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

APPELLANT: EL, Licensee,
(operating Little Light Day Care Centre)

RESPONDENT: Dr. James Lu, Medical Health Officer,
Vancouver Coastal Health

PANEL: Alison H. Narod, Panel Chair
Dianne Ledingham, Member
Sheila Ebenstiner, Member

DECISION

INTRODUCTION

[1] This decision concerns an appeal by EL (the "appellant") of a November 22, 2006 decision by the respondent Dr. Lu, a Medical Health Officer (the "MHO"), dismissing her application to reconsider the MHO's earlier decision to cancel her licence to operate Little Light Day Care Centre (the "facility"), pursuant to section 14 of the *Community Care and Assisted Living Act* (the "*Act"*).

[2] The appellant had been licensed to operate a family daycare since May 1996. On November 9, 2006, Vancouver Coastal Health (the "Licensing authority") commenced an investigation of a complaint made against the facility under section 15(1)(b)(ii) of the *Act*. By a decision dated November 9, 2006, the MHO cancelled the appellant's licence under section 14 of the *Act* (the "Original Decision"). By letter dated November 13, 2006, the appellant sought reconsideration of the MHO's decision to cancel her licence. The MHO conducted a reconsideration of his November 9, 2006 decision to cancel the appellant's licence and, by letter dated November 22, 2006, affirmed that decision, pursuant to section 17 of the *Act* (the "Reconsideration Decision").

[3] The Community Care and Assisted Living Appeal Board (the "Board") has authority to hear this appeal under section 29(2)(b) of the *Act*. Section 29(11) of the *Act* provides that the Board must receive evidence and argument as if a

proceeding before the Board were a decision of first instance, but the appellant bears the burden of proving that the decision under appeal was not justified. 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. Oral testimony was given by the appellant, the MHO and a number of witnesses employed by the Licensing authority.

ISSUES

[4] The main issues to be determined in this matter are:

1. Did the MHO have jurisdiction to cancel the appellant's licence under section 14 of the *Act*?

2. Was the appellant deprived of procedural fairness or natural justice in the conduct of the investigation or in the course of the MHO's subsequent decisions?

3. Were there reasonable grounds to believe there was an immediate risk to the health and safety of a person in care?

FACTS

[5] The appellant was the licensee and manager of a child care facility which she had operated, alone, for 10 years. The facility was licensed for a maximum of 8 children over 30 months of age, with the exception that, from March 14, 2005 to August 10, 2006, a condition was placed on her licence under section 14 of the *Act*, limiting the number of children in care to a maximum of three, due to repeated instances of alleged non-compliance with the *Act* and *Regulation*.

[6] The November 9, 2006 decision to cancel the appellant's licence was made as a result of an incident that occurred on November 8, 2006, when a child in care ("Child A") temporarily went missing from the facility. We will describe the November 9, 2006 incident, below. Before doing so, we note that the facility was located in a part of Richmond, B.C. that was near to open, water-filled ditches and there was an active construction site next door. We also note that the appellant had a lengthy prior history with the Licensing authority, which forms part of the background to this matter and is mentioned below as part of the description of the parties' positions and of the licensing authority's investigation and decision-making process.

[7] According to the appellant, she had 3 children in her care at the facility on November 8, 2006. One of them was Child A, who was four years old at the time. Child A started attending the facility in August, 2006. Child A had significant behavioural issues, such as being non-compliant and being aggressive to other children. The appellant had discussed these issues with

Child A's parents and understood that the child had an appointment to be seen at the Richmond Health Department.

[8] At about 1:30 p.m., while the appellant was helping a 2 ½ year old child in the washroom, another child came to tell her that Child A had left the premises. Apparently, Child A unlocked and opened the front door and exited the facility.

[9] The appellant was aware that Child A had previously tried unsuccessfully to open the front door and had only been able to open it successfully, once, when a parent came, but she had never before left the facility on her own. On this particular day, the front door was closed and locked. However, it did not have a childproof lock on it.

[10] On discovering that Child A was missing, the appellant immediately sought help to search for the child. First, she tried to contact Child A's father at home, as she understood that he sometimes did not work in the daytime and she thought it would be faster if he helped in the search because he had a car. She was unable to contact him. Next, she contacted Child A's mother at work. The appellant told the mother that she could not leave the facility to search for the child immediately, as she had to prepare the other children to do so. She assured the mother she would find Child A. She then quickly dressed the remaining children to go outdoors. They left the daycare at about 1:35 p.m. and searched for Child A for 15 to 20 minutes, but did not find her.

[11] According to notes contained in the Licensing authority file of a November 9, 2006 telephone conversation with Child A's mother, the mother said that the appellant called her between 1:15 and 1:30 p.m. to tell her that Child A was missing. The appellant told the mother that she would not leave the house because she had other children. The mother then tried unsuccessfully to reach her husband, but managed to contact a friend, "T" who worked near the facility and who agreed to help look for Child A. There is no evidence about whether or not the mother told the appellant she would find someone to help in the search.

[12] According to the appellant, on her return to the facility at about 1:50 p.m., the mother's friend, T, was at the facility. T had also undertaken an unsuccessful search for Child A. The appellant and T discussed calling the police and, at T's suggestion, the appellant called the mother to obtain permission to do so. During this call, she also advised the mother that she had gone out to look for the child. Then, at about 2:08 p.m., the appellant called 911 to report Child A missing. While calling 911, Child A arrived at the facility with her father. At 2:09 p.m., the appellant reported to 911 that the child had been found.

[13] Apparently, after Child A left the facility, a neighbour had noticed her wandering around and, guided by the child, the neighbour drove the child to her previous daycare. According to a November 8, 2006 statement written by

the previous caregiver, the neighbour and Child A arrived at the previous daycare at about 1:30 p.m. The previous caregiver recognized Child A, took custody of her and then contacted Child A's father on his cell phone at his home at about 1:45 p.m. She observed that the child was not dressed for the outdoors, that she was dirty and that she had a full diaper.

[14] In her written statement, the previous caregiver noted that the father arrived to pick up Child A at the previous daycare at about 1:55 p.m. While there, the father said that the child's mother had already told him that the appellant had notified her that Child A was missing. Additionally, the previous caregiver and the father discussed Child A's behavioural problems and the father advised that the family would be starting counselling in two weeks.

[15] The father left the previous daycare with Child A at about 2:05 p.m. At about 2:10 p.m., the previous caregiver reported the incident to the Licensing authority. This report prompted the Licensing authority to immediately commence an investigation into the incident.

[16] As part of this investigation, on November 8, 2006, Joyce Branscombe, a Senior Child Care Licensing Officer (the "SLO"), spoke with the previous caregiver and, the next day, obtained the above-noted written statement from the previous caregiver.

[17] The same day, the SLO contacted the appellant. The SLO advised the appellant to prepare an Incident Report and notified her that she would visit the facility the next day. No time was set for the visit and no notification was provided that this visit might result in summary action.

[18] The SLO and Adrienne Cathcart, another Licensing Officer (an "LO"), met with the appellant to interview her in the morning of November 9, 2006. At the time, the appellant was caring for 2 children at the facility.

[19] The appellant's evidence was that she was not aware that the interview could result in the cancellation of her licence and that she was distracted from devoting attention to the interview by having to simultaneously care for the children. For the purposes of considering the Licensing authority's approach to the investigation, it is of interest to note that the SLO made a point of stating, in connection with her views about the appellant's responsibility to supervise children in her care, that the presence of Licensing Officers at the facility does not alleviate the appellant's responsibility to supervise the children, herself. It is also of interest to note that the SLO views a caregiver's supervision to be inadequate if children in care are not in the same room as the caregiver or in her line of sight at all times. Such views affected the SLO's opinions about the quality of the appellant's performance of her responsibilities.

