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

# Commission Disclosure 1802

# Winnipeg Child and Family Services Branch

## Internal Case Review

## Phoenix Sinclair

April 28, 2006

# Kematch, Samantha and McKay, Karl Wesley

This case review has been completed in response to the death of Phoenix Sinclair in June 2005. All observations and comments in this report are based strictly on file reviews. Phoenix's mother, Samantha Kematch and her partner Karl Wesley McKay have both been charged with first-degree murder in Phoenix's death. Winnipeg Child and Family Services Branch were last involved with this family in March 2005. The purpose of this review is to examine the services provided to determine if those services complied with both provincial standards and Branch policies and procedures as well as to make recommendations to the Branch, Authority and or Province, based on this case review. In preparation for this report all files listed below were reviewed. Finally the reviewer met with the Acting Director and the two Services to Children and Families Program Managers to review the report and the resulting recommendations.

This review begins with a brief demographic profile of the family and the case status throughout the Branch's involvement with the family. This is followed by a chronological listing of significant events, reviewer comments and recommendations and lastly a detailed response to specific questions posed by the Child and Family Services General Authority.

Winnipeg Child and Family Services Branch first became involved with Samantha Kematch in July 1998 upon the birth of her first child. WCFS placed Samantha's first child under apprehension at the request of Cree Nations Child and Family Services, as Samantha was a permanent ward of their Agency.

WCFS again became involved with Samantha and her partner Steven Sinclair, upon the birth of Samantha's second child, Phoenix Sinclair on April 23, 2000. Thus began a series of case openings and closings with final involvement in March 2005. The case has been reopened as of March 9, 2006 after the Branch was notified of the suspected homicide death of Phoenix. Ms Kematch's children by her present partner Wesley McKay have been placed under apprehension as both Ms. Kematch and Mr. McKay have now been charged in the homicide of Phoenix on or around June 11, 2005.

## Demographics

**Primary Files**
File 1 – Samantha Kematch
File 2 – Steven Sinclair
File 3 – Karl Wesley McKay
File 4 – Phoenix Sinclair Child in Care

**Secondary Files**
File 1 – [redacted]
File 2 – [redacted]
File 3 – [redacted]
File 4 – [redacted] – DOE #3

## Significant Family Members

| Samantha Kematch | | | |
|---|---|---|---|
| **Partner** | [redacted] | **Steven Sinclair** | **Karl Wesley McKay** |
| **Children** | [redacted]<br>DOB July 23, 1998<br>PW Cree Nations CFS | Phoenix Sinclair<br>DOB Apr 23, 2000<br>DOD June 2005 | [redacted]<br>DOB Nov 30, 2004<br>In care WCFS |
| | | [redacted]<br>DOB Apr 29, 2001<br>DOD July 15, 2001 | [redacted]<br>DOB Dec 12, 2005<br>In care WCFS |

| Karl Wesley McKay | | | | |
|---|---|---|---|---|
| **Partner** | [redacted] | [redacted] -DOE#3 | [redacted] | **Samantha Kematch** |
| **Children** | [redacted]<br>Apr 24, 1986 | [redacted]<br>Step child to Wes<br>DOE# 2 | [redacted]<br>DOB March 22, 1995<br>Step child to Wes | [redacted]<br>See above |
| | [redacted]<br>DOB Dec 7, 1990 | [redacted]<br>DOE#1 | [redacted]<br>DOB Nov 24, 1996 | [redacted]<br>See above |
| | [redacted]<br>July 20, 1992 | [redacted]<br>DOB Feb 28, 1995 | | |
| | [redacted]<br>DOB Apr 4, 1994 | | | |

## Case Status

| Samantha Kematch | Steven Sinclair | Phoenix Sinclair |
|---|---|---|
| Open July 23, 1998 | | |
| Closed August 17, 1998 | | |
| Open April 24, 2000 | | Open April 24, 2000 |
| Waiting Closure July 6, 2001 | Open July 6, 2001 | Waiting Closure September 5, 2000 |
| Closed August 23, 2001 | Waiting Closure March 19, 2002 | Closed October 18, 2000 |
| Open January 15, 2004 | Closed March 25, 2002 | |
| Closed January 16, 2004 | Open February 26, 2003 | Open June 22, 2003 |
| Open May 11, 2004 | Waiting Closure October 13, 2003 | Waiting Closure October3, 2003 |
| Closed July 15, 2004 | Closed November 13, 2003 | Closed October 15, 2003 |
| Open December 1, 2004 | Open January 16, 2004 | |
| Closed December 7, 2004 | Closed February 16, 2004 | |
| Open March 5, 2005 | Open May 11, 2004 | |
| Closed March 9, 2005 | Closed May 13, 2004 | |
| Open March 9, 2006 | | |

# Chronology of Significant Events

## Samantha Kematch file

**July 23, 1998**
Cree Nations CFS contacted WCFS, requesting WCFS apprehend Samantha's baby [redacted], born that day. Samantha was a permanent ward of Cree Nations CFS. Background information was sent by Cree Nations CFS to support the apprehension. Apprehension was later transferred to **Cree Nations CFS. [redacted] later became a permanent ward of Cree Nations CFS due to Samantha's lifestyle and lack of interest in parenting [redacted]**

## Samantha Kematch and Steven Sinclair file (Steven Sinclair added to Samantha's existing file)

**April 24, 2000**
A referral was received from Health Sciences Center Social Worker. Samantha, age 18, had given birth to Phoenix Sinclair the previous day. Father of the baby is Steven Sinclair age 19. Samantha had received no prenatal care, couple had no preparation for the baby and Samantha's first child was made a permanent ward of Cree Nations CFS. Samantha and Steven both stated that they were not ready to parent. Baby **Phoenix was placed under apprehension.**

**April 25, 2000**
Samantha and Steven changed their minds and now wanted to parent the baby. Samantha stated her mother and aunt were on their way to Winnipeg to pick up the baby. Samantha shared information on her childhood, saying that her mother was abusive to her and has an addiction to alcohol. As a result the Agency did not agree to Samantha and Steven's plan. Phoenix was moved to an Agency placement. Cree Nations CFS was contacted for background on reasons for [redacted] (Samantha's first child) permanent order. A Social History provided by Cree Nations CFS supported the Agency's actions in apprehending Phoenix.

**April 28, 2000**
Planning meeting with Steven and Samantha. They brought an advocate from the Winnipeg Boys and Girls Club who had been working with them. They were also involved with MaMaWi. Samantha and Steven again stated that they would like the opportunity to parent Phoenix. Initial case plan was finalized as follows:

1) Agency will seek a three-month temporary order to further assess parents' ability to successfully parent Phoenix.
2) Agency will obtain more detailed information regarding the circumstances of Cree Nations permanent order on [redacted].
3) Samantha will undergo a psychological assessment to determine her parenting capacity.
4) Samantha and Steve will attend a parenting program.
5) Parents will attend all scheduled visits with Phoenix.
6) With Steven's consent, Agency will review Steven's sealed Child in Care file to obtain further assessment information and background.
7) Case to be transferred from Intake to Family Services for ongoing service to the family.

**August 2000**
Teaching homemaker assigned.
VPA signed for one month upon expiration of the temporary order to allow time for Phoenix to be transitioned home.

**September 5, 2000**
Service Agreement signed (on file). Agreement states:

1) Samantha will meet with Dr Gary Altman, consulting psychiatrist to WCFS. Samantha will follow any recommendations made.
2) Samantha and Steven will meet and work cooperatively with the teaching homemaker twice per week.
3) Samantha and Steven will work cooperatively with the Family Services Social Worker and will meet on a regular basis to further explore issues related to substance use and family violence.
4) Samantha and Steven will attend and participate in a parenting class that focuses on issues of child development.
5) Samantha and Steven will work cooperatively with the Public Health nurse assigned to the family.
6) The Agency Social Worker will assist in identifying a pediatrician for Phoenix.

This Service Agreement was signed by both Samantha and Steven and dated September 5, 2000.
**Phoenix was returned to her parents' care on September 5, 2000.**

**October 2, 2000**
Information gathered is from a transfer summary prepared on this date as the assigned Social Worker was leaving her position.
It noted that Steven was reluctant to allow access to his child in care file and there is no note that his file was ever accessed.
There is a statement in the Chief Medical Examiner's Review of [redacted]s death (see later contacts) regarding Steven (page 10). It was taken from a Case Summary prepared at Steven's discharge from care at age 18. It states:

> "Steven remains to be a highly disturbed individual who should not be left in charge of dependent children. He has numerous unresolved abuse issues."

This is important information that should have been available to the Social Worker in doing the assessment of couple's ability to parent Phoenix.
There is no assessment in the transfer summary to explain why Phoenix was returned to her parents' care on September 5, 2005 although there is a detailed Service Plan to outline service after Phoenix's return.
Samantha did meet with Dr Altman on September 15, 2000. Notes on the file state that Dr Altman saw no need for further assessment, and supported the parents' plan to parent Phoenix.
The transfer summary states that "it appears from positive community reports" and feedback from the in home support worker that Samantha and Steven are able to meet Phoenix's basic needs. It further states that 'ongoing assessment of their abilities to effectively meet her [Phoenix's] needs and provide her with a safe and nurturing home is necessary'. The transfer summary further states that

the parents are aware that if they do not cooperate with the Service Agreement it could result in Phoenix being removed from their care.

**November 30, 2000**
Family Support Contract expired. File noted that the Family Support Worker was impressed with Samantha and Steven's progress as parents.

**February 5, 2001**
Supervision notes outline an updated case plan. This plan however is just a restatement of the September 2000 Service Plan signed when Phoenix was returned to her parents care. There does not appear to be any direct contact between the Family Service worker and Samantha and Steven between Phoenix's return home and the writing of the Feb 5, 2001 case plan. In fact the supervision report states a short-term goal to be "to make contact with the family ASAP" to gather updates on progress to date re: service contract. A long-term goal is to refer the family to the Agency's Family Preservation program. There is no rationale for this activity and it would appear that this did not happen.

