**IN THE MATTER OF THE HEALTH PROFESSIONS ACT,
RSA 2000, c H-7, AS AMENDED;**

**AND IN THE MATTER OF A HEARING INTO THE CONDUCT OF
TERRY-ANN POON TIP, A PERMIT HOLDER OF THE ALBERTA COLLEGE OF
SOCIAL WORKERS;**

**AND IN THE MATTER OF A COMPLAINT BY THE COMPLAINTS DIRECTOR
PURSUANT TO S. 56 WITH RESPECT TO TERRY-ANN POON TIP'S CONDUCT;**

**AND IN THE MATTER OF A HEARING THAT PROCEEDED ON
NOVEMBER 14, 2024 AND ON SEPTEMBER 19, 2025**

FINDINGS DECISION
OF THE HEARING TRIBUNAL

I. Hearing

[1] This hearing was conducted virtually pursuant to the *Health Professions Act* (the "*HPA*") on November 14, 2024 (the "November 2024 Hearing") and September 19, 2025 (the "September 2025 Hearing") with the following persons participating:

Hearing Tribunal (the "Hearing Tribunal")

Vince Paniak, Chair and Public Member
Barbara Artzen, RSW
Jacqueline Mastenbroek, RSW

Note: At the commencement of the hearing Lyle Guard sat as a public member on the Hearing Tribunal. Shortly before the commencement of the September 2025 Hearing and due to a family matter, Mr. Guard advised the Hearing Tribunal Chair that he could not participate in the September 2025 Hearing. At the commencement of the September 2025 Hearing the Chair advised the Complaints Director of this and indicated that the Hearing Tribunal was relying on section 16(3) of the *HPA* to continue with the hearing in the absence of Mr. Guard and with Mr. Paniak, Ms. Artzen and Ms. Mastenbroek as the Hearing Tribunal members. The Complaints Director did not object to that.

Blair E. Maxston, K.C., Independent Legal Counsel to the Hearing Tribunal

The Alberta College of Social Workers (the "College")

Bruce Llewellyn, Complaints Director

Karen A. Smith, K.C., Complaints Director Legal Counsel

Rawan El-Maadaway, Articling Student at Ms. Smith's Firm*

Keslin Park, Director of Professional Conduct*

Vicki Georgoulas, Court Reporter

*These persons only attended the November 2024 Hearing.

As described below, neither Ms. Terry-Ann Poon Tip (the "Member") or legal counsel on her behalf participated in the hearing.

II. Preliminary and Other Matters

(a) Generally

[2] The Chair provided opening comments.

[3] None of the Hearing Tribunal members identified a conflict of interest. There were no objections concerning the composition or jurisdiction of the Hearing Tribunal.

(b) *HPA* Section 79(6) Application

[4] After the Chair's opening comments at the November 2024 Hearing, Ms. Smith advised that the Member and her legal counsel were not present at the hearing and made an application pursuant to section 79(6) of the *HPA* to proceed with the hearing in the absence of the Member.

[5] Ms. Smith provided a Notice of Application in that regard. As mentioned later in this decision, the Notice of Application was marked as Exhibit 1. The Notice of Application contained an Affidavit sworn by Tracy Kaiser, a legal assistant at the law firm of Parlee McLaws LLP ("Ms. Kaiser's Affidavit"). Ms. Kaiser's Affidavit included Exhibits A to I.

[6] Ms. Smith's submissions in support of her client's application to proceed with the hearing despite the non-attendance of the Member can be summarized as follows:

- Simon Renouf has been retained by the Member as her legal counsel, however, as per Exhibit E to Ms. Kaiser's Affidavit, Mr. Renouf has advised that his client will not be participating in the hearing.

- The Amended Notice of Hearing for the November 14, 2024 Hearing was served on the Member and Mr. Renouf.

- As per paragraph 9 of Ms. Kaiser's Affidavit and Exhibit G to that Affidavit, a copy of the Amended Notice of Hearing concerning the November 2024 Hearing was served on the Member through Mr. Renouf.

- Mr. Renouf is still retained as legal counsel for the Member and both Mr. Renouf and the Member were provided with a link for the November 2024 Hearing.

- The Member is aware of the hearing and has received full disclosure from the College.

[7] The Hearing Tribunal deliberated privately concerning the section 79(6) application. When the Hearing Tribunal reconvened, the Chair indicated that the Hearing Tribunal was granting the section 79(6) application. Accordingly, the hearing proceeded in the absence of the Member and her legal counsel.

[8] The Hearing Tribunal was satisfied that Ms. Kaiser's Affidavit and the Exhibits to it clearly established that the Member was properly served with the Amended Notice of Hearing, and was aware of the hearing and that her counsel of record, Mr. Renouf, indicated that the Member would not be participating in the hearing.

[9] Additionally, when the hearing reconvened on September 19, 2025, Ms. Smith referred the Hearing Tribunal to emails from October and November of 2024 indicating Mr. Renouf and his client would not be attending or participating in the November 2024 Hearing. That email was marked as Exhibit 13.

(c) <u>The Numbering of the Allegations</u>

[10] After her client's section 79(6) application, Ms. Smith advised the Hearing Tribunal that there was a numbering typographical error in the Amended Notice of Hearing. Specifically, there was a duplicate Allegation 3 and there were actually 6 allegations, not five. Ms. Smith asked that the duplicate Allegation 3 be changed to read as Allegation 4 and that the remaining allegations to be changed to read as Allegations 5 and 6. The Hearing Tribunal accepted that and the Amended Notice of Hearing was revised accordingly.

(d) <u>The Section 78(1)(a) Application</u>

[11] At the November 2024 Hearing, Ms. Smith made a request pursuant to section 78(1)(a) of the *HPA* for a "sealing order" concerning the Investigation Report which was Tab 4 to Exhibit 11, the Investigation Report prepared by the Office of the Child and Youth Advocate. Specifically, Ms. Smith asked that the portions of that Investigation Report that identify the deceased infant and family members be sealed and not be available to the public. Although the Hearing Tribunal did not issue a verbal decision in that regard at the November 2024 Hearing, the Hearing Tribunal now states that the section 78(1)(a) application made by Ms. Smith is granted.

(e) <u>Possible New Charges and Possible Re-Calling of Witnesses</u>

[12] At the conclusion of the November 2024 Hearing, Ms. Smith submitted that it was open to the Hearing Tribunal to add an additional allegation of unprofessional conduct in terms of the Member's failure to attend the hearing as that type of failure is part of the definition of "unprofessional conduct" in the *HPA*. In a November 14, 2024 email from the Hearing Tribunal's independent legal counsel to Ms. Smith, the Hearing Tribunal indicated that it would not be adding an additional charge relating to the Member's non-attendance at the hearing.

[13] After the conclusion of the testimony of the Complaints Director's witnesses at the November 2024 Hearing, Ms. Smith advised the Hearing Tribunal that it was open to them to recall any witnesses when the hearing resumed if they had questions for those witnesses. In a December 16, 2024 email from the Hearing Tribunal's independent legal counsel to Ms. Smith, the Hearing Tribunal indicated that it did not want to recall any of the witnesses that testified at the November 2024 Hearing.