[20] In her evidence, the SLO acknowledged that she was aware at the time of the interview that cancellation of the appellant's licence and closure of the facility could be a consequence of the investigation. However, she did not

communicate this to the appellant. She said it was not normal practice to do so.

[21] As requested, the appellant had completed an Incident Report and she gave it to the SLO during the November 9, 2006 visit. However, she omitted to mention in the Report that she had called the police. As seen below, this omission was seen as significant to the SLO and the MHO. According to the interview notes, the appellant told the LOs that she had called the police and explained that she omitted to mention this in the Report, as she thought it was not important because they had not helped to find the child. (Similarly, the Report failed to note T's involvement, although this omission was also discussed in the interview.) However, the Incident Report was not corrected to reflect this. The appellant now says that she simply forgot to include this fact in the Report and she tried to correct the omission, but was not permitted to do so. Despite finding this omission significant, the SLO did not provide any explanation for not ensuring the omission was corrected.

[22] Additionally, during the interview, it was discovered that the appellant did not have an emergency plan for dealing with a child's disappearance. We note that the MHO's evidence is that the Licensing authority does not have a recommended procedure or emergency plan for dealing with missing children. Moreover, there was some question about whether the appellant currently had a designated responsible adult readily available to assist her in emergencies. Furthermore, it was revealed that the appellant did not keep regular or fulsome records of the children in her care, including records of any unusual conditions or behaviours.

[23] A number of safety issues were noted during the visit and an Inspection Report was issued to, reviewed with and left with the appellant.

[24] After the visit to the facility on November 9, 2006, the SLO contacted the Richmond RCMP and was informed that there was no record of the appellant having called 911 between 1:00 and 2:30 p.m. on November 8, 2006. Furthermore, she was advised by the Richmond RCMP on November 15, 2006, that there was no record of the appellant having called the RCMP's general line in the same time-frame on November 8, 2006. During the hearing of this appeal, the appellant supplied a record from E-COMM, the agency that handles 911 calls for Richmond, verifying that there was indeed a 911 call from the appellant's phone number on November 8, 2006 at 2:08 p.m.

[25] Additionally, in the afternoon of November 9, 2006, the SLO had the above-noted telephone conversation with Child A's mother. The SLO did not contact Child A's father or T to see if either could verify the appellant's account of the events of November 8, 2006, including her contention that she had sought help to search for the child and was calling the police when the father arrived at the facility with Child A.

[26] In addition to the foregoing, after the SLO returned to the Licensing authority on November, 9, 2006, the SLO reviewed the Licensing authority's entire file for the facility. After considering the results of her investigation, the SLO formulated a recommendation for the MHO that summary action be taken to close the facility. She formed the view that she no longer had confidence that the appellant could provide safe care to children.

[27] The SLO met with the MHO for about an hour in the afternoon of November 8, 2006. She did not provide him with anything in writing. She did not give him the Licensing authority's file on the facility to review. She verbally summarized the results of her investigation, including the information she obtained from Child A's mother, from the previous caregiver, from the appellant and from the police. Among other things, she told the MHO that the appellant had not called the police. Additionally, she verbally summarized her review of the appellant's facility history. She conveyed her recommendation that summary action be taken to close the facility. The SLO gave evidence that it was during their meeting that the MHO decided to take the summary action of cancelling the appellant's licence.

[28] During his testimony, the MHO confirmed the SLO's account of their meeting and added that he understood from the SLO that Child A had attempted to leave on several occasions in the past and had successfully opened the door on one prior occasion. In his view, the appellant's efforts appeared to be disorganized and there were questions about whether the police were called and, if so, whether they were called immediately. The MHO understood that the appellant did not ask another adult to help search for the child. He was concerned that the outcome for the child could have been very different. The MHO confirmed that the SLO reviewed the appellant's file history, which gave a picture of a facility that had challenges in meeting the requirements of the *Act* and *Regulations*, particularly with respect to supervision and hazardous conditions. After deliberating alone for about a half hour, the MHO decided that immediate action was appropriate given what was then known.

[29] As a result, the MHO directed the SLO to prepare the November 8, 2006 letter which contained the Original Decision, as well as a note documenting the discussions they had in their meeting. The MHO identified a Briefing Note, dated November 10, 2006, as the document the SLO prepared to record their discussion. Among other things, the Briefing Note states that:

- "[the appellant] took no immediate action to assist in locating the missing child";
- "she did not immediately call either 911 or a neighbour to assist in searching for the child";

- "[the appellant] stated that she did call the RCMP, however the Incident Report submitted to Licensing does not indicate this action was taken";

- after being contacted by the appellant between 1:15 and 1:30 p.m., the mother "phoned her neighbour, [T] who immediately went in search of A".

[30] The Briefing Note also included a three-paragraph summary of the appellant's facility history.

[31] The Original Decision stated, in part:

> On November 8, 2006 our office received a complaint that alleged that a child left the [facility] unaccompanied by you and left without socks, shoes or a coat. The complaint alleges that the child was picked up by a motorist who took the child to another licensed child care facility. Our investigation confirms the child did leave the [facility] and was picked up by a motorist and taken to another child care facility. In allowing the child to leave your facility, not calling a second adult to assist you, not searching for the missing child and by not immediately contacting the RCMP you are in non-compliance with section 18 of the Child Care Licensing Regulation that states:
>
> > 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.
>
> Further you have contravened section 7 of the Community Care and Assisted Living Act that states:
>
> A licensee must:
>
> > Operate the community care facility in a manner that will promote the health, safety and dignity of the person in care.
>
> Given the serious risk your action or lack of action has caused to the persons in care and pursuant to section 14 of the Community Care and Assisted Living Act your Community Care Licence will be cancelled at 5:00 p.m. November 9, 2006.

[32] No mention was made about the appellant's facility history in the Original Decision, although, as noted below, the decision was based, in part, on that history.

[33] As section 14 of the *Act* did not require it, the MHO did not provide the appellant with reasons for the cancellation before taking action to cancel the appellant's licence. Nor did he provide the appellant with further reasons beyond those contained in the Original Decision after taking that action, or indeed until he issued the Reconsideration Decision.

[34] During his evidence, the MHO said that he considered the information the SLO supplied him to be sufficient and compelling; it convinced him that there was an immediate risk that justified the summary action. In his view, the incident had occurred, the outcome could have been serious, the response did not appear to be very organized and the licensee's history indicated that she had difficulty recognizing hazards to children.

[35] At 4:45 p.m. the same day, the SLO and the LO attended at the facility and delivered the Original Decision to the appellant. As a result of observing conditions at the daycare at this time, a second Inspection Report was issued to the appellant.

[36] On November 13, 2006, the appellant sought reconsideration of the Original Decision based on the MHO's reasons as set out in that decision. Among other things, she disagreed with the MHO's decision to cancel her licence, saying that she did call Child A's parents, she did attempt to look for her and she did alert the RCMP as soon as she realized that the child was not in the immediate vicinity. Additionally, she noted that Child A had significant behavioural problems that were stressing her and affecting her work and health. Moreover, the appellant committed to preventing a recurrence, as well as to complying with the *Act* and *Regulation* in future, supervising the children at all times and promoting their health and safety.

[37] By letter dated November 15, 2006, the SLO provided the appellant with a summary report of the incident and investigation regarding Child A's disappearance, as well as two Inspection reports dated November 9, 2006. None of these documents stated that they contained the MHO's written reasons for the Original Decision. Nor did they advise the appellant that their contents could be addressed or challenged as part of the appellant's application for reconsideration. The appellant was not provided with notes of the interview the SLO and the LO (together the "LOs") conducted with her on November 9, 2006 until January 8, 2007 as part of the appeal process. Indeed, the appellant was not advised of what materials would be placed before the MHO for consideration during the reconsideration process.

