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

Commission Disclosure 0001

A
SPECIAL CASE REVIEW

IN
REGARD TO

THE DEATH OF
PHOENIX SINCLAIR

Submitted to the Minister of Family Services & Housing
Province of Manitoba

by

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INTRODUCTION

In 2005, it is alleged that Phoenix Sinclair, a five year old girl, was severely abused by her birth mother and her common-law partner. This included severe physical abuse and emotional maltreatment. It was of such magnitude that some of it is difficult even to imagine. Ultimately her young life ended when she was allegedly beaten to death by these same caregivers.

There is sometimes the assumption that if a child is known to child protection authorities that this type of situation should not have occurred. In Manitoba, the public and the media have wanted to know whether this is indeed the case. After all, Phoenix and her family were known to child welfare authorities. When this information became public knowledge, the government of the day came under pressure to answer questions from the media, and the public as to how this death could have occurred.

These public questions included but were not limited to the follow.

- Why was Phoenix Victoria Sinclair returned to her family after being apprehended by Children and Family Services for a second time in 2003?
- What criteria were being used to handle her case?
- What were the circumstances around these decisions?
- Where did Phoenix go when she left care? Why did she go there, and who was responsible for that.
- What about the follow up? Was it adequate? Why didn't workers follow up to ensure the child was safe and the home was functioning?
- What are the gaps in the system?

As a result, a Special Case Review, of which this particular report is a part, was commissioned to look into what occurred. This investigator was given authority to evaluate the actions of the child protection agencies which were involved in the various case files involving Phoenix and her series of caregivers and to then make recommendations that will hopefully prevent similar incidents from occurring in the future in Manitoba.

Tragedies to children have occurred in all Canadian jurisdictions from time to time. The various inquests and inquiries have often provided diligent, practical input and appropriate adjustments to procedures, resources, training, and caseloads as needed. It is important then, that the recommendations in this report are considered and hopefully enacted. One can never prevent all deaths. There can be precipitating events that cannot be anticipated in some situations. In spite of best efforts, some parents will continue to abuse and ultimately kill their children beyond the reach of child welfare authorities. However, proficient child protection standards, the application of 'best practice', training, sufficient resource, and a coordinated system can significantly improve the lives of many others and decrease the odds of another tragedy such as occurred to Phoenix Sinclair.

The timing of this Review is such that the recommendations enclosed in this report can strengthen Manitoba's present governance model as it evolves. Manitoba is ahead of most other provinces in this regard. The establishment of the various Authorities is in itself, a progressive and culturally appropriate response to children, families and communities requiring child welfare services in the future. It is important, however, that sufficient resources are provided to each service provider including Winnipeg Child and Family Services. Each and every agency across Manitoba must retain the ability to provide services to a level that would protect children such as Phoenix in the future.

II) THE AUTHORIZATION FOR THIS 'SPECIAL CASE REVIEW'

In light of the public concern and wishes of the government to ascertain what had occurred in the province of Manitoba in regard to recent child deaths and with Phoenix Sinclair in particular, a Special Case Review was authorized under the following provincial legislation. The following description outlines this legislated authority and the resulting Terms of Reference.

THE TERMS OF REFERENCE

Legislative Basis for the Special Case Review

Under subsection 4(2)(c) of *The Child and Family Services Act*, and under section 25 of Child and Family Services Authorities Regulations, the Director or an Authority has power to:

> "conduct enquiries and carry out investigations with respect to the welfare of a child dealt with under this Act."

Further, under *The Child and Family Services Act*, the Director has the following powers to acquire information as part of an investigation launched pursuant to 4(2)(c).

> "require any person who in the opinion of the director is able to give information relating to any matter being investigated by the director
>
> (i) to furnish information to the director. And
>
> (ii) to produce and permit the director to make a copy of any record paper, or thing that, in the opinion of the director, relates to the matter being investigated and that may be in the possession or under the control of the person."

These powers may be delegated in writing to another person or agency at the discretion of the Director.

Review Panel

The special case review will be conducted by the Children's Advocate, through the contracting of an external consultant.

Delegation of Power

As authorized under subsection 4(3) of *The Child and Family Services Act*, for the purposes of conducting this review, the Panel will have the delegated investigatory powers of the Director.

Purpose of the Section 4 Special Case Review

Case Component

The review will examine and assess the services provided to Phoenix Sinclair and her family by all child and family services agencies. The focus will be to ascertain whether the services provided were consistent with established standards and best practice expectations.

The review will examine the circumstances that may have contributed to the death of Phoenix Sinclair and make recommendations that will help prevent similar incidents from

occurring in the future.

Scope of the Special Case Review
The review will be but not limited to:

- provide a profile of Phoenix Sinclair and her family;
- examine the assessment, risk determination methods and decision-making process used to determine the services and supports provided to Phoenix
- Sinclair and her family;
- examine the supervision, management practice, communication and lines of accountability as each pertains to the services provided in this case;
- review the criteria used to open or close the case for services;
- assess the degree to which the involvement of the Child and Family Services System met the protection needs of this child;
- assess the process used to evaluate the effectiveness of services provided to this child and her family;
- identify the factors that may have contributed to the death of this child; and
- analyze those factors that may have contributed to the agency or agencies either meeting or not being in compliance with standards and best practice expectations.

Method
The review will be conducted by:

- reviewing any file, report or other record kept by a child and family service agency, authority or the Child Protection Branch deemed relevant.
- interviewing any staff person employed by a child and family service agency, the Child Protection Branch or a Child and Family Services Authority,
- interviewing staff from the Office of the Chief Medical Examiner, collateral service providers, the police, R.C.M.P., or any other person considered appropriate; and access to C.M.E. files and agency files regardless if they are in possession of the R.C.M.P. or a Police Agency.

Report
Recommendations not deemed to be protected under section 76 of *The Child and Family Services Act* will be released to the public.

Date of Final Report
The final report will be submitted no later than September 30, 2006. The Director may extend this deadline as required.

Confidentiality
The Reviewers are bound by the confidentiality provisions contained in *The Child and Family Services Act*, the *Freedom of Information and Protection of Privacy Act*, and the *Personal Health Information Act.*

III) The Methodology for Completing the Review

The Authority to Investigate

As outlined in Part II of this report, this reviewer was designated 'a special investigator' under the designated authority of the Office of the Child Advocate for Manitoba. As such the report itself was completed in accordance with the provisions for the 'external consultant' outlined in the aforementioned Terms of Reference and more specifically defined within those parameters and Schedule "A" outlined below. This 'Agreement for Services between the Government of Manitoba and the consultant' provided the following contracted services.

1. To examine and assess the services provided to Phoenix Sinclair and her family by all child and family service agencies.

2. The focus will be to ascertain whether the services provided were consistent with the requirements of *The Child and Family Services Act* and the Program Standards as prescribed by Manitoba Family Services in relation to their management of the case.

3. To advise Ms. Billie Schibler, the Children's Advocate for the Province of Manitoba, on the circumstances that may have contributed to the death of Phoenix Sinclair and make recommendations that will help prevent similar incidents from occurring in the future.

The inclusion of the Children's Advocate provided the autonomy for this reviewer to independently investigate the case without reporting to the Child Protection Branch of the Provincial Government, which is still directly responsible for managing child welfare agencies in Manitoba. The Children's Advocate reports to the Provincial Legislature. In turn the Office of the Children's Advocate and the Office of the Provincial Ombudsman coordinated aspects of a concurrent examination of Manitoba's child welfare system in general.

The Context for Evaluating Case Management

Experience has demonstrated that a review of a child protection case requires consideration of other potential factors that influence case management practices. In addition to simply an evaluation of the case management process itself. Other factors, including the professional environment, within which the case is embedded, must be considered in order for a fair and realistic view of what indeed occurred; what was done by the child welfare agency; and the reasons for these actions or lack of actions.

Furthermore, one cannot simply judge the handling of a Child Welfare case by the fact that it ended tragically. It is crucial to look at the needs of the child and family and the Agency response at crucial points of time in the file history. For this reason each stage of the case was looked at independently, and **'Findings'** formulated at each step of the process. In other words, the reviewer's role is to look at a case at each given point in time and to ascertain what should have been done given the information that was known, accumulated, and would therefore provide the starting points for the assigned worker and his/her supervisor who would sign off on the casework decisions at various junctures.

In addition, the child protection actions in this case were also viewed within the accepted 'best practice' of the times. This definition of 'best practice' is intended to include what was done, or should have been done, when comparing it to accepted knowledge within the profession of Child Welfare at similar times in any Canadian jurisdiction. Accepted 'best practice' is constantly adjusting to new ideas and to research on an international level.

Sometimes, even when all policies and procedures are applied appropriately, and there is due diligence, there can be precipitating events which can change the risk level for children within a family This can occur so fast that a Child Welfare Agency is unable to respond in a timely manner. In regard to the case management involving Phoenix Sinclair, were there any of these precipitating events or factors that were beyond the control of the agency. If so, what were they?

The final consideration involves the determination as to whether the staff and the agency itself were able to provide the required resources to support the case manager of the file. This is another crucial area since it involves a consideration of whether there were sufficient degrees of supportive factors such as those outlined below;

- Appropriate supervision;
- Sufficient training at both the worker and supervisor level
- Clear policies and procedures that reflect ' best practice' in child protection;
- A reasonable workload at the worker level. This includes consideration of case numbers, administrative tasks and other specific responsibilities which may be expected to be performed during the carriage of the family file in question;
- A reasonable workload at the supervisory level. This includes consideration of number of workers in the 'span of control'; coverage responsibilities; administrative tasks; and other specific responsibilities. There are a multitude of tasks which are expected to be performed during time when the supervisor had responsibility to provide either consultation or to authorize actions of a particular worker such as in the files involving Phoenix Sinclair;
- A supportive agency culture and environment

With this context in mind, for four months ending in September, 2006, information pertinent to the terms of reference was investigated and evaluated. Sources of information included the following areas outlined below.

Meeting with the Police

On June 5, 2006, this reviewer submitted a written request to the Officer-in-Charge, Criminal Operations, for the Royal Canadian Mounted Police. This reviewer requested related information that might be available within the RCMP file regarding their investigation into the murder of Phoenix Sinclair. In particular, rumours had come to the reviewer's attention that a referral for another abuse investigation had been made in Fisher River First Nation, and may have been investigated by the agency which covered that area. Were there other people who may have reported concerns for Phoenix while she was living in Winnipeg? There was also limited public information as to what the police had been able to determine about what had actually occurred, when, and in what sequence of events. This information could have implications for this case review.

Included in the specific questions that I sought information on from the investigating officers on, were the following;

1. Did the child welfare agency covering Fisher River First Nation investigate the abuse of Phoenix or any other child residing in the home of Samantha Kematch, prior to the alleged murder of Phoenix? If so, what was the agency and who were the workers specifically?

2. If this did occur, have you interviewed any staff and do you have any agency case notes or police statements from that occurrence(s)?

3. Do you have any community witnesses who maintain that they reported abuse or neglect allegations to any child welfare agency including the agency covering Fisher River (First Nation)?

4. What did a former foster parent for Phoenix say about the transition of Phoenix back to Samantha Kematch's care in 2005?

5. I am interested in any police statements that she may have made.

As a result some relevant, helpful information related to the above questions was shared in person with this investigator. There was also some discussion about the situation in general. It was evident that there was great commitment by the officers involved to find out exactly what had occurred to Phoenix in the months leading up to her death.

This Special Case Review has also made its own inquiries and followed up on aspects of the case independently using knowledge that it had received from staff, community people, and referents mentioned in the case files.

Child Protection Staff Interviews

In the course of the investigation all available, former case managers and supervisors who had held responsibilities for the protection files involving Phoenix were interviewed in person. In addition several managers and senior staff for Winnipeg Child and Family Services were interviewed both in regard to the particular case files but also to inform the reviewer of agency procedures and present service challenges.

A branch supervisor and the office clerical person from the Fisher River First Nation office for Intertribal Child and Family Services was interviewed by this reviewer and the Child Advocate herself, whom I had asked to be involved in this part of the investigation.

In addition, this reviewer and a representative from the Office of the Child Advocate met with the Chief of Fisher River. This was done in order to show respect for the position of Chief by letting him know that we wished to visit his community. It also was a chance to provide an understanding of what the community had gone through since the death of Phoenix there. Finally it was a chance to be able to elicit any advice he may have had as to how we may proceed with our investigation of what involvement Intertribal CFS may have had with the family after they moved to that First Nation community.

Community (Client and Foster Parent) Interviews

During the course of this investigation, it came to light that there were a number of alleged referrals to child welfare agencies that apparently forewarned that Phoenix may be being abused. As a result of this two interviews were held. One of those interviewed was a former foster parent who looked after Phoenix during part of her life when her parents were not in a position to do so. She was interviewed in the Office of the Children's Advocate, and subsequently, there were several follow up telephone calls made with her in order to clarify her involvement.

Another interviewee was a client of Winnipeg Child and Family Services who was interviewed by phone. She had apparently called into the agency and talked to her worker in person about her suspicions. Two other adults, who had indicated that they had made calls to the agency or their worker, were also interviewed. One had apparently told a former foster parent of her concerns and another had indicated that she had called Intertribal Child and Family with concerns. The apparent referent to Intertribal CFS was interviewed in her home in person.

A Review of Other Protection and Child in Care Case Files

When an agency opens a file one of the first things that is expected is to look on the computer system and to determine whether there are other case files which may include information that would help in the present case. Sometimes there are previous incidents which may explain the present attitude and conduct of family members in their present situations. On occasion there are examples of previous behaviour which should be seen as troublesome, such as domestic violence and physical abuse. This knowledge would necessitate a higher degree of vigilance in the current case management if it is known.

In this regard the following files which would have been available to the case managers responsible for the service to Phoenix in her home were reviewed. They included protection files involving [redacted] (the name of client), and [redacted] who were former partners of Karl Wesley McKay. There was also another independent protection file on Karl Wesley McKay at a time when he was by himself. The child in care file for Phoenix was also reviewed but it was duplication in many ways of the family files which accompanied it. The results of these will be provided in the next section on case findings. '

A list of Documents that were Referenced in the completion of the Report

As previously indicated, The Terms of Reference for this review allowed for the request of specific information that was felt to be relevant to this review. As a result, internal reports and various official correspondence related to this investigation, were disclosed by various staff members when asked for by the consultant. The powers set out under a Section 4 Review (see the Terms of Reference Section) included the following. They

> "require any person who in the opinion of the director is able to give information relating to any matter being investigated by the director
>
> (i) to furnish information to the director. And

(ii) to produce and permit the director to make a copy of any record paper, or thing that, in the opinion of the director, relates to the matter being investigated and that may be in the possession or under the control of the person."

These powers may be delegated in writing to another person or agency at the discretion of the Director."

The specific documents are outlined below and will be submitted to the Office of the Child Advocate upon the conclusion of this review.

New Case Management Standards; a description provided on the efforts of the Child and Family Services to implement new case management standards. This was provided in the Bulletin-Child and Family Services Information Project. January 2000.

Manitoba Competency-Based In-service Training Program, July 2002 to march 31, 2003, revised July 5, 2002.

Foster Family Manual, (Prototype) Manitoba Family Services and Housing, June 24, 2002, 2nd proof by TP.

Case Management Process and Standards, Draft July 2001, created by the Child Protection and Support Services Branch.

The Manitoba Child and Family Services Workload Measurement System; This is a department document which outlines how service time for front line Child Welfare staff should be calculated and then reported. It was circulated in 1992.

Perinatal Assessments; details of a procedure circulated by the Winnipeg Child and Family Services, December 14, 2000.

Program Description for the Crisis Response Unit, Winnipeg Child and Family Services, (undated)

Program Outline for the Crisis Response Unit and After Hours Unit, Winnipeg Child and Family Services, (undated)

Crisis Response Unit, Recommendations on Recording Outline and Information Gathering, Winnipeg Child and Family Services, (undated)

Information to be Gathered at CRU/AHU Level, in regard to Abuse Cases, Appendix A, February 19, 2002.

Winnipeg Child and Family Services Abuse Intake Units, this is a program description and was in draft form March 13, 2001

Winnipeg Child & Family Services, Orientation Manual updated May 10, 2004

Winnipeg Child and Family Services Child Death/Serious Injury Protocol, Draft #1, September 15, 2004, Approved April 12, 2006

Winnipeg Child and Family Services Critical Incident Policy and Protocol, April 25, 2006

Crisis Response Unit Yearly Stats 2004

Crisis Response Unit Yearly Stats 2005

The Float Social Worker Program, draft 2005, Winnipeg Child and Family Services

Letters and memo's relating to Winnipeg Child and Family Services and the Child Protection Branch

Letter to Winnipeg CFS from the Child Protection Branch in regard to Case Management Standards Package', 'Workload Implications and Workload Measures, dated May 26, 1999

Letter from the Child Protection Branch to Executive Directors, Child and Family Services Agencies, Regional Managers, Regional Offices, and Winnipeg Child and Family Services in regard to Case Management Standards, dated May 11, 2001

Letter from the Child Protection Branch to All Mandated Agencies in regard to Standards for Child Welfare, dated July 12, 2001

Memo from Winnipeg Child and Family Services to the Child Protection Branch in regard to the Draft Standards, December 17, 2003

Memo from the Executive Director, Child Protection Branch to the Winnipeg Child and Family Services Branch in regard to the Draft Standards, dated February 4, 2004

Letter from Winnipeg Child and Family to the General Authority, in regard to Draft Standards, dated March 1, 2004

Draft Standards Review, submitted by Family Services Department, August 16, 2005

Other Articles

This reviewer researched some aspects of the Child Welfare practice from professional literature and from various field manuals. Particular attention was given to material which was Canadian and specific to Manitoba in particular. The topics included best practices as outlined in an excellent paper which was recently submitted to the Manitoba Ombudsman and Children's Advocate, outlining practices which should be considered over and above this particular report. In addition, material on the 'Authorities' was also considered as was material on other Canadian child death reviews and inquests.

Finally, this reviewer reread the report that he had submitted in 2003 on the Nadine Beaulieu

Inquest which was held in Dauphin, Manitoba under Justice Gregoire, to see whether any of the systems recommendations and findings remained relevant to the Phoenix Sinclair case.

Best Practice in Child Welfare: Definition, Application and the Context of Child Welfare in Manitoba, by A. Wright, A Review Submitted to the Manitoba Ombudsman and Children's Advocate in 2006

Bill 35, *The Child and Family Services Authorities Act*

Aboriginal Justice Inquiry-Child Welfare Initiative; The information included an entire 'download' of the website developed by the Manitoba Government and the other partners in the initiative.

Child Death Reviews and Child Mortality Data Collection in Canada; Jan Christianson-wood, Jane Lothian Murray, 1999.

*The Ontario Child Mortality Task Force Final Report; Published by the Ontario Association of Children's Aid Societies and the Office of the Chief Coroner of Ontario. July 1997.

Report of the 1997 Child Protection File Review; Ministry of Community and Social Services, Ontario, April 1998.

*Child Welfare Accountability Review; Final Report, Prepared for the Deputy Minister, Ministry of Community and Social Services Ontario. This was a documented prepared for the Ontario Government and submitted to them by the ARA Consulting Group Inc. January 12, 1998.

Liability Considerations in Child Welfare: Lessons from Canada; Karima Kanani, Cheryl Regehr, Marvin M. Bernstein, in Child Abuse and Neglect, 26 (2002) 1029-1043.

IV THE FINDINGS: A CHRONOLOGICAL REVIEW OF THE CASE MANAGEMENT FROM 1998 TO 2005

Each time that the file was opened up under the names of Samantha Kematch or Steven Sinclair the case was given a new section of this report. The more important contacts are outlined using the content of the files themselves. At crucial points in the case management process, there are **'Findings'** presented. Over all conclusions about the case management in general are offered in the following Section V after the entire file from start to finish has been reviewed in this Section IV.

A listing of the various care givers and the five children of Samantha Kematch are listed below.

The Family Members at Various Points in the Case Files
Samantha Kematch (date of birth: September 9, 1981) is the mother of the five children listed below. The Fathers for each of the children are also provided. At certain points each of the fathers was part of separate case file openings during the carriage of this case by the Winnipeg CFS.

The Fathers
[redacted] is the father of [redacted]
Steven Sinclair (date of birth: May 15, 1980) is the father of [redacted] and Phoenix
Karl Wesley McKay, March 28, 1962) is the father of [redacted] and [redacted]

The Children
[redacted] (date of birth: July 23, 1998);
Phoenix Victoria Sinclair; (April 23, 2000); (Allegedly murdered in June 2005)
[redacted] (date of birth: April 29, 2001; she died of natural causes related to pneumonia on July 15, 2001);
[redacted] (date of birth: November 30, 2004); and
[redacted] (date of birth: December 12, 2005).

1. THE FIRST PROTECTION FILE OPENING: FROM JULY 23, 1998 TO AUGUST 17, 1998

This file involved Samantha Kematch while she was still a permanent ward of the Cree Nations CFS. On July 23, 1998 a referral was received from Cree Nations CFS. They had wanted Winnipeg Child and Family Services to apprehend Samantha's first child, [redacted] who had been born that day. The Cree Nations CFS provided the necessary background information and the Winnipeg CFS placed him in a foster home after he was discharged from hospital.

The recordings state that, 'Given that Samantha had not prepared or informed anyone of the baby's birth and also because Samantha has difficulties managing her own life, let alone tending to a baby's needs' a decision was made to comply with the request. Samantha was interviewed at the hospital the same day by the worker and the opinion of the hospital staff was also garnered. The worker wrote that after she interviewed the mother it became obvious that 'she had no idea and shared little interest into decisions that took into account the baby's best interest'. Ultimately in August of 1998, the Cree nations CFS took over the application for permanent wardship and the Winnipeg Agency closed the file.

Findings:

F1. The worker provided a timely and appropriate response from the time of the referral until the point of the closing of the case file.

The worker responded to the initial request immediately. There were no delays at all in the provision of service since the assigned worker spoke to hospital staff and then to the new mother herself on the same day. The case was appropriately handled during the next several months and when Cree Nations CFS took back the court application for permanent wardship of [redacted] the case was closed.

F2. The Cree First Nation CFS provided detailed assessment material on Samantha Kematch as required at the referral.

This was important in order to justify the apprehension. It also showed the appropriate degree of co-operation between two independent child welfare agencies that is required to co-manage a situation such as this.

2. THE SECOND PROTECTION FILE OPENING: FROM APRIL 24, 2000 TO MARCH 2002.

At this point the agency's protection file on Samantha Kematch's from 1998 was reopened with the addition of Steven Sinclair now that he was known to be the father involved in the present situation with her.

April 24, 2000
The After Hours Emergency Services Unit received a referral from Health Sciences Center Social Worker. Samantha Kematch, now 18, had given birth to Phoenix Sinclair. Father of the baby was Steven Sinclair age 19.

The mother had sought no prenatal care and it appeared that the couple had no preparation for the baby. In light of the history that the hospital social worker was able to establish she made the referral for follow up by the agency. Immediate follow up by after- hours workers established that the mother was not in a position to care for the child upon discharge. The baby, Phoenix Sinclair, was then apprehended at the hospital.

Findings:

F3. The decision to apprehend by the After Hours workers was appropriate in order to protect Phoenix.

There was a lack of preparation by the mother, and there was a significant worry that the parents would not be able to parent the baby upon discharge. In addition, the agency provided an immediate response and appropriate supervisory decision making as called for in the Protection Standards.

