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

Commission Disclosure 1766

Iliffe, Lorraine (FSH)

From: Iliffe, Lorraine (FSH) on behalf of MacDonald, Darlene (FSH)
Sent: Thursday, March 16, 2006 2:54 PM
To: 'rwanddm@mts.net'
Subject: FW: Phoenix Sinclair
Attachments: Sinclair Review.doc

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From: Schellenberg, Dennis (FSH)
Sent: Thursday, March 16, 2006 2:23 PM
To: MacDonald, Darlene (FSH); Warren, Rhonda (FSH)
Cc: Wawyn, Pat (FSH); Burnside, Linda (FSH)
Subject: Phoenix Sinclair

Darlene/Rhonda – although I spoke to Darlene a few days ago about the internal review of this case, this is your formal request to conduct an internal review under Provincial Standards. I have attached questions that need to be addressed in the review. As you can imagine, this case continues to unfold so there may be more questions generated throughout the term of this review. Pat Wawyn is our contact person on this. Thank-you.

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The General Child and Family Services Authority

INTERNAL REVIEW

Name of Child: Phoenix Victoria Sinclair
Prepared for: Winnipeg Child and Family Services
Date: March 15, 2006

REQUEST FOR INTERNAL REVIEW:

The General Authority is requesting that Winnipeg Child and Family Services (WCFS) conduct an internal review of the Agency files. In addition to the specific questions contained in this document, we would expect that throughout the review, the focus would be whether the Agency was in compliance with legislation, standards, and agency procedures and whether there are broader systemic issues that may have impacted this case.

TIME FRAME: Completion date April 17, 2006

SPECIFIC QUESTIONS:

- WCFS became involved with Samantha Kematch and Steven Sinclair at the time of Phoenix's birth. Samantha had tried to conceal this pregnancy and received no pre-natal care. Samantha had previously given birth to another child, [redacted] when she was a minor. [redacted] was apprehended at birth as Samantha had tried to conceal her pregnancy, lack of prenatal care and lack of planning for the baby. [redacted] is a permanent ward of Island Lake. WCFS apprehended Phoenix as neither parent appeared to be ready or prepared to parent.

  In addition to the parents' lack of readiness to parent Phoenix, were there are other indicators, such as alcohol or drug abuse that would place Phoenix at risk in the care of her parents?

- Phoenix remained in Agency care until September 2000. Parents were viewed to be working cooperatively with the Agency and developing parenting skills. Phoenix returned to her parents' care with conditions outlined in a service agreement requiring their continued involvement and cooperation with the Agency.

  What programs/and or assessments had the parents completed prior to the return of Phoenix?

Were both parents consistent in attending visits with Phoenix? Were these visits supervised? If so, did the supervisor raise any concerns regarding their parenting abilities?

What were the conditions of the service agreement? Did the parents comply with these conditions?

What services/resources were provided to the couple when Phoenix was returned to their care?

How often did the Agency have contact with the parents prior to and after Phoenix was returned to their care?

- In April 2001, WCFS was notified that Samantha gave birth to a third child, [redacted]. Despite the Agency's efforts in monitoring, the pregnancy was not detected and the couple failed to disclose her pregnancy. [redacted] was not apprehended and was released from hospital.

How often did the Agency have contact with the family following Phoenix's return home?

Was an assessment completed on the family at this time to ensure the safety of [redacted] given the previous apprehension of Phoenix?

- In July 2001, concerns were expressed to WCFS regarding substance abuse and domestic violence. It was subsequently learned that Samantha and Steven had separated and the children were left in Steven's care. It was determined that Steven was parenting the children appropriately and although he was not interested in further Agency involvement, the file remained open at the family from July 06, 2001 to March 25, 2002. Samantha's file was closed on August 23, 2001.

What was the nature of the allegations of substance abuse and domestic violence?

Was the Winnipeg Police Service involved with this couple related to domestic violence?