[38] In reconsidering the Original Decision, the MHO reviewed the entire facility file, as well as the appellant's submission. On November 22, 2006, the MHO issued the Reconsideration Decision in which he dismissed the appellant's application for reconsideration and confirmed his earlier decision to cancel the appellant's licence. He wrote that he found nothing in the information she had submitted to cause him to change his decision and he expanded on his reasons for his earlier decision to cancel her licence. Ultimately, he issued the

November 22, 2006 Reconsideration Decision in which he declined to change the Original Decision.

[39] In the Reconsideration Decision, the MHO acknowledged that the appellant had called Child A's parents. He noted that she may have called the RCMP, but there was no record of such a call to 911 at all or to the RCMP's general line between 1:15 and 1:45 p.m., the "probable timeframe if a call were made in a timely fashion" that day. Moreover, the MHO noted that the appellant's Incident Report of November 9, 2006 did not mention that the police had been called.

[40] During his evidence, the MHO said that whether or not the appellant had called the police was a contentious issue at that time. Having subsequently learned, during the hearing of this appeal, that the appellant called 911 at 2:08 p.m. that day, he said he remained of the view that this was not a timely call, in the circumstances, and this new evidence would not alter his decision. Had the call to the police been within the timeframe he described as timely, it might have given him more comfort that the appellant understood the seriousness of the situation, thought it through and responded in the right sequence.

[41] In the Reconsideration Decision, the MHO acknowledged that the appellant had conducted a search for Child A, but said that those search efforts were superficial. He wrote:

> You did not ask for help from another adult either to look after the other children for you, or to help you in the search. Recollections of Child A's mother, of the telephone conversations with you at the time, painted a similar picture. In summary, my impression of your handling of the incident is one of disorganization and uncertainty.

[42] In his evidence before this Panel, the MHO addressed the nature of the search the appellant conducted herself. He questioned her ability to conduct an adequate search with a number of children in tow. He noted that the appellant claimed to have a responsible adult available to assist, if needed. The appellant failed to explain why she did not call that adult to either search for the child or look after the children remaining at the facility while the appellant searched for the child. The fact that T assisted in the search did not give the MHO comfort about the appellant, because he understood that it was Child A's mother, not the appellant, who secured T's assistance. He said his views might have been different if the appellant had found some help herself or had called the police.

[43] We find that the purpose of the appellant's telephone calls to Child A's father and then to her mother were to alert them to their child's disappearance and to seek their help in the search for her. Child A's father was unavailable and Child A's mother called a friend, T, who quickly came and helped search

for the child. After the searches conducted by the appellant and T were unsuccessful in finding the child in the immediate vicinity, the appellant first called Child A's mother and then called the police, albeit about 25 minutes outside of the timeframe that the MHO considered a timely call to the police should have been made.

[44] In the Reconsideration Decision, the MHO disagreed with the appellant's assertion that Child A's behaviour should have been a factor in the decision. The appellant was aware of the child's behaviour challenges and had agreed to take her into care. In fact, the appellant was aware that the child was capable of opening the front door of the facility. In his evidence, the MHO explained that the parents had entrusted the child to the appellant's care and she was responsible for the health and safety of that child, regardless of what she was like.

[45] The MHO was not persuaded to change his views by the appellant's assurances of future compliance. In the Reconsideration Decision, he wrote:

> I reviewed your licensing file. There has been a large number of concerns expressed by Licensing Officers since the beginning of your facility's licensing history. Many of the concerns are to do with the health and safety of the children under your care. A condition restricting your facility to a maximum capacity of three children in care was placed on your license between March 2005 and August 2006. The condition was issued due to safety concerns. Within a month after the condition was lifted, there was a serious concern regarding unsafe fencing in your facility's backyard.
>
> I acknowledge your assurance that you will comply with the Community Care and Assisted Living Act and regulations. However, the history of the operation of your day care does not demonstrate a commitment to compliance with the Community Care and Assisted Living Act and regulations. Further, your letter does not contain any concrete plans to address the risk of missing children in the future.
>
> ….Unfortunately, your facility's licensing history and this most recent and very serious incident do not assure me that you are capable of operating a licensed child care facility independently, in a manner that promotes the health and safety of the children in care.

[46] In his evidence, the MHO said that the picture he had from reviewing the facility file was that there was a history of challenges, particularly with health and safety issues. For whatever reason, the appellant was not capable of identifying hazards to children and pro-actively addressing them. Her history regarding similar hazards, such as fencing issues, was that she would comply

when hazards and infractions were brought to her attention and, even then, she might have to be asked to remedy them again if they again fell into hazardous conditions.

[47] With respect to Child A's disappearance, the MHO said that the interview evidence indicated that there were instances where the child had wanted to go outside. This suggested to him that the child did not want to be there. The appellant knew the child wanted to go out. She could have taken steps to address this, such as talking to the child. Given that the child wanted to go out and could unlock the door, the risk that she would leave without supervision was high. This, in his view, was fairly serious.

[48] The MHO said he also considered whether there were any options other than cancelling the licence, such as attaching conditions to the licence, for example with respect to specific hazards or with respect to capping the number of children in care. He ruled those options out, as he lacked confidence that the appellant could identify or anticipate hazards and take corrective action on her own. Accordingly, he was not confident that the appellant could ensure the health and safety of the children in her care.

THE PARTIES' POSITIONS

[i] The Appellant's Argument

[49] The appellant says that the MHO's decision was based on incorrect information resulting from inaccuracies and procedural flaws in the investigation conducted by the Licensing Officers. Additionally, she says, a number of minor and irrelevant factors from past inspections were taken into account which, in themselves, contained inaccuracies. All of this was unfair in her view.

[50] With respect to the incident involving Child A, the appellant disagrees with key findings. She says that this was the first time in her ten years of operation that a child had ever unlocked and opened the door and left the centre. The appellant submits that Child A's departure was not predictable. Although Child A had tried to open the front door in the past, and had succeeded once in doing so, she only did this when a parent came. There was no prior indication that she would leave the facility, unaccompanied. She says that the fact the child's behaviour was challenging ought to have been taken into account.

[51] With respect to the incident itself, the appellant says that she endeavoured to contact another adult as soon as she noticed that Child A was missing. Although she was unsuccessful in contacting Child A's father, she successfully contacted Child A's mother, who arranged for a friend to assist in a search for the child. She disagrees with Child A's mother's account that she said she could not search for the child and points out that she did in fact conduct a search for the child. On her return to the facility, she found the

mother's friend T present, after having also concluded an unsuccessful search. After calling the mother again to obtain permission to call the police, the appellant promptly called them and now has evidence proving that she did so. While talking to the police, the father arrived with the child, successfully concluding the search. We note that the appellant says she discovered the child was missing at 1:30 p.m. and she produced records of the call to the police showing that it occurred at 2:08 p.m.

[52] The appellant says that she had never been advised by the Licensing authority's staff that she required a childproof lock on the house door or a missing child procedure. This evidence is not disputed. In any event, she has now put a childproof lock on the door and has such a procedure.

[53] With respect to the investigation of the November 8, 2007 incident, the appellant says that although she was given notice that the Licensing authority's staff would attend at her facility the next day, she was not advised that they would do so during operating hours or that the result of their interviews with her that day could result in the cancellation of her licence. As a result, she was not able to devote proper attention to the Licensing Officers, as she was concurrently caring for children and distracted by them. She says that during the visit, she was not permitted to correct omissions in an Incident Report she had prepared for the Licensing Officers or inaccuracies in their interview notes. She says she was not provided with the interview notes until January 8, 2007.

