COMMUNITY CARE AND ASSISTED LIVING APPEAL BOARD

Community Care and Assisted Living Act
SBC 2002, c. 75

APPELLANT: DP, Licensee,
(operating Nana's Howse Family Daycare)

RESPONDENT: Clifford Daly, Assistant Director of Health Protection,
Interior Health Authority

PANEL: Alison H. Narod, Chair
Judy Pollard, Member
Gordon Armour, Member

DECISION

INTRODUCTION

[1] This decision concerns an appeal by DP (who we will refer to throughout this decision as "the appellant" but who is also referred to in some of the quoted correspondence as the licensee) of a June 2006 Reconsideration Decision by Clifford J. Daly, Assistant Director of Health Protection, ("the respondent") that upheld the decision of Dr. Robert Parker, Medical Health Officer ("the MHO"), cancelling the appellant's licence to operate a family child care facility known as "Nana's Howse Family Daycare" ("the facility").

[2] The appellant had been licensed to operate a family daycare since November 2001. In March 2006 the Interior Health Authority (the licensing "Authority") commenced an investigation of a complaint made against the facility under section 15(1)(b)(ii) of the *Community Care and Assisted Living Act* ("the *Act*"). The licensing Authority suspended the appellant's licence pending completion of the investigation under section 14 of the *Act* and as a result of the investigation the MHO cancelled the appellant's licence in April 2006 under section 13(1) of the *Act*. In June 2006 the respondent conducted a reconsideration of the MHO's cancellation decision under section 17 of the *Act*.

[3] The Community Care and Assisted Living Appeal Board has authority to hear this appeal under section 29(2)(b) of the *Act* and section 29(12) provides

that "the board may confirm, reverse or vary a decision under appeal, or may send the matter back for reconsideration, with or without directions, to the person whose decision is under appeal." The appeal was heard by way of an oral hearing. According to section 29(11) of the *Act* the appellant "bears the burden of proving that the decision under appeal was not justified".

ISSUES

[4] The main issues to be determined in this matter are whether the appellant contravened the *Act* and *Child Care Licensing Regulation* ("the *Regulation*") and if so, whether the decision to cancel the appellant's license was justified in all the circumstances.

[5] According to the reconsideration decision under appeal, the respondent found the appellant in contravention of sections 12, 18, 31 and 32 of the *Regulation*, as well as of section 7 of the *Act*. Those provisions are set out below. More particularly, he found that the appellant neglected an infant in her care, as defined by Schedule F of the *Regulation,* contrary to section 31(2) of the *Regulation* and failed to provide the child with a comprehensive and co-ordinated program of activities that met the standard of care required by section 32 of the *Regulation*. In this regard, he noted (at page 12):

> An infant was kept lying down by the licensee in a playpen for approximately one and a half hours. [The appellant] acknowledges she kept laying the child down from a sitting or standing position and would hold her hand on the infant's back to prevent him from getting up. Confining a child in a playpen for the purpose of an afternoon nap, despite their attempt to get up, indicates a failure to meet the care needs of the infant.
>
> [The appellant] stated she did not know the playpen mattress was upside down and did not notice the hard wooden-like cover that she laid the child on repeatedly for three days.

[6] Moreover, the respondent found that the appellant failed to ensure that persons in care were supervised at all times by a responsible adult, an educator or an assistant, and that a second adult is readily available, contrary to section 18 of the *Regulation* and that she failed to operate the facility in a manner that will promote the health, safety and dignity of persons in care, contrary to section 7 of the *Act*. In this regard, he noted that the appellant acknowledged that she had been found in contravention for the use of unauthorized areas of the facility for the provision of childcare on three occasions. She denied knowing that these amounted to contraventions of the Penticton Fire Department's requirements, but acknowledged the licensing contravention of lack of supervision. He observed that inspection reports (which we note were given to the appellant) clearly noted that these incidents also contravened the Penticton Fire Department licensing requirements.

[7] Additionally, the respondent found that the appellant contravened section 12 of the *Regulation* which sets out the qualifications necessary to qualify for

employment in a community care facility as a responsible adult. He noted that it had been confirmed during the monitoring of this facility and during the investigation of the matters at issue that substitute care providers at the facility did not meet the qualifications of a responsible adult.

[8] The respondent's Decision was set out in the following paragraphs (at pages 14 to 15):

> The evidence of neglecting the care needs of an infant in [the appellant's] care resulted in the child sustaining injuries/abrasions to the back of the child's head. The neglect of the infant's care needs is well below the standard of care required in a community care facility.
>
> [The appellant's] assertion that she did not know the use of unauthorized areas of the home were also a contravention of the Penticton's Fire Department's Requirement is contrary to the findings of the Licensing Officer. Of concern is [the appellant] acknowledges the contraventions and the attempts to deflect responsibility for these contraventions which included lack of supervision by stating that;
>
> > "*I ... feel that ... Licensing operates totally out of rules, regulations, books and ..., life sometimes does not fit into the questions asked by the computer and you don't always get a neat concise answer to life's situations.*"
>
> As to the question of whether the decision of the Medical Health Officer to cancel the Licence should be upheld, or whether a set of conditions that would ensure the health and safety of the children in the facility would be protected under the current Licence. In reviewing the options for conditions being placed on the Licence it is clear that given the history of non-compliance the history of the Licensee is such that compliance with any conditions attached to the Licence is unlikely.
>
> I find that the continued non-compliance by the Licensee and [the appellant's] inability to accept her responsibility in maintaining the facility in compliance with the Act and Regulations make her unsuitable to be a Licensee.
>
> Therefore the decision of the Medical Health Officer Dr. Parker to cancel the Licence of Nana'z Howze, Family Child Care is upheld.

