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

Commission Disclosure 0002

Department of Justice
Office of the Chief Medical Examiner

INVESTIGATION INTO THE SERVICES PROVIDED TO

PHOENIX VICTORIA HOPE SINCLAIR

Report to
The Honourable Christine Melnick
Minister of Family Services and Housing

September 18, 2006

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TERMS OF REFERENCE FOR THE REVIEW OF THE SERVICES PROVIDED TO PHOENIX VICTORIA HOPE SINCLAIR

Section 10(1) of The Fatality Inquiries Act states the following:

If Chief Medical Examiner receives an inquiry report about a deceased child who, at the time of death or within the one year period preceding the death,

(a) was in the care of an agency as defined in *The Child and Family Services Act*; or
(b) had a parent or guardian who was in receipt of services from an agency under *The Child and Family Services Act*;

the Special Investigator shall, for the purpose of assessing the quality or standard of care and service provided to the child and the parent or guardian of the child, examine the records of the agency with respect to the child and the parent or guardian and shall review the actions taken by the agency in relation to the child and the parent or guardian.

In carrying out this review, the Special Investigator is authorized to examine agency records and to make necessary confidential copies as required, to interview agency staff, and to exercise any other investigative powers under The Fatality Inquiries Act, Sections 7(5) and 9(7).

The purpose of this review will be to ascertain the facts regarding the involvement of mandated Child and Family Services Agencies with this child, the parents or guardians and any other significant others; the circumstances of the death, including the cause or probable cause of death; and, the action of Child and Family Services Agencies, in response to the death.

As required in Section 10(3) of The Fatality Inquiries Act, the Chief Medical Examiner shall deliver a confidential report to the Minister of Family Services and Housing. The report will include the factual information relevant to the events preceding the death of the child and make recommendations to the Minister of Family Services and Housing for any action required by the Department of Family Services and Housing to undertake corrective measures as may be identified in the course of the inquiry.

INQUIRY PROCESS

In accordance with The Fatality Inquiries Act (1990), Section 10(1), Child and Family Services Agencies, the Office of the Chief Medical Examiner received a report of the death of **Phoenix Sinclair**. At the time of death, a file was open due to the disappearance of Phoenix. Through the examination of available information from Child and Family Services, and interviews, the services provided by the Agency or Agencies were reviewed. They form the basis of this report.

This investigation was conducted by and the report prepared by Jan Christianson-Wood, MSW, RSW, Special Investigator, Office of the Chief Medical Examiner.

Relevant Dates

March 8 and 9, 2006	RCMP request information concerning the late [redacted] as part of the investigation into the disappearance of Phoenix Sinclair.
March 13, 2006	Confirmation of S.10 report and initiation of review using CFSIS.
March 20, 2006	Service reviews announced by the Minister of Family Services and Housing.
March 23, 2006[1]	Death of Phoenix Victoria Hope Sinclair.
March 29, 2006	File from CFSIS reviewed by Jan Christianson-Wood, Special Investigator, Office of the Chief Medical Examiner.
March 30, 2006	Telephone message left for Supervisor, Animikii Ozoson. Email sent to Intake Supervisor, Winnipeg Child and Family Services Branch.
March 31, 2006	Telephone message received from Supervisor, Animikii Ozoson. Telephone message received from Winnipeg Child and Family

[1] The date of death was assigned in the Office of the Chief Medical Examiner as Phoenix's body was not found and the identification of remains is ongoing.

	Services regarding file components and locations.
April 3, 2006	Call from Winnipeg CFS regarding request for file access or file copy. They will consult and call back regarding arrangements. Email exchange with Abuse Worker, Winnipeg CFS Branch
April 6, 2006	Reply from Supervisor, Animikii Ozoson; Phoenix's father is also the father of a 15 year old girl's 2 month old infant. Steven Sinclair has fathered other children.
April 7, 2006	Files reviewed at offices of Winnipeg Child and Family Services. Further file requests made for POS File and closed files.
April 10, 2006	Email from Winnipeg CFS Branch regarding closed file.
April 11, 2006	Email request to Resource Director, Winnipeg CFS Branch.
April 12, 2006	Email reply from Resource Director, Winnipeg CFS Branch.
April 18, 2006	Winnipeg Child and Family Services Place of Safety file received, copied and reviewed. Request made for criminal risk assessment. Request made for access to ward file of father, Steven Sinclair.
April 19, 2006	Results of criminal risk assessment received. Telephone inquiry to Child Protection Centre, Intake Nurse concerning February 2003 hospital visit by Phoenix. Telephone inquiry to Anishinaabe Child and Family Services concerning Kimberly Ann Edwards. Reply received and identity clarified regarding their foster mother of the same name.
April 20, 2006	Email to former worker regarding past involvement with Sinclair family.
April 21, 2006	Email request sent to Agency internal counsel; reply received Telephone message left for Agency external counsel.

April 21, 2006	Email exchanges with Resource Director, Winnipeg CFS Branch regarding POS foster mother.
April 24, 2006	Telephone message received from external counsel's office. Telephone message left for external counsel.
April 25, 2006	Email sent to former Agency supervisor for mother, Samantha Kematch. Reply received via email from supervisor. Email sent to former EIA workers for Kematch-Sinclair family.
April 26, 2006	Email sent to former Agency worker regarding Steven Sinclair. Message received from Agency's external counsel. Call returned. Email sent to Winnipeg CFS Branch concerning Public Health Involvement.
April 27, 2006	Voice message received from Agency's external counsel.
April 28, 2006	Telephone call from Agency's external counsel. A transcription of August 2003 Family Court proceedings has been ordered to provide the requested information. This was requested April 21 or April 25 and should be available in two weeks.
May 1, 2006	Telephone call from Winnipeg CFS Branch Program Manager regarding the writer's request to the former worker for Ms Kematch. The recordings by the former worker and supervisor will be sent to them for their comments.
May 2, 2006	Request sent to update request made April 18, 2006 for access to father's ward file. Email reply received from Program Manager advising that the request has been sent to Agency's external counsel for an opinion. Copy of report to Child Protection Branch by Southern Authority about service by Intertribal Child and Family Services received.
May 3, 2006	Telephone call from Agency external counsel advising that

access to the father's ward file can be provided.

May 5, 2006	Telephone call from Agency advising that father's file is available.
May 8, 2006	Telephone call to Agency's external counsel asking about the transcription. Writer was advised that an expedited version was not requested. A request has been made to move up the date. The writer is requested to call back on May 17. Second information request sent to former EIA worker.
May 9, 2006	Discussed with Child Death Specialist the information provided by the Crown Attorney concerning possible ICFS involvement in this matter. She will follow up. Review of Steven Sinclair's ward file at Winnipeg CFS.
May 10, 2006	Telephone message left for Branch Child Death Specialist regarding request for information. Reply from Winnipeg CFS regarding PHN involvement in 2004.
May 11, 2006	Consultation with CME and Director about allegation of ICFS involvement; RCMP to be contacted. Communication with Branch Child Death Specialist regarding case information. Telephone call to RCMP "D" Division liaison regarding request for information. The matter has been referred to Staff Sgt. Major Crimes Unit.
May 12, 2006	Meeting at Winnipeg CFS Branch with former supervisor, intake worker and Program Manager concerning PHN involvement after birth of [redacted] sister of Phoenix, in 2004. Letter faxed to Public Health concerning involvement with Sandra Kematch.
May 16, 2006	RCMP Liaison advises that Major Crimes Unit will be asked for further information concerning the alleged referral to ICFS concerning Phoenix.

May 17, 2006	Telephone call to office of Winnipeg CFS Branch's external Counsel concerning transcription; not ready yet. Telephone call to RCMP Liaison concerning information request. Telephone call from RCMP Major Crimes Unit Sgt.; one of their investigators will follow up concerning the request about a referral. Writer advised that this could result in an investigation by the Child Protection Branch. File copy received from the Public Health Office, Winnipeg.
May 18, 2006	Reply from Steven Sinclair's former Child in Care worker concerning the comment on the closing summary of the file. Voice message from RCMP Cst., Major Crimes Unit. Returned the call and left a message. Called a second time this date. Reply from RCMP; their witness is firm that a call was made to ICFS but WCFS Branch is the only Agency with a written record concerning contacts on case. RCMP have confirmed that Mr. McKay, mother's partner, is related to several staff at ICFS. RCMP will request that the lead investigator call the writer after May 24. This information was relayed to Branch's Child Death Specialist. Writer was advised that the E.D. of the Southern Authority was surprised by this allegation. Public Health Information reviewed.
May 19, 2006	Reply from Steven Sinclair's former CIC worker.
May 23, 2006	Letter sent to Intertribal CFS requesting information after a consultation with the Director, OCME. Third request sent to EIA for information.
May 24, 2006	RCMP provide copy of Informant's statement concerning a referral to ICFS prior to Phoenix's death. Copy of transcription received and additional question relayed to WCFS external counsel. Question answered and additional transcription requested for clarity. (Received.) Reply received from EIA.

May 25, 2006	Email exchange with EIA concerning parents of Phoenix.
May 29, 2006	Email from RCMP concerning interview with Informant about any referral made to ICFS prior to death of Phoenix.
May 30, 2006	Faxed copy of Legal file received from Agency external counsel.
June 6, 2006	Court transcripts received from Branch external counsel.
July 6, 2006	CIRC notes typed from May meeting. Conversation with Crown Attorney noted and acted upon.
July 19, 2006	Copy of memo from Southern Authority to Director, Child Protection Branch provided on request.
August 1, 2006	Email to RCMP Major Crimes investigator concerning allegation about a call to ICFS in June 2005.
August 2, 2006	Faxed copy received of allegations made by clients of Animikii Ozoson Child and Family Services.
August 11 & 14, 2006	Email exchanges with Child Protection Branch regarding POS standards.
August 15, 2006	Reply from RCMP liaison for the witness concerning the above inquiry.
September 19, 2006	Reply from Child Protection Branch to inquiry September 18, 2006 concerning report from Animikii Ozoson CFS; no further information was discovered. (Source: Executive Director and CEO Southern Authority)

Child and Family Services Files Reviewed

Samantha Kematch	Winnipeg Child and Family Services, Family file, open.
Stephen Sinclair	Winnipeg Child and Family Services, Family file, closed.
Phoenix Sinclair	Winnipeg Child and Family Services, Ward file, closed.
Kimberly Ann Edwards[2]	Winnipeg Child and Family Services, Foster Home file, closed.
Kimberly Ann Edwards and Rohan Stephenson	Winnipeg Child and Family Services, Place of Safety file, closed

Geographic Information

Phoenix lived with her father—and later her mother—in the City of Winnipeg. At some point in 2005, Phoenix moved with her mother and Karl Wesley McKay to a home on the Fisher River First Nation. From information available at the time of writing, it is believed that she died in this community.

[2] This person's date of birth is February 6, 1966 and she is <u>not</u> the former foster mother of Phoenix Sinclair despite having exactly the same name. The former foster mother's date of birth is August 5, 1970

KEY INDIVIDUALS

Deceased: **Phoenix Victoria Hope Sinclair**
Date of Birth: April 23, 2000
Date of Death: March 23, 2006

Mother: Samantha Kematch
Date of Birth: September 9, 1981

Father : Nelson Steven "Steve" Sinclair
Date of Birth: May 15, 1980

Siblings: [redacted]
Permanent Ward of Island Lake Child and Family Services
Date of Birth: July 23, 1998
Father: [redacted] AKA [redacted]

[redacted]
Date of Birth: April 29, 2001
Date of Death: July 15, 2001
Father: Steven Sinclair

[redacted]
Date of Birth: April 29, 2001
Father: Karl Wesley McKay

[redacted]
Date of Birth: December 12, 2005
Father: Karl Wesley McKay

Significant Others:

Former foster mother of Phoenix: Kimberly Ann Edwards Stephenson

Former foster father of Phoenix Rohan Stephenson

CASE HISTORY

The services provided by **Winnipeg Child and Family Services Branch** have been reviewed by the Special Investigator of the Office of the Chief Medical Examiner in accordance with Section 10 of The Fatality Inquiries Act. The Chief Medical Examiner has made six recommendations.

In an effort to produce a more concise report, the family history has been condensed. All Agency files provided were thoroughly reviewed. A more detailed history is contained in Phoenix Sinclair's file in the Office of the Chief Medical Examiner.

1. History to June 2003
(Adapted from the CME's Report Concerning Services to [redacted]

Phoenix and [redacted] Sinclair's parents, Samantha Kematch and Steven Sinclair, were known to child welfare agencies as both were Permanent Wards. Ms. Kematch was a Permanent Ward of Cree Nation Child and Family Caring Agency and Mr. Sinclair had been a Permanent Ward of Winnipeg Child and Family Services.

Ms. Kematch gave birth to her first child, [redacted] on July 23, 1998 at St. Boniface Hospital where staff were concerned as Ms. Kematch concealed her pregnancy and had no pre-natal care. She told staff that she discovered she was pregnant only a month before delivering [redacted] Hospital Staff noted that the boyfriend who accompanied Ms. Kematch was appropriate and his mother was very supportive. Ms. Kematch presented as "immature" and was described as "emotionally flat."

On July 23, 1999 Winnipeg Child and Family Services apprehended [redacted] on behalf of Cree Nation Child and Family Caring Agency as Ms. Kematch was a Permanent Ward and in an Independent living situation with Macdonald Youth Services.

Cree Nation CFCA's file stated "after delivery of her baby, Samantha was short with hospital staff and appeared to be emotionally flat when discussing future plans of her newborn. Samantha gave no indication that she was ready to parent this child. Due to Samantha's behaviour and attitude towards her newborn, Cree Nation CFCA felt it is in the child's best interest to be placed in care for a period of six months. Since the

apprehension, Samantha has indicated she would like to parent her child and has agreed to attend a facility for young mothers. Samantha will continue her weekly supervised visits. She will attend a facility for young mothers at Waywayseecappo First Nation for a period of six months once an opening is provided. [redacted] will remain in foster home until Samantha is admitted to the facility for young mothers."

On July 25, 1998 [redacted] was placed in a foster home.

[redacted] was placed with his mother at Oskki-Ikwe, a facility for young mothers at Waywayseecappo on September 14, 1998. After eleven weeks at the facility, both Ms. Kematch and [redacted] were discharged from Oskki-Ikwe due to unspecified safety concerns for [redacted][3]

[redacted] was replaced in his former foster home and Ms. Kematch returned to the Independent Living Program under Macdonald Youth Services until she reached the age of majority.