[54] Additionally, the appellant notes that the Original Decision to cancel her licence, dated November 9, 2006, was based on the incident of November 8, 2006, alone, and that the MHO's reconsideration of that decision took into account a prior history which had not formed part of the Original Decision. The appellant says this history was not relevant, and included minor incidents, misleading or inaccurate descriptions, and otherwise explicable circumstances. Moreover, she says, she has corrected all the health and safety issues referenced in the inspection reports.

[55] The appellant says that the revocation of her licence was far too severe a consequence in relation to the unfortunate incident involving Child A. This was an isolated incident involving a particularly challenging child. She did everything she could think of when the incident occurred, including contacting other adults, searching for the child, and phoning the police. She says this was a learning experience for her. She expresses confidence about her abilities to respond appropriately in future. Additionally, she commits to compliance with the *Act* and *Regulations*. She says that her financial well-being and livelihood is dependent on her licence.

(ii) The Respondent's Argument

[56] The respondents say that the incident concerning Child A was not an isolated incident, but was part of a history of incidents in which the health and

safety of children in the appellant's care were endangered by the actions or inactions of the appellant. This history had a significant bearing on the conduct of the investigation and the MHO's decisions to cancel the appellant's licence. This history included the following:

1. four instances in the past 3 years in which the appellant was alleged to be in contravention of the supervision requirements of section 18 of the *Regulation*;

2. inadequate fencing around the backyard play area:

   (a) in July 2005, when there was evidence that the backyard was not fully fenced, contrary to section 33(3) of the *Regulation*, which requires that licensees ensure that outdoor play areas be enclosed by a fence; and

   (b) in August 2006, when there was evidence that the fencing was in an unsatisfactory state of repair;

3. the repeated presence of plastic bags, constituting a suffocation hazard to children, contrary to section 7(1)(b) of the *Act*, which requires licensees to operate facilities in a manner that will promote the health, safety and dignity of persons in care; and

4. repeated instances of improper storage of medications and other products hazardous to the health and safety of children, contrary to section 7(1)(b) of the *Act*, and sections 27(a) and (b) of the *Regulation*, which require that licensees keep medications in locked containers and ensure that no poisonous or hazardous products are accessible to persons in care.

[57] The Licensing authority says that the appellant has been made well aware of the issues of non-compliance at the daycare over the years and given assistance and opportunities to correct these issues and maintain the facility in accordance with the *Act* and *Regulation*. Indeed, at one point in time, it added a condition to her licence restricting the capacity of the facility to three children in the hope that the appellant would be better able to cope with non-compliance issues if there were fewer children on the premises.

[58] Notwithstanding this, health and safety issues continued to exist up to and including the investigation of the incident that ultimately brought about the cancellation of the appellant's licence.

[59] The respondents say that these contraventions and many others were not minor incidents that were irrelevant to the matters at issue. The repetitive nature of these infractions and the appellant's apparent inability to identify health and safety hazards and proactively remedy them has caused the Licensing authority to lose confidence in the appellant's ability to comply with

the *Act* and *Regulation* in future and ensure the health and safety of children in care.

[60] With specific respect to the incident relating to Child A, the Licensing authority says that the appellant failed to implement an immediate and effective search procedure and points out that the outcome of this incident could have been very tragic. She did not have an emergency plan to guide her in the circumstances, contrary to section 28 of the *Regulation* which requires that licensees establish emergency procedures for such instances. Her response to the incident was disorganized and not timely. Although the Licensing authority acknowledges that the appellant called the police, she did not do so immediately on discovering the child missing, but waited until some 40 minutes later to do so.

[61] The Licensing authority says it was not apparent whether the appellant had a second adult readily available to supervise the children, as she was required to do under section 18 of the *Regulation*. If she did, she failed to call that person to assist her during this emergency. The Licensing authority notes that it was the child's mother who called the second adult to conduct or assist in the search for Child A.

[62] The Licensing authority says that the appellant's failure to implement an immediate and effective search procedure, including her failure to contact the police in a timely fashion and her failure to call a second responsible adult at all, show that the appellant failed to operate the facility in a manner that promotes the health, safety and dignity of the children in care, in contravention of section 7(1)(b) of the *Act*.

[63] With respect to the appellant's submission that Child A's behaviour ought to have been considered as a factor in the incident, the Licensing authority says that the licensee is obligated by statute to ensure that child's health, safety and dignity while in care. The child's behaviour does not negate the appellant's responsibility to comply with section 7(1)(b) of the *Act*. Further, it says that the appellant had knowledge that Child A could open the front door and failed to take preventative measures to prevent a recurrence until after the child went missing.

[64] The Licensing authority says that its staff have been very fair to the appellant in their dealings with her over the years. It takes issue with the allegation that its staff would not permit the appellant to make changes to the Incident Report or the Interview Notes. It says the evidence is to the contrary. It defends the timing of the November 9, 2006 visit, saying that its staff are required to conduct investigations in a timely manner, especially in instances of potentially serious risk to persons in care. It says the interview was conducted in a manner that was respectful of the needs of the children and the licensee.

[65] Moreover, the Licensing authority says that the MHO engaged in careful and thoughtful deliberations in reconsidering his decision to cancel the appellant's licence. He concluded that the appellant had failed to protect the health and safety of the children in care on numerous occasions, despite various attempts made by the Licensing authority to have her operate the facility in a manner that would protect and promote the health and safety of those children. The MHO considered options other than cancellation and found there were no viable options to ensure the protection of the health and safety of the children in care except to cancel the licence.

[66] Furthermore, the Licensing authority says that despite the appellant's promised commitment to future compliance with the *Act* and *Regulation*, her history indicates that when such commitments were made in the past, they did not have lasting consequence. Accordingly, it says there can be no confidence that she will operate the facility in future in compliance with the legislation and protect the health and safety of children in her care. Finally, it points out that the revocation of the licence will not deprive the appellant of her livelihood. She will still be able to seek employment as an Early Childhood Educator if she so chooses.

DISCUSSION AND ANALYSIS

1. Did the MHO have jurisdiction to cancel the appellant's licence under section 14 of the *Act*?

[67] In our view, the MHO had jurisdiction under section 15(1)(b) of the *Act* to investigate the complaint against the appellant relating to the temporary disappearance of Child A from the facility. Moreover, the MHO had jurisdiction to take summary action under section 14. The question which arises is whether the MHO had jurisdiction under section 14 to the take the particular action of cancelling the appellant's licence in the circumstances of this case.

[68] The statutory provisions relevant to this issue are as follows:

> **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...

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) ...

"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;

"written response" means a written response referred to in subsection (2)(b).

(2) *30 days before taking an action or as soon as practicable after taking a summary action*, a medical health officer must given the licensee or applicant for the licence

(a) written reasons for the action or summary action, and

(b) written notice that the licensee or applicant for the licence may give a written response to

> the medical health officer setting out reasons why the medical health officer should act under subsection (3)(a) or (b) respecting the action or summary action.
>
> (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 reasons to the licensee or applicant for the licence on acting or declining to act under subsection (3).
>
> (emphasis added)

[69] Section 14 of the *Act* is the statutory provision empowering a medical health officer to take summary action where he or she believes there is an immediate risk to the health and safety of a person in care. The type of action that a medical health officer may take is described in that section as "suspend the licence, attach terms or conditions to the licence, or vary terms or conditions of that licence, without notice". Section 14 does not expressly refer to a power to "cancel" a licence.

[70] In contrast, section 13 of the *Act*, which is the statutory provision empowering a medical health officer to take action where there is, among other things, non-compliance with the *Act* or *Regulation*, expressly refers to a power to "cancel" a licence. This is a notable distinction.