[9] On appeal, the respondent says that the reconsideration decision should be confirmed as the evidence establishes that the appellant has a history of non-compliance and that she does not have the "personality, ability and temperament necessary to operate a community care facility in a manner that maintains the spirit, dignity and individuality" of the children in her care as required by section 11(2)(iii) of the *Act*.

[10] The appellant seeks to have the decision reversed or varied and disputes some of the allegations of contraventions and facts giving rise to the alleged contraventions. She disputes the conclusions and the final decision reached by the licensing Authority on the basis of the allegations and facts. Moreover, she disagrees that any substantiated contraventions of the *Act* are sufficient to justify cancelling her licence to operate and thereby depriving her of her livelihood. In addition, the appellant alleges that she has been inappropriately treated and her character maligned by the licensing Authority in the course of the investigation and decision-making regarding her facility.

STATUTORY PROVISIONS

[11] The *Community Care and Assisted Living Act* and the *Child Care Licensing Regulation* govern the licensing and operation of child daycare facilities in British Columbia. The sections of the *Act* and *Regulation* that are of particular relevance to this matter are as follows:

Community Care and Assisted Living Act

Standards to be maintained

7 (1) A licensee must do all of the following:

(a) employ at a community care facility only persons of good character who meet the standards for employees specified in the regulations;

(b) operate the community care facility in a manner that will promote the health, safety and dignity of persons in care;

Powers of medical health officer

11 (2) A medical health officer must not issue a licence under subsection (1) unless the medical health officer is of the opinion that the applicant,

(a) if a person, other than a corporation,

(i) is of good character,

(ii) has the training, experience and other qualifications required under the regulations, and

(iii) has the personality, ability and temperament necessary to operate a community care facility in a manner that will maintain the spirit, dignity and individuality of the persons being cared for,

Suspension or cancellation of licence

13 (1) A medical health officer may suspend or cancel a licence, attach terms or conditions to a licence or vary the existing terms and conditions of a licence if, in the opinion of the medical health officer, the licensee

(a) no longer complies with this Act or the regulations,

Summary action

14 A medical health officer may suspend a licence, attach terms or conditions to the licence, or vary terms or conditions of that licence, without notice if the medical health officer has reasonable grounds to believe that there is an immediate risk to the health or safety of a person in care.

Duties of the medical health officer

15 (1) Within the area for which he or she is appointed, a medical health officer must

(b) investigate every complaint that

(ii) a community care facility is being operated that does not fully comply with this Act, the regulations or the terms or conditions of its licence,

(c) carry out inspections of any community care facility that is being operated, and

Reconsideration

17 (1) In this section:

"action", in relation to a licence, means

(c) a suspension or cancellation, an attachment of terms or conditions, or a variation of terms or conditions under section 13 (1), or

"summary action" means a suspension or cancellation of a licence, an attachment of terms or conditions to the licence, or a variation of those terms or conditions under section 14;

(3) If a medical health officer considers that this would be appropriate to give proper effect to section 11, 13, 14 or 16 in the circumstances, the medical health officer may, on receipt of a written response,

(a) delay or suspend the implementation of an action or a summary action until the medical health officer makes a decision under paragraph (b), or

(b) confirm, rescind, vary, or substitute for the action or summary action.

(5) A medical health officer must give written reasons to the licensee or applicant for the licence on acting or declining to act under subsection (3).

Appeals to the board

29 (2) A licensee, an applicant for a licence, a holder of a certificate under section 8, an applicant for a certificate under section 8, a registrant or an applicant for registration may appeal to the board in the prescribed manner within 30 days of receiving notification that

(b) a medical health officer has acted or declined to act under section 17 (3) (b),

(11) The board must receive evidence and argument as if a proceeding before the board were a decision of first instance but the applicant bears the burden of proving that the decision under appeal was not justified.

(12) The board may confirm, reverse or vary a decision under appeal, or may send the matter back for reconsideration, with or without directions, to the person whose decision is under appeal.

Child Care Licensing Regulation

Qualifications for responsible adults

12 To qualify for employment in a community care facility as a responsible adult, a person must

(a) be of good character,

(b) have reached 19 years of age,

(c) be able to provide care and mature guidance to persons in care,

(d) either have completed a course on the care of young children or have relevant work experience, and

(e) if persons in care in a residential care facility are

(i) less than 6 years of age, have completed a course on the care of young children or have relevant work experience, or

(ii) from 6 to less than 19 years of age, have completed a course in the care of children or youths or have relevant work experience.

Supervision of persons in care

18 The licensee must ensure that persons in care are supervised at all times by a responsible adult, an educator or an assistant, and that a second adult is readily available.

Discipline and abuse

31 (2) The licensee must ensure that a person in care is not, while under the care or supervision of the licensee, subjected to emotional abuse, physical abuse, sexual abuse or neglect as those terms are defined in Schedule F.

Program of activities

32 The licensee must provide to persons in care a comprehensive and coordinated program of activities that

(a) is designed for the development, care and protection of persons in care,

(b) is appropriate for the age and development of the persons in care in each group in the community care facility, and

(c) meets the standards set out in Schedule D.

Schedule F — Reportable Incidents

1 For the purpose of this regulation, any of the following is a reportable incident:

"neglect" means the failure of a care provider to meet the needs of a person in care, including food, shelter, care or supervision;

DISCUSSION AND ANALYSIS OF THE FACTS

March 2006 events and investigation

[12] The appellant has a lengthy history of interaction with the licensing Authority. This history culminated in a number of events that occurred in March 2006.

[13] The appellant took a new child, Child A, into care on Tuesday, March 7, 2006. In preparation for his arrival, the appellant gathered information from his parents about his sleeping habits, including that he was accustomed to napping twice a day, once in the morning and once in the afternoon.