April 25, 2000
On April 25th, 2000, the parents indicated that they wanted to have the baby returned and they said that Samantha's mother was going to arrive later that day. The worker indicated that her mother could talk to her about that. Over the next few days prior to transfer to another worker, the case manager made a number of contacts including a request by WCFS for more information from Cree Nations CFS. This included an assessment completed on Samantha while she was in care and it arrived on April 27. Prior to transfer on April 27th, the case was recorded and an initial assessment completed.

Findings:

F4. The Intake Worker completed her tasks appropriately, thoroughly, and in the best interests of Phoenix and her parents.

It was evident from the assessment which arrived that the grandmother would not be an appropriate care giver. The grandmother had apparently been rejecting and abusive to Samantha and she also apparently had an alcohol problem. In addition, Samantha herself had been known to be aggressive and get angry quite fast. The transfer recording was detailed and explanatory.

Of note was that an apparent conflict of interest arose with the worker and she declared it in the recording. All actions had to be done with the supervisor of the unit and not the worker from that point. The case was then given to another worker in the interim and formally transferred May 1, with an initial case plan in place.
It stated that....'

- *This agency to assign a family services worker for ongoing service and intervention.*
- *A 3 month temporary Order of Guardianship to be pursued*
- *This agency will await further case history from Cree nation C&FS and incorporate same into the on-gong case plan.*
- *Some form of psychiatric/psychological assessment will need to be undertaken with respect to Samantha (this to be arranged by the Agency) or the couple (with agency approval).*
- *Both parents are to commence participation in an appropriate parenting program.*
- *Both parents to attend all weekly visits with Phoenix. Visits to be transferred to the Jarvis office as soon as possible.*
- *Steven's CIC file may need to be reviewed should he agree to sign the appropriate consents for same'*

Findings:

F5. The initial case plan was appropriate and detailed.

August 2000
In August a home-maker was assigned to assist the parents and a VPA was signed for one month upon the expiration of the temporary care order. This was to allow for Phoenix to be hopefully placed back home.

September 5, 2000
Service Agreement signed (on file) stated that over the next six months the parents and the agency would follow through on the following:

1) 'Samantha will meet with Dr Gary Altman to assess her emotional stability. Samantha will follow recommendations made by Dr. Altman.
2) Samantha and Steven will meet and work cooperatively with the agency in-home support worker and will meet with her at least two times a week.
3) Samantha and Steven will work cooperatively with the Family Services Social

Worker, this includes meeting with the worker on a regular basis and allow the worker access to the family home. Samantha and Steve will also cooperate with the Agency worker regarding further exploration of issues related to substance use and family violence.
4) Samantha and Steven will attend and participate in a parenting class that focuses on issues related to child development.
5) Samantha and Steven will work cooperatively with the Public Health nurse as a method of gaining information regarding general health issues of small children.
6) The Agency Worker will assist Samantha and Steven with identifying a pediatrician to use for Phoenix's routine medical issues.'

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
On this date the worker did a transfer summary as she was leaving her position at the agency. Although not everything is explained in detail in regards to the parent's progress towards the stated goals it appears that much was accomplished in terms of regular visiting by the parents with Phoenix, completing an eight week parenting course, regular weekly contact with the worker and the parents, a homemaker had been assigned.

October 13, 2000
Dr. Altman had met with Samantha and the child care file case file notes indicated that 'he did not see any need for future assessments at this time, 'he feels that they are committed to one another and to parenting'. He believed that the 'couples responses and their interactions were genuine'. Also, he apparently stated to the worker that 'his impression was that the flat affect experienced with Samantha is likely due to her method and style of communication, not depression or feelings of sadness'. The worker also indicated that ongoing assessment of their parenting by the new worker would be necessary.

Findings:

F6. The case file management involving Phoenix and her parents was competent up to the point of worker transfer in October, 2000.

The interaction by the worker was purposeful and active. It may indeed be that the couple still had far to go to be competent parents but the agency had them on a specific plan and outside collaterals and professionals were involved appropriately.

Up to this point this case was on target with a realistic case plan. The problem was identified appropriately as there being two young adults, with traumatic childhoods who were now the parents of a very young child. The plan was to strengthen their parenting skills and ensure that they are psychologically able to parent. There was frequent outside contact by collaterals as well to ensure that the situation did not become dangerous for Phoenix.

For those who have done child protection case work, there was little at this point that

separated this family from many others open to protection services. There was a lack of parenting skills and other issues stemming from the parent's own childhood. In most of these situations the parents can retain their young children or babies with them under close supervision. Many parents with tragic upbringings can become good parents. It requires that they look at role models, find supports, or build a relationship with their worker, and assume the attitude that they can succeed. Furthermore, bonding between parents and their children is important, and, where possible, parents are given opportunities in the first few years of life to have frequent contact or custody of their child.

It should be understood, too, that the onus is on child welfare staff to prove that a parent cannot parent rather than the other way around. In this situation for example, a court already allowed a temporary care order to be converted into a voluntary agreement of care. Samantha Kematch and Steven Sinclair appeared to be trying at this juncture.

The Next Period after a New Worker Assigned November 14, 2000.

November 14, 2000
A new family service worker took over the case when the assigned worker transferred from the department.

November 16, and November 17,
Two phone calls were received from Cree Nation Child and Family Services in regard to information requests on [redacted]

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

February 1, 2001
The assigned worker visited the home and no one was there. She left a card.

February 5, 2001
The assigned worker had supervision. Typed notes from that supervision confirm that the contact was minimal. The importance of the PHN working with the parents is confirmed. No mention is made of any follow up in that regard. It also appears that the case plan which included family support is not occurring since the program had previously ended November 30th, 2000 as mentioned above.

The supervisor went over the six month contract that was still in place and scheduled to end by March 5, 2001. It appeared that the supervisor may have been anxious since a short term goal was to 'make contact with the family ASAP to gather updates on progress to date re: service contract'; 'identify child's pediatrician'; and to 'determine need for further in-home support services or identify referral to community resources e.g. Parenting programs'. Incidentally the only recording around this period was undated and showed no contact by the assigned worker

February 7, 2001
The assigned worker dropped by the house just when Samantha Kematch and Steven Sinclair were leaving. No mention is made of seeing Phoenix at that point when they were leaving the house. They refused to continue with the visit, and arrangements were made for February 9, 2001 for a scheduled visit instead.

February 9, 2001
The assigned worker visited the home. Steven did not participate and sat in a back room and Samantha appeared angry at the involvement of the worker. She watched TV at the same time as she was talking to the worker. She would 'nod or respond aggressively when asked a question'. There is no record of Phoenix being seen on the visit by the worker. Samantha stated that she had followed up with the parenting program and than they are connected to the Boys and Girls Club, and three other supports including MaMawiWitchiltata Centre Samantha also said that she would be getting a paediatrician to look at Phoenix. The worker indicated that she would continue to drop by and 'offer supports'. Her written plan from the visit consisted of 'Will drop by visit to monitor situation or as needed'.

April 30, 2001
This was a call from the Woman's Hospital informing the worker that Samantha Kematch had just given birth to a baby girl, [redacted] on April 29, 2001. She also indicated that a 'friend of theirs is keeping Phoenix until she is released from hospital. The referent indicated that the father had been 'actively visiting' and 'participating in the care of the baby'. The worker wrote in her notes that 'this is the third time that she had not disclosed to the Agency that she was pregnant'.

May 9, 2001
The worker attempted a home visit but no one was home.

June 18, 2001
This is an e-mail sent to the assigned worker from another staff member who had one of Steven's sisters on her caseload. The worker related that the sister had indicated that '(the sister) had been babysitting for Steven and Samantha. Given (her) functioning this would be of concern'. She went on to write, 'also of concern is a message I received wherein I was told that recently Steven had become violent and had assaulted both (his sister) and Samantha. Police were involved lately but I am not sure of what transpired.....for your information and follow-up'.

June 19, 2001
The worker updated the assigned case manager for Samantha that 'both young women (Samantha and Steven's sister) had spent the night at (a friend's) place and they were out shopping. No mention of the baby was made. For your information'.

June 29, 2001
The same worker did another e-mail to the assigned case worker. She stated that one of Samantha's brothers had called into CRU and related that...

'on June 15th Samantha and her partner (Steven Sinclair) were in a domestic dispute late in the evening and that Steven kicked Samantha out of the home with the small

infant, the 1 year old remained in the home with Steven. . SOR is concerned as he has not seen Samantha and the babe in a few days, and alleges that Steven has a drinking problem and on-going conflict with Samantha. SOR feels there needs to be some check on the safety and well-being of the children. I asked Cory to do a field to the home to check on the well-being of the children today'.

July 3, 2001
This was a concern expressed by another colleague at Winnipeg CFS. She indicated by e-mail that Steven Sinclair and one of his sisters spoke to her. This worker had been the worker for him when he was in care. They talked about the home situation and the fact that Samantha was drinking and had care of the youngest baby. The worker wrote that she *'spoke with Steven who stated that he did not know that he had a worker. He will call you and may come in after 2 p.m.'*

July 3, 2001
This was an After Hours Emergency Unit contact. A complaint was received from a sister of Steven and apparently the parents had separated on or about May 1, 2001, and both children were left in Steven's care. The following day the police had apparently assisted Samantha in having the child [redacted] removed from Steven and returned to her. Phoenix was apparently with a family friend. The next day Samantha had called to have [redacted] returned to Steven. Apparently Steven had been looking after both children for the last two months.

July 4, 2001
The following day a covering worker from the assigned worker's unit had visited the home. The worker indicated that Steven wanted to continue as a single parent. The covering worker wrote that *'Steven appeared sincere, open and honest in his discussion with him-Samantha left the home and the two children in care of their father. The house was clean and Steve did have assistance from extended family to care for the children if needed'*. The children were not mentioned.

July 4, 2001
The worker recorded in her notes that *'several concerns have been referred regarding the care of the children and the parent's use of alcohol and family violence'*. She then went on to write that her plan was to visit the home the same day. Apparently an emergency on call worker had visited the home and found Steven looking after the children.

July 6, 2001
On July 6, the worker had a full interview with Steven in his home. Phoenix was at a family friend called Kim Stephenson for the afternoon. Steven stated that he 'gets her to watch her (Phoenix) if he needs to go some where'. The worker felt that his interaction with [redacted] was appropriate. There was a discussion of the various events that had occurred. They are recorded below in the worker's own summary made that visit. It was also mentioned in the other part of the case continuous contact recording that Samantha had apparently had a physical fight with one of Steven's other sisters.

Here is the summary of the visit.

'Summary:

- *Steven has completed a Parenting Program through the Andrew Family Street Center last year — he will provide a copy of all his certificates for this worker*
- *Steven has consulted with Ma Ma Wi on assisting him on retaining a lawyer to file for full custody of his children Phoenix and* [redacted]
- *Steven has been separated from Samantha for about three weeks*
- *According to Steven, Samantha has resumed her relationship with* [redacted] *father of her oldest son —* [redacted] *has just recently got out of jail*
- *Steven has been formally charged with "Assault" on July 2". — It is alleged by Samantha that Steven had shook her up — According to Steven his sister Jenny witnessed the argument and has noted that "Steven" did not shake up Samantha.*
- *Steven has approached Ma Ma Wi to attend a parenting group for young fathers "Young Fathers" contact person is D.... B..... will be starting in August 2001*
- *Steven had charged and applied for a restraining order against "Samantha" after she Uttered Threats of Violence against him on July 3.*
- *Steven stated that he is not wanting any support services from the Agency i.e. Respite, homemaking at this time but will call the Agency if a need arises*
- *Steve stated he has not had a drink of "alcohol" for about 2 weeks and if he decides to go out — he will get his sister (Jenny) to care for the children*
- *Steven stated when and if he decides to have a few drinks - he usually only drinks for one evening — he does not go for days — and that alcohol is not a problem for him*
- *This worker cautioned him about drinking alcohol while the children are in the home -- this can lead to the children being removed from his care -- Steven nodded and stated he is well aware of this and stated that Jenny will care for them'*

Findings:

F7. The worker who received the case file in November 2001 did not maintain the necessary contacts and frequency with the parents of Phoenix during this period. There were only two actual home visits and an additional two other unsuccessful attempts in seven months.

If the typed updates of the worker's contacts are indeed accurate, there was only one visit to the home from the time the worker took over on November 14, 2000 until the unsuccessful contact on February 7, 2001 and the full home visit two days later.
The next visit was unsuccessful and occurred on May 9, 2001. Even after she was told on April 30, 2001 of the birth of a second child the day before, she did not visit the hospital or follow up at the home until a week and a half later. After that, the next contact where she actually saw Steven was not until July 5, 2001 and this was a day after she had been informed that the emergency services had had to deal with 'domestic violence' and the 'use of alcohol'.

She had also received three updated e-mails on additional concerns during the latter part of June, 2001. Two young babies were living in the home at this point and there should have been significant follow up and risk assessment of the situation. This lack of contact was

unacceptable case practice since the children could have been at considerable risk of harm considering the potential problems that could arise from the use of alcohol or from domestic violence.

F8. There is no recording of the worker actually seeing Phoenix during this case period.

This required contact may have occurred but there is no record of it and this is an extremely young child who could start to decline quite rapidly. There is no confirmation that any other collateral are visiting in the home and may have had an opportunity to view Phoenix and the baby [redacted] and to know that they were all right.

F9. The case work does not appear to be purposeful or to follow a plan.

The Case Management appears to be primarily a delayed response to events or crises with no contact in between and no meaningful pursuit of the original case plan. This is a dangerous approach since it puts the agency in a position of responding to rather than actually preventing possible catastrophes to children in need of its protection.

F10. It appears that at this point, Steven was marginally managing the situation with his two children and as a result, apprehension was not required in spite of the concerns for domestic violence and alcohol use.

In spite of the lack of involvement of the worker, up to this point at least, it did not appear that the two children were in immediate need of protection. Friends and relatives appeared to be providing some assistance. Steven had made some plans to better himself as a parent and he had been more open to a dialogue with his assigned worker. The assigned worker had made an immediate plan with him to follow up on a weekly basis.

As of July 6, 2001, the file on Samantha was closed and another protection file with Steven as the primary parent was opened.

On July 6, 2001, the protection file involving Phoenix changed to be under Steven Sinclair's name as he took over as the sole caregiver for Phoenix at that juncture after their separation. The "Samantha Kematch" part of the file was subsequently closed. This did not signify a break in service to Phoenix Sinclair and is not then considered a termination of service.

July 10, 2001
The worker stopped by at Steven Sinclair's home but no one was there.

July 15, 2001
The After hours Emergency Unit staff informed the supervisor that [redacted] had died that evening in hospital. Apparently [redacted] had been ill. The supervisor then contacted the worker at home

July 16, 2001

Samantha Kematch was eventually contacted by the police and she wanted Phoenix. The agency supported Steven remaining as the primary caregiver.

Finding:

F11. A report was completed for the Chief Medical Examiner. It found no fault in the death of [redacted]

It appears that there were no concerns that [redacted] had died as a result of abuse or neglect. [redacted] had apparently died as a result of 'acute and chronic lower respiratory tract infection' (page 14). The report from the Chief Medical Examiner stated on page 18 that...

> *'The Special Investigator feels that Winnipeg Child and Family Services has met their mandate with respect to this case. Summaries were complete and on file. Child in care reviews were complete. The file met Provincial Program Standards and was well maintained'.*

It concluded that *'the Chief Medical Examiner has no recommendations to make with respect to this matter'.*

March 1, 2002

This is the Closing Summary for Steven Sinclair's protection file. This recording has no indication of what contacts occurred with Steven and Phoenix. The last recorded contact on this family occurred in July of 2001. The reason for closing was given that 'Steven is the primary care-giver 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.' The recording itself indicated that there were as yet 'a number of unresolved problems' and it made 'recommendations for the future.

It is also noted that following the death of [redacted] no offer of grief counseling, or follow-up through in-home support or immediate safety assessment on Phoenix was recorded.

Finding:

F12. The absence of any recording and case notes for the period from July 16, 2001 until March 1, 2002 makes it difficult to determine what was attempted by the case worker during this period of time that the file was open.

It is possible that casework was completed by the assigned worker but no record or case notes can verify this.

F13. Significant problems existed which could have negatively affected the welfare of Phoenix Sinclair and they should have been followed up prior to

closing.

There were still protection concerns based on their past childhood traumas and the apparent use of alcohol that could still occur.

F14. The case management from November of 2000 until the closing in March of 2002 was substandard.

There were limited contacts, No risk assessments and assessments were completed and there is no indication of sound casework practice.

It was felt that Steven Sinclair might still have a drinking problem and it was unsure whether he was linked to collateral services to a sufficient degree. He was also felt to have unresolved trauma from his child hood. Regardless of this, the case file was ultimately closed without these being resolved. They should have been, due to the young age of Phoenix which made her high risk for abuse or neglect. Furthermore, the continued opening of the case need not have depended on whether Steven asked for continued support services but more on whether a supervisory order could be sought if the worker had sufficient child protection concerns and the father was uncooperative.
Collaterals were not called to find out what information they may have been able to offer.

3. THE THIRD PROTECTION OPENING: FROM FEBRUARY 26, 2003 TO NOVEMBER 2003.

February 26, 2003
This was an After Hours report from the After Hours Unit. The Agency had received a referral from the Child Protection Center at Children's Hospital. It appears that Phoenix's 'Godfather' had brought her to Emergency. Phoenix had a foreign body lodged in her nose since November 2002. It had now become infected. The hospital removed the foreign body and the nose was badly infected. The Child Protection Center recommended that the situation be *'assessed further given past concerns related to physical and medical neglect and inadequate care of the child.'*

CRU did a risk assessment and gave it a five-day response time in their transfer to intake for investigation.

February 28, 2003
Intake worker visited the home on this date. The recording indicates that *'Steven presented at the door in a rather foul but sober manner. He was also 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'.

The recording indicated that *'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 to ensure her well-being and Steven responded, "We will see about that".*
Steven also indicated that *'he was unaware of Phoenix's ailment'.*

March 12, 2003
Worker went to the home. He left a card since no one was there.

March 13, 2003
A follow-up letter from the hospital arrived outlining the specific issues related to the nose infection

March 31, 2003.
This was another visit to the home. No one was there.

April 17, 2003
This was another visit to the home. No one was there.

May 1, 2003
This was another visit to the home. No one was there.

May 9, 2003
This was another visit to the home. No one was there.

FINDINGS:

F15. The initial contact after the referral was made in two days rather than the five indicated on the safety assessment. This was appropriate since the child was very young.

The safety assessment provided too low a risk. Phoenix was a young child and it was important to establish that she was recovering. It was commendable that the assigned worker went earlier than had been previously assessed.

F16. Phoenix should have been physically viewed by the worker as soon as possible. This was not done.

The worker did try to establish contact, but this should have been more of a priority after the state that the father presented himself in with a black eye. It is possible during this period of time that Phoenix was with Kim and Rohan Stephenson on a semi-permanent basis (this is hard to determine even in a subsequent interview with Kim Stephenson herself as part of this review). This family had become known to the Winnipeg CFS the year before when Steven had mentioned that he had placed Phoenix there for an afternoon.

Although nothing serious happened to Phoenix in this period of the case file that we are aware of, the potential for harm was quite high and the agency should have been more assertive in their pursuit of establishing further contact with Steven. A court application for a supervisory order could have been one approach.

The Second Apprehension of Phoenix Sinclair.

June 21, 2003

The After Hours Unit received reports that Phoenix is at risk. The recording indicates that Phoenix was ultimately removed from her father's care due to concerns regarding his abuse of alcohol and drugs and exposure of the child to numerous, and sometimes inappropriate care givers over the weekend. It went on to say that *'Steven continued to abuse substance to the point of incapacity despite of his knowledge of pending contacts over the weekend with the AHS unit'.*

Phoenix was removed to a placement within the agency. Steven Sinclair was visited a number of times by the After Hours staff who were trying to give him a chance to sober up before they had to apprehend him. The workers did a record check after the first visit and this appeared to influence them on the eventual apprehension which was done with supervisory approval. Later, a sister of Steven Sinclair indicated that Steven had only looked after Phoenix for three or four days a month while she was in his care. The rest of the time it appears that she was looked after by friends.

June 27, 2003
The intake worker wrote a very insightful assessment prior to referring the situation to the new family worker. He wrote that

> *'They would do anything, or nothing, to keep the agency at bay. It is the worker's opinion that it is this attitude and disregard for the Agency that has probably resulted in the Agency's termination of services, and not a lack of child welfare issues. If one looks back in previous recording the identified and unresolved problems are still very much present in the family's current situation. The problems have not 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. 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.'*

He moved the case forward for transfer to Family Services for ongoing service once again.

Findings:

F17. The After Hours staff did appropriate after hours emergency service

Staff provided appropriate follow-up with the referral by visiting the home and then following up as long as there appeared to be a potential danger for Phoenix. The decision to ultimately apprehend her was also warranted. They did due diligence by completing a record check after the first visit when they returned to the office. Their recording was detailed and concise.

F18. The intake worker, in completing his assessment and writing what he did at the point of transfer, demonstrated the necessary conviction that it takes to keep children safe.

This is the dedication to a child's well being that is required and should be sought and then nurtured by a child welfare organization. I believe that he was trying to convey to the new ongoing worker that the agency needs to make sure that it did what was right for Phoenix. This is a highlight in the management of this case.

July 7, 2003
The worker went to the home of Steven Sinclair to discuss ideas and concerns in regard to Phoenix.

July 10, 2003
The worker presented Steven Sinclair with the option of attending at NAC then returning Phoenix home by way of a Supervisor Order. Notes indicate that Steven agreed to seek counseling and appeared eager to do so.

July 21, 2003
The worker made a home visit. Steven Sinclair was not there.

July 24, 2003
Case notes written by the worker in July of 2003 indicate that a treatment option was provided to Steven but he felt that he was not ready and as a result 'Plan B' three month temporary order was provided.

July 29, 2003
The worker made a Home visit to Rohan and Kim Stephenson 'regarding placement for Phoenix'.

July 31, 2003
Placed at Kim Stephenson's on July 31, 2003 after criminal record checks, child abuse registry check, and it was determined that she was not an open family case to WCFS. At that point documentation shows that she became an official 'Place of Safety' and would have received at least the regular per diem. She was returned on October 3, 03.

August 1, 2003
The worker called Kim Stephenson to see how things went with Phoenix. She replied to the worker that things were great and that Phoenix was doing well.

September 10, 2003
Notes indicate that the worker phoned Kim Stephenson and she indicated that 'Phoenix was doing fine and getting over the flu, Steven is coming around more often and spending more time with Phoenix and coming around when he was not drinking. 'All is well"

October 2, 2003
Phoenix was returned home. In the notes recording this home visit it is indicated that *'Steve states that he is ready and able to parent Phoenix and is ready to parent'.* The worker had his doubts and this is described below in the circumstances presented by the worker at the closing which occurred on November 13, 2003.

October 7, 2003
This was a closing summary for the place of safety (Kim Stephenson's home). In the recording the assigned worker indicated that *'Given time frame constrains, this worker was able to meet once with this care provider'.*

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 who were Phoenix's Godparents.

It further states that:

> *'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 care-givers when he feels the need for a break or time out for respite.'

It also provided recommendations for the future.

