BRITISH COLUMBIA

Community Care and Assisted Living Appeal Board

Fourth Floor, 747 Fort Street
Victoria, British Columbia
Telephone: (250) 387-3464
Facsimile: (250) 356-9923

Mailing Address:
PO Box 9425 Stn Prov Govt
Victoria BC V8W 9V1

NOTE: This is not the original version of this decision. It is a revised version that has been edited for public disclosure to protect confidential and third party personal information.

DECISION NO. 2015-CCA-002(b)

In the matter of an appeal under s.29 of the *Community Care and Assisted Living Act*, S.B.C. 2002, c. 75

BETWEEN:	X, Licensee, (operating as Z, a child care facility)	**APPELLANT**
AND:	Medical Health Officer, Y Health Authority	**RESPONDENT**
BEFORE:	A Panel of the Community Care and Assisted Living Appeal Board Lynn McBride, Panel Chair Donald Storch, Member Shelene Christie, Member	
DATE:	April 18 – 22, 2016	
PLACE:	British Columbia	
APPEARING:	For the Appellant: Self-represented For the Respondent: Kathryn Stuart, Counsel	

APPEAL

[1] The Appellant, X, was the Licensee of Z, a community care facility, operating two group child care facilities.

[2] She has appealed to the Community Care and Assisted Living Appeal Board (the "Board") to reverse the May 1, 2015 decision of the Respondent (the "Decision") that resulted in the cancellation of her licence to operate Z.

[3] This appeal is governed by section 29(11) of the *Community Care and Assisted Living Act* (the "*Act*")[1]. Under that section, the Appellant has the burden of proving that the Decision was not justified and the Board must receive evidence and argument as if the proceeding before it were a decision of first instance.

[1] The full text of sections of legislation and regulations referred to in these reasons are set out in Appendix 1

[4] The main issue to be decided is whether the Appellant has proven that the Decision to cancel her licence was not justified. To answer this question, the Panel has examined all of the evidence before it afresh to determine whether the Decision was justified on the totality of the evidence.

CONCLUSION

[5] For the reasons set out fully below, this appeal is dismissed as the Appellant has not satisfied the onus of proving that the Decision was not justified.

[6] We acknowledge the extensive efforts the Appellant undertook to defend against the Decision made by the Respondent, and we know that this conclusion must be very disappointing to her.

[7] The Appellant should know that she struck the Panel as a kind, caring and compassionate woman with a sincere and heartfelt commitment to all the children in her care and to their families. It is clear that the Appellant acted with the best of intentions during the years that she operated Z and that she was generous in offering support and assistance to a number of those families beyond the operations of her child care programs.

[8] We heard the dismay and distress the Appellant expressed at how she felt the Respondent portrayed her in this appeal proceeding: as someone with a “flawed character” who “put children in danger”. She went to great lengths during the hearing to present evidence that highlighted incidents where good care was delivered and aspects of the child care programs at both locations were operated in compliance with regulatory requirements.

[9] The Appellant should not interpret the dismissal of this appeal as a failure on her part to impress on the Panel that there were aspects of Z’s operations that she and many of the parents believe were excellent, or as a failure on the part of the Panel to appreciate that not all aspects of the operations were out of compliance with regulatory requirements.

[10] If it appears to the Appellant that not enough attention has been given to the positive incidents and aspects she stressed and to which witnesses gave testimony, it is not because we did not hear them or that we summarily dismissed them. We know that not all aspects of Z’s operations were non-compliant. However, we cannot base our decision solely on positive incidents and aspects that the Appellant points to where they do not relate to the events that raised the regulatory concerns that ultimately led to the cancellation of her licence. The primary focus of this appeal is on the incidents that raised regulatory concerns.

BACKGROUND

The Facility

[11] The Appellant was licensed to operate Z, a community care facility operating in two locations in BC:

- the A location, a licensed Group Child Care (school age) program with a maximum capacity of 10 children ("A daycare"), and
- the B location, a licensed Group Child Care (30 months to school age) / Multi-Age Child Care program with a maximum capacity of 24 children ("B daycare").

[12] The Appellant was the manager of both A daycare and B daycare.

What Prompted the Investigation

[13] On August 7, 2014, an incident occurred at the A daycare involving three children (the "Incident"). The Appellant was not there when the Incident occurred. The staff member who was present and discovered the Incident reported it to the Appellant.

[14] The Appellant investigated the Incident, including questioning the children involved. During her questioning, one of the children disclosed possible past abuse by a family member.

[15] On August 14, 2014, the Appellant called the Ministry of Children and Family Development ("MCFD") and reported the disclosure of possible abuse. She also reported some information to MCFD about the Incident that had occurred at the A daycare.

[16] MCFD started an investigation. As a result of information discovered during that investigation, an MCFD social worker eventually called (on September 25) the Community Care Facilities Licensing Program ("Licensing") to report what they had learned.

[17] Prior to being called by MCFD, Licensing had no knowledge of the Incident observed by the staff member at the A daycare on August 7, 2014. The Appellant had not reported the Incident to Licensing.

[18] Prompted by the information reported by MCFD, Licensing started an investigation (on September 26) into the Incident to determine if there was a breach of the *Act* and the Child Care Licensing Regulation (the "Regulations").

The Investigation

[19] Through the investigation process, Licensing identified concerns with the operation of Z in the following areas:

- Supervision of children
- Staffing – training/skills and abilities
- Staffing – group sizes and employee to child ratios
- Health and Safety Plan
- Care plans for children requiring extra support
- Record keeping
- Physical environment – outdoor play space
- Nutrition
- Ability of manager/Licensee

[20] On December 9, 2014, Licensing issued an Investigation Summary Report, which is a preliminary report that summarizes the findings of Licensing taking into consideration the information gathered during the investigation process. The purpose of this report is to present the findings to the licensee and provide the licensee with an opportunity to respond. The Appellant received that report and had the opportunity to correct, explain, comment and otherwise respond to the findings. The Investigation Summary Report does not include any recommendations for enforcement action.

[21] On February 19, 2015, the Appellant submitted a partial response (dated February 13, 2015) to the Investigation Summary Report. She submitted a final response dated March 4, 2015 that is date stamped as having been received by Licensing on Monday, March 9, 2015.

[22] After taking into consideration both of the Appellant's responses to the Investigation Summary Report, Licensing issued its Final Investigation Report. In that Report, Licensing made a recommendation to cancel the Appellant's licence. Licensing made the recommendation to the Respondent who then made a preliminary decision on what action to take.

The Medical Health Officer's Decision

[23] On March 30, 2015, the Respondent issued his Preliminary Decision. He accepted Licensing's recommendation and advised the Appellant that because of significant concerns raised about her ability, he intended to cancel her licence effective April 30, 2015. He also advised the Appellant of her right under section 17 of the *Act* to provide a written response setting out the reasons why he should not take that action.

[24] The Appellant provided a written response to the Respondent dated April 2, 2015, requesting that the Respondent make the cancellation of the licence effective in 90 days (June 30th) rather than 30 days (April 30th), and explaining her reasons for that request. She did not provide any reasons why he should not take the action of cancelling her licence.

[25] On May 1, 2015, the Respondent issued the Decision under appeal. In that Decision, he indicated that the Appellant's written response had not altered his original decision to cancel the Appellant's licence effective April 30, 2015.

[26] The Decision to cancel the Appellant's licence rests on alleged contraventions summarized by the Panel as follows:

- The Appellant failed to operate the daycare in a manner that would promote the health, safety and dignity of the children in care, contrary to section 7(1)(b)(i) of the *Act*.
- She failed to comply with the continuing duty to inform a medical health officer immediately of any change in the information provided under section 9 (applying for a licence), contrary to section 10(1) of the Regulations.
- She failed to ensure that a healthy and safe environment was provided at all times, contrary to section 13(1) of the Regulations.
- She failed to ensure that employees had the training and experience and demonstrated the skills necessary to care for children requiring extra support, contrary to section 19(3) of the Regulations.
- She failed to ensure that the children at the daycare were supervised at all times, contrary to section 39(1) of the Regulations.
- She failed to ensure that each child had healthy food and drink according to the Canada's Food Guide, contrary to section 48(1) of the Regulations.
- She failed to ensure that behavioral guidance was appropriate to the age and development of the child receiving the guidance, contrary to section 51(1)(a) of the Regulations.
- She failed to ensure that children were not subjected to harmful actions, contrary to section 52(2) and Schedule H of the Regulations.
- She failed to notify the medical health officer within 24 hours that, on August 7, 2014, three children had been involved in or may have been involved in a "reportable incident" as described in Schedule H, contrary to section 55(2)(a) of the Regulations.
- She failed to keep a log of unexpected events involving children, contrary to section 56(1)(f) of the Regulations.
- She failed to keep current and complete records for each child, contrary to section 57 of the Regulations.
- She failed to keep current care plans for each child requiring extra support, contrary to section 58 of the Regulations.