III. Allegations

[14] The allegations in the October 15, 2024 Amended Notice of Hearing are:

Case Management Failure

i. The Member failed to provide appropriate intervention, oversight, and compliance with policy with respect to a high-risk case involving four (4), three (3) of whom had been returned to the guardianship of their biological parents. Specifically:

- That the Member failed to undertake an appropriate review of the Supervision Order and implement the required steps.
- That the Member failed to ensure compliance with the Supervision Order of August 13, 2021.
- That the Member did not complete a documented safety plan during the time that she managed the file.
- That the Member did not conduct adequate follow up on the safety network and the safety goals regarding the family.
- That the Member failed to undertake appropriate safety scaling to measure safety scaling to measure safety of the children.
- That the Member failed to confirm that the expected daily check-ins were satisfied for the appropriate safety network.
- That the Member failed to update and implement appropriate safety planning for the family.
- That the Member failed to ensure safety planning and support networks were in place to ensure the safety and well-being of each child.
- That the Member failed to ensure appropriate monitoring was in place with the safety plan.
- That the Member failed to provide a cultural plan with respect to the children.
- That the Member failed to prepare timely ongoing assessment reports.

(“**Allegation 1**”).

ii. The Member failed to demonstrate critical thinking in relation to the safety concerns for these children (“**Allegation 2**”).

iii. The Member failed to properly consider the best interest of the children in planning and the decision-making process (“**Allegation 3**”).

Such conduct as described in Allegations 1-3 constitute a contravention of E.1(b), (c)(ii), G.1(a), G.3(a) of the Standards of Practice 2023 and Value 4 and 6 of the Code of Ethics 2005 and constitutes unprofessional conduct pursuant to s. (1) (pp) (i) (ii) and (xii) of the *Health Professions Act*, RSA, 2000, c-H-7, as amended.

Documentation Failure

iv. The Member failed to complete the required timely documentation, including but not limited to:

- Daily check-ins;
- Updated safety plan;
- Ongoing assessment and review of the Permanent Guardianship Order and the Supervision Order;
- Ongoing assessment review and/or consultations with your supervisor;
- Managerial consultations;
- Accurate details relating to the family and safety planning; and
- Reporting as to breaches of the Supervision Order.

("**Allegation 4**").

v. The Member failed to update the Permanent Guardianship Order application to a Supervision Order in an appropriate and timely manner ("**Allegation 5**").

Such conduct a described in Allegations 4 and 5 constitute a contravention of D.2(a)(g), E.1(b)(v), (c)(ii)(iii) of the Standards of Practice 2023 and Value 4 and 6 of the Code of Ethics 2005 and constitutes unprofessional conduct pursuant to s. (1) (pp) (i) (ii) and (xii) of the *Health Professions Act*, RSA, 2000, c-H-7, as amended.

Failure to be Candid

vi. The Member communicated to her supervisor that the safety network for the family was functioning properly when she had failed to ensure the information was accurate ("**Allegation 6**").

Such conduct as described in Allegation 6 constitutes a contravention of E.1(b)(iv), E.1(c)(i)(1)(3), E.1(c)(ii)(iii) of the Standards of Practice 2023 and Value 4 and 6 of the Code of Ethics 2005 and constitutes unprofessional conduct pursuant to s. (1) (pp) (i) (ii) and (xii) of the *Health Professions Act*, RSA, 2000, c-H-7, as amended.

IV. Exhibits

[15] The following documents were entered as exhibits at the November 2024 Hearing:

1. Notice of Application.
2. Amended Notice of Hearing.
3. Amended Notice to Attend.
4. Investigation Report.
5. Non-Disciplinary Complaint Resolution Agreement.

6. October 13, 2023 Section 66 Letter to Ms. Poon-Tip from Mr. Llewellyn.

7. Supervision Order.

8. Transcript Interview of Emmanuel Dumbi dated June 10, 2022.

9. Original Affidavit of Service.

10. Article – Calgary Herald.

11. Investigative Review.

12. Full copy, four pages, of the May 19, 2023 letter from Ms. Poon-Tip to Bruce Llewellyn.

[16] The following documents were entered as exhibits at the September 2025 Hearing:

1. Email from Simon Renouf stating that he and Ms. Poon-Tip will not be attending the Hearing.

2. CBC News Article dated July 23, 2025.

[17] The Hearing Tribunal also received and considered Written Submissions from the Complaints Director dated June 2, 2025.

V. Facts

[18] The facts as presented by the Complaints Director are uncontested by the Member and appear at paragraphs 9 to 24 of the Complaints Director's Written Submissions. Those facts are as follows:

> "9. At all relevant times, the Member was engaged in the provision of social work services through Child and Family Services ("**CFS**").
>
> 10. On or about March 29, 2023, Mr. Llewellyn received information in a completed investigation report by Dr. Badry relating to a family that was receiving child intervention services with CFS through a Supervision Order ("**SO**"). The investigation concerned the Member's supervisor, Mr. Dumbi. The investigation report provided Mr. Llewellyn reasonable grounds to believe that the Member's conduct at CFS constituted unprofessional conduct.
>
> 11. With respect to the investigation report of Mr. Dumbi, the ACSW entered into a Non-disciplinary Complaint Resolution Agreement. Mr. Dumbi's conduct is not at issue in this Hearing and is not to be assessed.
>
> 12. The Member was the caseworker responsible for monitoring and evaluating a highly complex case involving a family with four vulnerable children (the "**Family**"). The Family's first formal involvement with CFS commenced in February 2019. The Member oversaw responsibility for the Family in May 2019.
>
> 13. The Family was high risk because the children were all young and vulnerable, the youngest ones were not in school, the oldest one disabled and unable to communicate, and three of the four children were out of the parents' care for over approximately 400

days. The file documentation also revealed a significant history of domestic violence, substance and alcohol abuse by the parents.

14. The information in question received by Mr. Llewellyn related to the Member's role as the caseworker with the Family, her responsibility for the safety network documentation, and visitations with the Family and issues relating to the safety network before and after the filed SO of August 13, 2021.

15. The children's ages at that time were approximately, 13 ("**Child D**"), 3 ("**Child C**"), 18 months ("**Child G**") and a newborn ("**Child S**").

16. Child G ultimately died in the care of his parents on October 5, 2021.

17. On April 21, 2023, Mr. Llewellyn exercised powers pursuant to section 56 of the *HPA* to treat this information as a complaint and act upon it under section 55 of the *HPA* by appointing an investigator to conduct an investigation in accordance with section 55(2)(d) 8 of the *HPA*, notwithstanding that a complaint regarding the Member under section 54 of the *HPA* had not been made.

18. The Member provided her response to the Complaint on May 19, 2023 (the "**Response**").

19. The investigation report was completed by Mr. Ouellet on August 2, 2023 (the "**Investigation Report**").

20. On October 13, 2023, upon a full review of the investigation report, Mr. Llewellyn made a decision pursuant to section 66 (3)(a) of the *HPA* to refer the matter to the Hearings Director to schedule a hearing.

21. On November 27, 2023, the Hearings Director executed a copy of the Notice of Hearing returnable January 5, 2024 and a copy of same was served to the Member on November 28, 2023.