[redacted], [redacted]'s father, is from the community of Wasagamack. [redacted] eventually moved to a foster home licensed by Island Lake First Nation Family Services. [redacted] remains a Permanent Ward of Island Lake First Nation Family Services and had no contact with his mother after 1998 according to the file information. It was not clear from the file information if Mr. [redacted] had contact with his son. Information from the General Authority after Phoenix was reported missing indicated that [redacted] lives in a foster home in Winnipeg.[4]

On April 23, 2000 Phoenix Victoria Hope Sinclair was born at the Health Sciences Centre. Hospital staff called Winnipeg Child and Family Services as Ms. Kematch received no pre-natal care throughout her pregnancy. In discussing matters further, it was discovered that [redacted] had been removed from Ms. Kematch's care.

Steven Sinclair, Phoenix's father, had not parented a child but a summary from Winnipeg Child and Family Services, dated April 15, 1998 stated "...very hostile with authority figures and oppositional in behaviour; had a drinking problem but was not

[3] These were identified in other file material as a failure to feed the child adequately and a failure to provide satisfactory physical care.
[4] Background Information on Phoenix Sinclair prepared by the General Authority for the Child Protection Branch on March 13, 2006.

motivated to address his problem and this was impeding his ability to function in a school environment...was physically, sexually and emotionally abused as a child; seemed to have difficulty with women in authority. **Steven remains to be** (sic) **a highly disturbed individual who should not be left in charge of dependent children. He has numerous unresolved abuse issues."** (Emphasis added.)

When she was asked why [redacted] had been removed, Agency case notes reflect that Ms. Kematch had advised workers "Samantha thought that it was because they thought she may hurt the baby, as her mother did her. In further questioning the couple, it was discovered that they had not made any purchases for the baby whatsoever and Samantha indicated not being emotionally ready to parent. N/Duty workers attended the hospital on this date to meet with the parents, and both indicated that they were not prepared to care for this baby, either financially or emotionally...they both indicated that they required some time to think about their options and required the baby coming in to Agency care to do so." A subsequent conversation with Cree Nation CFCA revealed that Samantha, despite being given an opportunity to parent [redacted] had not been able to feed him or meet his "basic needs". Consequently, he was removed from her care.

On April 24, 2000 Phoenix was apprehended by Winnipeg Child and Family Services. When Agency workers went to the hospital on April 25 to pick up Phoenix, Ms. Kematch stated that she had "changed her mind and no longer wanted this writer to leave with her baby. She indicated that her mother and her aunt were on their way to Winnipeg from their home reserve (she did not know which reserve her mother lives on) and would be here at 6 pm to pick Phoenix up. This writer indicated that Phoenix is currently under Apprehension with the Agency, therefore, no one can simply come and pick the baby up. Samantha was advised to give her mother my phone number to discuss her interest in caring for Phoenix. It was at this point, that Samantha reiterated that her mother used to abuse her when she was younger and that this is why she was in Agency care. This writer then indicated that her mother would likely not make an appropriate care alternative for Phoenix under these circumstances. Samantha then thought that she had an aunt that may want to care for Phoenix. She was again directed to get anyone who is interested to make contact with this writer to discuss further. This writer invited the parents to help this writer to dress Phoenix and only Steve did so. Samantha seemed only vaguely interested in the process, and when we were walking downstairs, she seemed more interested in chatting and giggling with a friend. The girl that the couple met up with, appeared extremely shocked that they had just had a baby. She made it sound as though the couple had kept this a secret on purpose."

Phoenix was placed in an emergency foster home placement. It was noted that Phoenix was a happy and healthy infant and there were no concerns.

Ms. Kematch and Mr. Sinclair consented to a three month Temporary Order of Guardianship with respect to Phoenix. The file was transferred to a Family Service worker with a request that psychiatric or psychological evaluation of Ms. Kematch be undertaken. Both parents were requested to attend appropriate parenting classes and were to have weekly visits with Phoenix.

The intake worker noted "the assigned worker shall have two primary issues to sort through in the coming months. Firstly, the question of parental motivation and commitment will need to be assessed and weighed on an on-going basis. Secondly, it will be necessary to determine Samantha's parental capacity." (Despite the couple's plan to parent together and the concerns noted on Mr. Sinclair's file, no plan to assess him as a parent was recorded.)

Ms. Kematch and Mr. Sinclair had a strong advocate from The Boys and Girls Club who assisted them. On May 11 2000 their advocate advised the Agency that attempts were ongoing to have the parents meet the Agency's expectations. By mid-May Ms. Kematch and Mr. Sinclair had started a parenting group at the Andrews Street Centre. They attended every week for eight weeks and completed the program.

There was difficulty in finding a psychologist to assess Ms. Kematch—the worker noted that attempts were made in May, June and July of 2000 without success. The worker noted that it appeared that Ms Kematch's presentation and level of cooperation may have been factors in the failure to complete an assessment.

Phoenix moved from an Agency emergency shelter to an Agency foster home in [redacted] on May 5, 2000.

In the Place of Safety application signed by Rhon Stephenson and Kimberly Edwards Stephenson on September 23, 2003 the section titled "What are your principal reasons for wanting to be a foster parent?" was completed with "Love (Had child on and off since she was 3 mo. old)." Phoenix was returned to her parents at the age of four months. If the POS application is accurate, the parents began to delegate Phoenix's care to others almost as soon as she was returned to them.

An Agency summary from this time noted "through May to August the couple continued to visits (sic) with Phoenix on a weekly basis, Tuesdays from 10:30 a.m. to 12:30 p.m. It was also learned from [Name of Advocate] that they continued to attend the Boys and Girls Club's summer programming, they participated in a program focused on job training. [Advocate] also reported that the couple seems to be committed to parenting their child and wanted her returned to their care. The parents were cooperative with this worker however Samantha often appeared angry when she was required to discuss any of the relevant issues with this worker. It was as if that was her general demeanor (sic) with those in authority."

At the end of July 2000 Ms. Kematch and Mr. Sinclair consented to a one month Voluntary Placement Agreement with the goal being Phoenix's return to their care. The required psychological evaluation had not been completed and there remained an outstanding concern about Ms Kematch's emotional stability. No concerns about Mr. Sinclair were noted—it appeared that his functioning was not a critical factor in the decision to return Phoenix.

A teaching support worker was assigned to work with them and visits were increased to two hours twice weekly. In mid-August the visits were again increased and began to take place in the parents' home. The teaching support worker indicated to Agency workers that Ms. Kematch and Mr. Sinclair were very attentive to Phoenix and had begun to accumulate all the necessary items to care for her.

On September 5, 2000 Phoenix returned to the care of her parents. Her foster mother sent information about Phoenix in a letter to her parents. Ms Kematch and Mr. Sinclair also received photographs of their daughter. These show Phoenix as a beautiful, round-faced child with abundant dark hair. She was photographed playing in an 'exersaucer', looking into a tank of fish, sitting on a sofa, 'riding' a toy horse and drinking from a baby bottle.

On September 13, 2000 Ms. Kematch was assessed by a psychologist who indicated that she was not depressed but that her flat affect might be a manner in which to protect herself due to her life experiences or might simply be her style of presentation. The psychologist stated that the parents appeared committed to one another and felt they were genuine in their desire to parent Phoenix. The psychologist also noted that Ms

Kematch was a "closed book" in that she did not want to reveal information. Despite this, he did not feel that any further assessment was required.

The notes reviewed do not indicate whether Ms Kematch's history as a teenager, which includes references to hostility, aggression, criminal activities and sexually promiscuous behaviours were shared with the psychologist. There was no indication that an assessment of Mr. Sinclair was considered, despite the concerns noted in 1998 about the potential for harm to children placed in his care. The quality of this assessment—and the lack of insight it provided into Ms Kematch's capacity to parent adequately—was not challenged by the Agency.

Notes from the Family Support Worker (FSW), whose assessments of the parents' functioning were an important factor in deciding to return Phoenix to their care, were not found in the materials provided for review.

The teaching home support worker remained involved with the family under a six month Family Support Services Agreement signed on September 5, 2000 and the Agency continued to monitor the situation. The case was transferred to another worker by means of a transfer summary dated October 2, 2000.

A new worker was assigned in November 2000, according to a July 16, 2001 Section 182 report; Notification of the Death of a Child Not in Care.

File information noted that there was "minimal contact" with the couple until [redacted]'s birth in April 2001. Ms Kematch and Mr. Sinclair were difficult for the assigned worker to contact. Were they following through with the terms of the six month service agreement and contract signed in September 2000? As the Agency had a contract, why was it not a concern that the family was not seen by a social worker from October 2000 (when the former worker signed off the case), through November 2000 (when a new worker was assigned) and up to February 2001 when contact was established? Did the FSW continue to see the family and report on their parenting? As this was a child protection case, notes were an important and necessary part of case management. WCFS Branch has internal standards for support workers' recording. This incident may predate the introduction of those standards.

As Ms Kematch delivered [redacted] in April 2001, why was her pregnancy not noticed by the worker in February or reported by the FSW in her ongoing contacts? How were the

concerns in the service contract resolved if the Agency's workers had no contact with the family for several months?

The conditions in the support service agreement and the service contract had included twice-weekly meetings with the support worker, regular contact with the Family Services Worker, including access to the couple's home and cooperation with the Agency in exploring issues of family violence and substance abuse. The file does not indicate that these concerns were addressed or that Ms Kematch's aggressive and uncooperative presentation in February 2001 caused any heightened concern about her functioning as a parent. As her first child was removed from her care in 1998 due to her inability to provide for basic care needs, including feeding, sustained and in-depth observation of her parenting was required. The assessments needed were not found in the materials presented for review. .

An August 2001 summary noted that a visit had been made to the family home in February 2001 in an attempt to locate the couple after a period without contact. During a home visit on February 9, 2001, Ms Kematch "appeared angry" and Mr. Sinclair removed himself from the discussion. Ms Kematch was largely uncooperative with the worker's attempts to engage her—either responding aggressively or ignoring the worker in order to watch television. Samantha was clear that she felt she had done all that was asked of her and did not want further Agency involvement. Mr. Sinclair appeared involved in the ongoing care of Phoenix.

On April 29, 2001 [redacted] was born. The Agency did not note concerns with her birth or her parents at that time apart from noting that this was the third pregnancy concealed from the Agency. A home visit was attempted without success in May 2001.

Given the lack of contact between the Agency and the family, the basis for assuming that the parents could safely and successfully parent a second infant was unclear. The continued lack of contact after [redacted]s birth is concerning particularly as the Agency had learned that the pregnancy was concealed. The file had remained open during this period.

On July 2, 2001 Ms. Kematch asked the Winnipeg Police Services to assist her in regaining custody of [redacted]. On July 3, 2001 she reportedly returned [redacted] to Mr. Sinclair as she was not prepared to continue to care for her. Mr. Sinclair indicated that [redacted]

was dirty, hungry and smelly when she was returned as Ms Kematch was incapable of caring for an infant.

It was not recorded in the file if Ms Kematch showed any interest in Phoenix—was she uninterested in a toddler who required more attention than an infant?

On July 3, 2001 Mr. Sinclair's sister called the Agency's After Hours Unit with concerns that Ms. Kematch had left the home approximately *two months earlier*, telling Mr. Sinclair that he could have custody of both children. (Mr. Sinclair told the worker that he and Ms Kematch had been separated for three weeks.)

Why was the Agency unaware of what had been happening in the home? Monitoring is required practice in an open protection case, particularly one involving parents whose attachment to Phoenix was questionable from the start. File records describe Ms Kematch was verbally aggressive and uncooperative. Comments from Agency staff involved with Mr. Sinclair indicated that he continued to be reluctant to provide information about himself or his activities. The strongly worded warning from his Child in Care file raised further 'red flags' about the risk he posed to a child in his care.

After "several concerns" had been referred to the Agency concerning alcohol use and violence between the parents, the on-call worker made a visit to the Sinclair home. He learned that Ms Kematch had left the home and the children in Mr. Sinclair's care. Mr. Sinclair appeared to be coping and indicated that he had assistance from his family members. The assigned worker made a follow-up visit on July 6 and learned that Phoenix was at the home of Kim Edwards, a friend of Mr. Sinclair. He indicated that Ms Edwards was his usual sitter for Phoenix.

The home visit with Mr. Sinclair also revealed that he had been charged with assault by Ms Kematch when she retrieved [redacted] on July 2. He had obtained a restraining order against her for uttering threats. He indicated that Ms Kematch also had a physical confrontation with Sheila Sinclair, one of his sisters. She reportedly had also resumed her relationship with [redacted] upon his release from custody.

On July 6, 2001 the Agency worker met with Mr. Sinclair. The worker noted that the home was clean and [redacted], who appeared fine, was sleeping in her playpen in the living room. The worker noted "she then woke up, Steve prepared and fed her formula. She was alert, the interaction between, father and daughter was extremely positive. Steve

informed the worker, that him and Sam were separated for the past 3 weeks, as she is with her old boyfriend. .... Steve is claiming that he no longer plans to live, or co-parent with Samantha. Steve was offered supports, but once again he felt he had adequate family supports but would call if need be." He stated that he had not consumed alcohol for two weeks and used his sister, Genny (or Jenny) as a sitter. He stated that he drank for one evening at a time rather than for days at a time and that he did not have a problem with alcohol.[5] He was warned and cautioned about using alcohol with children in the home and advised that he would be visited weekly.

Genevieve (AKA Jenny AKA Genny or Genni) Sinclair, the sister referred to as the sitter for [redacted] and Phoenix, reportedly was associated with or employed by Ma Mawi Chi Itata. Mr. Sinclair's sisters include Angie (AKA Danielle) whose cognitive functioning, aggression and impulsiveness was a source of concern to the Agency and, according to CFSIS, Norma Jean Sinclair, who was convicted of assaulting and killing [redacted] in 1996. Another sister, Shella, had involvement with the child welfare system due to alcohol abuse, domestic violence and inadequate care of her own children.

On July 10, 2001 the worker attended the home but found no one there. A business card was left for Mr. Sinclair as the worker had promised.