The Appeal

Grounds for Appeal

[27] In her Notice of Appeal, the Appellant challenged the decision of the Respondent because:

- she felt she had "not been supplied with sufficient evidence of these contraventions" of the *Act* and Regulations, and that information, documents and evidence had been withheld from her;
- she "disagreed with many of the contraventions" and believes she has not contravened a number of the sections cited by the Respondent in his Decision; and
- she does "not feel a fair and thorough investigation was conducted" by Licensing.

[28] The Appellant elaborated on her reasons for challenging the Decision in her Statement of Points and at the hearing of this appeal. She alleged that Licensing was biased throughout the investigation and selectively sought evidence that would support findings that she had contravened the *Act* and Regulations and would lead to the cancellation of her licence. The thrust of her appeal was to point to evidence and tender new evidence that, in her opinion, demonstrated that most of the contraventions, or negative statements made about her in the investigation materials, were unfounded and not proven by the evidence relied upon by the Respondent in reaching the Decision.

Preliminary Application regarding Disclosure of Documents

[29] Several months prior to the hearing of this appeal, the Respondent made a preliminary application requesting that the Board exercise its discretionary authority under section 42 of the *Administrative Tribunals Act* (the "*ATA*") and direct that a number of specific documents be received in confidence to the exclusion of the Appellant. In the alternative, the Respondent requested that the documents in question be redacted so that certain information and names were not disclosed to the Appellant.

[30] The Respondent was seeking to restrict the Appellant's access to documents that had been considered by the Respondent in making the Decision to cancel the licence (the "Contested Documents").

[31] The Contested Documents contained the names of children and family members, as well as sensitive personal information about the children. The Respondent submitted that the Board should receive the Contested Documents in confidence to the exclusion of the Appellant because the nature of the information contained in them required that direction to ensure the proper administration of justice.

[32] The Appellant opposed the application and requested that all the Contested Documents be disclosed to her, without any redactions.

[33] With the exception of one paragraph in one of the Contested Documents, the Board was not satisfied that it was necessary to receive the Contested Documents in confidence to the exclusion of the Appellant in order to ensure the proper administration of justice. The Board ruled that the Contested Documents be disclosed to the Appellant, on conditions and with one paragraph redacted in one of the Contested Documents (CCALAB Decision No. 2015-CCA-002(a)).

[34] In addition to ordering disclosure of the Contested Documents to the Appellant on conditions, the Board also ordered that all of the Contested Documents be received to the exclusion of the public, stating:

> All of the Contested Documents contain names and personal information about children and their family members, and they all have a significant privacy interest in not having that information disclosed to the public. In my opinion, the desirability of avoiding disclosure of the Contested Documents in the interests of those children and their families outweighs the desirability of adhering to the principle that hearings be open to the public.
>
> There are many other documents in the Appeal Record which also contain names and personal information about those children and their families, and one or both of the parties to this appeal may seek to restrict public access to those documents at the hearing of the appeal pursuant to Rule 20(2)(a) [of the Rules for Appeals under the *Community Care and Assisted Living Act*] and section 41 of the *ATA*. That will be a matter for the Panel that hears the appeal to rule upon.
>
> (CCALAB Decision No. 2015-CCA-002(a), paragraphs [33 – 34])

Motion To Restrict Public Access

[35] At a pre-hearing conference on April 11, 2015, counsel for the Respondent notified the Appellant and the Board that the Respondent intended to make an application seeking to restrict public access to documents submitted at the hearing and to exclude the public from the hearing. The Appellant indicated that she was in agreement with such an order being made.

[36] At the outset of the appeal hearing, prior to the parties' opening statements, the Respondent made that application and the Appellant supported it.

[37] The Panel granted the order sought and directed that all the oral and documentary evidence submitted at the hearing be received to the exclusion of the public, on the ground that the desirability of avoiding disclosure in the interests of the children and their families outweighed the desirability of adhering to the principle that hearings be open to the public.

Oral Hearing

[38] During the oral hearing, the Respondent's legal counsel Kathryn Stuart called the following witnesses:

- C, Licensing Officer, Y Health Authority.
- D, Social Worker, MCFD.
- E, Licensing Officer, Y Health Authority.
- Medical Health Officer, Y Health Authority (the Medical Health Officer had retired from this position by the time this appeal was heard).

[39] The Appellant called the following witnesses:

- F, an employee of Z and the staff member who was present and discovered the Incident at the A daycare.
- G, the mother of one of the three children involved in the Incident ("Child #1").
- H, an employee of Z and the mother of another one of the children involved in the Incident ("Child #2).
- I, an employee of Z at the time of the Incident and the ensuing investigation.
- J, the father of the third child involved in the Incident ("Child #3).
- K, the father of a child who attended Z in the past (until 2008) but not at the time of the Incident or the ensuing investigation in 2014.
- L, a former employee of Z who was not employed at Z at the time of the Incident or the ensuing investigation.
- M, an employee of Z at the time of the Incident and the ensuing investigation.

[40] The Appellant herself did not testify, choosing to rely solely on the testimony of the witnesses listed above and the documentary evidence submitted during the hearing.

[41] In reaching our decision on this appeal, we are guided by the following principles:

> The Board's mandate is to determine whether the Appellant, after a full hearing, has met her burden of convincing us that the Decision to cancel her licence was not justified.
>
> The *Act* requires the Board to proceed as if the appeal were a decision "of first instance". The Panel must therefore conduct the proceedings as if it were a fresh hearing, examine the evidence and arguments anew, undertake its own analysis of the issues and, where appropriate, make its own findings of fact.

(*AMS v. Vancouver Island Health Authority,* Decision No. 2012-CCA-002(b), (December 17, 2014) at paragraphs [94 – 95])

[42] The Panel that reached the decision quoted above took the following approach during the hearing of that appeal:

> A large amount of the evidence which the Appellant wished to introduce appeared only tangentially relevant and did not address the specific events on which Licensing based their finding of contraventions. However, the Appellant felt that the evidence was necessary to provide a more balanced view of [the Appellant's] operations.
>
> The Panel extended an exceeding amount of latitude to the Appellant to ensure that there was a "full and fair disclosure of all matters relevant to the issues" [Section 38(1) of the *ATA*]. . . .
>
> . . .
>
> In addition, recognizing that the Appellant did not have legal counsel to assist her in the appeal, the Panel gave significant latitude to the Appellant's agents when presenting evidence, questioning witnesses and making submissions.
>
> (*AMS v. Vancouver Island Health Authority,* Decision No. 2012-CCA-002(b), (December 17, 2014) at paragraphs [102, 103 & 105])

[43] The Panel on this appeal took the same approach, and allowed the unrepresented Appellant a considerable amount of latitude when presenting evidence, questioning witnesses, and making submissions.

[44] On numerous occasions during her questioning of witnesses (during both direct and cross examinations), the Appellant would begin a question with a long preamble statement that included information based on the Appellant's own personal knowledge, observations and interpretations, in an apparent attempt to create the context or set the stage for the question she would then put to the witness. The Respondent objected to this a number of times, and the Panel cautioned the Appellant that she could not give her own testimony during the process of questioning witnesses, she could only elicit (or test during cross-examination) evidence from each witness based on that witness's own personal knowledge and observations.

[45] At the end of her case, once she had called all of her witnesses, the Appellant elected not to take the stand to give evidence on her own behalf.

[46] As a result of that election, the Panel has no oral evidence from the Appellant to assess and consider in determining this appeal. We must determine the issues on this appeal on the basis of the sworn testimony from witnesses, and the documents submitted and accepted as evidence during the hearing. Fortunately, the Appellant authored a number of those documents during the investigation and preliminary decision phases, so although she did not give oral evidence at the hearing, we have documentary evidence from her that speaks directly to many of the issues on appeal.

ISSUES ON APPEAL

[47] The primary issue to be determined on this appeal is whether the Decision that resulted in the cancellation of the Appellant's licence to operate Z was justified. In considering this issue, we have considered a number of sub-issues that we discuss below.

[48] At a pre-hearing teleconference on February 12, 2016, the Appellant stated that she did not intend to dispute three of the contraventions cited in the Decision:

- Section 10(1) of the Regulations: she failed to inform a medical health officer immediately of any change in the information provided under section 9 (applying for a licence).
- Section 55(2)(a) of the Regulations: she failed to notify the medical health officer within 24 hours that, on August 7, 2014, three children had been involved in or may have been involved in a "reportable incident" as described in Schedule H.
- Section 58 of the Regulations: she failed to keep current care plans for each child requiring extra support. The Appellant indicated that she was only conceding this contravention with respect to the three children who were involved in the Incident on August 7, 2014.

[49] At the hearing of the appeal, the Appellant did not lead evidence disputing those three contraventions.