**February 9, 2001**
Social Worker met with Samantha and Steven. Recording states that Samantha appeared angry that the Worker was there and that Steven sat in the back room and did not participate in the meeting. The Social Worker did gain information that Samantha and Steven did participate in a parenting program and that the couple was connected to the Andrews Street Resource Center and MaMaWi as well as continuing to see their case worker from the Winnipeg Boys and Girls Club. There is a statement that the family seems to be functioning well; that the home is clean and the child, Phoenix appears well cared for. Samantha demanded that the Social Worker write them a letter to set up any appointments in the future. The Social Worker clearly articulated that the plan would continue to include "drop by visits until the Agency is confident that the risk levels have been minimized". No further contact with the family is recorded until the next external referral information is received in April 2001.

**April 30, 2001**
Agency is informed by a Social Worker from Women's Hospital that **Samantha gave birth to [redacted] on April 29, 2001.**
According to the hospital Social Worker the parents were quite attentive to the baby and also had all of the required items for the baby. It is interesting to note that when the Social Worker visited with the family on February 9, 2001 she did not detect that Samantha was six and one half months pregnant. The Agency Social Worker did not visit with the parents at the hospital and Samantha and Steven took the child home with them without any input or assessment by the Agency. There is no record of any Social Work contact between this date and the After Hours referral in July. This would mean that there was no direct contact with this family from February 9, 2001 and July 3, 2001.

**July 3, 2001**
After Hours Contact
Complaint received from [redacted] According to [redacted] Samantha and Steven had split and Samantha left the children in Steven's care. The day previous Samantha returned to the home with the police who assisted in removing [redacted] and giving her to

Samantha. That night or the next night however Samantha called Steven to tell him to come and pick up [redacted] as she is 'not prepared to attend to her any longer'. Phoenix was not in Steven's care when Samantha removed [redacted], as she was at a friend's home at the time. [redacted] further stated that Samantha had nothing to do with Phoenix and in fact dropped both children off with Steven about two months ago. **This would put the date of the couple's separation on or around May 1, 2001 just a few days after [redacted]'s birth.**

**July 4, 2001**
Covering Social Worker visited Steven in his home in response to the After Hours contact. Notes state that Steven appeared sincere, open and honest in his discussion. He shared that he has no intention to reunite with Samantha and planned to care for both children as a single parent. Steven stated that he had assistance from extended family members if needed. There is no mention in the recording if the children were home with Steven during this visit.

**July 6, 2001**
Assigned Social Worker visited Steven in his home. [redacted] was there but Phoenix was at a friend's place. Friend was identified as Kim Edwards. Steven stated that he got Kim to look after Phoenix when needed. Steven stated that he did not want anything more to do with Samantha as she had become re-involved with [redacted], the father of Samantha's oldest child, [redacted]. Steven stated that he had been charged with assault against Samantha. He reported that Samantha claimed that he 'shook her up' although his sister Jenny witnessed the argument and at no time did he assault Samantha. Social Worker witnessed Steven's interaction with baby [redacted] which was recorded as positive. Steven identified his main support as his sister Jenny who worked at MaMaWi. Steven stated that he was coping OK and would call the Agency if he needed anything. A clear plan was identified as a result of this visit. The assigned Social Worker committed to visiting in the home on a weekly basis.

**July 15, 2001**
After Hours was informed by Children's Emergency department that baby [redacted] passed away on this date. [redacted] had been sick with a cold and fever. There was no concern that [redacted]'s death was suspicious. Steven's sister Jenny (Genni) was caring for Phoenix. There is a Chief Medical Examiners report on file documenting their review of [redacted]'s death. The CME had no concerns and made no recommendations regarding the Branch's involvement with the family.
**Note:** Steven's sister is referred to in the file by both the name Jenny and the name Genni. In Steven's mother, [redacted]'s file it is identified that Steven has two sisters, one named Jenny and one named Genni. It is difficult to determine which sister is being referred to in the file dictation.

**July 16, 2001**
Winnipeg City Police informed Samantha of [redacted]'s death. Samantha wanted Phoenix returned to her care however the Agency supported Phoenix remaining with Steven. **Samantha Kematch's file is closed and a separate file is opened for Steven Sinclair effective July 6, 2001.**

## Steven Sinclair file

**July 16, 2001**
Steven Sinclair's file is opened with a report on **Notification of Death of a Child not in Care.** The report ends with the following paragraph:

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

**March 27, 2002**
Closing Summary for Steven Sinclair's file.
There is no record of contact between July 16, 2001 and the date of closing even though a previous report stated that the Social Worker would have weekly contact. The closing summary states:

> "Steven is the primary caregiver for Phoenix. He has not requested any services from the Agency and at this time no community resources are indicating any concerns. Since there are no child welfare concerns at present, this worker recommends that this **file be closed."**

**February 26, 2003**
After Hours report. The Agency had received a call from the Child Protection Center at Children's Hospital. Phoenix's 'Godfather' had taken her to Emergency the previous day. Phoenix had a foreign body lodged in her nose, which had become infected. It had been there since November. The Child Protection Center requested that the matter be 'assessed further given past concerns related to physical and medical neglect and inadequate care of the child.' CRU assigned a low priority with a five-day response time and passed the file to Intake. A letter from the Child Protection Center outlines that Phoenix had been dropped off at her Godparents' residence a few days before. The Godfather had informed the hospital that he and his partner had advised Steven that he should get it looked at prior to Phoenix coming to their residence but that Steven had not followed through.
There is a copy of the Child Protection Center report regarding this incident on the file.

**February 28, 2003**
Intake worker attended the home of Steven Sinclair in response to the After Hours report from Feb 6. Steven presented at the door in a rather foul mood, sporting a sizable black eye, which he refused to discuss. Steven stated that Phoenix was still in the care of his friend and would remain there for a few days. Steven would not provide the worker with the friend's name or address. Worker stated that she would need to return to see Steven and Phoenix and Steven responded, "we will see about that". Steven did say that he was unaware of Phoenix's ailment, which contradicts the Godfather's statement. Visits were made to the home on March 12, April 17, May 1 and May 9, all without success in making contact with Steven.
In reviewing past Agency contact there is no record that any Social Worker has actually seen Phoenix since February 9, 2001, a period of **two years**.

**June 21, 2003**
After Hours receives an anonymous complaint that there was a drinking party occurring at the home of Steven Sinclair. The source of referral stated that Phoenix was in the home. It was further stated that the Winnipeg Police had been in attendance earlier. The After Hours worker did call the Police to confirm. There was no report of their attendance on this date but there was a report in April. After Hours workers did attend the home and both Steven and Phoenix were there. Steven did admit to drinking but he was sober and able to care for Phoenix when the workers were there. Steven was warned that After Hours would return later that night to conduct another sobriety check. Workers did return and found Steven passed out on the couch. Steven's sister Danielle who also lived in the home was sober and able to care for Phoenix. Upon returning to the office and doing a prior contact check on Danielle it was discovered that Danielle had an open protection file with children in care. When After Hours workers attended the home later Steven was awake and extremely belligerent. Steven's sister Jenny (Genni) was called who came to the house to pick Phoenix up. She was advised not to return Phoenix to Steven's care until workers approved it.

**June 22, 2003**
After Hours workers attended to Steven Sinclair's home, to discuss the party from the day before. After discussion Jenny was called to deliver Phoenix back to her father's care. Since there was little food in the house the After Hours workers returned at 6:00 PM. At that point Steven had discontinued his drinking but was smoking marijuana. After consultation with the on call supervisor, a decision was made to place Phoenix in care. **Phoenix was apprehended on this date and placed in Agency care. Steven Sinclair's file was reopened and passed to Intake for assessment.**

**June 23, 2003**
A call was received from Samantha Kematch who had been informed of Phoenix's apprehension. Samantha stated that she wanted Phoenix returned to her care. She stated that she was presently working at Club Regent and had been for five months. Samantha had not seen Phoenix since the spring when Steven's sister brought her for a visit. Worker contacted Steven's sister Jenny who confirmed that she had told Samantha of Phoenix's apprehension. Jenny further stated that while Phoenix was in Steven's care he only looked after her for three or four days a month. The rest of the time Phoenix was cared for by friends. This statement would appear to be supported in that no Social Worker had seen Phoenix in Steven's care since February 9, 2001.

**June 27, 2003**
This Intake transfer summary contains an assessment quite different from previous ones. It states:

> "It is the worker's opinion that [this couples] disregard for the Agency has probably resulted in the Agency's termination of services, and not a lack of child welfare issues."

It further states:

> "The obvious struggle in commitment, questionable parenting capacity, along with an unstable home environment and substance abuse issues, and lack of positive support system all lend to a situation that poses **a high level of risk** to this child, for maltreatment and / or placement in Agency care. Phoenix is in Agency care now,

> and it would probably not be in her best interests to be returned to either parent at this time or until they can show something to indicate that they can and will be more responsible and protective of her."

