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

Commision Disclosure 2164

SPECIAL CASE REVIEW UNDER THE CHILD AND FAMILY SERVICES ACT

TERMS OF REFERENCE

Legislative Basis for the Special Case Review

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

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

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

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

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

Review Panel

The special case review will be conducted by a two person panel (the Panel) comprised of the Office of the Children's Advocate and an external consultant.

Delegation of Power

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

Purpose of the Special Case Review

The review will have two components: one specific to the case of Phoenix Sinclair and one specific to unnatural deaths of children in care or receiving services from the Child and Family Services System within one year prior to their death. [Section 10, *Fatalities Enquiry Act*].

(a) Case Component

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

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

(b) Unnatural Child Death Component

The review will examine any case of a child who died in care or who died within one year of receiving service from the Child and Family Services System where the cause of death was identified as unnatural (e.g. – homicide or suicide) by the Office of the Chief Medical Examiner. At minimum, the review will examine such deaths that occurred during the years 2004 and 2005. The Panel may also choose to examine similar cases that occurred in years prior to 2004.

The review will examine the circumstances that may have contributed to the death of each child, assess the services provided by the Child and Family Services System and make recommendations that will help prevent similar incidents from occurring in the future.

Scope of the Special Case Review

For the case specific component, the review will, but not be limited to, the following activities:

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

For the unnatural component, the review will, but not be limited to, the following activities:

- examine all existing review and inquest reports done on cases of child homicide in 2004 and 2005 (and other years as deemed appropriate by the Panel); and
- assess whether further review or action is required on any of these cases.

Method

The review will be conducted by:

- reviewing any file, report or other record kept by a child and family service agency, authority or the Child Protection Branch deemed relevant by the Panel;
- interviewing any staff person employed by a child and family service agency, the Child Protection Branch or a child and family services authority;