The history from the Office of the Chief Medical Examiner's file indicated that [redacted] Sinclair reportedly had a cold beginning June 19, 2001. Her father took her to see a doctor who prescribed Tylenol and immunized her. No follow up appointment was arranged.

On July 15, 2001 [redacted] woke up about 7:00 a.m. Mr. Sinclair reported that he changed her and walked around with her before laying her down while he went to prepare her bottle. At 8:00 a.m. Mr. Sinclair came back to feed [redacted] and found her unresponsive and blue with vomit in her bed. He ran to get his sister who lived close by. When the sister attended the home, she found that [redacted]'s feet and fingers were discoloured and blue. An emergency call was placed and first responders attended the home.

When the police arrived, they were advised that the previous evening Mr. Sinclair had thought that [redacted] was hot. He had placed a fan in her room to cool her. The police report indicated that the home was hot and [redacted]'s temperature was elevated. The

[5] The denial of alcohol dependency or misuse was a recurring theme in Mr. Sinclair's ward file.

police note that the windows in the house were closed and [redacted] was in her playpen, dressed in a diaper and lying on a quilt.

The cause of [redacted]'s death was acute and chronic lower respiratory tract infection.

On July 15, 2001 the CRU Intake received the report of [redacted]'s death. The police advised the Agency that Genni Sinclair's partner, [redacted] AKA [redacted] had a criminal history involving violence and narcotics. This was offered as Genni Sinclair was providing care for Phoenix. Workers went out to the home but did not observe any concerns.

The Agency offered support to Ms. Kematch and Mr. Sinclair when [redacted] died. Case notes from July 16, 2001 documented "I offered my condolences and stated that if the Agency could help in anyway (sic) that he could contact us. I informed him that Samantha was made aware today of [redacted]'s death. Steve stated that he did not want Samantha anywhere near him or Phoenix who was staying with Kim Edwards. The funeral arrangements have been made for Wednesday, July 18, 2001 at 1PM. The Aboriginal Funeral Home is in charged (sic) of the funeral. Steve stated that he doesn't want Samantha or any of her family anywhere near the funeral. I share (sic) with Steve that this may pose a problem and to think over the matter carefully. Received PC from Samantha. She stated she wants to know where Phoenix was and that she wanted her. This worker informed her that the child is with her father Steve and that he was caring for her. Samantha stated that the police told her that the child was with CFS. This worker informed her that at the time of the [redacted]'s death (sic) that the child was being cared for by her father Steve. Samantha began to sound angry and stated that she wanted Phoenix and how we gave him Phoenix. I informed her that Steve was the primary caregiver of the children and that the Agency is aware that her and Steve have been separated for about one month. Samantha responded "yeah" - and that he had the child in his care and was the guardian. I further told her that "custody" or legal guardianship needs to settle by them and their lawyers." (sic)

The worker noted on August 16, 2001 in a Case Summary under "Recommendations for Future Intervention" the following, "If or when Mr. Sinclair and Ms. Kematch resolved their relationship and resume cohabitation, that the Agency accessed [assess] and monitor Ms. Kematch's parenting style. **There are concerns expressed by Mr. Sinclair about her treatment and disciplined (sic) methods used on Phoenix."**

(Emphasis added.) The worker concluded the file by noting that s/he was leaving the Agency.

There were no details provided in the Case Summary concerning this statement about Ms Kematch's treatment of Phoenix who was 15 months old at the time the summary was written. As she was an infant, the failure to follow up on an allegation of inappropriate discipline and/or mistreatment is concerning. Waiting for the couple to reconcile in order to assess and monitor Ms Kematch did not take into account the couple's reluctance to seek assistance from the Agency. There was also no contemplation of the very real possibility that Mr. Sinclair might decide to take a break from parenting by passing Phoenix back to her mother and that he would feel no obligation to involve the Agency. An examination of the files did not provide additional details in the handwritten recordings.

Ms Kematch's protection file was closed in August 2001.

Steven Sinclair's file was closed on March 27, 2002 with the notation that Mr. Sinclair did not respond to attempts to contact him in late August 2001. His sister, Shella, did contact the worker (who had a relationship with "three of the youngest Sinclairs") and relayed that Steven was doing well with Phoenix and that their sister, Jenny, was "helping out". Shella promised to pass along to Steven the worker's offer to be available to speak with him or provide service. The worker eventually wrote a letter to Mr. Sinclair (after another attempt to contact him) asking that he come to the office. No response was received and no further concerns were relayed to the Agency.

In closing the file, the worker noted that Steven's family experience had been one of alcohol abuse, domestic violence and sexual abuse. As a child in care, Steven did receive therapy but the worker was concerned that his "issues" would resurface at a future date. Mr. Sinclair was described as a "very quiet and private person" who found it difficult to ask for help or to speak of what was bothering him. The possibility that he could develop an alcohol problem was noted as an "unresolved problem" as Mr. Sinclair acknowledged using alcohol. He had been disappointed in his relationship with Ma Mawi where his sister, Jenny (or Genni), worked. The worker noted in "Recommendations for Future", *"There are concerns expressed by Mr. Sinclair about her [Samantha Kematch's] treatment and disciplined (sic) methods used on Phoenix.* Jenny Sinclair was described as "strong support" for her siblings. The worker believed her to be "a Christian" and alcohol free for a number of years.

The police had already notified the Agency that Ms Sinclair's partner, [redacted] AKA [redacted] had a criminal history related to narcotics and violence. Despite knowing that Mr. Sinclair relied on his sister for child care, no further checks were done to assure Phoenix's safety. Further, believing that Ms Sinclair was "a Christian" was not a guarantee of good parenting just as believing that someone has not used alcohol does not guarantee sobriety. When added to the warning in Mr. Sinclair's ward file and the "concerns" Mr. Sinclair shared about Ms Kematch's "discipline" of their 15 month old daughter, it is clear that further assessment of the adults around Phoenix was warranted.

No contact with Phoenix or her parents was recorded for over a year. It was believed that Phoenix was living with her father during this period; her exact whereabouts were not known to the Agency.

The Agency's Critical Response Unit Intake received a referral from the Child Protection Centre on February 26, 2003 concerning Phoenix who had been seen at Children's Emergency on February 25, 2003. The unidentified man who brought her in told staff that Phoenix had an object in her nose since November 2002 and that he had told Mr. Sinclair to take his daughter to a doctor. As Mr. Sinclair had not followed through, the man decided to seek treatment for her. The hospital advised that the object was removed and a "very foul smelling discharge" came from the child's nose which was red and sore inside. Antibiotics were prescribed but the referral source was not confident that Phoenix would receive them. The hospital requested that the Agency follow up concerning neglect and inadequate care.

An Agency worker visited Mr. Sinclair's home on February 28, 2003, within the five days allocated for follow-up to the referral from the Child Protection Centre. Mr. Sinclair was not cooperative with the workers, refusing to explain why he had "a rather sizable black eye" or to provide any information about the friend who was reported to be caring for Phoenix. He denied any knowledge of Phoenix's "ailment" and was resistant to the worker's statement that a return visit would be necessary to ensure that Phoenix was well.

Home visits were attempted without success on March 12, March 31, April 17, May 1 and May 9, 2003. The file contained no information suggesting that other family members, such as Genevieve Sinclair, were contacted to locate Phoenix.

As the "unidentified man" was clear that Mr. Sinclair had failed to follow through with necessary medical care reportedly for a period of months, Phoenix was, under s.17 of The Child and Family Services Act, a "child in need of protection". A check with the Child Protection Centre on April 19, 2006 revealed that the man identifying himself as Phoenix's "godfather" (no name was noted on the chart) and was clear that he had been concerned about Phoenix's condition since November particularly as her father had not acted to remedy it. There had been an earlier visit to a walk-in clinic which resulted in a recommendation to take Phoenix in to a hospital to have the object removed.

On June 21, 2003 Winnipeg Child and Family Services' After Hours Unit received a call stating that there was a drinking party in progress at Mr. Sinclair's home. Workers attended the home and found that Mr. Sinclair had had "one or two beers with his buddy." Mr. Sinclair would not make a commitment to stop drinking, resulting in Agency workers attending the home twice in the evening to do sobriety checks and supplying food as Mr. Sinclair had "lost" his money and had no food. Notes from the file indicate that the care being provided to Phoenix was not acceptable and Mr. Sinclair was not cooperative with the Agency or police. Consequently, Phoenix was apprehended on June 22, 2003. Her condition suggested that she was receiving good physical care at that time—it was noted that she called most females "mom".

The worker noted that Ms Kematch called on June 23 to inquire about Phoenix after hearing of the apprehension from Genevieve Sinclair, Steven's sister. Ms Kematch indicated that she was working and was in a position to take her daughter. She had been worried about Phoenix due to Steven's alcohol use and recent suicide attempt as described by Genevieve. She told the worker that Steven left Phoenix in the care of other people but severely limited her access to Phoenix. Her explanation for not pursuing custody of her daughter was that she did not know how to initiate the process and believed that the Agency would become involved. Ms Kematch was assured that the Agency *would* be involved in scrutinizing and challenging her actions and activities. She stated that she had not been involved in any counselling or programs as "she didn't need to". The worker advised that the assigned Family Service worker would be contacting her. Mr. Sinclair did not call.

On June 24, Genevieve Sinclair was contacted by the Agency. She had seen her brother and he stated that he "was going to get Phoenix back." **Ms Sinclair "could not fully explain why he only really provided care to Phoenix 3 or 4 days per month".**

(Emphasis added.) She acknowledged that Phoenix spent her time with "friends" (not identified) for the rest of the month. She acknowledged his use of alcohol and drugs and the "negative friends" in his life.

Attempts were made to contact Mr. Sinclair over the following days. His sister, Sheila Sinclair, who had an open Protection file, called to inquire about Phoenix and stated that she "often" had Phoenix stay with her. Ms Kematch contacted the worker about further involvement.

Phoenix's first days in care were documented in Agency logs. On her arrival at the emergency hotel placement at 9.15 p.m., she had a bath and something to eat. Staff noted that Phoenix appeared pleased to see that there was a baby staying in the same placement. She watched some television and went to bed uneventfully. On the following day, Phoenix played with another child in the placement, ate well and was noted to be coughing occasionally. On June 24, staff noted that Phoenix was toilet trained and generally well-behaved although she and another child had a small scuffle over a toy. She did ask for "Mom" on this date but was able to settle at night after a while. The shelter worker wrote "sweet dreams little one" and "have a great day tomorrow" in Phoenix's logbook. The next day passed uneventfully with Phoenix in a good mood and displaying a good appetite. This continued on June 26 with a notation that she became tired in the afternoon and was consequently "grumpy". Staff had been washing the outfit she came in and were attempting to organize additional clothing for her. On June 27, 2003, Phoenix moved to the foster home where she stayed until she moved again on July 31, 2003 to the home of Kim Edwards and Rohan Stephenson.

An intake assessment of the situation noted that Mr. Sinclair's capacity to parent had been deteriorating. Issues of concern included substance abuse, association with the Indian Posse gang, leaving Phoenix with unidentified caregivers for extended periods, medical neglect of Phoenix and a reported recent suicide attempt by Steven. The worker also noted that there were outstanding issues relating to both parents' coming from dysfunctional families and viewing the child welfare system as responsible for their difficulties. The worker noted that Phoenix was the only child Ms Kematch parented for "any significant length of time", having established a pattern of leaving her children and surfacing briefly in time of crisis but failing to follow through with promises. Mr. Sinclair had been more consistent than Ms Kematch in his care of [redacted] and Phoenix but had been, his sister reported, deteriorating since [redacted]'s death. The worker also noted that of his family, only Genevieve was believed to be an appropriate support. The worker

indicated that Steven's sister, Norma Jean Sinclair, was charged and convicted of the 1996 child abuse death of [redacted]. It was further noted that Mr. Sinclair was highly resistant to any involvement with the Agency and avoided contact after Phoenix came into care, making it difficult to address the identified concerns about his parenting.

Winnipeg Police Services had assisted in Phoenix's apprehension, advising Agency workers that although Mr. Sinclair was "not a bad guy", he was involved peripherally with the gang known as "Indian Posse."

The assessment continued:

> "Steven and Samantha have clearly indicated their mistrust and unwillingness to be involved with a child welfare agency however they have not demonstrated a capacity and commitment to ensure their child's wellbeing enough for the agency not to be involved. Unfortunately, because of their past involvement as wards of a child welfare agency they are not receptive to services from the agency and they deny or minimize any issues presented in an effort to keep the agency away from them. They would do anything, or nothing, to keep the agency at bay. **It is this worker's opinion that it is this attitude and disregard for the agency that has probably resulted in this agency's previous termination of services, and not a lack of child welfare issues.** If one looks back in previous recording the identified and unresolved problems are still very much present in the family's current situation. **The problems haven't gone away, and now neither can the agency. The obvious struggle in commitment, questionable parenting capacity, along with an unstable home environment and substance abuse issues, and lack of positive support system all lend to a situation that poses a high level of risk to their 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."** (Emphasis added.)

The After Hours Unit forwarded the file to a Family Service Unit for ongoing service including an assessment of what would be needed to make if safe for Phoenix to be returned to the care of either parent. The Agency applied for a three month Temporary Order with respect to Phoenix, giving both parents the opportunity to make lifestyle changes. As per Provincial protocol and standards, Winnipeg Child and Family Services advised Anishinaabe Child and Family Services about Phoenix's apprehension, the Agency's plan and the choice of placement.

In a letter from Anishinaabe Child and Family Services to its lawyer, it was noted "...the child would be placed in the care of the child's Godparents, one of whom (the Godmother) was a First Nation's person. In light of this and considering that it was a culturally appropriate placement the Anishinaabe worker indicated consent to the Three Month Temporary Order that Winnipeg was seeking."

In reviewing the court transcripts provided by the WCFS external counsel and the legal file provided by WCFS, it appears that, despite several requests, no particulars were provided by the assigned Family Services worker. The intake worker had developed a detailed and thoughtful assessment of the family and a recommendation that Phoenix stay in care until her safety could be assured by means of demonstrated, observable change in her parents. This worker was present at the court date when Ms. Kematch agreed to a consent order of three months and a suggested plan of a parenting capacity assessment and participation in a type of parenting education program.[6] The intake worker was clear that Mr. Sinclair had failed to respond to all efforts to involve him in the planning of what would be needed to bring Phoenix home. It was also clearly stated that ongoing planning would be the responsibility of the assigned Family Services worker.