**At this point the case was again transferred to Family Services for ongoing service.**

**November 13, 2003**
The closing summary states that the Agency received a three-month temporary order and Phoenix was placed in the Place of Safety home of Kim (and Rohan) Stephenson, Phoenix's Godparents. It further states:

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

As a final statement the reason for closing is stated as:

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

Case notes on the file inform that the Worker saw Steven on July 7, 10, 24 and October 2nd, the date Phoenix was returned home.
**The case was again closed in Family Services on November 13, 2003.**

**January 16, 2004**
The case was again opened on Intake after the Agency received a complaint from [redacted] The source of referral stated that Samantha 'goes out drinking frequently' and leaves her daughter Phoenix in the care of her mother [redacted] who 'smokes 'rock' (crack cocaine) in Phoenix's presence. The Intake worker attempted to sort out where Phoenix was actually residing. Employment and Income Assistance stated that Samantha Kematch had not been active with them since March 2003. Steven Sinclair was active and Phoenix was still included in his budget.
The source of referral further stated that at some point in November 2003 (Phoenix was returned to Steven's care in October 2003) Samantha received a call from Steven's sister Jenny saying that Steven had gone out and left Phoenix alone in the apartment. Samantha then went and picked Phoenix up. In early January 2004 some 'people' came and picked Phoenix up and took her to their residence on Selkirk Avenue. It is later determined that the 'people' who picked Phoenix up were Rohan and Kim Stephenson, Phoenix's previous place of safety parents, Phoenix's Godparents and family friends.

**January 21, 2004**
Intake workers visited the home of Rohan and Kim Stephenson, finding Phoenix present. Kim was not present. Rohan stated that they had been caring for Phoenix since January 2, 2004. Rohan refused to state where Steven was or what he was up to and said they would care for Phoenix as long as necessary on a private basis and did not want financial compensation from the Agency. Rohan did state that he did not live in the home but 'stays there sometimes'. Social Assistance financially supported Kim. Workers did not ask if he was the 'Godfather' that took Phoenix to Emergency on February 26, 2003. There is no record that the Social Worker followed up with a meeting with Kim to determine if she also agreed with the plan.

**February 5, 2004**
Intake Worker made contact with Steven Sinclair. He stated that he had heard that Phoenix was again at Rohan and Kim's home. When asked why Phoenix was not with him, he stated that he moved from his previous place and was staying with friends. He would not say why he had to move. He further stated that Phoenix was safe and it was fine for her to stay with Kim under a private arrangement.
In summary the Intake worker stated:

> "This worker cannot make an accurate assessment of Steven's current lifestyle due to lack of information provided. This worker would therefore determine that Phoenix would be **at high risk** of coming into care should she return **to Steven's care.** She would also be at **high risk** of coming into care should she be found **in Samantha's care**. Worker has therefore safety planned with the current caregivers to Phoenix, the Stephenson's. They have agreed to keep Phoenix in their care under a private arrangement".

The Intake closing summary further states that the **Stephenson's were sent a letter outlining the Agency expectations and concerns**. A copy of the letter is on Steven Sinclair's file and is dated February 13, 2004. It appears that no contact was ever made with Samantha to discuss the original concerns that resulted in the referral to the Agency. Also there is no recording that Samantha was told that she was not to remove Phoenix from the Stephenson's care without the Agency's notification and assessment. The letter to the Stephenson's does state that the Social Worker did inform Steven that he was not to remove Phoenix from their care "without contacting the Agency and having a risk assessment done". Unfortunately the letter does not specifically state that Samantha was also not to resume care of Phoenix without the Agency's reassessment even though the letter does state that the Agency did have concerns.
**On this date the file was again closed to the Agency.**

## Samantha Kematch file

**May 11, 2004**
On this date the Agency received a referral from Employment and Income Assistance. Samantha Kematch had brought them a letter from her lawyer claiming that she had been caring for Phoenix since November 2003. Please note that Phoenix was at the Stephenson's in January and February

2004. When the Intake worker attempted to contact the Stephenson's to find out what was happening the person answering the phone said it was a wrong number. The Intake worker then made contact with Samantha Kematch. In attempting to determine where Phoenix had actually been residing Samantha became upset and hung up the phone. Since Phoenix was apparently living with Samantha, and Steven could not be located, Samantha Kematch's file is again opened on Intake.

**May 13, 2004**
Intake worker visited Samantha's address. A man who identified himself as Wes (later determined to be Karl Wesley McKay) answered the door and said Samantha was not there but was at her Mother's. Workers visited this home but were told Samantha was visiting with friends. The Intake worker's card was left asking for Samantha to call.

**July 13, 2004**
Several attempts were made to connect with Samantha but it was not until July 13, 2004 that workers were successful in meeting with her. Phoenix was present and appeared healthy and well cared for. Samantha stated that Phoenix came to live with her because Steven was drinking. She placed Phoenix with the Stephenson's in January or February as she was traveling with her boyfriend who is a long distance truck driver. She further stated that her boyfriend 'stays with her' when he is in the city. Workers asked Samantha if she needed anything from the Agency but service was declined. The worker did send her information on community supports and the case was closed. In the closing statement the worker states:

> "The Statement of **Risk is low** as there is no sign that Samantha is abusing substances, she maintains that she is managing well, and Phoenix appeared well cared for."

**The case was closed at the Intake level on July 14, 2004.**

**December 1, 2004**
The Agency receives a referral that Samantha delivered her fourth child, a girl named [redacted], on November 30, 2004. The Social Worker from Women's Hospital stated that Samantha did receive good prenatal care, there was no reported drug or alcohol use during the pregnancy and that baby is healthy. In discussion with the Crisis Response Supervisor it was determined that the case should be referred to Intake for further assessment based on Samantha's history. A **safety assessment** was completed listing a response time of **48 hours (medium safety risk).** It appears from further dictation that the file, even though sent through to Intake, was returned to CRU for further follow-up. Attempts were made to connect with Samantha on Dec 2 and 3 without success. On December 3, 2004 the CRU worker consulted with the supervisor who suggested the worker call the Public Health nurse to see if she has connected with the family. On that same date the worker did connect with the Public Health Nurse but the nurse refused to share information based on recent training relating to the Personal Health Information Act (PHIA). The Public Health nurse did provide her supervisor's name and phone number, which was passed on to the CRU supervisor for follow-up. There is no indication in the file that this issue was resolved. The file was closed with the following statement:

> "After consultation with the Public Health nurse and a review of the information attached to CFSIS, it is determined that there **does not appear to be a known risk** to

the children residing in Samantha's care at this time. Therefore this matter is being closed at CRU until further information or a request for services is brought to the Agency's attention."

No contact was made with the couple and no home visit was done to determine first hand how the couple was doing.
**The case was again closed on December 7, 2004.**

**March 5, 2005**
A complaint is received from [redacted] who had received the concerning information from a previous foster child. The foster parent refused to provide the name of the original source of information.
The source of referral stated that she suspects that 'Phoenix is being abused by Samantha and also that Phoenix is being locked in her room'. The case was assigned within CRU for a worker to make a home visit to assess the situation. As an address was not known calls were made to collateral Agencies. Employment and Income Assistance did not have an open file but it was later determined that the name given to E & IA was wrong and that Samantha was active and an address was provided. A call was made to Winnipeg School division #1 but Phoenix was not attending school at that time although she had been registered in September 2004 and did attend Wellington School for a time. This in itself was not concerning as Phoenix was only four years old and nursery school attendance is not mandatory.

**March 9, 2005**
CRU workers attended Samantha's residence. Samantha answered the door but would not allow workers into her apartment as she had company. Workers informed Samantha that they were there as a result of a community complaint that she was abusing Phoenix. Samantha responded that she yelled at Phoenix a few days before but denied abusing Phoenix. Workers also asked her if she locked Phoenix in her room. Samantha admitted that she had a lock on the outside of the bedroom door. Workers cautioned her on this practice, as it was not safe in case of fire. Samantha briefly went into the apartment and got [redacted] and brought her out into the hall. The baby looked healthy and well cared for. Workers at no time saw Phoenix. In addition there is no recording to detail that any Social Worker has seen Phoenix since January 21, 2004 when the Stephenson's was caring for her. Samantha declined the offer of Agency supports and the file was closed with the following comment:

" Workers did not note any protection concerns and so this matter can be closed to the Crisis Response Unit at this time."

**Case is again closed March 9, 2005.**

**This is the last contact with this family until the notification from RCMP in March 2006 of Phoenix's death. Case notes from the file of [redacted] place Karl McKay in Peguis(?) as of April 2005. If this is accurate Samantha and Karl moved to Peguis (Fisher River) shortly after workers attended the home in response to the abuse allegations regarding Phoenix in March 2005.** DOE#3

**March 9, 2006**
WCFS Branch received a referral from the RCMP requesting assistance as they were going to be arresting Samantha and thought Samantha had a child with her. After Hours staff attended but RCMP had already arrested Samantha who indeed had a friend's child with her, apparently passing this child off as Phoenix. RCMP also had Samantha's newborn child [redacted] and Samantha's other child, [redacted] was believed to be in the possession of Karl Wesley McKay who is both [redacted]'s and [redacted]'s biological father. RCMP stated that they had reason to believe Phoenix was the subject of 'severe abuse and possible homicide'. No one had seen Phoenix for quite some time. RCMP later attended the Agency and informed the After Hours worker that both Samantha Kematch and Karl Wesley McKay are being investigated regarding a homicide. **Children [redacted] and [redacted] were both placed under apprehension.**
As of March 21, 2006 both Samantha Kematch and Karl Wesley McKay have been charged with first-degree murder in the death of Phoenix Sinclair. It is believed the homicide occurred in June 2005 on the Fisher River First Nation. The criminal investigation continues.

## Phoenix Sinclair Child in Care file

Phoenix's Child in Care file was originally opened on April 24, 2000 when she was admitted to care from hospital after her birth. She remained in care until September 5, 2000 at which point she was returned to her parents. Phoenix had a second admission to care on June 22, 2003 as a result of an extended drinking party while in her father's care. Parents had separated at this time and Steven Sinclair had primary care and control of Phoenix. Phoenix was returned to her father's care on October 3, 2003.
Much of the dictation in Phoenix's file is a duplication of family file dictation. There is however specific reference to Phoenix and her placements. Medical information from her time in care is also outlined in a separate report written by the Agency's nurse.

