the current limit of $1,300 if they are to be supported so that their children can be kept safe at home

- Funding decisions must take into account the complexity of some families' needs, and the added cost of providing services to particularly vulnerable families, many of whom are Aboriginal.

26. **Recommendation:** That a Bachelor of Social Work or equivalent degree, as recognized by the proposed Manitoba College of Social Workers, be required of all social workers hired by agencies to deliver services under the *Act*.

    Reason: Child welfare workers do complex, demanding work that requires a high level of knowledge, skills, and analytical abilities.

27. **Recommendation:** That a concerted effort be made to encourage Aboriginal people to enter the social work profession, by promoting social work as a career choice and supporting educational institutions in removing barriers to education through access programs and other initiatives.

    Reason: The child welfare system, which serves an overwhelmingly Aboriginal population, needs the unique insights and perspectives that Aboriginal social workers can bring to their practice.

28. **Recommendation:** That the four Authorities share information about their training programs, and share materials so that successful training tools, techniques, and programs can be adapted and implemented more broadly.

    Reason: Sharing of high-quality materials developed by an Authority will promote consistency of training across the province.

29. **Recommendation:** That workers be specifically trained on the multi-generational impacts of residential schools and on the role of poverty, poor housing, substance abuse and other social and economic factors in assessments of child neglect.

    Reason: Child welfare workers cannot adequately support families to protect their children unless they understand the underlying causes of the conditions that can lead to maltreatment.

30. **Recommendation:** That the Director share with the relevant Authority the findings and recommendations of the report of any investigation with respect to the welfare of any child dealt with under section 4(2)(c) of *The Child and Family Services Act* and that the Authority share those with agencies, to be shared with staff.

    Reason: These reports contain important information that can be used to improve child welfare services, promote best practice, acknowledge and encourage excellence in service, and provide ongoing learning opportunities for staff.

31. **Recommendation:** That all four Authorities ensure that the findings and recommendations in this report are shared and discussed with all child welfare staff and management.

Reason: This will improve child welfare services, promote best practice and provide ongoing learning opportunities for staff.

32. **Recommendation:** That the transitional board established under s. 77 of *The Social Work Profession Act* complete its work and report to the Minister by no later than June 30, 2014.

    Reason: Mandatory registration is an important tool for promoting accountability of social workers and delivery of service according to best practice.

33. **Recommendation:** That *The Social Work Profession Act* be:
    a) amended to require that anyone who practises social work in Manitoba, under whatever title, be registered by the Manitoba College of Social Workers; and
    b) proclaimed into law at the earliest possible date, following receipt of the report of the transitional board.

    Reason: This amendment will protect not only the title of "social worker" but will ensure that members of the profession are truly qualified, meet a standard of competence, and are governed by a code of ethics.

34. **Recommendation:** That *The Child and Family Services Act* be amended to allow for extension of services to any child who at the age of majority was receiving services under the *Act*, up to age 25.

    Reason: Many young people require support in the transition to adulthood, even past age 21, and this applies not only to those who were in care, but to those whose circumstances put them in need of services under the *Act*.

35. **Recommendation:** That a program be implemented to ensure that children who have been receiving services under the *Act*, at age 18, have available to them an individual social worker to coordinate services and ensure that they receive the necessary support for a successful transition into the community.

    Reason: Young people need help navigating a successful transition into adulthood.

36. **Recommendation:** That the position of a Manitoba Representative for Children and Youth be established under its own legislation, titled *The Representative for Children and Youth Act*, with these features:
    a) status as an Officer of the Legislature, with the same independence afforded to the Ombudsman and Auditor General;
    b) a mandate to advocate not only for children in the child welfare system, but for all children and youth in the province who are receiving or are eligible to receive any publicly funded service;
    c) responsibility to review not only deaths, but also critical injuries to any child in care and any child who had been involved with child welfare during the previous year; and

d) authority to make special reports to the Legislative Assembly where considered necessary, including reports on compliance with recommendations made previously by the Representative under the Act, such special reports to be delivered to the Speaker and the Standing Committee on Children and Youth.

Reason: Manitoba needs a truly independent officer of the legislature, with authority to advocate for all Manitoba children who receive, or are entitled to receive publicly funded services, and to report on matters that concern them.

37. **Recommendation:** That the Representative be appointed by a resolution of the Legislative Assembly, on the unanimous recommendation of the Standing Committee on Children and Youth following a search for a suitable candidate. In making its recommendation, the Committee must be required by the Act to consider the skills, qualifications, and experience of the candidate, including the candidate's understanding of the lives of Aboriginal children and families in Manitoba.

    Reason: This is an important position that requires the support of the child welfare system; and because of the large numbers of Aboriginal children to be served, it requires a person with understanding of their varied concerns and circumstances.

38. **Recommendation:** That the Representative for Children and Youth be appointed for a five-year term with an option for a second term, but no one should serve in the position beyond 10 years.

    Reason: A term in office of between five and ten years offers a balance between the need for experience in the position, and the advantages of fresh energy and insights that a new office holder can bring.

39. **Recommendation:** That a Deputy Representative be appointed by the Representative for Children and Youth.

    Reason: This will be a close working relationship and it will be important that the Representative be free to choose a person who complements the Representative's own strengths and areas of expertise.

40. **Recommendation:** That a Standing Committee on Children and Youth be established as a standing committee of the Legislature, and the Representative be required to report to it at least annually and to discuss special reports, and on other appropriate occasions.

    Reason: This committee will be a forum for collaboration between the Representative and the Legislature and it will promote greater understanding, both in the Legislature and in the public, of the workings of the child welfare system.

41. **Recommendation:** That the Representative be required to prepare:
    a) an annual service plan, with a statement of goals and specific objectives and performance measures, and
    b) an annual report including a report on the Representative's work with Aboriginal children and families and with others, and comparing results for the preceding year with the expected results set out in the service plan.

    Reason: This is a mechanism for ensuring accountability of the Representative to the people of Manitoba.

42. **Recommendation:** That all annual reports, special reports, and service plans are to be made public, following delivery to the Speaker for placement before the Legislative Assembly and the Standing Committee on Children and Youth.

    Reason: These will enhance public understanding of the child welfare system, and of the challenges facing other children in the province who are receiving, or are entitled to receive other publicly funded services.

43. **Recommendation:** That in the hiring of all new staff for the Office of the Representative, except those filling clerical roles, consideration be given to an applicant's understanding of the lives of Aboriginal children and families in Manitoba.

    Reason: A great deal of the work of this office will be with Aboriginal children and youth and their families: it is important not only that staff have an understanding of their concerns and life circumstances, but also that the people who need its services feel comfortable approaching the office.

44. **Recommendation:** That at the end of the term of the current Children's Advocate, an acting Children's Advocate be appointed, pending enactment of new legislation to create a Representative for Children and Youth. If any amendment to existing legislation is required to make that possible, that should be done now.

    Reason: This will ensure a smooth transition to the new position of Representative for Children and Youth.

45. **Recommendation:** That the new Act contain provisions similar to the following, which are contained in Section 6(1) of the *Representative for Children and Youth Act* of British Columbia:

6(1) The Representative is responsible for performing the following functions in accordance with this Act:

(a) support, assist, inform and advise children and their families respecting designated services, which activities include, without limitation,

(i) providing information and advice to children and their families about how to effectively access designated services and how to become effective self-advocates with respect to those services,

(ii) advocating on behalf of a child receiving or eligible to receive a designated service, and

(iii) supporting, promoting in communities and commenting publicly on advocacy services for children and their families with respect to designated services;

(a.1) support, assist, inform and advise young adults and their families respecting prescribed services and programs, which activities include, without limitation,

(i) providing information and advice to young adults and their families about how to effectively access prescribed services and programs and how to become effective self-advocates with respect to those services and programs,

(ii) advocating on behalf of a young adult receiving or eligible to receive a prescribed service or program, and

(iii) supporting, promoting in communities and commenting publicly on advocacy services for young adults and their families with respect to prescribed services and programs;

(b) review, investigate, and report on the critical injuries and deaths of children as set out in Part 4;

(c) perform any other prescribed functions;

Reason: These provisions have worked to the benefit of children and youth in British Columbia and I have every reason to believe that they will bring similar benefits in Manitoba.

46. **Recommendation:** That in drafting the new legislation, reference be made to British Columbia's *Representative for Children and Youth Act* to ascertain whether provisions other than those addressed in the above recommendations are suitable for inclusion.

Reason: These provisions have worked to the benefit of children and youth in British Columbia and I have every reason to believe that they will bring similar benefits in Manitoba.

47. **Recommendation:** That the responsibility of the Ombudsman with respect to special investigation reports be removed.

    Reason: This responsibility will be assumed by the Representative for Children and Youth.

48. **Recommendation:** That a public awareness campaign be undertaken to inform the public about the expanded mandate and role of the Representative for Children and Youth.

    Reason: If this new position is to offer support and protection to vulnerable members of society, it is essential that there be a broad public understanding of the office, and its role, and the extent of its authority.

49. **Recommendation:** That the Province take the lead to work in concert with the federal and municipal governments, First Nations, and the private sector to develop further strategies to increase availability of a variety of affordable housing, including incentives and supports for landlords, developers, and community-based housing associations.

    Reason: Bringing appropriate housing within reach will help alleviate a major stressor for many families living in poverty.

50. **Recommendation:** That the Province closely examine the 2009 report, The View From Here: Manitobans Call for a Poverty Reduction Plan, with a view to implementing the outstanding recommendations, paying particular attention to the area of adult education.

    Reason: Over the long term, education offers one of the best means of breaking the cycle of poverty, which is one of the major risk factors for children.

51. **Recommendation:** That social assistance housing allowances be increased to at least 75% of the median market rate.

    Reason: Increasing housing allowances will address the poverty-related issues that make families vulnerable and can lead them into contact with the child welfare system.

52. **Recommendation:** That supports for families transitioning from First Nation communities to urban centres be expanded and enhanced. To this end, Manitoba should collaborate with First Nations and other levels of government.

    Reason: Many families make this move and are ill-equipped to navigate among the services they need to make a successful transition.

53. **Recommendation:** That at the next meeting of the Council of the Federation (the Premiers of Canada's ten provinces and three territories), the Premier of Manitoba request placement on the agenda and the opportunity to speak to the unacceptably disproportionate number of Aboriginal children taken into care by child welfare authorities across Canada in comparison to non-Aboriginal children. Further, that if given the opportunity to speak to the matter, the Premier of Manitoba outline the severity and seriousness of the problem and the consequences for all of us, but particularly for Aboriginal children and families, if allowed to continue unabated; and that he explore whether collectively his colleagues are of a mind to take steps in search of a solution and a process for implementation of that solution over time.

    Reason: The over-representation of Aboriginal children in Canadian child welfare systems is a serious national problem for which a solution must be found for the benefit of Aboriginal children, and all Canadians.

54. **Recommendation:** That the Province amend *The Healthy Child Manitoba Act* to reflect the rights entrenched in the United Nations Convention on the Rights of the Child, in a manner similar to Alberta's *Children First Act*, stipulating that the well-being of children is paramount in the provision of all government services affecting children.

    Reason: The well-being, safety, security, education, and health of children must be at the forefront, not just of the child welfare system, but throughout government. This statement of children's rights must be entrenched in legislation: *The Healthy Child Manitoba Act* is the perfect home.

55. **Recommendation:** That the capacity of community-based organizations be enhanced by provision of sustained long-term funding to allow for delivery of holistic services, with particular emphasis on support for Aboriginal-led organizations and programs that promote cultural identity within Aboriginal communities.

    Reason: The evidence was clear that community-based organizations are effective in providing prevention services, both before and after involvement with the child welfare system. These organizations need consistent and sustained long-term funding to effectively plan for the delivery of those services.

56. **Recommendation:** That a legislated committee, functioning under the provisions of *The Healthy Child Manitoba Act* (in its present or amended form) be charged with:

    a) coordinating the services provided for children and families, between community-based organizations and government departments; and

b) allocating government funding to those community-based organizations, following meaningful and inclusive consultation. It is understood that funding from the private sector and other levels of government will continue to play an important role, as it has done, in supporting these organizations;

and that the composition of this committee mirror the committee described by s. 21(3) of *The Healthy Child Manitoba Act*, which reflects Manitoba's various regions and cultural diversity and includes representatives of the community and recognized experts.

Reason: Having recognized the role that these organizations can play in supporting families and protecting children, it is important that a formalized process be put in place to ensure that services are provided and accessible in a coordinated and fiscally responsible manner.

57. **Recommendation:** That child welfare agencies accommodate reasonable requests by parents or other caregivers and children and youth for participation of an individual they identify as a support in their dealings with the child welfare system.

    Reason: Community-based organizations and others can play an important role in supporting children and families in their interactions with the child welfare system. Their involvement can contribute to the building of more trusting relationships between agency workers and families.

58. **Recommendation:** That child welfare agencies meet regularly with community-based organizations that serve their clients, to discuss how they can best work together to meet the community's needs.

    Reason: Effective collaboration between child welfare agencies and community-based organizations who serve the same families is imperative to avoid gaps in provision of services. The agencies and community-based organizations need to be aware of the services each offers to work towards their common goal of supporting families and children.

59. **Recommendation:** That the Healthy Child Committee of Cabinet consider and recommend for legislative action a framework for the delivery of early childhood development programs with the following characteristics:
    a) voluntary but universally available;
    b) offering a place where children regularly attend to learn with other children;
    c) staffed by trained educators who follow a defined curriculum; and
    d) involving parents.

Reason: Early childhood education programs, whether kindergarten, childcare, or other pre-school programs, can significantly benefit children and their parents. Pre-school years offer the most significant opportunity to influence children's capacity to learn throughout their lifetime. Universal access to quality early childhood programs supports parents by allowing them to address their own health issues including substance misuse and mental health; to seek employment; and to further their education. Ultimately, quality early childhood education results in cost savings to health and justice and other systems and combats poverty. Establishment of such a legislative framework is in line with developments in other jurisdictions in Canada and elsewhere.

60. **Recommendation:** The legislative framework for delivery of early childhood development programs should also provide for establishment of integrated service delivery centres to provide a range of services in addition to early childhood education, including public health, employment and income assistance, housing, child welfare, and adult education. These integrated service centers should be located in existing infrastructures such as schools or facilities that house community-based organizations.

    Reason: Combining a range of services that children and families need in community-based locations makes those services more accessible. It also combats social isolation by giving parents and children the opportunity to connect with others, and promotes visibility of vulnerable children.

61. **Recommendation:** That government funding to support integrated service delivery centres be allocated, following meaningful and inclusive consultation, by a committee that mirrors the committee described by s. 21(3) of *The Healthy Child Manitoba Act* and reflects Manitoba's various regions and cultural diversity, including representatives of the community and recognized experts.

    Reason: There is compelling evidence that these centres promote social cohesion in neighbourhoods, combat poverty by enhancing families' capacity to be self-sustaining; increase the visibility of young children in their community; and neutralize the conditions that make families vulnerable and put children at risk of abuse or neglect.

62. **Recommendation:** That Aboriginal culture and history, including the history of colonization and the impact of residential schools, be integrated into the provincial curriculum, including early childhood education and extending through elementary and secondary school.

    Reason: A shared understanding of Manitoba's founding people will promote social cohesion, reduce the isolation felt by many Aboriginal families, and encourage school completion by Aboriginal students.

2 THE INQUIRY PROCESS

2.1 THE COMMISSION'S TERMS OF REFERENCE AND MANDATE

Phoenix Sinclair, at age five, was murdered by her mother, Samantha Kematch, and her mother's partner, Karl Wesley McKay, on June 11, 2005 at Fisher River in Manitoba.

Her death went undiscovered for nine months, until Kematch and McKay were arrested on March 9, 2006. They were convicted of first-degree murder on December 12, 2008 and were sentenced to life imprisonment without eligibility for parole for a minimum of 25 years. They both appealed their convictions and the Manitoba Court of Appeal dismissed their appeals on April 30, 2010.

By that time the criminal proceedings against Kematch and McKay had been fully covered in the media, but questions remained unanswered. Phoenix and members of her family had been in contact with the child welfare system on and off throughout their lives. How did a child who had been connected to a child welfare agency end up suffering such a tragic fate, and how did her death go undiscovered by law enforcement and child welfare officials for so long?

The Commission of Inquiry into the Circumstances Surrounding the Death of Phoenix Sinclair was established to inquire into those circumstances and to seek answers to these questions.

The authority for my appointment as Commissioner comes from ***The Manitoba Evidence Act.*** That Act gives the Lieutenant Governor in Council wide powers to order an inquiry into any matter within the jurisdiction of the Legislature that is of sufficient public importance to justify an inquiry.[1]

The parameters of an inquiry are defined by the Order in Council that gives it effect. My terms of reference are contained in Manitoba Order in Council 89/2011, dated March 23, 2011 (Appendix 1). This document requires that I inquire into the circumstances surrounding Phoenix Sinclair's death, and that I consider specifically:

- the child welfare services provided or not provided to Phoenix and her family under Manitoba's ***Child and Family Services Act***;
- any other circumstances, apart from the delivery of child welfare services, directly related to Phoenix's death; and
- why her death went undiscovered for nine months.