Information was requested on April 21, 2006 from WCFS Branch; specifically, what were the terms of the order sought by the Agency. Did the Agency have expectations for Mr. Sinclair concerning change to his lifestyle or his addictions? The transcript of court proceedings was provided by the external counsel. The transcript provided ***no*** *information about any expectations of Mr. Sinclair despite the circumstances under which Phoenix came into care and three years' accumulation of concerns about the quality of* ***both*** *parents' care of their daughter.*

The worker was asked to speak to the court about the Branch's position.

> "...he's been having some difficulties parenting his daughter, who he has basically parented for the last three years.[7]
>
> At this time the baby's come into care. Her name is Phoenix. And is now placed with a, a place of safety with the friends of the family, the godparents. And Mr.

[6] As the case would be managed by a worker providing ongoing Family Services, the intake worker's role in future planning was very limited.

[7] This statement is contradicted by earlier statements of Ms. Edwards and Mr. Sinclair's sisters that they provided care to Phoenix for substantial periods of time.

> Sinclair is, is feeling that he needs some time to, to get his business in order and we're prepared to support him in that venture.
>
> So, in this, in this light we're we're asking – we , we think this will take about three, three months to accomplish."

The Agency's counsel asked the worker if it would be sufficient time "for the plan to develop" if the order ran from the date of Ms Kematch's consent on July 2, 2003. The worker's response was affirmative with the proviso that it could be reassessed at the end of the order.

Anishinaabe's counsel did not object to the amorphous plan once the issue of a culturally appropriate placement was confirmed when the worker stated that Ms. Edwards was of aboriginal background.

The court process was intended to protect Phoenix at that time and to ensure that she returned to an improved situation—the end of the order was only seven weeks from the date of Mr. Sinclair's appearance in court. The plan presented by WCFS regarding Mr. Sinclair consisted of "get[ting] his business in order". What did that mean? What did that require in measurable, observable change?

WCFS failed to state a coherent plan for Mr. Sinclair to follow until it was judged safe to return Phoenix to him. ***She came into care because her father was under the influence of alcohol and drugs and was unwilling to take steps to ensure that she had a safe situation.*** Anishinaabe Child and Family Services did not advocate for Phoenix's best interests beyond a culturally appropriate placement and the court did not hold either Agency accountable to a higher standard in Phoenix's best interests. The transcript was clear that the counsel for Anishinaabe had instructions concerning only the cultural component of her placement. Although the provincial child welfare standards were mentioned in court, it was with respect to the requirement for culturally appropriate placements for aboriginal children. Provincial standards also address the need for concrete planning with measurable objectives and goals that are realistic, in addition to the evaluation of efforts toward those goals, i.e. outcome measures. *How else would an Agency know when risk was sufficiently reduced to return a child home safely? An issue related to this is whether there is a means available to all workers in the Province that enables them to measure the initial risk accurately and another to recognize when the child is safe enough to return home and when it is safe enough to close the case. Case supervision should be an important factor in arriving at the final*

decision to return the child home or to close the case but the use of a more reliable and objective means of assessing safety is needed.

Place of Safety with Kimberly Ann Edwards and Rohan Wayne Stephenson

It was at this point that the involvement of Kimberly and Rohan (also referred to as Rhon on CFSIS) Stephenson was formalized by the Agency. After Phoenix's disappearance became an issue in the media during the spring of 2006, Kimberly Edwards (also known as Stephenson) was vocal about the lengthy periods of care she and her former husband, Rohan, provided for the child.

Kimberly Edwards and Rohan Stephenson applied in 2003 to be licensed as a Place of Safety (POS) for Phoenix Sinclair. In the application forwarded to Manitoba Family Services, it was noted that Kimberly was living at 1331 Selkirk Avenue while Rohan lived in McMunn, a hamlet an hour east of Winnipeg in the R.M. of Reynolds. The information in the POS file indicated that the couple were separated at the time of the application. The reason for separation was not noted nor does it appear that a reason was requested or questions asked about why they were making a joint application, other than to note that they were co-parenting.

It was not clear from the file why Mr. Stephenson's place of residence was not examined for its suitability as a POS if the couple were co-parenting. In addition, the personal reference referred only to the suitability of Kimberly Ann Edwards. Mr. Stephenson remains an enigma. The reason for the couple's separation was not explored—was it due to alcohol, drugs, violence, gambling or incompatibility?

*Provincial Standard 411 for Place of Safety in a family residence specifies:" Placement in a family residence is **not to exceed two weeks** unless the family applies to provide care as an approved foster home." (Emphasis in original)*

Given that the placement did exceed two weeks and that the caregivers were a separated couple proposing (somehow) to co-parent, it was incumbent on the Agency to ensure that Phoenix was in a satisfactory placement. It was also required that the foster parents apply to be licensed. None of this was done during her placement.

Ms Edwards was noted to have a child, [redacted] aged 14 years, living at home as did Mr. Stephenson, whose son, [redacted] aged 12 years, lived at home.[8] The person who provided a reference had known Ms Edwards for "6 or 7 years" and stated that "Phoenix is better off there. Phoenix has been taken care of by Ron (sic) and Kim for extended periods of time. Positive reference."

Phoenix was moved from a [redacted] foster home to Ms Edwards' Winnipeg home on July 31, 2003. She became a Temporary Ward by an order of consent on August 13, 2003. The order would end October 2, 2003, seven weeks after Mr. Sinclair appeared in court.

Ms Edwards had some previous involvement with the Agency—a Protection file was opened and closed in her name on June 30, 1990. A child named [redacted] was referenced. As Ms Edwards indicated in the POS application that she had never received service from any child welfare agency, this is somewhat puzzling.

At the closing of the file on October 7, 2003, the care provider listed is Kimberly Stephenson only. The POS worker noted that Ms Stephenson should be invited to apply as a general foster home provider. In the letter to Ms Stephenson (there is no corresponding letter to Mr. Stephenson) it is noted that Phoenix left the home at 1331 Selkirk Avenue on October 3, 2003. She was discharged to her father, Steven Sinclair.

No visits to the foster home were documented in the file material provided for review other than the initial physical inspection of the home. No conversations with Ms Edwards or Mr. Stephenson were documented during the time that Phoenix was in their home. In terms of contact between Phoenix and her parents, the closing summary of the Child in Care file notes that "Dad visited on a regular basis while Mom and other relatives visited on occasion." No observations of any changed behaviours on the part of Mr. Sinclair were noted to justify returning Phoenix at the end of the court order. The file read "TO expired and Dad ready and willing to parent his daughter."

No assessment of Mr. Sinclair's functioning or a pre-discharge visit to his home was recorded on the file information presented for review.

[8] Media reports have indicated that Ms Edwards has a daughter, [redacted] who also spent time with Phoenix.

The POS file was closed with the note "Given time constrains (sic), this worker was able to meet once with this care provider. Nevertheless, she should be invited to apply as a general foster home provider." As the POS worker was not charged with monitoring Phoenix's placement, this limited contact was regrettable; of greater concern was the fact that the Family Services worker did not record contacts with Phoenix and her foster parents.

Under "Unresolved Problems" in the Child in Care closing summary, it is noted that "Mr. Sinclair requested his child stay in care until he felt strong enough to care for her once again." It was not specified how this 'strength' would be measured.

This is not why Phoenix came into care—she was removed from her father's home due to an unsatisfactory and dangerous situation. Mr. Sinclair had declined to stop drinking and using drugs in order to safeguard his daughter and thereby allow the Agency to maintain her at home. This failure to put her needs first was not addressed in any programming nor was the statement by Mr. Sinclair's sister that he parented Phoenix only "3 or 4 days a month" ever investigated further. The file continued,"He has had his time out and will parent Phoenix starting October 2, 2003. **He has done no programming and as such is prone to returning to an unhealthy way of managing stresses in his life. He is aware of the need to arrange for appropriate alternative caregivers when he feels the need for a break or time out for respite.**" The family file "will remain open to monitor his progress and be available to encourage and support his efforts to parent his daughter." (Emphasis added.)

As the court had granted an order for Phoenix as a child in need of protection, it is disturbing that the Agency would see "time out" as appropriate for the issues identified in the Intake summary. The use of "time out" suggests a relatively innocuous incident that can be dealt with by separating a person temporarily from a situation. Mr. Sinclair manipulated the Agency by evading contact and being resistant to any programming. The Agency's plan for the future—to compel programming only if things became dangerous for Phoenix again—was unacceptable. The Intake summary had identified that not requiring compliance on the part of the parent constituted the Agency's own failure to follow through. (See pp. 25-26) The Agency failed to act to reduce the risk of future harm to Phoenix. Instead, the Agency's plan was to wait for a dangerous situation to develop in the future and then to take action by requesting a longer court order and by placing Phoenix with Ms Edwards and Mr. Stephenson once again.

Why would it take a second finding of Phoenix being in need of protection to compel the Agency to take effective action? What was the back-up plan if Mr. Sinclair continued to do what worked well for him; ignoring Agency requests and evading contact? Phoenix was three years old at this point and a future placement of six months to a year (as the worker anticipated for any future placement) would have caused her additional disruption and trauma. Whose needs were met by the Agency failing to press for change at this point in Phoenix's life? It is generally held that best practice in child welfare involves minimizing disruption and trauma for the child[9]—why allow this opportunity to pass without attempting to ensure that Phoenix would be secure in the future? The Agency had a service unit for Early Intervention. Surely Phoenix's situation warranted such intervention.

On November 13, 2003, six weeks after returning Phoenix to her father, the Agency closed Mr. Sinclair's file, despite knowing that he had not made changes that would safeguard his daughter's future. The file summary noted that 'both parents...visited her on a regular basis." This is misleading as Ms Kematch visited only occasionally. Mr. Sinclair did, according to the file, visit regularly but as there are no documented individual contacts with Mr. Sinclair or the foster parents during this time, it is difficult to know how the worker established that this occurred.

The file closing did not document contacts with Mr. Sinclair or Phoenix in the six weeks between her return and the composition of the Closing Summary yet the file notes "Mr. Sinclair's file will close today as there are no outstanding child protection concerns." The Agency's own file noted that Mr. Sinclair had not satisfied the Agency that there had been changes in his functioning. There were no observations of Phoenix to ensure that her physical care was adequate and her father's practice of delegating her care to various other people had not resumed immediately upon her return. **In essence, the statement that there were "no outstanding child protection concerns" was not based on an outcome evaluation of treatment or direct observation and assessment of parent and child but, seemingly, on Mr. Sinclair's aversion to Agency contact.**

The intake worker had noted earlier in 2003 that the Agency's terminations with Phoenix's parents had not been due to problems solved, but rather the parents' disregard for the Agency. The writer also would add that the terminations appear linked to the Agency's failure to incorporate the content of its own files and information provided by collaterals a coherent family assessment or statement of risk once the case progressed past the intake level.

The lack of subsequent community referrals concerning a child who is monitored (or recently returned) by an Agency does not guarantee that child is in an improved or even a safe situation. The lack of referral may mean only that the child is invisible to the community at large and/or not protected by other adults in her life.

The failure to actually see a child who is being monitored in order to ensure that the child is, at the very least, physically sound, or accepting the assurances of another that the "not seen" child is healthy and happy, can have tragic consequences. The deaths of Sophia Schmidt (1996) and John Eric Demery (2003)[10] illustrate in different ways why monitoring children is important in attempting to ensure their safety. Observation and assessment is the foundation of the child welfare system's ability to protect children. Relying on community referrals or even the reports of other professionals comes with a risk that what the child welfare worker would flag as requiring closer monitoring or assessment could be missed or misinterpreted by someone without those skills and training. It also assumes, erroneously, that vulnerable children are visible in the community.

Not surprisingly, Mr. Sinclair came to the attention of the Agency again on January 16, 2004 after a former roommate of Ms Kematch called on January 15, 2004 to report that [redacted] Samantha's mother, was taking care of Phoenix while Samantha went out drinking. [redacted] was alleged to smoke "rock" (crack cocaine) with Phoenix present.[11]

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[9] Harden, Brenda Jones. (2000) Out of home care placement In *Handbook for Child Protection Practice*. Dubowitz, H. and DePanfilis, D., Eds. Sage Publications: Thousand Oaks, CA.

[10] These are children who had received service from Winnipeg CFS Branch. Inquests were called concerning the circumstances of their deaths.

[11] Samantha Kematch acknowledged after [redacted]'s birth that [redacted] had 'hurt' her as a child.

The Intake worker ascertained that Phoenix remained on her father's Income assistance budget. The referral source was contacted and provided additional information indicating that Ms Kematch had been called by Mr. Sinclair's sister in mid-November 2003 advising that Mr. Sinclair had left Phoenix alone. Ms Kematch reportedly picked up her daughter and had her until "some people" picked up Phoenix around January 2, 2004 and took her to their home outside the city, possibly in Selkirk. The Intake worker read the closing summary and concluded that the child might be with the Edwards/Stephenson family on Selkirk Avenue in Winnipeg. Neither telephone number for the couple was in operation. The Intake worker noted that Mr. Sinclair's file would be reopened and called both the former Family Services and Place of Safety social workers to find additional contact information for Ms Edwards and Mr. Stephenson due to the recommendation that Phoenix return to them should she require placement again. The CRU worker concluded:

> "Given that there is a possibility of risk to young Phoenix and with the uncertainty of where the child actually is at this time, it is recommended this file be opened to Northwest Intake for investigation and assessment. Because this situation has been an on-going concern as it would appear from discussion with SOR, coupled with the history in both parents' file, a 5 day response time is indicated."[12]

On January 21, 2004, Northeast Intake workers visited the home of Kimberly Edwards and Rohan Stephenson. They found Phoenix there and learned that the couple had been taking care of Phoenix since early January. They were unable or unwilling to tell the workers exactly what was happening with Mr. Sinclair but were clear that they would take care of Phoenix without any financial compensation. Mr. Stephenson explained that he sometimes lived at the home but worked outside Winnipeg. Kimberly Edwards had "other children" and was living on social assistance. They had no telephone.

The workers next visited Mr. Sinclair's home and found it clean and furnished but with holes in the walls and the lighting fixtures pulled out. After consulting the supervisor and speaking with the former supervisor, it was decided to leave Phoenix with Kimberly Edwards and reopen the Family Services file to determine if placement with Ms Edwards should be the "long term plan."