## Karl Wesley McKay file

This file was open between January and May 1997. All information on this file is duplicated from the various files of his partners. Specific information from these files as they relate to Karl Wesley McKay is outlined below.

## Other Related Files regarding Karl Wesley McKay

[redacted] file DOE#3

DOE#3 [redacted] is a previous partner of Karl Wesley McKay and her son [redacted], 1992) is the biological son of Mr. McKay. DOE#1

**March 8, 2006**

Agency received a phone call from [redacted], age [redacted], requesting to have a Social Worker. [redacted] was relating problems at home. Through questioning by the Social Worker Daniel related the following information:

"[redacted] said that he lived in Fisher River with his Dad last year for approximately four months. It didn't work out [redacted] said. His brother [redacted] had come for a visit during that time and CFS there became involved and returned both boys to their mother. [redacted] could not elaborate on what caused CFS in Fisher River to intervene." [redacted] later stated he "thinks that his Dad may be arrested." In putting these two families together and adding further context to this Intake, it is of concern that [redacted] appeared so sad, stating his father may be arrested, as [redacted] would possibly have been in the Kematch-McKay home in Fisher River at the time of Phoenix's homicide.

There is also mention in [redacted] file that in April 2005 [redacted] was making plans for [redacted] to go to live with his father Karl McKay on Peguis (Fisher River?) First Nation.
There is no other information relevant to Karl Wesley McKay on this file.

**[redacted] file**

[redacted] is a previous partner of Karl Wesley McKay and her daughter April (DOB April 24, 1986) is the biological daughter of Mr. McKay.

**March 22, 2002**

[redacted], age 16, presented at Intake stating she did not want to return to her Mother's house. She had lived with her father, Wes McKay until three weeks previous when he 'kicked her out'. She had gone to live with her father in 2001. [redacted] requested approval from the Agency to apply for Income Assistance under their emancipated minor program. [redacted] made her own living arrangements. This is the only mention of Mr. McKay in [redacted]'s file.

**[redacted] file**

[redacted] is a previous partner of Karl Wesley McKay and her daughter [redacted] (DOB November 24, 1996) is the biological daughter of Mr. McKay. Notes from her file relevant to Mr. McKay are as follows:

**March 26, 1996**

A referral was made to Agency After Hours that bruising was seen on [redacted]'s (age 1) neck. It was also reported that Karl Wesley McKay was physically abusive to [redacted] as well as [redacted]. The source of referral further stated that Mr. McKay consumes large amounts of alcohol on the weekends. The complaint was investigated and determined to be unsubstantiated and the Case was closed.

**June 9, 1996**

A referral was again made to Agency After Hours regarding bruising seen on [redacted]. The source of information (a male) wanted [redacted] to go to a Women's shelter as her boyfriend (Mr. McKay) beats her up. Allegations were not substantiated and [redacted] and Karl believed that someone was harassing them by making reports to the Agency. Case was again closed.

**March 30, 1997**
Wes McKay (now referred to as Wes rather than Karl) called After Hours stating that [redacted] leaves [redacted] alone. Wes had been taking care of [redacted] but [redacted] had come with the police to 'take her back'. The police accompanied [redacted] as she thought Wes 'would be angry'. There is no mention of [redacted] (age 4 months) and where she was at this time.

**October 2, 1997**
WCFS Central Area Intake receives a referral that Wes is in the Remand Center for assaulting [redacted]. Wesley apparently had 'legal guardianship' of [redacted] (DOB November 24, 1996) since she was one month old. Intake information states that [redacted] had gone to Wes's with police assistance and had retrieved [redacted]. The source of information stated that neither parent is capable of caring for these children. The case was closed as [redacted] was residing at a Women's shelter with both children.

**October 25, 1997**
After Hours received a report of a drinking party at the residence of [redacted] and Wes. The home was deemed to be a 'serious threat to the children due to the unsanitary and unsafe conditions'. **Both children were apprehended.** The case was referred to Northwest Area Intake. [redacted] and Wes agreed to addictions assessments, counseling around communication, and Wes further agreed to attend individual counseling at MaMawi to address his issues of self described 'temper and frustration'. **The children were returned on November 6, 1997.** This report makes no mention of the October 2, 1997 Intake in Central Area.
**The case was closed on November 25, 1997.**

**February 23, 1998**
After Hours received a complaint that [redacted] and Wes came home very intoxicated. After Hours warned the parents to get a babysitter for the whole night if they were going to drink so much that they could not care for the children even if they were home. The file was closed the next day.

**April 29, 1998**
After Hours received a report that Wes and [redacted] continue to have problems regarding alcohol use and domestic violence. The source of referral stated that the last occurrence of domestic abuse resulted in [redacted] having her nose broken by Wes. The file dictation states:

> "It was determined that the parents had little understanding of the impact of Domestic Violence on their children. The previous plan (developed in October 1997) for the parents to attend counseling, alcohol assessments and anger management was discussed and encouraged."

**The file was again closed on May 28, 1998.**

**June 5, 1998**
Winnipeg City Police bring [redacted] (age 3) to the office after finding her in the company of an 'extremely intoxicated' male walking in the downtown area. This male had been babysitting the children and when he left the home with [redacted] he left [redacted] behind, in the home alone. [redacted]

**and later [redacted] were both apprehended and placed in Agency care.** At this point the file is opened by Intake and transferred to Family Services for ongoing service.

**October 15, 1999**
In a case review report completed on this date [redacted] and [redacted] remained in care. It further described that Wesley had been referred to anger management treatment by probation as he had been charged with assault (of [redacted] on three separate occasions. A report from the Probation Officer assigned stated that on one of the occasions Wesley had beaten [redacted] to the point that she could not walk. Wesley had taken her into the bathroom, locked the door and beat her with the leg off of the bathroom sink. The assault continued until a neighbor called 911. In a later report from the Probation Officer in November 1998, she reported that Wesley although complying with the probation order to seek anger management counseling, had not internalized anything from his treatment and continued to deny and minimize his lack of control. The Social Worker's assessment however states that [redacted] and Wesley appeared to be committed to their children and were making progress. They remained together as a couple. Plans began to return the children to their care.

**February 16, 1999**
In a report from Wesley's Probation Officer it is reported that Wesley did not follow through with the Family Violence course he was to attend. The Probation Officer stated in a letter sent to the Agency that "Wesley is high risk and numerous concerns still exist". As a result the voluntary placement agreement signed with the parents for the children's placement in care is terminated and [redacted] and [redacted] are placed under apprehension. In a subsequent meeting with the parents where the worker informed them of the apprehension 'Wesley became agitated and aggressive and eventually stormed out'. After Wesley left the meeting [redacted] stated that she wanted to end the relationship with Wesley. Although [redacted] did separate from Wesley and moved to a Women's shelter she returned to Wesley after only a few days.

**March 11, 1999**
Another incident of drinking and domestic violence is reported to the Agency. [redacted] left the house and Wesley turned himself in to Police.

**March 29, 1999**
[redacted] remained separated from Wesley and enrolled in Addictions treatment at the Virginia Fontaine Treatment Center. She completed the program on May 4, 1999. The Agency later assigned a Family Support Worker to assist [redacted] to enter Second Stage Housing (for women who are leaving abusive relationships).

**October 15, 1999**
In a Family Service Transfer Summary, it states that at that point [redacted] had not followed through with Second Stage housing and there was some suspicion that, even though she remained separated from Wesley she was still having contact with him. The children remained in care. In January 2000 [redacted] was referred to the Agency's Preservation and Reunification program. This service was not successful. [redacted] continued to see Wesley and stopped attending visits with the children in June 2000. **Both children were eventually made permanent wards (in the name of Southeast Child and Family Services) on August 18, 2000.**

## Comments and Recommendations

### Family Contact

Based on the file review it is determined that during the majority of Agency contact, the Branch did not meet standards for contact with these families.

- Between April 2000, after Phoenix's birth, and October 2000 when the case was transferred to a new Social Worker in Family Services, contact was appropriate and assessment and intervention were thorough and appropriate. From October 2000 to the last contact with this family actual service was almost non-existent.
- There was no recorded contact between October 2000 and February 2001 even though the service Agreement signed on September 5, 2000 states "meeting with the worker on a regular basis".
- There was no direct contact between February 9, 2001 and July 4, 2001 even though the worker stated in a February 9, 2001 meeting "it is necessary to meet as they are an open file and we need to monitor and assess their family situation". The Social Worker clearly stated that the plan would continue to include "drop by visits until we are confident that the risk levels have been minimized and we feel the family has adequate supports to parent."
- Baby [redacted] was born on April 29, 2001, was discharged from hospital and went home with parents without Agency assessment and in fact no follow up was made to the home to see how the parents were coping.
- In a meeting with Steven on July 6, 2001 (or July 5, both dates are mentioned) following an After Hours report, the worker committed to meeting with Steven on a weekly basis.
- There appears to be no direct contact between July 6, 2001 and March 27, 2002 (date of closing) although two attempts were made. In response to [redacted]'s death on July 15, 2001 the only family contact listed is by telephone.
- On February 26, 2003 the Agency received a referral from Children's Hospital that Phoenix was brought to the hospital by her 'Godfather' as she had a foreign object stuck in her nose, which had become infected. The object had been there since November (3 months). The hospital did not get the name or address of the person who brought Phoenix to the hospital. The worker did attend Steven's home on February 28 to discuss the issue although Steven said he had no knowledge of it. In the letter from the Hospital the Godfather mentioned that they (he and Kim) had noticed that something was stuck in Phoenix's nose and had advised Steven to get it checked out, he did not and they sought medical attention as soon as Phoenix was placed in their care. Steven refused to give the worker the name of the person caring for Phoenix so no further follow-up was done. Allowing a child to have a foreign object embedded in her nose for three months without medical attention is clearly neglectful and a thorough investigation of Phoenix's living situation should have been conducted at that time, with or without Steven's consent. It must be noted that the Intake worker did make numerous attempts to connect with Steven during March, April and May 2003 but was not successful in finding him home.
- Upon transfer from Intake to Family Services on June 27, 2003 (Phoenix had been apprehended on June 22) the file was categorized as 'high risk'. The closing summary written on October 2, 2003 does not articulate any direct contact with Steven although it states that

Steven did visit with Phoenix regularly while she was in care. The file was closed on the same date that Phoenix was returned to Steven's care with no follow-up.