'In the event Mr. Sinclair returns to unhealthy ways of managing his life and caring for his daughter, it is recommended Phoenix be placed with A Place of Safety Foster parents, Rohan and Kimberly Stephenson. It is also recommended he attend to programming for lifestyle difficulties prior to him considering parenting his daughter Phoenix. It is anticipated a temporary order for six months to a year would be required.'

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.'

The case was closed once again on October 13, 2003. It was officially closed November 13, 2003 when the typing was completed.

Interview with the assigned worker for this period

The worker confirmed that Kim and Rohan Stephenson were the godparents referred to earlier in file and that she was a friend of the natural father and had indeed looked after Phoenix at different point since birth. Whenever Steven and Samantha had difficulties she would provide assistance on a voluntary basis. They discovered this by talking to Steven when the worker asked who could look after Phoenix closer to home. He indicated that accepted agency practice called for family and friends to look after children in a voluntary arrangement whenever possible since it was seen as less intrusive.

The worker indicated in his closing and in interview with him that he was concerned that if Steven Sinclair did not work on the identified issues that caused the case to be opened in the first place, then it would have to be re-opened. The worker felt that there had been movement in his approach. He was still grieving his loss of [redacted], and would drink on occasion as a result. The worker felt that he was resisting being involved in any criminal activity. Finally, he also felt that the separation and loss of Samantha after her leaving was also weighing on him.

The worker offered supports but the father withdrew from wanting them since he indicated that Kim Stephenson (later Edwards) was still in the position to support him and Phoenix. Therefore he already had his support system.

The worker told his supervisor that although there were protection issues which could arise, at present there were not any significant ones. As such, the protection reasons for keeping the case open were not evident. Also, the worker was transferring back to his former unit and the decision as to whether close or transfer the file had to be made. If so would the Phoenix Sinclair case file be assigned to a new worker or should it be sent to a new 'Authority' for its own follow up. With no identified protection issues occurring in the present, the worker felt that Steven Sinclair, Phoenix's father, would probably not respond to a mandatory approach since he was not requesting further service.

According to the worker he presented it to his supervisor in the following manner: He remembers saying that *'There are underlying issues here that have not really been addressed, just with some time passing but not with actual programs being completed, the decision is that we can either close this off or transfer it to the new authority'*. A discussion then ensued about closing off as the best option and then it could be re-opened to the new Southern Authority if more service was needed.

The Worker's Circumstances beyond the case file

The worker indicated that at that time his Client profile case list had him responsible for managing 46-48 cases (both family and children's files). The status of the children in care files was short term care. He had mentioned 'time frame constraints' in his October 7, recording.

The worker also indicated that just prior to this time period he was stationed at another office in Winnipeg CFS. Each unit where there were eight workers had agreed that it would give up one worker and he volunteered to go to the other unit. The numbers never did balance out and there was always a shortage of both workers and supervisors. He was also a field instructor and he had students for Inner City moving over with him. This was helpful for the unit both in an experienced worker and a good student in that regard.

He related that there were also shortages due to workers being away ill and so there was only a crisis response to service. Training plans worked towards staff development but this also caused caseload pressures on coverage. At this time in July the workers had to ensure all of their clients went through the 'Authority Determination Process'. He was part of the training to all staff regarding this. Incidentally, file perusal showed that the worker had indeed completed this process with the case file while he was carrying it on his caseload. This process also took time away from actual casework.

Interview with the worker's supervisor at this time period for the Protection File

This reviewer interviewed the Supervisor for the 2003 period. She was supervising a family service unit which consisted of eight workers and administrative assistant. She also had to cover other units periodically in this period of time. The caseloads of the family service workers would have been approximately 30 to 35 cases on average. This includes children in care from these family caseloads. With this excessive work load the supervisor had no choice but to rely on the extensive experience of workers such as this particular worker. He was also seen as a competent worker and she did not question his decision therefore she did not query the decision to close the file as much as she would have if he was relatively new. Unfortunately he too was overloaded.

After the child in care file was closed October 10, 2003, the worker closed Steven Sinclair's file in November 13, 2003. The family services worker and supervisor then ended contact.

Findings:

F19. The case should have been kept open after November 2003 since Steven Sinclair (Phoenix's father), had not yet accomplished his required tasks.

Steven Sinclair's problems were severe. They included violence and alcohol abuse Granted, Kim and Rohan Stephenson were a safeguard for Phoenix, but they should have been brought into the plan in a more active manner and specific contacts could have been set up with them. The child was too young to take a chance.

F20. There should have been follow up with the Rohan and Kim Stephens to determine whether Phoenix was safe and whether they were assisting in looking after Phoenix.

The outstanding issues remaining for Steven Sinclair to resolve were simply too severe to take a chance that everything would be all right. The previous history of Samantha Kematch and the ill will between them could also provide an unsatisfactory living arrangement for Phoenix.

F21. The worker did not have nearly the time to properly manage this case or others when numbers and other caseload responsibilities are factored in to his day to day responsibilities.

At this point his caseload was two to three times the recommended size. A recent child welfare, best practices paper presented to the Ombudsman's office and the Office of the Children's Advocate would support this contention. It talks about recommended caseloads being considerably lower and perhaps around the 17 mark for family service workers and lower for intake and crisis workers.

F21. High Caseloads and the Excessive Supervisory coverage were factors in the decision to close the case file.

The interview with the supervisor showed that she was covering the workers on at least one and sometimes two other units during this period of time. The recommended span of control is 5-6 workers. Beyond that the supervisor did not have the time to read or to consult with staff who report to her and who also have to follow standards. She was left to rely on the competence and experience of her staff in some situations rather than to dig deeply into file histories herself. She had little choice.

4. THE FOURTH PROTECTION OPENING: FROM JANUARY 15, 2004 TO FEBRUARY 13, 2004

January 16, 2004
The Crisis Response Unit received a referral that Phoenix Sinclair's mother, Samantha Kematch 'goes out drinking frequently leaving Phoenix with [redacted] allegedly smokes 'rock' when Phoenix is present. The referent had not heard anything more since she had left that home'.

A check with Income maintenance showed that Steven was still considered to have Phoenix with him. The referent indicated that in November Phoenix was picked up by Samantha after she had learnt that he had gone out and left her alone. Samantha had then taken her to the address where the alleged crack cocaine was used. The referent went on to say that around January 2nd the Stephensons (it was later learned) picked Phoenix up and moved her in with them.

January 21, 2004
The Assigned worker and a co-worker attended the home of Rohan and Kim Stephenson, who had been the place of safety for Phoenix Sinclair previously. They spoke to Rohan Stephenson and he told them that Phoenix had been staying with them since the beginning of January (2004).

The worker indicated that she asked him where Steven Sinclair was or what he was up to. He said he didn't know and that there's lots of rumors and everyone is saying different things. He would not elaborate. He said they are willing to take Phoenix as long as necessary. They do not care about the money from CFS in terms of being a POS again. They are happy to look after her. Rohan states he doesn't actually live here but stays here sometimes. He works in the country. Kim has other children and is on Social Assistance. I advised him I would be looking for Steven to talk to him and would get back to Rohan. They don't have a phone any more.'

January 22, 2004
The worker consulted with a supervisor on the case. She was advised to call the former supervisor and leave Phoenix with Rohan Stephenson for now.

January 23, 2004
The worker made a home visit to Stephen Sinclair. No one was home and she left a card. The home had appeared vandalized with damage to the interior of the home and holes punched in the walls.

January 28, 2004
Steven Sinclair called the worker and indicated that he would call back since he did not have a phone

February 5, 2004
The assigned worker received an internal e-mail from an income assistance worker who indicated that Steven Sinclair had told her that Phoenix was no longer staying with him and was at Kim and Rohan Stephenson temporarily until he found a place.

February 5, 2004
The Intake worker received a call from Steven Sinclair. He indicated that he had 'heard she was at Kim and Rohan's'. He indicated that he heard that 'Samantha is out of town'. He added that when he drinks he gets an appropriate babysitter to look after Phoenix or takes her to Kim and Rohan Stephenson. He further stated that Phoenix was safe and it was fine for her to stay with Kim under a private arrangement. The worker then advised him that 'Phoenix is not under apprehension and the agency is recommending she stay with Rohan and Kim. He said he agrees with this and can visit Phoenix any time he wants.

February 5, 2004
The worker phoned the income assistance worker back and they discussed the Steven Sinclair situation further.

In a summary statement in her recording the worker stated that

> *"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 care-givers to Phoenix, the Stephenson's. They have agreed to keep Phoenix in their care under a private arrangement. They will allow Steven to visit Phoenix in their home whenever he wants, though he has not come to date (January 21, 2004). Due to the fact that a private arrangement has been agreed to between Steven and the Stephenson, worker is recommending this file be closed at this time".*

Later in her 'Statement of Risk' the worker stated *'that the risk to Phoenix was low as long as she remains with the Stephenson's. Should she be found in the care of Steven or Samantha, risk would change to high'.*

The worker sent a letter to the Stephenson's which outlined their position.

Manitoba

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February 13, 2004

Rohan & Kim Stephenson
1331 Selkirk Ave.
Wpg MB
R2X0C9

Re: Phoenix Sinclair dob:April 23, 2000
Father: Steven Sinclair

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.

Should you have any further questions please call this writer at 944-4679 or after hours at 944-4050.

Thank you,

Sincerely,

L Mirochnick

Lisa Mirochnick, B.A., B.S.W.
Social Worker

The Intake closing summary stated that the Stephenson's were sent a letter outlining the Agency expectations and concerns. There is a copy in the file and it is reproduced on the next page in this report. It indicated that Steven was not to take Phoenix from this placement 'without contacting the Agency and having a risk assessment done'. After the letter was sent the file was once again closed.

Interview with the Assigned worker

The worker remembered that after the file was closed in October of 2003, there was no more contact until January 16th, 2004. At that time she was under the supervision of the intake supervisor. She also remembered that the intake supervisor called her and she recommended leaving her with the Stephenson's unofficially. The intake worker went to the Stephenson's.

In the intake re-opening in January of 2004, attempts were made to contact the previous worker and the licensed 'place of safety' 'child specific foster care' worker but they were unavailable. There was a backlog of approximately, 1400 licensing applications which had to be done in 3 months. The receiving agencies would not accept 'place of safety' homes that were not formally completed.

File was received on North East on the 20th of January and worker went out the following day. Phoenix was there when she visited. During this time Samantha never had unsupervised visits and arrangements were set up in the office or in Kim and Rohan's home. She never pursued it. The worker was definite about this arrangement.

In hindsight, the worker indicated that going over to the Wagner street address of Steven is the only thing she might do differently.

In-person Interview with the Former Foster Parent who looked after Phoenix during this Period of Time

Kim Stephenson (now Edwards) was interviewed at the Office of the Child Advocate and in the presence of another staff member who also participated. The interview was wide ranging as this investigator listened to her concerns in the handling of this file in general. She did indicate that in her remembrance Phoenix Sinclair lived with her on and off for her first three years. She was not clear on specific time frames and felt that some of the events occurred more in 2003 than in the beginning of 2004.

She thought that the agency had not contacted her after Steven received custody back from her in September of 2003. She also indicated that neither she nor Rohan Stephenson, her former husband, remember receiving the letter that was sent from Winnipeg CFS that is reproduced here in this report. She did not believe that she was still living at that address on Selkirk at that time. Later her husband Rohan apparently confirmed to her that he had not received the letter either. At that particular time she thought that she might have been looking after a friends' home which she did for three months in 2004, although she did concede that she had not officially moved nor changed her address with the post office. She was adamant that she did not receive the letter. Finally she felt that the letter was not from the right worker who had the file and that the date must be wrong. A later phone call from her also re-iterated her position that the letter was sent out at a time which was not consistent with her remembrance of when they were looking after Phoenix Sinclair.

FINDINGS:

F22. The letter to the Stephensons was an example of good practice.

Although it did not provide legal obligation for the Stephensons to call if Phoenix was taken from them by either parent, it did give leverage to them as caregivers if presented with that possibility. At that point the worker thought that being a former foster parent that the people did not need stronger encouragement since they were already firmly on the side of protecting Phoenix.

F23. The case file contained no returned envelope indicating that the Stephenson's had moved or that the letter had been returned.

Often child welfare agencies will include returned postage in the case file to show that there was an attempt to notify clients and collaterals in protection situations.

F24. The worker was right to believe, given the Stephenson's previous concern, that Phoenix would be safe there and that they would tell the agency if any attempt was made to pick her up.

The letter was clear in respect to Steven Sinclair not being able to pick up Phoenix without the agency's involvement. The Stephensons had been foster parents of the agency and had shown considerable caring for Phoenix in the past and had recently removed her from what appeared to be a crack house. Concerns about Samantha would have already been known by the Stephensons since they picked her up from the mother's care already. Unfortunately the separation of the Stephenson's was not disclosed to the worker at that time and was only brought out after the death of Phoenix. Even today Kim Stephenson (Edwards) indicates that she was 'house sitting' at a friends for three months at this time. In hindsight, Rohan Stephenson had not been completely forthcoming on the situation. The worker would have had no reason to disbelieve him since after all he had picked up Phoenix when he thought that she was in danger at the crack house.

F25. The worker attempted to do the right thing in her case management of this file even though there were some gaps that the agency could and should have pursued further.

There would have been merit in bringing this child into care while she still remained at the Stephensons but they were willing to take Phoenix on a voluntary basis, without this action, as reported to them by Rohan Stephenson. The worker had also indicated in her interview that there was a large backlog in assigning and assessing 'place of safety' homes and this was not a realistic option with a 1400 home backlog at the time. This was a systemic issue beyond the case management of the worker.

With the value of hindsight, this action would also have prevented the lack of co-ordination which appears to have occurred between the Stephensons and Winnipeg CFS in that a letter

sent with the best of intentions may not have been received by them as the case closed in February of 2004.

It should be noted that the worker would probably not have been able to have the case transferred to an ongoing worker or sought a supervision order at this time in the agency. This would have been due to the fact that this case appeared to be stable on the short run and staff was apparently dealing with high numbers of files already. Workers talked of the inability to keep cases open or transfer them if they did not show immediate crisis or children at significant urgent risk.

F25. Follow up with the Stephenson's on this case would have been beneficial and good practice due to the chronic problems that the parents were now exhibiting.

In an ideal situation, the case worker would have been advised to follow up with the Stephensons in person rather than just write a letter. This would have provided more emphasis to them on their concerns about the child going back to either parent and created a greater onus on the Stephenson to notify them if indeed this was attempted by either.

F26. The Stephensons, Kim in particular, provided crucial 'respite care' for Phoenix during significant periods in the first three years of her life. This occurred while Winnipeg CFS was active in their case management of the file and at times when there was little evidence of their involvement.

Presently Kim (Stephenson) Edwards is highly critical of the Winnipeg CFS. Some of it is justified as in the second year of Phoenix's birth when the case was open but not active. Kim maintains that she did look after Phoenix for long periods of time unknown to the case worker. At other times she is simply not aware of various attempts made by other concerned social workers. At this juncture there was also the miscommunication which is highly regrettable. Rohan Stephenson was also less than forthcoming about the whole situation in his discussion with the worker on the first home visit. Having said that, at the end of the day, Kim and Rohan Stephenson provided a caring home for this child at this juncture.

5. THE FIFTH PROTECTION OPENING: FROM MAY 11, 2004 TO JUNE 14, 2004

This time the protection file is reopened under Samantha Kematch name since Phoenix was considered to be living with her instead of Steven Sinclair.

May 11, 2004
The CRU worker 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.

When the Intake worker phoned the Stephenson's to find out what was happening the person answering the phone said it was a wrong number.

The Intake worker then phoned Samantha Kematch. The worker determined that she was not telling the truth since previous records indicated that the Stephensons had looked after Phoenix earlier in the year and Samantha Kematch told the worker that she had been looking after her since November. Samantha became angry, swore and hung up her phone when the worker questioned her on this.

Since Phoenix was apparently living with Samantha, and Steven could not be located, Samantha Kematch's protection file was opened to intake to make sure that Phoenix was in a proper living arrangement. The worker had seen the concerns written in the file if and when either Steven Sinclair or Samantha Kematch was take over the care of Phoenix again. She called for a 48 hour safety assessment response on this at the Intake level.

May 13, 2004
An internal memo from the branch provided information and a sequence of events that showed where Phoenix had stayed since she had been returned to her father, Steven Sinclair. The memo details were apparently provided by both the E&IA worker and the 'godparents' (the Stephensons), although it is not clear if both were talked to by the writer, It appears that Steven Sinclair looked after Phoenix for only a month or two until November when Samantha Kematch picked him up from his place. In January of 2004, the mother related that she took Phoenix to the Godparents and 'needed time to set up home'. It was indicated that she visited occasionally since then and Steven Sinclair had not visited. The memo went on to say that Samantha Kematch picked up Phoenix from the Stephensons a month ago (early April). The E&IA worker wanted an assessment done on the home of Samantha prior to providing financial support to her for the placement of Phoenix.

May 13, 2004
The Intake worker and a colleague visited Samantha's address. The recording identified the home as [redacted] *A male answered the door and identified himself as 'Wes'. He said that Samantha was not there but was at her Mother's.*

Workers visited this home as well but were told Samantha was visiting with friends. The Intake worker left a business card for Samantha to call.

May 17, 2004
The worker sent a letter to the mother

June 15, 2004
Worker visited the home. There was no answer and so she left card.

June 21, 2004
This was a phone call from the mother. Arrangements were made to meet her on June 29, 2004

June 28, 2004
The notes indicate that this was a *'phone call from Samantha. She requested that we change our appointment because she is moving with the block. This writer advised her that only needed to meet with her briefly and urged Samantha to keep the appointment. Samantha agreed to do so.'*

June 29, 2004
The worker visited. Unfortunately she was unable to 'gain entry into the block'.

July 9, 2004
On this date the worker e-mailed the mother's social assistance worker for her new address.

July 13, 2004
On this date the mother phoned the worker and the worker immediately went out to see her. The worker indicated that *'the home was tidy and well furnished. Phoenix was present and she appeared, clean, healthy and well cared for'*. Samantha appeared *'healthy- good coloring, clean and healthy weight'*. The worker told her about the referral concerns and Samantha indicated that she was not using drugs and she was not having any difficulties with Phoenix. Samantha indicated that her main support is *'her boyfriend who is a trucker and stays with her when he is in the city.'* After being asked, Samantha indicated that she did not need any help from the agency. She did show interest in knowing if there were any parent groups in the area. She advised the worker that she would be registering Phoenix in nursery school in the fall.

The worker did send her information on community supports and the case was closed on July 14, 2004. In the Intake Closing recording the worker wrote that

> *'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'.*

Interview with the Assigned Worker on the case
The worker indicated that if she had known the Wes' last name she would have contacted the police to get past history and done internal record check. She said that it was difficult to elicit information from Samantha and said there was a question of how far she could push for information. She indicated that she did check past history on the file. The reasons that she closed the case at this point in spite of the history in this file included the following points;

- At that time and in the present, the agency does not keep cases open where the only concern is 'a troubled past';
- She (the mother) has had the child in her care since November of 2004;
- The Stephensons who have shown caring for the child and have looked after Phoenix are not calling with any concerns;
- No referral has been made to the agency except the EIA worker to confirm she has the child and that it is all right for Samantha to receive benefits for Phoenix;.
- Had mother looked poorly but she was well nourished, if she looked like she was not taking care of herself, or the child looked poorly, she would not have closed the case'.
- She was also with a partner who went out with her.
- She also thought that if she closed it and there was another referral there would be a stronger case to work with her.

The Worker's Circumstances beyond the case file
The worker indicated that there were at least three colleagues on her unit sick at the time that she had carriage of the intake file on Samantha Kematch.

In addition, she stated that in 2004 as is the case now in 2006, Standards were not a priority for workers since the reality is that they cannot necessarily meet them. In particular, high medium or low time frames are not met and workers use their own judgment. Standards do not take context into consideration. The assignment of risk and the information comes from CRU and often the right information cannot necessarily be obtained by phone. She said that *'You don't feel that you can help people because you are running on a wheel and it feels like it is getting worse'.*

Findings:

F27. The Safety Assessment called for a 48 hour response. It would have been important to go out the same day when previous concerns about the mother's parenting and possible drug problems are considered.

The previous worker had written concerns about both parents in the previous closing. In addition, the agency had not had contact with Phoenix for months and it would be important due to her age to go out as soon as possible to determine her living conditions and safety. The CRU worker had to have the file accepted in Intake and work load may have been a consideration and so the time frame could have been tallored to meet the intake response capacity. Workers had indicated that this was done on occasion.

F28. It would have been good practice to obtain 'Wes's full name if the worker had thought that he was living in the home.

It is known now that the person who answered the door was Karl Wesley McKay and that he is alleged to have murdered Phoenix a year later. It is easy to look back and so that someone should have at this point known who he was and therefore done a record check. At his point, based on what the worker knew, it would have been simply good practice. The home was not Samantha Kematch's since the worker referred to going out to [redacted] and as such perhaps meeting someone at the door at someone else's apartment meant that there was less of an onus on the worker to obtain a name. Standards call for obtaining the names of all people who reside in a residence where a child is currently living and checking background information on them were possible.

F29. It would have been difficult to access the CFSIS system to obtain information on 'Wes' even if more information was known (see finding from next referral in December 2004.

F30. This file should have been transferred to Family Services due to the past history of the case, the mother's possible drug and alcohol problems and the young age of Phoenix Sinclair.

The worker gave the reasons for why this case was not opened when she was interviewed in person. The fact that cases were not able to be transferred to family services when the worker could not demonstrate that there were severe present problems in spite of chronic past history, is troublesome.

F31. The Statement of Risk for Phoenix was assessed at too low level for the risk factors that were known to exist in the recent past.

The worker felt that the risk to Phoenix was low because there was no sign that Samantha Kematch was abusing substances; she maintained that she was managing well; and her observations were that Phoenix 'appeared well cared for'.

This assessment was only through one visit and there were still unknowns in this situation as to whether Samantha really was avoiding drugs. Also, problems were recent as of January 2004 when there was a report that she had apparently left Phoenix at a home were a friend was using crack cocaine. Was the mother using crack cocaine herself? What was known was that mother also appeared to have an unstable record of staying in one residence and using appropriate caregivers and this could be difficult for Phoenix depending on where and with whom, the mother moved in the future. Finally, although the mother did not want services, there was enough recent concern to warrant at least a supervision order through the CFSA and possibly wardship.

6. THE SIXTH PROTECTION OPENING: FROM DECEMBER 1, 2004 TO DECEMBER 7, 2004.

December 1, 2004
A social worker at the Woman's Hospital called to say that Samantha Kematch had delivered her fourth child, a baby girl named [redacted]. She went on to say that she did receive good pre-natal care prior to the birth and notes that there are no known health concerns with respect to [redacted] at this time. She also stated that there was no reported drug and alcohol use during this pregnancy. The father was reported to be a 'Wes McKay'. The worker performed a CFSIS past record check and received file information but she could not track Wesley McKay since she did not have a birth date.

The worker phoned back to the hospital to find the time of discharge and on the call back she was told that it would be the following day.

The worker then contacted the Income and Assistance Worker to inquire about 'demographic information' on Samantha's common-law partner. The income and assistance worker did not have any partner listed therefore the birth date of 'Wes McKay' could not be determined at that point.

The worker consulted with the Crisis Response Supervisor as to what to do on this case. The supervisor agreed that it should be referred to intake for assessment and intervention. A safety assessment was completed listing a response time of 48 hours (medium safety risk).