The Order in Council requires me to report my findings and make recommendations to better protect Manitoba children, bearing in mind the recommendations that had already been made in six reports that were commissioned after the discovery of Phoenix's death.

2.2 THREE PHASES OF INQUIRY

The Commission approached its task in three phases.

2.2.1 PHASE ONE

> *How it is that in Manitoba, a small child can become so invisible—invisible to an entire community, one that includes social service agencies, schools, neighbours, friends and family—so invisible as to literally disappear?*[2]

This is the question that was posed more than once by Commission Counsel, and it is the central question the Commission sought to answer in Phase One. Over the course of 54 days of hearings in this phase, I heard from 82 witnesses.

By pure coincidence, Phase One of the Inquiry ended on what would have been Phoenix's 13th birthday: April 23, 2013.

2.2.2 PHASE TWO

Five years had passed between the discovery of Phoenix Sinclair's death and the creation of this Commission of Inquiry. During that time, many lessons were learned and changes made. In this phase, the focus was on those changes to the child welfare system so that I could understand how Manitoba's children today, facing the same risks as Phoenix faced, would be served by today's child welfare system. I also heard about issues particular to the delivery of child welfare services both to and by First Nations communities.

2.2.3 PHASE THREE

Here, the Commission stepped back to look at a broader question: What brings a vulnerable family to come into contact with the child welfare system?

Having heard repeatedly that the child welfare system alone cannot address the social conditions that result in children needing protection, the Commission asked: What resources, beyond the child welfare system, can support those families?

Particular attention in Phase Three was paid to challenges facing Aboriginal families in Winnipeg, given the facts of this case.

To find answers to these questions the Commission sought the wisdom of some First Nations elders—the grandmothers—and of academics and others with expertise, both local and international, in the areas of poverty; homelessness; addictions; early childhood development; public health policy; and capacity-building in Aboriginal communities.

2.3 THE SIX REPORTS COMMISSIONED AFTER PHOENIX'S DEATH

I was to take into account the findings of the six reports referred to in the Order in Council and the manner in which their recommendations have been implemented, to avoid duplication in my recommendations and to ensure that my recommendations would be relevant to the current state of child welfare services in Manitoba. I considered the findings of those reports in that context. Two of the six

reports focused on the facts of Phoenix's case; the others were systemic reviews of Manitoba's child welfare system. Many of their recommendations have been implemented, as will become evident in the Phase Two chapters of this report.

The investigations by the writers of the fact-specific reviews were conducted under more restricted timelines and circumstances than this Inquiry, and while criminal proceedings were still pending. I did not rely on the findings of those reviews, but during the course of the Inquiry, Commission Counsel put those findings to individual witnesses for comment, which evidence I considered.

Following is a general overview of the nature, purpose, and scope of each of these reports.

1. ***A Special Case Review in Regard to the Death of Phoenix Sinclair, Andrew J. Koster and Billie Schibler, September 2006***[3]

This was the first of the two fact-specific reviews. It was conducted by the Office of the Children's Advocate and a consultant, Andrew J. Koster. The Children's Advocate at the time was Billie Schibler. The review was done pursuant to s. 4 of ***The Child and Family Services Act***, which authorizes the Director of Child Protection to conduct enquiries and investigations with respect to the welfare of a child dealt with under the Act or to delegate that power to another.[4] The Special Case Review was submitted to the Minister of Family Services and Housing. Its complete findings and recommendations were not available to the public until the review was filed at the Inquiry. This review was frequently referred to in the proceedings as "the Section 4 report."

The purpose of the Special Case Review was to:

- examine and assess the services provided to Phoenix Sinclair and her family by all child and family service agencies;
- ascertain whether those services were consistent with established standards and best practice expectations;
- examine the circumstances that may have contributed to Phoenix's death; and
- make recommendations to help prevent similar incidents in the future.[5]

The scope of the review was to:

- provide a profile of Phoenix Sinclair and her family;
- examine the specific child welfare services provided at both the worker and supervisor level;
- identify the factors that may have contributed to her death;
- assess the degree to which the child welfare system met her needs; and
- if services did not comply with standards or best practices, assess what factors may have contributed to non-compliance.

Relevant files, reports, and child welfare records were reviewed, and child welfare staff and others who had interacted with Phoenix or her family were interviewed.

2. ***Investigation into the Services Provided to Phoenix Victoria Hope Sinclair, Department of Justice, Office of the Chief Medical Examiner, September 18, 2006***[6]

This was the second of the fact-specific reviews. Its findings and recommendations were made a matter of public record for the first time at the Inquiry. It was prepared by the Office of the Chief Medical Examiner under the authority of *The Fatality Inquiries Act.*[7] At the time Phoenix's death was discovered, that Act provided:

> 10(1) If the chief medical examiner receives an inquiry report about a deceased child who, at the time of death or within the one year period before the death,
>
> (a) was in the care of an agency as defined in *The Child and Family Services Act;* or
>
> (b) had a parent or guardian who was in receipt of services from an agency under *The Child and Family Services Act*;
>
> the chief medical examiner shall assess the quality or standard of care and service provided by the agency by
>
> (c) examining the records of the agency respecting the child and the parent or guardian; and
>
> (d) reviewing the actions taken by the agency in relation to the child and the parent or guardian.

Jan Christianson-Wood, a Special Investigator with the Office of the Chief Medical Examiner, conducted the investigation and prepared the report. It was required to be submitted on a confidential basis to the Minister of Family Services and Housing.

The purpose of the report was to investigate:

- the involvement of child and family services with Phoenix Sinclair, her parents and guardians, and significant others;
- the circumstances of her death; and
- the action of child and family service agencies in response to her death.[8]

This report reviewed the facts surrounding the involvement of child welfare in Phoenix Sinclair's life and the life of her family. It was based on a review of the relevant child welfare files and transcripts of child protection court proceedings, and on written and telephone communication with law enforcement and with staff of child welfare agencies.

The report was often referred to in the Inquiry's proceedings as the "Section 10 Report."

3. ***Strengthen the Commitment: An External Review of the Child Welfare System, Micheal Hardy, Irene Hamilton, and Billie Schibler, September 29, 2006***

This is a comprehensive and thorough review of the landscape of Manitoba's child welfare system in and around the time that Phoenix's death was discovered. It was called for by the Minister of Family Services and Housing (now the Department of Family Services) on March 20, 2006, 11 days after Phoenix's death was discovered.[9]

The review's purpose, as described by its Co-Chairs (Irene Hamilton, Manitoba's Ombudsman; Micheal Hardy, Executive Director, Tikinagan Child and Family Services, Sioux Lookout, Ontario; and Billie Schibler, the Children's Advocate) included:

> *. . . to examine and provide recommendations for improvements in standards, processes and protocols surrounding the opening, transfer and closing of cases in child and family services, as well as the caseloads managed by front line workers. We were also to raise other concerns identified by us. Numerous other concerns were identified during the review, and are addressed in the report.*

They described the scope of the review as follows:

> *In the course of the review we consulted with people in government, the authorities, and agencies in 32 communities across the province. Over 700 people who work within or are affected by the system provided input to the review. We heard from children and youth in the system whose perspectives were critical in order to understand how child welfare has affected them. We also heard from care providers, service providers and collateral service providers. These are people with a genuine commitment to the work that they do and a desire to achieve the best for the children and families with whom they work. The views of the people interviewed throughout the review are reflected in this report.*[10]

A team of 10 people performed the review. The report made a number of findings related to Manitoba's child welfare system, along with 111 recommendations for change.

As part of the review, a paper was commissioned to review best practices in child welfare work in Manitoba. That paper, *Best Practice in Child Welfare: Definition, Application and the Context of Child Welfare in Manitoba,*[11] was written by Alexandra Wright, PhD, who at the time was an Assistant Professor in the Faculty of Social Work at the University of Manitoba. As will be discussed later, at the Commission's request an updated version of that paper was prepared by Wright and entered as an exhibit.[12]

4. ***Honouring their Spirits, The Child Death Review: A Report to the Minister of Family Services and Housing, Province of Manitoba, Billie Schibler and James H. Newton, September, 2006***[13]

After the discovery of Phoenix's death, the Minister of Family Services and Housing on March 21, 2006 called for an investigation into the deaths of all children who had died between January 2004 and May 2006 having received child welfare services within the last year of life. There turned out to be 99 such children. Although the report was commissioned as a result of the discovery of Phoenix's death, it was a systemic review, rooted in an examination of the services provided to each of those 99 children.

Like the Special Case Review mentioned above, this review was carried out pursuant to section 4(2)(c) of *The Child and Family Services Act*. It was chaired by the then Children's Advocate Billie Schibler, and James H. Newton, Head of Psychology at the Manitoba Adolescent Treatment Centre. They were assisted by a team of four investigators who reviewed documents and interviewed child welfare agency staff and collateral service providers. [14]

The review found common themes, and made a number of findings as well as 80 recommendations.

5. ***Strengthening our Youth: Their Journey to Competence and Independence, A Report on Youth Leaving Manitoba's Child Welfare System, Billie Schibler, Children's Advocate, and Alice McEwan-Morris, November, 2006***[15]

This report, prepared by Alice McEwan-Morris, was commissioned by the Office of the Children's Advocate, to examine the well-being of youth transitioning out of the child welfare system.

The report's Executive Summary concisely describes the purpose and scope of the review:

> *Almost 1,600 youth will be aging out of the child and family services system in Manitoba in the next three years. According to the Department of Family Services and Housing, Child and Family Services Information System (CFSIS), most of the youth (70%) are Aboriginal and a significant number have a diagnosed disability (28%). Many of the youth have not acquired the skills necessary to manage adult tasks and few have the support of family to help them out. Some have disabilities, while others may be struggling with mental health issues. As youth differ, so do their needs, but without question, the majority of youth leaving care are alone and vulnerable. Concern about the vulnerability of youth after they leave care has been a reoccurring theme in the work of the Office of the Children's Advocate. This review examines the issues affecting former youth in care, provides a comparative analysis of policy and research findings and makes recommendations. Research on youth transitioning from care shows many negative outcomes. A large number of former youth in care are homeless, do not complete high school, are receiving social assistance, are more likely to be incarcerated, self harm, have suicidal impulses, are depressed and are at high risk of exploitation, especially in the sex trade.*[16]

It is worth noting that this was the situation that Phoenix's parents faced: they both "aged out" of the care of the child welfare system when they reached the age of majority, without the skills and supports they needed at this vulnerable time in their lives.

The review found a number of areas for improvement in the child welfare system in relation to youth aging out of care, and made 45 recommendations.

6. ***Audit of the Child and Family Services Division, Pre-devolution Child in Care Processes and Practices, Carol Bellringer, Auditor General, December, 2006***[17]

This review was conducted by the Office of the Auditor General of Manitoba, and was provided to the Speaker of the Legislative Assembly in December 2006.[18]

The purpose of the audit was:

- to determine whether the Child and Family Services (CFS) Division had an effectively functioning accountability framework in place as at March 31, 2004 and to ensure that the mandated agencies were performing as expected by the Division;
- to determine whether the mandated agency funding model for children in care was appropriate to ensure fair and equitable funding levels, consistent with the expected quality and quantity of services;
- to determine whether the Division's management practices were sufficient to effectively address the needs of children in care; and
- to gain an understanding of the roles and responsibilities of the CFS Authority boards of directors, and review the governance structures put in place by each CFS Authority by March 31, 2005.[19]

The Auditor General conducted interviews and reviewed documents and records.[20] The audit made a number of findings and 86 recommendations for changes to the child welfare system.

2.4 PURPOSE AND NATURE OF PUBLIC INQUIRIES

A public inquiry is a tool for truth seeking. It also can serve the important purpose of educating and informing the public in the wake of a tragedy.

The design and operation of a public inquiry is a significant responsibility. As an investigative tool, it has wide-ranging powers. But it is more than that. The true purpose of a public inquiry has been eloquently described by Supreme Court of Canada Justice Peter Cory:[21]

> *One of the primary functions of public inquiries is fact-finding. They are often convened, in the wake of public shock, horror, disillusionment, or skepticism, in order to uncover "the truth". Inquiries are, like the judiciary, independent; unlike the judiciary, they are often endowed with wide-ranging investigative powers. In following their mandates, commissions of inquiry*

are, ideally, free from partisan loyalties and better able than Parliament or the legislatures to take a long-term view of the problem presented. Cynics decry public inquiries as a means used by the government to postpone acting in circumstances which often call for speedy action. Yet, these inquiries can and do fulfill an important function in Canadian society. In times of public questioning, stress and concern they provide the means for Canadians to be apprised of the conditions pertaining to a worrisome community problem and to be a part of the recommendations that are aimed at resolving the problem.

Both the status and high respect for the commissioner and the open and public nature of the hearing help to restore public confidence in not only the institution or situation investigated but also in the process of the government as a whole. They are an excellent means of informing and educating concerned members of the public.[22]

Throughout this process I have aimed to provide, as far as possible, a forum for community healing after the tragedy of Phoenix's death. I adopt these comments of Justice Cory:

Open hearings function as a means of restoring the public confidence in the affected industry and in the regulations pertaining to it and their enforcement. As well, it can serve as a type of healing therapy for a community shocked and angered by a tragedy. It can channel the natural desire to assign blame and exact retribution into a constructive exercise providing recommendations for reform and improvement.[23]

Independence, transparency, and community healing were elements that I, and my counsel, kept foremost in our minds throughout every step of this process. We also aimed for the highest degree of procedural fairness for all participants, while keeping in mind the goal of proceeding as expeditiously as possible.

Ideals of fairness, openness, and independence guided all of the Inquiry's work, from the drafting of rules of procedure and practice to the call for applications for standing; the pre-hearing investigative phase; public and media presence at the hearings; participation of counsel at the hearings; and media and public access to documents via the Commission's website.

The Order in Council establishing my mandate set out that I was to perform my duties without expressing any conclusion or recommendation about civil or criminal liability of any person. This is in keeping with the purpose of an inquiry to find facts, inform, and make recommendations for reform.

An inquiry is not a trial. Its proceedings, while quasi-judicial, are not a sitting of a court. Because of this, the rules of evidence may be relaxed in an inquiry's proceedings. I appreciate, however, that the findings in my report have the potential to identify improper or unprofessional behaviour, bad management, or other shortcomings on the part of those who testified. In making my report, I have relied on the testimony of 126 witnesses called to testify at the Inquiry and 353 documents introduced into the public record at the Inquiry's proceedings. With the

agreement of counsel, and in the interests of expediency, on certain occasions I received evidence by way of written admissions of fact provided by parties to the inquiry. On one occasion, with the consent of all counsel, I received a witness's testimony by way of a written summary of evidence.

2.5 APPOINTMENT OF COMMISSION COUNSEL

One of my first tasks upon accepting my appointment as Commissioner was the selection of counsel to the Inquiry. I appointed as lead Commission Counsel, Sherri Walsh, a lawyer with 25 years of experience in all areas of civil litigation including public interest litigation, and extensive experience in administrative and regulatory proceedings as an advocate, nominee, and hearing officer. Given what turned out to be the large scope of this Inquiry, Commission Counsel required the assistance of a number of counsel at various times throughout the Inquiry.

They were: Senior Associate Commission Counsel, Derek Olson; and Associate Commission Counsel Madeline Low, Kathleen McCandless, Elizabeth McCandless, Noah Globerman, and Rohith Mascarenhas. The Commission also retained the services of lawyer Karen Dyck, who served as a Community Research Analyst for the work of Phase Three.

Olson assisted Walsh with interviews in the pre-hearing investigative stage and in the examination of witnesses at the hearing. Associate counsel supported Walsh and Olson by conducting research as necessary; reviewing the many documents received by the Commission; making necessary redactions to documents (blacking out information in accordance with the Commissioner's ruling); preparing binders of documents for each interview and for each witness who testified; assisting with the preparation of court documents; and on occasion by examining witnesses at the hearing.

2.6 ROLE OF COMMISSION COUNSEL

Commission counsel's role differs from the role of a lawyer in an adversarial trial process. Commission counsel has been described as an extension of the Commissioner, or the Commissioner's alter ego. For that reason, it is important that commission counsel remain impartial. But impartiality has to be balanced with the responsibility to vigorously represent the public interest.