- In January 2004 the Agency received another complaint form [redacted] alleging alcohol and drug use in the home. Phoenix was now supposedly living with her Mother. Intake workers found Phoenix at family friends who had cared for Phoenix in the past and were Phoenix's 'place of safety' placement in 2003. Phoenix was allowed to stay there. No contact was made with Samantha and Steven was only contacted by telephone. The file was again closed.
- In May 2004 Phoenix is reported to be living with Samantha. Intake workers visited Samantha, saw Phoenix and determined there were no protection concerns and the file could be closed.
- In December 2004 the Agency received a report that Samantha had just delivered another child. The hospital did not have any concerns and the baby was discharged to parents without follow-up.
- In March 2005 a complaint was received stating Samantha was abusing Phoenix and locking her in a bedroom. Intake workers attended the home but only spoke to Samantha in the hallway. Samantha denied abuse. She did admit to having a lock on the outside of the bedroom door, which supports the legitimacy of the anonymous source of referral in regards to the allegation of abuse as well. Intake workers did not enter the apartment, see Phoenix or complete any Abuse investigation. The case was again closed citing no protection concerns.
- Between April 2000 and March 2006, while in her parent's care recording supports that Phoenix was only seen three times and on one of the three times she was brought into care. Phoenix was seen one additional time in the care of the Stephenson's.

It must be stated that service to this family did not meet Best Practice Standards. Mixed messages were given and Branch commitments for service were not kept. This is evident through numerous statements made to Samantha and Steven that the Branch would be making regular visits to ensure Phoenix's safety, even if the couple did not want intervention. When the workers did not follow through with the visits, Samantha and Steven must have been confused whether the concerns were taken seriously by the Branch.

The provincial case management standards do outline frequency of contact expectations based on Risk. The Branch has communicated with both the Province and the General Authority to state that these expectations are not achievable. The response has been that the Standards are service requirements that must be met. To date there has been no resolution to this issue. The Province, the Authority and the Agencies need to give priority to resolution of this issue in order that expectations are clear and **achievable**. CFSIS data from April 4, 2006 shows the average caseload within the family services program at Winnipeg Child and family Branch are 32.36 cases per worker. This is five cases per worker above the 27 cases that were determined to be the average caseload size used for the AJI-CWI resource allocations.

**Recommendation:**

1. That the Province, the Authorities and the Agencies give priority to resolving the Case Management Standards and their stated expectations. Workload issues must be a recognized component in any Agency's ability to meet the Standards of Service.

Supervisors need to monitor case involvement in regularly scheduled supervision to ensure that the case is receiving adequate service. This is the Branch's responsibility. The April 4, 2006 workload information details that each Family Services supervisor is responsible for an average of 245 cases. This is an exceedingly large number of cases for any individual supervisor to keep track of given numerous other expectations of similar priority.

**Recommendation:**

1. That all supervisors complete a review of all open cases in their unit to determine the level of contact between the Social Worker and the family and whether that level of contact is appropriate for the stated needs (risk) of the case.

2. That the Branch compiles information from this case review on whether the aggregate case need for service is achievable within the current human resource base. This information should be shared with both the Authority and the Child Protection Branch to inform future planning and expectations.

## Family Assessment

The preliminary assessment done by Intake in 2000 had clear goals and activities outlined. The activities were logical and directly related to the definition of the 'problem'. Once the case was transferred to Family Services (other than a short period of time between May and October 2000) assessments are lacking. There is a detailed initial assessment done by Intake in June 2003 but once the file is transferred to Family Services the recommendations seem to have been ignored and Phoenix is returned home without the parents making changes.
Information must be gathered to support Family Assessments. Assessments need to detail family background and how previous life experiences contribute to the family's issues. They need to include both formal and informal supports that the family will rely on during times of stress. They also need to outline motivation and capacity for change. They are used to form the basis of intervention and evaluation of those interventions.

**Recommendations:**

1. That the issue of access to sealed Child in Care files be reviewed with both the Province and the Authorities. The Child and Family Services Act does allow for access to those files by Agencies if there is a belief that the information is necessary for the protection of a child. A statement of practice needs to be developed.

2. That standardized assessment 'questions' be developed with the expectation that these questions will be addressed as part of every family assessment. This process must involve the Province, the Authorities and the Agencies to ensure provincial consistency.

3. That Family Assessment be part of Social Worker training with new graduates upon commencement of employment with the Branch and that skill level in Family Assessment be

a component of regular yearly Social Worker evaluations. If assessment capabilities are deemed to be an area requiring improvement, training in that area should be addressed as part of the employee's professional development as soon as appropriate training becomes available.

**Risk Assessment**

Statements of risk change from low to high without any change in circumstance. Statements of Safety are referred to as Statements of Risk. A family situation may be high risk even if on any given day the child is deemed to be safe. Unfortunately in this case 'low safety assessments' were deemed to be 'low risk assessments' which were not the case. This continuous error resulted in this case being closed numerous times without adequate intervention by the Agency. An Intake worker clearly articulated this problem in an assessment done in June 2003. She states:

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

Unfortunately this statement was ignored once the case was transferred for ongoing service. Based on this case review it is apparent that Risk Assessment is not universally understood by Agency staff.

**Recommendations:**

1. That Risk Assessments, once signed off by a supervisor should not be changed without thorough re-assessment and updated information to justify the change.

2. That the Branch, in partnership with the Province and Authority develop an outline, much the same as the Safety Assessment used in the Crisis Response Unit, giving examples of case situations which would place the case in low, medium or high risk categories.

3. That no case with a high-risk indicator be closed to the Branch unless there are no children in the home.

4. That CFSIS be developed to have a "Statement of Risk" window for easy access to information by After Hours. This window should be completed on every open case and every closed case at time of closing.

5. Risk indicators should be reviewed every six months or when there is a new incident in the family and should be signed off by the supervisor.

6. That the Branch policy on Risk (that no child under the age of twelve be discharged from care without the completion of either the Competency Based Training or the Manitoba Risk Estimation System) be reviewed with all staff.

## Intervention

Most of the intervention in this case, other than the initial intervention in 2000, seems to be phone calls or visits by Social Workers to 'warn and caution' the family. It is clear this intervention was unsuccessful in resulting in any noticeable change within the family. It merely resulted in the Agency 'going away' until the next crisis. Basic theories in Social Work practice speak to the importance of therapeutic relationship in effecting change. Perhaps if this case had been kept open for an extended period of time a Social Worker could have developed such a trusting relationship with this family and positive change could have been supported. If no change had occurred through intense proactive involvement perhaps Phoenix would have been removed from the parents care on a permanent basis with a clear rationale why it was necessary.

It is not an uncommon occurrence to see activities restated over and over again in file reviews without examining why the activity has not been undertaken or successfully completed. This is particularly apparent in situations of Addictions and Family Violence. Failure to follow through on interventions may be the result of the family's disagreement with the issue, it may be that the family is unmotivated to make the change or it may be that the barriers are too great for the family to achieve their goal. Interventions should be clearly stated as measurable outcomes with timeframes for completion and clarity of who is responsible. By doing this families will be clear on what needs to change before children are returned home or cases closed. It will also be easier to evaluate whether tasks have been completed and if not why not. This would form the basis for modifying activities, providing more support if necessary or ultimately making a decision to make permanent plans for children in care.

The provincial case management standards recording outlines, supported by Competency Based Training, follow this format.

**Recommendations:**

1. That the Province put the Case Management Standards recording formats back on the Agenda and give priority to formatting them to be used electronically. These recording outlines give very clear guidelines for what information is deemed to be important and require case plans to be recorded as measurable activities and timeframes.

2. That once the recording forms are successfully templated in electronic format, the Agency use the Provincial Case Management Standards recording outlines to identify specific activities, timeframes for completion and who is responsible for that activity.

3. That 'activities' be reviewed in supervision every three months to ensure successful completion or re-evaluation.

4. That the Branch invite the Provincial Intake Module staff to meet with all supervisors to review Intake Module training as there continues to be confusion on what information is available to a supervisor once the 'Intake case' is closed and the CFSIS case is opened. The reviewer was informed that once JIRU goes live and is deemed to be a separate Agency, WCFS Branch will not have access to Intake information. If that is the case it will quickly need a resolution, if it is an error, it speaks to the issue of ongoing assistance to the field in learning new systems.

## Assessment of New Partners

In May 2004 there was an indication that Samantha had entered into a new relationship. In July 2004 Samantha confirms this information when she tells the Social Worker that her boyfriend is a long distance truck driver but that he stays with her when he is in the city. There is no documentation that the attending Social Worker asked for any identifying information regarding this individual. The status of the relationship was further clarified in December when Samantha gave birth to her forth child and [Karl] Wes McKay was identified as the father and as Samantha's common law partner. Karl Wesley McKay is listed in CFSIS and is attached to three other families. If this information would have been accessed it would have presented some concerning information in relation to family violence issues and would have resulted in the Social Worker doing further work to verify if this was indeed the individual living with Samantha and her children.