December 2, 2004
Unfortunately on the following day, the same date as [redacted]'s discharge, CRU was told that the file would not be accepted at intake and they were to...

> *'offer family supports, and close the file to CRU – if the Agency is unable to mandate services within the home at this time.'*

December 2, 2004
Worker contacted hospital to ascertain that indeed [redacted] had gone home with her mother
December 2, 2004
The worker then tried to contact the mother at her home by phone but there was no answer.

December 3, 2004
Another attempt was made to contact Samantha.

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. The nurse would not share any information since she had just been to FIPPA training. After a long debate which is recorded in the file 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 comment as to what if any information was provided by the public health department.

The CRU 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.'*

Interview with the Assigned Worker

The worker confirmed that she had the file December 1, 2004 as a staff person in CRU. Woman's hospital had no concerns and worker decided that in spite of that due to her troubled past history that it should indeed be opened to CRU and then passed on to Intake.

For reasons that she was not sure of, it was given back to CRU and to make contact with the PHN as follow up by her supervisor. The worker had hoped that a full assessment on the family and all the people in it would be done at the intake level. The workers are never told why a case is returned and this was no exception.

She provided more information about the computer system back in 2004. In regard to the checking of 'Wes McKay's' identity in the past records, the worker indicated that now the intake module is better but there were problems in finding information at opening in 2004. She stated that

> *'you can access actual recording on the computer and it asks for specific information. Back then CFSIS was more general and not specific enough unless you could specifically identify the person you were looking for. Now if you put Wesley McKay in it would automatically ask for other information. If you did not know specific birthday then this would be difficult. January 1, 1950 is the one used when you do not know the actual meeting."*

The worker confirmed that she was unable to get information from PHN due to FIPPA. She stated there is still some difficulty and Employment and Income Assistance who will still not give out information if there is not a specific allegation and disclose information prior to getting the requested information. This in itself breaches confidentiality.

She concluded her interview by stating that no one had identified specific concerns (other professionals) and therefore it would not be accepted by the Intake Department.

The Worker's Circumstances beyond the case file

The worker was interviewed in regard to the use of Provincial Standards in the Crisis Response Unit. She indicated that historically CRU has been doing abuse cases for determining validity even though CRU feels that there is already enough information to warrant transfer to Intake.

Interview with the Worker's Supervisor at this Opening

This was a very experienced and knowledgeable supervisor. She indicted that simply put, the case was not accepted in intake, and so CRU was basically told to handle it themselves. In addition, she said another problem was that there was no clear policy in regard to how hospital referrals involved past clients with a history of child protection involvement should be handled. She said that his was especially true when there were no immediate pressing child welfare

problems identified.

The common law partner 'Wes McKay' had no birth date and if there were more significant concerns related by the referral perhaps the worker would have done a record check. The worker did contact Employment and Income assistance to get more demographic information on 'Wes McKay' and they are not aware of any common law partner and so she was not able to have more information. Once again, the supervisor reiterated the referral itself this time was not presented as a 'bad' one by the hospital.

She stated that CRU still pursued it and a crucial part of their decision to close at that point after the rejection by Intake was that Phoenix had been seen in July of 2004. She had been graded as 'low risk' and Samantha seemed to be doing well.

The supervisor provided insight into how the discussion with supervisors from different departments occurred when new files were presented for possible opening. Sometimes debate was so heated that program managers had to be involved in resolving them. She believed that the CRU manager should make the call as to whether a case should be opened. (Actually a document shows that this was the intent in the CRU procedures when the unit was formed) It was a huge problem mainly on a workload issue. When she left in November of 2005 it was still an issue. It was referred to by several staff people as the 'Walk of Shame' when a supervisor had to return with the file to CRU that had been rejected (I had heard this from a number of staff and I had asked her about this). She was asked about specific case numbers and she indicated that her 16 staff members in CRU have about 1300 referrals a month to handle. Sometimes as in 2004 there were shortages and approximately 12 workers would be actually working at any given time. (Please note: I have included the statistics for 2005 in this report and the numbers are indeed validated)

In regards to the FIPPA concerns, she related that she had spent time with staff on Employment and Income Assistance, Mental Health, FIPPA. She indicated that workers are supplied with section of the CFSA which shows that this supersedes.

F32. This was the first time that the agency was officially aware that there was a 'Wes McKay' in the home and a partner to Samantha Kematch.

F33. The CRU worker and supervisor made the right decision to open the file to Intake for Assessment and Intervention.

F34. The refusal to have the file open to Intake as requested is a major error in the Winnipeg CFS case management of the protection file.

This is another major turning point in this file history and with the closing the agency lost its ability to intercede in what was undoubtedly a slide towards a catastrophe. This was a file which should have been opened without question. A new young baby was in the home and this only added stress and risk to unstable home. There was also a partner for whom the agency did not yet have information on in regard to his child protection contacts if they were there. In light of the mother's history it should have raised alarm bells that she may have a

partner who has issues himself.

F35. It is evident that excessive caseloads and unit pressures were determinants in the rejection of the file for opening at the Intake level

Caseload pressures and an agency culture of everyone feeling that they were overworked (a reality) appear to be factors in the decision not to accept the case for opening.

This case did not present in crisis and as such it did not appear to be as immediately crucial as other situations and as such it did not meet informal criteria for acceptance in a unit that was itself somewhat overwhelmed with case numbers.

F36. The Computer Data System at WCFS (CFSIS) may not have provided the cross-reference that was required to ascertain which 'Wes" McKay the agency had dealt with in the past.

This reviewer checked the computer data system himself. Six names came up with the last name McKay. Some of them were under Karl and several under Wes or Wesley. Each of them was a different person although five of the six were adults. If the agency had then found the right McKay there were then three other files that they would have had to take out and go through before they would find any worrisome information that Phoenix was at risk.

The information which would have been crucial to determining that Karl Wesley McKay was a potential danger to young children due to past allegations of physical abuse to a one year old, domestic violence, and alcoholism were only found in one file which was under another name as well, [redacted]. This information was from the late 1990's case management notes within that file. There is still no cross-reference ability within the computerized information system.

F37. The unwillingness of the public health nurse to provide information was regretful and made the possibility of obtaining a birth date for the father more difficult.

It is true that the worker herself could have gone out of the case to obtain that data and this would have been advisable in hindsight. However, the request came at the very beginning when justification was being required to immediately transfer a case before a young baby went home. Finding a cross reference match with the name 'Wes McKay' in itself would have given the CRU worker an extra factor to warrant the intake opening. This would be true even if specific child protection behaviours (abuse or domestic violence) were not immediately found in one of the specific case files to which he was connected. At this time domestic violence that had occurred 6-8 years ago may not itself provided reasons to open the case since some staff had indicated that there was and still is not clear policy in the agency as to whether or not to re-open when there is a past history of domestic violence.

7. The Seventh Protection Opening: From March 5, 2005 to March 9, 2005.

March 5, 2005
An agency foster parent called CRU to make a referral. The CRU recording stated the following;

> [redacted] *spoke to an ex foster child today. She refused to provide me with the person's name. This person told* [redacted] *that she suspects that Samantha Kematch is abusing her daughter Phoenix.* [redacted] *does not have any details as to what this alleged abuse might be. Also this person suspects that Samantha may be locking Phoenix in her bedroom. I explained that we need to speak directly to* [redacted]*'s SOR (source of referral) but despite being an agency foster home she refused to disclose the name.* [redacted] *does not have an address or phone number for Samantha other than she lives in apartment one beside the Maryland hotel. I explained that without an address we will be unable to follow up. The last address on CFSIS is on McGee.*

March 7, 2005 Richard B.
The case was assigned to worker #1. He called Employment and Income Assistance who did not have a listing for this family.

March 7, 2005
The worker called the Winnipeg One School Division who provided information on the last known address. It was also discovered that Phoenix had not attended school since September of 2004. (As a note by the reviewer, school was not mandatory for Phoenix at age 4)

March 7, 2005
The worker called back to E&I and found out that Samantha herself is an active file.

March 7, 2005
The worker attended the home, waited five minutes and then left since he could not get into the building.

March 7, 2005
Worker #1 and his supervisor recommended that it be opened at Intake for assessment and intervention. It was not accepted by Intake and returned to CRU and to a new worker #2.

March 9, 2005 — Chris
Worker #2 the newly assigned worker and another more experienced worker in support, attended Samantha Kematch's residence. Worker #2, the assigned worker wrote that Samantha

> *'greeted workers at the door with a somewhat shy demeanor but did not want to allow workers into her apartment as she had someone visiting with her. Workers could hear that the television was quietly on. This writer did not notice any sounds of a party occurring or that there was more than one other adult in the home.*

Agency workers spoke with Samantha in the hallway and provided her with the details of the presenting problem. Samantha was curious about who called and was advised that the Agency cannot legally provide that information. Samantha accepted this and speculated that she knew who the Source of Referral was.

Workers initially advised Samantha that the referral was about an allegation of her abusing Phoenix. Samantha responded by saying that she had yelled at Phoenix a few days ago and seemed surprised that someone may have heard her. This writer then indicated that the referral indicated that it was believed that Samantha had locked Phoenix in her bedroom. Samantha stated that she and Phoenix share a bedroom. This writer then asked if the bedroom door has a lock on the outside of the room. Samantha confirmed that there is a lock on the outside of the door. Workers warned Samantha that it is not safe to lock her in the room in case of a fire. Samantha agreed.

At this time Samantha could hear that her youngest child, [redacted] was becoming upset inside the apartment. Samantha returned into her apartment and brought [redacted] into the hallway. [redacted] appeared to be a content, healthy, clean, and well-dressed baby. She was smiling and comfortable with Samantha.

Workers asked if Phoenix is attending school or daycare. Samantha advised that she is not in daycare and will be attending school next September.

This writer asked if there was anything that Samantha needed support with from the agency and if she also had supports as a parent. Samantha indicated that she was doing well and did not require agency supports. This writer provided Samantha with an Agency card should she require any Agency supports'.

On the same day the file was closed with the final recording placed just before the worker and supervisory signatures. B.W.L.

"This writer and Worker (#3) met with Samantha at #1-747 McGee Street. Samantha presented as calm and somewhat shy. She did not want to allow workers into the home as she had company. Workers warned and cautioned Samantha about locking Phoenix in her bedroom. Workers viewed [redacted]
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. The family was apparently in Fisher River First Nation in April of 2005, a month later. The agency did have other contacts subsequent to the RCMP investigation the following year but this are not a subject of this review.****

Interview with Worker #1
The worker indicated that he was concerned that there could have been abuse and that is why he recommended that it be passed on to Intake. However it was returned and due to the rotational system in place in CRU it was then given to another CRU worker.

He related that when he started his worker he did not even begin with an address. The name was also under Sinclair and so EIA did not have any file. He asked them to recheck after he had gone to the address and then their computer. He made two attempts the same day he got the case to go out and visit once he had determined it. He could not get into the building. It was not passed on to Abuse Intake since there was no address and the name was wrong. This was made more difficult since the computer data system (CFSIS) had what he called a six month ribbon and one could not get back into the system.

Interview with Worker #2
He indicated that the first call came in March 5, 2005, after-hours, and the call was taken by an after-hours worker. Often after hours only dealt with immediate emergencies

The worker related that CRU *'tries to ascertain if there was merit to a call'*. He had been in the abuse unit in 2002 for seven months. He did have experience. He said that he definitely had been trained to believe that this would not warrant investigation by the abuse unit. In his words *'more information would have to be required, also if just the word abuse was a criteria then the abuse unit, would be further swamped'*.

Worker remembers the mother was acting in a shy manner and gave him the message that she does not want her visitor to know it is CFS at the door. She stepped into the hall way after Chris identified himself. Chris thought that her answers to the concerns were good. If he had seen anything to raise his suspicions at the home, he would have been more intrusive.

He went on to say that *'even today cases are sent back "hey this isn't ours(abuse units) if there is no confirmation of bruising. They are the ones that are supposed to confirm the abuse but if there is not confirmation at the beginning they do not want to receive them and it is left to CRU to make the decision.* He concluded with saying that 'best *practice to look at all the recording of past history. Sometimes he is able and sometimes not.'*

Interview with Worker #3
He has no remembrance of this particular referral and visit out to the home. As such this reviewer asked him about procedures in general and specifically the Child Protection Standards. He indicated that they are probably something they give you to read when you first start. He is not sure what standards are in place.

This worker has been at the agency for an extensive period of time (17 years) and has much protection experience. He was the back up worker for the assigned CRU worker in this case. He indicated that a back up sometimes goes out in situations 'when you do not want to go out alone'. Sometimes this could be to help workers in risky situation but also to help with transportation of children for example. He felt that this was beneficial for all concerned and he would like the backup system put into procedure. However, he said, with high caseloads it

makes it sometimes impossible and it could delay the investigation of other cases. He believes, however, that it could also be a 'health and safety issue' for workers.

He believes that the Crisis Response Unit is a good system but '*in reality backups throughout the system backlog everything.*'

Supervisor Interview for the March 5, 2005 Referral

The Supervisor indicated that the referral was second hand information that there were abuse allegation and that the child was locked in her room. This was second hand information, not provided with original source, with no details on the allegations. The Worker pursued the foster parent to get her to tell but she would not. The worker believed that was problem number one because it did not then meet the criteria for acceptance either by intake or for the abuse intake unit.

Supervisor attested to the fact that the abuse unit would never have taken this and there had been general meetings in the agency to resolve this issue. The abuse criteria for referral to them at the time would be abuse as defined under the act ....which would be injury or sexual abuse and or discipline with an implement. No pre occurrence no identified incident, no description of what occurred and so abuse intake would not necessarily receive this and carry out a full investigation from there.

As a result her staff had to then take it back yet treat it as an open case so that they could '*go out on and a determination as to whether it would then be treated as an abuse case. Without specifics the worker felt that they were limited.*' She said that the workers felt that they had to talk outside since she had company and they were trying to respect her confidentiality.

Furthermore, she said, this would not have been normal supervisory sign off. The supervisor indicated that normally she would want children to be seen. However she indicated in response to a question that '*there was no expectation on the unit by the supervisor's managers that in every case that a child be seen...no*'.

The supervisor said that the initial referral was not alleging that the common law partner was abusing Phoenix. Finally, in regard to this case the supervisor indicated that this was a 'pre intake module situation. After this time the new module makes the reporting and recording more accessible to the supervisor. It makes information more accessible. Finally and most importantly for her especially when there was so much overwork, she trusted Worker #3 to make the right decision on the visit and to be a help to #2 who was less experienced. She indicated that worker #3 *"was a seasoned worker and the supervisor would trust that judgment when he went out with a less experienced worker who did not do abuse."*

In regard to the CRU Unit Context the supervisor indicated that there were four referrals per day per worker. It was impossible to resolve them all and that assumed that you have a full complement which was we did not. She indicated that there was sick leave, calling in sick, and there were no replacement at that time. CRU did not have fill in. Other units did on occasion. She said that there is now an abuse program proposal for Joint investigation.

Interview with the Foster Parent who called in the March 5, 2005 Referral
She indicated that she told the worker that the referent had heard a noise like whimpering.

She indicated that the agency did not want to take the call because it was not the direct person who had the information of the alleged abuse. They did not ask for the name of the former foster child. She said that *'they wanted me to get her to call. The girl will not because of her experiences with Winnipeg CFS and her fear that she would loose her own children if she was seen to be causing trouble'.*

She also said that the initial person with the concern had talked to her worker separately. I asked the foster parent for the name of the client and she gave it to me and said that she would ask the person to call my phone number collect. The client did call me and her account is in the next section.

F39 The previous involvement section of the CRU recording does not include the December 2004 CRU contact.

This may have been a CFSIS glitch in which recording which was not open at least to the intake level may not have been readily cross-referenced.

F38. The Agency erred in not treating this as an alleged abuse call and not allowing it to be opened as an abuse referral assigned to the abuse Unit.

When the CRU did not find any reason to overturn the intake decision they had little choice but to close it. The CRU did not have the agency mandate to continue on with cases on there own that did not meet intake criteria for opening.

F39. The determination not to treat this as an abuse case because it did not in their opinion, meet the strict definition of the *Act* was inappropriate and not in the spirit of the legislation. It was a direct reflection of an agency adjusting its practice to meet an overload situation.

F40. This decision had dire consequences for Phoenix because it meant that the 14 required steps in an abuse investigation which would have potentially saved her life were not met.

F41. Phoenix should have been seen and the case should not have been closed but the blame does not lie with the line staff and supervisor directly involved. They attempted to have this case assessed and sought for intervention as an open intake case.

In May of 2004 there was an updated Orientation Manual Circulated to Staff. In the absence of clear Provincial Standards (will be discussed in Conclusions and recommendations Sections)

Winnipeg CFS had its own internal Abuse Procedures.

This Manual includes those standards. When the set procedures below are reviewed and compared to what was done by the two workers and indeed the agency since it was not considered 'abuse' the difference in required diligence is tremendously significant and undoubtedly would have enabled the child to be seen by the workers and indeed medically examined immediately. Up to 14 additional steps would have been required. The actual procedures are reproduced on the following two pages. Asterisks have been added to those addition steps which could have saved Phoenix.

SERVICES PROVISION AND ASSESSMENT
Procedures for Abuse Investigations

***Interview Referral Source**
To be done before interviewing the child to gain as much information as possible.

***Previous Involvement with Child Welfare**
- Check CFSIS
- Have unit secretary do a file check, including miscellaneous contacts
- Abuse Registry Check on CFSIS — have designated person check

***Background Check With Winnipeg Police Service Abuse Unit / RCMP Detachment**
Check regarding previous investigations involving both the child and the alleged offender. If there is a concern of violence in the home, have police check regarding past criminal involvement and domestic interventions.

***Background Check with the Child Protection Centre**
Check previous contact with the child's family and the offender's family.

***Determine Response Time with Supervisor**
When— response time determined based on safety assessment.

***Interview Victim**
Where - Child should be interviewed alone in a quiet, safe place. In interfamilial cases, this should be done away from the family home if at all possible.

How- Child should be interviewed alone. Exceptions could be made if the child is very young and needs the support of someone he/she knows. (Note that certain school divisions require that the child be specifically asked if/who they would like in the room). This person should be notified of the interview process beforehand and should be a silent observer only during the interview. This person should also be neutral to the proceedings.

***Arrange Medical Appointment**
In cases of acute or visible injury, this should be done immediately, ideally through the Child Protection Centre. Private practitioners may be used to document minor physical injuries, but Child Protection Centre is preferred as they keep background information. Child Protection Centre should always be used for cases of complex physical abuse and for all cases of sexual abuse. In cases of sexual assault, Child Protection Centre should be notified immediately, but may book a future appointment at the sexual assault clinic depending on the abuse described.

Interview Sibling
In intrafamilial abuse cases, siblings should be interviewed before parents, if possible. In all other cases, siblings should be interviewed if they have also had contact with the alleged offender. This could be done after the parents have been interviewed, but should be done before the investigation is concluded.

***Interview Parents**
In cases of intra-familial abuse where the police investigation is pending or ongoing, the parents should not be interviewed without the investigating officers' consent. If an apprehension is necessary, parents must be notified of such, but are only informed that the child has been found in need of protection and an investigation is pending. (If parents are persistent, consult with unit supervisor). Parents are interviewed

only when the police have completed their investigation or give their consent for the Branch to proceed. There are exceptions in interviewing the non-offending parent, e.g. non-offending parent has no knowledge of the abuse, as reported by the victim, and may be supportive. All exceptions should be discussed with the police and abuse unit supervisor before proceeding. The Abuse Coordinator is available for consultation to the family service workers if an abuse investigation required is on an open protection family file.

***Interview Offender**

As outlined in the Child and Family Services Act the offender should be interviewed only at the conclusion of the investigation. In all cases of abuse, the offender should always be interviewed unless he/she refuses. In instances where the offender is dangerous, intervention should be discussed with unit supervisor or abuse coordinator to ensure worker safety. Where a criminal investigation has occurred, consultation with the assigned officer or Sergeant to occur when criminal interview completed.

***Report To Police for Investigation**

Police should be notified immediately after interviewing the victim if there is a disclosure. **In cases of severe injury or death (such as shaken baby syndrome, multiple sexual assaults, or offenders in positions of trust, these cases need to be reported to police prior to investigation as police may want to interview prior to Branch worker).** In cases where the worker is unsure of procedures, the abuse supervisor or the abuse coordinator should be consulted. Even if there is not enough information to launch a police investigation, police should be given the details as information, which they will hold pending further details. Reports to the police should always be made through the Child Abuse Unit (986-6378). They will prioritize and may assign the case to the Abuse Unit, the Youth Division/Sex Crimes Unit, or the local district. All of the information, however, is coordinated and funneled through the Winnipeg Police Service, Child Abuse Unit. In rural areas and dependent on the jurisdiction where the offense occurred, a report may also be made to a specific detachment of the RCMP.

Report To Employer

As per the legislation, some cases must be reported to employers. This process is never done without prior consultation with the abuse intake supervisor, the abuse coordinator, and/or the assistant program manager and/or the Branch lawyer. The Director of Child Welfare, the Child Protection Branch located at 114 Garry is responsible for advising employers that someone who is on the Child Abuse Registry is employed in their organization.

***Abuse Submission to the Abuse Coordinator**

In all instances where there is an abuse investigation the assigned social worker is responsible for submitting an incident report to the Abuse Co. within 30 days of the date of the referral to the Branch. The legislation requires this. The Abuse Coordinator presents the incident at the monthly regional child abuse committee. This process must begin the first working day. of the month in order to meet the regional committee deadline. Completion of these reports must be given priority in order to meet the necessary deadlines for profiling/presentation at Committee. A photocopy of this completed form is to be kept by the worker and placed in the family file.

Final submissions can be submitted prior to the final criminal court dispositions if the offender is not in a position of trust (if applicable). The worker is still expected to make the abuse coordinator aware of any criminal court proceedings, however, and, at the final disposition, the abuse coordinator is to be notified through a memo. The abuse coordinator will add this information to the abuse submission form.

If the worker has been made aware of a criminal court conviction, the abuse coordinator needs to know what the conviction date is, as well as the offender's birth date. This information is absolutely necessary in order to obtain proper documentation for the Abuse Registry. The police will always have the offender's

birth date if they have been involved. If police have not been involved, it is the worker's responsibility to get this information.

***Report To the Provincial Abuse Registry**
This is the Abuse Coordinator's responsibility in consultation with the Regional Child Abuse Committee. The worker will be notified if registration process is to proceed.

F42. The Crisis Response Unit had case load expectations that far exceeded reasonable limits. This was an additional pressure.

A chart of CRU statistics for 2005 is included on the next page. Statistics for 2004 were also reviewed and appeared comparable. It includes the time of the 'abuse' call. As can be seen the numbers outlined by the supervisor in her interview with this reviewer are substantiated.