22. Following ongoing correspondence regarding a meeting between Ms. Smith and Mr. Renouf, a meeting between the Parties occurred on April 12, 2024.

23. On October 15, 2024, the Hearings Director issued an Amended Notice of Hearing to the Member returnable November 14, 2024 and a copy of same was served on the Member that day.

24. On July 26, 2024, and November 8, 2024, the Member and/or her counsel confirmed they would not be in attendance for the Hearing."

These facts are uncontested and the Hearing Tribunal accepts them. The Hearing Tribunal also utilizes the abbreviations set out above for this decision where applicable. The Hearing Tribunal also carefully considered the summaries that appeared in Part IV "Evidence at the Hearing" of the Complaints Director's Written Submissions and accepts them as accurate summaries concerning the testimony provided by the Complaints Director's witnesses.

VI. Submissions of the Complaints Director

[19] At the beginning of the November 2024 Hearing, Ms. Smith made a brief opening statement reviewing the facts giving rise to the allegations, the witnesses that the Complaints Director would be calling and a request to ask the Hearing Tribunal to carefully review all of the documents before them.

VII. Witnesses

[20] The Complaints Director called the following witnesses at the November 2024 Hearing:

- Bruce Llewellyn, College Complaints Director.
- Richard Ouellet, Investigator appointed by College pursuant to Part 4 of the *HPA*.
- Emanuel Dumbi, Case Worker and Supervisor of the Member.

(a) Bruce Llewellyn

[21] The key parts of Mr. Llewellyn's testimony can be summarized as follows:

- Mr. Llewellyn reviewed his educational and work background and his responsibilities as the College's Complaints Director.
- Mr. Llewellyn reviewed the *HPA* section 57 employer complaint regarding the Member and his decision to refer the matter to investigation. Mr. Llewellyn also reviewed how he initiated a section 56 complaint against the Member after receiving the Investigation Report.
- Mr. Llewellyn reviewed the Exhibit 4 Investigation Report and the Exhibit 5 Complaint Resolution Agreement entered into with Mr. Dumbi.
- Mr. Llewellyn reviewed his decision under section 66(3) of the *HPA* to refer the matter to hearing and that complete disclosure was made to the Member.

[22] The Hearing Tribunal had no questions for Mr. Llewellyn.

(b) Richard Ouellet

[23] The key parts of Mr. Ouellet's testimony can be summarized as follows:

- Mr. Ouellet began working as a contracted investigator for the College in August of 2013. In an April 21, 2023 letter, Mr. Ouellet was asked by the Complaints Director to investigate the allegations against the Member. Mr. Ouellet was provided with Dorothy Badry's report concerning Mr. Dumbi and was provided with the CFS report.
- Mr. Ouellet reviewed the steps he took in the investigation including his steps to maintain objectivity. Only after he interviewed the Member did he review the Investigation Report regarding Mr. Dumbi and the CFS report regarding the Member.
- Mr. Ouellet reviewed his Investigation Report which was marked as Exhibit 4.

- Mr. Ouellet reviewed issues of concern regarding the Member's conduct which arose due to his role as a fact finder to gather and evaluate information in support of or against the allegations.

- Mr. Ouellet reviewed the return of the children to their parents after they had been removed for 400 days and that the Member was the case worker assigned to monitor the safety of the children.

- Mr. Ouellet reviewed how family members were to check in and report any issues to the Member and reviewed parts of Exhibit 5 which contain summaries of the check-in's. The check-in's decreased to 0% by September and October of 2021.

- The Member showed very little critical thinking for such a complex case and "safety scaling" was not occurring here. There was not an ongoing assessment of risk.

- The Member carried out cutting and pasting of prior safety plans and there were no regular checks or balances.

[24] The Hearing Tribunal had no questions for Mr. Ouellet.

(c) Emanuel Dumbi

[25] The key parts of Mr. Dumbi's testimony can be summarized as follows:

- Mr. Dumbi stated that he was the subject of an employer *HPA* complaint to the College.

- Mr. Dumbi reviewed the Dr. Badry investigation concerning these issues and his June 10, 2022 interview.

- Mr. Dumbi has worked at CFS since 2013 and has been a supervisor at CFS since 2018.

- Mr. Dumbi reviewed how issues concerning the family came to the attention of CFS in 2017 and 2018.

- Mr. Dumbi reviewed the decrease in daily check-in's and that he did not find out about that from the Member until October 6 of 2021. Mr. Dumbi felt betrayed by the Member and asserted that she lied to him.

- Mr. Dumbi acknowledged he had a responsibility to do more monitoring and broke down emotionally when he was asked about the impact of this case on him personally and professionally.

- Mr. Dumbi testified that he took responsibility for his actions and didn't blame the Member for everything.

- The Member advised Mr. Dumbi that she had handwritten notes regarding her duties in terms of the family but there were no handwritten notes.

- There was nothing extraordinary about the Member's caseload. She was not overloaded.

[26] Ms. Smith emphasized that Mr. Dumbi's conduct was not the subject of the Hearing.

[27] The Hearing Tribunal had no questions for Mr. Dumbi.

[28] The November 2024 Hearing closed with brief comments from Ms. Smith concerning next steps.

VIII. Complaints Director's Closing Submissions

[29] Ms. Smith's closing submissions at the September 2025 Hearing can be summarized as follows:

- Ms. Smith submitted that the Hearing Tribunal must review the Notice of Hearing, the *HPA* definition of unprofessional conduct, the College's Standards of Practice from 2019 and the College's Code of Ethics.

- The Hearing Tribunal should only properly look at the six (6) allegations in the Notice of Hearing.

- There can be no doubt that there is clear and overwhelming evidence which absolutely supports the facts and that they constitute unprofessional conduct. The abrogation of responsibility by the Member is large.

- The overriding obligation of the Hearing Tribunal is protection of the public. Practicing in a profession is a privilege and not a right. In exchange for that privilege, regulated members of the College such as the Member have an obligation to uphold applicable standards. That is missing from the very core in terms of this Member in this hearing.

- All of the Complaints Director's witnesses were credible and the Hearing Tribunal should accept their evidence.

- There is no competing of credibility here. The Member made unsworn and untested statements in the Investigation Report.

- The Member was a compellable witness and it was not an option for her to fail to attend the hearing but she did that.

- Ms. Smith reviewed the allegations and the Complaints Director's view that the Member's conduct was inexplicable and inexcusable. There was only one home visit after the family reunification and the Member's safety plan was a cut and paste. The Member reported to her supervisor that the safety checks were occurring but that was not true.

- The Member did not do any assessment regarding this family and was clearly only engaged in box-checking and cutting and pasting. The Member's failure to act in the best interests of the children was blatant over the two-year time period that the Member had carriage of this matter.

- Mr. Dumbi's evidence was clear that the Member's workload was not insurmountable.
- There was no ongoing case assessment and this was a marked departure from the critical thing required of a regulated member of the College.
- There are inaccurate and incomplete entries by the Member in the documents she prepared concerning the family. There are ongoing deficiencies in every area.
- The Member was not truthful in her report that there were additional handwritten records and she failed to be candid.
- The CFS report indicates that there was a fundamental breakdown by the Member and no critical assessment by her at any time. There was no substantive safety planning.
- There was a complete failure by the Member in terms of her professional obligations.
- Without any qualification, there is a strong evidentiary foundation to make findings of fact and to make findings that unprofessional conduct occurred. Without qualification, all six (6) allegations are completely and absolutely proven and substantiated.