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[12] Based on Phoenix's age (three years), the uncertainty around where she was and the histories of her parents, it can be argued that a maximum response time should have been 48 hours. The Intake Request for Service standard lists "child is missing" as a reason for a 48 hour response. The 24 hour response is recommended for occasions when "there may be immediate danger to the child." A missing three year old with Phoenix's history could well be in immediate danger.

Repeated efforts were made to contact Mr. Sinclair and he finally connected with the worker on February 5, 2004. Mr. Sinclair was "surprised" that Phoenix had been with Ms Edwards for a month. He denied having any contact with Ms Kematch and insisted he knew nothing about her situation. He was reluctant to provide information about why he had moved and agreed that Phoenix should stay with Kimberly Edwards "under a private arrangement." His income assistance worker was contacted and advised that Mr. Sinclair did not seem worried about obtaining his cheque but agreed to meet with her to discuss his situation. She did not know why Phoenix was not living with him.

This intake established that at the time the Family Service file closed on November 13, 2003 without contact with Mr. Sinclair, the statement that there were no child protection concerns was inaccurate. A home visit to Mr. Sinclair would have established that his daughter was not living with him in mid-November.

When Mr. Sinclair was asked why he had changed Phoenix's living arrangements he was "very vague". He was staying with [redacted].

The worker noted concerns about Mr. Sinclair leaving Phoenix with Ms Kematch so soon after he received her back from the Agency and with his unwillingness to provide information about what he had been doing in addition to the lack of information concerning his source of income. The worker noted that it was not possible to assess Mr. Sinclair's situation due to a lack of information but rated the risk to Phoenix as "high" if she were found in either her mother or her father's care. As the Edwards/Stephenson family had agreed to care for Phoenix and Mr. Sinclair did not oppose the arrangement, it was decided to close the file. **The risk to Phoenix was rated as "low" if she remained there but "high" if she were subsequently found in the care of <u>either</u> of her biological parents.** If, as described earlier, Ms Edwards was unwilling to state what the couple knew about why Phoenix had returned to live with them, the risk to Phoenix might be higher than "low".

At this point, the Agency was acquiescing to an arrangement for Phoenix that was tenuous at best. Mr. Sinclair had not satisfied the Agency about his whereabouts and the circumstances under which Phoenix reportedly had lived with him, Ms Kematch and Ms Edwards in the space of less than three months, from October 2003 to January 2004. (The Agency's conversation with Ms Kematch later in 2004 offered little illumination as to what she had been doing either.) In addition, the Agency now knew

that Mr. Stephenson and/or Ms Edwards felt no need to advise the Agency that Phoenix's living situation was unstable. As they did not have legal custody of Phoenix, she was vulnerable to being reclaimed by whichever parent was in the mood to resume caring for her again. This is, in fact, what happened—Ms Kematch reclaimed her daughter and, despite the Agency's misgivings about both parents, nothing further was done to ascertain that Phoenix was living in a stable, nurturing home environment. In fact, the Agency's risk statement quoted above was clear that she would not be considered safe if she lived with either of her biological parents.

What did the Agency do to address this situation?

The income assistance worker had emailed the Agency on February 5, 2004 asking about the plans for Phoenix. From the file, it is clear that the plan involved leaving Phoenix with Kim Edwards indefinitely but without any plans to ensure that at least one of her parents became an acceptable caregiver. What kind of future would Phoenix have under these conditions?

The next documented contact with Employment and Income Assistance occurred on May 11, 2004 when an income assistance worker called to report that Ms Kematch had brought in a letter claiming she had been caring for Phoenix since November 2003 and requesting financial assistance. She claimed that Mr. Sinclair had given the allowance he received for Phoenix to Kimberley and Rohan as they had been caring for the child. The income assistance worker was concerned about the risk to Phoenix in her mother's care. The intake worker confirmed the statement of risk and attempted to contact both Kimberly Edwards and Steven Sinclair but without success.

The worker called Ms Kematch and challenged her on the inaccurate information about where Phoenix had been, how long Ms Kematch had cared for her and Ms Kematch's assertion that Ms Edwards had cared for Phoenix for only a month. Ms Kematch ended the call after swearing at the worker. The CRU intake worker assigned a 48 hour response time for a safety assessment due to the history and the risk level.

As Ms Kematch was designed a "high risk" caregiver, a response time reflecting this would have been appropriate.

The supervisor recorded on May 13 that contact with the "godparents" established the following timeline:

November 2003	Ms Kematch takes over care of Phoenix from Mr. Sinclair
January 2004	Ms Kematch takes Phoenix to "godparents" in order to set up a home. She visits occasionally but Mr. Sinclair does not.
March 2004	Ms Kematch retrieves Phoenix from Kimberly Edwards.
April 2004	Ms Kematch starts a custody application through Legal Aid.
May 2004	Income Assistance ends Mr. Sinclair's benefits and requests an assessment of Ms Kematch before assigning benefits to her.

The Stephensons had been sent a letter by the Agency in February 2004 about the placement of Phoenix in their home. Unfortunately, the letter was neither protective nor assertive and did not require that the Agency be contacted immediately if Ms Kematch or Mr. Sinclair appeared and claimed Phoenix. (See Appendix A).

The Abuse Intake Services investigation report completed by WCFS in April 2006 notes,

> "WCFS assessed that Phoenix would be at high risk of coming into care if she returned to the care of Steven or Samantha. Phoenix remained in a private arrangement with the Stephensons who agreed to contact the Agency should the parents attempt to remove her. The letter was written on February 13, 2004 by Intake to Rohan and Kim Stephenson acknowledging that they have Phoenix in their care under a private arrangement with Steven and that they are not to return Phoenix without contacting Winnipeg Child and Family Services. The letter stated that a risk assessment would need to be done on the parents as "I (worker) have told Steven that the agency has serious concerns about his current lifestyle, as well as Samantha's." p.10

The writer notes that the child welfare system will not protect children like Phoenix if workers believe that placing a child in protective care is a greater risk than removing them from a potentially dangerous situation. A child may be at risk of harm or maltreatment with a high probability of coming into care in that situation. Risk, in this situation, involved the chance or statistical probability that something dangerous or harmful would occur. The protection of children should be held as a higher good than the refusal to disrupt their living arrangements, however dysfunctional.

Elizabeth Bartholet, a professor at Harvard Law School, writes in *Nobody's Children: Abuse and neglect, foster drift and the adoption alternative* (1999) that the mindset of family preservation is expressed in descriptions of families as "being at risk of losing their children to institutional care. The very definition is revealing: *the risk that is the*

focus is the risk of the family being broken up, not the risk of the child being harmed." (Emphasis in original) p. 114

Unfortunately, the abuse investigation summary does not correctly characterize the letter sent to the Stephensons. The "risk assessment" referred to in the letter clearly refers only to Steven reclaiming Phoenix, yet letter accurately refers to "serious concerns" about Samantha's lifestyle. The letter does not compel the Stephensons to contact the Agency before changing Phoenix's living arrangements. The worker writes only that the Agency "hopes" that they will continue to care for Phoenix and will contact the Agency "should this situation change." There is a great deal of difference between "hoping" that a person will do something and requiring that they do it. Further, the stated plan of sanctioning a private arrangement between a neglectful parent with a history of abandonment of Phoenix, i.e. Steven, and friends who place Steven's interests above those of Phoenix is inherently flawed and ultimately proved dangerous to Phoenix. ***The Agency's letter is neither clear nor forceful about the need to protect Phoenix from removal by her mother.***

It must be noted that subsequent contact with Ms Edwards established that Ms Kematch reclaimed Phoenix from Mr. Stephenson who did not notify the Agency. Despite her statements to the media after Phoenix was found to be missing and presumed dead, Ms Edwards did not contact the Agency to warn that Phoenix had been removed by Ms. Kematch.

By failing to obtain an order from the court, even one of supervision, the Agency failed to ensure that it had the means to enforce its "hopes" for Phoenix. A child's future, particularly one with Phoenix's history of fragmented care relationships, should not rest on the hopes of an Agency.

On May 17, 2004, a message was left with [redacted] asking that Samantha Kematch contact the assigned caseworker.

Phoenix Returns to Her Mother's Care

An earlier social history from Cree Nation Child and Family Caring Agency revealed Ms Kematch's turbulent history as a child. Her parents were violent, chronic alcoholics. After her father's death in a drunken fall down stairs in 1989, Samantha's mother took

over the care of the children she had abandoned earlier. Samantha was physically and emotionally abused when she was with her mother.[13] Efforts by family members to provide care for her had been unsuccessful as they were afraid of her physical aggression—she had also terrorized 'intervenors' who stayed with her in hotel placements. [redacted] cared for Samantha and her brother, Mickey, beginning in June 1993 until Samantha left in May 1997. Another brother, [redacted], had remained with [redacted] but took his life in 1993 while intoxicated as a consequence of living with his mother, [redacted] reported.[14]

The social history described Ms Kematch as sullen, angry and unresponsive. "There were incidents in the foster home when she struck one of the children." After Ms Kematch gave birth in 1998 to [redacted], her first child, Cree Nation CFCA noted that she was not cooperative with plans to assist her in parenting [redacted]

Most of these issues with Ms Kematch remained outstanding in 2004 when she reclaimed Phoenix from Kimberly Edwards and Rohan Stephenson. There was no assessment on file indicating that her issues of anger management, resistance to intervention, opposition to authority or lack of attachment to her children had been addressed in any way that presented a measurable improvement. These concerns also had been identified earlier by WCFS staff.

Ms Kematch's brief involvement with a Family Support Worker in 2000 reportedly resulted in the home being kept clean and both parents appearing attentive to Phoenix after she was returned to them. None of the FSW's own notes were found in the material provided. A few comments attributed to the FSW appear in the file but none of these addressed the issue of Ms Kematch's attachment to her child. She remained uncommunicative and sullen when the social worker met with her, making it clear that she greatly resented having the worker in the couple's apartment. Less than a year later, [redacted] told the worker on July 16, 2001, that Ms Kematch had treated the children badly and had "said things about them". No elaboration of this was recorded nor was the matter discussed with either parent.

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[13] When [redacted], Ms Kematch's first child, was removed at birth, she told workers that it was because workers were afraid that she would hurt him as her mother hurt her.

[14] [redacted], aged 17 years, committed suicide by jumping from a height on May 21, 1993. He was intoxicated and was reported to be depressed also. CME file No. 1279/93.

Agency workers acted promptly on the information that Phoenix was living with her mother, Samantha Kematch. A home visit was made on May 13, 2004, and the door was answered by a male who identified himself as "Wes". He told the workers that Samantha and Phoenix were with [redacted]. The workers next went to [redacted]'s home and were told that Samantha and Phoenix were "visiting friends". The worker left a business card with a request that Ms Kematch call the Agency. The Agency learned on this date that Phoenix had been added to Ms Kematch's family budget.

The worker sent a letter to Ms Kematch on May 17, 2004 requesting that they meet. An unsuccessful home visit was made on June 2, 2004 and another letter was sent on June 15, 2004. Ms Kematch contacted the Agency on June 21 and an arrangement was made to meet on June 29. When the worker went out as arranged, the apartment block was not accessible to a visitor. On July 9, the worker obtained a new address for Ms Kematch. The worker received a telephone call from Ms Kematch on July 13 and arranged to visit her home within 10 minutes. *With the assistance of her family and through her own efforts, Ms Kematch had avoided Agency scrutiny for two months after the income assistance worker's call to the Agency.*

The worker noted the condition of the home as satisfactory. Phoenix was present "and she appeared, clean, healthy and well cared for." Samantha also looked to be in good health. She advised that Phoenix had come into her care in November 2003 (when the worker closed the file noting that Phoenix was in her father's care) and had gone to stay with the Stephensons for "a month" while she was "travelling". The worker queried her about this disruption in care but Ms Kematch did not feel that there were any resulting problems in her relationship with Phoenix. (It must be noted that Ms Kematch's previous parenting of Phoenix was interrupted and short term, at best.) Ms Kematch advised that her main support was her "boyfriend" who was a "trucker" and lived with her when he was in Winnipeg. When asked if she needed any assistance from the Agency, Ms Kematch—not surprisingly—denied that she needed anything but did accept an offer of information on parent and child focused programming in her area of the city. She told the worker that she would be registering Phoenix for nursery school in the fall.

The worker's assessment was that mother and daughter appeared healthy, suggesting that Ms Kematch was not abusing drugs. Ms Kematch denied having any difficulty coping with Phoenix. The worker noted, "Given there are no apparent child protection concerns, this file can be closed."

Once again, Ms. Kematch's avoidance of the Agency worked in her favour—the Agency was satisfied with the most superficial of contacts and the history of concerns faded into the background again.

Richard Gelles, a well-known academic, writer and researcher of family violence, in writing about the circumstances leading to the death of a child left in a dysfunctional home despite earlier indications of concern, noted that workers often make an "olfactory risk assessment" judging clean homes as low risk and dirty homes as high risk.[15] He goes on to state that "the best possible predictor of future behaviour [is] past behaviour."[16] *The best indicator of risk is how parents have treated their child in the past.* Based on this, the expressed concerns of several workers about Samantha's abandonment of [redacted], her ambivalence toward Phoenix at birth and subsequent abandonments (multiple) of the child should have resulted in a much more vigilant stance toward her resumption of care in 2004. Using the same standard, Mr. Sinclair's care of Phoenix on her return in October 2003 also required vigilant monitoring.