CRU YEARLY STATS
2005

REQUEST FOR SERVICE

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	
[redacted]													
[redacted]													
[redacted]													
[redacted]													
[redacted]				0	0	0	0	0	0	0	0	0	5227

OUTCOME/DISPOSITION

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	
1. Information Only	[redacted]												
2. Open File & Transfer to Service Unit													
Central Intake													238
North East Intake													245
North West Intake													308
South Intake													272
North Abuse Intake													187
South Abuse Intake													192
Abuse Coordinator													7
EIA Liaison Worker - S. Reid													28
Perinatal Service Unit													93
Other Service Unit													24
Subtotal Open File & Transfer to Service Unit	360	371	411	414	0	0	0	0	0	0	0	0	1556
3. Open & Close File	[redacted]												
OUTCOME/DISPOSITION OF THE REQUEST FOR SERVICE TOTAL	[redacted]												

APPREHENSION (Number of Children)

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
1. New Case	[redacted]												73

ALLEGED REFERRALS TO WINNIPEG CFS IN 2005 PRIOR TO THE DEATH OF PHOENIX SINCLAIR.

Interview with Client who had talked to the foster parent

The client indicated that she was the person who had spoken to the foster parent. She had known her from the past. She had called her and told her that something was not right with the Samantha home and with Phoenix in particular. She thought that she had heard something, and although she was terrified to come forward herself she asked the foster mother to do so because she was concerned. She did not know the exact address, only the block where the apartment was. She felt that something terrible was going to happen. She said that she had phoned into the agency as well. In addition she mentioned that she had a friend who had also been an open Winnipeg CFS who had called in and also told her worker.

Interview with Second Client

This client indicated to me that she told her worker that she was concerned about Phoenix the daughter of her friend. She had given the address and the building to the agency emergency number. Apparently the worker on emergency asked for exact address but didn't know. She indicated that the number that she called was the after-hours 944-4050 and she talked to a female. She said also that she was told that if she didn't give her name they were not going to do anything. The client then went on to say that she had concerns about Samantha and there is something wrong. Next she said that she was asked if she had witnessed anything. The client then said that there was the one thing she got mad at her for getting her new outfit dirty. She had just been playing outside. Samantha got really mad and left. After-hours was told this.

A telephone call to the worker who has since left the agency (May 10, 2005 indicated that she had no remembrance of any such conversation with her client. She does remember that the client on a number of situations would deflect her own situation by eluding that others around her needed to be investigated. On those occasions she had told her to call intake at the number that she provided.

Action Taken by Reviewer

Winnipeg Log sheets were checked for the time period January 2005 until May 2000. These are reports that did not generate a specific report. If a client comes forward with information that cannot immediately be followed up or identified a record is still kept for a set period of time. No such anonymous referrals alleging concerns for this family were found.

There is also an 'After-hours Miscellaneous Directory at Winnipeg CFS. If the agency came across an situation with no addresses or names, then put it is into an after-hours directory and then cross reference if another came. There was no record in this Directory. Presently there are twenty-two such files going back to 2004. None involve that type of referral.

Another Possible Referent

At the bottom of a letter outlined below on regards to another possible referent there was evidence of a request to Animikii Ozoson CFS to provide information on their connection to Phoenix Sinclair..

The Executive Director of that agency made immediate arrangements for information to be provided. It outlined that a client had told her worker at Animikii Ozoson that he had previously called his former worker at Winnipeg CFS while he and she were still there and had allegedly indicated that Phoenix may have been put into a 'duffle bag' and placed in a closet.

Interview with the Former CFS Worker

The former worker indicated to me that she had no recollection of either the first client or her former husband who was the client mentioned from Animikii Ozoson ever telling her about the situation with Samantha Kematch and Phoenix. She did indicate that clients sometimes told her why are you investigating me when I know that so and so are a lot worse than me. That type of situation did occur.

In my opinion it is hard to determine whether there was indeed another concern specific enough to have been formally reported and then investigated by Winnipeg CFS

ALLEGED REFERRAL TO INTERTRIBAL CFS IN 2005 PRIOR TO THE DEATH OF PHOENIX SINCLAIR.

In this course of this investigation several rumours had surfaced about the fact that perhaps Intertribal CFS had received an abuse referral prior to Phoenix's death at Fisher River First Nation. I planned to go up to the community but I talked to the Southern Authority Executive Director, Else Flette, who was very open and said that there was a letter that she had written on this very topic. She provided it to me.

It showed that on June 26, 2006, Elsie Flette the Director of The First Nations of Southern Manitoba CFS Authority wrote to Jay Rodgers, Director of the Child protection Branch in order to respond to questions as to whether Intertribal Child and Families Services had indeed received an earlier referral from (the name of client). Copies of the letter are on the accompanying disc. She wrote.

> ***Re: Phoenix Sinclair***
>
> *Update on the involvement of Intertribal Child and Family Services in the matter of Phoenix Sinclair*
>
> *Further to the report sent to the Child Protection Branch on March 20/06, and further to the concern brought to our attention following the CIRC meeting of May 5/06, namely that (the name of client) had told the police that she made a referral to ICFS in the summer of 2005 that Phoenix was in need of protection. According to our information, (the name of client) stated that the worker (whose name she did not know) said that it was summer and that they were very busy.*
> *The report sent in March 06, based on the agency's reporting of the incident, outlined a series of events that occurred in July 2005 involving ICFS, Peguis CFS, (the name of client), and (the name of client's) two sons. There was no mention in the agency's report of any referral from (the name of client) regarding Phoenix Sinclair.*
>
> *At that time, TCFS workers were in touch with (the name of client) on at least two occasions. The first was when the ICFS workers first went to the house and found the two sons there. The second contact was when the TCFS workers called (the name of client) to make sure that the boys had returned safely to her home. The Peguis CFS worker brought the boys from Fisher River to Winnipeg and had contact with (the name of client) at that time. There is nothing on the file that would indicate that (name of client) made a referral to ICPS or Peguis regarding Phoenix.*
>
> *In March 2006, (name of client) advised ICFS of the disclosure that her sons had made to her about Phoenix Sinclair. The notes from ICFS indicate that ICFS contacted the police that same day.*
>
> *I spoke with ....., the Executive Director of ICFS, on May 9/06 regarding the information that had come from the CIRC meeting. The executive director stated that she had not found anything on any of their records that would support (the name of client's) claim that she had, in fact, made a referral regarding Phoenix in the summer of 2005. The*

executive director stated that the agency had reviewed all their phone logs and their intake reports, but had been unable to find any record of a referral by phone or letter from (the name of client). I have requested a letter from Ms. Cochrane to confirm this.

ICFS did not have a case file on Phoenix Sinclair, as they were not involved with the Kematch xx McKay xx Sinclair family, other than the brief service provided to (the name of client's) boys on July 12/05.

With this as a beginning, I contacted the client and after several attempts interviewed her in her home in Winnipeg. She said that she had concerns for her son who was staying with Karl Wesley McKay and Samantha Kematch. She knew that he was unhappy about something and she understood that perhaps it could be that a young girl in the home, Phoenix, was being mistreated. She indicated that she had called the after hours emergency service at Intertribal CFS and talked to a woman. The woman allegedly told her that she would not receive the referral because it was summer and they were short staffed.

The Children's Advocate and I visited the agency at Fisher River First Nation and interviewed a supervisor and an office support person. We checked all emergency after-hours logs and telephone numbers of people who were listed in their telephone bills for that period of time in 2005. There was no indication that Intertribal CFS had received a referral. The staff person who was interviewed said that while she was covering after-hours services for some periods in the summer she did not receive any calls in regard to Phoenix. She indicated that to her knowledge no one else did either. The same staff person indicated that there had never been, to her recollection, any conversation by telephone with the alleged source of referral. As we continued to look through file information for on-call coverage we noted that there had been telephone contact with this worker. There was a telephone number match on the agency's monthly statement to that of the alleged referent. When queried as to whether there was an open file on Phoenix she indicated that there wasn't. However, upon questioning further, she did confirm that there had been a file open on Samantha and Wesley McKay. When reviewing the file, we also noted the telephone number of the alleged referent in it. She now recollected that there had been one call to the referent to ensure that a child from that home had arrived in Winnipeg safely.

In my opinion it is hard to determine whether there was indeed another concern specific enough to have been formally reported and investigated by Intertribal CFS.

III) CONCLUSIONS

C1. Based on the evidence presented this review concludes significant errors were made by Winnipeg Child and Family Services in the case management of the file involving the protection of Phoenix Sinclair.

These specific concerns are outlined in specific 'Findings' found in the previous section. Some periods of case work were done well, other parts were substandard.

C2. These were errors which stem from longstanding resource and caseload and Standards issues. They do not stem from the willingness and competence of many of the staff directly involved in this case.

This was a difficult case to review for several reasons. First, there has been the terrible death of a young child and secondly there was the frustration of viewing a system which was so overwhelmed at certain points due to a lack of staff and resources that it made incorrect decisions that proved to be so fatal. There were many staff, who were interviewed who were frustrated that they could not do more to protect Phoenix and they were anxious to let me know what was urgently required for their agency to provide better service in the future.

C3. At several crucial points in the case management of the files relating to Phoenix Sinclair, services provided were not at all consistent with the requirements of *The Child and Family Services Act* and the Program Standards as prescribed by Manitoba Family Services.

As requested at the start of this review (see Section III), a significant amount of time was spent determining whether these aforementioned procedures outlined in the Provincial Child Protection Standards were followed appropriately and if not, why not. .

There were substantial Indications of non-compliance with Provincial Standards in the case files associated with Phoenix Sinclair. Sometimes it was difficult to determine whether a Standard was not followed or simply not recorded. None of the workers who were interviewed on this case allowed their case work to be guided by standards. Internal processes had been substituted and the staff felt that they were not feasible to be done and as such they were simply not followed in their agency or elsewhere in the province.

Although this case was opened in 1999, the first year of the New Protection Standards, special attention in this review, has been accorded to the correspondence sent in 2004 and 2005, the periods of time when the case management of Phoenix Sinclair is the most problematic.

One worker indicated that in the 2004 period, for example, that although she has been in agency for many years, she cannot remember being given training on the Child Protection Standards. Today, this worker believes that she follows an agency policy to protect children and to leave families intact where possible but does not necessarily follow the provincial standards. She indicates that her supervisors find it difficult to set supervision time. In fact she indicated that

she has never had a set time just open doors when they are available. Attempts are made by supervisors but virtually impossible due to supervisors meetings. She also reported that workers often have to cover other caseloads which double their responsibilities. She indicated that this is because there was and is an ongoing crisis of people not being replaced immediately. One team has been down couple of people for over a year.

Another stated that in 2004 as is the case now in 2006, Standards are not a priority for workers since the reality is that they cannot necessarily meet them. In particular, high medium or low time frames are not met and workers use their own judgment. Standards do not take context into consideration. The assignment of risk and the information comes from CRU and often the right information cannot necessarily be obtained by phone. She said that 'You don't feel that you can help people because you are running on a wheel and it feels like it is getting worse'.

C4. Correspondence between the Child Protection Branch, Winnipeg CFS and the Authorities from 1999 to 2006 shows that the full institution of child protection standards has been problematic.

C5. The difficulty of instituting, reinforcing and auditing Child Protection Standards is directly related to the chronic lack of resources and staffing during the period of this case file. This is evident at all levels which include the Child Protection Branch, Winnipeg CFS and other child welfare agencies across the Province of Manitoba.

The official letters and e-mails which support this contention (C4. and C5.) are provided in chronological order below. They span the years from 1999 until the present. The letters themselves have been submitted to the Office of the Child Advocate for Manitoba as part of this Section 4 review.

In 1999 a draft of new Protection Standards were circulated to the field. The expected process from that point on was explained in part in a letter from the Acting Executive Director of Child Protection to Winnipeg Child and Family Services dated May 26, 1999

> "In short, we are suggesting that the "narrative" be excepted as is for the present and next step efforts be focused on ensuring that the forms and instruction components meet the needs for which they are designed. Later in this correspondence you will also see that we are suggesting it is now time to begin to consider the issue of workload impact and workload measurement."

The next letter sent to Executive Directors, Child and Family Services Agencies, Regional Managers, Regional Offices and Winnipeg Child and Family Services indicates the next stage in the process in instituting the Provincial Standards. By May 11, 2001 seven agencies had piloted the original standards.

> *"Thank you to everyone who participated in the review of the standards, and special thanks to the seven agencies that piloted the forms:*

- *Child and Family Services of Western Manitoba*
- *Southeast Child and Family Services*
- *Anishinaabe Child and Family Services*
- *Dakota Ojibway Child and Family Services*
- *Winnipeg Child and Family Services*
- *Parkland Region*
- *Norman Region*

I am aware of the extra effort that many put into this project. My thanks as well to Richard Voss, who kept the initial process on track and initiated the pilot process.

The evaluation identified a number of issues related to format, technology, training, and a few content issues. The majority of the problems with the forms related to the lack of fit with the information system and the duplication of work required when filling out paper forms. Workers needed to be able to generate information needed for court documents, referrals, service agreements and financial reports/requests for funds. Additional information was suggested for some of the stages, as well as changes to the child assessment form. The major recommendation was to eliminate the concept of case category and to move to a "case is a case" approach. -

Staff from Child Protection and Support Services began to redraft standards to address these issues. When the first phase of the AJI-CWI began, resources for this project were diverted. However, it is my sense that there is still general support for a standard approach to case management and documentation. Therefore, we are again putting the process in motion."(Page 1)

Later in the letter it indicates that

"The implementation process will involve training of supervisors beginning in September 2001. Supervisors will then be responsible to train their staff. Training will cover the case management process, the expectations contained in the standards and the role of the supervisor and case manager. The Agency Relations staff will be available to consult with supervisors on an individual basis regarding case management and documentation.

It is expected that all agencies will be using the new case management standards by January 1, 2002.

As the development of standards is an ongoing process, once the standards are implemented, further suggestions or concerns may be raised with the Agency Relations staff. A committee of agency and program staff will meet quarterly to review concerns and develop solutions to ensure standard practices across all agencies." (Page 2)

A follow up letter from the Acting Executive Director of Child Protection, on July 12, 2001 to all mandated agencies provided further clarification

"Further to my letter bf May 11, 2001, we have agreed to delay implementation of the

Case Management Standards to enable the four authorities to deliver the training necessary to support their use. It is hoped that these standards will be in effect by April 2002.

During the implementation of the AJI-CWI it is essential that there continue to be clear direction as to what is expected in Manitoba to keep children safe and protected. This direction is currently provided under the Child and Family Services Act and the Adoptions Act and their accompanying Regulations and the attached administrative standards. I will continue to keep you informed of any changes as they occur.

The Case Management Standards provide further direction to help interpret or to supplement the requirements set out in legislation and regulations. I have included a draft of these standards as a guideline to assist you if you are already in the process of developing new agency policy and procedures. The Agency Relations staff will continue to be available to consult with managers and supervisors on an individual basis regarding case management and documentation."

As of December 17, 2003 it is evident that the draft standards and the timeframes set in the previous letter had not been met. There is a memo written by administration at Winnipeg Child and Family in regard to recommendations from the Chief Medical Examiner who had recommended that the Branch should be using the draft standards.

"In a recent report, the Chief Medical Examiner recommended the Branch should be using the Draft standards. Enclosed is a copy of a letter dated May 26, 1999 which outlines the need for test sites to be established, where the material could be jointly supervised by representatives from the sites and the Child Protection Branch. We were to focus on ensuring the forms and instructions met the needs for which they were designed.

As you are aware the pilot project ended and we were told to use the draft standards, if we found them helpful. To date we have not been given direction to use this Standards package and no. changes have been made to make it more user friendly. We continue to follow the Program Standards Manual and continue to use our Branch's recording outline policy.

Would you please clarify the expectations of the Child Protection Branch and General Authority with respect to the use of the Draft Standards.

Thank you for your attention to this matter."

As of February 4, 2004 the status of the Standards had still not been resolved. A memo sent from the Executive Director of Child protection to Winnipeg Child and Family and Family, the General CFS Authority, and the CFS Branch talked about the 'Draft Standards'

"In response to your memo of December 17, 2003, child and family, services agencies are expected to use the Case Management Standards in conjunction with the administrative standards distributed July 12, 2001 (see attached letter to all mandated

agencies). 1 understand your confusion with respect to the Case Management Standards, however, the letter clearly states that staff are to use the administrative standards provided in place of the Program Standards Manual.

The forms that were developed to accompany the Case Management Standards have not been implemented. There are changes to electronic systems currently in process to assist agencies to record and track case management activity. These will be ongoing as standard development proceeds with the partners and resources permit.

The Child Protection Branch is currently in the process of reviewing existing standards to determine what changes are required with the proclamation of The Child and Family Services Authorities Act. A new package of the Foundational Standards will be distributed at that time. In the meantime, I have enclosed the most recent version of the Case Management Standards.
If you have any questions with respect to standards or procedures, please contact the General Child and Family Services Authority at 984-9360."

On March 1 of the same year, 2004, Winnipeg Child and Family Services sought further clarification about the 'Draft Standards'. They wrote to the Child and Family Services General Authority with copies to the Child protection branch of the Provincial Government.

"Further to the memo received from Joy Cramer February 6, 2004, Winnipeg Child and Family Services is seeking further clarification.

In Ms. Cramer's first paragraph she states that CFS agencies are expected to use the Case Management Standards in conjunction with the Administrative Standards that were distributed on July 12, 2001. However, in the attachment from yourself you state "we have delayed implementation of the Case Management Standards to enable the four Authorities to deliver training necessary to support their use. It is hoped that these standards will be in effect by April 2002."

Winnipeg Child and Family Services is attempting to adhere to the Administrative Standards and has distributed the Case Management Process and Standards for information only. We recognize the forms that were developed have not been implemented nor has a workload measurement tool been developed.

We are requesting clarification that our current practice of referring to the Administrative Standards is acceptable, and we trust we are to refer to the Case Management Standards as we continue to revisit our Branch's policies and procedures. If our assumptions were incorrect your direction would be greatly appreciated."

The Winnipeg Child and Family Services analyzed and provided feedback on the Draft Standards which were now being proposed with the advent of the Authorities.

The document was submitted by Family Service Department on August 16, 2005
Although it itemizes and comments on certain of the proposed standards the note at the bottom provides significant insight into the conditions for the agency and its staff.

"Note: It has become increasingly confusing to determine exactly what Standards the Branch is expected to follow given the many drafts. When this review is completed will the Agency/Branch be forwarded exact copies of what we are expected to follow? Currently there are 2001 Standards that have been revised and the current on-line Standards differ from them. Some knowledge of what to discard would be beneficial."

Feedback on the CFS Foundational Draft Standards by the General Child and Family Services Authority provided on August 30, 2005

Overall Feedback

- *Agencies continue to request a communication and implementation plan in regards to an orientation and training for the standards.*
- *A further request was made that forms, templates and needed documents are developed to support the changes to the standards.*
- *Resources, compliance, non-compliance and workload require discussion as the draft standards set requirements that will increase the strain on existing resources.*
- *Feedback was provided by the General Authority agencies in January 2005 to the Draft Chapter One standards. There is no indication as to the process that was completed in terms of responding back to the Authority and its mandated agencies.*
- *A concern exists that the new set of draft standards will impact on staff recruitment and retention. Without sufficient resources, staff morale will be impacted by the declining quality of service they are able to provide and the perception that they are not meeting standards.*

C4. At various points in the case files relating to the safety of Phoenix Sinclair, the case managers and team supervisors were dealing with far too many cases than would be possible to manage appropriately.

There were some important internal Agency factors affecting Child Welfare practice in Winnipeg Child and Family Services at the time of Phoenix Sinclair's death. They are listed below:

- The Agency was in a transitional time and writing its own policies. They are still partially in draft and have not yet been circulated to all staff due to a lack of clarity from the Child Protection Branch.
- The workers had not received enough training.
- Caseloads in various departments were excessive at the time of
- There were gaps in staff due to holidays, training and stress leaves.
- Funding issues appear to be continuous and this has affected programming and appropriate levels of staffing.

One of the interviewed workers involved with Phoenix Sinclair indicated that supervision is once a month and at that time (2004) there was no set time. It consisted usually of going through case lists and asking questions about case plans etc. Today there is no clinical supervision since there is not the time. On intake it is more about planning to move the case on rather than developing relationships with clients. On intake it is easier to pop in and ask questions.

C5. Workload issues need to be addressed immediately at Winnipeg CFS.

On of the workers on the Phoenix Sinclair file indicated that there is lots of turnover, experienced workers are more inclined to get loaded up. Negative reward system if you close off cases you get loaded up and then resentful.

It appears that workload has been an issue since 1999 and is now apparently more of a problem today. Correspondence was requested and the first sample of the problem of workload is from a letter from Manitoba Family Services to Winnipeg Child and Family Services dated May 26, 1999

> *"Workload Implications/Workload Measures*
> *I am suggesting that concurrent with the testing...that we begin to identify the ingredients or components of workload measurement. Simply taking a 'before and after' approach to the test will not suffice because we do not yet have an agreement on what constitutes a useful workload measurement. This varies from agency to agency...and in some cases from unit to unit within a given agency.*
>
> *Therefore it is important and timely that we use the next steps in the case management implementation process to begin to identify the items that describe workload from a field and supervisory prospective. (Example: case loads size, case complexity, travel vagaries, number of staff supervised, etc.)*
>
> *In the past, considerable work has been undertaken in this area but it has been idiosyncratic. I am suggesting that the standards implementation committee (described in greater detail in subsequent section of this correspondence) take responsibility for initiating this process. The goal for this exercise will be to construct an approach to workload measurement that has acceptance by all agencies delivering child and family services (as this pertains to the case management standards) and the funding authority." (page 3)*

C8. The role of the Crisis Response unit requires examination. It needs to have more control on what cases are opened for further service and a formal right of appeal if there are refusals to accept its files. It needs to be able to respond sooner with consideration given to moving towards CWLA staffing levels for a unit such as this.

One of the workers interviewed for this file review indicated that 'at that time a five day response was given but today in 2006, the CRU workers do not recommend time frames for service visits since they are too backlogged. This is a problem. Sometimes cases are sent over for opening at intake and are not proceeded with. This is also problematic'.

The Chronic Workload Problems at CRU

One worker, who was interviewed in regard to the case in question, indicated that

> *'Historically CRU has been doing abuse cases for determining validity even though CRU*

feels that there is already enough information to warrant transfer to them.

The issue is that abuse is tied up. The worker provided the example that if 'Johnny' is beaten up by his parents and he has been beaten in the past.....CRU would still have to keep the case as in this case and do the initial work of interviewing the child. Another example where a child is alleging that she is being choked and still CRU ends up doing the initial work. CRU struggles now and in the future it will have to do abuse investigations even though it continues to be understaffed. She indicated that apparently the two abuse intake units will become simply auxiliary workers to assist in ongoing family service cases.

Presently they are expected to hold 6-8 cases with turn around for 48 hours. Now she has to maintain them for up to a month. As we became government employees and even though in JIROU we are expected to now respond to crisis cases it is not the only situation. We now have to manage file requests, histories, requests from other provinces, and people writing in with custody and access requests ....simply because they see us as the first contact. Because every body is backed up CRU ends up with them. While family services tried to transfer to the Authorities everyone got backed up. As a result now CRU is 'muddled'.

The Crisis Response Unit's program description provides the following definition.

'The CRU's mandate is to process all referrals for service to the Agency, to gather and screen information, to determine the validity of the referrals, and to assign priority levels to referrals to ensure further assessment or investigation occurs if required. As well, the CR0 would have the primary obligation to ensure the safety and well-being of children at risk (as prescribed in the Child and Family Services Act, Part III, Child Protection), which may include responding to and investigating allegations of serious physical and or sexual abuse and or neglect.'