IX. Reasons

(a) Generally

[30] The Hearing Tribunal acknowledged that there is only one standard of proof in civil proceedings such as this: proof on a balance of probabilities. Accordingly, the Hearing Tribunal is tasked with determining whether it is more likely or not that the conduct occurred as alleged. Furthermore, the Complaints Director has the burden of proof to prove that facts occurred on a balance of probabilities and to then establish that proven facts rise to the level of unprofessional conduct as defined in the *HPA*.

[31] For the reasons that follow in this decision, the Hearing Tribunal makes the following findings:

- Allegation 1 - Guilty
- Allegation 2 - Guilty
- Allegation 3 – Guilty
- Allegation 4 – Guilty
- Allegation 5 – Guilty
- Allegation 6 – Guilty

(b) Assessment of the Complaints Director's Witnesses

[32] The Hearing Tribunal recognizes that it was responsible for assessing the credibility of the Complaints Director's witnesses when they testified at the hearing. Among other things, the Hearing Tribunal applies the following factors in that regard:

- Appearance or demeanor.
- Ability to perceive.
- Ability to recall.
- Motivation.
- Probability or plausibility.
- Internal consistency.
- External consistency.

[33] From an overall perspective, the Hearing Tribunal accepts the evidence of the Complaints Director's witnesses. Their evidence was clear, credible and consistent and their credibility was high in the opinion of the Hearing Tribunal. The Hearing Tribunal preferred the evidence of the Complaints Director's witnesses when it contradicted with the Member's statements in the documentary materials that were before the Hearing Tribunal.

(c) CASE MANAGEMENT FAILURE Allegation 1: The Member failed to provide appropriate intervention, oversight, and compliance with policy with respect to a high-risk case involving four (4) children, three (3) of whom had been returned to the guardianship of their biological parents

[34] The CS Report detailed the findings of a comprehensive systematic audit of Children's Services involvement with the family. The CS Report found that the Member's compliance with policy, procedures and practice supports was low and did not meet provincial safety standards.

[35] For background and based on the knowledge and experience of the social worker members of the Hearing Tribunal, every child involved with Children's Services must have a plan of service on file. The plan is to be updated as the family or child's situation changes, especially when there is a change in legal authority (Ie: changing from a Temporary Care Plan to a Supervision Order Plan). The plan is meant to assist the family, service providers, and case team to assess what is working well (strengths), what the ongoing worries (risks) are, and what needs to happen to ensure the continued safety of the children (who is doing what, when). It details the harm that has happened, risks to be addressed, safety goals, and the roles and responsibilities of the safety network to move the family along a trajectory of successful reunification.

[36] The plan is also meant to guide the intervention and to be reviewed and updated regularly. The plan is to be developed by the delegated caseworker in collaboration with the family, safety network, and service providers, and it is the responsibility of the legally delegated caseworker to ensure that it is in place, functional, and effective, as well as completed on the regulation form and uploaded to the electronic information system (CICIO). It is critical that a current detailed plan be available on CICIO should there be a family crisis after-hours that requires a response.

[37] The caseworker is expected to update the plan regularly to reflect the progress of the family and the ongoing assessment of risk. Scaling (0 = safety is low, 10 = safety is high) by all case team members, including the reasons for the number they chose, is required to be documented to assist in critical thinking and demonstrate that analysis is taking place to support decisions.

[38] The plans completed by the Member evidence that they were "cut and pasted" from previous documents which indicates a lack of understanding of the function of a plan, and no analysis of risk or case progress. There is no evidence that the Member herself completed a safety plan during the time she managed the file. The only safety plan referenced and found on file was completed by a contracted service agency, prepared by an agency staff and using agency letterhead. The agency staff was not delegated to provide child protection services and was not responsible for ensuring the safety of the children.

[39] Evidence showed that the agency safety plan did not address risk and safety as required by Children's Services policy and practice. There was no evidence that the Member followed provincial practice expectations regarding the safety network, safety goals, and safely scaling.

[40] There was also no evidence that the Member completed safety scaling with the case team, the supervisor, or the manager, to analyze the risks to the children. Had this scaling been completed, it might have shown that concern by the team was increasing rather than decreasing.

[41] An Ongoing Assessment Report (OAR) is required every 6 months and information before the Hearing Tribunal establishes that the Member did not complete this assessment in the 2.5 years she was involved with the family.

[42] The Supervision Order (that enabled the three oldest children to be returned to care of the parents) required daily check-ins by an identified member of the safety network. Evidence establishes that the Member failed to confirm that the check-ins were actually happening. The check-in requirements consisted of a written confirmation (text or email) to the Member that visual contact was made with the family every day. Evidence establishes that by the time the children were returned to parental care in August 2021, compliance with daily check-ins had fallen to 19% in August 2021, 0% in September and 0% for October 2021. Child G's death was reported on October 5, 2021.

[43] There was no evidence that the safety network members fully understood their roles or responsibilities, nor what to do should the family not be functioning as hoped. It was the role of the Member to ensure safety network monitoring and functioning and that daily check-ins happened. The Member admitted that she had not known, and had not confirmed or checked to ensure, that the check-ins had ceased. The Member denied any responsibility for this failure, indicating that a high caseload was to blame.

[44] Finally, the evidence establishes that the Member failed to create and implement a cultural plan with respect to the children, all identified as Indigenous. Evidence indicated that no cultural planning was found on the children's files.

(d) Allegation 2: The Member failed to demonstrate critical thinking in relation to the safety concerns for these children

[45] Evidence establishes that the Member did not accept accountability for any decisions made regarding the return of the children to parental care after 20 months in Children's Services care. The Member indicated that it was management who made the decision. However, witness testimony and written evidence confirmed that management made the final decision to return the children to parental care. That decision was made based on information and assurances from the Member that the family was doing well, was following all expectations, and the safety plan and network were fully functioning.

[46] Evidence indicates that while the Member was making assurances to management, the safety plan was already failing and the Member never knew or checked to see if the safety plan was adequate.

[47] The Member advised management that she had no reason not to trust the family, illustrating a lack of critical thinking by the Member. The CS Report indicated multiple reasons not to believe the family could be trusted (parental failed drug test, failure to attend drug testing, parents lying to the Member, parents continuously breaching the no-contact order, parents avoiding the Member). Additionally, the children had previously been removed from the parents because of their addictions, violence, and poor life skills.

[48] The onus was on the Member to start from a position of not trusting the parents (thereby protecting the children) and support them to demonstrate their trustworthiness over time, gradually decreasing Children's Services involvement when the evidence demonstrated that the parents could successfully manage. Instead, the Member did the reverse. According to the CS Report, the trust the Member had in the family was not supported by evidence.