Another factor for consideration in a risk assessment, Gelles asserts, is whether the child protection service has made any "meaningful or effective intervention" after the first identification of concerns. In the case of Phoenix, the involvement of the Family Support Worker was intended to 'fix' their parenting. The history of both parents, the limited family support outcome information in the file, the parents' ongoing avoidance of contact, their resistance to treatment or intervention coupled with denial of any concerns, their sporadic interest in parenting Phoenix and the Agency's own statements of the difficulty involved in maintaining contact with them and obtaining current, in-depth information about their circumstances, all point to the inability to assert with confidence that there were "no child protection concerns." When Mr. McKay's contact with the child welfare system is reviewed, his own resistance to intervention due to the denial of any issues, coupled with a history of domestic violence and reports of abuse of his own children, elevate the level of risk. Gelles is clear that valid, comprehensive risk assessment coupled with the ability to provide intervention appropriately matched to where individuals are in the stages of change needed to eliminate dangerous behaviours offers the only hope for reducing fatal child abuse. Resistance to

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[15] Gelles, R. (1996). *A Book of David: How preserving families can cost children's lives.* Harper Collins Publishers: New York. p. 73
[16] Ibid. p. 74

intervention (denial of concerns) may be inaccurately categorized by the child welfare system as anger, rather than as a significant risk factor in itself.[17]

Issues of attachment and parenting capacity usually require more than one visit to assess—they require observation and in-depth interviewing. Ms Kematch's history as a parent—up to July 13, 2004—had not been distinguished by consistency of care or sustained periods of care. The information about Ms Kematch's functioning as an adult was limited and her presentation made it difficult to acquire more—as an earlier assessment had indicated. This was a problem that the Agency needed to solve **before** deciding that there were no child protection concerns. When the timeline of Ms Kematch's care of Phoenix is constructed, the gaps suggest a lack of attachment to Phoenix.

April 23, 2000	Phoenix was born and apprehended
September 5, 2000	Phoenix was returned to her parents with a support agreement
April 29, 2001	[redacted] Sinclair was born after "minimal [Agency] contact" with her parents (the pregnancy was concealed from the Agency)
July 2 & 3, 2001	Agency learned from Mr. Sinclair that Ms Kematch left the girls with him approximately two months earlier.
July 15, 2001	[redacted] died in her father's care from natural causes. Phoenix remained with her father.
February 23, 2003	Phoenix was seen at hospital with a "godfather" for treatment due to medical neglect by her father; object in nose.
June 22, 2003	Phoenix was apprehended from her father.
October 2, 2003	Phoenix was returned to her father; mother had occasional visits while Phoenix was in care; father visited regularly.
November 13, 2003	Father's file closed without a recorded visit to Phoenix at home.
November 2003	Mother said that she took Phoenix from father who left her alone.
January 2004	Kim Edwards reported that she took over care of Phoenix.
March 2004	Mother resumed care of Phoenix
May 2004	Mother applied for custody of Phoenix and for social allowance to be transferred to her from father. Karl Wesley McKay is with Ms Kematch as her partner.
July 13, 2004	Phoenix was seen by a worker during a home visit. File was closed as mother and child appeared physically well.

[17] Ibid. pp 86-89

In addition to a sparse history as Phoenix's caregiver, Ms Kematch had just acknowledged that a new man was playing the part of a parent to Phoenix. Given the disruption in the child's experiences of parenting, more information about Mr. McKay was needed.

From this timeline—based on the file notes—it is evident that by July 13, 2004, Ms Kematch had Phoenix in her joint or exclusive care for approximately 16 months of a possible 51 months of the child's life. The question of her attachment to Phoenix must be raised—as it was by earlier workers who were cognizant of her history as a teenager, her earlier attempt to parent [redacted] and her ambivalence toward Phoenix. These workers recommended that the parents' attachment to Phoenix be assessed as part of the case management process. Mr. Sinclair's abandonment of Phoenix in favour of drugs and alcohol in 2003 provided a graphic illustration of what interfered with his care of her. Ms Kematch's attachment to her daughter was more difficult to gauge as the Agency had little contact with her when she was parenting on her own and was accessible to the Agency for monitoring. This lack of information demanded that the Agency obtain more information about the mother-daughter relationship before pronouncing the relationship safe for Phoenix. The presence of an unknown man in the family home was not seen as worthy of further investigation. Any addition of a person to a family constellation requires a new assessment of how relationships impact on the care of children.[16] By July 2004, Phoenix had experienced substantial disruption and movement between alternate caregivers during her life. Some of these caregivers—such as the Edwards-Stephenson family—appear to have provided Phoenix with good physical care. The quality of emotional care she was receiving cannot be determined from the information available.

The question that remains unanswered is "What meaning did Phoenix Sinclair have for Samantha Kematch?" Her reaction at the time of [redacted]'s death suggests that Ms Kematch may have regarded Phoenix as property—she demanded that Phoenix be brought to her immediately. When Ms Kematch began a relationship with Mr. McKay, did she become an unwanted reminder of a previous relationship? Was there a lack of attachment between mother and daughter related to Ms Kematch's ambivalence at the time of Phoenix's birth and her absence in most of Phoenix's first four months of life?

[16] The death of [redacted] provides an example of what happens when an Agency fails to identify new males in the family, particularly those residing with the custodial parent and having access to the children.

Did this absence make it easier for Ms Kematch either to abuse Phoenix herself or to acquiesce to abuse perpetrated by others? Without the assessments recommended early in the Agency's involvement with Phoenix Sinclair and her family, the role that attachment and parenting capacity played can only be inferred from the history.[19]

The question of what meaning Phoenix had for Karl Wesley McKay, her 'stepfather', must also be considered in light of the Agency's failure to locate information about his history until after Phoenix's death. Reder and Duncan (1999)[20] write:

> "Clearly it is equally relevant to understand the meaning for men of caring for children in the light of their own background and personal relationships and for non-biological fathers of caring for a child from the mother's previous liaison. For example, cohabiters or stepfathers may be jealous of the mother's previous intimacy with another man and may experience the child as a constant reminder of this." (p. 74)

On December 1, 2004, the CRU passed along a referral from a local hospital to the Agency's Intake unit as Ms Kematch had delivered her fourth child, a daughter who had been named [redacted]. The hospital advised that Ms Kematch was living with Wes McKay who was the father of her child. Mr. McKay's date of birth was not known to the hospital. The CRU supervisor agreed that the Intake unit should be requested to follow up and assess the home environment within 48 hours. The file summary noted that Samantha had been in care but did not include information on her functioning in care.

The CRU worker received the file back from the supervisor with direction to follow up and complete the needed assessment including offering supports. If mandated services were not required, the file was to be closed to the CRU. Attempts were made on December 2 and 3 to contact Ms Kematch but were unsuccessful. The supervisor directed that the Public Health Nurse (PHN) should be contacted and, if there were no concerns identified by the PHN, the Agency file would be closed.

The assigned PHN was identified and contacted about the family. The PHN had been to the home but wanted to know why the Agency was contacting Public Health for information and whether Ms Kematch was aware that Public Health had been called.

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[19] The brief assessment of Ms Kematch on September 13, 2000 had no information on her functioning as a parent.

[20] Reder, P. and Duncan, S. (1999) *Lost Innocents: A follow-up study of fatal child abuse.* Routledge: London.

Despite the worker's efforts to explain that the CFS Act took precedence in this situation, the PHN refused to provide information or to agree to call if there were concerns. The worker referred the matter to her supervisor with a recommendation that the PHN's supervisor be called about the misunderstanding about the Personal Health Information Act. The outcome of this was not recorded on CFSIS. An email message was sent to the former CFS supervisor on April 25, 2006 with a request for information and an interview with the staff involved was conducted by the writer.

The concerns about Ms Kematch's ability to parent over time had not been addressed nor had past issues including her inability to care for [redacted] *and her ultimate abandonment of him. Her new partner was not known (beyond greeting workers at the door in May 2004) and the Agency, despite Ms Kematch's previous known partners having issues with criminal activity* [redacted] *and substance abuse (Mr. Sinclair) did not inquire further to determine if "Wes" was a safe choice. As "Wes" was nearly 20 years older than Ms Kematch, it would have been reasonable to assume that he had life experiences—possibly with other partners and other children—that would have provided the Branch with reassurance or raised concern after he joined Phoenix's family. It is not evident from this recording that the presence of "Wes" in Ms Kematch's home on May 13, 2004 was linked with her statements about a trucker boyfriend who lived with her sporadically—the file does not indicate that "Wes" was questioned about his identity.*

So little was known about Ms Kematch's functioning that it is concerning that her outward apparent physical well-being was used as a measurement of her cognitive abilities and functioning as well as her parenting capacity. As neither Ms Kematch nor Mr. Sinclair had parented Phoenix consistently—this was known to the Agency—it was incumbent on the Agency to understand how the disruptions in parenting had affected Phoenix. Was she socially indiscriminate? Was she developmentally on target? Who did she identify as her main caregivers? Did she have a relationship with Ms Kematch or was Samantha just another in a procession of female caregivers that included Genevieve Sinclair, Angie Sinclair, Shella Sinclair and Kim Edwards?

On Saturday, March 5, 2005, the Agency received a telephone call from an Agency foster parent who advised that a "former foster child" had passed on information about Samantha Kematch's daughter, Phoenix. The person suspected that Ms Kematch was abusing Phoenix and also that she was locking the child in a bedroom. The foster mother refused to provide the worker with the name of the person expressing these

concerns. When the foster mother was unable to provide an address but did provide a location, "apartment one beside the Maryland Hotel", the worker "explained that without an address we will be unable to follow up." The referral was passed from the After Hours Unit to the Crisis Response Unit "for consideration".

The assigned worker contacted Employment and Income Assistance (EIA) and learned that there was no listing for the family. The school division was contacted and advised that Phoenix last registered for school in September 2004. The school division referred to her status as "inactive". The last known address was provided to the worker who went to that address and could not enter the building. After another call to EIA, the worker learned that Ms Kematch had an active file. Another visit was made to the home less than three hours after the first visit but it was also unsuccessful. The worker recommended that the Intake Unit open the file for further service. Instead, the file returned to a worker in the Crisis Response Unit on Monday, March 7, 2005. The worker went out to the home again on Wednesday, March 9 and gained entry to the building when another tenant was entering.

The worker described Ms Kematch as having "a somewhat shy demeanour". She refused to let workers enter, stating that she had a visitor. The television was on and the worker did not believe that any adult other than Ms Kematch was in the home. The reason for the visit was explained; Ms Kematch acknowledged that she had "yelled at Phoenix a few days ago". She was also advised of the report that Phoenix was being locked in her bedroom. Ms Kematch stated that she and Phoenix shared a bedroom and confirmed there was a lock on the door. She was warned not to lock Phoenix in the room due to the danger of fire. "Samantha agreed."

There is no indication in the file that Ms Kematch was asked directly if she had ever locked Phoenix in the bedroom.

The worker noted that Ms Kematch brought [redacted] out into the hallway as the child was "upset". The child was "content, healthy, clean, and well-dressed." Ms Kematch advised, in response to a question, that Phoenix was not in daycare and would not attend school until next September. Ms Kematch was asked if she needed support—and as she had every time this question had been asked in the past, Ms Kematch denied needing service from the Agency.

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

Although the Agency had sent workers out to investigate a complaint of maltreatment of Phoenix, the child was not seen nor was her location requested. [redacted]'s condition was accepted as a proxy for Phoenix's condition.

The problems with this approach are obvious; if one child in the family is used as a proxy for the health, condition and developmental progress of other children in the family, a sick child can be missed and an abused or neglected child overlooked. This phenomenon and other scenarios are described in Reder, Duncan and Gray's study of child maltreatment fatalities, *Beyond Blame*. In the chapter titled "The Family-Professional Systems", Reder et al. describe the dual roles carried by social workers in child welfare work; the controlling role of a police officer and the role of community helper/caring professional. They cite cases in which workers are drawn into relationships or interactions with families in which the focus is on the parents, rather than the children, leaving the children without the monitoring and protection that the system is mandated to provide.[21] In other cases, the family tightens the boundary around itself to reduce contact with the external world. Reder et al. refer to this as "closure" and define it as an issue of control over who is admitted into the family circle. Not surprisingly, child welfare workers are not among the few (if any) admitted by families evoking closure as a means of discouraging or redirecting child welfare workers. They state,

> "Only in retrospect was it possible to know that the closure was terminal. It manifested itself in the same way as other episodes and **we believe that all closure should be considered as indicative of increased risk of fatal abuse.** The length of time of such closure varied across the cases, ranging from a few days or weeks to ten months." p. 101 (Emphasis added.)

When parents are persistently difficult to locate, refuse to provide information when asked, do not answer the door or put off the social worker who is visiting to view a child, the danger of a negative outcome is increased. A further concern in the case of Phoenix Sinclair is the way in which the "system" re-interpreted the family's lack of visibility to reduce the level of risk. This is done by stating in the file that a lack of contact by the

[21] Reder, P, Duncan, Sylvia and Gray, Moira. (1993). *Beyond blame: child abuse tragedies revisited.* Brunner-Routledge: Essex, UK. Chapter 9, p. 95-102

family or by community members expressing concern about what they have seen indicates that all is well; that there are "no child protection concerns." In fact, the lack of contact may signal that the family's functioning is deteriorating or that there is an increase in violence and control within the family. This is further exacerbated when the Agency does not press for information on a child's location and seek out the child.

In fairness to the Agency, it must be stated that there were other occasions when workers did press for more information. When told by Karl Wesley McKay in May 2004 that Ms Kematch and Phoenix were at her mother's home, the worker attempted to locate Ms Kematch there. [redacted] deflected the worker by stating that Ms Kematch was "visiting friends" but simulated compliance by promising to pass on a message asking her daughter to contact the Agency. In her contacts with the Agency in the spring and early summer of 2004, Ms Kematch employed 'disguised compliance' to neutralize the worker's authority and protective stance[22]. By refusing service but accepting program information, Ms Kematch deflected the Agency sufficiently that she was able to avoid contact or monitoring. In 2005, Ms Kematch's semi-open stance (speaking with the workers at her door but denying them entry to the suite) was a further example of disguised compliance. For families with a history of child welfare involvement, this is an effective way to hold the system at bay until there is a crisis.

Following the last Agency contact, in March 2005, the Kematch-McKay household adopted another strategy used by abusive or neglectful parents; that of flight.

> "Flight was a variant of closure in which families closed their boundaries and retreated from contact with the external world by moving elsewhere. The families repeatedly withdrew to other temporary homes where they were not known or else said that they intended to do so. They usually moved "anonymously", leaving no forwarding address and not registering with helping agents in the new area. The effect was the same as closure, since they created an emotional and physical distance between themselves and professionals, seemingly as a way to control the relationship. Indeed, some cases involved episodes of both flight and closure." p. 102

Periods of Phoenix's life typified the pattern of closure and/or flight. Mr. Sinclair avoided scrutiny at times by placing Phoenix with the Edwards/Stephenson family or his sister, Genevieve, thereby distracting the Agency from focusing on his activities. The file revealed that Mr. Sinclair resided, for a period of time, with [redacted]. The

[22] Ibid. p. 106

coincidence of Mr. Sinclair living with a [redacted] while his daughter lived with a Ms Edwards warranted a closer look at the relationship between Rohan Stephenson, Steven Sinclair and Kimberly Edwards.