The case management decisions at the CRU or Crisis Response Unit stage would include:

- Is the referral eligible and/ or appropriate for Winnipeg Child and Family Services?
- Are the children safe or in need of protection?
- What immediacy of response does the referral warrant?
- Will the referral be opened to the Agency, and (if so), under what case category?
- Can the case be opened and closed at the CR0 level? If so, what are the criteria for doing so?

With respect to the day-to-day provision of services the CRUs would:

(1) interface with Intake and Abuse Units as well as with the Agency as whole and with external Agencies.

(2) respond to crises involving assessing and intervening in situations where a child may be at acute risk of severe abuse and/or neglect. This would clearly suggest that in any assessment which results in an Agency response being scored as 'Immediate (within 24 hours)', that the CR0 staff would be responsible for making the necessary contact(s) with the child(ren) and any other significant others, completing the 'Safety Assessment' and

managing the crisis prior to referring the case to the Intake, Abuse Intake and/or After Hours Unit.

C7. Based on the Review Findings, Winnipeg Child and Family Services presently lacks the staffing and resources to adequately protect children under its care.

On May 10th, 2006, eleven staff members from child protection at Winnipeg Child and Family wrote to the Dean of the School of Social Work and the Manitoba Association of Social Workers. Similar copies were sent to administrators internally. The letter outlines issues which appear to need resolution or at least clarification as to accuracy. From what I saw in case numbers and shortage of staff in the review of the Phoenix Sinclair death, these concerns are similar to what was expressed over the course of the file history. The complete text has been included in this report so that it can be fully considered.

> *"Many of our clients identify themselves as First Nations. Approximately 40% of our current caseloads are First Nations persons and we continue to receive such cases from the Intake Unit at that percentage rate. In May 2005, the corresponding resources (such as personnel and support services, and finances) were conveyed to the other three Authorities (North, South, and Métis) and there is no option to reconcile the current discrepancy.*
>
> *Also worthy of mention is the rising number of new Canadians that are coming to the attention of Winnipeg Child and Family Services. Manitoba plans to welcome and receive 10,000 new Canadians this year. The majority tends to settle in Winnipeg; specifically Downtown Winnipeg. Many of our newest citizens have come from war torn countries and refugee camps. These traumatic experiences have translated into some very unsafe parenting practices that must be patiently attended to by our child protection system.*
>
> *In the meantime, our caseloads continue to grow. We are at the raw number of 36 very complex cases for each Child Protection Worker. As a result, the quality of service is wanting, albeit we are desperately trying to meet the designed standards and provide the services our clients expect and deserve. According to the Standards of Practice outlined in the Canadian and American studies that were quoted in the discussion papers submitted prior to the 1999 Winnipeg Child and Family Services reconfiguration, the maximum number of cases that a Child Protection worker should safely manage in the Core Area of a large City would be twenty (20). This number is prepossessed by the facts that many of the service recipients exhibit multifaceted difficulties in parenting safely due to a preponderance of issues layered upon issues; such as, substance use, mental health management difficulties, histories of abuse, poverty, and a paucity of positive family-of-origin parenting experiences."*

Of final note is a report sent by managers in regard to their concerns for child safety. This was sent on July 4, 2006. The report of six pages has been included at the back of this report so that the issues it expresses can be addressed. In my opinion, the fact that both staff and managers

have serious concerns has to be addressed in a positive manner, and the fact that they have had the courage to speak up is commendable. I say this because their concerns mirror those which were evident in the Phoenix tragedy. The environment for another tragedy still exists.

C8. Recommended Good Practices for Protection Case Management were often not followed in the carriage of the protection files associated with the care of Phoenix Sinclair.

There appeared to be more emphasis on the visiting itself, monitoring, or seeing the people rather than on what therapeutic interaction, case planning and goal setting. Although some cases do require strictly behaviour management and monitoring, many other family situations can improve if the right approach is applied.

C9. A Review of previous case files would have found that Karl Wesley McKay had a history of abuse, alcoholism and domestic violence.

The [redacted] protection file has Karl Wesley McKay as her former partner. This was a protection file which had numerous examples of his alcohol abuse, domestic violence and several allegations of physical abuse against his young children. One referent thought that he was not capable of looking after young children. Another alleged that he had left bruising on his one year old child. He was charged with assault on his partner three times. There were three separate charges of assault on [redacted]. One report from a Probation Officer indicated that on one occasion Wesley had beaten [redacted] to a point where she could not walk after he had beaten her with the leg of a bathroom sink. The Probation Officer also reported at a later point in the file that Karl Wesley McKay had not internalized any of the anger management courses that he had attended. The file included a quote by the then worker who stated that "It was determined that the parents had little understanding of the impact of Domestic Violence on their children.

C10. The decision to prevent cases from being deemed 'abuse' unless they meet the rigid criteria in both the 'Abuse Opening Procedure' and the later version dated April 29, 2005 is unacceptable and could contribute to future child deaths.

It had a significant bearing on the March 5, 2005 allegation of abuse not being properly investigated and the responsibility to look at this situation was left with workers who were not ordinarily expected to deal with abuse situations.

VI) RECOMMENDATIONS

The Phoenix represents our capacity for vision. While collecting sensory information about our environment and the events unfolding within it, the Phoenix never dies. It rises anew from the ashes, symbolizing a spiritual rebirth.

It has the ability to leave this world and its problems behind, flying toward the sun in clear blue skies.

According to legend, the Phoenix's absence represents disharmony. Its resurrection teaches that we need a renewal stage, a recycling, and an interruption of the status quo.

For the Spirit of little Phoenix, we pray that her short life and tragic death will count for something. May her spirit "rise from the ashes" and help guide the important work of the changes that need to be made.

Words by Billie Schibler
Manitoba Children's Advocate

As mandated under the Terms of Reference for this Special Case Review, this report sought to examine 'the circumstances that may have contributed to the death of Phoenix Sinclair and make recommendations that will help prevent similar incidents from occurring in the future' (see Section II). Section V is offered with this goal. This reviewer has come to the belief that this was preventable if the child welfare system had responded to the issues brought before it, and done so in a more meaningful and systematic manner and for which it had been originally legislated.

The Terms of Reference also indicated that 'recommendations not deemed to be protected under section 76 of *The Child and Family Services Act* will be released to the public (see section II).

A. SPECIFIC RECOMMENDATIONS IN REGARD TO WINNIPEG CHILD AND FAMILY SERVICES

STAFFING LEVELS

RW1 That Winnipeg Child and Family Services will work towards ensuring that staffing levels for social workers and supervisors meet CWLA standards

This will require the government itself to inject additional child welfare funding for staffing, and training issues.

RW2 That Winnipeg Child and Family Services be provided with the financial resources to expand the 'Float Social Worker Program' as outlined in the 2005 and 2006 Draft Documents at Winnipeg Child and Family

This Winnipeg CFS program provides needed help when a particular unit has illness or gaps in its complement. It is needed to ensure a timely response to child protection issues.

RW3 That the concerns expressed by Winnipeg CFS regarding the implications for increased caseloads within their agency be addressed prior to the full institution of the Joint Intake and Response Unit (JIRU) as an independent body.

In order to be a fully participating partner in the move to Authorities, Winnipeg must be able to maintain a viable response to the cases that it presently holds and for those that it can anticipate receiving from JIRU in the future.

THE PROTECTION ROLE

RW4 That Winnipeg Child and Family Services will ensure that it will reinforce a more structured approach to family work with an enhanced emphasis on assessment, diagnosis, and goal planning in order to decrease the present role of intervention at a crisis management level.

It appears that workers have been so used to being overwhelmed that they are more used to responding to crises than they are to planned, orderly casework with families and their children at risk. Some workers may have to be retrained where needed with proper casework practice procedures instituted.

RW5 Winnipeg Child and Family Services will consider eliminating the present practice of one worker having both the family file and the child file from those families when the children come into care.

When a child in care has his or her own worker there is often better child focused work done with children in care. Family workers are often spending their time trying to prevent children being hurt on their caseloads. In addition, a family worker and children's services worker can co-ordinate better planning and the result can be a more child-focused perspective in case planning. Both should have equal say on the case management decisions as it affects the child in care. If Phoenix had had her own worker while she was in care, would the same decisions still have been made?

RW6 Staff should be reinforced that it is important to provide social work counseling and intervention at the case management level with children and with families

There is the need to re-emphasize the individual intervention and change that can be initiated by Winnipeg Child and Family Services social workers, using social work techniques. It should be reinforced and made part of individual service plans with children and their families. Long standing employees of Winnipeg CFS used to demonstrate and reinforce more of these skills a number of years ago in supervision. However, given the crisis response atmosphere it would seem that this practice has diminished.

CHILD WELFARE/STRENGTH BASED ASSESSMENTS AND RISK ASSESSMENT

RW7 That Winnipeg Child and Family Services will ensure that there are full strength based assessments and risk assessments on all families where a child is found to be in need of protective services.

Even though the Child Protection Standards call for detailed comprehensive assessments the recording presented as evidence showed little adherence to these expectations.

There appears to be a great difficulty now in 2006 to meet provincial assessment standards due to high caseloads and limited training. However, it is a crucial component of effective casework. Everything flows from the assessment of need (see appendix on assessment). More details about the aspects of child safety that can be processed through an appropriate assessment and risk assessment as outlined in Appendix 1 of this report. Although discussion of assessment issues is important in case conferences it is also important to have a written assessment as well.

One of the former Directors of Child Welfare for Manitoba indicated in testimony at the Nadine Beaulieu Inquest, four years ago in 2003, about "the importance of recording and having written assessments, and then using the assessment as part of the ongoing process of working with children and families. He also emphasized the importance of looking at "what does information mean in spelling out an implementation plan and (in) evaluating in some way what the worker is doing, to resolve the issues and dynamics, priorities, etc."

Historically, and in practice, assessments were sometimes completed by workers in their mind

and transmitted in conversations and conferences but not written. I was also strongly influenced by one of the other witnesses at the same inquest who reported that 'if you cannot write it down you probably do not understand it".

I concur that the comprehensive assessment is crucial information and everything flows from the assessment of the child's needs, the family dynamics, and the resulting safety plan. If all cases used this methodology, the risk to children would be significantly reduced. Cases would be managed with an understanding of the underlying dynamics, which may have precipitated the Child Welfare concerns, rather than relying only on the presenting problems, which were evident upon receiving the initial referral. Obviously, for those situations that do not require intervention at the family services level as an open case, an exhaustive assessment would not be required.

There are always new things arising and dynamics changing and the worker should reflect that. This reviewer supports that contention since the formulation of a written plan forces the social worker to go through a step-by-step process leading directly to a narrative assessment and then a service plan.

An outline of what this assessment could include can be found in the Appendix section of this report. They are simply provided to show what assessments could tell case managers.

RECORD KEEPING (INCLUDING ALL RECORDING FORMS, CASE NOTES AND CASE CONFERENCE FORMS)

RW8 That Winnipeg Child and Family Services will reinforce with their social workers and supervisors that it is important to maintain detailed recording.

At certain crucial points in the case file, it was difficult to know what had actually been done or not done. Recording at set stages or at closing can provide an overview but it does not help the next worker know about what the ongoing strengths and weaknesses are in dealing with the family. It is not clear to what extent this lack of recording was a factor in the series of tragic events that led to Phoenix Sinclair's death but there was certainly potential for serious implications.

There is a need to reinforce the importance of recording with staff. This is important in any Agency. It is even more important when working within family groups who may share intergenerational issues. What is written or learned from one case file may be helpful in understanding another.

RW9 That Winnipeg Child and Family Services will improve its case note system on protection files.

This will facilitate better planning, provide a better record of Agency contact, and guide any covering worker in attempting to implement the right course of action to be taken in an emergency situation. Requirements of appropriate case notes are outlined in Appendix 2.

INTERNAL POLICIES AND PROCEDURES MANUALS

RW10 That Winnipeg Child and Family Services will combine all internal procedures into one policy manual once the new Authority Standards are finalized.

Presently the manuals are difficult to access. Some standards, policies and program descriptions are in an orientation manual and others are still in draft due to the fact that some programs are still in transition. Once the system stabilizes there needs to be a central access point or manual and this should be accessible in electronic folders for ready access for staff at their work stations.

AGENCY TRAINING

RWII That Winnipeg Child and Family Services will ensure that Intra Agency training has been provided to all front line and supervisory staff in the following specific areas:

- How to complete comprehensive assessments, make diagnostic statements and then formulate case plans flowing from this assessment.
- How to develop goals and service contract planning in casework.
- How to maintain the primacy of a child safety focus in the intervention while still considering the needs of the family.
- How to provide social work counseling and intervention at the case management level with children and with families where there are significant risk factors evident
- How all of various departments in a child welfare agency work together in a coordinated manner to ensure that the protection needs of children and their families are met in the most appropriate manner possible.
- How social workers and supervisors have discretion to question decisions made by other departments and the right to look further into situations if they are not satisfied in regard to child safety issues.
- Supervisors have not had the chance to do true clinical supervision for staff involved in child protection due to their responsibility for larger number of workers and staff caseloads. Training modules should be introduced to help supervisors in this regard if and when these pressures are reduced.

CHILD PLANNING CONFERENCES

RW12 That Winnipeg Child and Family Services will ensure that case reviews (conferences) are completed as per the Standards on all children in care and recorded in both the family and the child's files.

Phoenix Sinclair for one was never the subject of an internal conference or planning meeting while she was in care. This should be incorporated into standard practice with resource staff, case managers, foster parents and the parents and children themselves able to attend where possible.

FOSTER CARE

RW13 That Winnipeg Child and Family Services will ensure that there are Procedures outlining safe guards for children in out-of-care-alternative-care Arrangements.

Child safeguard procedures need to be added in order to provide guidance to workers in determining when child protection cases can be closed after children are in out-of-care, alternative care arrangements

RW14 That Winnipeg Child and Family Services will ensure that all open foster home files have completed detailed home studies.

The backlog in some home studies was problematic at Winnipeg CFS and contributed to why the former foster parents were not made 'place of safety' parents again.

COMPUTERIZED INFORMATION SYSTEM

RW15 That funds be made available to Winnipeg Child and Family Services to ensure that the computerized information system provides timely and coordinated information on children at risk and their families

The CFSIS has improved since the time the Phoenix tragedy but more access to past information and cross reference of files still needs to occur. This is also a provincial problem but it is focused here because of the case situation.

GOVERNANCE AND ACCOUNTABILITY

RW16 That an Advisory Council be established to provide guidance and Accountability and Resolution of Internal Issues for the Winnipeg Child and Family Services. This should be instituted within six months of this report.

Winnipeg CFS is now an arm of government. All other child welfare agencies in Manitoba have a board of directors and as such a body which has a governance and advocacy capacity. The degeneration of service delivery at Winnipeg CFS since the Board of Directors needs to be reserved with some public accountability and oversight.

As provincial employees, staff is no longer part of an independent agency. They can however work under the auspices of an Advisory Council which could be made up of members of the previous community councils which were set up to provide guidance to agency services and to develop a rapport with local communities.

If additional members of this Advisory Council were added from schools of social work and other notable groups then this group could then receive internal reports, advocate on behalf of the agency and provide insight into the delivery of service. They should have the ability to make their meetings public.

This Advisory Council can assure that in the future, Winnipeg Child and Family Services remains a full partner with other service providers in the various Child Welfare Authorities. It needs to be more clearly under the governance of the General Authority. This Advisory Board would assist in this. A healthy vibrant Winnipeg CFS is vital to a healthy child welfare system since it has many clients in Manitoba's largest city.

WINNIPEG CHILD AND FAMILY SERVICES RECOMMENDATIONS PROVIDED BY THE STAFF THEMSELVES

Preamble to Other submitted Recommendations

On the following pages I have included recommendations made by the staff themselves on this tragic case and on service at Winnipeg CFS in general. They are included here to demonstrate that the agency has good people who care about children and service, who are loyal but who want to work in an improved service environment.

- Smaller caseloads mean more in-depth knowledge of families and ability to see them more, allowing the supervisors to be more familiar as well.

- Supervisor competency based training is fine but we need self awareness training. If you are only responding to crises and worker's crises, making the time to hear about the case and finding out how the workers are coping but also taking time to assess how the supervisors themselves are coping....becoming more self aware.

- Perhaps actual clinical supervision is needed. Competency training is sound but task focused.

- Emotions also need to be trained. If a supervisor is having a horrible time there needs to be someone who can respond to that. The integrated services delivery needs to have community area directors able to know what protection supervisors are going through in their particular stresses.

- Want to see standards enforced and followed in all agencies in Manitoba.

- 'Are we forgetting what our aim is?' We need to do what we should be doing and we need more resources. By simply closing cases and not giving what children and families need we are hurting. If it is not high risk then cases can be closed. Conversely families who need to be open are sometimes closed...example when a family denies the referral issue and the case is then closed. We need to change this!

SUGGESTED COMMENTS AND RECOMMENDATIONS (FROM FILE REVIEWS ONLY)

An individual working for the Manitoba Child Protection Branch was previously an employee of the Winnipeg CFS. Earlier this individual had been requested by the branch to do an internal report on the Phoenix Sinclair files. Her findings were very thorough and consistent with the findings of this particular reviewer. Her recommendations for change are included below and are worthy of consideration.

Family Contact

The provincial case management standards do outline frequency of contact expectations based on Risk. The Agency has communicated with both the Province and the General Authority to state that these expectations are not achievable. To date there has been no resolution to this issue. The Province, the Authority and the Agency need to give priority to resolution of this issue in order that expectations are clear and achievable so individuals are not blamed when something goes wrong.

Recommendations:

1. That the Province, the Authorities and the Agencies give priority to resolving the Case Management Standards and their stated expectations. In this case however, even if the standards for contact are unachievable, contact was so below the stated requirement that the Standards issue cannot explain it. 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.

2. That an audit be done on all open cases to determine the level of contact between the Social Worker and the family.

Family Assessment

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. Other than the initial Intake assessments stated none of this is apparent in this case. Instead of pro actively planning based on thorough assessment information, the Agency merely reacted to crisis situations with this family.

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.

2. That standardized assessment 'questions' be developed with the expectation that these questions will be addressed as part of every family assessment.

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

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 time-frames 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 Agency use the Provincial Case Management Standards recording outlines to identify specific activities, time-frames for completion and who is responsible for that activity.

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

Assessment of New Partners

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

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.

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. 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, 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, preferably alone, to determine safety.

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. 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.

Recommendations:

1. That the 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 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.

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. 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.

Disagreements between Agency Programs

Variances in assessment and intervention by 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 High Risk Committee format could be utilized to discuss varying opinions and develop a plan with input from all involved parties. In this way no one person is responsible for making decisions in difficult or complex cases.

Collateral Communication

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

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. 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.

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 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.

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 Supervisory Competency Based Training is provided as professional development prior to any employee assuming a Supervisory position.

BROADER SYSTEM RECOMMENDATIONS FOR MANITOBA

RS1 That the Provincial Government work collaboratively with the Authorities to determine sufficient funding to adequately resource the child protection system in Manitoba to address workload, training, and necessary case-support services for front line workers and supervisors.

Insufficient resources and high caseloads were often mentioned by those staff who were interviewed. Internal reports and submissions that were requested as part of the investigation at Winnipeg Child and Family support their longstanding concerns. It is also apparent that previous reports and findings from inquests in Manitoba have uncovered the same lack of resources across the Province. Several months ago a Provincial Judge in Manitoba publicly stated that he had recommended reduced caseloads for social workers in an inquest over which he resided.

Insufficient resources have affected the ability of mandated agencies to competently carry out their responsibilities. It was a significant contributing factor for why appropriate case vigilance did not occur on a consistent basis in the last years of Phoenix Sinclair's tragic life.

The recommendations below are a presented with the knowledge that there may be immediate, additional financial costs to government. They represent what 'sufficient' funding could help to provide. Sufficient time allotted to attend to "child at risk" situations; adequate training for staff; the culture of child welfare organizations themselves; and culturally appropriate service delivery as envisioned by the move to Authorities, are crucial.

In respect to the move to the Child Welfare Authorities model, this reviewer believes that this initiative is timely and will best serve the children, their families and communities in a progressive manner. Unfortunately, it will only work if each Authority and agency is provided with sufficient resources to keep children safe. Right now this does not appear to be the case as evidenced by Winnipeg CFS. A visit to another child welfare agency connected to this review also showed that it too had limited funding to provide adequate staff levels. Three years ago, when this Reviewer provided input to the Nadine Beaulieu inquest, those issues were also a factor there.

Over the long haul, it is safe to project that there would be major opportunities for re-investment as child risk factors and family dysfunction begin to be dealt with in a more systemic, purposeful manner, given the resources to do so. In regards to today, there is an accurate, public perception that it is the responsibility of governments (provincial and federal) to provide sufficient resources to keep children safe wherever possible. Many of the subsequent recommendations are offered on this premise.

PROVINCIAL CASELOAD LIMITS

RS2 That the Child Protection Branch work with the Authorities towards meeting the CWLA standards of workload, for the various classifications of social workers and their supervisors

RS3 That the Child Protection Branch work with the Authorities to maintain these standards once they have been reached

PRESENT PROVINCIAL STANDARDS AND PROCEDURES

RS4 That the Child Protection Branch will work in partnership with the Authorities to develop a set of Provincial Standards which will apply to all mandated child welfare agencies

RS5 That the Child Protection Branch, in partnership with the various Authorities ensure that all Child Welfare Agencies follow these provincially approved Standards unless specific written permission to modify or be exempt is granted in writing to them through the designated Authority by the Child Protection Branch

Often a Child Welfare Agency can only work to decrease the risk that a child will be hurt. It achieves this by adhering to policies and procedures which, when followed, will reduce the possibility of injury or death.

All jurisdictions develop a somewhat similar series of interrelated policies and procedures that they hope will provide for effective Child Welfare casework and best practice. These are usually called practice standards and are mandatory in Manitoba. Procedures linked to these Standards are expected to be followed as well and usually there is an accountability relationship between the Agency following the Standards and the government department that is responsible for the administration of provincial Child Welfare policies and procedures. In Manitoba, the Authorities also have responsibilities but they in turn are presently responsible to the Child Protection Branch of the Provincial government. The majority of these relevant protection, child care, and foster care standards are connected to the Branch's Program Standards Manual.

Having recommended this, standards need to be enforced. This needs to occur in order to ensure compliance with competent professional Child Welfare service regardless of whatever cultural group is being served and protected in the Child Welfare Authorities. Presently, there is increased risk that a mistake may be made where a child in need of protection as long as there is confusion as to what needs to occur. In addition there may be the belief by some staff across the province that something may not need to be done because it is not a firm practice expectation.

The Child Protection Standards were approved in 1999 and have been updated several times since. Some are still in draft form as the new Authorities take shape. The standards themselves reflect acceptable child welfare best practice principles.

As a result, the present problem in Manitoba is that they are not always followed. Individual agencies including Winnipeg Child and Family have tried to rectify by seeking government direction and clarification. As one can determine from the series of correspondence which this reviewer requested from various staff at Winnipeg Child and Family, there is still confusion as to what is procedurally required by staff. In addition, difficulties in performing the standards have been duly noted and explained.

When this is combined with a significant lack of resources, the result can produce catastrophic results on individual cases such as the one that is the subject of this review involving Phoenix Sinclair.

Furthermore, each profession acts within its set of good practice expectations. As such, there is the public expectation that the provincial government and the Authorities will provide sufficient vigilance and guidance in order to ensure that standards and expectations of good services are carried through to children, families, and communities, at an individual Child Welfare Agency.