[14] Additionally, in preparation for Child A's arrival, the appellant put fresh bed-sheets in a playpen in one of two sleep rooms in which she permitted the children in her care to take naps. Unfortunately, in doing so, she put the bed-sheets on the wrong side of the playpen mat and put it in the playpen, upside-down, with the hard side facing up. This hard side had velcro tabs and gaps between the slats attached to it.

[15] The first day of Child A's attendance was relatively uneventful. The child was upset when dropped off by his mother in the morning. He was unable to settle for a nap when the appellant put him and the other children down for naps at approximately 12:30 p.m. So, the appellant spent the approximately 1½ hour nap-time holding Child A while rocking him in a rocking chair. The appellant attributed Child A's restless behaviour to the fact that his mother continued to breastfeed him and he was having separation anxiety.

[16] The second day, the child was dropped off by his father. The child was upset when he was dropped off, but not as upset as the first day. Again, he had difficulty going to sleep when the appellant attempted to put him down for a nap in the playpen at approximately 12:30 p.m. The appellant tried repeatedly to calm him in the rocker and then lay him down in the playpen, but he woke whenever she tried to leave him. She said he slept for about 1½ hours on the second day, but she also said that he was only in the playpen, on and off, for about 20 minutes. The appellant again attributed the child's behaviour to breastfeeding and separation anxiety.

[17] Later on the second day, the appellant noted that the child had a small red mark on his head, which she suspected might be impetigo. When the mother picked the child up, the appellant told her that his nap had been very restless and pointed out the small red mark, noting her concern that it might be impetigo.

[18] There is some controversy about what happened on the third day. The appellant said both the child and the mother were extremely anxious when the child was dropped off. There is little dispute that the appellant attempted to put the child down for a nap in the playpen at approximately 12:30 p.m. (give or take 15 minutes) and she took him out of the playpen at approximately 2:00 p.m. After removing the child from the playpen at the end of nap-time, the

appellant observed that he had a series of five abrasive marks from ear to ear across the back of his head. The parties agree that the child sustained these injuries while he was in the playpen. The controversy relates to what occurred while the child was in the playpen and the appellant's conduct during that period of time.

[19] The impression gained from an interview later conducted by the Licensing Officer, Michelle Page ("the LO") and a Senior Licensing Officer, Darlene Kuzyk, (a transcript of which is also the subject of controversy), the child had difficulty falling asleep when he was put down for the mid-day nap. He was wiggling and fighting sleep. He was making yearning noises. The appellant felt he was being persistent. She too was being persistent in her objective of getting him to nap in the playpen. She was aware that the child wanted her to pick him up, but she wanted him to adapt to not being held while falling asleep. She laid him on his back in the play pen and encouraged him to sleep by stroking him and continuing to hold her hand gently on him. Accordingly to the transcript of the interview, the appellant "probably" picked the child up in about 1½ hours.

[20] The appellant maintains that she stayed with the child the whole time and did not leave the child alone in the room at all while she encouraged him to nap in the playpen. The appellant says that she did not hold the child down. Rather, when he would sit or stand up, she repeatedly laid him down, every three to five minutes. On her view, she probably did this in excess of fifteen to thirty times. Despite this, she did not notice that the playpen mat was upside-down, that the side facing up was hard, uneven or rough, or that the child was developing the above-noted abrasions on his head. The appellant maintains she never saw the back of the child's head at all while he was in the playpen.

[21] Indeed, the appellant maintains she did not notice the abrasions until she took the child out of the playpen at about 2:00 p.m. Despite this, she did not notify the parents, immediately. Nor did she document the incident or report it to the licensing Authority.

[22] Once the appellant discovered the injuries, she put some ointment on them. When the mother came to pick the child up, the appellant told her that the child had been restless all day. She pointed out the abrasions to the mother, but said she did not know how they had happened. She discussed with the mother her continued concerns about the mother's breastfeeding and the child's separation anxiety, as well as her views about their effect on his adjustment to the daycare. The mother disagreed with the appellant.

[23] As mentioned earlier, there is some controversy about what transpired while the child was in the playpen. The appellant was interviewed on March 17, 2006. The appellant also gave evidence about the events before the Panel. The version of the transcript of the interview that was originally given to the appellant in March 2006 was not a complete transcription, for reasons of inadvertence. This was the version that was used during the process that resulted in the reconsideration decision that is under appeal. Once the fact the transcript was incomplete was later discovered, a complete version was prepared and sent to the appellant in November 2006. The appellant acknowledges

receipt of the cover letter, but says she did not receive the full version of the transcript.

[24] During the hearing of this appeal, the appellant was given time to review the full version of the transcript, after which she agreed that the gist of the missing portion was correct, and she made some changes and corrections to the transcript that were not material to most of the key issues. The transcript supports the view that the appellant did not take the child out of the playpen at all while she endeavoured to get him to nap on the third day. Rather, she was persistent in her efforts to keep him in a supine position, by laying him down whenever he sat or stood up. Among other things, portions of the full transcript, which are not disputed, state (at pages 12 to 13):

> DK: so what would happen when the child tried to roll over or move?
> DP: Then I was just..just secure him..just gently like that…
> DK: and that was enough to keep him lying flat?
> DP: He would be pacified yes.. and I would just continue and hold my hand gently on him.
> MP: they did say he would sit or stand.
> DP: He did when I was in and out of the room.. yup..
> …
> MP: So he'd be standing up when you walked in?..
> DP: Yup…
> MP: Then how would he get down to a laying down..
> DP: Then I would lay him down again.
> …
> MP: Ok..so your demonstrating though that your hand would be underneath his head?…and your would pull it out gently..
> DP: Well I..ya..cause I would lift him like this and then I would have to alter to to take from my arms..my hands from underneath his arms to secure his head, to secure his bottom, lie him down like this pull this hand over and secure him…so that he could continue lying down.
> MP: …so both your hands were under him?…..
> MP:..Ok so your laying him down by your hand being on his head and his bottom.
> DP: Yup…
> MP: Bring him down onto the mat and then taking your hands out from underneath him..
> DP: yup..yup I would, but I would probably never release this hand from him, I would take this hand out, but I would probably..this hand would be underneath…but I would probably bring it right around like this and just continue rubbing him like this.