The role was eloquently described by the Manitoba Court of Appeal when it was called upon to rule on a procedural question in this Inquiry. (The decision is at Appendix 13.) Quoting with approval a decision of another tribunal, Steel, J.A. said:

> *Impartiality on the part of commission counsel is not to be confused with a lack of rigour and vigilance in seeking the truth. Commission counsel must still act forcefully whenever necessary to overcome resistance that could obscure truth. This persistence is particularly important whenever the transparency of public inquiries motivates resistance on the part of those with*

something to hide. What makes commission counsel's role unique is that they must take into consideration the public interest, the interests of all parties, and furthermore, must explore conscientiously all plausible explanations and outcomes regardless of whose interests are advanced. We have now reached a point in the evolution of commission counsel's role where it can be confidently asserted that every task they undertake must be infused with impartiality inseparable in degree from that of the commissioner.[24]

The Court agreed with that view, and continued:

> *It is commission counsel who has the primary responsibility to vigorously and completely represent the public interest, including the interests, issues and theories of all parties. In order to do so, commission counsel needs to foster effective communication with all of the parties to the Inquiry. By way of illustration, the parties may be able to shed light on information not initially thought to be relevant or suggest additional fields of inquiry. Conversely, commission counsel should ensure that relevant information is getting to the parties on a timely basis, and should be available to discuss issues with other counsel.*

The functions of commission counsel have been summarized as follows:

1. to advise and guide the Commissioner throughout the process;
2. to supervise and conduct the investigation into all information relevant to the terms of reference;
3. to develop and maintain open communication with all parties and encourage cooperation in facilitating disclosure and presentation of evidence;
4. to call evidence at the hearings, including those witnesses the parties seek to call;
5. to assist the Commissioner in writing the report; and
6. to serve as media spokesperson for the Commission.[25]

To assist the Commissioner in getting to the truth, commission counsel must ensure that all relevant evidence is presented. On occasion, this may require counsel to be forceful or vigorous in examining witnesses—not to advance the interests of a party, but to ensure a thorough review of the evidence. Commission Counsel at this Inquiry carried out these responsibilities in accordance with these important principles and requirements.

2.7 ADMINISTRATIVE MATTERS

2.7.1 ADMINISTRATIVE STAFF

To ensure all administrative matters of the Inquiry were attended to, the Commission engaged Marcia Ewatski as Chief Administrative Officer. She came to the Commission with 35 years of experience working within government and extensive experience administering quasi-judicial tribunals. She was charged with

overseeing all administrative aspects of the Inquiry: developing a documents management system; organizing the Commission's thousands of pages of disclosure; hiring and managing administrative staff for all of the Inquiry's day-to-day work; coordinating and scheduling locations for public hearings; ensuring all relevant information and documentation was provided to participants on a timely basis; and liaising with counsel, witnesses, and the Commission's investigators. Ewatski was assisted in this important work by the Commission's office manager, Cindy Pearson, along with additional administrative staff.

A list of commission counsel and staff is found at Appendix 2.

2.7.2 CONFIDENTIALITY

All Commission counsel, staff, and contractors were required to sign an undertaking that information and documents obtained via the work of the Commission would remain confidential unless and until becoming part of the public record at the Inquiry's proceedings. All witnesses and all lawyers, whether for parties, intervenors, or witnesses, were also required to sign confidentiality undertakings before receiving disclosure.

2.7.3 DOCUMENTS MANAGEMENT

A major task of the Inquiry was the organization and distribution of documentary disclosure. Early in its investigative stage the Commission received more than 60,000 pages of disclosure from the parties and intervenors, and from other entities at the Commission's own initiative. The Commission then had to review these documents to determine which would form part of the master disclosure list.

A number of these documents contained confidential personal information about the child welfare history of individuals, as well as medical and law enforcement records. Personal information not relevant to the Commission's mandate had to be edited out, or "redacted," from thousands of pages of disclosure.

The documents included in the Commission's master disclosure list were then scanned and provided to all parties and intervenors in electronic form. Each document was given a Commission disclosure number to serve as a unique identifier at each step of the Inquiry.

Disclosure was an ongoing process: documents received after completion of the master list and entered into the public record at the hearings were marked as exhibits and referred to by exhibit number. The Commission's master disclosure list totaled 2,164 documents, containing 46,398 pages. Of those, 192 documents were entered into the public record at the hearing, and an additional 161 exhibits were filed. Documents that were part of the Commission's master disclosure list were simply referenced by their disclosure number when entered into the public record.

At the public hearings, documents were accessed via monitors situated at the Commissioner's and lawyers' tables, the witness stand, on media tables and in the public gallery. Each page of the Commission's disclosure was accessible in

electronic form, reducing the amount of paper used at the hearings. It also allowed for documents to be quickly called up in the course of the proceedings, ensuring that everyone was literally "on the same page" at the same time.

2.7.4 WEBSITE

A website was developed for the Commission, to enhance public access to its proceedings and evidence. Through this website, the media and the public were given full access to all motions and affidavits filed with the Commission, and to all documents entered into the public record at the hearings. The Commission uploaded all these documents to its website as soon as possible after they were filed and on occasion met requests from the media for access to documents filed but not yet available on the website.

When the public hearings began, transcripts of all public sessions were uploaded regularly to the Commission's website, which was—and is—available to all.

2.7.5 OFFICE SPACE AND HEARING ROOM

Soon after appointment of Commission Counsel, the Commission sought out office space to accommodate staff, counsel, and documents. Walsh's law firm accommodated the Commission temporarily, before its move to 1801-155 Carlton Street in Winnipeg in August 2011, in time to receive the thousands of documents that came in from parties and intervenors.

The Commission's offices were well suited to the task, with sufficient office space for counsel; a secured room to house the Commission's documents; and a boardroom to accommodate interviews and meetings. Some pre-hearing interviews were conducted around the boardroom table, while others took place in a more relaxed and informal environment. This was important because many witnesses, especially those who had had a relationship with Phoenix or had witnessed some of the abuse she suffered, were being asked to speak about difficult and traumatic experiences. It was important that all witnesses be made to feel as comfortable as possible, given the most difficult subject matter of this Inquiry.

The Commission opened its public sessions on June 28, 2011, and concluded on July 30, 2013. There was no designated facility for the public hearing so the Commission rented space at various locations. All locations needed to be able to support the Commission's technological requirements, including a video feed to media outlets and facilities to accommodate the members of the media who attended daily. Most hearings took place at the Winnipeg Convention Centre, but from time to time hearings were held in downtown Winnipeg hotels.

2.7.6 MEDIA FACILITIES

The hearing rooms provided seating for the public and tables for the media. The Commission created a media protocol that provided for one fixed camera during the proceedings, with a feed to all media outlets. The inquiry's hearings were not televised in their entirety. To contain costs, the Commission itself did not provide live streaming of the public hearings. But media outlets did use video and audio

excerpts of the proceedings in their reports. For certain witnesses whose testimony was subject to publication and broadcast restrictions, the Commission developed a separate protocol, which is discussed later in this chapter.

2.8 RULES OF PROCEDURE

As is typically the case for inquiries, the Commission created its own rules of procedure. My counsel and I studied rules used by previous inquiries and drew upon those that best suited our needs. The Commission also tailored some rules to meet its unique circumstances. Our aim was a process that would allow the inquiry to fulfill its mandate in the most fair and expeditious manner, having regard to the participants with standing, the witnesses, and the public interest.

We strove to ensure, to the extent possible, that there would be no surprises at the public hearings. No one was to be "ambushed" on the witness stand. All participants were to be fully aware of the evidence expected to be presented. The purpose of this was twofold: to ensure fairness to individual witnesses, and to promote the public interest in seeing that all necessary and relevant evidence was presented.

The Commission's rules contained sections related to standing, evidence (documents, witness interviews, and oral testimony), and notices of alleged misconduct. The rules were circulated in draft form to all those who applied for standing in advance of the standing hearing. I approved the rules after hearing submissions from counsel and incorporating some of their suggested changes. On August 23, 2011, I amended the rules to add a procedure for dealing with motions. The Amended Rules of Procedure and Practice were posted on the Commission's website and are found at Appendix 3. The procedures for filing of motions and for cross-examination on affidavits were helpful as the Inquiry progressed and a number of procedural motions were filed.

The rules required all parties and intervenors to produce to the Commission copies of all relevant and non-privileged documents in their possession or control bearing on the subject matter of the Inquiry. Parties and intervenors were also asked for names and contact information for witnesses they wished to have called.

The Commission's procedure for witness interviews was designed to provide a more relaxed interview atmosphere when needed. The aim was to foster a feeling of openness and to promote full and open disclosure in the pre-hearing interview process. I appreciated that the subject matter would be difficult and emotional for many of the individuals the Commission would interview. The rules permitted witnesses to be interviewed with their lawyer present if they so chose. More is said below about these interviews and witness summaries.

2.9 STANDING AND FUNDING

2.9.1 STANDING

The Commission's rules provided that Commission Counsel would have standing throughout the inquiry and would have the primary responsibility for representing the public interest. By "standing," I mean the right to participate in the proceedings.

The rules permitted me to grant full or partial standing as a party if I was satisfied that the person or entity had a direct and substantial interest in all or a part of the Inquiry's subject matter. I could also grant standing as an intervenor to a person or entity who had no direct or substantial interest but who had a genuine and demonstrated concern about the issues and a particular perspective or expertise that might assist me. An intervenor had the right to participate in the proceeding but on a more limited basis than a party, particularly with respect to the right to question witnesses. It was within my jurisdiction to set terms on which a party or intervenor would be granted standing, or to order that a number of applicants share in a single grant of standing.

In some cases, I granted standing limited to certain phases of the Inquiry.

Striving to ensure that a wide range of perspectives would be represented at the Inquiry, in April and May 2011 the Commission published calls for applications for standing. Also, certain individuals and entities were directly invited to apply for standing.

2.9.2 INITIAL RULING ON STANDING – JUNE 2011

The Commission received written applications for standing in early June 2011, following which I heard oral submissions and gave my initial ruling on standing on June 29, 2011. It is found at Appendix 4.

My initial ruling on standing granted full party standing for all phases to each of the following:

- the Government of Manitoba's Department of Family Services and Consumer Affairs (later the Department of Family Services and Labour and now the Department of Family Services);
- the Manitoba Government and General Employees' Union (MGEU); and
- Intertribal Child and Family Services (ICFS).

I made a single grant of full party standing for all phases of the Inquiry to be shared by two individual applicants: Phoenix's father, Nelson Draper Steve Sinclair (Steve Sinclair); and his friend, Kimberly-Ann Edwards, who had cared for Phoenix from time to time.

I also made a single grant of full party standing to be shared by:

- The General Child and Family Services Authority (General Authority);

- First Nations of Northern Manitoba Child and Family Services Authority (Northern Authority);
- First Nations of Southern Manitoba Child and Family Services Authority (Southern Authority); and
- Child and Family All Nations Coordinated Response Network (ANCR).

These parties are collectively referred to as "the Authorities/ANCR." This single grant at first was limited to Phases Two and Three but on March 6, 2012 I approved an application for an extension to include Phase One of the inquiry as well. (This shared grant was later split, as discussed below.)

In my initial ruling I also granted intervenor standing to:

- the University of Manitoba, Faculty of Social Work;
- the Assembly of Manitoba Chiefs (AMC); and
- the Southern Chiefs' Organization (SCO).

On July 4, 2012, the AMC and SCO applied for a single grant of shared standing as a party for Phases Two and Three of the inquiry and I granted that request on July 24, 2012.

2.9.3 APPLICATIONS RECEIVED AFTER INITIAL RULING

After my initial ruling on standing, I received applications from a number of organizations wanting an opportunity to contribute to the Inquiry, and in particular to Phases Two and Three. I granted intervenor standing to:

- the Manitoba Métis Federation and the Métis Child and Family Services Authority Inc.;
- the Aboriginal Council of Winnipeg; and
- Ka Ni Kanichihk Inc.

A list of all counsel who appeared at the inquiry is found at Appendix 5.

2.9.4 AUTHORITIES/ANCR SPLITTING OF SHARED GRANT

Initially, the Authorities/ANCR shared a single grant of standing. During the course of the Inquiry's public hearings, in February 2013, an issue of conflict of interest arose: it became apparent that certain entities and individuals were sharing their legal representation although they had possibly divergent interests. To address this conflict while ensuring that the proceedings continued in a timely fashion, on March 19, 2013 I ordered that this shared grant of standing be split. (Appendix 6) The result was that for the remainder of the Inquiry,

- The General Authority was given party standing for all phases; and
- The Northern Authority, the Southern Authority, and ANCR shared a grant of intervenor standing for Phase One, and party standing for Phases Two and Three.

At the same time, several individual witnesses were required to retain new legal representation, as outlined in my ruling.

2.9.5 FUNDING

As Commissioner, I had no authority to make orders for funding for parties or intervenors. After my initial ruling on standing on June 29, 2011, Commission Counsel acted as the conduit by which requests for funding were delivered to the Government of Manitoba. The Commission had no other involvement in funding decisions, nor was the Commission privy to any funding arrangements ultimately arrived at.

2.10 INVESTIGATION PROCEDURES

2.10.1 DOCUMENT PRODUCTION

The Commission's documentary investigation was wide-ranging and substantial. The Commission received, among other things:

- records from child welfare agencies that had provided services to Phoenix Sinclair and her family;
- records of the RCMP's extensive investigation that ultimately led to criminal proceedings against Kematch and McKay;
- records of those criminal proceedings in the Manitoba Court of Queen's Bench; and
- records of the government's response to the discovery of Phoenix's death, including changes to the child welfare system.

The Commission had the power under ***The Manitoba Evidence Act***[26] to subpoena any documents that it considered necessary for a full investigation.

2.10.2 CHILD WELFARE RECORDS

In spite of the Commission's subpoena power, we realized early on that the documentary record that would be central to the Inquiry's work—the records of child welfare services provided to Phoenix Sinclair and her family—would not be available to the Commission without a court order. This was because the Commission's subpoena power did not supersede sections 76(3) and 76(14) of *The Child and Family Services Act,*[27] which provide for confidentiality of records made under that Act. But subsections 76(3)(b) and 76(14)(a) do permit disclosure if allowed by order of the court. The Manitoba Court of Appeal has ruled that the "court" is the Court of Queen's Bench of Manitoba.[28]

So, the Commission devised a process to identify for the Court those documents it required. After I made my initial ruling on standing, and after the parties and intervenors had settled funding issues with the Department of Justice, each party and intervenor was asked for a list of the documents it intended to disclose to the Commission. The documents identified by the Commission, the parties, or intervenors as subject to the confidentiality provisions of ***The Child and Family Services Act*** then became the subject of an application by me to the Court of

Queen's Bench, for an order requiring their production to the Commission. Those who were in possession of the documents, and individuals who were the subjects of the records, were notified of the application. The Commission ensured that the identity of the subjects of the child welfare records was kept confidential. Where names had to be used in court documents, the Commission obtained sealing orders to ensure that the identity of an individual was not revealed to the public unless that person's identity ultimately became relevant and known via the Inquiry's public hearings.

With the cooperation of all involved and the consent of all respondents, on December 2, 2011 the Commission obtained its order from the Court of Queen's Bench. It is found at Appendix 7. The Court ordered that records that would otherwise be protected by ***The Child and Family Services Act*** be produced to the Commission for use in the Inquiry, on terms to be decided by me, and in accordance with the Commission's rules.

After the bulk of the documentary disclosure had been received and our investigation was underway, it came to the Commission's attention that there were additional child welfare records that had not been disclosed, which might be relevant to the Inquiry. A second application was made to the Court of Queen's Bench and again, with the cooperation and consent of the respondents, a further order for production of documents was obtained on June 22, 2012. (Appendix 8)

2.10.3 RCMP DISCLOSURE

The criminal investigation and proceedings against Kematch and McKay were extensive and there was a significant investigation file, which the Commission requested from the RCMP. The Commission's subpoena power under ***The Manitoba Evidence Act*** permitted disclosure of the file by the RCMP and the RCMP accommodated the Commission's request on a timely basis.

2.10.4 REDACTION OF DOCUMENTS

Many of the documents that the Commission received contained personal information, the disclosure of which was not necessary for the Commission's purposes. For example, there were child welfare records; law enforcement records and investigative materials; documents from child protection proceedings; and personal health records. Commission Counsel was mindful of the need to fully disclose all relevant information to parties and intervenors while at the same time preserving personal privacy as far as possible.

After the Commission compiled its documents to be disclosed, I received written submissions from parties, intervenors, and counsel for certain individuals who were the subject of child welfare records, about the categories of information that ought to be redacted.

I gave my ruling on redactions on December 2, 2011, setting out which information was to be redacted before documents would be distributed to the parties and intervenors. The ruling, found at Appendix 9, required the Commission to redact the identities of:

- informants (also known as "sources of referral" or "SORs") under ***The Child and Family Services Act***;
- anyone who was a child at the time a record was created, unless the person's identity was relevant to the Commission's mandate (as in the case of Phoenix herself);
- foster parents; and
- other individuals whose identities were not relevant to the mandate.