Standards need to be followed and they need to be relevant to the various Authorities making up Manitoba's child welfare system. The following related recommendations are designed to reinforce these standards and decrease the likelihood of future preventable deaths and serious injuries to children under the care of the Province of Manitoba. This needs to happen as soon as possible.

RS6 That in the development of the provincial Standards, the Child Protection Branch and the Authorities will consider Best Practice in Child Welfare: Definition, Application and the Context of Child Welfare in Manitoba, by A. Wright as a guiding resource when finalizing best practice standards in Manitoba within the various Authorities.

This is an excellent University of Manitoba document which was recently submitted to the Office of the Ombudsman and the Office of the Children's Advocate in 2006

ENHANCING EDUCATIONAL OPPORTUNITIES FOR CHILD WELFARE STAFF

RS7 That all workers acting in all front line positions in Manitoba's child welfare agencies be provided with essential core training in abuse, CFSA, assessments, risk assessment, counseling, breaking through resistance, and relationship building with difficult clients.

RS8 (A) That this training be delivered in a manner which is appropriate to the

learning needs of new, and experienced workers and supervisors.

This is extremely important and it would have been beneficial for workers to have been sufficiently trained in this during the carriage of the file in question.

RS8 That this training be offered in a 'refresher' format to experienced workers and supervisors as required.

As a result of new research in the field, best practice can change and it is important that experienced workers remain current. In addition, workers who do not use specific child protection skills for a long period of time, can loose their ability to perform them.

PROTOCOLS BETWEEN CHILD WELFARE AGENCIES AND COMMUNITY AGENCIES

RS9 That the Department of Health and the Child Protection Branch will ensure that local protocols between Child Welfare Authorities and all Manitoba health professionals allow for the health professionals to share information when there is a request during a child protection investigation.

RS10 That the Income Support Program ensure that there are protocols between themselves and the Child Welfare Authorities to allow for sharing of information when there is such a request during a child protection investigation.

Confidentiality is important but children such as Phoenix need to be given a priority and consideration when their wellbeing is potentially at stake.

CONFLICT OF INTEREST POLICY AND PROCEDURES

RS11 That the Child Protection Branch encourage each Authority to institute a comprehensive conflict of interest policy for staff dealing with high risk situations involving relatives

One conflict of interest arose and was declared in the case file at Winnipeg CFS. There were concerns in regard to another potential conflict of interest in another protection agency involved in the case. It would be good practice to have agencies define their policy at a Board of Directors level. Once a policy is in place, staff needs to be made aware of their professional obligations in this regard.

KINSHIP CARE/COMMUNITY PLACEMENTS OF CHILDREN AT RISK

RS12 That the Child Protection Branch will ensure that provincial standards and procedures are in place to guide workers in determining whether kinship homes are to be used for children, who would otherwise be in need of protection.

RS13 That the Child Protection Branch will release a position paper that clearly delineates when a placement is 'a place of safety' and when a child in care is sent on an 'extended family visit' in terms of whether a child is still considered to be in care and under what limitations.

A clarification in regards to the responsibilities of an agency when a child leaves a high risk situation to live with an alternative care giver would be helpful in ensuring that a safety plan for the child exists. This was an issue in the Phoenix Sinclair matter as there was no formal arrangement to oversee the placement or the subsequent decision to return the child to an unstable, high risk situation.

C. THE ROLE OF THE OFFICE OF THE CHILDREN'S ADVOCATE

RCA1 That as an independent body, the Office of the Children's Advocate be provided a role in the auditing of children's case files (compliancy).

This is the first time that this reviewer has provided a report for a provincial child advocate. Although it is recognized that the quality assurance around compliance with standards will be within the purview of the Authorities, there is still a role for the Office of the Children's Advocate in ensuring the safety and well-being of children.

Annual Audits for Compliancy in Case Service Delivery should be overseen by an independent body who has a commitment to the welfare of children. This would provide the general public with the assurance of transparency in the child welfare system and create public confidence in the process. There is some value of having the Office of the Children's Advocate be involved directly in these case reviews as long as there are clear expectations on how the results will be used.

File audits can encourage agencies to provide consistent, competent service to children and clients. Funding for required resources could be built into the process. Most agencies generally will do the best they can and often internal audits are done with great integrity. One must always attempt however, to build systems that put safeguards in place for the minority of situations where there this may not always be the case.

While there may never be complete assurances that children receiving child welfare services will remain safe from harm, the potential risks can be reduced. Child Welfare in Canada has too many situations where agencies did less than adequate case management.

To minimize this risk, audits should be done on an annual basis, through a random selection of Agency files from various departments such as intake, family services, family support, resources, and from children in care. There is some value in having an independent arm of government perform this task as long as there is a clear reporting relationship and positive ways of coordinating with the Child Protection Branch on compliance deficiencies that have been found.

RCA2 That the Child Protection Branch, consider the Office of the Children's Advocate to have a partnering role in the provision of Child Welfare Accreditation once it is established in Manitoba.

There could also be consideration for the Office of the Children's Advocate to be involved in overseeing aspects of an accreditation system for child protection in Manitoba, once it has been established. Accreditation can also provide for good appraisals of service delivery there are some difficulties in this approach. First, accreditations usually have a four to five year gap between reviews and when they are done there are often limited numbers of cases drawn for audit. Sometimes these are not randomly selected or 'pulled' at the time of the on site visit. There is also no mechanism to require agencies to improve deficient areas of child service. It

relies on good will and does not have the clout that a government audit can provide. Agencies that do not immediately pass accreditation standards can be placed on 'Continuous Improvement Programs' as occurs in successful accreditation programs operating in N.S.W. Australia and in New Zealand.

RCA3 That the Child Protection Branch provide a detailed report to the Office of the Children's Advocate indicating the status of the recommendations listed in this report. This should be submitted within nine months after the completion of this case review.

This recommendation is suggested due to the fact that often in a number of other jurisdictions one does not see evidence of follow-ups to recommendations that have been brought forward by a judge at the conclusion of specific Inquests or reports in to child deaths. Perhaps this is not normally required, but I include this as an extra incentive for those Child Welfare agencies and governments to at least consider concluding some of the suggestions or explaining why they have not needed to be put into operation.

VII APPENDICES

APPENDIX 1: ASSESSMENTS AND RISK ASSESSMENT

There was an absence of both a full family assessment during the carriage of the case files involving Phoenix Sinclair. This was problematic since a full understanding of what is occurring enhances the accuracy of what is actually required in order to keep children such as Phoenix safe. More information on assessments and what they are important for is included in Appendix 1. A culturally appropriate assessment and risk assessment model should be required for all cases. I would suggest that in both a large city such as Winnipeg or on a First Nation Community there is interplay of many diverse, social, economic and community factors that affect child safety.

A strength based assessment that is accurate in its child protection concerns is a good starting point for positive intervention with families in their mutual goal of effecting child safety and eliminating risk factors.

When another worker is responsible for providing direct services, orchestrating or monitoring services, the report represents a presentation of information regarding the family that will assist that worker in devising a responsive service plan. In some cases, the report may be submitted to the court to assist the judge in making a disposition.

It should be noted that there is a specific area of the strength based assessment that also incorporates the findings of a completed Risk Assessment. This should occur for all cases in which the file is to be transferred to ongoing child protection services. Besides including areas of Life functioning and areas of distress it should conclude in addressing the following child-focused areas of concern;

The family's potential to harm the child. For example, does the parent fear that the child may *be reinsured? Is either parent suffering from severe physical or emotional problems? What* are the disciplinary patterns?

- The family's ability to protect the child or prevent future harm. For example, is one parent able to protect the child? Do the parents recognize and admit to their abuse/neglect problems? Are the parents able to "bail" each other out? Is the child old enough to protect himself or herself when a potentially harmful situation exists?

- Past and current level of family functioning. For example, how does the family interact? What are the stresses the family is experiencing? How do they deal with stress? What are the internal strengths the family can draw upon to make needed changes? Is the family socially isolated?

- Past and current level of functioning of individual family members. Strengths, problems and needs of parents, children and any significant others in the home must be assessed. For example, what is the child's current physical, emotional, and social developmental status? How does the child relate to the parents and extended family

members?

- Available supports to the family. For example, do family members have people they can turn to in times of stress? Do they use them?

- Family members' verbal and nonverbal communication. For example, does a mother report that she has no problems with her child, although the worker observes that her body becomes rigid when the child cries?

- The family's capacity to care for the child. For example, is there parental agreement on child rearing? Do the parents act overwhelmed or helpless in carrying out the tasks of parenting? Can the parents recognize and individualize the needs of their children? Do the parents compete with the children, acting like siblings rather than parents? Are parental expectations of the children appropriate? Do the parents show praise or affection for the children? Is one child in the family seen as "different" or "bad"?

- The family's ability to accept and use help. For example, do the parents recognize the existence of problems? Do they understand some of the reasons for the problems? Can they seek help? Do they want to change?

- The home environment. For example, is the home physically safe or are there broken screens, cluttered stairways, lack of utilities (gas, water, electricity)? These factors are often beyond the family's control.

- Other valuable sources of information regarding the family. For example, what do the child's school records indicate? Have other community service providers seen any indications of abuse/neglect problems? Is there a history of spouse abuse or assault and battery?

Following the assessment, an individualized service plan must be developed with each family and each family member where relevant to a child's safety. When developing service plans there are two basic issues that must be addressed. The first focuses on establishing priorities, that is, determining services to meet the needs of the family to prevent abuse or further abuse and/or neglect of the child(ren). The second concerns the needs of individual family members that have resulted in or contributed to the abuse/neglect, followed from the abuse/neglect, or are incidentally discovered during the investigation or assessment.

APPENDIX 2: THE IMPORTANCE OF CASE NOTES

There was a serious absence of case notes in the case files pertaining to Phoenix Sinclair. As a result it is difficult for any new worker to truly determine what has occurred in a file and what the amount of casework has actually been.

Case notes are a worker's ongoing recorded observations of all activity related to a specific case. The purpose of case notes is to both concisely and accurately, record all contact with clients, collaterals or colleagues pertaining to the work of the Agency with each client or family. Case notes should create a picture that another person could understand and use if they need to work from case notes to service the file.

Case notes should be written so that they remind the worker of the given situation regardless of the time that has transpired.

Case notes should be legibly written in ink, signed & dated. In some cases they can be used with a computer template although many agencies are not yet at that stage. Those that are electronic can have a computerized signature or an automatic date that is implanted in the note.

Types of Entries:

- Case notes should be made after face to face and other contacts with clients, collateral professionals, co-workers or supervisors regarding the family.
- Missed appointments, messages left and unreturned calls should also be documented.
- Contacts made by any Agency staff should also be documented.

Case Notes should include:

- Details of each contact with the client – date, time, location, length of visit/phone call, nature of contact (e.g. home visit, office meeting);
- Identifying information of those present including full names, relationship to the family, address or phone number, if known;
- Note the source of all information and when it was provided;
- Note the conversation as close to verbatim as possible, use quotations.
- Note detailed observations of the physical scene – positive and negative.
- Note any perceptions, conclusions or plans at the end of the contact.
- Note plans for future appointments.

Case Notes should not include:

- The words and language used in case notes should reflect an objective, fair and non-judgmental approach and hence they are not the place for judgmental statements, jargon or diagnostic labels.

Timing of Case Notes:

- All case notes should be made contemporaneously i.e. during or ASAP after the contact and within 24 hours.

Corrections

- Any errors can be corrected by crossing out the inaccurate entry, and then initialing the correction. Case notes cannot be otherwise modified once it has been completed. Inaccurate factual information should be corrected by creating a subsequent case note.

Maintenance of Case Notes

- Case notes should be kept in a case note binder or folder.
- Case notes should be accessible to your supervisor when you are away from the office.
- Case notes should be placed on the file at closing or transfer.

Use of Case Notes for Court

- Case notes are used to refresh a worker's memory on the stand but should not be used as a 'script'.

Appendix 3 Internal Report: Declining Morale/Workload Challenges at WCFS Branch

On the following pages is an internal report constructed and finalized by managers at Winnipeg CFS this year. It shows the problems that are at a crisis level. Some of the actual data may be inaccurate or challenged but no one that I have talked to will dispute the essence of their concerns. It is reproduced here with the intent to show that the staff at Winnipeg CFS knows the challenges and they desperately want resource assistance and guidance from the system as a whole. The management staff is attempting to move the agency forward but they are doing it somewhat in isolation as long as the needed staffing and resources are provided. Child safety in the future is directly connected to how these identified problems below are actually resolved.

Appendix 3

Manitoba

Memorandum

DATE: 04 July 2006

TO: Darlene MacDonald,
Acting C.E.O.

FROM: Dan Berg, Program Manager
Rob Rogala, Program Manager

PHONE: 944-4492

SUBJECT: DECLINING MORALE/WORKLOAD CHALLENGES AT WCFS BRANCH

The issue of declining morale at the Winnipeg Child and Family Services Branch is entirely understandable and predictable when we examine the continuous upward trend of workload/caseload increases over the past year.

We had one of our supervisors, Cam Evans, and his admin. collate 96 reports from CFSIS, creating raw data spreadsheets and charts to verify the increasing total cases and total child in care trends from May/05 to May/06. We have attached these reports for your perusal.

Date				
May/05	59.5 F.T.E.	1197	20.18	
May/06	59.5 F.T.E.	1961	32.95	*An increase of almost 13 cases per worker in 1 year*

Our staffing complement for the Family Service and Perinatal programs from May/05 to May/06 has been constant at 59.5 FTE. Our total case numbers in May/05 were 1197, leaving us with a caseload average May/05 of 20.18 cases per worker. Our May/06 numbers show a total case increase of 764 cases over a one year period, which translates into a 32.95 per worker caseload average. This is an almost 13 case per worker increase in a one year period. It is scary to think where we may be a year from now should this increase in caseload trend continue as our earlier indicators suggest it will.

Date				*May/06**
May/05	59.5 F.T.E.	437	7.34	
May/06	59.5 F.T.E.	718	12	*An increase of almost 5 cases per worker in 1 year*

Our child in care numbers went from May/05 from a total of 437 children in care or 7.34 children in care cases per worker to a May/06 total of 718 children in care cases, which translates into an average of 12 child in care cases per worker. (See Charts 1 & 2 attached).

Joint Intake and Response Unit

In an earlier report, we established and reported that Winnipeg CFS was allocated resources resultant of the A.D.P. process at between 41 and 42%.

JIRU provided our Branch with Family Service case transfer numbers, and more recently the child in care case transfer numbers for a six month period, from January/06 to May/06 indicate that WCFS is continuing to receive 55% of the total Family Service case transfers from JIRU and 52% of all children in care transfers from JIRU as compared to the other authorities.

We are receiving Family Service case transfers at a rate of 13% and child in care transfers at a rate of 10% higher than we were initially resourced for resultant of the A.D.P. allocation process. (See Charts 3 & 4 attached).

We are suggesting two initiatives worth considering which would have a positive impact on the workload issues at Winnipeg C.F.S.:

1) There needs to be a review of the allocation of resources based on a current re-evalulation of A.D.P. and total case numbers.
2) Failing #1 above, there needs to be an interim F.T.E. adjustment for Winnipeg CFS that is reflective of workload/caseload increases and a recognition of resource reductions for the Winnipeg Branch in terms of less support work availability and less placement resources available post-A.J.I.

Workload increases at Winnipeg CFS have been experienced across a number of our program areas. An interim plan to address declining morale issues and workload overload should have an across program staffing increase focus as outlined below. Here are some of our thoughts across program lines.

1. A) Family Support needs to have permission to lift the hiring freeze, independent of whether JIRU "goes live" in the fall or not. We need the coordinator of the program to advertise and do a hiring blitz to ensure we can meet Winnipeg CFS client transfers from JIRU and current active Winnipeg caseload Family Support needs. Our Branch reputation for being able to provide this valuable resource to families in need is constantly being challenged at the worker/community level.

   B) An additional Family Support Coordinator may need to be hired depending on how many new family support workers are hired.

2) Family Service (including Perinatal, Family Preservation, Floats):
   We require three Perinatal workers to expand this program into a specialized 7.5 social workers, 1 Supervisor, 1 Admin. unit. There is a currently 1 admin., a current supervisor and 4.5 Perinatal F.T.E. in place along with 4 other F.T.E. Family Service staff in this unit. We propose that we should expand the current Perinatal mandate to take on additional cases and to reduce the workload of other Family Service units.

We propose that the 4 F.T.E. Family Service workers should become part of a North-end Family Service unit. We would propose the hiring of 4 F.T.E. Family Service workers, 1 admin., and 1 supervisor to create an expanded Family Service team to bolster services in our core area. These

4 new social work hires should be focused to carry cases related to immigrant/refugee clientele and core area Aboriginal families who have chosen General Authority for ongoing service provision.

The four remaining suburban offices at St. James-Assiniboia, Rivereast Access centre, St. Boniface/St. Vital, and Fort Rouge/River Heights each require a Band II Service Assistant position to assist with client related activity which will alleviate workload responsibilities currently performed by the caseworker. These additional positions would allow us to double team staff in situations where worker health and safety is an issue.

We believe what we have submitted in terms of staffing needs is reasonable in light of workload increasing demands. We would appreciate the opportunity to consult with our Family Service supervisory colleagues if there is any F.T.E. expansion of staffing in the Family Service program.

3) Permanency Planning program:
The permanency planning program post A.J.I. had 250 permanent wards assigned to 7 F.T.E. within Winnipeg C.F.S. The distribution average was approximately 36 cases per worker. As of May/06, there remain 38 permanent ward cases currently being managed across the Winnipeg C.F.S. family service units. The eventual plan would be to transfer these thirty eight cases to the permanency planning program.

Aboriginal Permanent Ward numbers within Winnipeg C.F.S. are continuing to rise resultant of there being no agreement from the aboriginal bands to proceed with adoption planning and no direction from the aboriginal authorities to accept case transfers of these Permanent Wards.

Ongoing negotiations need to happen so these numbers of displaced aboriginal Permanent Wards do not continue to grow. These children need to be permanently planned for as is their right and consistent with our Branch goal for all children in care.

It is recommended that 3 F.T.E. Permanent Ward positions are required to meet this growing number of aboriginal children in permanent care of Winnipeg C.F.S. and to accept the transfers of permanent wards from the Family Service units.

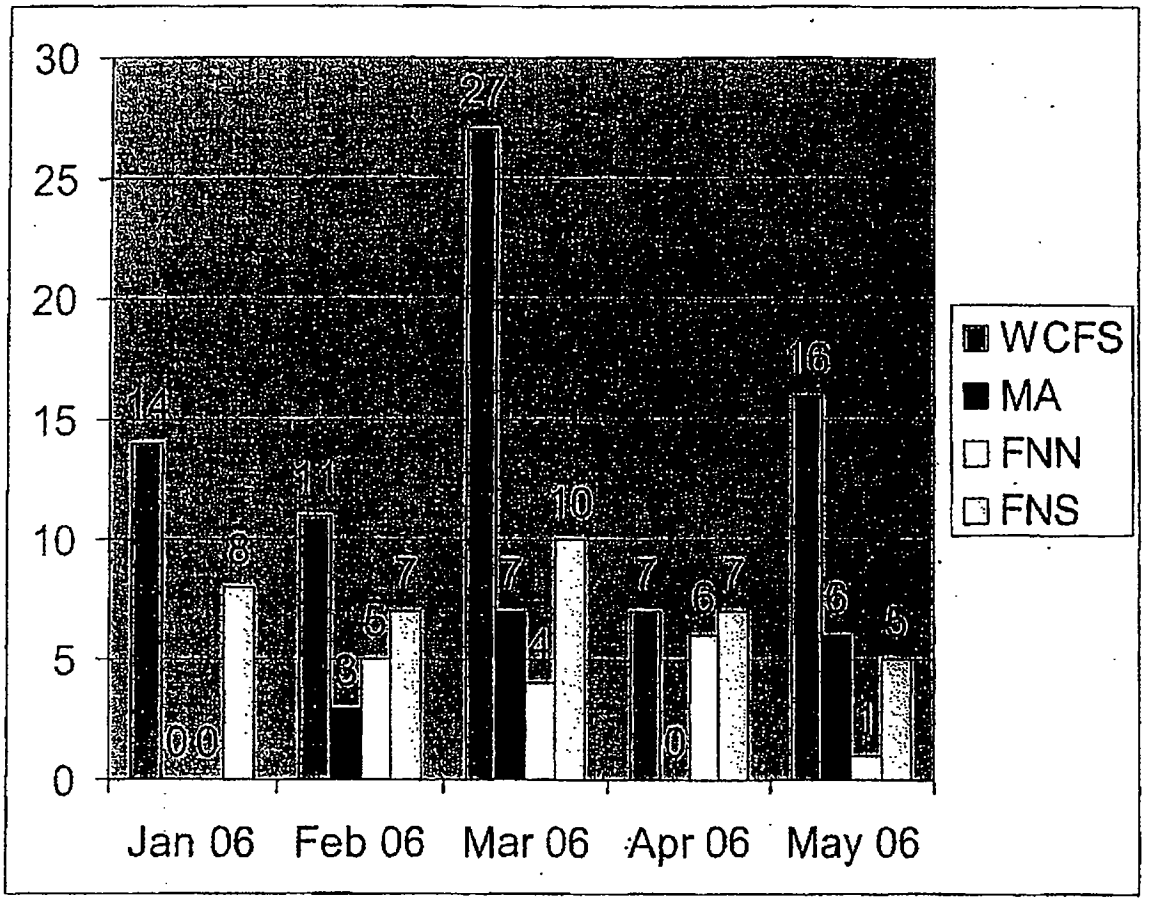
Recommendations regarding Immediate Workload Reduction Impact:
- 1 Family support coordinator
- 3 direct case carrying Perinatal workers
- 4 Band II Service Assistants for the suburban Family Service units
- 4 Family Service workers for the North End service unit
- 1 Admin. for the North End Family Service unit
- 1 Supervisor for the North End Family Service unit
- 3 Permanent Ward workers

The expansion of case carrying workers in the Family Service program would be increased from 59.5 to 66.5 F.T.E. Family Service total case numbers 1961 divided by 66.5 E.F.T. would average out to 29.94 cases per worker.
cc: Martin Billinkoff

4

Chart 1

[redacted]



5

Chart 2

Percentage of Children in Care Transfers from J.I.R.U. Across Authorities - Jan/06 - May/06