[25] The appellant was emphatic, when giving evidence, that she had picked up the child many times during nap-time. The appellant's evidence was that she did not hold the child down, but that, whenever he sat or stood up, she laid him down to a supine position. However, her evidence about this event was not consistent with an assertion that she picked the child up and lifted him out of the playpen to hold and comfort him. Rather her evidence and the transcript evidence is consistent with the view that whenever the child sat or stood up, she

persistently returned him to a supine position. Moreover, the transcript evidence and that of the licensing officers who attended the interview is consistent with the view that the appellant laid the child down on his back and, gently or otherwise, endeavoured to keep him in a supine position in an effort to get him to sleep in the playpen.

[26] Although we think it difficult to accept the appellant's version of events, particularly of the transcript evidence that she intermittently left the room and because we think it highly unlikely that she could have laid the child down so many times in the manner she described without noticing that the mat was upside-down and was causing the child discomfort, we think that on either view of what happened that day, the result, for the purposes of these proceedings, is the same. The appellant kept Child A in a playpen for approximately 1 ½ hours on March 9, 2006 and persistently endeavoured to keep him lying on his back on a hard, uneven and rough surface while he wiggled, protested and resisted her efforts to get him to sleep in the playpen. As a result, the child sustained the above-mentioned abrasions to his head. This will be discussed further below.

[27] Over the weekend, Child A's parents considered the events and, the following Monday, complained to the licensing Authority. As a result of the complaint, the licensing Authority initiated an investigation and notified the Penticton RCMP, who initiated their own investigation. The RCMP, however, later concluded there was no evidence of child abuse.

[28] As part of the licensing Authority's investigation, the LO interviewed Child A's mother, who explained that the appellant told her that Child A received the abrasions when she tried to get him to nap for twenty minutes on the third day. The appellant said she was convinced the child could take a single, afternoon nap. Although the appellant told the mother that she did not push it hard, and said she had intermittently left and returned to the room, she also said she had been rubbing him. The mother suspected that the appellant had been restraining the child, as he usually stood up in his crib when he was upset. Photos of the child were obtained and revealed five circular rub marks on the back half of his head. The child was taken to a doctor to assess his injuries, but no report was given to the licensing Authority, despite its request for same. Ultimately, the licensing Authority was advised that a pediatrician had indicated that there was no evidence that the child had been harmed.

[29] Additionally, as a result of receiving the complaint, the LO visited the facility at approximately 1:20 p.m. on March 13, 2006. This visit lasted approximately 1 hour and 40 minutes. On her arrival, the LO observed the appellant coming up the stairway from the basement, followed moments later by a child. As mentioned, use of the basement by a child, was in contravention of fire and licensing requirements. Indeed, this was the third incident in which the LO had discovered the appellant permitting children to use the basement. The LO advised the appellant that, effective immediately, she must ensure that she and the children use only the approved areas during childcare hours.

[30] In her evidence, the appellant acknowledged that a child used the downstairs washroom on March 13, 2006. She claimed that the child did not

routinely use this washroom, but also said he liked his privacy, and she did not think this was a problem.

[31] Additionally, the LO advised the appellant that there had been a complaint of physical abuse about Child A which would be investigated by the licensing Authority, as well as by the RCMP. She explained that the licensing Authority now required that a "health and safety plan" be put in place until the investigation concluded. They discussed having the appellant's adult daughter monitor (or "job shadow") the facility pending conclusion of the investigation. Accordingly, the LO advised the appellant to submit a written health and safety plan by 4:00 p.m. that day for the licensing Authority's review and approval.

[32] Moreover, the LO prepared a Facility Inspection Report, in which she referenced a recent incident where a 14 year old foster child had been present in the facility without appropriate documentation, and she reminded the appellant that criminal record check consents and results had to be obtained prior to persons moving in or ordinarily being present in the facility. In that Report, the LO gave the facility a "high" hazard rating and left the Report with the appellant.

[33] The LO returned to the facility for a second visit at 4:00 p.m. that day and stayed for 40 minutes. During this visit, the appellant initially refused to sign the Facility Inspection Report that the LO had left earlier but, ultimately, signed it.

[34] During this visit, the appellant and the LO examined the playpen that Child A had used and the LO noticed that the mat was upside-down. It was at this time that the appellant first discovered that the mat was upside-down in the playpen with its hard, bottom side facing up. She expressed surprise about this to the LO and acknowledged that this had probably occurred when she changed the playpen sheets in anticipation of Child A's arrival.

[35] Additionally, during this second visit, the appellant gave the LO a written health and safety plan which confirmed that the appellant's daughter would monitor the facility pending completion of the necessary investigations. The LO was aware that the appellant's daughter had previously had a family childcare licence and currently had a pending facility file with the licensing Authority. The LO advised the appellant that a criminal record check result was required for her daughter.

[36] On March 14, 2006, the LO dropped by the facility to deliver a criminal record check form for the appellant's daughter, who was present at the time. Additionally, the LO advised the appellant that her health and safety plan had been approved. Later the same day, the LO received advice that the Ministry of Child and Family Development ("the Ministry") already had a criminal record check indicating that the daughter had no criminal record. Arrangements were made to fax the results to the LO. The fax was received on March 15, 2006.