Associate Commission Counsel redacted the documents in accordance with my ruling, before they were disclosed to the parties and intervenors. All of the documents disclosed by the Commission remained confidential unless and until they were entered into the public record at the Inquiry's public hearings.

2.10.5 COMMISSION INVESTIGATORS

The Commission engaged the services of two investigators who assisted the Commission throughout its investigative stage and during the public hearings. Sam Anderson, a retired member of the RCMP, assisted the Commission mainly in its early investigative stages, by locating and speaking with witnesses and informing the Commission about potential areas of inquiry. Bruce Foster, a retired member of the Winnipeg Police Service, assisted mainly in the later investigative stages and throughout the public hearings. Both Anderson and Foster transported witnesses who were not represented by lawyers, to and from pre-hearing interviews. Foster served subpoenas on unrepresented witnesses and transported them to and from the public hearings. He also reviewed certain telephone records and provided a written report to the Commission, which was entered into evidence at the public hearings.[29]

2.10.6 WITNESS INTERVIEWS

The Commission's rules provided that Commission Counsel could interview any person believed to have documents or information relevant to the Inquiry. Witnesses had the option of having a lawyer attend the interview with them if they so chose. The rules permitted the Commissioner to attend witness interviews but I chose not to because I preferred to hear the evidence for the first time in the Inquiry's public hearings.

Before the interview, in the case of a witness who was represented by a lawyer, the lawyer would be given the documents relating to the witness's involvement in the matter, or would be told which documents Commission Counsel expected to refer to in the interview. In the case of witnesses not represented by lawyers, they were given copies of the relevant documents at the interview and had an opportunity to

review them. Before being given any documents or information, all interview participants were required to sign confidentiality undertakings.

Most of the Commission's interviews were completed before the public hearings began. If it was decided that a person who had been interviewed would be called as a witness in the public hearings, Commission Counsel would prepare a summary of that witness's expected testimony. A copy of the summary was given to the witness or his or her lawyer for any suggested revisions, and for approval. The summaries also listed the documents counsel expected the witness would reference in their testimony. After that approval, the witness summary was circulated to lawyers for parties and intervenors and sometimes lawyers for witnesses. The summary was not to be used for the purpose of cross-examining the witness at the Inquiry.

These were never intended to be transcripts of the pre-hearing interviews. Early in the process, Associate Commission Counsel took notes of these interviews, but these lawyers were soon needed for other tasks, so the Commission engaged the services of professional note-takers. Eventually, to keep the most accurate record of the interviews, the Commission began to make audio recordings, which then were transcribed and used as the basis for the witness summaries. This final process was one the Commission used for the majority of its interviews.

In the case of individual witnesses who had their own lawyers, the Commission also provided summaries of the testimony of other relevant witnesses. That way, a lawyer for the witness had notice of expected testimony of other witnesses and could apply to the Commission for limited standing to cross-examine particular witnesses.

2.10.7 LAWYERS FOR INDIVIDUAL WITNESSES

A number of the witnesses who were called to testify were not otherwise represented before the Commission by counsel for a party or intervenor. Some had access to a lawyer through their employer. But early on, Commission Counsel identified a number of individuals who would be called to testify about crucial, highly personal, and sensitive matters and who might not have access to legal representation.

Commission Counsel advised all unrepresented witnesses that they were entitled to be assisted by a lawyer and could seek funding from the Department of Justice for those services.

2.11 COUNSEL MEETINGS AND STATEMENTS BY THE COMMISSION

Throughout the course of the Inquiry, Commission Counsel adopted a collaborative approach and worked to maintain cooperation and full and open communication with counsel for the parties and intervenors, to ensure the smooth operation of all aspects of the process. To this end, from the time the Inquiry was established in 2011, to the conclusion of the proceedings, Commission Counsel met regularly with counsel for all participants with standing. At various points

throughout, Commission Counsel called all-counsel meetings to discuss procedural, evidentiary or practical issues. Meetings were also held with various witnesses both on an individual and group basis to address expectations and concerns from all sides. The first of these meetings was held before the standing hearings, with all potential applicants for standing, to discuss various matters including the draft rules of procedure.

Commission Counsel also regularly kept the public and the media informed about the direction the Commission was taking and the Commission's priorities and areas of interest, via statements she made during the course of the Inquiry's public sessions. This helped to serve the Inquiry's function of informing and educating the public.

2.12 STATED CASES AND PROCEDURAL MOTIONS

2.12.1 GENERAL

The procedure for motions before the Commission was set out in the Commission's rules. In addition to applications for standing, the Commission heard a total of 10 motions from parties, intervenors, and witnesses.

The procedure to be used by a party wishing to challenge a Commission decision or the validity of the Commission itself was provided in ***The Manitoba Evidence Act*.** The Commission fielded two challenges under that Act. The first was a challenge to the validity of the Commission itself, and the second was a challenge to a Commission decision on a motion brought before it. These were ruled upon by the Manitoba Court of Appeal.

2.12.2 STATED CASE NO.1: A CHALLENGE TO THE COMMISSION'S VALIDITY

While the Commission was in its pre-hearing investigative stage, on January 31, 2012, I received a request from the Manitoba Government and General Employees' Union (MGEU) to state a case to the Manitoba Court of Appeal concerning the validity of the inquiry.

The statutory basis for the request for a stated case is found in section 95 of ***The Manitoba Evidence Act***. That section provides that if the validity of a commission is called into question by any person affected by it, the commissioner, upon the request of that person, "shall state a case" to the Court of Appeal and the court's decision is final and binding.[30]

The MGEU based its request for a stated case on an argument that the Commission was not valid because section 83(1) of ***The Manitoba Evidence Act*** authorizes the Lieutenant Governor in Council to order an inquiry only "if the inquiry is not otherwise regulated."[31] The MGEU suggested that Phase One of the inquiry was otherwise regulated by virtue of the fact that ***The Child and Family Services Act*** provides processes for investigation after the death of a child who had been in contact with the child welfare system, and ***The Fatality Inquiries Act*** authorizes the Chief Medical Examiner to order an inquest.[32] I was asked to state a case to the Manitoba Court of Appeal, asking whether this Inquiry, particularized in the Order

in Council 89/2011, was otherwise regulated by ***The Child and Family Services Act*** and ***The Fatality Inquiries Act***. After considering the request to state a case, I declined to do so.

The MGEU then asked the Manitoba Court of Appeal to require me to state the case. Its motion was filed with the court on February 3, 2012, using the procedure set out in ***The Manitoba Evidence Act***. Commission Counsel did not take a position on the motion. The Manitoba Department of Justice applied to intervene to defend the validity of its Order in Council and opposed the order sought by the MGEU. Freedman J.A., in Chambers, granted intervenor status to the Department of Justice, and dismissed the MGEU's motion. The ruling is at Appendix 10.

In that decision are some useful comments on section 95 (1) of ***The Manitoba Evidence Act***, which provides that if a person affected by an order of a commission asks a commissioner to state a case to court, the commissioner "shall" do so. But, as the Court's decision points out, if the word "shall" in that section were interpreted as mandatory, the result would be untenable:

> *In my opinion, it is an untenable interpretation of the Act that a case must be stated (with the consequential suspension of the entire work of a commission; see s.95(3)), every time a party affected so requests, without regard to all relevant circumstances, including the justifiability of the request. Such an interpretation would be inconsistent with the object of the statutory provisions and the intention of the Legislature in enacting them, and could impose unjustified consequences seriously prejudicial to the work of a commission. The better view is that where used in s.95 (1), "shall" is directory and not mandatory.*
>
> *If the approach proposed by the applicant was correct, the result would be that the work of a commission could be brought to a halt, at any time, and from time to time, by any party affected who called into question any matter referred to in s.95 (1), even if there was little or no merit in that party's request for a stated case. It is not difficult to imagine that parties who are apprehensive about what a commissioner might report could seek to obstruct the proceedings by this method, perhaps on a repeated basis, and perhaps with little justification for the requests. The commissioner would have no choice under the Act but to state the case as requested and suspend all proceedings. In my view, that cannot have been the intention of the Legislature when it used the word "shall" in s.95(1).*
>
> *The object and purpose of s.95 (1) is to provide a mechanism whereby persons affected by a commission may question the commission's validity and jurisdiction, or decisions, orders, directions or acts of the commissioner. In responding, the commissioner is entitled to evaluate the request for the stated case and to exercise judgment on its justifiability. To deny the commissioner that exercise of judgment would render him or her a mere automaton. That surely cannot be what was requested. Some evaluation of the justifiability of the request for the stated case is necessary.*[33]

The decision also provides guidance on the judge's role when considering such a motion. Freedman J.A. held that the role of the judge is in effect, to act as a gatekeeper:

> *Thus, in my opinion, the role of the judge on an application such as this is to determine two matters. First, the judge determines if the applicant for the stated case has shown the matter proposed to be determined is of some importance, warranting the attention of the court. If the work of a commission is to be suspended, that should only occur if the issue raised meets that standard. Second, the judge determines if the applicant has shown that the case it proposes be heard by the full court is an arguable case that has a reasonable prospect of success. Weak cases with little chance of success should not be sent for a hearing with the consequential suspension of the proceedings of a commission.*[34]

This decision proved to be a useful precedent when the Commission was asked on a second occasion to state a case to the Court of Appeal.

2.12.3 STATED CASE NO.2: MOTION TO PRODUCE COMMISSION TRANSCRIPTS

As discussed earlier in this chapter, the Commission's rules provided that if Commission Counsel decided that a witness would be called to testify, the parties and intervenors would be given a summary of the witness's expected testimony. The Commission's rules did not provide or contemplate that its notes, recordings, or transcripts of the pre-hearing interviews would be distributed. But well into the Commission's investigative stage, it received a request from the Authorities/ANCR for production of the transcribed records of the pre-hearing witness interviews. (There was no request for the notes taken by Associate Commission Counsel or by stenographers.)

The request was contained in a motion filed with the Commission on July 4, 2012. The Authorities/ANCR argued that the transcripts were relevant, non-privileged documents in the possession of the Commission, which the Commission was required to disclose pursuant to its own rules. Counsel for Edwards and Sinclair supported the Authorities/ANCR in its motion.

Commission Counsel objected to the request on a number of grounds. First, the request was contrary to the Commission's rules of procedure, which allowed for only summaries to be provided to counsel and not the notes or transcripts from interviews. Second, the request was contrary to the expectations of witnesses and therefore contrary to the principles of fairness. As all counsel were aware, at the start of every interview, Commission Counsel advised the witness that if it was determined that the witness would be called to testify, only a summary of evidence would be provided to counsel for parties and intervenors. Finally, granting the request would have caused significant cost and delay. During their interviews many of the witnesses spoke about highly personal matters that were not relevant to the Commission's mandate and which would have had to be redacted before the transcripts could be disclosed.

I heard argument on the motion on July 24, 2012 and on August 1, 2012 I gave my decision, dismissing the motion. It is found at Appendix 11.

Two days later, counsel for the Authorities/ANCR asked me to state a case to the Court of Appeal to address these questions:

1. Was there an apprehension of bias, given that Commission Counsel had taken a position opposing the motion?
2. Was disclosure of the witness interview transcripts to the parties and intervenors required by the Commission's rules? and
3. Was such disclosure required by the principles of natural justice and procedural fairness?

On August 9, 2012, I declined to state the case.

The Authorities/ANCR then brought a motion in the Manitoba Court of Appeal, asking for an order requiring me to state the case. Argument was heard in chambers on August 28, 2012 and the decision was reserved. Commission Counsel did not take a position on the motion.

The Commission began its public hearings on September 5, 2012 but on September 7, the Court of Appeal granted the request for a stated case (Appendix 12). Citing the earlier authority of Freedman J.A., the Judge noted that the decision to be made on the motion was not whether my decision would ultimately be upheld by a panel of judges of the Court of Appeal, but whether the issue raised "a matter of some importance" and whether the case had a reasonable prospect of success.[35] The Judge did, however, dismiss the request as it pertained to the issue of a reasonable apprehension of bias. He found that the Authorities/ANCR had not established a reasonable prospect of success on that issue.

The inquiry's proceedings were brought to a halt. As provided by ***The Manitoba Evidence Act***, proceedings were stayed until the stated case could be heard and decided. To minimize delay, Commission Counsel and the parties worked quickly to have the matter heard as soon as reasonably possible. The stated case was heard by Scott C.J.M., Steel J.A., and Hamilton J.A. in the Court of Appeal on October 9, 2012. The Commission retained independent counsel, Simone Ruel, to oppose the request for production. Counsel for Edwards and Sinclair intervened in support of the Authorities/ANCR's application. An individual witness (who was ultimately called to testify at the inquiry's public hearings) intervened in opposition.

The Court of Appeal delivered its decision quickly. On October 22, 2012 the application for disclosure of the interview transcripts was dismissed. [36]

The Court found that the standard of review was that of reasonableness. The Court found that my decision, that the Commission's rules did not require disclosure of the transcripts was a reasonable one. On the question of whether natural justice and fairness required disclosure of the transcripts, the Judge said the following:

. . . . For the reasons that follow, I conclude that procedural fairness, in this instance, is satisfied by the provision of detailed, meaningful summaries of the witnesses' evidence and, therefore, the disclosure of the transcripts is not required. I note that, in addition to the summary of an individual witness's expected evidence, Commission Counsel included a list of documents likely to be referenced in that witness's examination-in-chief. Furthermore, at the request of some counsel, Commission Counsel has identified the specific page numbers of documents which are likely to be referred to by a particular witness.

The parties never expected to receive more than summaries of the witness's evidence. They were fully involved in the development of the Commission rules and made no objection to the disclosure being made by way of summaries.

. . . .In my opinion, whether junior Commission counsel took notes of an interview, an assistant took shorthand, or a verbatim transcript was recorded is irrelevant to the central issue of the parties' legitimate expectations. They always expected to receive summaries of the expected testimony of the witnesses, and this is what happened.[37]

After the Court of Appeal's decision the Commission worked to resume public hearings as quickly as possible, which happened on November 14, 2012.

2.12.4 PUBLICATION BAN MOTIONS – JULY 2012

In addition to the stated cases, both before and during its public hearings, the Commission heard motions from parties and witnesses seeking restrictions on publication of the identities of certain individuals who were called to testify. The first group of motions was heard and decided before the public hearings began, and the second group was heard during Phase One of the hearings.

In August 2011, the MGEU filed a motion seeking to protect the identity of all past and present social workers who would testify at the Inquiry. Because this was early in the Commission's process, before documentary disclosure, and before pre-hearing interviews, the motion was deferred until the pre-hearing investigation was further advanced.

By the time this motion was heard July 4 to 6, 2012, the Commission had received similar requests from the Authorities/ANCR and from ICFS and submissions were heard on all these motions. The three parties had agreed on the orders they were seeking: they wanted a prohibition on any form of publishing, broadcasting, or otherwise communicating by any means:

- the identity or image of any past or present social worker called to testify at the inquiry; and
- the name of any social worker identified in documents produced at the inquiry.

MGEU and ICFS also asked, in the alternative, for an order prohibiting video or audio recording or broadcasting of testimony by social workers at the inquiry. The University of Manitoba's Faculty of Social Work supported the motions. A consortium of the media, Edwards and Sinclair, and the AMC/SCO opposed the motions.

During those three days in July 2012, the Commission also received and heard submissions on motions for orders to protect the identity of witnesses identified by the Commission as informants, or "sources of referral" ("SORs"). In my ruling on redaction, I had ordered that the identity of any SOR was to be redacted from documents in Commission disclosure. Lawyers representing SORs #1, #2, #3, #4, #5, #6, and #7, asked for bans on publication of their identities, and in the case of SORs #5 and #6, an order also excluding the public from the hearing room during their testimony. The media consortium did not take a position with respect to these motions but reserved the right to bring the matter back before me if the evidence indicated that a source of referral had played a significant role in the subject matter of the Inquiry, other than as a source of referral. These motions were not opposed by any of the parties or intervenors.

I dismissed the motions filed by MGEU, the Authorities/ANCR, and ICFS in their entirety. After considering the applicable law and evidence I found that, contrary to what was argued by the applicants, a ban on publication of the identity of social workers was not necessary to prevent a serious risk to the child welfare system or to the best interests of children.

I granted the orders sought by the sources of referral, on the basis of the statutory prohibition on disclosure of the identity of any person who reports a child in need of protection.[38]

My ruling on publication bans, issued July 12, 2012, is found at Appendix 14.

Another motion that was heard during oral submissions in July 2012 was filed by the Department of Family Services and Housing, asking that my ruling on redactions continue to apply to the documents entered into the public record at the public hearings. No objection was made to the motion and, on that basis and for the reasons set out in that ruling, I granted the order sought by the Department.