[50] Because a number of the regulatory contraventions are closely related to one another and the facts underlying them are so intertwined, we have grouped the issues raised on this appeal as follows:

A. Staffing and Supervision

B. Record Keeping

C. Environment – Outdoor Play Space

D. Nutrition

E. Ability of Appellant

F. Fairness of the Investigation and the Allegation of Bias

DISCUSSION AND ANALYSIS

Review of Evidence and Findings of Fact

The Incident on August 7, 2014

[51] On August 7, 2014, F was the sole staff person on duty at the A daycare, a licensed Group Child Care (school age) program with a maximum capacity of 10

children. Having a single staff person on duty was in compliance with the minimum requirements in the Regulations (Schedule E, 10:1 child to staff ratio).

[52] F does not have an Early Childhood Educator certificate, but she has completed the required training to qualify as a responsible adult and has taken Food Safe and First Aid courses. This is in compliance with what is required by the Regulations for supervising a school age child care program.

[53] F described the A daycare building as having five windows, and two doors facing the back yard. A floor plan of the A daycare was entered into evidence at the appeal; it shows that three of the five windows also face the back yard.

[54] F said that children at the A daycare would be playing inside the building and outside in the back yard at the same time. The children who were outside had to be in F's view at all times and if they were not, she had them come inside.

[55] On August 7, 2014, F saw some of the boys in the back yard behind the toy shed, peeking out, and she said that one of them had a suspicious look on his face. She went outside to check on them and observed that they had their pants down. She had the boys come inside the daycare. F then talked to the Appellant on the phone and asked the Appellant to come in to the A daycare because she had a situation with which she needed help.

[56] When she spoke with F on the phone, the Appellant was on her way to the A daycare to pick up the children whom she transported from the daycare to their homes. According to the Appellant's own typed notes about what happened that day, when she arrived at the A daycare, F told the Appellant that "she found them showing their private parts." Those same notes describe what the Appellant did next:

> I called all three boys into a separate room and talked to them. I told them this is not ok! I will be telling your parents. From now on we will have to change how [A daycare] runs we opened that program so we could respect that the children are older and more responsible and they get more space. The privilege of playing outside or inside is now revoked. All children will have to be where [F] is at all times. I also reminded [Child #2] and [Child #1] of the last time they were inappropriate and how that led to [Child #2] not being allowed to be near [Child #1]. I said you realize that will happen again right! He said yes. I left. I finished the drive [transporting children home] then told [Child #2's mother who is also an employee of Z] what happened at this time I only thought they had showed their privates. I told [F] to tell [Child #3's] dad I would talk to him in the am when I see him. I then phoned [Child #1's mother] got her voice mail and left a message to phone me.

Subsequent communications with the children and parents

[57] On the evening of August 7, 2014, the Appellant received a text message from H, setting out what her son, Child#2, told her about what happened between the boys. Later that same evening, the Appellant talked to G (Child #1's mother) on the phone and "told her what [H] had texted". The Appellant then "listened to

what [Child #1] had told her [his mother G] and we decided since the stories were quite different I would talk to [Child #3] and [Child #1] in the morning."

[58] Although Child #2's and Child #1's descriptions of what happened (as relayed to the Appellant by their mothers) were different and conflicting, each of their descriptions had this in common: each of the boys described some form of sexualized behavior with one another that went beyond exposing themselves.

[59] The next morning (August 8, 2014), the Appellant spoke with J, Child #3's father. She told J that F had reported she "caught the kids showing their privates" but "that [Child #2] had said a lot more was going on." The Appellant told J she "was going to talk with [Child #3 and Child #1] and find out more." She talked to Child #3 first, and he said "that they only had their pants down". She asked him more questions, and his responses confirmed for her that the boys were engaging in some form of sexualized behavior that went beyond exposing themselves to one another. Child #3's responses to the Appellant's questions also revealed that they had "done stuff before" August 7, 2014.

[60] After talking with Child #3, the Appellant then talked with Child #1. Although Child #1 disclosed different information than Child #3 had disclosed, Child #1's description of what happened also confirmed that the boys were engaging in some form of sexualized behavior that went beyond exposing themselves to one another.

[61] Based on the Appellant's own notes about what she was told on August 7 and 8, 2014, it is clear to the Panel and we find that the Appellant was aware that the three boys had been engaging in some type of sexually intrusive behavior with one another at the A daycare and that it had happened more than once.

[62] The Appellant did not report the Incident to Licensing on August 7th or 8th.

[63] G (Child #1's mother) testified at the hearing of the appeal. The Panel found her to be a forthright and sincere witness who exhibited deep care and concern for her son. It was also apparent that she had great respect for the Appellant, whom she described as always being a big support and sounding board to her and as someone who maintained excellent communications with her.

[64] G testified that the Appellant called her on August 13th and told her that J (Child #3's father) had talked to Child #3 about what was happening between the boys. According to G's testimony, Child #3 disclosed information to his father (1) that Child #3 had not disclosed to the Appellant when she questioned him on August 8th and (2) that neither of the other two boys had disclosed to their mothers or to the Appellant. When J talked to Child #3 about what had been happening between the boys, Child #3 disclosed a greater extent of sexually intrusive behavior and also revealed possible abuse of Child #1 by a cousin. The Appellant told G that she (the Appellant) would call MCFD.

[65] The Appellant's own notes about what transpired on August 13th are consistent with G's evidence. Those notes also provide many additional details,

including a statement made in a text message on August 13th that "I am reporting it [to MCFD] because [Child #3] has said there is a cousin doing it to [Child #1]."

The Appellant's report to MCFD

[66] On August 14, 2014, the Appellant called MCFD and "was transferred to an intake worker by the name of [N]. I relayed my conversations with the parents…."

[67] The MCFD records and the Appellant's own notes and accounts about what happened are not consistent with one another. The Appellant took great issue with the MCFD records, and the Panel acknowledges that MCFD could have been more balanced and fair in interpreting, recording and reporting information that it received. Nevertheless, the MCFD records and the Appellant's recording of information are congruent to this extent: the boys all disclosed that the three of them were engaging in some form or other of sexually intrusive behavior with one another at the A daycare, and the Appellant was aware of that information in August 2014. Despite being aware of that information, the Appellant did not notify or report to Licensing.

[68] When the Appellant called and reported to MCFD on August 14, 2014, she told MCFD that she had not reported the Incident to Licensing. Following the Appellant's call, MCFD began an investigation that same day. MCFD did not contact Licensing at that time.

MCFD's report to Licensing

[69] On September 25, 2014, MCFD contacted and told Licensing about the Appellant's report to MCFD, the resulting MCFD investigation, and the information MCFD had discovered during its investigation.

[70] The MCFD social worker who testified at the appeal could not explain why there were several weeks between the Appellant's report to MCFD (August 14) and MCFD contacting Licensing (September 25). All she could say was that "for whatever reason" MCFD didn't contact Licensing until September 25, 2014.

[71] In e-mail communications between Licensing and MCFD on September 26, 2014, C, Licensing Officer, asked "why Licensing was not contacted by MCFD sooner. I thought we had an agreement, a protocol that is followed when incidents occur at licensed resources. Do you know if this has changed?"

[72] C received a reply from O, Team Leader, MCFD, which confirmed that "there is definitely a protocol in place – the report in mid August resulted in 3 different incidents being created that went to 3 different social workers so based on multiple sw's it appears we dropped the ball. I apologize for that. I was away then on holidays. We always abide by the protocol so I don't know what happened this time."

The Licensing investigation

[73] The day after Licensing was contacted by MCFD, two licensing officers visited the A daycare to investigate the Incident. At that time and based on the information received from MCFD, the licensing officers were concerned about three potential regulatory breaches:

- section 7(1)(b)(i) of the *Act*: a licensee must operate the community care facility in a manner that will promote the health, safety and dignity of the children in care;
- section 39(1) of the Regulations: children must be supervised at all times; and
- section 52(2) of the Regulations: a licensee must ensure that a child is not, while under the licensee's care and supervision, subjected to emotional abuse, physical abuse, sexual abuse or neglect (as defined in Schedule H).

[74] As the Licensing investigation continued, the licensing officers identified other concerns and potential regulatory breaches in addition to the ones listed above.

[75] At the conclusion of its investigation, Licensing found that the children were not being appropriately supervised at all times at the A daycare and were able to engage in harmful actions with one another. Licensing also found that the Appellant failed to comply with her obligation under the Regulations to report the Incident to Licensing. In addition, after she was well aware of the sexually intrusive behaviours taking place between the three boys, she failed to put care plans in place, did not make or failed to follow appropriate supervision changes and adaptations to her program, and thereby placed the children at greater risk for further harm. Licensing found that the Appellant failed to operate Z in a manner that maintained the health, safety and dignity of the children in care.

[76] Licensing also identified a number of additional areas of concern, and found on a balance of probabilities that the Appellant had contravened section 7(1)(b)(i) of the *Act* and a number of sections of the Regulations. Licensing recommended that the Appellant's licence be cancelled.

[77] The Respondent accepted the licensing officer's recommendation and cancelled the Appellant's licence.