[37] In the afternoon of March 14, 2006, the appellant learned that her daughter could not continue being a monitor at the facility because she was a foster parent and, as such, she was not permitted to attend at a facility being investigated for child abuse while caring for a foster child. The appellant did not

immediately notify the licensing Authority of this fact. In her evidence, the appellant said that this was because she learned of her daughter's unavailability at 4:00 p.m. on March 14, 2006, a time at which the licensing Authority's office was closed. As a result, she arranged for a friend to act as monitor and left a message for the LO at 8:30 a.m. the next day that her daughter was not available and her friend would now be monitoring the facility.

[38] There is some controversy about the events of March 15, 2006 and, in particular, the length of time that the appellant operated the facility alone, in contravention of the approved health and safety plan, that day.

[39] According to the LO, she was out of the office in the morning of March 15, 2006 interviewing Child A's mother. However, after receiving the appellant's March 15, 2006 voicemail about the change of monitors, the LO made a drop-in visit to the facility in the afternoon of March 15, 2006. On arrival, she discovered that the appellant was alone with four children. By the end of her 40 minute visit the appellant's friend arrived. The friend told the LO that she had arrived at the facility at 7:00 a.m. that day and was returning from a one hour absence.

[40] On questioning the friend, the LO discovered that she did not have the minimum documentation required to volunteer, work or be at a facility, such as: a criminal record check result; references; proof of immunization; and a doctor's report of wellness. Moreover, the friend had not been approved as a monitor by the licensing Authority. According to the LO, the appellant claimed she did not know that she needed to ensure that monitors had such documentation.

[41] In the LO's view, this was another incident in which persons without the requisite documentation had been discovered at the facility. The LO gave the appellant a Facility Inspection Report, dated March 15, 2007, in which she gave the facility a "high" hazard rating. She noted that the previously approved health and safety plan permitting the appellant's daughter to monitor the facility was no longer in place. The LO stipulated that a new health and safety plan (to have her friend monitor) was required and needed approval by 3:00 p.m. that day. The appellant signed the Report, but noted on it that she was not in agreement with the "high" risk assessment.

[42] According to the appellant, her friend arrived at the daycare at 7:00 a.m. and stayed until about 9:00 a.m. She was absent for about an hour. The appellant contends that the LO arrived in the morning, not the afternoon, and was present when her friend returned. Therefore, the appellant was only alone for about an hour. The appellant also maintains that the licensing Authority was treating her arbitrarily and discriminatorily by finding her in contravention of regulatory requirements for her friend's lack of documentation when it accepted her daughter's lack of documentation.

[43] On the appellant's version of events, her friend returned at about 10:00 a.m. On the LO's version of events, she was interviewing Child A's mother at that time and did not attend at the daycare until the early afternoon of March 15, 2006. On the whole of the evidence, we prefer the LO's version of events, which

is supported by her notes of her activities that day which are relatively contemporaneous. Although the appellant called her friend as a witness, the friend's evidence did not confirm either version of events. Additionally, we note that the appellant's daughter had the requisite documentation, part of which was at the Ministry. The appellant's friend lacked the requisite documentation. Moreover, there is no doubt the appellant was operating in non-compliance with the health and safety plan put in place pending completion of the investigation by being alone with children in care on March 15, 2006.

[44] In any event, after discussing the matter with the Senior Licensing Officer, the LO contacted the appellant to advise that her friend's criminal record check would not be required until the next day, March 16, 2006, and that the other requisite documentation would not be required until the following morning, March 17, 2006, failing which, summary action on the licence would be taken.

Prior events

[45] The relevant prior events relate to unauthorized use of the appellant's basement and the presence of unauthorized persons in the facility. We describe them below under separate headings.

(a) unauthorized use of the basement

[46] The appellant operated the daycare facility in the upper floor of a two-floor house and maintained her residence in the lower, basement level. This was because she had been informed by the Penticton Fire Department that she could not obtain a licence to operate a daycare business out of the basement, since it lacked two exits. Indeed, she so advised a LO, of this fact during the process leading to her obtaining a daycare licence.

[47] The appellant acknowledges that there were instances in which a child or children were found to be present in the basement, despite the fact it was not licensed for use as a daycare facility by either the licensing Authority or the Penticton Fire Department. In her application for reconsideration, dated May 17, 2006, the appellant acknowledged that the facility had been given a high hazard rating on three occasions as a result of findings that she had allowed children to use the basement, but she maintained that it was her initial understanding that this was an issue because of supervision concerns. It was only afterwards that she realized the nature of the concerns related to fire regulations.

[48] This, however, is contradicted by the evidence which demonstrates that the appellant was well aware that there were fire related concerns about using the basement for a daycare facility. That evidence indicates that on October 4, 2001, during the LO's first visit to her home, the appellant advised the LO that she had been informed by the Penticton Fire Department that she could not operate a daycare business out of her basement, as the basement lacked the requisite two exits. As a result, she moved the daycare from the basement to the ground level of her home and began using the basement as her residence.

[49] The first of the "high" hazard ratings was given to the facility on April 19, 2002, when the LO conducted a drop-in inspection of the daycare operation. The LO discovered that there were a total of six children present at the daycare; two were asleep upstairs and four were watching a movie downstairs. According to a Facility Inspection Report of the same date, the appellant said that this was the first time the children had ever been downstairs and that they were using the basement to avoid disturbing two children who were sleeping upstairs. In her evidence before the Panel, however, the appellant maintained that the children were downstairs having a "movie day" because their plans to do something outdoors had not been possible due to rainy weather. She also said that the LO had "ordered" them out of the basement. The appellant thought this was a little heavy handed of the LO. She felt there were no safety issues, as the children were close to the exit. Indeed, she never felt the children in her care were unsafe. The LO disagreed with the appellant's description of her conduct and views about child safety.