The Commission devised a protocol to be used by SORs called to testify at the public hearings, to ensure compliance with the prohibition on disclosure of their identities while permitting the fullest public access to the proceedings. Sources of referral testified from an off-site location, via audio and video link. The video portion appeared on a single monitor, visible only to me. The public, media, and all counsel (with the exception of Commission Counsel and the witness's lawyer) were excluded from the hearing room when the witness was identified and sworn in but were otherwise present to hear the testimony via audio feed only. The witness could see and hear counsel in the public hearing room via video feed.

2.12.5 PUBLICATION BAN MOTION – MARCH 2013

During the public hearings, on February 5, 2013, a further motion was filed, seeking to protect the identities of four witnesses who would be called to testify at the Inquiry. Those witnesses, referred to as Doe #1, Doe #2, Doe #3, and Doe #4, were all relatives of McKay. Doe #3 also filed a separate motion on February 13, 2013, for an order declaring her a source of referral.

The motions were argued on March 11, 2013. Of the parties and intervenors in the inquiry, only ICFS and AMC/SCO opposed the motions. The media consortium did not take a position. On March 12, 2013 I granted the motion for a ban on publication of the identities of all four, on the basis that their health or safety could be put at risk if their identities were revealed during the Inquiry. The ruling is at Appendix 15. Because the identity of Doe #3 was protected by my order, it was not necessary for me to decide whether she was a source of referral. The effect of my ruling was that further redactions needed to be made to Commission documents.

When called to testify at the public hearings, each of Does #1, #2, #3, and #4 testified in the same manner as the sources of referral, which allowed public access to the proceedings while keeping their identities confidential.

2.13 CONDUCT OF PUBLIC HEARINGS

The Commission's rules set out the procedure for examination of witnesses at the public hearings. For the most part, Commission Counsel conducted examinations-in-chief, followed by cross-examination by parties with standing, to the extent of their interest in the testimony of that witness. The parties themselves determined the order of cross-examination. Counsel for the witness had an opportunity to examine the witness, followed by a re-examination by Commission Counsel.

The rules permitted counsel for a witness to apply to the Commission to be allowed to present the witness's examination-in-chief. No such application was made in Phase One of the Inquiry. In Phases Two and Three, requests were made and granted from time to time. In those cases, Commission Counsel questioned the witness after the examination-in-chief, followed by cross-examination by parties with standing. The witness's lawyer then had an opportunity to re-examine, followed by a final re-examination by Commission Counsel.

I did not impose time limits on cross-examination of witnesses. Time limits turned out to be unnecessary in any event, as counsel were generally efficient in their cross-examinations without compromising thoroughness.

For Phase Three of the Inquiry, some of the evidence was presented in a panel format. The subject matter lent itself well to this style of presentation, as that phase was aimed at exploring issues within the community and making recommendations.

Commission Counsel did not make a closing submission. Lawyers for the parties and intervenors presented written submissions, limited for the most part to 40 pages in length, and then supplemented those with oral submissions, which took place over a period of seven days in late July.

2.14 NOTICES OF ALLEGED MISCONDUCT

I was required to perform my duties "without expressing any conclusion or recommendation about criminal or civil liability of any person."[39] But because my report would have the potential to affect individual reputations and in keeping with the practice followed by inquiries in Canada and the law that has developed in this regard, Commission Counsel issued notices to those about whom I might make findings of fact amounting to findings of misconduct.

The preamble of the notices of alleged misconduct read as follows:

> *This letter is delivered, in confidence, in accordance with rules 47 and 48 of the Amended Rules of Procedure and Practice of the Commission of Inquiry into the Circumstances Surrounding the Death of Phoenix Sinclair ("the Inquiry").*
>
> *These rules provide that it is open to Commissioner Hughes when he writes his report to make findings of fact that may amount to "misconduct". The guideline as to what amounts to misconduct is found in the Supreme Court of Canada decision:* **Canada (Attorney General) v. Canada (Commission of Inquiry on the Blood System),** *[1997] 3 S.C.R. 440. In this decision, the Court found that "misconduct" is a broad term encompassing anything from "improper or unprofessional behaviour" to "bad management".*
>
> *In this Inquiry, "misconduct" will be assessed by the Commissioner, having regard to the mandate of* **The Child and Family Services Act** *in effect during the time of the delivery of services to Phoenix Sinclair and her family.*
>
> *The purpose of this letter is to notify you that based on the evidence adduced at the public hearings, it is open to the Commissioner to make findings of fact about your conduct that may amount to "misconduct". The substance of such alleged misconduct is as follows: . . . .*

Commission Counsel issued a number of such notices. We decided that the appropriate time to issue them was after all evidence in Phase Three had been heard, and before closing submissions.

The principle behind the notices was fairness—to give advance notice of the substance of potential findings, and advise recipients of their opportunity to make written or oral responses to the Commissioner, or to call additional evidence. The issuance of the notices and any written responses were confidential. No recipient of a notice exercised the option to call additional evidence.

2.15 EXTENSIONS OF THE COMMISSION'S DEADLINE

Although my terms of reference[40] required me to report to the Minister of Justice by March 30, 2012, it became apparent early on that this deadline would not be achievable, given the need to apply for a court order allowing for access to the key documents for Phase One.

The Commission's public hearings began September 5, 2012 but they were adjourned from September 7 to November 14 while the stated case was pending before the Court of Appeal. The hearings then continued relatively uninterrupted until a further adjournment was required in March 2013 to address the conflict of interest issue with respect to counsel for Authorities/ANCR. The hearings resumed on April 15, 2013 and continued, uninterrupted, until final submissions concluded on July 30, 2013.

In total, the Commission interviewed and then heard evidence from 126 witnesses who testified over the course of 85 days. The Commission heard final submissions from counsel for the parties and intervenors over a period of 7 days, for a total of 92 days of public hearings. Given this volume, and the legal challenges and motions to which the Commission was subject, it ultimately became necessary for the Commission to obtain an extension to December 15, 2013 for the submission of my report. This was done by virtue of further Orders in Council (Appendices 16, 17, and 18).

2.16 REPORTS PREPARED FOR THE COMMISSION

To inform me in analyzing the evidence and formulating recommendations, the Commission requested the preparation of four reports from known experts in the field of child welfare, public health, and early childhood development. The reports were prepared by

- Dr. Alexandra Wright;[41]
- Dr. Nico Trocmé;[42]
- Dr. Marnie Brownell;[43] and
- Ms. Kerry McCuaig.[44]

The report of Brownell is attached as Appendix 19, and the report of McCuaig as Appendix 20. Each of these reports is discussed in the context of the evidence given by the authors, each of whom testified before the Inquiry.

[1] R.S.M. 1987, c. E150, s. 83(1)
[2] Transcript, September 2012, p.9, l.23 – p.10, l.4
[3] Commission Disclosure 1
[4] ss. 4(2)(b) and 4(3)
[5] Commission Disclosure 1, pp. 7-8
[6] Commission Disclosure 2
[7] S.M. 1989-09, c. 30
[8] Commission Disclosure 2, p.119
[9] Commission Disclosure 3, p.190
[10] Commission Disclosure 3, p.184
[11] Exhibit 42
[12] Exhibit 42
[13] Commission Disclosure 4
[14] Commission Disclosure 4, p.426
[15] Commission Disclosure 5
[16] Commission Disclosure 5, p.551
[17] Commission Disclosure 6
[18] *The Auditor General Act*, S.M. 2009, c. 39, s.28(1)
[19] Commission Disclosure 6, p.651
[20] Commission Disclosure 6, p.660
[21] *Phillips v. Nova Scotia (Commissioner, Public Inquiries Act)* [1995] 2 S.C.R. 97
[22] *Ibid.*, at para.62
[23] *Ibid.*, at para.117
[24] *The Southern First Nations Network of Care et al. v. The Honourable Edward Hughes*, 2012 MBCA 99, paras. 78-79
[25] E. Ratushny, *The Conduct of Public Inquiries, Law Policy and Practice*, (Toronto: Irwin Law Inc., 2009), p.219
[26] R.S.M. 1987, c. E150, s.88(1)
[27] S.M. 1985-86, c. 8, ss.76(3), 76(14)
[28] *Canadian Broadcasting Corp. v. Manitoba (Attorney General) et al.*, 2008 MBCA 94
[29] Exhibit No. 33
[30] *The Manitoba Evidence Act*, R.S.M. 1987, c. E150, s.95
[31] *Ibid., s.83(1)*
[32] *The Child and Family Services Act*, S.M.1985-86, c. 8, ss. 4(2)(c), 8.2.3; *The Fatality Inquiries Act,* R.S.M. 1989-90, c. 30, ss.19, 25
[33] *The Manitoba Government and General Employees' Union v. The Honourable Edward Hughes*, 2012 MBCA 16 (*"M.G.E.U. v. Hughes")*, paras. 35, 41-42 [Appendix 10]
[34] *Ibid.*, para. 56
[35] *The Southern First Nations Network of Care et al. v. The Honourable Edward Hughes*, 2012 MBCA 83, para. 39. [Appendix 12]
[36] Appendix 13
[37] *The Southern First Nations Network of Care, et. al. v. The Honourable Edward Hughes,* 2012 MBCA 99, paras. 39-40, 42 [Appendix 13]
[38] *The Child and Family Services Act*, S.M. 1985-86, c. 8, s.18.1(2)
[39] Order in Council 89/2011
[40] Order in Council 89/2011

[41] Exhibit 42
[42] Exhibit 111
[43] Exhibit 139
[44] Exhibit 121

3 THE CHILD WELFARE SYSTEM IN MANITOBA

3.1 THE STATUTORY MANDATE

The mandate of the child welfare system is to support and ensure the safety of children, while strengthening their families' capacity to provide them with the nurturing care they need.[45] It was essentially the same throughout the years that are the focus of this Inquiry, and remains so today.

3.1.1 GUIDING PRINCIPLES

During the time that services were delivered to Phoenix and her family, the following Declaration of Principles set out in *The Child and Family Services Act* (CFSA) guided the provision of services to children and families:[46]

1. The best interests of children are a fundamental responsibility of society.
2. The family is the basic unit of society and its well-being should be supported and preserved.
3. The family is the basic source of care, nurture and acculturation of children and parents have the primary responsibility to ensure the well-being of their children.
4. Families and children have the right to the least interference with their affairs to the extent compatible with the best interests of children and the responsibilities of society.
5. Children have a right to a continuous family environment in which they can flourish.
6. Families and children are entitled to be informed of their rights and to participate in the decisions affecting those rights.
7. Families are entitled to receive preventative and supportive services directed to preserving the family unit.
8. Families are entitled to services which respect their cultural and linguistic heritage.
9. Decisions to remove or place children should be based on the best interests of the child and not on the basis of the family's financial status.
10. Communities have a responsibility to promote the best interests of their children and families and have the right to participate in services to their families and children.
11. Indian bands are entitled to the provision of child and family services in a manner which respects their unique status as Aboriginal peoples.[47]

In 2008 the first principle in that list was changed. It now reads: "The safety, security and well-being of children and their best interests are fundamental responsibilities of society." Otherwise, the principles are the same today as they were between 2000 and 2005.

The CFSA empowers child welfare agencies to protect children and support families through both voluntary and involuntary services.

3.1.2 VOLUNTARY SERVICES

Voluntary services are designed to be preventative in nature: to support and work with families who are seeking help, before children are actually placed at risk.[48] Other voluntary services address permanency planning and adoption.[49]

3.1.3 INVOLUNTARY SERVICES

Involuntary services, also known as "mandated services," address protection issues. Agencies such as Winnipeg Child and Family Services (CFS), at the time that services were delivered to Phoenix and her family (and currently), were responsible for receiving reports of suspected child abuse or neglect; investigating; assessing; and if required, intervening to protect children.[50] As the term "mandated," suggests, these are services the family is required to receive, as a result of an abuse investigation or a finding that a child is in need of protection.[51] In such cases a child might be brought into the care of a child welfare agency.

3.1.4 WHAT IS "ABUSE"?

The CFSA defines "abuse" as an act or omission by any person that results in

a) *physical injury to the child;*
b) *emotional disability of a permanent nature in the child, or is likely to result in such a disability; or*
c) *sexual exploitation of the child with or without the child's consent.*[52]

The definition is the same today as it was when services were delivered to Phoenix and her family.

3.1.5 WHAT DOES IT MEAN TO BE "IN NEED OF PROTECTION"?

According to section 17 of the CFSA:

> *". . . a child is in need of protection where the life, health or emotional well-being of the child is endangered by the act or omission of a person."*

It goes on to give examples. A child in need of protection would include a child who:

a) *is without adequate care, supervision or control;*
b) *is in the care, custody, control or charge of a person*
   - *(i) who is unable or unwilling to provide adequate care, supervision or control of the child, or*
   - *(ii) whose conduct endangers or might endanger the life, health or emotional well-being of the child, or*

(iii) who neglects or refuses to provide or obtain proper medical or other remedial care or treatment necessary for the health or well-being of the child or who refuses to permit such care or treatment to be provided to the child when the care or treatment is recommended by a duly qualified medical practitioner;

a) is abused or is in danger of being abused;

b) is beyond the control of a person who has the care, custody, control or charge of the child;

c) is likely to suffer harm or injury due to the behavior, condition, domestic environment or associations of the child or of a person having care, custody, control or charge of the child;

d) is subjected to aggression or sexual harassment that endangers the life, health or emotional well-being of the child;

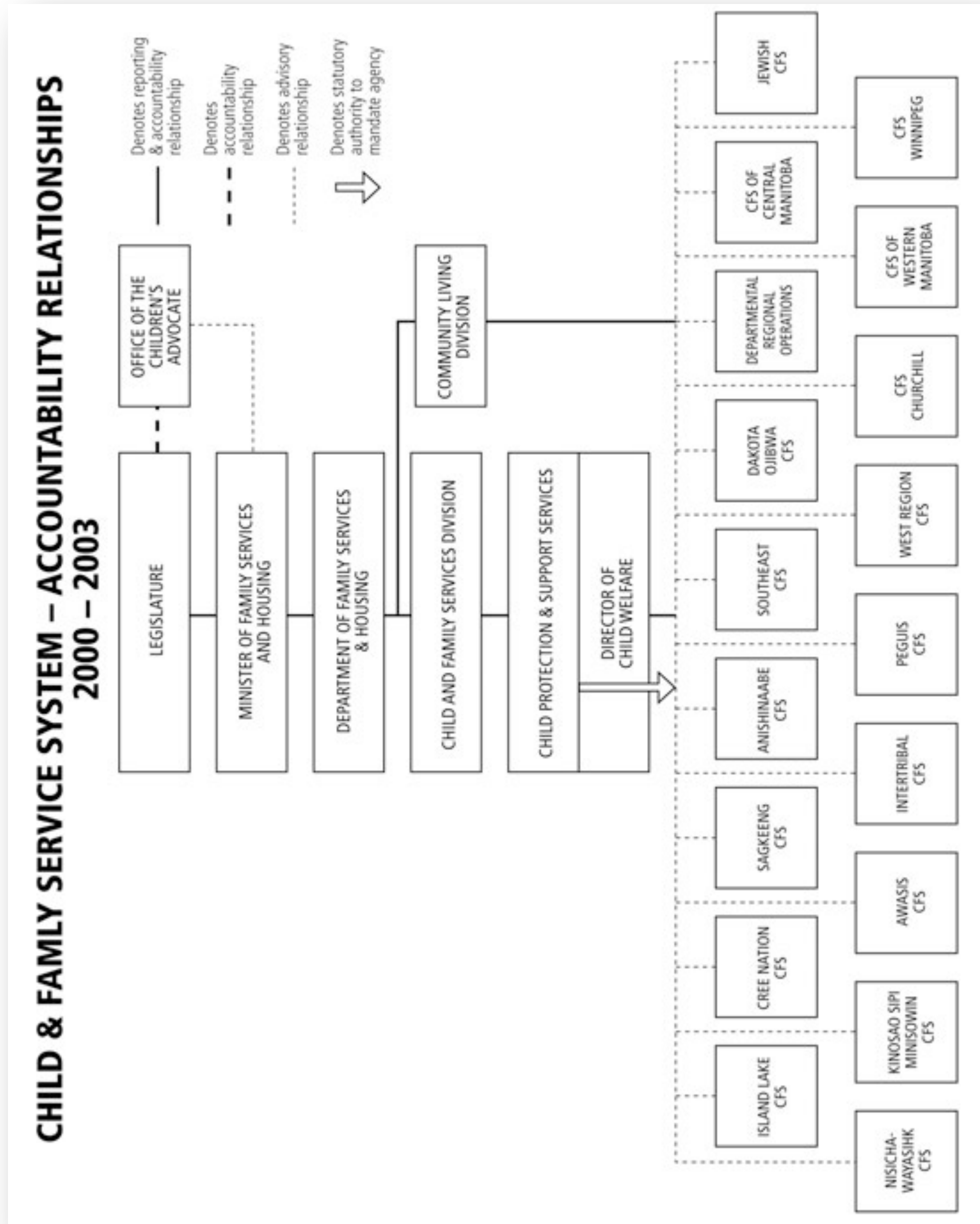
e) being under the age of 12 years, is left unattended and without reasonable provision being made for the supervision and safety of the child; or

f) is the subject, or is about to become the subject, of an unlawful adoption under The Adoption Act or of a sale under section 84.[53]

This was the list of examples in the Act during the years 2000 - 2005. Since then, another example has been added, to address the risk of harm from pornography.