Positions of the Parties on Appeal

The Respondent

[78] The Respondent says that there is a substantial body of evidence, both from the documents filed before the hearing and from the witnesses testifying at the hearing, to support the Decision to cancel the Appellant's licence to operate Z. The Licensing investigation of Z found 12 separate contraventions of the *Act* and Regulations. The Respondent says that the process leading up to the decision and

the reconsideration were conducted in a fair manner and provided the Appellant with due process and an opportunity to respond to each of the issues before the Respondent made the final decision. Accordingly, the Respondent asks the Panel to confirm the decision to cancel the licence.

The Appellant

[79] The Appellant disagrees with the Respondent that the Decision should be upheld. In regard to those contraventions to which she has admitted, she pointed to evidence throughout the hearing and in closing argument that she felt provided explanations and context and demonstrated her efforts to address and learn from her mistakes. In regard to the other contraventions, she challenged the accuracy of statements in the summary and final investigation reports and pointed to evidence which she felt demonstrated that some of the contraventions were not proven.

[80] The Appellant agrees that her greatest error was that when she learned of the sexual activity, she was wrong in not reporting it to Licensing. However, she points to evidence of things that were done well at Z and asks the Panel to weigh the infractions based on all the evidence and consider whether the proven contraventions are sufficient to cancel her licence.

Issues for Determination

A. Staffing and Supervision

[81] Section 39(1) of the Regulations requires a licensee to "ensure that children are supervised at all times by an educator, an assistant or a responsible adult." This requirement of constant supervision has been described and explained as follows:

> …The Appellant must exhibit a standard of care of the children in her care that ensures their safety. This can only be achieved if she has the children in her supervision (by which we mean line of sight or hearing) and that they are not left in situations that are potentially unsafe.
>
> (*KR v Fraser Health Authority,* Decision No. 2008 BCCCALAB 3 (March 6, 2008) at paragraph [84])

[82] This standard of care applies not only when the Appellant herself is present and supervising children; it also applies when any other staff member is supervising children.

[83] The Appellant's own notes about her conversations and text messages with staff and parents following the Incident establish that the Incident on August 7th was not the first time that the boys had engaged in sexualized behavior with one another. According to those notes, J (Child #3's father) phoned the Appellant on August 13th and told her that "[Child #3] had told him everything. He figures this has been happening since about April."

[84] During cross-examination, F was asked when she became aware that sexually intrusive behaviours were occurring between the three boys. She said that she heard about it later. She also said that she found it hard to believe that those behaviours happened at the A daycare. She said that she could hear everything all the time and that she checked on the children "as much as I could".

[85] G, the mother of one of the boys involved in the Incident, gave telling evidence at the appeal. She testified that after the Incident, she and her son continued to talk about it. She was "trying to understand how this could happen." Her son said "they would know when people were coming to pick up [children]. They were aware of when their opportune times were, like when there was a parent … picking up a child." G said "They knew. They knew when to do it. He told me that they would time it so that there was no one around. They knew when they had that small break of opportunity. He admitted to knowing that."

[86] In her final reply to the Investigation Summary Report, the Appellant states the following about the A daycare and the Incident that occurred there:

> [D]uring summer months there were two doors and three windows to the backyard. All were left open and you could hear as well as see into the backyard. This gave the children more freedom and space. I was not aware [F] was not providing adequate supervision of all the space until the August 7th incident where it was clearly not enough supervision.

[87] It is the Appellant's responsibility as the licensee to ensure that children are being adequately supervised at all times, and it is no excuse to say that she was not aware that a staff member was not providing adequate supervision.

[88] It is clear to the Panel and we find that the level of supervision at the A daycare was inadequate and in breach of the standard of supervision required by the Regulations.

[89] Despite the Appellant's recognition, following the Incident, that there was not enough supervision at the A daycare, supervision continued to be an issue and an area of concern.

[90] On September 26, 2014, the day after MCFD reported the Incident to Licensing, two licensing officers visited the A daycare to investigate the Incident and inspect the facility. They concluded that a serious incident had occurred on August 7, 2014 and that children were not being supervised at all times. Licensing sent an e-mail message to the Appellant on September 26th, "requesting a Health and Safety plan on how you will ensure the safety of all the children while this investigation proceeds."

[91] The Appellant provided a health and safety plan to Licensing dated September 28th, 2014, which includes the following statements:

- As a daycare we can improve supervision and we have since the incident. [F] is aware as well as the children that they will be inside and with the teacher either in sight or hearing range at all times.

- I will increase my assistance with [F] as she is very overwhelmed by this situation. I finish driving children home every day by 3:30 at that time I will go to the A daycare program to assist [F] with supervision and guidance.
- Care plans will be written for [the boys] and signed off by [F], myself and the parents.

[92] Licensing accepted that the health and safety plan would be adequate since it provided for increased care and supervision.

[93] On October 7, 2014, the same two licensing officers went to the A daycare to do a spot inspection and ensure that the health and safety plan was being followed. They arrived near 4:00 p.m. and discovered that neither the Appellant nor F were at the facility. There was another staff member present – not the regular supervisor of the program – and she was the only staff member in the facility. Two of the boys who had been involved in the Incident were at the facility at that time, but they were not in the same room as the staff member. Both the boys were in another room with other children.

[94] The licensing officers spoke to the staff member and learned that she was aware that the boys needed to be supervised and was aware of the Incident, and had been told that the boys involved in the Incident could not play together. The staff member knew nothing about care plans for the boys. The licensing officers had not at that point seen any care plans for the boys.

[95] In her closing argument, the Appellant stated that at the time of the October 7, 2014 Licensing visit, the care plans were only verbally created, not put on paper. That is insufficient. The Appellant's health and safety plan called for care plans to be written for the three boys, and signed off by the Appellant, F, and the boys' parents. That wasn't done.

[96] The next day, October 8th, Licensing sent a letter to the Appellant regarding the failure to follow the health and safety plan. They noted that they were at the A daycare after 3:30 p.m. and the Appellant was not present, and that they had observed the staff person in one room and the boys in another room with other children. They also noted that care plans were not in place as required by the health and safety plan. They requested a new and very detailed health and safety plan ensuring the safety of all the children. They also requested information on the supervision of the children during the transportation services.

[97] In response to these requests, the Appellant asserted that she was complying with her safety plan. She felt she only needed to be present at the A daycare to assist with supervision and guidance when F was there, but not when any other staff member was there. She pointed out that the "safety plan states I will assist [F] with supervision." She asked Licensing for "more specifics on how I was not complying with my safety plan as I feel by what I have written I have followed completely." The Appellant did not provide any response about the issue of care plans not being in place for the boys involved in the Incident.

[98] This response from the Appellant is troubling and demonstrates that she is either unable or unwilling to appreciate the gravity of the behaviours the boys had been engaging in at the A daycare and that they were able to do so because they were left alone and unsupervised for long enough to engage in those behaviours. Once it was known that those types of behaviours had been occurring, the health and safety plan was put in place to increase supervision at the A daycare and ensure the safety of *all* the children, not just the children involved in the Incident. Although the wording of the plan referred to F specifically, as she was the regular supervisor of the program, the purpose of the plan was to ensure continuous supervision given the layout of the indoor and outdoor spaces at the A daycare by having more than one staff member on site to supervise the group of children. The essential element of the health and safety plan was to have two people – one staff member *and* the manager (the Appellant) – present at the facility to provide increased supervision and ensure the safety of all the children. If the Appellant did not understand that, it calls her judgment and ability as a licensee into serious question.

[99] On October 8, 2014, the Appellant did provide a new health and safety plan but it was not accepted by Licensing. Licensing sent the Appellant an e-mail requesting a new plan and attaching some material to assist her in developing the health and safety plan: three information sheets about (1) health and safety plans, (2) supervision of children, and (3) care plans and what information needs to be included in a care plan.

[100] On October 9, 2014, the Appellant provided a further health and safety plan to Licensing, with a covering e-mail message that indicates "I ran out of time but if you would consider this a start and give me recommendations on what more you would need it would be greatly appreciated." In that health and safety plan, the Appellant acknowledges that the "cause and source of the risk was the supervision policy in place at the [A daycare] location that allotted more freedom to children of an older age" and then she states:

> This resulted in an incident on August 7, 2009 [sic]. 3 boys were involved at this time. One child stated they had it down pat to avoid being caught! They would tell the teacher they were looking for spiders as this was a favorite activity all the children at the center had been involved in. They would wait for the teacher assisting other children and would go behind the shed while one child kept watch.

[101] The health and safety plan then sets out details about changes that will be implemented, including increased staffing, seating changes in the transportation van, and changes to supervision policies. The plan specifically states that "at [A daycare] there will be two staff on while it is operating" and acknowledges that "[w]e are aware of the facility of [A daycare] and the different rooms and difficulty this can lead to with a group of children" and then sets out two alternative suggestions for addressing that difficulty. No care plans relating to specific children were included in or with this October 9th health and safety plan.

[102] E, Licensing Officer, testified at the appeal that she and C still had concerns about lacking elements in the October 9th health and safety plan submitted by the Appellant. The plan was not accepted by Licensing, and they discussed with her the option to temporarily close the A daycare pending the investigation.