[50] In a Facility Inspection Report of April 19, 2002 and contemporaneous notes, the LO documented that she advised the appellant that the use of the basement did not meet the requirements of the *Regulation*. Not only was it impossible to supervise children on two levels of the home, the basement was not approved for childcare as there was no second exit as required by the Penticton Fire Department and by the *Act*. Evidently, the appellant did not agree with the LO, as she made the following note on the Facility Inspection Report of April 19, 2002: "I feel that my time spent discussing issues with Michelle is more hazardous than anything stated here."

[51] Moreover, the LO noted that the appellant was not co-operative with her efforts to deal with the situation and that the appellant was reluctant to make herself available to discuss the matter further. The LO was sufficiently concerned that she brought the matter to the attention of the Chief Licensing Officer and expressed the view that she lacked confidence that the appellant would operate the daycare facility in compliance with the *Act* and *Regulation*.

[52] During the LO's follow-up inspection on May 2, 2002, the appellant told the LO that she did not believe there had been any hazard on April 19, 2002. The LO asked for a supervision plan, but the appellant declined to write one right away, stating in a tone that the LO found loud and angry that she did not have time to do it. Ultimately, they arranged to meet the next day and develop the requested plan. The LO again consulted with the Chief Licensing Officer about her concerns regarding hazard risk and non-compliance at the facility. Among other things, she noted that she wished to have a second licensing officer attend all inspections with her, as the appellant was confrontational and maintained that there was no "hazard". Ultimately, at the next facility inspection, on May 3, 2002, the appellant apologized to the LO for her prior behaviour and they discussed at length fire safety, supervision and regulatory requirements.

[53] The second instance when unauthorized use of the basement attracted a "high" hazard occurred on March 31, 2004. On that day, the LO dropped in to visit the daycare facility at 1:05 p.m. to discuss a complaint that was ultimately determined to be unsubstantiated. At 2:15 p.m. the appellant asked the LO to

leave and return the next day as she had two sleeping children that she had to wake to take to an appointment at 3:00 p.m. When the LO asked to see the children, she learned that one child was upstairs. However, it was not until she made a further inquiry about the whereabouts of the second child that she learned that the second child was downstairs. Although the appellant had checked the child in the upstairs sleep room during the visit, the appellant did not check the child in the basement at all during the visit.

[54] In her Facility Inspection Report of the same date, the LO again gave the facility a "high" risk rating. She pointed out that the basement was not an approved area for childcare. It had not been approved by the Penticton Fire Department for such use because it did not have a second exit. In a Supplementary Report of the same date, the LO noted:

> Should Dianne be found in non-compliance to Licensing and Fire Regulations again, action may be taken on her Licence.

[55] Additionally, the LO stipulated that, effective immediately, the appellant was to ensure that only the approved areas of the premises were used for childcare and that children were supervised in accordance with the *Regulation*.

[56] When the LO delivered these Reports to the appellant on April 1, 2004, the appellant signed the reports, but denied leaving a child downstairs, unattended, writing that she only left the child unattended to answer the door in response to the LO's visit, and otherwise did a rotation every three minutes or less.

[57] At the hearing of this appeal, the appellant said that the child who was downstairs was using the bathroom, not sleeping in the basement. When it was pointed out that the child was downstairs for 45 minutes, she acknowledged that the child was not in the bathroom the whole time and that she did not know what the child was doing during that time. Despite this, she denied the suggestion that the child was unattended during this time and said she had a monitor and could hear him.

[58] The third occasion when unauthorised use of the basement attracted a "high" hazard rating occurred on March 13, 2006, when Ms Page attended the facility in response to the complaint about Child A and found another child using the basement. That incident is described above and will not be repeated here.

(b) presence of unauthorized persons

[59] There were four instances in which persons without the requisite documentation or authorization were found to be working or living at the facility.

[60] The first occurred on January 17, 2002, when the LO conducted a drop-in visit of the daycare and found that a substitute caregiver, who was covering the appellant for a pre-approved absence, was present at the facility with two children. The LO learned that the substitute caregiver lacked some of the requisite documentation needed to work as a staff member in a licensed family daycare facility, such as a doctor's letter of fitness, a record of immunizations and reference checks. The LO left a Facility Inspection Report containing

instructions requiring that the appellant ensure that all staff documentation was complete before permitting a substitute to work in the daycare. During her evidence, the LO stated that she considered this to be a contravention of the *Regulation*.

[61] Then, on June 13, 2002, the LO learned that the appellant had been employing a substitute who lacked the requisite documentation to work in a licensed daycare facility. Apparently, the appellant had visited the licensing Authority's office to obtain a criminal record check form for the substitute, at which time, a licensing clerk had informed the appellant that no children could be left alone with the substitute unless all necessary documentation was on file. The same day, the LO left a Facility Inspection Report at the facility confirming that someone had been working in the facility without a criminal record search result and stating that no one could work alone with children in the facility unless they had all of the qualifications and documentation required for a "responsible adult". In the Report, the LO instructed the appellant to contact her to discuss her plans for a substitute caregiver.

[62] As a result of not hearing from the appellant, the LO telephoned the appellant on June 19, 2002. In the LO's notes of the conversation, she recorded that the appellant questioned the *Act* and *Regulation* and did not understand the risk to children of leaving them alone in the circumstances.