The legislation obliges all individuals, including anyone who acquires information in the course of professional duties, to report a child in need of protection. The only exception is for information protected by solicitor-client privilege.[54]

3.2 ACCOUNTABILITY RELATIONSHIPS



3.2.1 2000-2003

The chart on the previous page illustrates the reporting and accountability structure of Manitoba's child welfare system for the period from 2000 to 2003.[55]

The Children's Advocate was appointed by the Legislative Assembly and was required to report to it annually.

The Department of Family Services and Housing reported to the Minister, who reported to the legislature. The Department had two divisions: Child and Family Services; and Community Living. The Child and Family Services Division was responsible for child protection and support services, and included the position of Director of Child Welfare.[56]

The duties of the Director of Child Welfare included:

- enforcing the provisions of *The Child and Family Services Act;*
- advising the Minister on child welfare issues;
- overseeing all child and family service agencies;
- establishing standards of practice and ensuring that agencies were meeting those standards;
- setting the annual budget and providing child maintenance and operational funding to child welfare agencies;
- licensing residential child care placements;
- hearing appeals regarding foster home licensing; and
- maintaining the central adoption registry and the child abuse registry.[57]

There were 18 child welfare agencies that were accountable to the Director during this period and each had its own board of directors. [58]

During the period from 2000 to 2003, each agency was mandated to provide services only in a specific geographic area. That meant that a First Nations agency could provide services only on its reserve.[59]

3.2.2 DEVOLUTION

Significant changes to the structure of the child welfare system began in 2004, with the process known as "devolution."

In 1988, the Government of Manitoba had created the Aboriginal Justice Inquiry to examine the relationship between First Nations people of Manitoba and the justice system. Its report, released in 1991, dedicated a chapter to the child welfare system. It recognized that many of the issues facing First Nations people were rooted in a history of colonization; the residential school system; and the 1960s expansion of the child welfare system into First Nations communities, which had resulted in the adoption of a large population of children into non-First Nations families.[60]

In 2000, the Government of Manitoba established the Aboriginal Justice Implementation Commission to advise the government on how to implement the Aboriginal Justice Inquiry's recommendations.

As a result, the Aboriginal Justice Inquiry–Child Welfare Initiative (AJI-CWI) was established, in response to the recommendation that the Government of Manitoba work with First Nations and Métis leaders to develop a plan that would result in First Nations delivering their own child welfare services throughout Manitoba, including the City of Winnipeg.[61] In other words, the Child Welfare Initiative was designed to transfer (devolve) child welfare services to the First Nations people of Manitoba.

The Child and Family Services Authorities Act was enacted on August 9, 2002, and proclaimed on November 24, 2003. It created the foundation for designated child welfare authorities to provide oversight to child welfare agencies. This was the first step in the devolution of power over Aboriginal child welfare from the Government of Manitoba to First Nations and Métis people. The *Authorities Act* established four child welfare Authorities:

- the First Nations of Northern Manitoba Child and Family Services Authority (the Northern Authority);
- the First Nations of Southern Manitoba Child and Family Services Authority (the Southern Authority);
- the Métis Child and Family Services Authority (the Métis Authority); and
- the General Child and Family Services Authority (the General Authority).[62]

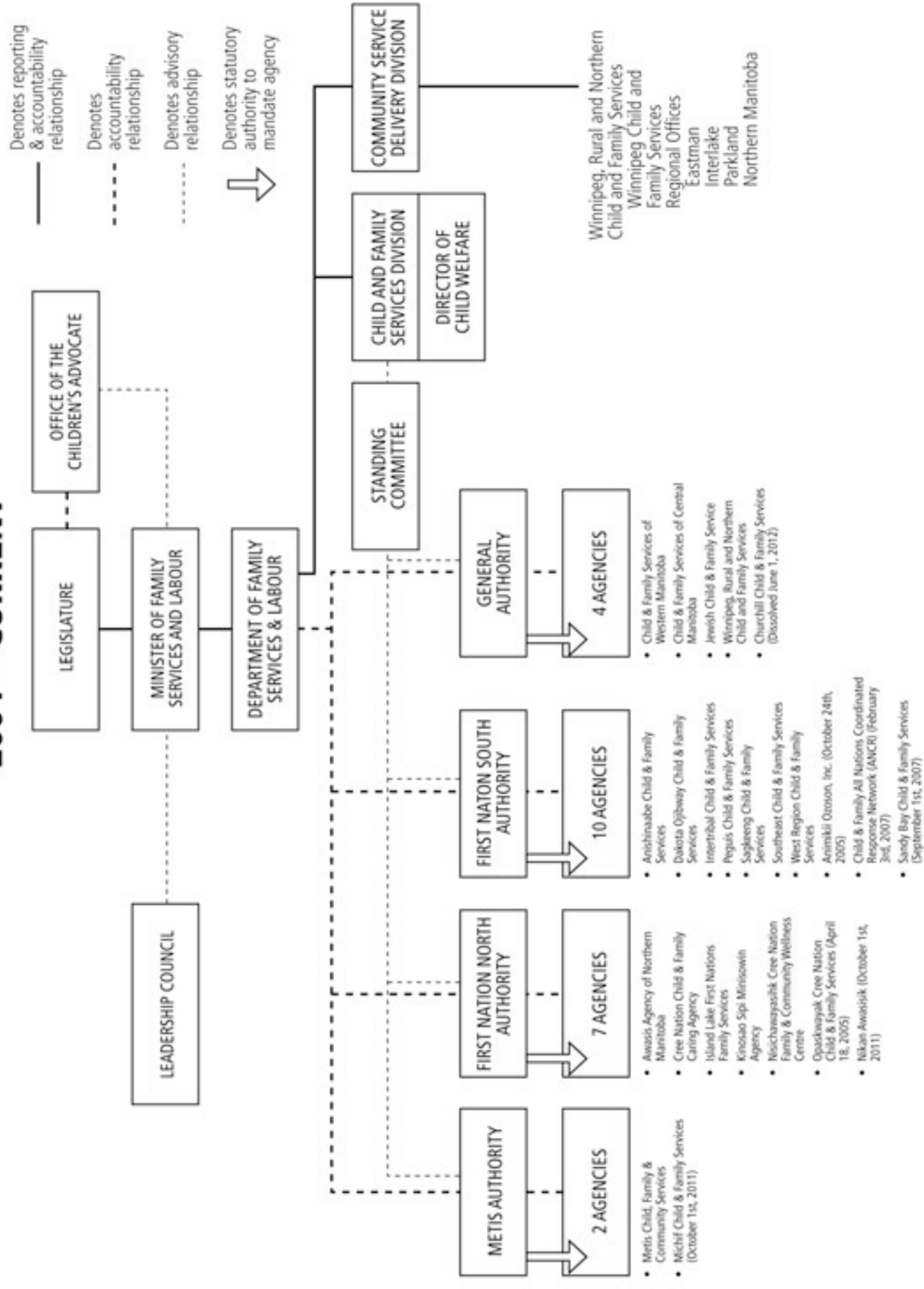
Section 6(1) of *the Authorities Act* requires that each Authority be managed by a board of directors, and the legislation specifies how the boards were to be appointed:[63]

- The board of the Northern Authority was to be appointed by Manitoba Keewatinowi Okimakanak.
- The board of the Southern Authority was to be appointed by the Assembly of Manitoba Chiefs Secretariat Inc., on the recommendation of the Assembly's southern First Nations members.
- The board of the Métis Authority was to be appointed by the Manitoba Métis Federation Inc.
- The board of the General Authority was to be appointed by the responsible Minister.

The main features of the post-devolution child welfare system, as established by *the Authorities Act, and as described by the Department,* are:

> **Delegation of Powers**: The new system grants significant powers to Aboriginal people and their political structures. These new Authorities have taken on, for the most part, the powers formerly vested in the Director of Child Welfare. They are governed by boards of directors appointed by their respective political bodies. Accountability does still remain with the Crown, through the Minister, but the exclusive power of the Authorities is considerable. They may create a mandated child and family service agency or take it over if they believe it necessary to do so. They are the funders of the agencies and may direct them to take action.
>
> **Concurrent Jurisdiction:** Formerly, the province was divided into geographical areas and a single agency or government office was responsible for providing child protection services to all citizens in that area. Now, each of the Authorities has province-wide jurisdiction. In any geographic area of the province there may be multiple child and family service agencies in operation. In Winnipeg, for instance, 19 of the 24 agencies mandated by one of the four Authorities are available to provide a full range of child protection services.
>
> **Intake Services:** The Legislature recognized that concurrent jurisdiction would require co-ordination and a central point for intake, to avoid confusion for police, schools, daycares, and others. *The Authorities Act* requires the Authorities to jointly designate a single agency (the designated agency) to provide intake services in defined geographic areas of the province. Most commonly, this will be one of the existing agencies in the area; or it may be an agency created for this purpose, as is the case in Winnipeg.
>
> **Authority determination process:** An intake agency will interview a family to determine which Authority would be most culturally appropriate to provide the needed services.
>
> **Choice:** Although the system assumes that most families will choose the most culturally appropriate Authority, with limited exceptions they are entitled to choose any of the four Authorities. Children who are expecting or who are independent may make this choice for themselves.[64]

The process of devolution took place between November 2003 and May 2005.[65] Winnipeg CFS was the last agency to initiate the transfer process, beginning on May 2, 2005 and completing the process October 24 that year.[66] During that period, Winnipeg CFS moved some 2,500 files, along with human and capital resources, to the three First Nations Authorities.[67] Approximately 58% of Winnipeg CFS staff were transferred in this process.


CHILD & FAMLY SERVICE SYSTEM – ACCOUNTABILITY RELATIONSHIPS
2004 – CURRENT
Denotes reporting & accountability relationship
Denotes accountability relationship
Denotes advisory relationship
Denotes statutory authority to mandate agency
LEGISLATURE
OFFICE OF THE CHILDREN'S ADVOCATE
LEADERSHIP COUNCIL
MINISTER OF FAMILY SERVICES AND LABOUR
DEPARTMENT OF FAMILY SERVICES & LABOUR
STANDING COMMITTEE
CHILD AND FAMILY SERVICES DIVISION
DIRECTOR OF CHILD WELFARE
COMMUNITY SERVICE DELIVERY DIVISION
METIS AUTHORITY
FIRST NATION NORTH AUTHORITY
FIRST NATON SOUTH AUTHORITY
GENERAL AUTHORITY
2 AGENCIES
7 AGENCIES
10 AGENCIES
4 AGENCIES
• Metis Child, Family & Community Services
• Michif Child & Family Services (October 1st, 2011)
• Awasis Agency of Northern Manitoba
• Cree Nation Child & Family Caring Agency
• Island Lake First Nations Family Services
• Kinosao Sipi Minisowin Agency
• Nisichawayasihk Cree Nation Family & Community Wellness Centre
• Opaskwayak Cree Nation Child & Family Services (April 18, 2005)
• Nikan Awasisik (October 1st, 2011)
• Anishinaabe Child & Family Services
• Dakota Ojibway Child & Family Services
• Intertribal Child & Family Services
• Peguis Child & Family Services
• Sagkeeng Child & Family Services
• Southeast Child & Family Services
• West Region Child & Family Services
• Animikii Ozoson, Inc. (October 24th, 2005)
• Child & Family All Nations Coordinated Response Network (ANCR) (February 3rd, 2007)
• Sandy Bay Child & Family Services (September 1st, 2007)
• Child & Family Services of Western Manitoba
• Child & Family Services of Central Manitoba
• Jewish Child & Family Service
• Winnipeg, Rural and Northern Child and Family Services
• Churchill Child & Family Services (Dissolved June 1, 2012)
Winnipeg, Rural and Northern Child and Family Services
Winnipeg Child and Family Services
Regional Offices
Eastman
Interlake
Parkland
Northern Manitoba

3.2.3 2004 - PRESENT

The chart above illustrates the structure of Manitoba's child welfare system, as it has existed from 2004 to the present:[68]

As can be seen from the chart, two primary relationships remain unchanged: both the Office of the Children's Advocate, and the Minister of Family Services still report to and are accountable to the Legislative Assembly.

The Leadership Council was established pursuant to *The Authorities Act* to serve as a forum for discussion of issues related to child welfare services.[69] Council members are: the Minister of Family Services; the Minister of Aboriginal and Northern Affairs; the Grand Chief of the Southern Chiefs' Organization; the Grand Chief of Manitoba Keewatinowi Okimakanak; and the president of the Manitoba Métis Federation. The Grand Chief of the Assembly of Manitoba Chiefs is an ex-officio member.

Under this current structure, the Child and Family Services Division of the Department of Family Services is responsible for policy and program development, quality assurance, standards, and budgeting for child and family services. This Division also has direct responsibility for development of child placement resources, licensing of childcare facilities, and management of centralized registries such as the adoption registry and the child abuse registry. The Child Protection Branch and the Director of Child Welfare were and are part of the Child and Family Services Division.

The Community Service Delivery Division of the Department was and is responsible for the delivery of all programs and services on behalf of the Department throughout the province, including community living and disability services; child disability services; family conciliation; and child and family services, including child protection services.[70]

The Authorities Act created the Standing Committee, whose members are the CEOs of the four Authorities, the Director of Child Welfare, and an additional member appointed by the Métis Authority. The Standing Committee is the mechanism by which the Department ensures consistency in the delivery of services across the province, and facilitates cooperation and coordination of child welfare services.[71]

As of 2003, Winnipeg CFS has been a separate branch within government. It is unique in that it does not have a board of directors, but reports to the Assistant Deputy Minister within the Community Service Delivery Division. It also has an accountability relationship to the General Authority.[72]

The Child and Family Services Act[73] directs the Director of Child and Family Services to ensure the development of standards of services to children and families, including practices and procedures relating to a child's safety and security. The four Authorities are required to ensure the development of culturally appropriate standards for service delivery, and to ensure that they are consistent with provincial standards.[74]

3.3 WINNIPEG CHILD AND FAMILY SERVICES, 2000 - 2005

3.3.1 CHANGE FROM AREA-BASED TO PROGRAM-BASED SERVICES

All of the child welfare services that were delivered to Phoenix Sinclair and her family were provided through one agency—Winnipeg CFS.[75]

Winnipeg CFS went through a major reorganization in 1999. Before that, the agency had provided services based on geographic area. A full range of services, including intake and after-hours services; services to children and families; and early intervention, was provided in each of four areas of the city, independently of each other.[76]

After reorganization, the agency moved to a program-based model aimed at providing consistent services across the city. By 2000, Winnipeg CFS provided the following programs city-wide: Services to Children and Families; Permanency Planning; Resources in Support of Services; Community-Based Early Intervention; Aboriginal Liaison; and Quality Assurance, Research, and Planning.[77]

The Services to Children and Families program was responsible for intake, after hours, and abuse services; services to children and families; perinatal services; kinship services; and legal services.[78]

3.3.2 INTAKE, AFTER HOURS, AND ABUSE SERVICES, 2000-2003

During the period from 2000 to 2003, Winnipeg CFS provided all its intake services at 835 Portage Avenue. Intake was the door through which new referrals, or reports of a child possibly in need of protection, would come to Winnipeg CFS. Intake services were provided on a 24-hour basis and included assessment, investigation, and intervention if a child was found to be in need of protection.[79]

As of July 2001, intake workers were expected to follow the procedures and practice set out in the document titled, *Intake Program Description and Procedures*,[80] which described the various intake units, and their roles.

Intake included four programs, each of which provided a special function: Crisis Response; General Intake (also known as "Tier Two"); Abuse Intake and Abuse Coordination; and After Hours Service.

CRISIS RESPONSE

In 2000, intake screening was performed by a triage team composed of one staff member assigned on a rotational basis from each of four intake units. They would answer calls, gather information, and assign a level of risk and response priority, for follow up by Intake.