[103] The Appellant did decide to voluntarily close the A daycare and on October 16, 2014, she submitted a health and safety plan for the A daycare that "[A daycare] will not be operating pending the investigation. All children have found alternate solutions for child care. . . . No child that has attended [A daycare] will be in attendance at [the B daycare] during this investigation." Licensing accepted that plan.

[104] The lack of supervision at the A daycare allowed a serious incident to occur. The Appellant discovered that this type of incident between the three boys had repeatedly occurred in the past at the A daycare. Licensing gave her the opportunity to correct the situation during the investigation phase through the health and safety plan, but the Appellant was unable to accomplish this to an acceptable degree and allowed supervision to fall short. She did not follow through with putting written care plans in place to ensure the safety of the children, as required by the health and safety plan.

[105] The Panel finds that the Appellant failed to ensure that a healthy and safe environment was provided at all times, contrary to section 13(1) of the Regulations; failed to ensure that children were not subjected to harmful actions, contrary to section 52(2) and Schedule H of the regulations; and failed to keep current care plans for each child requiring extra support (i.e. the three boys involved in the Incident), contrary to section 58 of the Regulations.

B. Record Keeping

[106] Section 57 of the Regulations stipulates that a licensee must keep, for each child, a record showing specific information including, among other things, a daily attendance record and the name and telephone number of a parent, medical practitioner and emergency contact.

[107] During the course of their investigation, the licensing officers reviewed a variety of different records from the A daycare: attendance records from June 2014 through to early October 2014; contact lists and registration papers for the children; and the "blog" which functioned as a log or journal about the day to day operations at the A daycare.

[108] The licensing officers found that the records were not complete or accurate, and many files were missing key pieces of information. For example, two weeks of attendance sheets were missing. Further, they found seven or eight instances where the attendance sheets and the blog did not match with regard to the number of children who were in attendance. And for some days, the blog contained no information about the children at the A daycare.

[109] With respect to the contact lists and the registration papers for the children, inconsistencies and inaccuracies were found. Several of the registration forms had out of date contact information. For some children, the information on the contact list showed different contact phone numbers than the registration forms for the same children. In some instances, the emergency card and the registration information for a given child showed different primary caregivers.

[110] Licensing concluded that the Appellant was not complying with the regulatory requirement to keep accurate and up to date records about the children attending the A daycare.

[111] In her February 13, 2015 response to the Investigation Summary Report, the Appellant admits that she was in breach of the record keeping requirements:

> I fully admit the files, care plans and administrative responsibilities of [A daycare] were not being properly maintained to be in full compliance with legislature. I admit in whole this is an area I am not giving sufficient time and effort to maintain to standards required by legislature. . . . I take full responsibility for not ensuring [F] was keeping records to the level expected of her in the policies and procedures manual of [Z] as well as Childcare Regulations.

[112] There is ample evidence and the Panel finds that the Appellant failed to comply with the record keeping requirements of the Regulations (section 56(1)(f) and section 57).

C. Environment – Outdoor Play Space

[113] Pursuant to section 13(1) of the Regulations, a licensee must ensure that a healthy and safe environment is provided at all times while children are under the supervision of employees.

[114] On September 26, 2014 (the day after MCFD contacted Licensing about the Incident), two licensing officers visited the A daycare to investigate the Incident and inspect the facility. While they were there, they spoke with the Appellant and with F, the school age supervisor at the A daycare.

[115] In the backyard, the licensing officers found three large nails protruding from the side of the shed. The heads of the nails (not the sharp ends) were protruding from the shed. The Appellant explained that they were for hanging towels. C, one of the licensing officers, described the nails as being at her eye level.

[116] The licensing officers also found a manual push lawnmower with exposed blades in the backyard. According to C's testimony at the appeal, the Appellant explained that it was for the children to mow the lawn.

[117] F also gave evidence at the appeal about the mower. She said that the Appellant had used the push mower to mow the lawn in the backyard, and the children wanted to try it. The Appellant taught them how to use the mower. F left the mower outside.

[118] The Appellant's February 13, 2015 response to the Investigation Summary Report states that the "lawn mower had actually evolved to an activity the children participated in. These children are all of school age and after watching me cut the lawn with the push mower they showed an interest in wanting to help. They were taught how to safely use the mower and were allowed access to carry out that task."

[119] During their inspection on September 26, 2014, the licensing officers also observed some tin cans on a table outside in the backyard. The lids had been removed from the tin cans leaving sharp edges exposed and accessible to children.

[120] At the appeal, F testified that the children had painted the tin cans as an art activity. F said she told the children they were sharp and not to play with them. She also said that the children were learning life skills as a result.

[121] In her February 13, 2015 response to the Investigation Summary Report, the Appellant stated that the tin cans "were requested by the children as an art activity. That is why they were all painted. I did talk to [F] after that and suggested we get a can opener that does not leave a sharp edge or taping them prior to using them for art."

[122] At the hearing of this appeal, the Appellant asked G (the mother of one of the boys involved in the Incident) about the lawnmower and the tin cans. G said that she gave permission for her son to use the lawnmower at the daycare and that she had no concerns about the tin can art project. The Appellant asked G if her son had been injured by the lawnmower or the tin cans, and G said he was not injured.

[123] Permission from a parent or lack of concern on the part of a parent, and the absence of injury to a child, do not equate with compliance with section 13(1) of the Regulations. Further, the Appellant did not demonstrate to the Panel's satisfaction that as a licensed caregiver, she accepts and is willing to provide a standard of care that ensures children in her care are not inappropriately at risk and that exceeds that which might be deemed acceptable by a parent in regard to their own child in their own home.

[124] Although the Appellant pointed to evidence that the lawnmower and tin cans were part of her life skills programming, she failed to grasp that the issue was not that they were tools being used by the children under staff supervision as part of that programming, but that they were left out in a location where any child could access them inappropriately, or in the case of the lawnmower that has exposed blades, could trip or fall into it, in an environment where there was inadequate supervision. The Appellant must ensure a safe environment is provided, and that means eliminating or reducing safety *risks*.

[125] Licensing concluded that minimum standards were not being met in regards to the physical environment and the outdoor play space. The Panel finds that the evidence about the outdoor play space speaks to a lack of awareness and appreciation for safety risks on the part of F and the Appellant. The evidence supports the conclusion reached by Licensing that minimum standards were not

being met, and the Appellant has not led any evidence that convincingly refutes that conclusion.

D. Nutrition

[126] Pursuant to section 48(1) of the Regulations, a licensee must ensure that each child has healthy food and drink according to the Canada's Food Guide.

[127] On Friday, September 26, 2014 when Licensing was at the A daycare, the licensing officers observed that there was only popcorn for the afternoon snack. C testified that she asked F if there was any other food besides popcorn for the snack, and that F confirmed that there was nothing else to serve.

[128] Licensing requested several months of records from the Appellant and reviewed those records for information about the snacks provided at the A daycare. The records showed that popcorn alone was regularly served on Friday afternoons. On some days, there was no record kept of what snacks were served.

[129] At the appeal, F testified that Licensing knew about popcorn being served on Fridays and that it wasn't an issue until after the Incident. She also said that fruit was always available to the children; however, the records do not reflect that.

[130] Licensing concluded that the food served to the children at the A daycare did not follow Canada's Food Guide. They found that the Appellant was not meeting minimum standards regarding the nutritional needs of the children or following Canada's Food Guide.

[131] In her February 13, 2015 response to the Investigation Summary Report, the Appellant stated that Friday afternoons was "movie and popcorn day" at all Z locations, but "it also was a day that all leftover and unused fruits and vegetables would be used up." She went on to say that the "children would be offered the leftover fruits thru out the day" and that "[i]t is nothing we have ever hid". She points out a particular entry in the blog "that clearly stated am snack was banana's, plums and cheese nips. Pm snack was popcorn." She observes "[a]t no time did [C] express concern or ask for a change."

[132] In that response to the Investigation Summary Report, the Appellant indicates that she found the nutrition citation to be "one of the most hurtful inaccurate claims yet." She states that she has "supplemented many children's lunches for all the years I have been open. Last summer we had thirteen children we fed lunch daily at my cost just because there was a need."

[133] The Panel is of the view that there is not a strong evidentiary basis for Licensing's conclusion regarding nutrition. However, the evidence does demonstrate that, at the very least, there was not appropriate recording of what snacks were being provided.

[134] The Panel finds that the contravention under section 48(1) is not sufficiently proven on the evidence; however, it does not change our conclusion that the

Appellant has failed to satisfy the onus of proving that the Decision to cancel her licence was not justified based on the other more serious contraventions.

E. Ability of Appellant

[135] During its investigation process, Licensing noted a number of concerns regarding the Appellant's skills and ability as a licensee. In the Investigation Summary Report, Licensing stated that it had lost faith in the Appellant's ability to comply with the *Act* and the Regulations. In the Final Investigation Report, Licensing notes that it "is ultimately the licensee's responsibility to comply with the requirements of the [*Act* and Regulations]" and finds that the Appellant "does not accept full responsibility for her role in ensuring a safe environment for children and compliance with the legislation. We do not believe that terms or conditions or a suspension of the license would ensure sustained compliance and a safe environment for children."