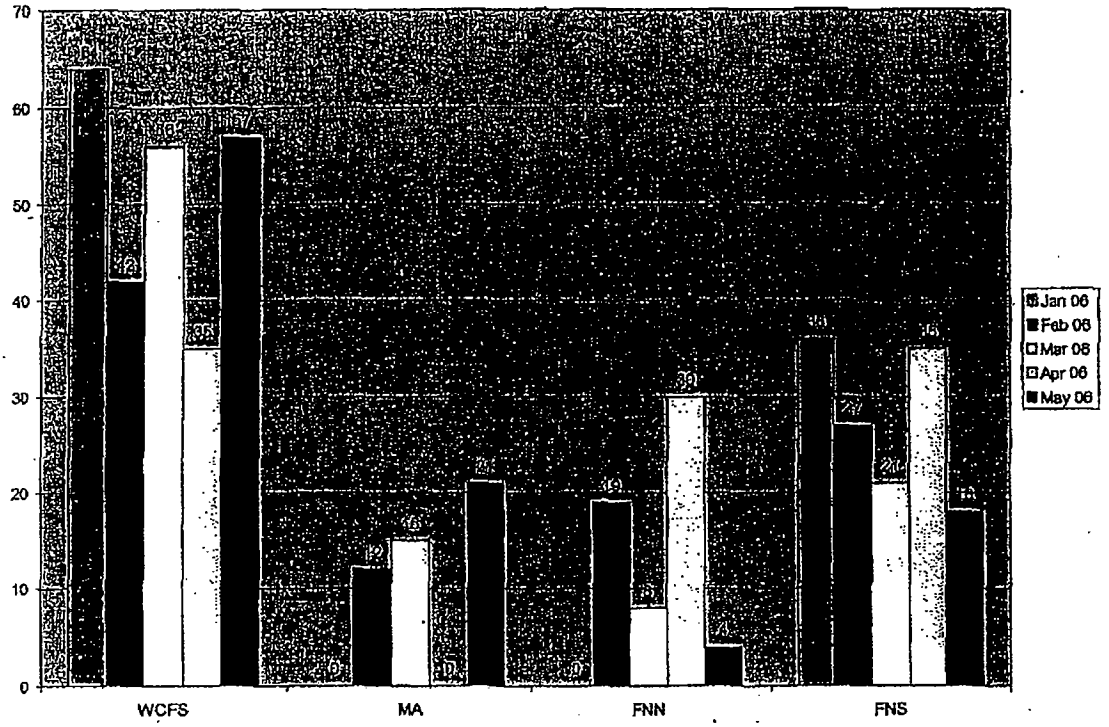


Chart 3

Numbers of Family Service Cases Transferrred from J.I.R.U.
Jan./06-May/06

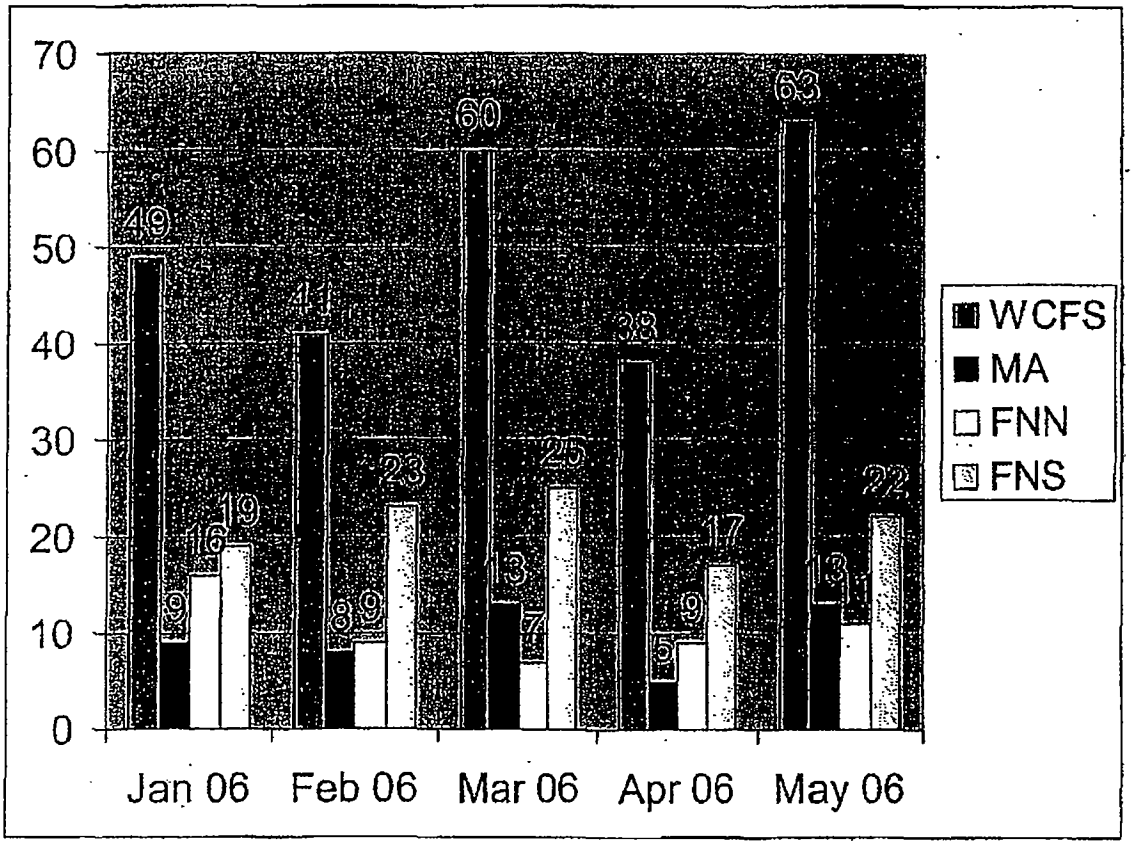


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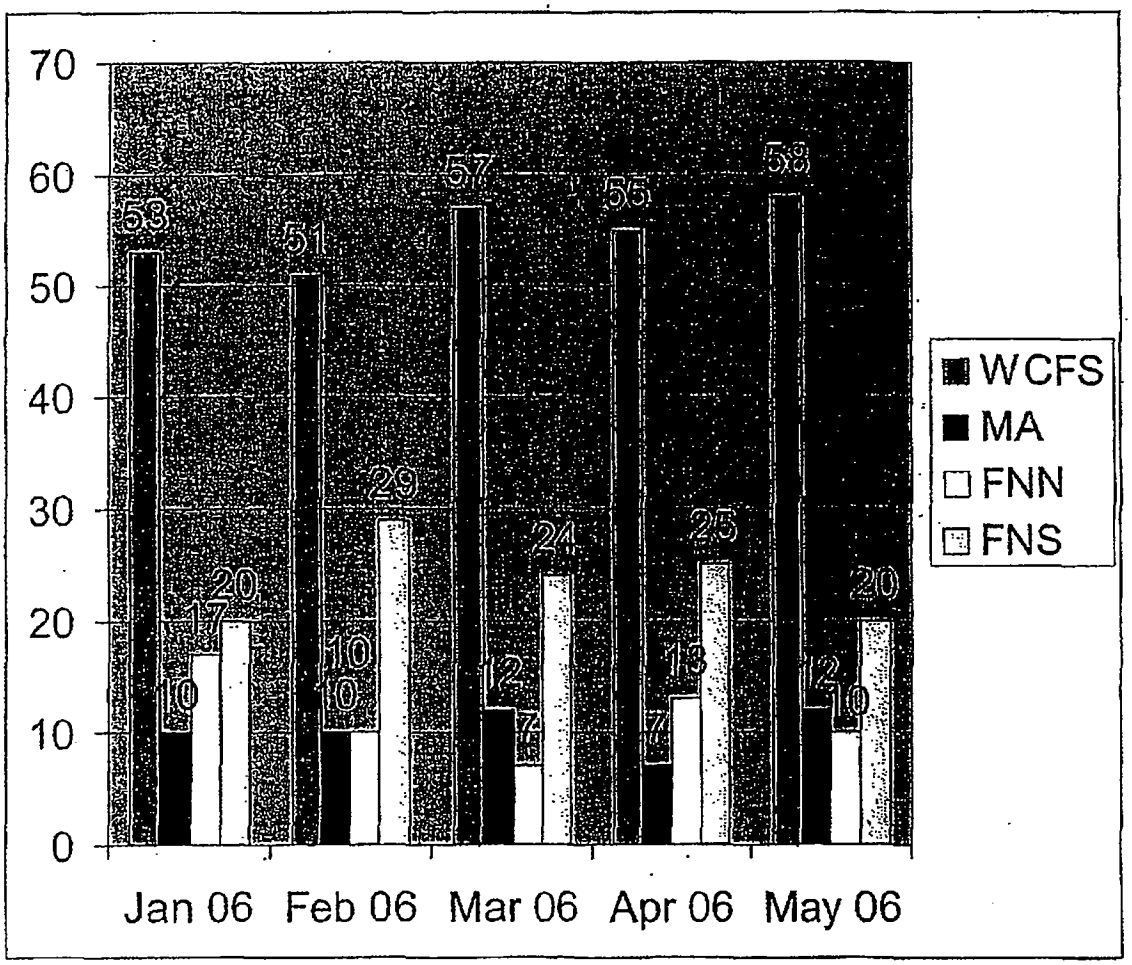
Chart 4


70
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20
Jan 06
Feb 06
Mar 06
Apr 06
May 06
WCFS
MA
FNN
FNS

Manitoba

Family Services
and Housing

Winnipeg Child and Family Services

720 Broadway
Winnipeg, Manitoba
R3G 0X1
CANADA

(204) 944-4170
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10 May 2006

Mr. Peter Olfert,
President
MGEU
601-275 Broadway Avenue
Winnipeg, Manitoba
R3C 4M6

Ms Miriam Browne,
Executive Director
MASW/MIRSW
4-2015 Portage Avenue
Winnipeg, Manitoba
R3J 0K3

Dr. Robert Mullaly,
Dean
Faculty of Social Work
521 Tier Building
University of Manitoba
Winnipeg, Manitoba
R3T 2N2

Dear Mr. Olfert/Ms Miriam Browne/Dr. Mullaly;

We are a Child Protection Team of Social Workers and Support Staff who are employed by Winnipeg Child and Family Services in the Downtown Unit (720 Broadway Avenue). We are writing to you for assistance as we do not have a voice on behalf of ourselves or our clients. Amongst the eleven of us (eight Child Protection Workers, one Secretary, one Social Work Assistant, and one Team Manager), we have 143 years of Child Welfare experience.

As you are aware, our Child Welfare System in Manitoba, and specifically in Winnipeg, has experienced many changes and rearrangements over the last 21 years. The last major rearrangement was in May 2005, where Winnipeg Child and Family Services once had four Child Protection Units providing service to the Down Town Area of Winnipeg, there is now one. Services are now provided by First Nation Agencies to some of our former clientele. The forecast did not account for the First Nations clientele who would choose to continue receiving services from the General Authority.

Many of our clients identify themselves as First Nations. Approximately 40% of our current caseloads are First Nations persons and we continue to receive such cases from the Intake Unit at that percentage rate. In May 2005, the corresponding resources (such as personnel and support services, and finances) were conveyed to the other three Authorities (North, South, and Metis) and there is no option to reconcile the current discrepancy.

Also worthy of mention is the rising number of new Canadians that are coming to the attention of Winnipeg Child and Family Services. Manitoba plans to welcome and receive 10,000 new Canadians this year. The majority tends to settle in Winnipeg; specifically Downtown Winnipeg. Many of our newest citizens have come from war torn countries and refugee camps. These traumatic experiences have translated into some very unsafe parenting practices that must be patiently attended to by our child protection system.

In the meantime, our caseloads continue to grow. **We are at the raw number of 36 very complex cases for each Child Protection Worker.** As a result, the quality of service is wanting, albeit we are desperately trying to meet the designed standards and provide the services our clients expect and deserve. According to the Standards of Practice outlined in the Canadian and American studies that were quoted in the discussion papers submitted prior to the 1999 Winnipeg Child and Family Services reconfiguration, the **maximum number of cases that a Child Protection worker should safely manage in the Core Area of a large City would be twenty (20).** This number is prepossessed by the facts that many of the service recipients exhibit multifaceted difficulties in parenting safely due to a preponderance of issues layered upon issues; such as, substance use, mental health management difficulties, histories of abuse, poverty, and a paucity of positive family-of-origin parenting experiences.

We are appealing to you for support and assistance in helping to raise the awareness about the realities of the quality of services for children and their families who require child protection intervention and services. When each Child Protection Worker has 16 more cases than what has been suggested in order to be managed safely according to "best practice", it is simple to see that the service our clients need and deserve is not occurring. **Those 16 cases translate into 44% extra work that we are expected to accomplish during the work day according to set standards.** We have been trying to meet the established Manitoba Child and Family Services Standards (approved 01 January 2005). Those standards are policies (executive and administrative decisions that are procedural operating rules) that must be followed so the quality of service is similar for all service recipients throughout our Province. Our inability to meet Program Standards despite our best attempts is worrisome. Our clients are not receiving the service the public expects.

We are worn and we are troubled about our collective response to child protection matters. Currently, our response to most matters is reactive. There is little time to reflect and develop case plans that could be preventive and supportive. In conjunction with our clients and other service providers, regular planning discussions would be a welcome and effective process in our Social Work practice. Also, the Winnipeg Integrated Services model (into which Child Protection is in the process of being assimilated into the 8 paired community areas of Winnipeg) suggests that service meetings occur in order for WRHA and FSH Service Providers to jointly discuss and design a service plan with service recipients who are accessing a variety of Health Services and Social Services.

We agree with this approach regarding planning and communication and responsibility. According to the Declaration of Principles in the Child and Family Services Act, Child Welfare activities are to be designed so as to provide support, counseling, assessments, and protection. Currently, we assess and protect.

As mentioned earlier, **the intention of this letter is to create awareness of our workload and to state the realities of how difficult it is to provide quality service. We are in need of support, validation, solutions, and resolutions to our professional calamity.**

We are sending the same letter to our Union, the Faculty of Social Work, and the Manitoba Association of Social Workers so the three organizations that have professional attachments and responsibilities for the integrity of our work and profession receive the same call for help. **We are also sending a letter to our Program Manager and CEO of Winnipeg Child and Family Services.** Our Executive Management has repeatedly been apprised of our situation; however, our concerns have not been presented to them in written form until now.

We are sending this letter to our Union as MGEU represents Child Welfare Workers across the Province. All of us pay Union dues and we would appreciate active advocacy. We need assistance in raising the larger work issue concerning Child Protection Workers and their support staff. That work issue is equity/fairness. The largest employer of Social Workers in this Province continues to insist upon a certain standard of service while not ensuring that we have the proper tools and resources so we can realize and attain what is necessary on behalf of this Province's children and families. Our work culture and the environment within which we work are both oppressive and dismissive towards our work and to those who we are providing the service. A proper workload measurement tool would be beneficial in this regard. We do not disagree with the Standards that were mentioned earlier. We would like to comfortably and realistically attain them as those Standards are designed in a fashion which clearly speaks to preserving families and protecting children in a respectful, non-intrusive, and professionally accountable manner.

We are sending this letter to the Manitoba Association of Social Workers as MASW educates members as well as the public and is in the forefront of the profession through advocacy and social action. Our Child Protection System needs help in order to develop to its full potential. In Section 3.8 of the MASW Standards of Practice (September 2004), it states that "if there is a conflict between the standards of practice and a member's employing environment, the member's primary obligation is to the CASW Code of Ethics, the CASW Standards of Practice, and the MASW/MIRSW Standards of Practice. In such instances, the Social Worker is expected to take reasonable measures to advise the employer of the conflict and of their professional obligation. Social Workers are advised to contact their professional association for consultation and guidance should this situation arise." Since some of us are MASW/MIRSW members, please consider this letter as our formal outreach and contact with our professional association for advocacy.

There are 16,000 Child Welfare Workers across Canada. We are not certain; however, there must be close to 1,000 Social Workers in Child Protection in our Province. The licencing of Social Workers in this Province has been an issue for nearly four decades.

MASW advocacy for Child Protection Workers in this province could have implications across Canada whereupon more Social Workers may want to become registered which reinforces the licencing issue. In the meantime, we want to know what MASW can do for us so we can improve the service our clients need, expect, and deserve. It is our ethical duty and obligation, according to the CASW Code of Ethics, to advocate for workplace conditions and policies that are consistent with the code. As such, we are advocating for our clients' best interests. One of their interests is quality service that is provided with integrity and objectivity. The other interest is competent service. Currently, our work place culture and environment is not designed for either to occur with regularity or frequency. We are doing our best to provide a quality and competent service against mounting odds.

We are writing the Faculty of Social Work as the majority of us are alumni of the faculty. We have been exposed to many learnings throughout our studies and onwards throughout our professional growth. We know about anti-oppression, advocacy, and activism. We need help to change the course of Child Protection now. There has never been a time in the history of Child Welfare in this province when your support has been so needed.

The realities of our work are interfering and intruding upon our Social Work Values, MASW Standards of Practice, and the quality of service to Children and Families. We are appealing to you **(Union, MASW, Faculty)** for support and assistance. As the profession of Social Work focuses on problem-solving and change, we are ready and willing to enter into productive discussions in that regard.

We would like to meet with a representative of your respective institutions to discuss how we may work together to make a positive difference in the development of mandated Child Protection Services so our System's potential is realized. Our clients' experiences with our service, along with the service providers' experiences in providing those services, needs attention now.

We hope to receive a written response to the outlined issues by June 1, 2006 with tentative meeting dates to discuss options available to address same on either June 7 or June 14th, 2006.

Thank you for your valuable time and attention.

Yours truly,

Aaron Klein, BA BSW MSW RSW (Sup)

Karen London, Unit Secretary

Alfred Koineh, BEd, BSW, MSW

Candace Sangster, BSW

Jane Ransom, BSc, BSW

Jennifer Cohen, BA, BSW

Kim Marcino, BA(Hons), BSc, BSW

Lisa Vokrri, BA, BSW, RSW

Penny Scurfield, BA(Hons), MSW

Sabrina Whyte, BSW

Terry Jesmer, Case Aide

Appendix 4: Previous Experience and Qualifications (Andrew Koster)

The following is a brief synopsis of my experience and qualifications:

- Masters of Social Work degree
- Thirty-three continuous years of continuous experience of various Children's Aid Societies in Ontario, including being

  A child care worker in a receiving and assessment center for children;

  A front line social worker in child care and then child protection from 1972 until 1984;

  An intake supervisor of a child protection team for four years;

  A Director of Services for another eleven including Brant CAS and Niagara Family & Children's Services, an child welfare agency serving a population of 400,000;

  In 1999, become the Executive Director of The Children's Aid Society of Brant. This is the position I still presently hold. The Agency with a staff of 210 is responsible for all aspects of child welfare protection, support, and residential services to 140,000 residents in the city of Brantford and other municipalities in Brant County, Ontario. The agency provides generic child welfare services to two Aboriginal Reserves (Six Nations of the Grand River and Mississaugas of the New Credit First Nation).
- Seconded to the Ontario government in September 2006 for six months in order to assist in the development of an Accountability Framework for child welfare in Ontario. Will resume Brant CAS duties upon completion of the project.

In Addition:

- Written or assisted in curriculum development and provided extensive training for child protection managers and staff during the past thirteen years under the auspices of the Institute for the Prevention of Child Abuse and the Ontario Association of Children's Aid Societies. This has included topics such as risk assessment, front-line child welfare core training, management training, Aboriginal child welfare training, sexual abuse investigation (ISOC 1996-1997), treatment modalities, and stress management for staff;
- Served on a joint government and OACAS committee reviewing all child protection training in Ontario;
- There have also been numerous requests to do ad hoc training and consultation with various groups, government, and child welfare agencies;

- Participated in two Ontario government committees, between 1986 and 1992, which wrote the Standards and Guidelines on the Investigation and Assessment of Child Abuse in Ontario (1992);

- On the 19992 committee that wrote the accompanying training manual that provided guidance to all protection social workers on child abuse standards;

- In the area of social work in general co-authored, as a child welfare representative, the first ethics and standards handbook for the College of Social Work in Ontario 1988 and the first update edition. This organization was responsible for voluntarily certifying social workers until recent Ontario legislation that has allowed for statutory regulation;

- Co-leader for 4 years to an adult incest offenders group that was initiated in 1985 and is still in operation today in Hamilton, Ontario;

- Given evidence in criminal court as an 'expert witness' on sexual abuse in the 1980's;

- Provided 'expert' evidence on sexual abuse at a disciplinary hearing held by the Ontario College of Social Work (1989).

- Initiated and provided group leadership for three adolescent sexual offenders groups and one for men involved in domestic violence through a child welfare agency partnership with a Women's Shelter.

Consultations and Reviews

- As a result of this experience;

- Reviewed contentious cases in Ontario and have participated in two comprehensive reviews of other Children's Aid Societies in Ontario;

- Between 1994 and 1996 co-authored with Brian Hillier, the extensive reports for the Province of Nova Scotia associated with the child welfare reviews of a 'shaken baby' death, and a sexually abusing foster parent;

- 1996, a colleague, Brian Hillier and myself provided another report to the New Brunswick provincial government in regard to John Ryan Turner case in New Brunswick, a situation involving a four-year-old child who was starved to death by his parents on an army base;

- From 1994, a Part time faculty member of the School of Social Work at McMaster University, teaching child abuse issues, child welfare and group work. My last teaching assignment was in the spring of 2004 for a fourth-year B.S.W child abuse course;

- Co-author in a published work on risk assessment found in the Child Welfare League of America Journal (1999) and a co-developer of a computerized risk assessment tool based on the Child Well-being Scales;

- Participated in five Accreditation teams that have reviewed children's Aid societies in Ontario. Acted as the Team Leader in two others;

  From September 1997 until October 19, 1998, seconded from my position as Director of Services at Niagara Family and Children's Services, to be the Project Manager for the Aboriginal Child Welfare Review in Ontario. Commissioned by the Ontario Government, the team undertook a comprehensive program review to look at how the five mandated Aboriginal Child Welfare Agencies situated in Northern Ontario were operating, and to make recommendations on changes if needed. I was the only non-Aboriginal member of the project team.

  It emphasized protection and safety of the children; the number of children in care; the use of customary care; the costs to operate the services; and, accountability and governance. In addition, the reviews assessed through on-site visits, hundreds of interviews, and dialogue with community leaders, the extent to which these agencies were fulfilling the child protection mandate and operating in accordance with the legislation, the regulations, and ministry policies and procedures. Five individual reports were submitted on each agency and a 'comprehensive review' made recommendations for change.

- In 1999, reviewed Nova Scotia's child protection protocols, interviewed numerous stakeholders, and then made numerous recommendations that were received by the Nova Scotia Department of Community Services;

- In 2000, retained by the Department of the Attorney General in British Columbia to write a child protection report;

- From 2000 to the present, provided management training to supervisors and senior staff in Ontario under the auspices of the Ontario Association of Children's Aid Societies. Presently certified in the '500 series' management training program;

- Submitted numerous reports in regard to contentious case management situations arising from case files managed in the 1960's, 1970's and 1980's;

- In 2002-2003, at the request of the Department of Justice in Manitoba, I was retained as an expert witness to appear in the court and to provide ongoing assistance to the Crown at an inquest in regard to a foster child who was allegedly beaten to death. Subsequently, submitted a report containing recommendations for changes in how child welfare procedures should be administered in this case and provincially in Manitoba;

- Recently a member of the Social Action Committee for the Child Welfare League of Canada. It prepared a report for a review of Canadian 'child at risk' issues for a Senate Committee;

- Recently a member of an OACAS committee, which is reviewing the present curriculum for manager training;

- 2003-2006, The Zone Chair representing the Grand River Zone (11 CAS agencies) on a provincial OACAS Executive Director committee;

- 2003-2006, the Executive Director, asked by the Zone Chairs Committee of the OACAS to spearhead 'champion' a Quality Assurance initiative that is scheduled to be in place in all CAS agencies by 2007;

- The Project Manager for a recently completed, two year provincial initiative of the Ontario Association of Children's Aid Societies designed to enhance worker client relationship and collaboration with children, families, and communities. It provided the underpinnings to support the Ontario Government's Secretariat Transformation Initiatives;

- A member of the Secretariat's Differential Response Advisory Committee until August 2006.