**Recommendations:**

1. That if a new partner becomes involved with a family and spends any significant time in the family home, background information on the individual be gathered, CFSIS prior contact checks completed, Abuse Registry checks completed and if there is reason to believe the person has had contact with the justice system, Police contacted to provide a criminal risk assessment.

## Accessing Previous Agency Involvement Information

It was determined that information regarding Samantha Kematch and Steven Sinclair was appropriately placed in both files as reference. In situations involving a series of partners it is important to state cross-reference file information in order that all information is available for future reference if needed. CFSIS has the capacity to record such information. In this case important information was available on Karl Wesley McKay. Although the Agency did not have information to clearly identify that the cases on CFSIS and the man involved with Samantha Kematch were the same person, the information should have been reviewed to determine if a connection could be made.

**Recommendations:**

1. That if the family or an individual in a family has been attached to another family that the case name and file number be routinely recorded both in CFSIS and on the file to alert any new worker to the fact that there is significant information to be found in another file.

## After Care Follow-up

There should routinely be a transition period after children are returned home from Agency care. Issues may, and in all likelihood will arise that did not surface during visitation. This should be deemed as normal within the circumstances and the Social Worker should be available to process and problem solve these issues with the family to ensure a successful reunification.
In this case there was little contact after Phoenix's first period of time in care. These were in effect first time parents. Both Samantha and Steven had been permanent wards of the Child Welfare system, indicating that they did not have a nurturing family of origin to model their own parenting from. The couple had initially stated they were not prepared to parent. The odds were high that this couple would experience difficulty as parents.

After Phoenix was returned home from her second time in care the file was closed on the same day as her discharge. This action is even more alarming as the Social Worker states that Steven did nothing to make changes in his life during Phoenix's time in care. Follow-up services should not be open to negotiation in such cases. Regardless of parental wishes a period of after care monitoring and support should be mandatory.

**Recommendations:**

1. That when a child in care has been discharged home after any significant time in care, the file remains open for at least a period of three months to ensure reunification is successful. This follow-up should involve at least monthly contact with the family and the child should be seen, alone if applicable, to determine safety.

2. If a child has been admitted to care at the Intake level, the case should never be closed without an in person follow-up contact to ensure that ongoing service is not required.

## Family Violence Issues

Domestic Violence is an issue that affects the entire family. It should never be assumed that the violence occurs between the parents only and the children are not affected. Individuals that resort to violent outbursts toward their partner during times of stress present a high risk to similar outbursts toward their children. This issue was given very little attention in this family. Family Violence was also a major issue in the [redacted] file yet even after hearing of a very serious assault on [redacted] by Wesley McKay, the Agency continued to plan for the children's return home. Family Violence issues should be taken very seriously and warrant mandated involvement with families.

Also cases should not be immediately closed when a woman and her children leave a violent relationship and enter a shelter. It is not uncommon for women to return to their violent partners after only a few days placing all family members at risk for further incidents. This was evidenced in the [redacted] file.

**Recommendations:**

1. That the Child Protection Branch institute mandatory training in the area of Family Violence and its effects on children. It should also include assessment and intervention techniques.

2. That the WCFS Branch enacts a policy that no case be immediately closed when a woman enters a shelter as in many cases the family reunites after a short period of time. A protocol could also be developed with the Women's Shelters regarding Branch notification when women with children return to the violent relationship.

3. That if a worker becomes aware of an incident of family violence that the Police and or Probation Services are routinely consulted to determine the frequency and seriousness as it relates to safety of all family members. This recommendation may also require the involvement of either the CPB or the Authority to develop a protocol for sharing of information as Police responsiveness to inquiries is not consistent.

4. That the Province, the Authorities and all Child and Family Services Agencies explore the issue of Child Welfare intervention with families experiencing family violence issues. Mandatory intervention with all such families would present a significant increase in workload but the issue of violence within families must be addressed.

## Child Abuse Investigations

Provincial standards and Agency policies are very clear in responding to allegations of child abuse. In this case those standards and policies were not adhered to. There is no record that Child Abuse Registry Checks were completed, CFSIS prior contact checks were completed on all adults living in the home, police were contacted for risk assessments of individuals in the home, the Agency Abuse Coordinator was consulted and the child was seen or interviewed. The Unit Supervisor signed off this 'investigation'. Agency personnel must be vigilant in ensuring all requirements are met before cases are signed off for closure of an investigation.

**Recommendation:**

1. That the Branch review this issue with all Intake and Family Service units to ensure mandatory reporting of incidents to both the Supervisor and the Abuse Coordinator to ensure that a thorough investigation is completed.

2. That the Child Protection Branch and the Authorities give priority to finalizing the JIRU Abuse Model as presently, the Family Service units within WCFS Branch are asked to complete Abuse investigations on cases active on their caseloads, resulting in investigations

being done by Social Workers who are not familiar with the process and stringent requirements.

## Disagreements between Agency Programs

On December 1, 2004 the Agency was notified that Samantha had delivered her forth child. The Crisis Response Unit categorized the case as moderate risk, listing a 48-hour response and referred the case to Intake for follow-up. It would appear that Intake refused the referral and returned the case to CRU asking that they follow-up and only return the case if mandated service was required. When the case was returned to CRU and the Social Worker was unsuccessful in connecting with Samantha and her new partner the supervisor asked the Social Worker to call Public Health for their assessment. The result was that no follow-up was done and the family was not seen. Variances in assessment and intervention by peers (in this case the CRU and Intake supervisors) should be referred to a Program Manager for resolution.

**Recommendation:**

1. That a policy be enacted that any disagreement between peers in case planning be brought to the attention of the Supervisor(s) or Program Manager for resolution. The Complex Case Committee format could be utilized to discuss varying opinions and develop a plan with input from all involved parties. Management representation on the Committee would also ensure that difficult decisions are signed off prior to implementation, offering support to both Social Workers and Supervisors. In this way no one person is responsible for making decisions in difficult or complex cases.

## Collateral Communication

On December 1, 2004 when the case was returned to the Crisis Response Unit the Supervisor asked the Social Worker to connect with Public Health to see if a Nurse had visited the home, and what her assessment of Samantha's (and her partner's) parenting capacity was. The Public Health Nurse was contacted. She did verify that she had been out to the home but would not share information, as instructed in recent PHIA training. The Social Worker informed her of her responsibility to report child protection concerns to the Agency. The Public Health Nurse acknowledged that she was aware of this requirement but again refused to share any information. She did provide the name of her supervisor. That name was passed to the Crisis Response Unit supervisor for resolution. There is no record in the file that contact was ever made with the Public Health Supervisor. One can make the assumption that since the Public Health Nurse was aware of her duty to report, and she did not, that there were no protection concerns. Contact with the Public Health Supervisor should have occurred for two reasons. First, it was important to know absolutely that the Public Health Nurse had no concerns in this specific case, and second that protocols for sharing of information between the Agency and Public Health were clear for both organizations.

**Recommendations:**

1. That if an issue is brought to the attention of the supervisor, the supervisor must make contact with the collateral to resolve the issue and make note of the resolution in the case file. If the situation cannot be resolved at that level the issue must be immediately brought to the attention of the Program Manager and again any resolution be brought back to the Social Worker for recording in the case file. If the issue is one that would affect more than a specific case, the issue and any resolution must also be shared with all staff for future reference.

## File Recording

All observations and comments in this report are based on file reviews. There was a marked absence of detailed contact recording during some of the periods when the case was open to Family Services. For these periods, information was found in transfer and closing summaries. There is a possibility that more family contact occurred during these times but, since there were no contact notes this reviewer had to rely on family contacts stated in the case summaries. The requirement for case contact recording is necessary, to support worker assessments and observations made in file reviews and summaries. Administrative requirements have always been an issue for Social Workers. Comments are continually made that the Social Worker's job is to work with families and not to do copious amounts of 'paperwork'. This case review offers a prime example of the necessity of recording specific case contacts. The Branch does have a recording policy. It is the Supervisor's responsibility to ensure that all Social Workers follow that policy.

**Recommendation:**

1. It is recommended that the Branch recording policy be reviewed with staff to restate that contact notes of each family contact, when it happened, the purpose of the contact and any outcome information be kept in the case file for future reference. This process is currently underway at WCFS Branch.

## Support to Staff in Dealing with Resistant Clients

Resistant families are difficult to engage and angry clients are unpleasant to deal with. These are the families that most require a detailed intervention plan monitored closely by the Unit Supervisor. Cases such as these are also the ones that require the most supervisory support for the assigned Social Worker.

**Recommendation:**

1. That, in partnership with the Province's Training Coordinator, the Branch develops an outline for Unit Supervisors on 'how to' supervise staff dealing with resistant clients. This should involve a training component to provide tools for the supervisor to both supervise and support their staff. This topic should also be included in the ongoing Competency Based Training for Supervisors.

2. That the Province and Authorities give consideration to retaining a group of external 'experts' to assist in consultation and formulation of intervention strategies for resistant clients.

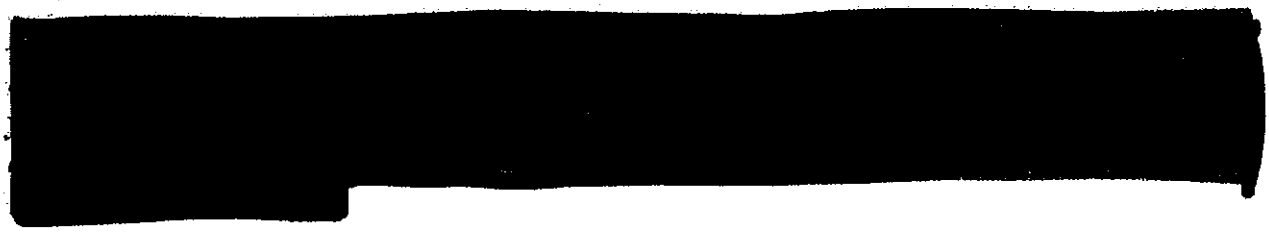
## Orientation and Training

Presently there is no allowance for orientation and training for newly hired Social Workers or for Social Workers recently promoted to Supervisory positions. Due to the demands of the job recent hires are immediately given caseloads, which they are responsible for with minimal tools to do what is required. Recently hired Supervisors are in the same position and, without training or mentoring, take on their responsibilities as best they know how. Presently Competency Based Training is available only after employees assume positions and it may be months before a training spot is available.