[49] The Member indicated that she did not identify concerns nor speak to her supervisor about any concerns she may have had about the children's return to parental care. The Member further stated that she and an agency staff member (not a delegated child protection worker) decided that once the children were returned to parental care, they should stand back and let the family cope and let Children's Services be the voluntary back-up, should the family reach out. Evidence establishes that the role of the Children's Services under a Supervision Order is not to "stand back and see," but rather is a very active period of involvement, requiring close supervision and service provision to ensure the safety of the children. If the family was unable to be successful during the Supervision Order, a second Supervision Order could have been sought.

[50] The CS Report states that the Member did not complete planning or analysis beyond service provision, which focused on substance abuse and family violence. The plan made by the previous CS caseworker was still in use 2.5 years later.

[51] The Member also failed to identify and consider the family's needs and how difficult it would be for parents to suddenly assume the full-time care of four children, three of whom were 3 years old and under. As demonstrated in the evidence before the Hearing Tribunal, the parents had not successfully parented an 11-year-old child and a baby previously, had never parented the 18-month-old child who died, and had a newborn in the home. At the time of return, the parents had not provided any full-time parenting for almost two years, until the birth of the fourth child in May of 2021. There is also no evidence that the individual needs of each child was considered in the reunification, indicating a lack of child-focussed planning.

[52] The Member demonstrated a lack of understanding and critical thinking concerning the differences between a support network and a safety network. A support network member may or may not understand the risks to the children, but is willing and able to provide support to a family where that understanding isn't critical (ie: pick up groceries, provide transportation to a parent, etc.). They do not provide child care and do not function as monitors.

[53] Safety network members must have knowledge of the family, live a healthy lifestyle themselves, understand the risks to the children and agree to watch for indicators that risks are increasing or decreasing. Safety network members agree to hold the parents accountable as needed, and they monitor the family and report to the caseworker truthfully when the situation changes and risk increases.

[54] The evidence establishes that the safety network was not functioning, and the Member did not notice or react when she stopped receiving check-in reports, even though the agency plan outlined some "red flags" that would indicate to the network that concerns were arising.

[55] Documentary evidence shows that the safety network members did not make contact with the Member, as required, in September or October, 2021. The Member had no face-to-face contact with any member of the family after September 1, 2021. The only home visit with the Member and the family after the August 18 return of the children to parental care until the report of Child G's death on October 5, 2021.

[56] A term of the Supervision Order was that the Director was to have announced and unannounced access to the children at any time. The Member did not exercise this access order to ensure the safety of the children. The Member saw the children on September 1, 2021, but there is no information on the file that she spoke to, or laid eyes on any of the children individually. The September 27, 2021 visit by the agency staff was for a food hamper drop-off, with no access to the children or the home. A planned face-to-face contact with the family on October 5 was cancelled by the mother.

(e) <u>Allegation 3: The Member failed to properly consider the best interest of the children in planning and the decision-making process</u>

[57] Evidence in the CS Report showed that the limited planning available was almost exclusively focused on the parents' substance abuse and family violence concerns. Planning was service-focused and failed to consider the best interest of each of the four children. There was some evidence provided regarding the needs of the oldest child (profound hearing loss and developmental delays). There was no evidence that included the continuous risk assessment and safety planning for each child.

[58] Based on the evidence before the Hearing Tribunal, the Member does not appear to have given consideration to returning the children to parental care in a staggered way with attention to the needs of each child. The mandatory consultation with the manager when the decision was made to return the children and withdraw the PGO application, does not appear to have focused on the needs of the children. According to the CS Report "… it appeared that the priority was on preserving family and focusing on strengths rather than mitigating risk and ensuring the safety of the children" (CS Report, p.27).

[59] The three oldest children lived in three different foster homes for the 20 months they were in care. Evidence establishes that the kinship care (extended family) providers who cared for Child G from birth to his return to parental care in August 2021, expressed concerns about

the ability of the parents to meet the needs of Child G in June 2021. Evidence establishes that the Member referred this kinship family to the manager to discuss their concerns, who, based on reports made by the Member, assured the family that the safety network was functioning. The concerns raised by the kinship care providers appear to have been dismissed, though they were valid.

[60] Safety planning and safety network tasks were limited to checking in with the family (relying on self-reports) and laying eyes on all family members. The CS Report identified several concerns with the composition of the Safety Network. Safety planning was not focused on the needs of the children.

[61] The safety plan did not appear to identify any safety network members as possible alternative caregivers should the parents need respite. Had this been part of a safety plan, it would have likely noted that that the 13 year old sibling did not have the capacity to care for his young siblings.

[62] There was no evidence that any planning occurred that addressed the needs of each of the four children, though all were special needs, even if just by virtue of their time in care. The temporary care plans were copied time after time for 2.5 years of the Members involvement. Evidence shows that parents were given copies of the plans and were asked if they had questions but never signed the plans.

[63] The three oldest children were returned to parental care on August 18, 2021. The Member made only one home visit after their return, on September 1, 2021. While the Member recorded that she saw the children, there was no evidence that she spoke to, individually examined, or observed any of the four children with regard to their milestones and development.

[64] There was no evidence that the quality of interactions between each child and each parent and each child to child was ever observed or assessed in the entirety of the Member's involvement over 2.5 years. There was evidence that the Member completed adequate face to face visits with each child in their individual foster homes, as required by policy.

(f) <u>DOCUMENTATION FAILURE Allegation 4: The Member failed to complete the required timely documentation, including but not limited to:</u>

- Entering contact notes on CICIO
- Documenting daily check-ins and uploading to CICIO
- Completing a plan of service that includes a Safety Plan and uploading to CICIO
- Completing current plans of service
- Completing the Ongoing Assessment Report
- Updating the legal authority on CICIO
- Documenting the review of the Permanent Guardianship Order Application
- Documenting the decision to apply for a Supervision Order
- Documenting consultations with the supervisor and manager
- Documenting accurate and complete details relating to the family and safety planning
- Reporting breaches of the Supervision Order to the supervisor and manager

[65] Evidence in the CS Report shows that the Member did not meet provincial standards or policy expectations in any of the above noted areas. Evidence from the Member is that she practiced "old school" as though this might be a reasonable explanation for failing to practice and document according to policy. As part of the CS Report review, all file documentation was audited for compliance to practice and policy standards. The results for each policy and standard was compared to a provincially approved checklist.

(g) Allegation 5: The Member failed to update the Permanent Guardianship Order application to a Supervision Order in an appropriate and timely manner ("Allegation 5").

[66] The evidence establishes that CICIO was not updated to reflect accurate legal authority and a new plan until after the death of Child G. Furthermore, the final updates were not entered by the Member. Instead, they were entered by her supervisor.

(h) FAILURE TO BE CANDID Allegation 6:The Member communicated to her supervisor that the safety network for the family was functioning properly when she had failed to ensure the information was accurate

[67] There was evidence of several instances where the Member failed to be candid or accurate with her information. The CS Report showed that the safety network, which was tasked to report to the caseworker daily, in writing (by text or email), was frequently failing to report, and either the Member did not notice or she did not respond to less frequent reports.

[68] By August of 2021, evidence showed compliance was at 19%, and in September and October, there was 0% compliance. In July of 2021, when the Member reported to management that the safety network was fully functioning, data shows that reports were made only 55% of the time.