[71] Additionally, section 17 defines, for the purposes of that section, the terms "action" and "summary action" and sets out what appear to be somewhat different procedures, depending on whether the medical health officer takes "action" as opposed to "summary action". Notably, section 17 defines the term "summary action" as including "cancellation" of a licence.

[72] As previously mentioned, section 14, the empowering section, does not reference the word "cancel". This raises the question of whether or not the MHO had the power under section 14 of the *Act* to make the decision to cancel the appellant's licence, a decision that he later affirmed on reconsideration

under section 17 of the *Act* in the Reconsideration Decision that is now under appeal before this Panel.

[73] As this issue was not raised during the oral hearing, the parties were provided with an opportunity to make submissions. We have reviewed those submissions and describe them, below.

[74] The appellant submits that in matters of statutory construction, there is a presumption of uniform expression: the legislature uses the same words to express the same meaning, and different words to express different meanings. The legislature's intent in drafting sections 13 and 14 of the *Act* must have been to specifically exclude the ability to cancel a licence under section 14 of the *Act*. The scope of section 14 cannot be expanded to include that which was specifically excluded.

[75] The appellant says that this interpretation is consistent with the history of the legislation. More particularly, the predecessor to this legislation, the *Community Care Facility Act*, conferred on the Director (a term which included a medical health officer) a power under section 6 to attach terms and conditions to, suspend or cancel the licence of a licensee who has contravened an enactment. Additionally, section 7(1) of that legislation conferred on the Director an ability to attach terms or conditions to or suspend a licence, without notice or a hearing - but not to cancel one - where the Director had reasonable grounds to believe that the health or safety of persons in care was at risk. The appellant says that the same scope of power should be imported into the current *Act*.

[76] The appellant goes on to say that sections 13 and 14 accomplish two different purposes. Section 14 confers a power to act immediately, without notice, to, among other things, suspend a licence, but not to cancel one. On the other hand, section 13 confers a power to cancel a licence, but does not permit immediate cancellation.

[77] Moreover, the appellant says that although there is an apparent conflict between section 14 and the definition of summary action in section 17 of the *Act*, it would be unfair to apply the definition of summary action in section 17 to section 14, which specifically excludes the power to cancel a licence. An interpretation of section 14 that excludes the power to cancel a licence reflects the intention of the provision and is consistent with the legislative history.

[78] In the result, the appellant says that the MHO decided to take immediate action to cancel her licence. Although he had the power to take immediate action pursuant to section 14, he did not have the power to cancel the licence. Accordingly, he made a decision he had no authority to make. The appellant submits that the decision cannot stand and should be set aside as if it was never made. Consequently, the appellant should continue to hold a valid licence.

[79] In contrast, the respondent acknowledges that under section 14 the MHO does not appear to have the authority to summarily cancel a licence and that there appears to be a legislative drafting error, either in section 14 or section 17 of the *Act*, when section 14 is considered in isolation and not in the context of the *Act*. The respondent also says that the definition of "summary action" in section 17 is said to include the power to cancel a licence and this definition caused the MHO to believe he had that authority. The respondent characterizes this as a procedural matter and says that, if there was a procedural error, it has been cured during the full Appeal Board hearing process, which permits the Board to make a "decision of first instance".

[80] The respondent says that the scheme of the current *Act* significantly altered the jurisdiction, function and role of the Appeal Board from that conferred on it by the former *Community Care Facility Act*. The primary object and intention of the legislature under the current *Act* is to ensure the health and safety of persons in care in licensed community care facilities, including children at a licensed daycare, to ensure that they are not placed at risk. Moreover, the object and intention of the legislature is to ensure that any decision by the Board on appeal focuses on the merits of the case and the need to protect children from risk of harm, rather than focusing on any procedural requirements or procedural errors that may have occurred beforehand.

[81] The respondent says that the *Act* reinforces his views in two respects. First, section 29(2)(b) provides that the decision under appeal is the MHO's Reconsideration Decision and not the Original Decision. Section 17(3)(b) permits the MHO to confirm, rescind, vary, or substitute for "summary action", which term is defined in section 17 to include cancellation of a licence. Additionally, pursuant to section 29(11), the appellant bears the burden of proving the decision under appeal was not justified. The decision to cancel the licence is not to be set aside even if there were procedural irregularities in the initial November 9, 2006 summary action decision if, on all the evidence before the Appeal Board, the November 22, 2006 Reconsideration Decision was justified on the merits.

[82] The respondent goes on to say that, while it appears that the MHO did not have the power to cancel the appellant's licence pursuant to section 14, there should be no consequence flowing from that conclusion. This is because the Appeal Board is making a decision of first instance under section 29(11) and any procedural errors that may have occurred prior to its hearing have been cured during its hearing process. The respondent says that the appellant was provided with full due process and natural justice during those proceedings. However, she failed to discharge the burden of proving that the reconsideration decision was not justified. The respondent says there is more than ample evidence before the Board to support the decision to cancel the licence. Accordingly, the respondent says the appeal should be dismissed.

[83] We have carefully considered the parties' submissions about this issue and, with due respect to the respondent, we are unable to characterize the issue as a procedural one. The extent of a decision-maker's power to make a decision or grant relief is a matter of substance. Where a statutory decision-maker has made a decision without jurisdiction, that decision can be set aside (*IBX International Ltd. v. Workers Compensation Board*, (1988) unreported, B.C.C.A. No. CA006753, *Banks v. British Columbia (Workers Compensation Board)*, [1988] B.C.J. No. 662, 25 B.C.L.R. (2d) 282 (B.C.S.C.) and *British Columbia and Yukon Territory Building and Construction Trades Council v. Cairns Electric Ltd.*, [1989] B.C.J. No. 1578, 39 B.C.L.R. (2d) 248 (B.C.C.A.)).

[84] The respondent is correct that the decision under appeal in the instant case is the Reconsideration Decision made under section 17. The MHO gained his power to reconsider from section 17(3)(b). That subsection states that, if an MHO considers it would be appropriate "to give proper effect to section ... 13, [or] 14 ... in the circumstances, the MHO may, on receipt of a written response, ... (b) confirm, rescind, vary, or substitute for the action or summary action."

[85] There is no dispute that the MHO was reconsidering a summary action under section 14. Despite the definition of summary action in section 17(1) as including a "cancellation of a licence" under section 14, that statutory provision (section 14) does not reference a cancellation of a licence. In contrast, section 13(1) expressly references a cancellation of a licence. Meaning must be given to the terms of the legislation and the legislature's use of different language in section 13 and section 14 of the *Act*.

[86] As noted, sections 13 and 14 confer statutory powers to take specified actions. Section 17 confers a power of reconsideration of those specified actions and describes the procedures and steps that must be taken in connection with, first, taking those actions and, then, reconsidering them.

[87] Notably, section 13 describes a broader power of action than section 14. Section 13 permits a variety of actions to be taken for a number of reasons, including contraventions of the *Act* or *Regulation*, of other relevant enactments or of a term or condition of a licence. Section 17 provides a process whereby, when such action is taken, the licensee is ensured some measure of due process by being provided with written reasons for the action, in advance of the decision, as well as a right to respond and seek reconsideration afterwards. In this fashion, the licensee is apprised of the case against him or her and provided with an opportunity to respond to that case before he or she may sustain adverse consequences, by way of, for example, suspension or cancellation of his or her licence.

[88] There is a singular, limited exception to this process, which is contained in section 14. Pursuant to section 14, a medical health officer may take action "without notice" against a licensee where 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". In such exceptional circumstances, the medical health officer may suspend a licence, attach terms or conditions to the licence, vary terms or conditions of that licence without prior notice, but he cannot cancel that licence. In such an exigent event, section 17 provides that the licensee must be given written reasons for such action "as soon as practicable" afterwards.