[136] There is ample evidence to support those findings by Licensing.

[137] In her notes about the Incident and what happened in the days following it, the Appellant states that she "really felt it was not a reportable incident" and that she had "discussed it with all 3 parents and [M]" (an employee of Z).

[138] In her February 13, 2015 response to the Investigation Summary Report, the Appellant describes how she discovered additional information about what had happened between the boys through questioning the boys and talking to the parents in the days following the Incident. She then states:

> At this stage my greatest error in judgement was made. After serious consideration and talking with my staff and parents we all incorrectly interpreted the serious incident requirements for reporting. I admit we focused on the section on sexual abuse and it did not seem to fit the situation. I admitted this to [the licensing officers] on September 26th. I have never denied I was wrong and should have reported to Licensing.

[139] While the Appellant accepts her error in judgment, she seems to be unaware that it is *her* responsibility as a licensee to know and understand the Regulations and comply with them at all times. Clearly, she was uncertain whether the Incident was a reportable incident or not. But she did not contact Licensing for assistance in interpreting the Regulations. Instead, she discussed it with staff and parents. It appears that it never occurred to her to contact Licensing for help. This is troubling and points to a lack of prudent judgment about where to turn for help in interpreting and applying the Regulations.

[140] From her written responses to Licensing, and from the nature of the evidence she led at the appeal and the questions she asked witnesses, it appears to the Panel that the Appellant does not understand or appreciate her reporting responsibilities as a licensee. Reporting the incident to MCFD and telling MCFD that she had not reported the matter to Licensing is not enough. Assuming or expecting that MCFD would report the matter to Licensing according to the usual protocol is

insufficient. It is most regrettable that MCFD did not inform Licensing immediately and in accordance with the usual protocol, but that does not absolve the Appellant of her responsibility under the *Act* and Regulations.

[141] We have already noted our concern about the Appellant's interpretation and understanding of the first health and safety plan she submitted to Licensing. She did not appreciate that the requirement that she be present at the A daycare didn't turn on F being the staff person on duty; the key was to have the Appellant – the manager – present as a second supervising person so that supervision would be adequate to ensure the safety of the children.

[142] The Appellant's conduct in response to the Incident is also of grave concern to the Panel. She shared information received from each child's parent with the parents of the other children. She herself questioned the children both together and individually. When one of the children resisted answering her questions, she insisted that he tell her, as described in her own notes about what happened on August 8, 2014:

> I asked [Child #2] to come talk with me. He said he didn't want to and his mom said he didn't have to talk to anyone. I had him sit down and explained I had already talked to [Child #3] and [Child #1] and now wanted to hear what he had to say. He again said no he was not talking. I said this is serious and it happened at my daycare and I want to hear it. He then told me it was [Child #1] who started it and made him do it.

[143] The Respondent testified at the appeal. He was asked what he considered to be the most serious regulatory contravention by the Appellant. He said that it was the delay for one week (August 7 to 14) in reporting the Incident, and then reporting it to MCFD but not to Licensing. The other serious issue was the fact that the Appellant took it upon herself to interview the children herself. He stated that even licensing officers don't interview children about this type of incident, and that is why there is a requirement to report within 24 hours, and let professionals, who are trained, take over and conduct the interviews with the children. The Panel agrees with these statements.

[144] The Respondent also pointed to the Appellant's failure to follow her own health and safety plan that was put in place after the Licensing investigation had started. He observed that she wrote the plan but did not follow through with it. He stated that putting care plans in place was part of the Appellant's health and safety plan and the fact that she did not do it goes to her character. In his opinion, the Appellant had a serious character flaw and did not have the good character required of a licensee under the *Act*.

[145] The Panel does not agree that the Appellant has a character flaw or lacks good character. However, we find that her failure to follow the health and safety plan and put written care plans in place are serious concerns that support the Respondent's loss of confidence in the Appellant's ability to ensure her responsibilities would be met in future.

[146] The Respondent explained that as the investigation proceeded and more concerns were identified, the infractions were getting to be too many, so Licensing started looking at progressive enforcement. There was a prior complaint in January 2014 regarding alleged cocaine use by the Appellant, which factored in to their progressive enforcement and concerns about her character. The investigation of that complaint did substantiate that the Appellant had used cocaine, but Licensing could not prove that she had ever used cocaine and then been at work in the daycare. Licensing concluded at that time there was a breach of section 19 of the Regulations regarding character and skill requirements. In response to the investigation, the Appellant submitted a plan to address her emotional health and wellbeing. That plan was accepted by Licensing and no action was taken on her licence.

[147] The Appellant took issue with the fact that Licensing looked to the past complaint and investigation regarding cocaine use, and argued that this was evidence of bias and "tunnel vision" on the part of Licensing. The Panel does not agree. It is reasonable for Licensing to consider past investigations, even ones where no action is taken against the licence, as they must consider the history of the facility in ensuring the protection of vulnerable children.

[148] Another serious concern for the Respondent relates to the Appellant's conversation with one of the boys about suicidal thoughts.

[149] In her February 13, 2015 reply to the Investigation Summary Report, the Appellant refers to and reproduces a copy of a serious incident report relating to one of the boys who had been involved in the Incident on August 7, 2014. The serious incident report begins with the statement "Attempted suicide or unusual behavior: no attempt but lots of talk of wanting to kill himself and how he will do it." It then goes on to describe details of the incident, including the following:

> [Child #3] arrived at 7:30 am very distraught and would not leave the stairs.
> . . .
>
> I [the Appellant] asked him what's wrong he started to cry. I said come up here and talk to me. He was sobbing saying he is so upset he doesn't want to live anymore this is his entire fault. I just want this to go away. I asked him to go into the kitchen to talk further.
>
> In the kitchen [Child #3] was talking about how he wished he could climb up to a tall building and jump off he doesn't want to live anymore. Then he said I just want to pull my hair out and he grabbed two fists of hair.
>
> I asked him why he is so upset what is making him feel this way. He said he just wants licensing to go away it's his entire fault.
>
> I told him it's not his fault it's actually my fault for not reporting and it's me they are investigating. The steps we have to take like extra supervision and him sitting in front of the van are to make sure I am doing my job right. I told him I understand sometimes I just want to have an out too, but then I think of …all the kids and I know I could never kill myself because that would hurt all of you. I reminded him

> his Mom and Dad already lost a son it would be too sad if something happened to him.

[150] The Respondent testified that the Appellant's sharing of her own suicidal thoughts was of serious concern to him. The Panel shares that concern. Asking the child why he was so upset and assuring him that it was not his fault was appropriate. Talking about her own thoughts of suicide, and saying that she could never kill herself because it would hurt all the children, and then reminding him about his brother who died, were not appropriate comments to make to an obviously distraught child. The Respondent felt this was a breach of section 51(1) of the Regulations.

[151] As a result of all these serious concerns about the Appellant's conduct, and the numerous contraventions of the Regulations established by the evidence, Licensing concluded that the Appellant failed to operate the facility in a manner that would promote the health, safety and dignity of persons in care, contrary to section 7(1)(b)(i) of the *Act*. The Panel agrees with this conclusion.

F. Fairness of the Investigation and the Allegation of Bias

[152] One of the grounds of appeal was that the Appellant did "not feel a fair and thorough investigation was conducted" by Licensing. She alleged that Licensing was biased throughout the investigation and selectively sought evidence that would support findings that she had contravened the *Act* and Regulations and would lead to cancellation of her licence.

[153] At the appeal, the Appellant filed a number of affidavits:

- from a retired supported childcare worker who had supported a child who attended Z (not one of the children involved in the Incident);
- from a parent whose five daughters all attended Z; and
- from a parent who had six of her nine children attending Z (she was not the parent of any of the children involved in the Incident).

[154] In each of those affidavits, the affiant states her opinion about Z in relation to the safety of the environment, nutrition, skills and training, and the Appellant's character and suitability. None of those affidavits refer to the Incident of August 7, 2014 nor do they reveal whether any of the affiants have any knowledge about the Incident or the subsequent Licensing investigation into it. They are simply offering their opinions about the Appellant and how Z operated generally, based on their experiences and observations. There is no indication whether the children they refer to were attending the A daycare or the B daycare.

[155] The Appellant called K as a witness at the appeal. K is the father of a child who attended Z in the past (until 2008), but not at the time of the Incident or the ensuing investigation in 2014. K spoke very highly of the Appellant and the care she provided to his son. He was essentially a character witness who spoke to the

Appellant's ability, compassion and caring based on his experience and knowledge of her in 2007 and 2008.

[156] The Appellant also called L, a former employee of Z who was not employed there at the time of the Incident or the ensuing investigation. She testified about her experience working with various children in the program (none of them were children involved in the Incident), and about the operation of the Z daycare programs.