[63] On November 15, 2005, the LO made a drop-in inspection of the facility as a result of receiving a number of complaints, including one that indicated that a 14 year old foster child had been left alone with a child in care in July 2005. The appellant acknowledged that she was a foster parent and had a 14 year old child in care for two weeks during the summer. She denied having left children unattended. The LO reviewed with the appellant the necessity that the licensing Authority be given a criminal record check for any foster child of 12 years of age or more before the foster child would be permitted to live at a home containing a daycare facility. At the hearing, the LO testified that the presence of a 14 year old in the facility without a criminal record check was a regulatory contravention.

[64] The fourth instance in which a person lacking the requisite documentation or authority to work at a licensed daycare facility was the incident of March 13, 2006, when the appellant's friend was found to have attended to monitor the facility. That incident is described above and will not be repeated here.

CONCLUSION

[65] The Panel has decided to confirm the reconsideration decision. Indeed, the Panel has decided that the decision to cancel the appellant's licence is justifiable, not only on the basis set out in the respondent's reconsideration decision, but also on the basis of the appellant's version of the relevant events.

[66] In reaching this decision, the Panel has considered not only the material that was before the respondent, but also the evidence and submissions received in the oral hearing. We have not recited all of the evidence and submissions in these reasons. We note, however, that we found the evidence given by the

witnesses of the licensing Authority to be credible and reliable, as well as internally consistent and consistent with the record.

[67] We found the appellant's evidence to inconsistent, unreliable and generally lacking in credibility. As indicated above, her evidence was inconsistent, not only with the evidence of the licensing Authority's witnesses, but also with the record and with her own submissions in the reconsideration and appeal process. The evidence of her witness was of little assistance, insofar as it lacked helpful detail. Accordingly, we accept the evidence of the licensing Authority's witnesses over the appellant's evidence, wherever the appellant's evidence is inconsistent with theirs.

[68] In our view, the licensing Authority has established that:

1. on three occasions, the appellant permitted one or more children in care at the daycare facility to use the basement, despite knowing that the basement was not authorized either by the licensing Authority or the Penticton Fire Department for such use and, in particular, that it was considered by the Fire Department not to meet licensing requirements, for safety reasons, because it lacked a second exit, in contravention of section 7(1)(b) of the *Act* and section 18 of the *Regulation*.

2. on four occasions, the appellant permitted persons lacking the requisite documentation to work or live in the facility and on at least two of those occasions permitted such persons to be alone in the facility with children in care, in contravention of section 7(1)(a) of the *Act* and sections 8 and 12 of the *Regulation*.

3. on March 13, 2006, the appellant operated the facility in contravention of a health and safety plan by operating the facility without the monitor designated in the plan, without a monitor at all, and with a monitor who lacked the requisite documentation and approval from the licensing Authority. Moreover, she did so knowing that no person could work in the facility without the requisite documentation and knowing that she was not entitled to operate the facility except in compliance with an approved health and safety plan because the facility was being investigated for child abuse.

4. The appellant failed to meet the needs of an infant in care, Child A, and failed to provide him with a comprehensive and coordinated program of activities that met the standard of care as required by section 7(1)(b) of the *Act* and sections 31 and 32 of the *Regulation*.

[69] In our view, the evidence supports the conclusion that the appellant contravened the *Act* and *Regulation* in the various respects described in this decision. Moreover, the appellant has failed to establish that the respondent erred in the reconsideration decision by deciding to uphold the MHO's decision to cancel her licence to operate the daycare facility as a result of these contraventions.

[70] With respect to the respondent's finding of neglect, we do not think that the respondent's decision goes as far as to say that the appellant held the child down for the duration of the one and a half hour nap-time on March 9, 2006. However, we agree that the evidence supports his finding that the appellant kept laying the child down from a sitting or standing position, endeavoured to keep him lying down and confined him to the play pen for approximately one and a half hours. It was clear that the child wanted to get up and be held and that his needs were not met in the circumstances. As a result of the appellant's activities, the child sustained the aforementioned series of five abrasive marks from ear to ear, across the back of his head.

[71] With respect to the issue of whether the appellant possessed the judgment and temperament to be licensed to operate a daycare facility, we note that, even on her view of her care of Child A, the evidence established she lacked the requisite judgment and temperament.

[72] More particularly, the appellant's own evidence confirms that she was persistent in her efforts to get a child who was used to two naps a day to fit into her schedule of one nap a day, despite his difficulties in adjusting to a new sleep schedule within days of his arrival at the facility. She kept him in the play pen while he was agitated, knowing he wanted her to hold him.

[73] Perhaps most importantly, the appellant failed to recognize while she was repeatedly laying the child down (some fifteen to thirty times on her version of events), that the child was being required to lie, for an extended period, on an upside-down mat whose surface was hard, rough and uneven and that this was causing the infant harm. Even on her version of events, it is difficult to accept that the appellant would not have noticed that the mat was upside down when she repeatedly laid him on it or that the child was sustaining injuries from his agitated movements while lying on the mat. If, as the appellant says, she was with the child the whole time, but she did not see the back of the child's head until nap-time was over, this confirms that she failed to investigate the child's agitation to see if there was a physical cause for it. This demonstrated a lack of judgment and appropriate temperament on the appellant's part and amounted to neglect of Child A as defined by the *Regulation*.

[74] The events of March 9, 2006 alone may or may not have been sufficient to warrant a cancellation of the appellant's licence. To those events, however, we add the fact that Child A began sustaining injury from being placed in the same play pen, on the same upside down mat, the prior day. This compounds the evidence of lack of judgment and of neglect on the appellant's part. Furthermore, the events of March 9 and 10, 2006 are evidence of the appellant's continuing failure to provide Child A with a comprehensive and coordinated program of activities that met the standard of care required by section 32 of the *Regulation*.