[89] The reason for this departure from the ordinary course set out in sections 13 and 17 appears self-evident. There may be circumstances that are so urgent that it is appropriate to abridge procedural and natural justice rights somewhat and take immediate steps, without notice to the licensee. The protection for the licensee is that the summary action that may be taken is for limited reasons, in exceptional circumstances, and the licensee must be given written reasons "as soon as practicable", as well as an opportunity to seek reconsideration to have the summary action modified or set aside. As a result, the abridgement of the licensee's procedural and natural justice rights can be "cured" in the reconsideration process.

[90] It is important to note that the medical health officer's power on reconsideration under section 17 is to "confirm, rescind, vary or substitute for the action or summary action". The Original Decision that the MHO had before him to reconsider was a "summary action" under section 14 of the *Act*, there being no other action before him. The summary action initially taken (the purported cancellation of the appellant's licence) was action that the parties agree the MHO did not have the authority to take under section 14. They differ with respect to the nature and consequences of this; the appellant says it is a substantive error that cannot be cured and the respondent ways that it is a procedural error that has been or can be cured in the reconsideration and appeal process.

[91] Accordingly, we find that the MHO reconsidered and confirmed a summary action that he lacked jurisdiction to take. The MHO had the jurisdiction to enter upon the inquiry specified in section 15 and take the type of summary action specified in section 14, which included the power to suspend the appellant's licence. However, he lacked the power under section 14 to take a summary action that would make the suspension permanent by cancelling the licence. In confirming the summary cancellation on reconsideration, the MHO again exceeded his jurisdiction and took an action that he was without jurisdiction to take.

[92] However, a finding that the MHO did not have jurisdiction to cancel the licence under section 14 is not determinative of the appeal. We do not agree with the appellant's submission that if there was no authority to take the specific type of action at issue, the Panel must set the Original Decision aside as if it was never made, such that the appellant's licence continued to be valid.

[93] The question which arises is what is the result of our finding. Traditionally, a tribunal which makes a determination that is a nullity has been

permitted to reconsider the matter afresh and render a valid decision (*Chandler v. Alberta Association of Architects*, [1989] 2 S.C.R. 848, *Powell Estate v. British Columbia (Workers Compensation Board)*, 2001 BCSC 1661). In the instant case, as the respondents correctly note, the statute states that the Board must receive evidence and argument as if a proceeding before the Board were a decision of first instance, but the appellant bears the burden of proving that the decision under appeal was not justified (section 29(11)). Additionally, after conducting a rehearing of the matter on appeal, the Panel 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 (section 29(12)).

[94] In our view, the appellant has satisfied the burden of proving that the Reconsideration Decision to affirm the cancellation of her licence was not justified, because the MHO, on reconsideration, lacked the jurisdiction to confirm a summary action under section 14 that purported to permanently cancel the appellant's licence. In his Reconsideration Decision, the MHO ought to have varied or substituted summary action under section 14 that conformed with his powers under section 14. More particularly, he ought to have varied or substituted for the summary action so that it went no further than taking the types of summary actions that the MHO was entitled to take under section 14, such as suspending the appellant's licence, attaching terms or conditions to that licence, or varying the terms or conditions of that licence, providing that he remained of the view that there were reasonable grounds to believe there was an immediate risk to the health or safety of a person in care.

[95] For reasons that will be discussed directly below and also under issue #2, the Panel is of the view that it is not appropriate for the Panel on this appeal to convert what commenced as a decision under section 14 to a decision under section 13 and decide, at this point, and as a matter of first instance on the merits, to cancel the appellant's licence, in the circumstances of this case. To do so would frustrate the legislative intention of creating two decision-making processes: one, the summary action process, for instances where immediate risk to the health or safety of a person in care and where procedural and natural justice rights are statutorily modified due to the exigencies of the circumstances; and, the other, the ordinary action process, for non-emergency circumstances, where a more extensive range of procedural and natural justice rights are afforded.

[96] Although it is clearly important to protect the health and safety of persons in care, it is also important to protect the livelihood of licensees who may be adversely affected by administrative decisions that are taken without jurisdiction, procedural fairness or natural justice. To conflate the two statutory decision-making processes and allow an appellate tribunal to do what the MHO could not might encourage licensing authorities to take what are said to be "summary actions" without sufficient attention to whether they comply with the *Act*, with the expectation that an appellate tribunal will cure any flaws by rendering new, original decisions at the end of the day. (The Panel is not

suggesting that is what took place in the instant case.) Additionally, it would deprive appellants of the right to appeal the new "original decision" through the statutory reconsideration and appeal channels.

2. Was the appellant deprived of procedural fairness or natural justice in the conduct of the investigation or in the course of the MHO's subsequent decisions?

[97] Upon receiving the complaint regarding the November 8, 2006 incident, the MHO had an obligation to investigate under section 15(1)(b) and form an opinion about whether action was warranted under other provisions of the *Act*. It is well recognized that where a tribunal has a duty to investigate and form an opinion, there is a duty of fairness which requires the tribunal or administrative authority to notify the person affected and afford that person an opportunity to answer the allegations against them. As Lord Denning said in *Selvarajan v. Race Relations Board*, [1976] 1 All. E.R. 13, at page 19:

> In recent years we have had to consider the procedure of many bodies who are required to make an investigation and form an opinion .... In all these cases it has been held that the investigating body is under a duty to act fairly; but that which fairness requires depends on the nature of the investigation and the consequences which it may have on persons affected by it. The fundamental rule is that, if a person may be subjected to pains or penalties, or be exposed to prosecution or proceedings, or deprived of remedies or redress, or in some such way adversely affected by the investigation and report, then he should be told the case made against him and be afforded a fair opportunity of answering it.

[98] The task of investigating was delegated to the SLO, who formed the view that there was an immediate risk to the health and safety of a person in care that warranted summary action and, as a result, her investigation was conducted and concluded with dispatch. It was this investigation that collected the information on which the MHO based his Original Decision to cancel the appellant's licence, without notice to her. Similarly, it was this investigation, the appellant's November 13, 2006 submissions and the MHO's review of the appellant's facility file on which he based his decision in the Reconsideration Decision, to affirm the Original Decision.

[99] The legislation permits the MHO to take summary action, short of cancellation of a licence, but requires that the MHO give reasons to the licensee for taking such action as soon as practicable thereafter, as well as an opportunity to give a written response and seek reconsideration. All of this contemplates that a licensee who may be adversely affected by a summary action will be afforded procedural fairness and natural justice in the investigation and decision-making process.

[100] On November 8, 2006, the Licensing authority commenced an investigation that included the LOs' meeting and interview with the appellant on November 9, 2006. Although the appellant was given prior notice of the date the LOs would meet with her, she was not given the time, which may have provided her an opportunity to make prior arrangements to prepare herself for and minimize any distractions during the interview. Nor was she informed before the interview that the result of the interview might lead to cancellation of her licence. The interview with the appellant was conducted during the facility's operating hours while the appellant was caring for children and was distracted by them from this important interview.

[101] During the November 9, 2006 meeting, the appellant gave the LOs her Incident Report. During the interview, the appellant informed her interviewers that her Incident Report omitted information, such as that she called the police on November 8, 2007 and that T assisted in the search for the child. The Incident Report was not corrected to reflect this. As is now known, this omission was relied on to her detriment. Shortly before the interview concluded, the appellant was advised that action might be taken on her licence. When the appellant indicated that she had to attend to the daycare and suggested the matter be discussed later, no arrangements were made to do so. The appellant maintains that she was not given the opportunity to correct information that the LOs obtained in the interview. She was not given a copy of the interview notes until they were provided by the Licensing authority as part of the Licensing Appeal Record on January 8, 2007.