[157] The evidence of those two witnesses and the opinions expressed in those three affidavits do not assist the Appellant in proving that the Decision to cancel her licence was not justified. We cannot base our decision on this appeal on positive opinions from parents or staff who point to examples and aspects of the daycare operations that do not relate to the events that raised the regulatory concerns that led to the cancellation of the Appellant's licence. Further, the fact that Licensing did not seek out or consider such opinions is not evidence of bias in the investigation. The focus of this appeal – and the focus of the investigation by Licensing – is on the incidents that raised regulatory concerns.

[158] The Appellant also filed her own affidavit and an affidavit from Child #2's stepmother P. Child #2 was one of the boys involved in the Incident. Both those affidavits contain information that the Appellant and P discovered as a result of a custody proceeding between H (Child #2's mother) and J (Child # 2's father and P's common law spouse). In particular, they learned certain information about Child #2 that, had she learned it earlier, the Appellant claims would have led her to change the supervision policy at the A daycare prior to August 2014 when the Incident occurred.

[159] The Appellant called H as a witness at the appeal hearing. H testified that her son, Child #2, attended the SCAN clinic about an incident that happened outside of Z daycare. She said that SCAN made a few recommendations but the only one she could remember was that Child #2 should not share bedrooms or be left alone with other children. H did not share that information with the Appellant or with F (the regular supervisor of the school age program at the A daycare) because she "did not want [Child #2] singled out" and she thought there was "already supervision going on between [Child #2] and [Child #1]" due to a prior incident between them in October 2013.

[160] During her closing submissions, the Appellant referred to her own affidavit and P's affidavit, and to the testimony of H. She questioned why H didn't disclose the information about Child #2 to Z so the Appellant and her staff knew and could protect the children. She referred to G's testimony about a prior incident (in 2013) when Child #1 and Child #2 were found under a table at the A daycare with "guilty looks" on their faces. The Appellant said that was not enough to raise a red flag about the need for increased supervision. She asserted that she had no prior knowledge of sexualized behaviour. She submitted that H was "the only player" who could have revealed that information and "that would have alerted me" and "we would have changed the supervision policy at [A daycare]. But we did not know. No one saw this coming. We weren't prepared".

[161] There is evidence from the Appellant, submitted to Licensing in response to the investigation, which establishes that she was aware of concerns about past sexual behaviours on the part of Child #2. In her own notes about talking to all three boys on the day of the Incident, she says she "reminded [Child #2 and Child #1] of the last time they were inappropriate and how that led to [Child #2] not being allowed to be near [Child #1]." And in her final reply to the Investigation Summary Report (letter to Licensing dated March 4, 2015), she stated:

> The only thing I was aware of was we once had caught [Child #2] and [Child #1] under a table. At that time [Child #2's mother] had mentioned she had a concern [Child #2] **may** be abused by a 12 year old boy when he was with his dad. She also said she had concerns with him and his step sister. I never received any more details than that…. I was never told any updates on this situation or if in fact there was abuse.

[162] The Appellant may not have known for certain that Child #2 had been sexually abused outside the daycare, or that Child #2 and Child #1 had in fact engaged in sexualized behaviour during the 2013 incident under the table at the A daycare, but she definitely had enough information to flag the need for increased supervision well prior to August of 2014.

[163] The *Act* and the Regulations set out the Appellant's obligations as a licensee. Her duty is to know and understand those obligations and comply with them. She must ensure that children are supervised at all times and that they are not subjected to harmful actions. She must operate the daycare in a manner that promotes the health, safety and dignity of the children in care. Based on all the evidence before us, the Panel finds that she failed to comply with those obligations. While we agree with the Appellant that it would have been helpful to her, the fact that H did not disclose the information about Child #2 and the SCAN clinic's recommendation does not absolve or excuse the Appellant. And the fact that Licensing did not rely upon that non-disclosure to reach a different conclusion does not establish bias in the investigation.

DECISION

[164] In making this decision, we have considered all of the oral and documentary evidence presented during the hearing of this appeal, as well as all of the submissions made by the parties, whether or not they are referred to in these reasons.

[165] The Panel agrees with the Appellant that some of the contraventions cited by Licensing may have been less serious and/or not adequately proven, but we do not agree that this is evidence of unfairness or bias on the part of Licensing. The standards set out in the *Act* and Regulations are minimum standards that all facilities are expected to meet at all times.

[166] The Panel also accepts the positive evidence from employees, a support worker and parents of some of the children who had attended the daycare in the past. We do not doubt that the Appellant has been a caring operator. However, that is not enough for a licensed community care facility. Licensing and the Appeal

Board must be satisfied that operators are providing a level of care to the children that anticipates their needs and ensures their ultimate safety.

[167] In her closing argument, the Appellant said she had chosen not to contest the contraventions of section 10(1) and section 55(2)(a) of the Regulations, but that she had admitted her error in judgment in failing to inform and notify Licensing as required by those sections. She said her failure to report the Incident to Licensing in August 2014 was an error in interpretation. She referred to the fact that she did report it to MCFD and that MCFD admitted that they "dropped the ball". She seemed to be implying that because those contraventions were errors of judgment and interpretation to which she admitted and for which she took responsibility, the Decision to cancel her licence based on those contraventions was not justified.

[168] Supervision at the A daycare was inadequate. The Appellant demonstrated poor judgment in responding to the serious incidents occurring at the facility, coupled with a demonstrated inability to appropriately address the supervision and safety issues, even during the investigation when we would expect her to be most motivated to ensure compliance. We find that the Respondent's lack of confidence in the Appellant's ability to ensure that serious issues will not occur, or will be appropriately handled in future, is justified. These are serious concerns and constitute strong grounds for cancelling the licence, particularly where the Appellant also engaged in other, albeit less serious, contraventions, and was unable to comply with an appropriate health and safety plan while the Incident was investigated. Therefore, we find that licence cancellation is warranted in all the circumstances of this case.

[169] We have not discussed or made findings with respect to some of the contraventions cited and relied upon by the Respondent in reaching his Decision to cancel the Appellant's licence, because we find that the following contraventions are proven on the evidence (or have not been disputed by the Appellant) and justify cancellation of the Appellant's licence:

- Section 7(1)(b)(i) of the *Act*,
- Sections 10(1), 55(2)(a) and 58 of the Regulations (the contraventions that the Appellant did not dispute), and
- Sections 13(1), 39(1), 52(2) and 57 of the Regulations.

[170] For all of the reasons stated above, and on considering all of the issues raised in this appeal, the Panel finds that the Appellant has not met the burden under section 29(11) of the *Act* of proving that the Decision was not justified. Accordingly under section 29(12) of the *Act,* the Panel confirms the Respondent's decision to cancel the Appellant's licence to operate Z.

[171] The appeal is dismissed.

[172] Finally, the Panel acknowledges that this appeal concluded on April 22, 2016, and our decision is issued past the usual 90-day post-hearing period referenced in the Board's practice directives, and to which the Board is able to adhere in most cases. Due to the length of the hearing, the amount of evidence (documents and

testimony), and the complexity of the issues, this matter required extra time. We considered it with the care required in the circumstances and having regard to its importance to the Appellant.

"Lynn McBride"

Lynn McBride, Panel Chair
Community Care and Assisted Living Appeal Board

"Donald Storch"

Donald Storch, Member
Community Care and Assisted Living Appeal Board

"Shelene Christie"

Shelene Christie, Member
Community Care and Assisted Living Appeal Board

October 24, 2016

APPENDIX 1 – Excerpts of Legislation and Regulations referred to

COMMUNITY CARE AND ASSISTED LIVING ACT

[SBC 2002] CHAPTER 75

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

(i) the health, safety and dignity of persons in care, 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

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

(2) Thirty days before taking an action or as soon as practicable after taking a summary action, a medical health officer must give 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.

(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.

ADMINISTRATIVE TRIBUNALS ACT

[SBC 2004] CHAPTER 45

Examination of witnesses

38 (1) Subject to subsection (2), in an oral or electronic hearing a party to an application may call and examine witnesses, present evidence and submissions and conduct cross examination of witnesses as reasonably required by the tribunal for a full and fair disclosure of all matters relevant to the issues in the application.

Hearings open to public

41 (1) An oral hearing must be open to the public.

(2) Despite subsection (1), the tribunal may direct that all or part of the information be received to the exclusion of the public if the tribunal is of the opinion that

> (a) the desirability of avoiding disclosure in the interests of any person or party affected or in the public interest outweighs the desirability of adhering to the principle that hearings be open to the public, or

(b) it is not practicable to hold the hearing in a manner that is open to the public.

(3) The tribunal must make a document submitted in a hearing accessible to the public unless the tribunal is of the opinion that subsection (2) (a) or section 42 applies to that document.

Discretion to receive evidence in confidence

42 The tribunal may direct that all or part of the evidence of a witness or documentary evidence be received by it in confidence to the exclusion of a party or parties or any interveners, on terms the tribunal considers necessary, if the tribunal is of the opinion that the nature of the information or documents requires that direction to ensure the proper administration of justice.