**Recommendations:**

1. That the Province, the Authorities and the Agencies support Competency Based Training be provided to all new Social Worker hires prior to the employee becoming totally responsible for an entire caseload.

2. That the Province, the Authorities and the Agencies support Supervisory Competency Based Training be provided as professional development prior to any employee assuming a Supervisory position.



# RESPONSE TO GENERAL AUTHORITY QUESTIONS

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**
***Responses to the following questions appear in blue italics.***

## 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 parent's 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?**

*Response*

*At the time of Phoenix's apprehension, very little information was known. The Agency did have a recording of Samantha's first child's apprehension. This information as well as information from the hospital stating that Samantha had received no prenatal care was the basis for Phoenix's apprehension. Also when the Social Worker attended the hospital immediately after Phoenix's birth Samantha and Steven stated that they were not prepared to parent a baby at that time.*

*Information regarding Cree Nations CFS receipt of a permanent order regarding [redacted] (Samantha's first child) was received from Cree Nations CFS on April 27, 2000. Substance abuse was not an issue outlined in Cree Nations CFS contact with Samantha. Samantha did however identify substance abuse as an issue in her family of origin. As Steven's child in care file (he had been a permanent ward of WCFS) was sealed, with the Supervisor believing Steven's consent was required for the file to be accessed, no information was know at the time of Phoenix's apprehension.*

- 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?**

*At the point that the case was transferred from Intake to Family Services a preliminary plan had been developed that would assist the parents in working toward their plan to parent their baby. The plan was as follows:*

1. *For the case to be assigned to an ongoing Social Worker in Family Services.*
2. *A three-month temporary order would be pursued.*
3. *To obtain further history from Cree Nations CFS outlining the reasons for they're obtaining a permanent order on [redacted]*
4. *A psychiatric / psychological assessment to be undertaken with respect to Samantha.*
5. *Both parents are to commence participation in an appropriate parenting program.*
6. *Both parents are to attend all scheduled visits with Phoenix.*
7. *Steven's sealed Child in Care file may need to be reviewed, requiring Steven's permission.*

*A social worker from Winnipeg Boys and Girls Club was already involved with Samantha and Steven and attended the planning meeting as an advocate and support. She agreed to assist the parents in accessing resources to meet Agency expectations.*

- *There were difficulties in accessing a psychiatric / psychological assessment within the community and as a result Agency consulting psychiatrist, Dr. Gary Altman was requested to meet with Samantha. This however could not happen until the fall of 2000 due to scheduling difficulties.*
- *In mid May 2000 Samantha and Steven began attending a parenting group offered through the Andrews Street Resource Center. Parents attended every week and successfully completed the eight-week program.*
- *Parents attended all weekly visits with Phoenix.*
- *Parents cooperated with the Agency Social Worker although there remained some concern that Samantha appeared angry when discussing issues.*
- *The services of a teaching support worker were added to the plan in July. The role of the teaching support worker was to assess the parenting abilities during transition visits and provide teaching when needed. Observations made by the teaching support worker indicated that the parents were attentive to and appropriate with Phoenix.*

- *Further information was obtained from Cree Nations CFS regarding the reasons for their obtaining a permanent order on [redacted]. Samantha had remained clear that she did not want to parent [redacted] and in essence had no contact with him. She did not contest Cree Nations plan for a permanent order.*
- *The only requirement not met when Phoenix was returned to her parents on September 5, 2000 was for the psychological assessment of Samantha to be completed. This was completed on September 15, 2000 and psychiatrist Dr Gary Altman supported the plan for the couple to be given the chance to parent.*

**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?**

*Explained above.*

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

*The initial service agreement is outlined above. A second service contract was signed with the parents on September 5, 2000, the date Phoenix was returned to their care. The conditions in this contract were as follows:*

- *Samantha will meet with Dr Altman to assess her emotional stability and Samantha will follow and recommendations made.*
- *Samantha and Steven will work cooperatively with the In Home Support Worker and will meet with her two times per week.*
- *Samantha and Steven will work cooperatively with the Agency Social Worker. Further the couple will cooperate regarding further exploration of issues related to substance use and family violence. Note: although this is an expectation there is no record in the file of either of these topics being an issue at this time.*
- *Samantha and Steven will participate in a parenting class focusing on issues of child development.*
- *Samantha and Steven will work cooperatively with the Public Health nurse.*
- *The Agency worker will assist Samantha and Steven in identifying a pediatrician for Phoenix.*

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

*Shortly after Phoenix's return home the case was transferred as the existing worker was moving to a new position. The case was assigned to a new Social Worker on November 14, 2000. The first attempted contact with the family is recorded as February 7, 2001 and an initial meeting with the new worker occurred on February 9, 2001. Samantha appeared angry at the new Social Worker's involvement and was only minimally cooperative in providing information. It is noted that Steven went to another room and did not participate in the meeting. Samantha did share that she and Steven had complied with the conditions of the Service Agreement by*

- *Participating in a parenting program through Andrews Street Resource Center.*
- *Continuing involvement with the teaching in home support worker.*

- *Continued connection to their worker at the Winnipeg Boys and Girls Club.*
- *Involvement with MaMaWi.*
- *Completion of an assessment with Dr Gary Altman.*

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

*File information indicates that actual contact with Samantha and Steven was minimal between October 2000 and April 2001 when the couple's second child, [redacted] was born. Although specific contact notes are not recorded on the file, it would appear based on the wording of the October 2000 transfer summary that regular contact did occur prior to Phoenix's return home.*

- 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?**

*See above. In response to [redacted]'s birth, she was discharged from hospital to parents' care without Agency contact and no contact was ever made to determine how the couple was coping once the baby left hospital.*

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

*Based on the information in the file there was no assessment conducted prior to [redacted]'s discharge from hospital. The only information in the file is from the Social Worker at Women's Hospital who indicated the parents were attentive and had the necessary supplies for the baby. A home visit was attempted in May 2001 but no one was home. The next contact is in July when After Hours received a complaint regarding the care of the children, the parents' use of alcohol and family violence issues. At that time Samantha had left the home, leaving both children in Steven's care.*

- 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?**

*The only mention of alcohol abuse is in relation to Samantha who had left the home. The statement is in relation to the woman Samantha was supposed to be staying with (an active client with the Agency) and states "it would be important to know if she is having Samantha live with her while it is alleged that Samantha is abusing alcohol".*

*In relation to the issue of family violence, the report states that Samantha had gone to Steven's home on July 2, 2001 accompanied by the Winnipeg Police who assisted her in taking baby [redacted] (she called Steven the next day telling him to come and get [redacted]). The report also states that Samantha and Steven cannot have direct contact with each other. It is later determined that Steven had been charged with assault toward Samantha when she came to pick [redacted] up on July 2, 2001. Issues of Steven's Alcohol and Drug Abuse arose later.*

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

*In a meeting with Steven on July 6, 2001 he informs the Social Worker that he was charged with the assault on the date that Samantha came to remove [redacted] from his care. He explained that Samantha said he pushed her around at which point she called the police and they assisted her in removing [redacted] from Steven's care. Although charged, Steven denies the assault and states that his sister was there as a witness and no assault occurred. There is no record that the assigned Social Worker contacted police at that time to get more detail of the alleged assault or to determine if there had ever been other police involvement regarding family violence issues.*

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

*The After Hours Social Worker met with Steven on July 4, 2001 in response to the recent complaint and stated that Steven had the assistance of extended family in the care of his children. Agency assistance was declined.*
*The assigned Social Worker met with Steven on July 6, 2001. [redacted] was there but Phoenix was being cared for by Kim Edwards, a family friend. Steven again declined the offer of supports and it was left that he would call if he needed anything. He did outline a number of community supports he is utilizing.*
*A safety plan was outlined as follows:*

- *Steven attended a parenting program (already mentioned)*
- *Steven has consulted with MaMaWi for assistance in formalizing his status as caregiver for the children.*
- *Steven will remain separated from Samantha*
- *Steven to attend a parenting group at MaMaWi beginning in August.*
- *Steven has applied for a restraining order against Samantha and has charged her with uttering threats against him.*
- *Steven will call the Agency if he needs anything or is having difficulty in parenting the children.*
- *Steven has not had a drink in two weeks and if he does drink he will make arrangements to have someone else care for the children.*
- *Social Worker will drop by once per week to monitor how he is doing.*

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

*Although the Social Worker stated that she would be visiting the home on a weekly basis to assess how he is coping with the care of the children this plan was not fulfilled. An attempt*

*was made to visit Steven on July 10 however no one was home. The next contact occurred on July 15, 2001 when the Agency was informed of [redacted]'s death by Children's Hospital Emergency department and the Winnipeg City Police. At this point Winnipeg City Police did share Steven's history of charges. In addition to the June 30 assault charge during Samantha's attempt to remove [redacted] from Steven's care, he had a past conviction for assaulting a police officer in July 1999, an impaired driving conviction and a stayed charge of possession of goods obtained by crime in September 2000. There appears to be no direct contact with Steven (the Worker spoke to him by telephone on July 16) after [redacted]'s death and the file was closed on March 27, 2002*