What services were offered to Steven who was now a single parent and parenting two young children?

How often did the Agency have contact with Mr. Sinclair?

Were other agencies involved?

- On February 23, 2003, WCFS reopened the file due to reported medical concerns about Phoenix having a foreign object in her nose which became infected. Mr.

Sinclair reported that Phoenix was in the care of a friend. The Agency made a number of subsequent visits, however, never did see Steven or Phoenix. The hospital reported that the child was released to Phoenix's godfather. Mr. Sinclair was aware of this arrangement but had no knowledge of her medical concerns.

Were attempts made to determine the whereabouts of Phoenix and the name of the godfather?

Was an assessment completed on her current caregiver?

- Phoenix was apprehended from Steven on June 22 or 23, 2003 due to concerns about his use of alcohol and drugs and exposure of Phoenix to numerous and sometimes inappropriate caregivers.

- On July 3, 2003, WCFS was granted a three-month Temporary Order of guardianship. Parents consented to the order and had regular access to Phoenix who was placed with her godparents, Kim and Rohn Stephenson under a place of safety.

Was it determined if these were the same godparents who had care of Phoenix when she had a foreign object lodged in her nose?

What were the expectations of the parents during this three-month order?

Were any assessments/programs completed?

- At the end of the temporary order on October 2, 2003, Phoenix was returned to her father's care. It is noted that Mr. Sinclair had done no programming while Phoenix was in care and as such was prone to returning to an unhealthy way of managing stress. The file was to remain open for a period of time to monitor the family. The file was closed on November 13, 2003.

Given that Mr. Sinclair had completed no programming and it was predicted that he would return to an unhealthy way of managing stress, did the Agency complete a risk assessment prior to returning this child to her caregiver?

What was the Agency contact between October 2, 2003 and the time of closure on November 13, 2003?

How did the Agency reach a decision to close the file within a six week period given the serious risk indicators that had not previously been addressed?

- On January 16, 2004, Samantha's friend reported to WCFS that Samantha frequently goes out drinking, leaving Phoenix in the care of her maternal grandmother who allegedly smokes "rock" when Phoenix is present. It was learned that Phoenix had

been living with Samantha since mid-November 2003, as she had been left alone by her father.

- The Agency investigated and determined that Phoenix had been staying with the Stephensons since early January 2004. Steven Sinclair was located and agreed to have Phoenix remain with her godparents under a private arrangement until he gets his life together. The Stephenson's refused Agency assistance, however, were warned and cautioned that that Phoenix not to be returned to Steven, the custodial parent, until the Agency first conducted an assessment. WCFS followed up by sending the Stephensons a letter outlining the Agency expectations and concerns. Mr. Sinclair's file was closed on February 16, 2004.

  WCFS assessed that Phoenix would be at **high risk** of coming into care if she returned to Steven or Samantha.

  Was another assessment conducted on the Stephenson home prior to the agency's agreement to agree to the private arrangement?

  Did the contents of the letter also reference that the Agency be contacted should Samantha attempt to remove her?

  Did the Agency have any contact with the Stephensons prior to the file closing in February 2004?

  Did the Stephensons report any concerns to the Agency with respect to the parents intervening in their care?

  Did the parents have access to Phoenix while she was in the Stephensons' care? Were there stipulations around access?

- In May 2004, Samantha produced a letter to Employment and Income Assistance (EIA) from her lawyer claiming that she had been caring for Phoenix since November 2003. EIA requested that WCFS conduct an assessment to determine if Phoenix was safe in Samantha's care. Intake noted that a safety assessment is assessed to be within a 48 hour follow-up response following a telephone conversation with Samantha on May 11, 2004.

  Although this file was flagged as high risk, the Agency did not make face to face contact with Samantha until July 13, 2004. Samantha related that she removed Samantha from the Stephensons care in approximately February 2004.