[69] In her written response to the ACSW complaint, the Member wrote (May 19, 2023) that she believed that the safety network had been functioning and that she would have been notified if there was a problem. When the evidence was provided to the Member that the safety network had not been functioning at all, the Member, in interviews with the investigator expressed surprise and indicated that she had at some point stopped monitoring her texts and her email. She blamed this failure on being overwhelmed with her caseload the expectations.

[70] In the Member's written response, she indicated that she had met all Children's Services policy standards and expectations for action and documentation, and that any file information not on the electronic system would be found as paper documentation. Evidence provided by the CS Report contradicts this assertion as a thorough review showed low to no compliance with documentation requirements. The CS Report and the Investigation Report show that there was no paper documentation of actions or activities found after the death of Child G, prepared by the Member.

[71] In her written response, to the College complaint, the Member indicated that caseloads were overwhelming and did not meet the provincial standard. The CS Report and the verbal testimony of her supervisor (Mr. Dumbi) show that the Member's caseload assignment was within the provincial standard. Further testimony of Mr. Dumbi indicated that the Member had not been assigned any extra duties and had not been covering for any other child protection workers during her time managing the cases of these four children.

[72] The Member has not accepted any accountability for managing her role in monitoring the safety network as the legally delegated child protection worker.

X. Concluding Comments

[73] The Hearing Tribunal finds that the Member committed unprofessional conduct regarding Allegations 1, 2, 3, 4, 5 and 6.

[74] At the September 2025 Hearing, Ms. Smith indicated that she would provide written sanction submissions as soon as possible after receipt of the Hearing Tribunal's written decision if there are any findings of unprofessional conduct. Ms. Smith also suggested that there would then be a virtual penalty hearing. The Hearing Tribunal agrees with Ms. Smith and directs that a virtual penalty hearing be scheduled for as soon as reasonably possible.

Signed on behalf of the Hearing Tribunal this 15 day of October, 2025.

Vince Paniak, Chair
On behalf of the Hearing Tribunal

**IN THE MATTER OF THE HEALTH PROFESSIONS ACT,
RSA 2000, c H-7, AS AMENDED;**

**AND IN THE MATTER OF A HEARING INTO THE CONDUCT OF
TERRY-ANN POON TIP, A PERMIT HOLDER OF THE ALBERTA COLLEGE OF
SOCIAL WORKERS;**

**AND IN THE MATTER OF A COMPLAINT BY THE COMPLAINTS DIRECTOR
PURSUANT TO S. 56 WITH RESPECT TO TERRY-ANN POON TIP'S CONDUCT;**

**AND IN THE MATTER OF A HEARING THAT PROCEEDED ON
NOVEMBER 14, 2024 AND ON SEPTEMBER 19, 2025**

SANCTIONS DECISION
OF THE HEARING TRIBUNAL

I. Introduction

[1] This hearing was conducted virtually pursuant to the *Health Professions Act* (the "*HPA*") on November 14, 2024 and September 19, 2025.

[2] In a October 15, 2025 written decision, the Hearing Tribunal made findings of unprofessional conduct concerning all of the charges in the October 16, 2024 Amended Notice of Hearing as follows:

Case Management Failure

i. The Member failed to provide appropriate intervention, oversight, and compliance with policy with respect to a high-risk case involving four (4), three (3) of whom had been returned to the guardianship of their biological parents. Specifically:

- That the Member failed to undertake an appropriate review of the Supervision Order and implement the required steps.
- That the Member failed to ensure compliance with the Supervision Order of August 13, 2021.
- That the Member did not complete a documented safety plan during the time that she managed the file.
- That the Member did not conduct adequate follow up on the safety network and the safety goals regarding the family.
- That the Member failed to undertake appropriate safety scaling to measure safety scaling to measure safety of the children.
- That the Member failed to confirm that the expected daily check-ins were satisfied for the appropriate safety network.
- That the Member failed to update and implement appropriate safety planning for the family.

- That the Member failed to ensure safety planning and support networks were in place to ensure the safety and well-being of each child.
- That the Member failed to ensure appropriate monitoring was in place with the safety plan.
- That the Member failed to provide a cultural plan with respect to the children.
- That the Member failed to prepare timely ongoing assessment reports.

ii. The Member failed to demonstrate critical thinking in relation to the safety concerns for these children.

iii. The Member failed to properly consider the best interest of the children in planning and the decision-making process.

Such conduct as described in Allegations 1-3 constitute a contravention of E.1(b), (c)(ii), G.1(a), G.3(a) of the Standards of Practice 2023 and Value 4 and 6 of the Code of Ethics 2005 and constitutes unprofessional conduct pursuant to s. (1) (pp) (i) (ii) and (xii) of the *Health Professions Act*, RSA, 2000, c-H-7, as amended.

Documentation Failure

iv. The Member failed to complete the required timely documentation, including but not limited to:

- Daily check-ins;
- Updated safety plan;
- Ongoing assessment and review of the Permanent Guardianship Order and the Supervision Order;
- Ongoing assessment review and/or consultations with your supervisor;
- Managerial consultations;
- Accurate details relating to the family and safety planning; and
- Reporting as to breaches of the Supervision Order.

v. The Member failed to update the Permanent Guardianship Order application to a Supervision Order in an appropriate and timely manner.

Such conduct a described in Allegations 4 and 5 constitute a contravention of D.2(a)(g), E.1(b)(v), (c)(ii)(iii) of the Standards of Practice 2023 and Value 4 and 6 of the Code of Ethics 2005 and constitutes unprofessional conduct pursuant to s. (1) (pp) (i) (ii) and (xii) of the *Health Professions Act*, RSA, 2000, c-H-7, as amended.

Failure to be Candid

vi. The Member communicated to her supervisor that the safety network for the family was functioning properly when she had failed to ensure the information was accurate

Such conduct as described in Allegation 6 constitutes a contravention of E.1(b)(iv), E.1(c)(i)(1)(3), E.1(c)(ii)(iii) of the Standards of Practice 2023 and Value 4 and 6 of the Code of Ethics 2005 and constitutes unprofessional conduct pursuant to s. (1) (pp) (i) (ii) and (xii) of the *Health Professions Act*, RSA, 2000, c-H-7, as amended.

[3] In a June 9, 2024 email from the Member's previous legal counsel, the Hearing Tribunal was advised that the Member would not be attending or participating in any College proceedings. Accordingly, the Hearing Tribunal determined that the Member has abandoned these proceedings and only requested penalty submissions from the Complaints Director.

[4] The Hearing Tribunal determined that the penalty and costs phase of the hearing would proceed by written submissions only. As a result, the Hearing Tribunal requested written submissions regarding penalty orders and a costs order from the Complaints Director. The Hearing Tribunal received written submissions dated March 5, 2026 from the Complaints Director concerning penalty and costs orders.

II. Submissions of the Complaints Director

[5] The position of the Complaints Director is set out in his written submissions and does not have to be repeated in detail in this decision but can be summarized as follows.

[6] First, the Complaints Director is requesting the following penalty orders and costs order:

1. The Complaints Director requests the following sanctions:

   a. A reprimand shall be issued against the Member;

   b. The Member be found as ungovernable and her registration with the ACSW shall be cancelled, or in the alternative, suspended for five (5) years commencing the date of this Hearing Tribunal Order;

   c. There shall be publication of this matter on a "with names" basis as a result of the cancellation, or in the alternative, the suspension; and

   d. The issue of the Member's non-attendance at the Hearing be considered for referral to the Hearing Tribunal.