**Were other agencies involved?**

*See above.*

- 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?**

*As a result of the February 23, 2003 referral Steven's file was reopened to Intake. The Intake worker made a visit to the home on February 28, 2003. Steven was resistant to the Social Worker's contact; he presented in a 'foul' mood and had a sizable black eye, which he refused to discuss. He stated that Phoenix was still in the care of a family friend but refused to share the name. Steven further stated that he knew nothing of Phoenix's 'ailment'. This information is contradicted by the Godfather, found in the Hospital's report to the Agency of Phoenix's visit to Emergency. Further attempts were made to see Steven on March 12, March 31, April 17, May 1, and May 9, 2003. All attempts were unsuccessful as no one answered the door.*

**Was an assessment completed on her current caregiver?**

*The intake worker made an attempt to find out the name of the person(s) caring for Phoenix on the date she was taken to Emergency by contacting the hospital social worker. The only record on the chart stated that Phoenix was accompanied to the hospital by her 'Godfather". No name or address of this 'Godfather' appeared on the hospital chart. Thorough review of the file as well as Samantha Kematch's closed file would have revealed the caregivers were likely the Stephenson's.*

- 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 Rohan 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?**

*There is no mention in the file that Rohan Stephenson is the 'Godfather' who took Phoenix to the hospital in February. The only assumption that it was he is the reference to 'Godfather'. This issue should have been addressed with the Stephenson's when the Place of Safety information was being compiled. There is a Criminal Record check on file which states that neither of the Stephenson's had records.*

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

*At the point of transfer from Intake to Family Services on June 27, 2003 it is stated that the Agency will be asking for a three to six month order to allow for further assessment and to implement a plan for reunification. An ADP was not completed on Intake due to both parents lack of response to meet with the Intake Worker.*

**Were any assessments/programs completed?**

*Documentation after the file was transferred from Intake is practically non-existent. The closing summary dated October 2, 2003 (typed on November 13, 2003) states that while Phoenix was in care both parents visited her on a regular basis. Under* ***unresolved problems*** *it states that Mr. Sinclair has 'done no programming'. In fact it refers to Phoenix's placement as a 'time out' for Steven.*

- 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?**

*There is no documentation that a risk assessment was ever done. In addition it appears that no assessment was done and there is no understandable rationale for Phoenix's return to her father's care.*

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

*No contact is documented. The closing summary states that the family file will be closed on October 2, 2003 (although it was not processed until November 13) so it can be assumed that no contact was made after Phoenix's discharge from care.*

**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?**

*It would appear that the only rationale is that Phoenix was in care, Steven visited and wanted her back, and therefore Phoenix was returned at the expiration of the court order. Further comments have been made on this issue in this reviewer's report.*

- 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?**

*Intake Workers attended the Stephenson home on January 21, 2004. Information gained from Rohan Stephenson at this time is quite concerning in that the file was closed with no further contact.*

- *Rohan either did not know or refused to say what Steven was up to or how Phoenix happened to be in their care.*
- *Rohan stated that they would be prepared to look after Phoenix for as long as necessary on a private basis.*
- *Rohan stated that he did not actually live there, but stays there sometimes.*
- *If Rohan did not actually live in the home it is not understood how the Agency could accept his commitment on behalf of Kim. File notes do not indicate that the Intake Workers even talked to Kim directly to further assess the safety or suitability of the placement.*

- *Intake Workers did consult with both their supervisor and the previous supervisor when the case was last open to Family Services. Both supervisors supported the placement.*
- *Intake Workers could not get in touch with Samantha as she was out of town 'traveling'.*
- *Intake Workers did talk to Steven who was evasive but did agree that Phoenix should stay with Kim and Rohan.*

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

*The letter to the Stephenson's states the following:*

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

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

*No further contact was made with the Stephenson's after the initial contact with Rohan on January 21, 2004 and the letter of the same date. The case was closed on Intake on February 13, 2004.*

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

*There is no record of any further contact from the Stevenson's.*

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

*It is unknown if any contact occurred between Phoenix and her parents during the placement as the file was closed.*

- 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.**

*Please note that a 48-hour response time is given to moderate risk cases. High risk Intakes must be responded to that same day and low risk cases are given a five-day response time. All of these response times are stipulated in the standards.*

*Attempts were made to meet with Samantha prior to the date of actual contact and in fact the Intake Worker did make a home visit within the 48 hour Safety Assessment response time.*

- *On May 13, 2004 workers attended Samantha's residence. A man named Wes answered the door and said Samantha and Phoenix were at her Mother's.*
- *On the same date a visit was made to the home of [redacted] Samantha's mother. Samantha was not there and [redacted] said she and Phoenix were visiting friends.*
- *May 17, 2004 a letter was sent to Samantha saying the Intake Worker needed to meet with her.*
- *On June 2, 2004 the Intake Worker attended Samantha's residence. Again there was no answer.*
- *On June 15, 2004 another letter was sent saying the Intake Worker needed to meet with Samantha.*
- *June 21, 2004 Samantha calls as she has received the letter.*
- *On June 28, 2004 Samantha calls to reschedule the next days meeting as she is moving. Samantha agreed to meet for a short while on the next day.*
- *June 29, 2004 Intake Worker attended Samantha's address but could not gain entry to the block.*
- *July 9, 2004 Intake Worker gets Samantha's new address from E &IA.*
- *July 13, 2004 Samantha makes contact with the Intake Worker who goes out to meet with her immediately.*
- *Samantha reports that she is doing fine with Phoenix. Workers see Phoenix who appears well cared for. Samantha also looks healthy and denies drug or alcohol use. There is no discussion of who Wes is or what his relationship is to Samantha. Samantha does state that her main support is her boyfriend who is a trucker and stays with her when he is in the city.*
- *Agency supports are offered to Samantha who declines. Community resource information is provided to her and the case is closed on Intake.*

**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.**

*Mr. McKay's identity was not known at this time, as the Worker did not ask for his name, even though Samantha stated that he stayed there when in the city.*

**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?**

*There is no information on the file to state that another assessment was ever done. The only supporting documentation is the fact that both Phoenix and Samantha 'looked healthy'. Information was taken at face value and no attempts were made to verify the information. The* [redacted] *were not contacted to process how and why Phoenix left their care to live with Samantha even though the letter sent to them outlining that the Agency had serious concerns about both parents and asked that they contact the Agency if the care arrangement changed. No information was gathered on Karl Wesley McKay even though he was listed on CFSIS and other files contained concerning information regarding domestic violence to both adults and children (although reports of violence to children was never substantiated). Neither were police contacted regarding a risk assessment on Mr. McKay. The attending workers did not ask for his name.*

- 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 ***no*** 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?**

*In reviewing the file information it is determined that the Crisis Response Unit recommended that the file be sent to Intake for further assessment of the home environment. Further notes indicate the file was returned to CRU with the request that CRU connect with Samantha, offer family supports and close the file at CRU if mandated service were not required. After consultation with the CRU Supervisor, the Social Worker in CRU then called Public Health to see if they had been out to the home to see Samantha and the new baby. When the Public Health Nurse refused to share information, based on recent 'Personal Health Information Act' training her supervisor's name was taken and passed to the CRU supervisor for follow-up. There is no information on the file stating this issue was ever followed up on.*
*Although Wes McKay's birth date was not known his name was in CFSIS and in fact he had a file under his own name as well as being a significant other in various other files. By reading the dictation in these other files it was easy to determine that he was the same person. The information in these files presents concerning information on Wes McKay's violence to previous partners and possibly children. To be absolutely sure it was the same person the Social Workers should have made direct contact with both Samantha and Wes to do a proper assessment and conclude this Intake.*

**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.**

*See comments above*

**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?**

*See above*

**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?**

*To this reviewer's knowledge from reviewing the entire file information there was no reason to change the risk assessment.*

- 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.

*Please note that there would be no reason to be concerned that Phoenix was not attending school at this point, as she was only four years old and attendance in nursery school programs are not mandatory.*

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?**

*There would be no 'obligation' for the foster parent to provide the name of the source of information as the Act clearly states that community members do not need to provide their name in order to make a report of a child possibly in need to protection. It certainly would have been beneficial to have the name so the Agency could make direct contact with the source of the information but since the source had asked the foster parent not to provide the information the Agency would need to respect those wishes.*

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

*It is determined, after review that the Agency did not meet standards in completing this investigation.*

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

*The Agency's response to this complaint is concerning. Phoenix was not seen. The apartment was not seen. Samantha admitted that there was a lock on the outside of the bedroom door she and Phoenix shared. No reason for this lock was given. If the lock was deemed necessary by Samantha due to acting out by Phoenix, this would indicate that there were problems in Mom's ability to control this little girl. The history of this case, whereby so many sporadic caregivers had cared for Phoenix should have resulted in a red flag to the workers that all was not well in this home. No questions were asked about Samantha's present partner and father to baby [redacted] Add the allegation that Samantha (and or Wes) was being abusive to Phoenix should have put this case in a 'high risk' category and a complete investigation and assessment should have occurred.*

**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?**

*There is no record that the Branch was notified of [redacted]'s birth. It is possible that the family was residing in Fisher River at this time but specific dates are not known to the Agency.*

**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?**

*A section 182.3 report was completed on March 14, 2006. Past practice dictates this report is submitted to the Director of Child and Family Services and the appropriate Authority. The Acting Chief Executive Officer of the Branch has informed that she did notify Intake that a report needed to be done immediately, and sent on to the Authority however it was not done until March 14, 2006. It is recommended that the finalization of JIRU as a separate Agency be prioritized. Presently JIRU remains part of Winnipeg Child and Family Services Branch. Policies and Protocols for JIRU's future relationship with the Agencies are being developed and are in various stages of implementation. This transition phase presents some confusion regarding reporting structure and accountability.*

Completed by Rhonda Warren
Winnipeg Child and Family Services