In January 2001, a new Crisis Response Unit (CRU) was established.[81] The role of the CRU was to perform these intake functions:

1. receive referrals;
2. gather information to assess the validity of referrals;
3. make community referrals where child welfare involvement was not required;
4. do child safety assessments, to determine response time; and
5. intervene on an emergency basis where required to ensure child safety.[82]

CRU consisted of two units, each with six social workers, an administrative assistant, and a supervisor. The two units rotated on a regular basis. While one unit performed the first four CRU functions, the other unit would be available for field investigations and interventions. This latter function was referred to as "backup."[83]

GENERAL INTAKE UNITS (TIER TWO)

Referrals were transferred from the CRU to one of four General Intake Units, each with six or seven social workers, an administrative assistant, and a supervisor. Cases were assigned on the basis of the family's geographic location in the city. These units were responsible for further investigation or assessment; for brief interventions to reduce risk to a child; and for referrals to Family Services units in situations requiring longer term assistance. General Intake Units were responsible for emergency crisis intervention in new incidents, but only within regular business hours. (After hours response is described below.) [84]

ABUSE INTAKE AND COORDINATION

This unit's two abuse intake teams were responsible for managing child abuse cases by area: one for north Winnipeg, and one for south Winnipeg and southeast rural Manitoba. The teams, each with six to eight social workers, an administrative assistant, and a supervisor, would investigate all new suspected abuse cases that came to Winnipeg CFS.[85] They were also responsible for investigating allegations of abuse in foster homes, day cares, and schools.[86]

The work of the teams was coordinated by an Abuse Coordinator and administrative assistant, who tracked all investigations and transferred substantiated cases to one of Winnipeg CFS's two Abuse Committees.

The Abuse Coordinator and the supervisors of each of the two teams provided supervision on all abuse incidents in cases open to the Family Service Units.[87]

AFTER HOURS UNIT

As the name implies, the After Hours Unit (AHU) provided services outside normal business hours. It performed the same functions as the CRU, and in addition would intervene on an emergency basis in cases already open in the agency's service units. AHU had 14 social workers and two supervisors.[88] Together, the CRU and AHU provided 24-hour emergency response throughout the city and the rural areas it covered.

3.3.3 REORGANIZATION, 2003

In 2003 Winnipeg CFS ceased to be a stand-alone agency and became a branch of the Government of Manitoba's Department of Family Services and Housing. At that point the agency (branch) was divided into three program areas, each with a program manager who reported directly to the agency's Chief Executive Officer. The three program areas were: Intake and Early Intervention; Services to Children and Families; and Resources.[89] This structure was maintained until 2007.

INTAKE AND EARLY INTERVENTION

After the general reorganization in 2003, intake and early intervention services were provided by two After Hours Units, two Crisis Response Units, four General Intake units, two Abuse Units, and three Community Service Units. Abuse Coordination was no longer an Intake function; it moved to the Services to Children and Families program.

CRU received additional resources and took on a more robust role.[90] Community Programs was discontinued as a stand-alone program and joined Intake.

SERVICES TO CHILDREN AND FAMILIES – FAMILY SERVICE TEAMS

Families requiring service beyond the intake level (CRU or General Intake) would be transferred for ongoing service within one of the unit's 16 Family Service teams. Each team had six to eight social workers and a supervisor and files were assigned to teams on a geographic basis.[91] This unit no longer included an intake function.

The 16 family service teams were only one of three components within Services to Children and Families. The others were: a perinatal services unit; and six permanency placement planning units. Each of these three program areas (family services; perinatal; and permanent placement) were managed by an assistant program manager, who reported to the program manager for Services to Children and Families. [92]

The roles of the family service teams were largely unchanged from before reorganization. Their primary focus was to reduce risk and ensure child safety. Towards this goal, they performed family assessments to identify a family's strengths, resources, and risk factors; engaged in service planning to help families address their challenges; and intervened as necessary to ensure child safety. Evaluation and reassessment were also functions of this unit, with a view to ultimately reducing the risk to children and closing the file. These units handled both child protection and voluntary services, and dealt with children in the agency's care.[93]

3.3.4 STAFF AND MANAGEMENT AT WINNIPEG CFS, 2000 – 2005

At the frontline of the agency was a social worker, who would be assigned to one of the 16 teams and who reported directly to a supervisor. Supervisors reported to an Assistant Program Manager or a Program Manager. Program Managers reported to the Director of Program Services (later, Chief Operating Officer). At the top of the heirarchy was the Chief Executive Officer, who reported to the Associate Deputy Minister for Community Service Delivery, and then the Deputy Minister.

The following chart shows the hierarchy of staff in place during the time that services were provided to Phoenix and her family. In all, 27 workers and supervisors played a role in relation to this family.[94]

Phoenix Sinclair Case Workers, Supervisors etc.

Date	Social Worker	Supervisor	Asst. Program Manager	Program Manager	Director of Program Services (Later Chief Operating Officer)	CEO	ADM Community Service Delivery	DM
April 23, 2000 - April 28, 2000	Marnie Sanderson - (Intake)	Andrew Orobko	Rhonda Warren	Darlene McDonald	Elaine Gelmon	Lance Barber	Not Applicable	Not Applicable
April 24, 2000	Diana Verrier (AHU)	Todd Perreaux	Rhonda Warren	Darlene McDonald	Elaine Gelmon	Lance Barber	Not Applicable	Not Applicable
April 24, 2000	Cindy Murdock (AHU)	Todd Perreaux	Rhonda Warren	Darlene McDonald	Elaine Gelmon	Lance Barber	Not Applicable	Not Applicable
April 28, 2000 - May 5, 2000	No Intake Worker Assigned	Andrew Orobko	Rhonda Warren	Darlene McDonald	Elaine Gelmon	Lance Barber	Not Applicable	Not Applicable
May 5, 2000 to October 10, 2000	Kerri-Lynn Greeley (Family Service Worker)	Lorna Hanson (until June 30, 2000) Angie Balan (after June 30, 2000)	Glenda Edwards	Darlene McDonald	Elaine Gelmon	Lance Barber	Not Applicable	Not Applicable

October 10, 2000 to November 14, 2000	No worker assigned	Angie Balan	Glenda Edwards	Darlene McDonald	Elaine Gelmon	Lance Barber	Not Applicable	Not Applicable
November 14, 2000 to August 16, 2001	Delores Chief-Abigosis (Family Service Worker)	Angie Balan (until June 1, 2001) Lorna Hanson (after June 1, 2001)	Glenda Edwards	Darlene McDonald	Elaine Gelmon	Lance Barber (until July 2, 2001) Linda Trigg (after July 2, 2001)	Not Applicable	Not Applicable
August 16, 2001 - March 1, 2002	Kathy Epps (Family Service Worker)	Lorna Hanson	Glenda Edwards	Darlene McDonald	Elaine Gelmon	Linda Trigg	Not Applicable	Not Applicable
February 26, 2003	Roberta Dick (CRU)	Diva Faria	Rhonda Warren	Darlene McDonald	Elaine Gelmon	Linda Trigg	Not Applicable	Not Applicable
February 28, 2003 - July 2, 2003	Laura Forrest (Intake)	Andrew Orobko	Rhonda Warren (Until March 22, 2003) Dan Berg (after March 22, 2003)	Darlene McDonald (Until March 22, 2003) Patrick Harrison (after March 22, 2003)	Elaine Gelmon (Until March 22, 2003, then direct report to CEO)	Linda Trigg	Martin Billinkoff (Commencing April 1, 2003)	(Commencing April 1, 2003) Tannis Mindell
July 3, 2003-November 13, 2003	Stan Williams (Family Service Worker)	Heather Edinborough	Penny Smith	Darlene McDonald	Not Applicable	Linda Trigg	Martin Billinkoff	Tannis Mindell (until November 3, 2003) Debra Woodgate (after November 3, 2003)

January 16, 2004	Barbara Klos (CRU)	Diva Faria	Dan Berg	Patrick Harrison	Not Applicable	Linda Trigg	Martin Billinkoff	Debra Woodgate
January 20, 2004 - February 13, 2004	Lisa Mirochnick (Intake)	Doug Ingram	Rob Wilson	Patrick Harrison	Not Applicable	Linda Trigg	Martin Billinkoff	Debra Woodgate
May 11, 2004	Debbie De-Gale (CRU)	Diana Verrier	Rob Wilson	Patrick Harrison	Not Applicable	Linda Trigg	Martin Billinkoff	Debra Woodgate
May 13, 2004 to July 15, 2004	Tracy Forbes (Intake)	Carolyn Parsons	Dan Berg	Patrick Harrison	Not Applicable	Linda Trigg (until July 5, 2004) Jay Rodgers (after July 5, 2004)	Martin Billinkoff	Debra Woodgate
December 1, 2004 to December 7, 2004	Shelley Wiebe (CRU)	Diva Faria	Dan Berg	Patrick Harrison	Not Applicable	Jay Rodgers	Martin Billinkoff	Debra Woodgate
March 5, 2005	Jacki Davidson (AHU)	Rick Manteuffel	Not Applicable	Patrick Harrison	Not Applicable	Jay Rodgers	Martin Billinkoff	Milton Sussman
March 5, 2005 to March 7, 2005	Bill Leskiw, Christopher Zalevich (CRU) Richard Buchkowski (CRU)	Diva Faria Diana Verrier	Dan Berg Rob Wilson	Patrick Harrison	Not Applicable	Jay Rodgers	Martin Billinkoff	Milton Sussman

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3.3.5 STRUCTURE OF WINNIPEG CFS AFTER DEVOLUTION

STAFF MOVE TO NEW AGENCIES

The result of the devolution process was that within the City of Winnipeg, services were being provided by 15 First Nations agencies and two General Authority (non-First Nations) agencies. The two General Authority agencies were Winnipeg CFS and Jewish CFS.[95]

Winnipeg CFS units were reduced from 23 to 11: seven Family Service Units; one combined Family Service and Perinatal unit; two Permanency Planning units; and one Family Preservation/Reunification Unit. Staff levels at Winnipeg CFS were reduced from approximately 555 to about 230.[96]

JIRU BECOMES SINGLE ENTRY POINT

With so many agencies operating in Winnipeg, a single entry point was needed, to avoid confusion by the public, and to prevent gaps in services. The new Joint Intake Response Unit (JIRU) was created to serve that purpose, with 150 staff positions that were moved from Winnipeg CFS. JIRU now provided intake and emergency response services for all agencies in Winnipeg.

JIRU included CRU, AHU, the Abuse Unit, General Intake, and Community Programs. Their roles remained largely unchanged from the earlier Winnipeg CFS Intake Unit; workers continued to receive calls and process referrals. But after devolution, at the point of referral from Intake to a Family Service Unit, the family would choose the Authority from which it wished to receive services.[97]

After February 3, 2007, there was no longer any intake function within Winnipeg CFS. The JIRU became an independent agency, reconstituted as the Child and Family All Nations Coordinated Response Network (ANCR). It was, and continues to be, mandated by the Southern Authority.[98] This is now the entry point for referrals throughout Winnipeg.

3.4 CHILD AND FAMILY SERVICES INFORMATION SYSTEM (CFSIS)

Throughout the Inquiry reference was made to the Child and Family Services Information System (CFSIS). CFSIS is a computerized case management tool and data source. Workers document their day-to-day casework to create searchable electronic records for province-wide use. It has been in use since 1993, when it was developed by a team of social workers and computer developers. CFSIS will be discussed more fully in the context of evidence heard in Phase Two, including changes that were made in 2005, and ongoing challenges such as connectivity, accuracy, and ease of use.

Those with access to CFSIS include social workers, supervisors, administrative assistants, and agency executives. During the time that services were delivered to Phoenix and her family, CFSIS was widely used by child welfare social workers and supervisors in their day-to-day practice. The Health Sciences Centre, Children's Emergency Department and the Office of the Children's Advocate have limited access, on a read-only basis.[99]

"Person records" are the foundation of the CFSIS database. A person record includes information such as birthdate, and address for a particular person. That record also lists every CFS case that the person is attached or linked to.[100]

A "prior contact check" is a search function that can show a social worker whether a person has had any previous recorded contact with the child welfare system. A search will return up to 100 closest matches, in terms of names that are spelled alike or sound alike, aliases, maiden names, or other names a person may be known by, and similarity of birthdate.[101]

Each case in CFSIS contains information about the type of case, case status, the individuals involved, and the worker and supervisor responsible for the case.

During the time services were delivered to Phoenix and her family, whenever the agency opened a file, records were maintained in both a paper file and on CFSIS.

[45] Transcript, September 5, 2012, p. 38, l. 6-10
[46] Exhibit 8, p.1
[47] Exhibit 8, Schedule A
[48] Transcript, September 5, 2012, p. 49, l. 21 – p 50, l.8
[49] Transcript, September 5, 2012, p. 38, l. 4-22
[50] Exhibit 13, p.1
[51] Transcript, September 5, 2012, p.50, l.12-20
[52] *The Child and Family Services Act*, S.M. 1985-86, c. 8, s. 1(1)
[53] *The Child and Family Services Act*, S.M. 1985-86, c. 8, s. 17
[54] Transcript, September 5, 2012, p. 54, l. 3-14
[55] Exhibit 9
[56] Transcript, September 5, 2012, p. 57, l. 10 – p. 58, l. 16
[57] Transcript, September 5, 2012, p. 58, l. 21 – p. 59. l. 11
[58] Transcript, September 5, 2012, p. 59, l. 12 – p. 61, l. 1
[59] Transcript, September 5, 2012, p. 64, l. 8 – p. 65, l. 3
[60] Transcript, September 5, 2012, p. 66, l. 3-18
[61] Exhibit 10
[62] *The Child and Family Services Authorities Act,* S.M. c.35, s.4
[63] *Ibid.*, ss.6(2)-6(5)
[64] Exhibit 10, p.4-5
[65] Exhibit 10, p.5
[66] Exhibit 12, p.4
[67] Exhibit 13, p.13
[68] Exhibit 11
[69] Transcript, September 5, 2012, p. 75, l. 18 – p. 77, l. 12
[70] Transcript, September 5, 2012, p. 77, l. 17 – p. 78, l. 21
[71] Transcript, May 13, 2012, p. 57, l. 6-17
[72] Transcript, September 5, 2012, p. 80, l. 18 – p. 86, l. 16
[73] s.4(1)(d)
[74] Transcript, September 5, 2012, p. 85, l. 2-21
[75] Transcript, September 5, 2012, p. 35, l. 11-15
[76] Exhibit 13, p. 1
[77] Exhibit 13, p. 2
[78] Exhibit 13, p. 2-3
[79] Exhibit 13, p. 5
[80] Commission Disclosure No. 992
[81] Exhibit 13, p. 6
[82] Exhibit 13, p. 5-6
[83] For a complete description of CRU's functions, see Commission Disclosure No. 992, p. 19628 - 19639
[84] Exhibit 13, p. 5. For a complete description of Intake functions, see Commission Disclosure 992, p. 19640-19643
[85] Exhibit 13, p. 7
[86] For a complete description of Abuse Intake and Abuse Coordination functions, see Commission Disclosure 992, p. 19644-19658
[87] Exhibit 13, p. 8
[88] Exhibit 13, p. 8
[89] Exhibit 13, p. 10
[90] Exhibit 13, p. 11
[91] Exhibit 13, p. 9
[92] Exhibit 13, p. 12

[93] Exhibit 13, p. 9
[94] Exhibit 15
[95] Exhibit 13, p. 13
[96] Exhibit 12, p. 4; Exhibit 13, p. 13
[97] Exhibit 13, p. 14
[98] Exhibit 13, p. 14-15
[99] Transcript, September 5, 2012 p. 121, l.18 –p. 124, l. 21
[100] Transcript, September 5, 2012, p. 125, l. 1-12
[101] Transcript, September 5, 2012, p. 126, l. 9-23

4 CHILD WELFARE PRACTICE: A FRAMEWORK FOR ANALYSIS

Before I could properly consider the experience of Phoenix Sinclair and her family with the child welfare system, I needed a basic understanding of the issues confronting that system. To provide this context, and at the Commission's request, two acknowledged experts in the field shared their knowledge and experience, both in writing and in testimony before the Inquiry.

4.1 DR. ALEXANDRA WRIGHT: BEST PRACTICES

Dr. Alexandra Wright is one of Manitoba's leading academics in the field of child welfare. She testified at the outset of Phase Two of the Inquiry, and provided to the Commission at its request an updated version of her paper titled, *A Review of Best Practices in Child Welfare*.[102] The paper surveys the relevant literature and provides many real-world examples of the practices and approaches she discusses. In her testimony she explained and expanded upon her paper. She was not asked to look at the specifics of Phoenix Sinclair and her family.[103]

I found Wright's explanation and analysis of best practice extremely helpful in my task of reviewing the child welfare services delivered to Phoenix and her family, and analyzing the changes that have since been made to the child welfare system. Her evidence informed my findings and my recommendations.

What follows is a synopsis of the most relevant portions of Wright's paper and her testimony before the Inquiry.