Reder et al. describe another contributing factor in the family-professional system as "fragmentation"[23] in which the family grants selected information to some agencies while withholding information from others. This was typical of Ms Kematch and Mr. Sinclair's reaction to attempts to ensure Phoenix's safety as a very young infant. They were uncommunicative and Mr. Sinclair denied the worker's request to review his ward file. This left the Agency with a strongly worded warning on its file but with little historical information and limited opportunities to determine the source. The movement of Phoenix between caregivers is also a variant of fragmentation as the child's history was held by multiple care providers. (The issue of what these moves did to her ability or opportunity to attach to a primary caregiver was not explored in the notes reviewed.)

In some circumstances an Agency contributes to the problems of fragmentation by failing to make inquiries about new people in the family's inner circle. In the case of Samantha Kematch and her new partner, Karl Wesley McKay, the Agency's reluctance to press for confirmation of Mr. McKay's identity was a 'tipping point' in the case. The Agency was remarkably incurious about Ms Kematch's new live-in partner. Reder and Duncan (1999) state:

> Professionals in the child protection network also need to give equal consideration to the child's father or father substitute, including being aware of his personal history, functioning and caretaking role, as well as the nature of the couple relationship.[24]

The combination of Ms Kematch's troubled past and her generalized lack of cooperation with the Agency should have resulted in Mr. McKay being regarded with some curiosity. Further, asking for identification would have provided Mr. McKay's correct name and date of birth—as a trucker he would have had a driver's license—and allowed the Agency to obtain a criminal risk assessment. The writer requested one as part of the review process and was provided with a list that, as of May 2004 would have shown convictions dating from 1991 for assault and failure to comply with orders of the court in addition to a series of stays of proceedings. Some searching of child welfare records in

[23] Ibid, p. 104.

Manitoba would have established his history of abusive relationships. The writer believed that this would have encouraged the Agency to be more assertive in its monitoring of Phoenix Sinclair's condition or to track her after the family left Winnipeg.

In concluding their chapter on family-professional systems, Reder et al. describe the "not exist double bind" process.[25] In this process, the parents refuse access to the child the workers have come to visit but the workers leave the home satisfied that all is well and that the child is either safe elsewhere in the house or staying with friends or relatives. In the case of Phoenix, this was exemplified in the "no child protection concerns" comments at the file closings. Reder et al. believe that workers' mistaken satisfaction about the child's safety is the result of being caught up in a double binding interaction with the parents.[26]

The "not exist" part of the process involves workers accepting assurances that the child in question is well but without seeing the child themselves in order to know that this is true. An example given by Reder et al. is that of Malcolm Page, a child whose death while unseen by the systems intended to safeguard his wellbeing is similar to that of Jeffrey Baldwin in Toronto and, to a less dramatic extent, that of John Erik Demery in Manitoba.

> "During the final weeks of Malcolm Page's life, the social worker made a number of home visits and found the downstairs of the house warm and clean. However, she did not see Malcolm upstairs, who was starving in a cold and filthy room, as though he had ceased to exist." p. 108

It is not possible at the time of writing to know what the Agency would have found if Phoenix had been seen in March 2005. Would the Agency have met a happy child, well-nourished and showing signs of living in a home where she was loved and wanted? Would the abuse she is alleged to have suffered once her family left Winnipeg have been evident at that time, allowing the Agency to intervene to protect her? By not insisting on seeing a child alleged to have been abused and to have been locked in a bedroom, in effect a "child in need of protection", the Agency was caught in the "not exist double bind". Being reassured that Phoenix was visiting elsewhere (2004) or being distracted by the presence of another child who appeared well tended (2005) provided

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[24] Reder, P. and Duncan, S. (1999) *Lost innocents: A follow-up study of fatal child abuse.* London: Routledge. P. 60.
[25] Ibid. p. 107
[26] Ibid. p. 107

confirmation to workers that even if they had not seen Phoenix, she continued to exist and was well. It was not recorded in the file if the workers asked where Phoenix was at the time of the 2005 visit.

In cases of this type, Reder et al believe, the relationships dominated by issues of care and control within the family were repeated in interactions with the Agency workers. This can be seen in the relationships between the Agency, Ms Kematch and Mr. Sinclair. The couple evaded Agency monitoring except where it was impossible to achieve their goals without some contact. In 2003, Mr. Sinclair did not participate in any programming for substance abuse yet received Phoenix back in his care with the worker's note that he had needed a "time out"[27]. Ms Kematch avoided serious scrutiny by the Agency in 2004 and again in 2005 while offering minimal compliance and drawing the Agency into a double bind by appearing compliant and distracting the Agency from past issues and present referrals—as in March 2005.

2. Events Leading to the Death of Phoenix Sinclair

Sometime after March 2005 Phoenix Sinclair is believed to have moved, with Mr. McKay, Ms Kematch and [redacted] to Fisher River First Nation, Mr. McKay's home. In December 2005, Ms Kematch gave birth to another child, [redacted]. The circumstances surrounding his birth did not result in any recorded referral to a child welfare agency.

During the summer of 2005, two of Mr. McKay's children had stayed in the Kematch-McKay household in Fisher River. These youths were from Winnipeg and were in the home when a Probation Officer called on another matter and the youths told this person that they wanted to return to Winnipeg. The Probation Officer notified the local Intertribal Child and Family Services office and arrangements were made to transport the youths back to their mother in Winnipeg. They had not been, as far as was known, in need of protection. Instead, they said they were unhappy about being in the care of their non-custodial parent and wanted to return home to their mother. Intertribal enlisted Peguis

[27] The Agency's legal counsel arranged for transcripts of the proceedings in order to address the writer's inquiry about the plan consented to in court. The mother consented to parenting assessment and/or programming. The Agency placed no conditions on the father.

First Nation CFS to facilitate the transport of the children as their mother is a member of that First Nation.[28]

In March of 2006, the Agency became involved with the family of Phoenix Sinclair in an attempt by police to locate Phoenix. When Ms Kematch appeared with another younger child whom she attempted to pass off as Phoenix, the police acted and the child in Ms Kematch's care [redacted] was apprehended. [redacted] who was in Mr. McKay's care, was apprehended several hours later when Mr. McKay was taken into custody by police.

3. Events After the Death of Phoenix Sinclair

Since March of 2006, there has been extensive media coverage and speculation about what happened to Phoenix Sinclair in Fisher River. Her mother and Mr. McKay have been charged with first degree homicide. [redacted] and [redacted] are in the care of West Region Child and Family Services. What is generally accepted as true is that Phoenix moved to Fisher River with the family and is believed to have died there as a consequence of foul play. A search is underway for her remains.

The Minister of Family Services and Housing announced three service reviews on March 20, 2006. These included a review of the death of Phoenix Sinclair by an out-of-province consultant and an internal review under Section Four of the *Child and Family Services Act*. An external review was also planned. The internal and external reviews, are jointly under the direction of the Children's Advocate, the Ombudsman and others. Other related reviews have also been described; in a newsletter of CFS of Western Manitoba (2006), an article referred to *five* reviews resulting from Phoenix's death.

The Special Investigator learned that the RCMP investigation included an interview with a person who stated that this individual had telephoned Intertribal Child and Family Services' Fisher River First Nation office to report concerns about the care of Phoenix Sinclair at a time when Phoenix was believed to be alive. The call reportedly was made at the end of the week and the Agency employee taking the call reportedly indicated that it was unlikely that any action would be taken at that time due to vacation staffing levels and the time of the call. The caller reported being contacted later by Mr. McKay

[28] The sources of this information are reports from Intertribal Child and Family Services to the Southern Authority and that Authority's communication with the Child Protection Branch of Manitoba Family Services and Housing.

and warned that nothing would come of the report due to his relationship to staff employed by that Agency. The RCMP advised that other members of the community have made similar claims of calling to report concerns about the child.

Based on this information, a letter was sent to the main office of Intertribal Child and Family Services on May 23, 2006 requesting information on any contact between this family and the Agency's office in Fisher River. The Agency and the Southern Authority have advised the Branch that there is no record of the call in the Agency's telephone logs or file material. The Agency's involvement with the Karl McKay household was limited to the July 2005 contact during which Karl McKay's two teenaged sons were removed from the home and returned to their mother after stating that they did not want to stay with their father.

On August 1, 2006, the writer sent an inquiry to the RCMP concerning the witness statement about a call in June 2005 requesting Agency intervention to protect Phoenix. A reply was received on August 15, 2006 from a member of the RCMP that supports the assertion by Intertribal CFS that there was no call about Phoenix from the individual in question in June 2005.

On August 2, 2006, the OCME received a copy of case notes written on May 5, 2006 by a worker with Animikii Ozoson Child and Family Services in which a Protection services client disclosed to a worker that she had expressed concern about Phoenix's situation to her former worker. The client alleged that her former worker had not responded to her concerns. The client stated that she knew of one occasion on which "CFS" had attended the Kematch home and had no concerns as "...Samantha was very good at presenting well and keeping a clean house,..." She referred to an incident involving a friend who had visited Samantha Kematch's home and later spoke of hearing Phoenix in the home. The friend discounted her own remarks, stating that she had been drinking at that time and did not trust her memory. The client's husband, with whom she was involved in a custody dispute, had previously disclosed to an Animikii Ozoson worker on Thursday, April 13, 2006 that he had witnessed mistreatment of Phoenix. Recordings of this interview were included and revealed that the client's husband and his mother had made allegations that the family's former worker had not responded appropriately to their expressions of concern about Phoenix. The client was definite that her husband had never been to the Kematch home and had no first hand knowledge of any abuse. The client's husband has a history of violence toward his own children.

No recordings by the former worker were included with these recordings which were provided by the Child Protection Branch at the writer's request. The matter had been referred to the Chief Executive Officer of the Southern Authority by the Agency's Executive Director with assurances that the file was being reviewed for any other information concerning Phoenix Sinclair. The RCMP had interviewed the former worker's supervisor in March 2006 to obtain information about how to contact the former worker and to obtain information about the allegations that the client family had attempted to alert the former Animikii worker to their concerns for Phoenix's safety. The Executive Director wrote that the supervisor indicated that the client family was frequently untruthful and that the former worker would not have known if their reports were true. Consequently, "she didn't follow up." The Executive Director undertook to review the files in question personally and contact the Authority if further information was found.

An Inquiry to the Child Protection Branch (September 18 and 19, 2006) revealed that no further information was provided to the Southern Authority or to the Child Protection Branch. Given the elapsed time, this would indicate that Animikii Ozoson found no further information related to the allegations.

CONCLUSIONS AND RECOMMENDATIONS

The service provided to Phoenix Sinclair and her parents can be characterized as uneven in its quality. The file contained skilled and perceptive assessments of the difficulties she faced and the notable shortcomings in the parenting she received. The plans associated with these assessments demonstrated an understanding of what is needed to protect and nurture children. The file assessments indicated that the histories of both parents were concerning and both parents' attachment (or lack of it) to Phoenix was understood to be a source of danger.

Alternately, the files contained examples of casework that did not demonstrate an application of sound child welfare practice or knowledge and only minimal compliance with program standards. During these contacts, stable, nurturing parenting for Phoenix was not a priority and "no child protection concerns" was used to justify premature termination of service. This uneven quality of practice includes an August 2003 case plan articulated in court by a worker that should have resulted in protest from an Agency supervisor, its lawyer or the courts. It is not surprising that Mr. Sinclair consented to a plan that placed no demands for change on him. This plan involved Mr. Sinclair regaining custody of his daughter without any indication he had changed in any significant way. This was compounded by a failure to observe how he was coping with having Phoenix back in his care—he abandoned her to Ms. Kematch within weeks of her return. Despite knowing this and knowing that Ms. Kematch herself had been sporadic in her parenting of Phoenix, the Agency did not challenge Ms. Kematch reclaiming Phoenix in 2004. The Agency's own files contain assessments by workers that neither parent was cooperative, communicative or inclined to make any lifestyle changes required by the Agency. (These reports are unchanged from their presentation while in care as teenagers.) These same assessments correctly identify the Agency's own failure to act to protect Phoenix.

Apart from descriptions of Phoenix as a child in foster care and later in an Agency shelter, she remains almost invisible in the files describing service undertaken to ensure that she received the protection owed her as a child in Manitoba. Neither parent demonstrated any significant relationship with her and the file lacked observations of any routines of their care of her—other than the practice of depositing her with someone else. The photographs of her first time in foster care, those offered by the Edwards-Stephenson family in their interactions with the news media after her death and the Shelter workers' notes are the only evidence that she spent time with people who seemed to enjoy her presence. Yet, Ms Edwards and Mr. Stephenson, despite their professed affection for her, acquiesced to her removal from them without notifying the Agency that she was gone—again.

The Agency's final 'contact' with Phoenix in March 2005 should have resulted in a demand to see her, to see her home and to ensure that she was well and living with her mother. The family history demanded this as a minimum standard of casework following up on a report of possible child abuse—the current program standards for child protection (2001) *specifically* require that the child who is the subject of an abuse report be seen by the investigating worker. There was no observation of the child or any record of a demand to see her. Considering that the allegation involved child abuse and confining a child in a locked room, the Agency's willingness to once more be dismissed by Ms Kematch is deeply disturbing. *It is, however, when the literature on child deaths is considered, not unique.* While the Branch complied by ensuring that there was a timely follow-up of the allegation, the remainder of the investigation did not meet the standards.

The new online Child Welfare Standards for Intake services provide direction to workers in situations such as these. Under "Intake Decision" on p.3 of the Intake section, the case management decision at that point (among others) is **"Are all children involved safe?"** Based on this question, the decision to close the Intake in March 2005 without ensuring that Phoenix was safe was a violation of the newest Provincial Standards. The report, which included allegations of confinement and physical abuse, warranted a Child Protection investigation under the Assessment section of the standards. **The investigation, under Section 18.4 of *The Child and Family Services Act*, required that the case manager have "face to face contact with: the child alleged to be in need of protection,** any other children living in the household, any caregiver, custodial parent or guardian (other than the alleged offender). (p.5 of the 2001 Assessment section).