2. The Complaints Director requests the following fine:

   a. The Member shall pay a total fine of $25,000 payable within one (1) year (plus 2 percent interest for late payment).

3. The Complaints Director requests the following costs:

   a. The Member shall pay $5,000 of the ACSW's costs of the investigation and Hearing, payable within one (1) year (plus 2 percent interest for late payment).

[7] Second, reasons advanced by the Complaints Director in support of his sanctions orders can be summarized as follows. The Complaints Director referred to the penalty factors in *Jaswal v. Newfoundland Medical Board*[1] and submitted as follows:

- The Member's complete failure to attend to her case management responsibilities represented a serious departure from professional standards.
- The false assurances provided by the Member to her supervisor were a serious breach of the profession's duty to ensure that such processes are conducted with accuracy and integrity.
- The Member's actions in failing to appropriately ensure that the safety network was implemented for the family with four vulnerable children (the "Family") prior to the reunification is serious and harms the integrity of the profession.
- The Member's failure to be candid when making representations to her supervisor about the daily check-ins and failing to verify information was a fundamental failure.
- The Member's unprofessional conduct concerning document deficiencies was unacceptable.
- The Member was a mature and experienced social worker who should have understood her professional obligations.
- The Member has demonstrated a complete failure to recognize or acknowledge the complaint or to be responsive in terms of the discipline process.
- The events giving rise to the findings of unprofessional conduct were deeply distressing and contributed to the most serious outcome, the loss of Child G.
- General and specific deterrence considerations support that the sanctions must be serious. The same factors are relevant to maintaining the public's confidence in the integrity of the profession.
- In accordance with section 82(1)(k), a fine of $5,000.00 for each finding of unprofessional conduct is permitted to a maximum of $25,000.00. Significant fines are necessary in terms of deterrence to the membership.

[8] In terms of the costs order, the Complaints Director submitted:

- The Complaints Director reviewed the costs principles in *Charkhandeh v. College of Dental Surgeons of Alberta*[2]. The Complaints Director advised that the complete costs incurred for the investigation, hearing and submissions including sanctions are approximately $75,000.00 and it is reasonable for some of those costs to be borne by the Member.

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[1] *Jaswal v. Newfoundland Medical Board*, 1996 CarswellNFld 32 (TD), at para 35.

[2] *Charkhandeh v. College of Dental Surgeons of Alberta,* 2025 ABCA 258.

- The Complaints Director was successful in proving all 6 allegations, the investigation and hearing were prolonged by the Member's lack of cooperation and failure to attend which increased the length and expense of the proceedings.

- The $5,000.00 costs order represents only a minor portion of the overall costs properly incurred.

- The sum of $5,000.00 is not "a crushing financial blow" to the Member.

III. Authority of the Hearing Tribunal Concerning Penalties

[9] Pursuant to section 82(1) of the *Health Professions Act* (the "Act"), the Hearing Tribunal is given the discretion to order a wide range of penalties in these circumstances. That section states:

> 82(1) If the hearing tribunal decides that the conduct of an investigated person constitutes unprofessional conduct, the hearing tribunal may make one or more of the following orders:
>
> (a) caution the investigated person;
>
> (b) reprimand the investigated person;
>
> (c) impose conditions on the investigated person's practice permit generally or in any area of the practice of the regulated profession, including conditions that the investigated person
>
> (i) practise under supervision,
>
> (ii) practise with one or more other regulated members,
>
> (iii) not practise in an area of the practice of the regulated profession until the investigated person has successfully completed a specific course of studies or obtained supervised practical experience of a type described in the order,
>
> (iv) not practise in an area of the regulated profession, or
>
> (v) report on specific matters to the hearing tribunal, council, committee or individual specified in the order;
>
> (d) direct the investigated person to satisfy the hearing tribunal, committee or individual specified in the order that the investigated person is not incapacitated and suspend the investigated person's practice permit until the hearing tribunal, committee or individual is so satisfied;
>
> (e) require the investigated person to undertake counselling or a treatment program that in its opinion is appropriate;
>
> (f) direct that within the time set by the order the investigated person must pass a specific course of study, obtain supervised practical experience of a type described in the order or satisfy the hearing tribunal, committee or individual specified in the order as to the investigated person's competence generally or in an area of the practice of the regulated profession;
>
> (g) subject to subsection (1.1), suspend the practice permit of the investigated person for a stated period or until
>
> (i) the investigated person has successfully completed a specific course of studies or obtained supervised practical experience of a type described in the order, or
>
> (ii) the hearing tribunal or a committee or individual specified in the order is satisfied as to the competence of the investigated person generally or in a specified area of the practice of the regulated profession;
>
> (h) subject to subsection (1.1), cancel the registration and practice permit of the investigated person;
>
> (i) if, in the opinion of the hearing tribunal, the investigated person's fees for professional services were improper or inappropriate or the professional services that the investigated person provided were improperly rendered or required the

complainant to undergo remedial treatment, the hearing tribunal may direct the investigated person to waive, reduce or repay the fee for professional services provided by the investigated person;

(j) direct, subject to any regulations under section 134(a), that the investigated person pay within the time set in the order all or part of the expenses of, costs of and fees related to the investigation or hearing or both, including but not restricted to

(i) the expenses of an expert who assessed and provided a written report on the subject-matter of the complaint,

(ii) legal expenses and legal fees for legal services provided to the college, complaints director and hearing tribunal,

(iii) travelling expenses and a daily allowance, as determined by the council, for the complaints director, the investigator and the members of the hearing tribunal who are not public members,

(iv) witness fees, expert witness fees and expenses of witnesses and expert witnesses,

(v) the costs of creating a record of the proceedings and transcripts and of serving notices and documents, and

(vi) any other expenses of the college directly attributable to the investigation or hearing or both;

(k) direct that the investigated person pay to the college within the time set in the order a fine not exceeding the amount set out in the column of the unprofessional conduct fines table that is specified for the college in a schedule to this Act for each finding of unprofessional conduct or the aggregate amount set out in that column for all of the findings arising out of the hearing;

(l) any order that the hearing tribunal considers appropriate for the protection of the public.

IV. Penalty Considerations

[10] Given that *Charkhandeh* establishes that penalty orders and costs orders are separate, this decision will also address those matters separately.

(a) Generally

[11] The College's mandate under the *HPA* is to govern its members in a manner that protects the public and serves the public's interests. A fundamental purpose of penalty orders is to ensure that the public is protected from acts of unprofessional conduct. Bearing in mind this public protection principle, the Hearing Tribunal can also consider deterrence to the member and the profession, rehabilitation, fairness and the integrity of the profession as part of the objectives for determining penalties.

V. Penalty Orders and Analysis

[12] For the reasons that follow, the Hearing Tribunal accepts all of the penalty orders proposed by the Complaints Director.

(a) Nature and Gravity of the Proven Allegations

[13] The Complaints Director's submissions concerning the nature and gravity of the proven allegations are entirely accurate based on the facts and are accepted by the Hearing Tribunal.