4.1.1 CHILD WELFARE DEFINED

"Child welfare" can be defined as a system of service planning and delivery aimed at both supporting and protecting children and their families.[104]

Canada's child welfare system is a complex system, based in federal, provincial, and territorial legislation and policies; funded by various bodies; and offering services through government and also through private non-profit agencies.[105]

4.1.2 BEST PRACTICES USE EVIDENCE TO PRODUCE BETTER OUTCOMES

"Best practices" can be defined as the measurement, benchmarking, and identification of processes that result in better outcomes. It is an evidence-based approach to decision-making. The use of evidence in social work practice, according to Wright, gives social workers the means to manage uncertainty in their complex and challenging work environments.[106]

The term "best practice" reflects what is most desirable in service planning and delivery, at every level from the child welfare system as a whole, to the level of the social worker engaging with a family. Best practice doesn't mean that mistakes will not be made, or that there will be no unforeseen outcomes; but lessons are learned from those mistakes, and new knowledge becomes a basis for improvement.[107]

Best practices at the systems level: Best practices applied in the child welfare system would set expectations for consistency in services across jurisdictions and would result in better outcomes for children, families, and communities. Some of the challenges facing child welfare systems in Canada are:

- adequacy of funding to meet assessed needs;
- Canada's history of colonization and its effects on Aboriginal communities;
- division of responsibility among jurisdictions; and
- the nature of the work itself, which can be complex, and hard on frontline social workers and supervisors.[108]

Best practices at a systems level would address those challenges. In particular, jurisdictional disputes would be eliminated, to put the needs of children and families first. A comprehensive national strategy would be implemented, to resource, monitor, maintain, and evaluate the well-being of Canada's children.[109]

Best practices at the community level: At a community level, best practices enable community members to engage with one another and with service providers, to develop informal support networks for the benefit of families and children. This requires long-term commitment from the agency and identification of workers to engage with specific communities and build trusting relationships. Best practice at a community level would:

- recognize the importance of community, and see a child's needs and strengths in the context of the family and community;
- focus on engagement and empowerment, with culturally respectful services; and
- turn to the community for solutions to the negative effects of colonization on Aboriginal people, families, and communities.[110]

Best practices at the organizational level: Child welfare agencies can incorporate best practices in every aspect of their organization: in governance; management; human resources; program administration; planning and design; programs and services; workload factors; interagency relations; community relations; and information technology.[111]

Best practice dictates a family support approach to child welfare work, instead of the case management approach that so often prevails in an environment where work is crisis-driven. A child welfare agency operating with a case management approach provides a minimum of service, and relies on collateral service providers to establish relationships with the family. By contrast, in a family support approach, collateral services do have a role to play, but it is the social worker who develops the primary relationship with the family. Working in partnership with the social worker to build on its strengths, the family is empowered to identify and develop its own abilities, and better outcomes are achieved.[112]

This approach requires personal commitment by social workers, and retention of these workers, so there can be continuity in the relationship between family and social worker, giving the children and family someone they can depend on.[113] Working together, the social worker and family can develop a plan, and identify areas for change and the means to effect that change. But relationships take time to build, so there are implications for workload. As long as social workers are focusing on moving from crisis to crisis, it is difficult to imagine how a family support approach is possible.

And since positive change will not happen immediately, evaluation of these approaches cannot be done immediately. Evaluation of success may need to wait until the process has been in place for some time.[114]

Wright acknowledged a number of impediments to best practice that are commonly identified by social workers. Some are financial: general limitations on resources; practice decisions based on economic considerations; and inadequate pay rates for frontline workers. Others are personnel issues: caseload size; staff turnover and vacancies; inadequate or badly timed training; and lack of expertise among supervisors. Social workers find that recommendations made as a result of reports and projects often are not implemented. And they say that good practice is not recognized, leaving them feeling vulnerable and unsupported by their employer, in the event of a crisis.[115]

In most cases, only the social worker and his or her direct supervisor will have any knowledge of the facts of a particular file. This means that the role of the supervisor is key to best practices from an organizational perspective. Supervisors set the tone of an organization and ensure accountability to the organization, to funders, and to families and children who are receiving services. Supervisors are responsible for identifying substandard services and then ensuring that necessary improvements are made. They need to have sufficient education and training, including continuing professional development; their own regular supervision; and the capability to support their staff.[116]

If social workers find that they are unable to accomplish their work because of workload pressures, they have a responsibility, at the very least, to let their supervisors know; and supervisors have a responsibility to address these issues with managers.[117]

Professional coordination, collaboration, and information sharing is an element of best practice, whether within the child welfare system itself, as when a family is transferred from intake to family services; or between organizations, for example, between a family services worker and the education system.[118]

In a best practices approach, evaluation is a component of every aspect of the agency's work, allowing for monitoring and constant improvement of service planning and delivery. An agency may incorporate best practices as service delivery standards.[119]

Best practices at the direct practice level: A solid approach at the organizational level can enhance and sustain best practices at the level of direct service. It's difficult for frontline social workers to achieve best practices without organizational support.[120]

There are six general stages to child welfare practice: intake; investigation; assessment (including risk assessment); service provision; evaluation; and closure (or transfer for continued services). Throughout the service stages, best practice requires that workers document relevant information and familiarize themselves with the history of any previous involvement with the child welfare system, as they prepare to work with the family.[121] A family's previous involvement may reveal issues that still need to be addressed, or could point to positive changes that the family has achieved.

If an allegation of maltreatment is reported, the worker investigates and meets with family members to discuss concerns. Attachment between parent and child is one element to be assessed.

The investigation and prior history will inform the social worker's assessment and evaluation of the family's situation. Risk assessment is one component, which aims to determine whether a child is at risk of abuse or neglect and if so, to gauge the seriousness of the risk. Risk assessment tools can be used to systematically address variables that affect child well-being, but should not be used as a computational model, neglecting the application of professional judgment.[122]

Based on the assessment of the family's needs and strengths, the family and the worker then collaborate to develop a service plan. The plan will set specific goals. Family members and service providers are assigned tasks and responsibilities, with timelines. The plan should also take into account other needs, such as food, housing and education, and should specify the roles of collateral service providers and other professionals.

The service plan then becomes the basis for evaluating results. At ongoing meetings, the worker and family will identify goals attained, and modify the plan to take account of new information. Services are ended when the goals have been reached and family functioning is stable.[123]

During initial and ongoing assessments, it is crucial that the worker has physical access to the children and meets with them to assess their well-being. Changes in the family's composition—such as a new partner—and the impact this has on the children are key to the ongoing assessment.[124]

When dealing with families where maltreatment has occurred in the past, and who resist contact with child welfare, workers must take an authoritative and decisive stance to ensure the child is protected, regardless of how uncomfortable this may be for the worker.[125]

4.1.3 AN ECOLOGICAL APPROACH TO CHILD WELFARE PRACTICE

An ecological approach to child welfare service planning and provision means that a child or a family is seen not in isolation, but in relation to the broader community, Wright explains in her paper. An ecological approach recognizes the impact of such forces as racism, sexism, and poverty and sees child maltreatment as a consequence of the interplay between a complex set of risk and protective factors at the individual, family, community, and society levels.[126]

A child welfare system needs to be seen in its economic, cultural, political, and social context. An ecological approach focuses not on blame, but on working with a family's strengths, within that larger context.[127]

Studies show that the majority of poor families do not abuse their children, but children in poor families are more likely than others to experience maltreatment because poverty exposes their families to greater stress, and their communities offer fewer supports to families.[128]

Poverty is a particularly significant factor in the experience of Aboriginal children, and women with children. Wright quotes Statistics Canada reports that in 2006, 21% of non-Aboriginal children lived in low-income families compared with 57% of First Nations children, 45% of Inuit, and 42% of Métis. Communities that aren't economically sustainable offer fewer opportunities and fewer support services, creating greater stressors for families. A best practices approach to child welfare in its broader sense would address these issues, Wright testified.[129]

4.1.4 PREVENTION REQUIRES A LONGER VIEW

There will always be a need for interventions to protect children, but too often the focus has been on this aspect of child welfare, to the detriment of early prevention, and support to families. A longer view would focus instead on prevention, which can occur on three levels:[130]

- At the primary level, child welfare issues are prevented from arising, with activities such as public awareness campaigns.
- At the secondary level, services are targeted to identified risks; substance abuse treatment programs are an example.
- At the tertiary level, the aim is to prevent recurrence of maltreatment that has already happened.

Careful investment in early detection, prevention, and treatment programs is not only a moral imperative, it is also sound fiscal policy that would directly benefit all Canadians by reducing the multiplier effects of child maltreatment, including costs associated with criminal justice, substance abuse, and taking children into care.[131]

This is a theme that was to be repeated throughout the testimony heard in Phases Two and Three.

4.1.5 WELL-BEING MEANS MORE THAN SAFETY

Child welfare legislation focuses on the best interests of children and recognizes that the family is the best place for children to grow up. So society needs to support families to be able to raise their children in a positive and functioning way.[132]

Enabling children to reach their true potential requires a focus on their well-being as the desired outcome, with safety being only one aspect of well-being. But promoting a child's well-being is time-consuming and requires resources, skill, and knowledge. It calls for building genuine relationships between service providers and individuals or families, to empower them to make positive changes and choices.[133]

4.1.6 CHILDREN ARE A COMMUNITY RESPONSIBILITY

Communities have both the right to determine what is best for their children, and the responsibility to ensure their well-being. Children are a community responsibility and their protection is a collective concern.

Recognition of the importance of community in the child welfare context is not new. But unlike traditional welfare practice, community approaches include members of the community in defining and suggesting responses to their problems, according to Wright. Coming from an ecological perspective, community practice emphasizes engagement in the community, informal support networks, and promoting community responsibility for the protection of children.[134] The community development section that existed some years ago in Winnipeg CFS was an example of effective community practice: they provided a clothing depot and met other basic needs, as a means of building trust.

Some challenges to practice on a community level include the time it takes to build trusting relationships, and the tension between the roles of professional social workers and experienced local people.[135]

4.1.7 ABORIGINAL CHILD WELFARE FACES UNIQUE CHALLENGES

In Canada, Aboriginal families are involved with the child welfare system, and their children are in care of child welfare agencies, in disproportionate numbers. Studies suggest that high rates of Aboriginal children in care, suicides, domestic violence, and overall loss of culture are not individual problems: they affect entire communities and require community healing to prevent further intergenerational damage. This need to heal communities and reverse the negative impact of colonization has been a key driver behind the establishment of Aboriginal child and family service agencies. An Aboriginal approach to child welfare applies traditional values and strives to maintain children within their communities, which are seen as the focus of support and empowerment, says Wright.[136]

Best practice in relation to Aboriginal families integrates traditional cultural practices and beliefs with the use of evidence-based knowledge.[137] Culturally appropriate standards of practice for Aboriginal child welfare can be similar to conventional standards, though differing views on how those standards are implemented can cause tension and division.[138]

In Manitoba, the child's cultural, linguistic, racial, and religious heritage is listed as a relevant matter in determining best interests and the *Authorities Act* states that values, beliefs, customs, and traditional communities must be respected in service planning and delivery to Aboriginal people.

Positive developments include the number of Aboriginal people graduating with degrees in social work and working within their communities; and the greater integration of traditional Aboriginal practices such as family group conferencing and working with extended families.[139]

First Nations child welfare services are funded federally, and at a much lower level, per child, than for other children. Further, there are jurisdictional disputes over what costs can be recovered, and at what level, Wright testified. [140]

Families living on reserves don't have access to the range of collateral service providers that are found in other communities. Because the child and family service agency is often the only support available on reserve, staff burnout is common. And because those staff often live on reserve, they are subject to additional stresses on a day-to-day basis.[141]

4.2 DR. NICO TROCMÉ: IMMEDIATE SAFETY AND LONG-TERM WELL-BEING

At the Commission's request, Dr. Nico Trocmé, another of Canada's leading academics in the child welfare field, prepared a presentation for the benefit of the Inquiry[142] and testified at the public hearing.

He first addressed for the Commission the overrepresentation of Aboriginal children in the Canadian child welfare system. I will discuss this aspect of his presentation and testimony in chapters relating to Phase Three of this Inquiry.

His other topic concerns the relationship between keeping children safe, and promoting their long-term well-being. Child welfare systems, he says, tend to focus on immediate threats to a child's safety while paying little heed to the potentially more harmful effects of chronic neglect.

The dual mandate of child welfare services—to protect children from physical harm, and to support their well-being—poses a significant challenge to the child welfare system in cases involving the parenting problems often associated with child neglect, according to Trocmé. He testified that only about 14% of cases that come to the attention of child welfare pose the type of immediate risk to a child that calls for rapid protective intervention. The other 86% of cases require quite a different set of responses, he suggests.[143] Although there is no immediate risk to the child's safety the potential long-term effects are potentially far more serious.[144] These ideas are discussed more fully in Chapter 9 dealing with the differential response practice model.

Speaking broadly, Trocmé testified that the child welfare system generally fails to fully acknowledge the complexity of the types of cases it encounters. "The First Nations children and families coming into contact with the child welfare system," he said, "are coming into contact because life is not good for them. And if we look more carefully at understanding some of the issues, clearly, they speak to something more than a need for better reporting or more investigation. It really speaks to what kind of services we need to be providing, and at what level, with what level of intensity."[145]

Trocmé's call for more sustained responses to child welfare cases, and for services that address the range of issues that bring a family to the child welfare system, is one that was heard from many witnesses throughout the Inquiry.

Disentangling notions of immediate safety from long-term well-being is essential to understanding the context in which the child welfare system responded to Phoenix and her family, Trocmé said. Throughout Phase One, the Inquiry heard time and again that because there was no perceived threat to Phoenix's immediate safety, no intervention was warranted.

His evidence, along with Wright's about best practice, has informed my analysis of the services that were delivered to Phoenix and her family at various times during her life as she moved between parents, each of whom posed different risks to her safety or well-being. It is upon this framework that I proceed with my report on the evidence heard during the three phases of this Inquiry.

[102] Exhibit 42
[103] Transcript, April 24, 2013, p. 19, l. 18 – 23
[104] Transcript, April 24, 2013, p. 21, l. 24 – p. 22, l. 2
[105] Exhibit 42, p. 1; Transcript, April 24, 2013, p. 22, l. 15 – p. 23, l. 3
[106] Exhibit 42, p. 3
[107] Transcript, April 24, 2013, p. 28, l. 6-23
[108] Transcript, April 24, 2013, p. 23, l. 11-19
[109] Exhibit 42, p. 13; Transcript, April 24, 2013, p. 59, l. 22 – p. 62, l. 24
[110] Exhibit 42, p. 23
[111] Exhibit 42, p. 23
[112] Transcript, April 24, 2013, p. 92, l. 20 – p. 93, l. 7
[113] Transcript, April 24, 2013, p. 88, l. 20 – p. 89, l. 25
[114] Transcript, April 24, 2013, p. 64, l. 1-18
[115] Exhibit 42, p. 25; Transcript, April 24, 2013, p. 80, l. 15 – p. 81, l. 22
[116] Transcript, April 24, 2013, p. 93, l. 11 – p. 96, l. 17
[117] Transcript, April 24, 2013, p. 82, l. 20 – p. 81, l. 7
[118] Transcript, April 24, 2013, p. 97, l. 9-13
[119] Transcript, April 24, 2013, p. 29, l. 21 – p. 30, l. 30
[120] Transcript, May 15, 2013, p. 33, l. 5-12
[121] Transcript, April 24, 2013, p. 101, l. 10 – p. 102, l. 13
[122] Transcript, April 24, 2013, p. 107, l. 8-12
[123] Exhibit 42, p. 36-37
[124] Exhibit 42, p. 37
[125] Exhibit 42, p. 37; Transcript, April 24, 2013, p. 114, l. 12-25
[126] Exhibit 42, p. 6
[127] Transcript, April 24, 2013, p. 33, l. 18 – p. 34, l. 5
[128] Exhibit 42, p. 7
[129] Exhibit 42, p. 8; Transcript, April 24, 2013, p. 37, l. 14 – p. 39, l. 9
[130] Exhibit 42, p. 11
[131] Exhibit 42, p. 12; Transcript, April 24, 2013, p. 58, l. 44 – p. 59, l. 20
[132] Transcript, April 24, 2013, p. 44, l. 20 – p. 45, l. 3
[133] Transcript, April 24, 2013, p. 45, l. 24 – p. 46, l. 7
[134] Exhibit 42, p. 13-16
[135] Exhibit 42, p. 13- 15
[136] Exhibit 42, p. 17-18
[137] Exhibit 42, p. 18
[138] Exhibit 42, p. 22
[139] Transcript, April 24, 2013, p. 50, l. 5 - 25
[140] Transcript, April 24, 2013, p. 53, l. 12-23
[141] Transcript, April 24, 2013, p. 53, l. 24 – p. 54, l. 7
[142] Exhibit 111
[143] Transcript, May 28, 2013, p. 197, l. 17-22
[144] Exhibit 111, slide 20, 21
[145] Transcript, May 28, 2013, p. 185, l. 14 – p. 186, l. 7