[102] The SLO also conducted a telephone interview with and took a statement from Child A's mother. She spoke with and obtained a written statement from Child A's prior caregiver. She obtained a preliminary report from the police indicating that there was no record of the appellant's 911 call to them. She did not give the appellant copies of the statements or advise the appellant of the police report. The SLO did not interview Child A's father, who was said to be present when the appellant called the police, or T, who helped search for Child A and was said to be present at the facility when the appellant returned from her own unsuccessful search for Child A. Each of the father and T had first-hand knowledge about relevant facts.

[103] The results of the SLO's investigation were conveyed to the MHO, verbally. The MHO relied solely on this verbal information in reaching his decision to cancel the appellant's licence. Among other things, the SLO informed the MHO that the appellant did not take immediate action to assist in locating the child, that she did not search for the child and that she did not call the police. In the circumstances, the MHO concluded on the basis of the information presented to him that the appellant contravened the *Act* and *Regulation* by "not calling a second adult to assist you, not searching for the missing child and by not immediately contacting the RCMP".

[104] As is now known, the first two of these findings were not correct – the appellant had promptly contacted Child A's mother who assisted by enlisting T

to help search for the child and the appellant did conduct a search, although the quality and efficacy of that search is in question. The third finding is based on a conclusion that the appellant did not call the police at all and, although we now know she did call them, the timeliness of the call is in dispute. In the result, on November 8, 2006, the MHO decided that there were reasonable grounds to believe that there was an immediate risk to the health and safety of persons in care warranting summary action.

[105] In our view, the investigation was deficient in a number of respects, including the following: (a) the appellant ought to have been given notice before the interview commenced that an investigation was being undertaken which could have resulted in summary action being taken, as well as some description of the summary action permitted under section 14 (and, where practicable, the interview ought to have been undertaken in a setting that was reasonably free from legitimate distractions); (b) in light of the SLO's belief that there was a conflict in the evidence and her awareness of at least two witnesses who likely had first-hand knowledge of key facts (Child A's father and T), she ought to have made reasonable efforts to contact the witnesses to resolve the conflicts; and (c) the appellant ought to have been informed of the substance of any information obtained in the investigation that was relevant and prejudicial to her interests and given an opportunity to correct or comment on it, including the allegations arising from the past history of her facility file. Moreover, those corrections and comments ought to have been conveyed to the decision-maker, ie. the MHO.

[106] There may be circumstances in which the requirement to comply with procedural fairness and natural justice may be relaxed or even excused. For instance, lack of full disclosure may be excused in an emergency. Deficiencies in an investigation conducted in emergency circumstances under section 14 may or may not fatally compromise a decision to take summary action. This will depend on the urgency of the immediate risk and the practicality of complying with procedural fairness and natural justice safeguards in those circumstances. The deficiencies may attract greater scrutiny and may be cured if and when the summary action is reconsidered.

[107] In our view, had the investigation not been flawed and had its results supported the MHO's findings of fact, there would have been a proper basis for taking summary action, including suspending the appellant's licence for an appropriate period of time, such as a period of time that would have permitted the MHO to investigate and consider whether other, more significant, action ought to have been taken under section 13 of the *Act*.

[108] However, given the substantial procedural flaws in the investigation and the unresolved conflicts in the evidence then available, there was not a basis for a lengthy suspension, without conducting a further investigation in accordance with procedural fairness and natural justice. In the instant case, there was no further investigation of the incident other than to confirm with

the Richmond RCMP that they had no record of the appellant calling its general line.

[109] In light of the foregoing, we are of the view that the failure to comply with procedural fairness and natural justice in the investigation and the decision-making process that resulted in the Original Decision and the failure to then correct those deficiencies in the reconsideration process fatally compromised the Reconsideration Decision.

[110] In addition to the foregoing, we are of the view that there were substantive flaws in carrying out the procedures mandated by section 17 that fatally compromised the Reconsideration Decision. For instance, we note that the MHO failed to comply with section 17(2)(a), insofar as he failed to give written reasons for the action as soon as practicable after taking that action. Although the SLO provided the appellant with a summary report of the incident and investigation and two Inspection Reports of November 9, 2006, by letter dated November 15, 2006, these documents did not inform the appellant that they set out the MHO's written reasons for cancelling her licence. Nor did they inform her that she could address them as part of her application for reconsideration. Indeed, the appellant made no additional submissions. Notably, she made no submissions about the MHO's reliance on her facility history. In fact, she could not have been expected to do so as the MHO's reliance on that history had not been disclosed in his reasons.

[111] Moreover, deficiencies in the investigation give rise to serious questions about the reliability of the evidence considered in the reconsideration process. For instance, as noted above, the appellant was not apprised beforehand of the fact that the interview could lead to cancellation of her licence. Additionally, it was undertaken in circumstances where the appellant was understandably unable to devote full attention to the answers she gave to this important interview. Further, her Incident Report was not corrected to reflect her statements that she had called the police and that T had assisted in the search. Accordingly, the reliability of the evidence gathered for the purposes of reconsideration was a matter of some doubt. Additionally, the appellant was not provided with the notes of the interview the LOs conducted on November 9, 2006. She could not seek to make corrections or comments about it afterwards.

[112] In the circumstances, given the emergency circumstances in which the investigation was conducted and the issues relating to the conflicts in and the reliability of the evidence, it may have been prudent to conduct a more fulsome investigation after the Original Decision was made. Had proper consideration been given to taking action under section 14, there would have been an opportunity to undertake such an investigation.

[113] The Original Decision was based, in part, on the appellant's history with the Licensing authority. Neither that fact nor the history relied on was disclosed to the appellant in the Original Decision or as part of the written

reasons that the MHO was obliged to provide her with as soon as practicable after the Original Decision. The appellant was not informed that her facility history which contained information that was prejudicial to her interests, was going to be taken into consideration in the reconsideration process and she was not given an opportunity to correct, contradict or otherwise comment on it. Indeed, she was not provided with copies of all of the relevant and prejudicial documents that the MHO considered and relied on in making the Reconsideration Decision. Accordingly, the appellant was not apprised of a substantial part of the case against her and she was thereby deprived of the ability to respond to it in the reconsideration process. This is a fundamental breach of the principles of procedural fairness and natural justice.

[114] The purpose of providing a licensee with written reasons as soon as practicable after summary action is taken and an opportunity to provide a written response in order to seek reconsideration is to ensure that a licensee is advised of the case against her and provided with an opportunity to make full submissions to the MHO who is reconsidering the summary action. Although it is anticipated that summary action will be taken immediately, because the power to take summary action is only exercisable in exigent circumstances, the legislation clearly contemplates that a thorough and considered review can be undertaken after the fact in compliance with procedural fairness and natural justice.

[115] In summary on this point, the Reconsideration Decision was fundamentally and fatally flawed by breaches of procedural fairness and natural justice.

3. Were there reasonable grounds to believe there was an immediate risk to the health and safety of a person in care?

[116] Section 29(11) of the *Act* says that 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. For the reasons stated above, the applicant has satisfied that burden.

[117] The question which now arises is what flows from that conclusion. Section 29(12) says 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.

[118] The subject of the Reconsideration Decision was the Original Decision, in which the MHO took summary action under section 14 of the *Act*. Pursuant to that section, he had jurisdiction to take summary action to “suspend a licence, attach terms or conditions to the licence, or vary terms or conditions of that licence”, where he had “reasonable grounds to believe that there is an immediate risk to the health or safety of a person in care”. The matter before us is an appeal of the MHO’s decision, on reconsideration pursuant to section

17, to affirm his summary action under section 14 of the *Act*. Since the original exercise of the MHO's jurisdiction was under section 14, the exercise of our jurisdiction on the merits of the appeal must begin with an assessment of the application of that section to the facts as we now know them.