[14] The proven unprofessional conduct of the Member represents a clear and fundamental departure from the core values, standards and ethical responsibilities of a social worker. This is not in any way a "grey area". Instead, the Member's unprofessional conduct was of the most serious nature and ultimately significantly contributed to the most serious adverse outcome --- the death of Child G and the significant and profound emotional distress for the remaining children of the Family.

[15] The Member's complete failure to attend to her case management responsibilities (including the implementation and oversight of the safety network for a highly complex case involving a family with 4 vulnerable children) was clearly a serious departure from professional standards. As the Complaints Director noted, this was particularly troubling given that there was a consistent history of domestic violence and substance and alcohol abuse by the parents.

[16] Reuniting the children with their biological parents was based on the Member's advice to her supervisor that daily check-ins were being conducted and reports received with no significant concerns. The proven facts reveal that the Member deliberately provided inaccurate and false assurances in that regard. Her actions were entirely inconsistent with the fundamental duty she had to ensure accuracy and integrity in these circumstances. Her obligations included safeguarding the children's health and safety particularly when returning children to their guardians but she failed to meet those obligations.

[17] The Member's failure to address concerns and gaps in the support network prior to unification of the children with their biological parents was a fundamental breach of her social work obligations. Her failure to attend contributed to the death of Child G.

[18] The Member's repeated failures to be candid and honest when making representations to her supervisor about the daily check-ins is a fundamental failure to meet the standards of professionalism of social workers and seriously undermines the public's trust in the social work profession.

[19] The document deficiencies by the Member were widespread and consistent. The document deficiencies included no evidence of cultural plans for the children, no assessment being completed by the Member during the duration of her management of the Family's file and the absence of documented supervisory consultations.

[20] As the Complaints Director noted, documentation was especially important in this matter having regard to the vulnerability of the children and because the safety checks and network were the cornerstone of the decision to reunify.

[21] As the Complaints Director stated at paragraph 25 of his written submissions, the "breadth, number of violations and the ultimate result of the violations, are aggravating factors.".

(b) Experience Level and Age

[22] The Member was an experienced social worker who should have understood the applicable standards for her work as a social worker. As the Complaints Director stated, the Member's misconduct cannot be explained by inexperience or inadvertence. This is clearly an aggravating factor.

(c) Role of the Member in Acknowledging what has Occurred

[23] Consistent with the Complaints Director's comments at paragraph 29 of his written submissions, the Hearing Tribunal agrees that the Member demonstrated a complete failure to recognize or acknowledge the complaint and the seriousness of her conduct. As the Complaints Director correctly noted, the Member failed to acknowledge the complaint, engage fully with the investigation or respond at all to the hearing process.

[24] The Hearing Tribunal accepts and adopts the following statement at paragraph 29 of the Complaints Director's written submissions:

> "This demonstrates a total denial of the events that occurred and a disregard for her professional obligations and accountability. This reflects a complete lack of remorse and insight into the serious of [her] misconduct and constitutes a significant aggravating factor.".

(d) Impact of the Incident on the Complainants

[25] There is no question that the unprofessional conduct had a profound and harmful effect on all those involved. As the Complaints Director properly submitted, the Member's unprofessional conduct ultimately contributed to the most serious outcome --- the loss of Child G --- and also resulted in significant emotional distress for the remaining children of the Family. The distressing, emotional and fatal impact on those involved is a serious aggravating factor.

(e) Deterrence and Maintaining the Public's Confidence in the Profession

[26] The unprofessional conduct of the Member is extremely serious and the consequences for her actions must clearly communicate to her and to members of the profession that this type of conduct will not in any way be tolerated. Significant penalties are also necessary to maintain the public's confidence in the integrity of the profession to indicate that the ACSW views these matters extremely seriously.

(f) Degree to which the Offensive Conduct Falls Outside the Range of Permitted Conduct

[27] For all of the reasons set out above, it is unquestionable that the Member's unprofessional conduct was a significant departure from the acceptable standards for the profession of social work and clearly falls well beyond permitted conduct for social workers.

[28] For all of the reasons mentioned above, the Complaints Director's request for a global fine of $25,000.00 (which is the maximum aggregate amount allowed pursuant to the *HPA*) is supportable and necessary.

[29] The Member's departure from fundamental and core aspects of the profession of social work and the resulting consequences (including the death of Child G) support a significant fine.

[30] The amount of the $25,000.00 fine is also warranted having regard to the Member's unprofessional conduct was not due to inexperience or inadvertence but was instead a deliberate and consistent pattern of extremely serious unprofessional conduct.

(g) Final Comments

[31] For all of the above reasons, the Hearing Tribunal concludes that permanent cancellation of the Member's registration is clearly warranted and appropriate.

VI. Costs Order and Analysis

[32] The Hearing Tribunal agrees with the Complaints Director that the principles in *Charkhandeh* justify the $5,000.00 costs order.

[33] Among other things, the Complaints Director was successful in proving all 6 allegations and it is reasonable that the Member should reimburse the College for some of the costs associated with these matters.

[34] The Hearing Tribunal also accepts that the investigation and hearing were prolonged by difficulties arising from the Member's behavior including lack of cooperation and failure to attend which in turn unnecessarily increased both the length and expense of the proceedings. There was absolutely no cooperation by the Member and no assistance in avoiding a contested hearing.

[35] As well, the $5,000.00 costs order represents only a small portion of the overall costs of $75,000.00. The Complaints Director is acting fairly and reasonably in seeking a costs order of this amount.

[36] Also, there is no evidence to contradict the Complaints Director's submission that a $5,000.00 costs order is not "a crushing financial blow" to the Member.

[37] For these reasons, the Hearing Tribunal concludes that the $5,000.00 costs order is fair, warranted and supportable having regard to all of the circumstances.

VII. Concluding Comments

[38] The Hearing Tribunal has determined that the Member is ungovernable. She has demonstrated no understanding of the fundamental and core aspects of being a regulated professional. Not only has the Member abandoned the hearing process, there was also lack of cooperation by her throughout the entire discipline process. For all of these reasons, the Member is ungovernable and cancellation of her registration with the ACSW as described below is justified.

[39] The Hearing Tribunal issues the following penalty and costs order:

1. The following sanctions are ordered:

    a. A reprimand shall be issued against the Member ;

    b. The Member's registration with the ACSW is permanently cancelled effective the date of this Hearing Tribunal Order;

    c. There shall be publication of this matter on a "with names" basis as a result of the cancellation.

2. The Member shall pay a total fine of $25,000 payable within one (1) year commencing the date of this Hearing Tribunal Order (plus 2 percent interest for late payment).

3. The Member shall pay $5,000 of the ACSW's costs of the investigation and Hearing, payable within one (1) year commencing the date of this Hearing Tribunal Order (plus 2 percent interest for late payment).

[40] Given the Hearing Tribunal's order that the Member's registration with the ACSW be permanently cancelled, the Hearing Tribunal declines to refer the issue of the Member 's non-attendance at the Hearing to the Hearing Tribunal.

Signed on behalf of the Hearing Tribunal this 8th day of June 2026.

VJ Paniak

Vince Paniak, Chair
On behalf of the Hearing Tribunal