NOTICE OF PUBLICATION BAN

In the matter of College of Early Childhood Educators and Jina Kim this is notice that the Discipline Committee ordered that no person shall publish or broadcast the identity of, or any information that could identify, any person who is under 18 years old and is a witness in the hearing, or the subject of evidence in the hearing or under subsection 35.1(3) of the *Early Childhood Educators Act, 2007*.

DISCIPLINE COMMITTEE
OF THE COLLEGE OF EARLY CHILDHOOD EDUCATORS

PANEL[1]: CeCil Kim, RECE, Chair
Melissa Downey, RECE

BETWEEN:

COLLEGE OF EARLY CHILDHOOD EDUCATORS	)	Vered Beylin For the College of Early Childhood Educators
and	)	
JINA KIM REGISTRATION # 45364	)	Deniz Sarikaya For the Member
	)	Elyse Sunshine, Rosen Sunshine LLP Independent Legal Counsel
	)	Heard: September 22 & 23, 2021; January 20, 2022, February 14,15 & 16, 2022, August 25, 2022, September 28 & 29, 2022, October 3, 2022

[1] A third public appointed panel member became unable to participate in the hearing midway through this proceeding. With the agreement of the parties, and in accordance with section 23 of the *Early Childhood Educators Act* and section 4.4 of the *Statutory Powers Procedure Act*, the remaining members of the Panel completed the hearing and rendered their decision with respect to this matter.

DECISION AND REASONS

This matter was heard by a panel of the Discipline Committee (the "Panel") of the College of Early Childhood Educators (the "College") on September 22 & 23, 2021; January 20, 2022, February 14,15 & 16, 2022, August 25, 2022, September 28 & 29, 2022, and October 3, 2022. The hearing proceeded electronically (by videoconference) pursuant to the *Early Childhood Educators Act, 2007* (the "Act"), *the Hearings in Tribunal Proceedings (Temporary Measures) Act, 2020* and the College's Rules of Procedure of the Discipline Committee and of the Fitness to Practise Committee.

At the outset, the Panel noted that the hearing was being recorded in the Zoom platform at the direction of the Panel for the hearing record, and ordered that no person shall make any audio or video recording of these proceedings by any other means.

PUBLICATION

The Panel ordered a publication ban following a motion by College Counsel, on consent of the Member, pursuant to section 35.1(3) of the Act. The order bans the public disclosure, publication and broadcasting outside of the hearing room, any names or identifying information of any minor children who may be the subject of evidence in the hearing.

THE ALLEGATIONS

The allegations against the Member were contained in the Notice of Hearing dated May 7, 2021, (Exhibit 1) which provided as follows:

1. At all material times, Jina Kim (the "Member") was a member of the College of Early Childhood Educators and was employed as an Early Childhood Educator ("ECE") at a childcare centre (the "Centre") in Ontario.

2. On or about November 30, 2016, the Member and two educational assistants ("ECAs") were supervising a group of toddlers, including a 2-year-old (the "Child") inside the toddler room. At approximately 2 P.M. the Member became frustrated with the Child and repeatedly asked them to apologize to one of the ECAs for not listening to her. The Child began crying. The Member then forcefully held the Child by their upper arms, as she lifted them and carried them a short distance from the room to the hallway.

3. The Child continued crying in the hallway. The Member then took hold of the Child with both of her hands on their upper arms and pulled them down to a seated position. The Member then briefly covered the Child's mouth with her hand, in an attempt to stop their crying.

4. The Member then lifted the Child up, tightly holding them on both their upper arms, and moved them to an adjacent bathroom. The Child continued crying, and the Member yelled at them words to the effect of "stop crying, you need to listen". A few minutes later the Child and the Member returned to the room. The Child continued crying for some time, and was very upset and overwhelmed for the rest of the day.

5. As a result of the Member's conduct, the Child suffered deep bruising on both upper arms, including one bruise in the shape of a hand print, in the location they were held by the Member.

6. By engaging in the conduct set out in paragraphs 2 – 5 above, the Member engaged in professional misconduct as defined in subsection 33(2) of the Act, in that:

   a) she verbally abused a child who was under her professional supervision, contrary Ontario Regulation 223/08, subsection 2(3);

   b) she physically abused a child who was under her professional supervision, contrary to Ontario Regulation 223/08, subsection 2(3.1);

   c) she psychologically or emotionally abused a child who was under her professional supervision, contrary to Ontario Regulation 223/08, subsection 2(3.2);

   d) she failed to maintain the standards of the profession, contrary to Ontario Regulation 223/08, subsection 2(8), in that:

. she failed to provide a nurturing learning environment where children thrive, contrary to Standard I.D of the Standards of Practice;

i. she failed to establish professional and caring relationships with children and/or to respond appropriately to the needs of children, contrary to Standard I.E of the Standards of Practice;

ii. she failed to maintain a safe and healthy learning environment, contrary to Standard III.A.1 of the Standards of Practice;

iii. she failed to support children in developmentally sensitive ways and to provide caring, stimulating, and respectful opportunities for learning and care that are welcoming to children and their families, contrary to Standard III.C.1;

iv. she failed to know, understand and abide by the legislation, policies and procedures that are relevant to her professional practice and to the care and learning of children under her professional supervision, contrary to Standard IV.A.2 of the Standards of Practice;

v. she failed to make decisions, resolve challenges and/or provide behaviour guidance in the best interests of the children under her professional supervision, contrary to Standard IV.B.4 of the Standards of Practice; and

vi. she failed to work collaboratively with colleagues in her workplace in order to provide safe, secure, healthy and inviting environments for children and families, contrary to Standard IV.C.1 of the Standards of Practice; and

vii. she conducted herself in a manner that could reasonably be perceived as reflecting negatively on the profession of early childhood education, contrary to Standard IV.E.2 of the Standards of Practice.

e) she acted or failed to act in a manner that, having regard to the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, contrary to Ontario Regulation 223/08, subsection 2(10); and

f) she conducted herself in a manner that is unbecoming of a member, contrary to Ontario Regulation 223/08, subsection 2(22).

THE MEMBER'S PLEA

The Member pleaded not guilty to all allegations.

EVIDENCE

Documentary Evidence:

The following documents were entered into evidence at the hearing:

Exhibit #	Description
EXHIBIT 1	NOH with AOS
EXHIBIT 2	Affidavit of MD, College's Director of Professional Practise
EXHIBIT 3	Floor Plan of Centre
EXHIBIT 4	Centre's Program Statement (Nov 2016)
EXHIBIT 5	Centre's Guide to Behaviour Management
EXHIBIT 6	Photographs taken by KY
EXHIBIT 7	Serious Occurrence Report, dated Dec 2, 2016
EXHIBIT 8	Investigation Notes of KY, dated Dec 16, 2016
EXHIBIT 9	Letter of Suspension, dated Dec r 30, 2016
EXHIBIT 10	Mandatory Employer Report, dated Dec 30, 2016
EXHIBIT 11	Behaviour Management Log - Nov 2, 2016 to Dec 1, 2016
EXHIBIT 12	Letter from Children's Aid Society ("CAS") to the Centre, dated May 24, 2017
EXHIBIT 13	Termination Letter, dated May 26, 2017
EXHIBIT 14	Email to College from the Child's mother (the "Mother") attaching photographs, dated Feb 25, 2019
EXHIBIT 15	CAS first interview of AR, dated Dec 2, 2016(Redacted)
EXHIBIT 16	CAS interview of BW, dated Dec 2, 2016(Redacted)
EXHIBIT 17	CAS Contact Log, dated Dec 2, 2016
EXHIBIT 18	CAS interview of LM, dated Dec 2, 2016
EXHIBIT 19	Police Witness Statement - Jina Kim, dated Dec 4, 2016

EXHIBIT 20	Police Occurrence Report deciding not to lay charges, dated Dec 28, 2016
EXHIBIT 21	Supplementary Occurrence Report, dated Jan 4, 2017
EXHIBIT 22	CAS note re Verification Conference, dated March 15, 2017
EXHIBIT 23	College Interview of AR by College investigator, dated Feb 21, 2019(Redacted)
EXHIBIT 24	College Interview of BW by College investigator, dated February 22, 2019(Redacted)
EXHIBIT 25	Interview of LM by College investigator, dated Feb 22, 2019
EXHIBIT 26	College's initial notification to Jina Kim re Mandatory Employer Report, dated Nov 22, 2018
EXHIBIT 27	Response #1 of Jina Kim, dated Jan 21, 2019
EXHIBIT 28	College's Letter to Jina Kim enclosing book of documents ("BOD"), dated April 3, 2019
EXHIBIT 29	Response #2 of Jina Kim, dated April 17, 2019
EXHIBIT 30	College's Letter to Jina Kim enclosing Addendum BOD, dated May 1, 2020
EXHIBIT 31	College's email exchange with Jina Kim re providing extension to respond to Addendum BOD dated May 12, 2020
EXHIBIT 32	Response #3 of Jina Kim, dated May 19, 2020
EXHIBIT 33	CC contact log March 17, 2017
EXHIBIT 34	CC observations of the Child Dec 1, 2016
EXHIBIT 35	College Investigator interview with the Mother
EXHIBIT 36	Tracy Saarikoski, CV
EXHIBIT 37	Tracy Saarikoski Retainer Letter without enclosures
EXHIBIT 38	Acknowledgement of Expert's Duty, dated Aug 27, 2021
EXHIBIT 39	Expert Witness Report, dated Aug 29, 2021

Witness Evidence of the College:

Counsel for the College called seven witnesses whose testimony is summarized as follows:

Evidence of KY (Director of Children's Services at the Centre):

KY is the Director and owner of the Centre which operates two locations, including the Centre. The licensed capacity for the Centre is 128 children. At the time of the Incident at issue (the "Incident") there were a combined total of 150 children enrolled on either a full or part time basis.