[119] Accordingly, our first task is to consider whether or not there were reasonable grounds to believe that there was an immediate risk to the health and safety of a person in care arising out of or in connection with the disappearance of Child A on November 8, 2006, in all the circumstances. This analysis is somewhat different than the analysis under section 13, because it requires an assessment of whether or not there were reasonable grounds, on objective evidence, to believe that there was a risk to the health or safety of a person in care that was "immediate". In our view, there were ample and reasonable grounds, on objective evidence, to believe that there was an "immediate" risk to the health or safety of a person in care in the circumstances and on the basis of the evidence now before us.

[120] The appellant agreed to take Child A into care at her daycare facility. This facility was geographically located near hazardous conditions, such as open water-filled ditches and a neighbouring construction site.

[121] By November 8, 2006, the appellant was aware that Child A, who was four years old, had behavioural issues that reflected challenging and disobedient conduct. Among other things, she was aware that Child A had demonstrated an interest in opening the front door, having attempted it on a number of occasions, and having succeeded on at least one occasion in unlocking, opening and exiting the door. We agree with the MHO that there was a serious risk that this child would exit the facility without supervision.

[122] This was not a matter that was entirely out of the appellant's control. Despite knowing of the child's proclivities, the appellant did not take action to minimize the likelihood that the child would exit the facility without supervision. She did not install a childproof lock. There was no evidence that she spoke to the child, to tell her not to open the door. In our view, a person who had operated a daycare facility for ten years, caring for children over the age of 30 months, ought to know that some children and, in particular, challenging children, may develop an interest in opening the doors and exiting the premises. Having known that Child A had developed such an interest, the appellant ought to have known that Child A would have to be closely supervised around the front door and that precautions, such as installing childproof locks, ought to be taken to prevent an unsupervised exit.

[123] As noted elsewhere herein, the appellant was aware that the Licensing authority was concerned about "containment" of the children in her care in safe areas. For instance, it had been brought to her attention that fencing in the backyard had to be replaced and/or repaired on prior occasions and that safety gates inside the facility had to be in place. These measures were necessary to

prevent children from exiting safe areas and encountering hazardous conditions.

[124] We agree with the MHO that the appellant's conduct on discovering Child A's disappearance was disorganized and inadequate. She lacked an emergency plan to deal with such circumstances. She lacked ready access to a designated, responsible adult to come and assist her in emergency circumstances, such as a disappearance of a child.

[125] Although the appellant immediately endeavoured to contact Child A's father to ask him to assist in the search, he was not available. Next, she endeavoured to contact Child A's mother for assistance. Child A's mother then secured the assistance of her friend T, who came and conducted her own, unsuccessful search.

[126] In the meantime, the appellant endeavoured to conduct her own search, with the remaining two children in her care in tow. We agree with the MHO that the appellant's ability to conduct an adequate search with two preschool children in tow would be limited. In the circumstances, given her hampered ability to conduct a search in a residential area that had open ditches and nearby construction sites, it would have been prudent to immediately contact the RCMP.

[127] As noted, the appellant conducted a limited search and, on her return to the facility, met with T to find that she, too, had been unsuccessful in a search for the child. The appellant then contacted Child A's mother again to discuss calling the police with her and ultimately called the police approximately 40 minutes after the appellant believed that the child had disappeared.

[128] At the time of the Original Decision and the Reconsideration Decision there was some controversy about whether or not the appellant had indeed called the police. By the time of the hearing, the appellant secured evidence that corroborated her assertion that she had called 911. That information confirms that she called 911 at 2:08 p.m. to report that Child A was missing and, while doing so, the child's father had arrived with the child. The MHO, at the hearing of this matter, maintained that this call was not a timely one, as he would have expected such a call to be made between 1:15 and 1:30 p.m.

[129] On the whole of the circumstances, it is doubtful that such a delay, alone, would justify taking summary action. However, on the whole of the circumstances, it combines with other evidence to demonstrate that the appellant's response was inadequate and disorganized.

[130] Moreover, her disorganized and inadequate response to the incident is significant when considered in light of the appellant's history with the Licensing authority, the appellant's failure to take preventative action to minimize the likelihood that Child A would exit the facility, unsupervised, and her failure to

have in place any plan or readily available second adult to assist. We agree with the MHO that the appellant's history demonstrates, for whatever reason, an inability to identify and anticipate hazards to the children in her care on her own and to proactively eliminate or minimize those hazards. Rather, on a number of occasions she has had to be told by Licensing Officers of the existence of hazards, to remedy them, and to prevent their recurrence. Despite this, some of these hazards or similar hazards have recurred. The incident of Child A's disappearance is a much more serious variant of this problem. Fortunately, the incident did not have the serious consequences that were possible.

[131] We are of the view that there were reasonable grounds on which to believe that there was an immediate risk to the health and safety of a person in care, in the circumstances that existed at the facility on November 8, 2006. Moreover, we are of the view that the nature of this immediate risk was sufficient to justify suspending the appellant's licence from and after that time and until full and proper consideration could be taken to determine whether or not appropriate action ought to be taken under section 13 of the *Act*.

CONCLUSION

[132] In our view, the incident, in the circumstances, and in particular in light of the appellant's history with the Licensing authority, was sufficiently serious that a lesser action than suspension is not appropriate at this time. We agree with the MHO that it would be inappropriate to attach terms or conditions to the appellant's licence instead of imposing a suspension because, on the evidence before us, we lack comfort that at the time of the November 8, 2006 incident, the appellant could comply with her obligations under the *Act* and *Regulation* and ensure the health and safety of children in her care on her own. That is, we lack confidence that she could identify and remedy serious hazards to children in her care, on her own, and proactively remedy them and prevent their recurrence, without being prompted to do so and being closely supervised by the Licensing authority. The appellant's circumstances may have changed since then. The MHO's concerns have been brought emphatically home to the appellant in the interim.

[133] In light of our decision, we anticipate that the Licensing authority may wish to consider whether or not to take action under section 13 of the *Act*, in which case, we encourage it to take our reasons respecting procedural fairness and natural justice into consideration. Moreover, we anticipate that the appellant will be provided with full opportunity to know the case against her and make submissions to a medical health officer in those proceedings. The appellant may wish to address the issues raised in these proceedings, including, if such issues are raised, her ability to identify and anticipate hazards to children in her care and proactively minimize or eliminate them. We leave all of that to a future proceeding.

[134] In the result, in the instant case, we vary the Reconsideration Decision and substitute a suspension of the appellant's licence commencing November 9, 2006 and expiring three months from the date of this Decision, at which time the suspension shall cease. Subject to any action the Licensing authority may take under section 13, the appellant's license shall be reinstated when the suspension expires with the condition described below. We recommend that, in the event that the Licensing authority takes no further action in connection with this matter, the appellant's resumed operation of the facility be monitored by a Licensing Officer who has not previously been involved with the appellant, preferably one who has an Early Childhood Education Certificate qualifying that individual to operate a daycare facility under the *Act*. Moreover, we recommend that this monitoring continue until the earlier of the time that the Licensing Officer is satisfied that the appellant is capable of operating the facility in compliance with the *Act* and *Regulation* or a date that is one year from the date of expiry of the suspension. To facilitate a program of monitoring, we add a condition to the appellant's licence that she co-operate fully with any program of monitoring of the facility that the MHO may implement in the year following a resumption of operations pursuant to the appellant's reinstated licence. Nothing in this Decision should be interpreted as preventing a Medical Health Officer from taking whatever future action is deemed appropriate under relevant provisions of the *Act* or *Regulation* in connection with the appellant's licence.

October 24, 2007

Alison H. Narod, Panel Chair

Dianne Ledingham, Member

Sheila Ebenstiner, Member