The current situation of fragmented standards, some dating from 1988 or 2001 and others adopted in the past year and available online make it challenging to determine precisely which standards are applicable. The existing standards do not provide an easy to access package for workers under pressure to meet deadlines on caseloads. Further, the provision of the newest standards online may place workers in Agencies without easy access to the Internet at a significant disadvantage.

The Agency's acquiescence to multiple, serial caregivers for Phoenix, of whom only Ms. Edwards and Mr. Stephenson might have been adequate is also deeply disturbing. The failure of the Agency (now the Winnipeg CFS Branch) to closely scrutinize this couple left Phoenix in situations that were both tenuous and dangerous. These "godparents" had no legal ability to retain control of Phoenix in 2004 if either parent arrived to reclaim her. Despite knowing that

both parents had serious shortcomings, the "godparents" were not charged *specifically* with notifying the Agency if *either* parent asserted their legal right to reclaim Phoenix like so much misplaced luggage. Despite an assessment indicating that leaving Phoenix in the care of either parent would place her at risk, no attempt was made (by means of multiple observations of their parenting) to ensure that there had been sustained change in both parents to address elements of risk identified. As a result, when Ms Kematch reclaimed Phoenix in 2004, the child went to a home and a living situation about which the Agency had no direct knowledge, including the presence in the family of a new common-law partner for Ms Kematch.

The contradictions contained within the Agency's file raise issues about whether the quality of service within the Agency is consistent. Why would one supervisor accept a worker's detailed assessment that neither parent was safe yet another would sign off on perfunctory contacts with little in the way of data yet with an assessment that all was well and the file could be safely closed? The constant in this situation was that **neither parent had changed for the better in any measurable way** yet the assessments of their competence as parents varied widely. The more information referenced in the assessment, the less positive the view of their competence or of the safety issues involved in leaving Phoenix with either parent.

The Agency's inability in 2004 and 2005 to gain any understanding of Ms Kematch's relationship with Mr. McKay is another serious flaw in the services provided to Phoenix Sinclair. Despite a search for Ms. Kematch in 2004 that was intended to ascertain that she was a safe caregiver for Phoenix after arriving back in her life after an absence of some months, little information was found to support the decision to close the file again. Despite learning that there was a new man in her life, the scanty information provided by Ms Kematch about Mr. McKay was accepted. She did not have a history of selecting well-functioning partners. The history of her life as a young person in care did not support an optimistic view of her future in relationships or parenting. Her relationships with the fathers of her children were neither stable nor supportive and the Agency had clear evidence by 2004 that her relationship with Phoenix had taken second place to other events in her life for a notable portion of Phoenix's existence. (In fairness, the same can be said for Mr. Sinclair who was willing to allow others to care for Phoenix.)

The witness report of a call to Intertribal Child and Family Services in June 2005 is most likely unfounded. Intertribal CFS has reported that its records have been searched and no record of the call can be found. Without information such as a date or the name of the person who received the call, Intertribal has done what it can with respect to this call. An additional inquiry to the RCMP was made during the writing of this report and the reply was that the call *might* have

been made in July 2005 and that it might have been made to the Agency's toll-free telephone number.

The Agency's placement of Phoenix in the Edwards-Stephenson home did not meet **Section 411, Place of Safety** of the provincial Program Standards which requires that a placement of longer than two weeks be studied for a foster home license. Despite Mr. Stephenson indicating that the couple were separated, that he lived elsewhere and that they would be co-parenting, the Agency failed to question this arrangement further or to make inquiries about the circumstances surrounding the separation. Consequently, Mr. Stephenson is "invisible" in the file although he played a critical role in 2004 when he reportedly allowed Ms Kematch to reclaim Phoenix despite the Agency's letter of February 13, 2004. The letter expressed concern about both parents' lifestyles but did **not** contain a forceful warning about further disruption in Phoenix's life. (See Appendix A) The Agency, by condoning a private arrangement between a parent about whose lifestyle the Agency had "serious concern" and that parent's friends, afforded Phoenix no protection at all. The godparents had no legal authority to withhold Phoenix from either or her parents and no legal compulsion (as with a foster home or even a Place of Safety home) to report her removal from their home. The Chief Medical Examiner has expressed reservations in the past about the involvement of mandated agencies in so-called "private arrangements". If a mandated agency is involved in brokering or informally sanctioning such arrangements, just how "private" are they—agencies are accountable to the Authorities which are ultimately accountable to the government and the people of Manitoba.

The Child Protection Branch has advised that the process of drafting new standards continues; the Child Protection Standards are next. The Branch advised the writer that there are two ways in which an Agency may be involved in private arrangements. The first occurs when the Agency is aware that a family open for Protection services is making its own arrangements for the care of the children. In such cases, the Branch advises that the type of assessment needed would be different from cases in which the Agency is discharging a child in care to someone other than the parent or guardian. There is, the writer would argue, a third situation in which the Agency would take the child into care if the child remained with the parent but has allowed the parent to seek a placement for the child with someone of the parent's choice. This is different from the first situation in that the risk to the child would be higher due to an imminent apprehension. This was the situation facing Phoenix in 2004 when she was living with Kim Edwards and Rohan Stephenson. The Agency clearly was not confident that either parent would provide acceptable care for Phoenix. In such cases, the Agency is more than a bystander and the arrangement—be it known as a private arrangement or some other name—should formalize the Agency's involvement in some way that affords the child the greatest

protection. Private arrangements should not be used as an 'easy' substitute for alternate care such as a Place of Safety or a foster home. By either acquiescing to or participating in such arrangements, the Agency is a party to the process and shares responsibility for the outcome, just as declining to become involved would also carry with it the responsibility for a share in the outcome.

RECOMMENDATIONS

RECOMMENDATION ONE

CPB

THE CHIEF MEDICAL EXAMINER RECOMMENDS THAT THE CHILD PROTECTION BRANCH DEVELOP A PROGRAM STANDARD TO ADDRESS THE USE OF PRIVATE ARRANGEMENTS WHEN THERE ARE CHILD PROTECTION CONCERNS SUCH AS ABANDONMENT, ABUSE OR NEGLECT. FURTHER, THE CHIEF MEDICAL EXAMINER RECOMMENDS THAT ADULT PARTICIPANTS IN SUCH ARRANGEMENTS BE CLEARLY ADVISED THAT NO CHILD IS TO BE PLACED ELSEWHERE, INCLUDING WITH THE ORIGINAL CAREGIVER(S), UNTIL THE APPROPRIATE AGENCY HAS BEEN ADVISED AND HAS ASSESSED THE SITUATION IN WHICH THE CHILD WOULD BE LIVING.

The Declaration of Principles for *The Child and Family Services Act includes the following statement:* "Families and children have the right to the least interference with their affairs to the extent compatible with the best interests of children and the responsibilities of society." C.C.S.M. c. C90

The child welfare doctrine of least intrusive intervention should not result in the Province withdrawing from cases involving the protection of children and entrusting a family with a history of abandonment, abuse or neglect to make choices which further compromise the children's safety. This can be the result of choosing a poorly functioning family as alternate caregivers or choosing alternate caregivers who will defer to the family and surrender the children without protest or without notifying a child welfare agency to ensure the children's safety. The Agency's involvement, whether active (by assessing or completing any checks on the alternate caregivers) or passive (by not opposing the placement), makes it a part of this process and should provide the child in question with the protection of the child welfare system.

RECOMMENDATION TWO

GA

THE CHIEF MEDICAL EXAMINER RECOMMENDS THAT THE GENERAL AUTHORITY ENSURE THAT THE PROGRAM STANDARDS FOR INVESTIGATION OF ALLEGATIONS OF MISTREATMENT OF CHILDREN ARE FOLLOWED BY AGENCIES UNDER ITS JURISDICTION, SPECIFICALLY THE REQUIREMENT TO ENSURE THAT THE CHILDREN

INVOLVED ARE SAFE BE FULFILLED BY ENSURING THAT A CHILD ABOUT WHOM A REPORT OF SUSPECTED ABUSE OR NEGLECT IS MADE IS SEEN BY THE INVESTIGATING WORKER(S).

The Child and Family Services standards (1.1.1) online list specify under "Intake Process" that one of the case management decisions to be made is "Are all children involved safe?"

Allowing the parent about whom an allegation of child abuse or neglect has been made to deflect the Agency's inquiries about that child affords the child no protection. It is logically inconsistent to accept assurances from a parent accused of confining a child that the child is not confined, particularly when the child cannot be seen. Failing to see the child after being denied access to a home after an allegation of abuse and confinement should result in renewed efforts to see the child in order to ensure that the child is not at risk of maltreatment. This report from the community required *investigation* and an accompanying healthy scepticism about whether a person accused of confining and mistreating a child would readily admit to doing so.[29] The 2001 standards require that the child be seen if there is an allegation of maltreatment. In this particular case, the Agency's second line of protection (supervision) also failed to protect the child.

The lessons learned in child abuse tragedies emphasize the importance of seeing the child about whom a report is made.

RECOMMENDATION THREE

cpb

THE CHIEF MEDICAL EXAMINER RECOMMENDS THAT THE CHILD PROTECTION BRANCH ENSURE PROVINCIAL TRAINING FOR CHILD PROTECTION INCLUDES OR REFERENCES LITERATURE EMPHASIZING THAT THE CARE OR CONDITION OF ONE CHILD IN A FAMILY CANNOT BE TAKEN AS A PROXY FOR THE CARE OR CONDITION OF ANY OTHER CHILD IN THE SAME FAMILY.

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[29] Munro, E. (2005) In *A systems approach to investigating child abuse deaths*, British Journal of Social Work, Vol. 35, pp 531-546 describes this as "strategic factors", tradeoffs among conflicting goals that may be endemic to the work or amplified by organizational issues, such as recent changes to the way work is done.

THIS POINT SHOULD BE EXTENDED TO ELIMINATE THE USE OF HOUSEHOLD CLEANLINESS AND ORDER AS A PROXY FOR GOOD PARENTING AND THE ABSENCE OF ABUSE.

Abuse in families may involve all the children or the maltreatment may target one child only. Using a proxy (another child, an orderly home, abundant food) to represent the safety of an unseen child is not a reliable measure of safety.

It is not uncommon for the writer to read comments about the order and cleanliness of a home (or a lack of it) when a worker visits a home. In cases where neglect is an issue, cleanliness and order can provide a worker with a quick means of checking the family's basic functioning at the beginning of a more thorough assessment of the children's care. Using this same "ruler" to measure the presence or absence of maltreatment does not produce the same result as children may be mistreated in clean homes while others may be safe in untidy homes.

RECOMMENDATION FOUR

CPS

THE CHIEF MEDICAL EXAMINER RECOMMENDS THAT THE CHILD PROTECTION BRANCH ENSURE THE PROGRAM STANDARDS CURRENTLY UNDER DEVELOPMENT FOR CHILD PROTECTION SERVICES INCLUDE A WARNING OR REMINDER TO WORKERS THAT ONE CHILD MAY BE THE TARGET OF ABUSE OR NEGLECT IN A FAMILY THAT APPEARS TO BE FUNCTIONING ADEQUATELY.

In addition to teaching this in child protection training, the material supporting the written standard should reference the underlying reasons for thorough investigations.

RECOMMEDATION FIVE

GA+ WCF

THE CHIEF MEDICAL EXAMINER RECOMMENDS THAT THE GENERAL AUTHORITY IN CONJUNCTION WITH WINNIPEG CHILD AND FAMILY SERVICES BRANCH ENSURE THAT FULL NAMES ARE OBTAINED FOR PERSONS ASSOCIATED WITH PROTECTION CASES UPON THE BRANCH BECOMING AWARE OF THE INVOLVEMENT OF A NEW

INDIVIDUAL IN A CASE. THE CHIEF MEDICAL EXAMINER FURTHER RECOMMENDS THAT CRIMINAL RISK ASSESSMENTS OF NEW FAMILY MEMBERS OR ASSOCIATES BE REQUESTED IN CASES INVOLVING FAMILIES WITH A HISTORY OF CHILD PROTECTION CONCERNS.

A similar recommendation was made in the review of service to the late Amelia Severight. The Province has made a resource available in the form of the Criminal Risk Assessment unit to assist child welfare agencies in determining if new family members or associates pose a threat to the children in a family.

The Special Investigator has been made aware that some Agencies ask that identification be provided in such circumstances.

RECOMMENDATION SIX

CPB×GA×WCFS

THE CHIEF MEDICAL EXAMINER RECOMMENDS THAT THE CHILD PROTECTION BRANCH AND THE GENERAL AUTHORITY, IN CONJUNCTION WITH THE WINNIPEG CHILD AND FAMILY SERVICES BRANCH, REVIEW THE MARCH 5, 2005 INTAKE TO DETERMINE WHAT CAN BE DONE TO PREVENT SIMILAR INCIDENTS IN THE FUTURE AND TO ASCERTAIN WHETHER THIS WAS A UNIQUE RESPONSE TO REPORTS OF ALLEGED MALTREATMENT OF CHILDREN OR RELATED TO SYSTEMIC ISSUES SUCH AS A SHORTAGE OF RESOURCES.

Despite the requirements of the existing Program Standards, a referral alleging confinement and abuse of a young child did not result in the child being seen. In addition, the Agency accepted a proxy for the child alleged to have been abused. The actions taken by the investigating staff were signed off by a supervisor despite the shortcomings in practice and the failure to meet existing standards.

The writer is aware that there is a chronic shortage of resources in the child welfare system and that this may impact on the time available to follow up intake reports. If this shortage impacted the investigation of the March 5, 2005 maltreatment report, action is required to ensure that sufficient resources are available to provide service that meets the provincial standards.

This report was prepared by Jan Christianson-Wood

Jan Christianson-Wood, MSW, RSW
Special Investigator

APPENDICES

*MEDICAL EXAMINER'S REPORT
*AUTOPSY REPORT
APPENDIX A

*As criminal charges have been laid in this case, these documents cannot be released without the permission of the Crown Attorney.

Appendix A

Manitoba

Family Services and Housing

Winnipeg Child and Family Services

835 Portage Avenue
Winnipeg, Manitoba
R3G 0N6
CANADA

(204) 944-4200
Fax: (204) 944-4250

February 13, 2004

Roban & 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