  During this interview with Samantha, she presented as stable and denied any substance abusing any substances. She did not exhibit any symptoms of drug abuse. Phoenix presented as healthy and well cared for. It was also noted that

Samantha was involved in a relationship with Karl Wesley McKay who was employed as a truck driver.

WCFS assessed the risk to Phoenix as being low. Samantha declined services, but requested information community resources which were provided by the Agency. The file was closed on July 15, 2004.

Given the serious concerns of January 2004 that Samantha was abusing alcohol, leaving Phoenix with inappropriate caregivers and was not to have care of the child, what assessment was done to change the Agency's risk assessment from high to low?

- On December 1, 2004, Women's Hospital reported to WCFS that Samantha delivered a baby girl, [redacted], on November 30, 2004. It was reported that Samantha received good pre-natal care and there were known health concerns with respect to the baby. There was no reported drug or alcohol use during this pregnancy. It was known that Samantha was residing with Wes McKay at this time.

In that it was now confirmed that Samantha was living with McKay, was there consideration given to conducting a PCC or criminal records check on McKay?

Given the previous recorded documentation on CFSIS, the matter was referred to Intake for ongoing follow-up and assessment of the home environment.

The Agency could not obtain the birth date of Mr. McKay from EIA records as Samantha had only one child listed on her budget and there is not expected to be a common-law partner residing in the home.

The Safety Assessment is considered within a 48-hour response. It was recommended that the file be opened for assessment and intervention.

As the Agency was not able to contact Samantha by phone, the Supervisor suggested that the worker contact the PHN to inquire if Public Health had been out to the home. If there were no concerns identified by the PHN, the file would be closed.

Although the PHN had been to see Samantha since her discharge from hospital, however, the PHN was reluctant to share any information regarding any concerns for the family due to PHIA. The PHN was advised a training sessions that she is not share information with WCFS due to PHIA and that WCFS does not share information due to confidentiality of the CFS Act. The PHN was aware that of her professional obligation to report to WCFS risk to a child if there are concerns.

The lack of communication between PHN and WCFS was reported to the worker's supervisor so that future incidents could be rectified at the managerial level.

After consultation with the PHN and a review of information on CFSIS, it was determined that there does not appear to be a known risk to the children residing in Samantha's care at this time. The matter was closed at Intake.

Was communication between WCFS and the health system resolved?

What assessment was done to change the plan not to conduct an assessment of the home environment and close the Intake given that non-committal response from the PHN?

- On March 5, 2005, an Agency foster parent reported to the Agency that an ex-foster child alleged that Samantha Kematch is abusing Phoenix and that she may be locking Phoenix in her bedroom. No further details were provided and the foster mother refused to disclose the name of the informant. EIA provided an address for Samantha. Phoenix was not registered for school since September 2004.

  On March 9, 2005, CRU staff met with Samantha in the hallway of her apartment. She did not allow workers into her apartment as she had someone visiting with her. There were no sounds of partying. Samantha responded to the allegations that she yelled at Phoenix a few days ago. Samantha confirmed that there was a lock on the outside of the bedroom that she shares with Phoenix. Workers warned Samantha that it is not safe to lock her in the room in the case of a fire. Workers inquired on Phoenix but did not request to see her. Workers viewed [redacted] who appeared to be healthy and well-cared for. Samantha indicated that she was doing well and did not require agency supports. She was provided with an Agency card.

  What is the obligation of foster parents to comply with Agency requests for information?

  Did the Agency comply with standards in conducting an abuse investigation?

  Did the Agency comply with Agency procedures when conducting this investigation?

  Did the hospital notify the Agency of [redacted]'s birth in December 2005? If so, was there an assessment conducted on the family at that time?

  We are aware that the agency was involved in the case on March 9, 2006 and the General Authority was informed of this on March 13, 2006 via the news media. Was there any consideration given to advising the General Authority immediately as per previous directive in high profile cases?

Dennis H. Schellenberg
Chief Executive Officer
The General Child and Family Services Authority