[75] Moreover, these events, when viewed in the context of the history of the appellant's contraventions of the *Act* and *Regulation,* support the reconsideration decision's affirmation of the cancellation of her licence. In this regard, we refer to the four instances, described above, when the appellant knowingly permitted

persons lacking the requisite documentation to qualify as “responsible adults” to work or live at the facility, which included two instances in which they worked alone with the children. Additionally, we refer to the three instances in which the appellant permitted a child or children to use the basement of the facility, despite knowing that use of the basement as part of the daycare operation was not authorized either by the Penticton Fire Department or by the licensing Authority. Further, we refer to the fact that the appellant operated the facility on March 13, 2006, in contravention of a health and safety plan by continuing to operate it without the designated monitor, with a substitute monitor who lacked proper documentation, and without any approved monitor at all, despite knowing that the licensing Authority would not have permitted this.

[76] Additionally, we agree with the respondent’s concerns about the appellant’s ability to operate the facility in compliance with the *Act* and *Regulation*, in future. In addition to the concerns about her neglect and lack of appropriate care of Child A, there are legitimate concerns about her lack of judgment and understanding respecting the risks posed to children of repeatedly permitting the use of unapproved areas of the premises and permitting unsupervised child care activities. There are legitimate concerns about her repeated use of underqualified substitute care providers while she was absent from the premises.

[77] More importantly, there are legitimate concerns about the appellant’s approach to compliance with the *Act* and *Regulation*, as well as her attitude towards and lack of cooperation with the licensing Authority’s officers. In this regard, we refer to the appellant’s lengthy history of non-compliance with restrictions on the use of her basement and with restrictions on the use of substitute care-givers. We agree with the respondent’s concern about the appellant’s non-compliance on March 13, 2006 with the health and safety plan by operating the facility without the designated monitor, by operating it with an underqualified substitute and by operating it without any monitor at all despite understanding there was a need for one. Moreover, we agree with his concern about the appellant’s response to the investigation and complaint allegations, which revealed a lack of cooperation and constructive attitude and, ultimately, a confrontational approach.

[78] Additionally, we are concerned with the appellant’s attitude, temperament, and judgment. She repeatedly disregarded the licensing Authority’s requirements and, where she disagreed with those requirements, she continued to contravene them. In her view, those requirements were dispensable if she did not think them necessary. Quite clearly, she believed the children in her care were safe and therefore she did not need to comply with statutory and regulatory obligations intended to protect them against risk of harm. She did not ensure that she understood the necessity for complying with those obligations. Moreover, she did not ensure she understood the implications and consequences of failure to comply with those obligations.

[79] The appellant’s response to the licensing Authority’s attempts to bring the necessity for compliance home to her, through Facility Inspection Reports containing high hazard ratings and through the efforts of licensing officers to

explain her obligations to her, also revealed lack of judgment. She was defiant and non-cooperative. Her difficulties interacting with the licensing Authority became increasingly confrontational.

[80] The appellant's response to the culminating events of March 2006 further demonstrated her lack of judgment and temperament. Her treatment of Child A reflects her persistent and uncompromising approach to child-care, as well as her lack of sensitivity and attention to the details of appropriate child-care. As noted above, she placed an infant child in equipment likely to injure him and persistently endeavoured to compel him to nap in circumstances which, had she been attentive, ought to have led her to realize that he was in discomfort and was sustaining injury. On her own version of events, she laid the child down fifteen to thirty times, within the space of an hour and a half, but failed to notice that he was justifiably uncomfortable, agitated and upset on being required to lie down on a hard, uneven, and rough surface for that length of time.

[81] The appellant's response to the parents' complaint about her care of their child also demonstrated the lack of seriousness with which she viewed concerns about her conduct. She was dismissive of the parents' concerns. During the oral hearing, she said that they had a "knee jerk" reaction, even though they spent several days considering whether or not to complain.

[82] The appellant's response to the licensing Authority's investigation was to feel defensive and attacked, rather than to take seriously its concerns about the risks that her conduct and history of non-compliance posed to children. Among other things, she accused the licensing Authority of arbitrary, discriminatory and dilatory treatment of her. We found no evidence to support these allegations. We note that the transcript of the interview was not fully transcribed until the Fall of 2006, through inadvertence. Although the full transcript was not provided to the respondent, and the appellant claimed she had not received a copy of the full transcript before these proceedings, despite receiving a letter from the licensing Authority said to enclose a copy of it, the appellant had an opportunity in these proceedings to review and make submissions about the full transcript, which she said reflected the gist of the interview. In our view, the missing passages were not so material as to alter the result of this appeal. However, it may have been prudent and helped to mollify the appellant's sense of maltreatment by the licensing Authority had she been given a copy of the tapes of the interview at an early date, as she had requested, rather than simply the transcript itself.

[83] Finally, we note that the appellant continues to take the view that Child A's injuries are "explained" by the discovery that the playpen mat was upside down and she queries why the matter was further pursued, since there was not proof of child abuse. There was, however, neglect within the meaning of the *Regulation*. The appellant's failure to appreciate the significance of her neglectful conduct towards Child A demonstrates a lack of understanding of the risk that her actions posed to the child and the need to comply with a licensee's statutory and regulatory obligations, whether she agrees with them or not.

SUMMARY

[84] After carefully considering all the evidence and submissions before the Panel, and for all the reasons stated above, the Panel finds that the appellant has failed to establish that the respondent erred in the reconsideration decision in deciding to uphold the MHO's decision to cancel her daycare facility licence. The Panel finds that the decision to affirm the cancellation is supported not only by the evidence that was before the respondent, but also by the evidence that was before us. Accordingly, the Panel confirms the reconsideration decision and the appeal is dismissed.

August 20, 2007

Alison H. Narod, Chair

Judy Pollard, Member

Gordon Armour, Member