B.C. Reg. 332/2007
O.C. 728/2007

Community Care and Assisted Living Act
CHILD CARE LICENSING REGULATION

Applying for a licence

9 (1) A person who is 19 years old or older may apply for a licence by submitting to a medical health officer both

(a) an application, and

(b) records respecting all of the matters set out in Schedule B.

Continuing duty to inform

10 (1) Applicants for licences and licensees must notify a medical health officer immediately of any change in the information provided under section 9 *[applying for a licence]*.

Division 2 — Facility Requirements

Environment

13 (1) A licensee must ensure that a healthy and safe environment is provided at all times while children are under the supervision of employees.

Character and skill requirements

19 (2) A licensee must not employ a person in a community care facility unless the licensee is satisfied, based on the information available to the licensee under subsection (1) and the licensee's or, in the case of an employee who is not the manager, the manager's own observations on meeting the person, that the person

(a) is of good character,

(b) has the personality, ability and temperament necessary to manage or work with children, and

(c) has the training and experience and demonstrates the skills necessary to carry out the duties assigned to the manager or employee.

(3) Without limiting subsection (2), if the duties of an employee include care for a child who requires extra support, a licensee must ensure that the employee has the training and experience and demonstrates the skills necessary to care for that child.

Continuous supervision required

39 (1) A licensee must ensure that children are supervised at all times by a person who is an educator, an assistant or a responsible adult.

Nutrition

48 (1) A licensee must

(a) ensure that each child has healthy food and drink according to the Canada's Food Guide, and

(b) promote healthy eating and nutritional habits.

Division 2 — Guidance and Treatment of Children

Behavioural guidance

51 (1) A licensee must

(a) ensure that behavioural guidance is appropriate to the age and development of the child who is receiving the guidance, and

Harmful actions not permitted

52 (2) A licensee must ensure that a child 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 H.

Notification of illness or injury

(2) A licensee must notify the medical health officer within 24 hours after

(a) a child is involved in, or may have been involved in, a reportable incident described in Schedule H while under the care or supervision of the licensee, or

Division 4 — Records

Community care facility records and policies

56 (1) A licensee must keep current records of each of the following:

(f) a log of minor accidents, illnesses and unexpected events involving children, that did not require medical attention and were not reportable incidents described in Schedule H.

(2) A licensee must ensure that the policies and procedures referred to in subsection (1) are implemented by employees.

Records for each child

57 (1) A licensee must keep current records for each child showing

(a) the information set out in subsection (2),

(b) if applicable, the information and agreements set out in subsections (2.1) and (2.2), and

(c) the consents referred to in subsection (3).

(2) A licensee must keep, for each child, a record showing the following information:

(a) name, sex, date of birth, medical insurance plan number and immunization status;

(b) date of enrolment in the community care facility;

(c) daily attendance record, indicating for each day whether the child is absent or, if the child is present, the time of arrival and departure;

(d) name and telephone number of a parent, medical practitioner and emergency contact;

(e) any illness, allergy or medical disability disclosed to the licensee by the child or his or her parent or medical practitioner;

(f) any medication administered to the child, including the amount and the time at which the medication was administered;

(g) any notification of a parent, emergency contact or medical health officer made under section 55 *[notification of illness or injury]*;

(h) any special instruction respecting the child's diet, medication, participation in a program of activities, or other matter relevant to the child's care,

[173] (i) given by the child's parent to the licensee in writing, and

[174] (ii) agreed to by the licensee;

(i) a photograph or digital image of the child, and other information that can be used to readily identify the child in an emergency;

(j) a record of any person who is not permitted access to the child;

(k) the date on which the child stops attending the community care facility.

(3) A licensee must have in writing from a parent, and maintain at the community care facility, consent

(a) to call a medical practitioner or ambulance in case of accident or illness if the parent cannot immediately be reached, and

(b) to release a child to someone other than the parent.

Care plans

58 (1) A licensee must keep, for each child requiring extra support, a current care plan showing the following information:

(a) the diagnoses relevant to the child's requirement for extra support, as made by health care professionals;

(b) the courses of action recommended by health care professionals to address the needs of the child requiring extra support;

(c) the resources to be made available to the child requiring extra support by the licensee, including

[175] (i) any adaptation of the community care facility necessary to ensure the child's safety or comfort, and

[176] (ii) any modification to the program of activities necessary to enable the child to participate in or benefit from the program.

(2) The licensee must

(a) develop the care plan in consultation, and

(b) review the care plan at least once each year

with a parent of the child requiring extra support and any person requested by the parent.

(3) The licensee must record compliance with the care plan of a child requiring extra support in respect of each of the following that are applicable to the child:

(a) any therapeutic diet given to the child by the licensee;

(b) any medication administered to the child by the licensee, including the amount and the time at which the medication was administered;

(c) any modification to the program of activities for the child's benefit;

(d) any behavioural guidance provided to the child, and its effect;

(e) any other matter for which the licensee has agreed with the parent of the child to record compliance.

Schedule E

[am. B.C. Regs. 176/2010; 202/2011, s. 23.]

(Section 34 [group sizes and employee to children ratios])

Group sizes and employee to children ratios

1 (1) In Column 3 of the table, "≤" signifies a number of children that is less than or equal to the number specified.

(2) Subject to subsections (4) to (5), a licensee providing a care program described in Column 1 must ensure that

(a) children are divided into groups such that the number of children in each group is no more than that set out in Column 2 opposite the care program, and

(b) the ratio of employees to children for each group is no less than that set out in Column 4 opposite

[1] (i) the care program, and

[2] (ii) the number of children in the group, as set out in Column 3.

Column 1 **Care program**	**Column 2** **Maximum group size**	**Column 3** **Children per**	**Column 4** **Ratio of employees to**

		group	**children in each group**
Group Child Care (30 Months to School Age)	25, with not more than 2 children younger than 36 months old in a single group	≤ 8	One educator
		9 — 16	One educator and one assistant
		17 — 25	One educator and 2 assistants
Group Child Care (School Age), if any preschool child or child in grade 1 is present	24	≤ 12	One responsible adult
		13 — 24	2 responsible adults
Group Child Care (School Age), if no preschool child or child in grade 1 is present	30	≤ 15	One responsible adult
		16 — 30	2 responsible adults

Schedule H

[am. B.C. Regs. 95/2009, s. 4; 205/2013, Sch. 1; 178/2016, Sch. 1, s. 9.]

(Sections 52 and 55 [harmful actions not permitted; notification of illness or injury])

Reportable incidents

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

"aggressive or unusual behaviour", which means aggressive or unusual behaviour by a child towards other persons, including another child, which has not been appropriately assessed in the child's care plan;

"attempted suicide", which means an attempt by a child to take his or her own life;

"choking" means a choking incident involving a person in care that requires

(a) first aid,

(b) emergency care by a medical practitioner or nurse practitioner, or

(c) transfer to a hospital;

"death", which means any death of a child;

"disease outbreak or occurrence", which means an outbreak or the occurrence of a disease above the incident level that is normally expected;

"emergency restraint", which means a restraint that is necessary to protect the child or others from imminent serious physical harm that is not approved and documented in a child's care plan;

"emotional abuse", which means any act, or lack of action, which may diminish the sense of well-being of a child, such as verbal harassment, yelling or confinement, perpetrated by a person not in care;

"fall", which means a fall of such seriousness, experienced by a child, as to require emergency care by a medical practitioner or nurse practitioner, or transfer to a hospital;

"financial abuse", which means

(a) the misuse of the funds and assets of a child by a person not in care, or

(b) the obtaining of the property and funds of a child by a person not in care without the knowledge and full consent of the child or the child's parent;

"food poisoning" means a food borne illness involving a person in care that requires emergency care by a medical practitioner or nurse practitioner, or transfer to a hospital;

"medication error", which means an error in the administration of a medication which adversely affects a child or requires emergency intervention or transfer to a hospital;

"missing or wandering person", which means a child who is missing;

"motor vehicle injury", which means an injury to a child that occurs during transit by motor vehicle while the child is under the care or supervision of the licensee;

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

"other injury", which means an injury to a child that requires emergency care by a medical practitioner or transfer to a hospital;

"physical abuse", which means any physical force that is excessive for, or is inappropriate to, a situation involving a child and perpetrated by a person not in care;

"poisoning", which means the ingestion of a poison or toxic substance by a child;

"service delivery problem", which means any condition or event which could reasonably be expected to impair the ability of the licensee or his or her employees to provide care, or which affects the health, safety or well-being of children;

"sexual abuse", which means any sexual behaviour directed towards a child by an employee of the licensee, a volunteer or any other person in a position of trust, power or authority, and includes

(a) any sexual exploitation, whether consensual or not, and

(b) sexual activity between children if the difference in age or power between them is so significant that the older or more powerful child is clearly taking sexual advantage of the younger or less powerful child;

"unexpected illness", which means any unexpected illness of such seriousness that it requires a child to receive emergency care by a medical practitioner or transfer to a hospital.