KY has been registered with the College since 2009 and had worked as an Registered Early Childhood Educator ("RECE") for 10 years – 6 years as a classroom RECE and 4 years as a Supervisor.

There are two additional supervisors at the Centre, TJ and JT. The offices for all supervisory staff are located on the first floor by the main entrance.

KY testified that in addition to her supervisory duties, she also at times works in the classrooms and that she is familiar with all children in her building.

KY described the physical premises of the Centre and discussed how the Centre operated. The Toddler 2 classroom is licensed for 15 children. This classroom is located on the second floor along with 3 other classrooms and washrooms. KY indicated that as far as she could recall there were about 13 ECAs and 9 RECEs employed at the time of the Incident.

KY testified that the Member commenced work for the Centre in July 2016 in the Toddler 1 classroom. Shortly after, she was assigned as the RECE to the Toddler 2 classroom with two ECAs, LM and AR. The team responsibilities included: supervising children, programming, ensuring the health and safety of the children, meeting the children's basic needs, and working collaboratively with other team members.

Both LM and ARs had worked with the Member in the classroom for several months prior to the Incident.

KY stated that the Centre's *Program Statement* was created in 2014 by the staff and sets out the expectations that families can have of the Centre. It is reviewed and signed prior to employment and annually thereafter. KY stated this process was typically completed by each staff member between January and March. KY communicated that every staff is bound by this document, but it does not necessarily encompass all staff responsibilities and expectations.

The Guide to Behaviour Management (the "Guide") is a document that outlines age appropriate and realistic expectations for children. The Guide identifies relevant consequences and prohibited forms of punishments outlined in the *Child Care and Early Years Act* ("CCEYA"). The Guide came into effect prior to the Incident. It is a requirement for all Centre staff to follow the Guide.

The Guide is reviewed and signed annually by each staff member and is used as a tool to facilitate ongoing professional development**.**

The Centre also uses Behaviour Logs to monitor staff behavior management practices. Ongoing monitoring is completed by KY and two supervisors to address any issues. Behaviour Logs were also used to document individual staff and classroom observations, challenges, ongoing professional development, and any follow up action needed to support the staff member and/or classroom.

On December 1, 2016, KY received a voicemail from the Mother asking about the cause of bruises on the Child's upper arms. KY called the Mother and said she would look into the matter and get back to her.

KY asked a staff member to bring the Child to the office where KY, TJ, and JT viewed the Child's arms and KY took photographs of the Child's upper arms.

KY arranged to interview any staff who might have been involved. She was accompanied by TJ and JT during the interview process. KY took point form notes during the interviews and immediately transposed them into an electronic document after each individual interview. She then shredded her original rough notes. She had TJ and JT review the transcribed notes but did not have them sign them.

The first staff member to be interviewed was LM who recalled that the Member was frustrated with the Child and asked the Child repeatedly to apologize to a staff member. LM could not view the Child during this interaction but could hear the Child crying.

The second staff to be interviewed was AR. AR observed the Child to be yelling, and that the Member removed the Child to the hallway. AR reported that the Member appeared to be frustrated with the Child and was trying to get the Child to apologize.

The third staff interviewed was BW, an ECA in the adjoining Preschool 2 classroom. BW stated that she came to her classroom door because she heard loud crying and screaming, which then became muffled as though a hand had been placed over the mouth. BW saw the Member take the Child into the bathroom and heard 4 loud thuds. KY stated that at this point she was concerned about the 4 loud thuds and that all 3 stories were consistent.

KY testified that she interviewed the Member to inquire about what had happened in the hallway. She admitted to being upset with the Member and may have yelled at her during the interview. The Member admitted to KY that she removed the Child from the classroom into the hallway to help calm the Child down. The Member admitted to covering the Child's mouth with her hand. The Member confirmed she moved the Child to the washroom and motioned that she took them by the arms. This confirmed to KY that the Child had been moved and it matched the bruises. KY immediately stopped the interview and the CAS was called. The Member was suspended as per the Centre's policy.

KY reported the incident to CAS at 11:30 am on December 1, 2016 and received a call back from CC (a Community Caregiver Investigations Worker for CAS) at 12:15pm to indicate she would be arriving on site that afternoon to interview staff. When she arrived at the Centre, CC contacted the local police to become involved in the investigation.

After the conversation with CC, KY called the Mother to inform her of the CAS investigation.

KY testified that she instructed the involved staff not to discuss the Incident or any details about it. This was to protect the integrity of the investigation.

On December 2, 2016, KY filed a Serious Occurrence Report with the Ministry of Education.

KY testified that LM was interviewed by the police at the Centre on December 1, 2016 and AR and BW were questioned at the police station on December 2, 2016.

On Monday, December 5, 2016, at a regular scheduled staff meeting, KY cautioned all staff who were present to refrain from discussing the investigation. The following day, KY discovered that LM had gone to the Member's home the previous evening and discussed the banging sound that LM heard on the wall. The Member told LM it was the Child banging their head on the wall. KY again cautioned LM against having any discussion regarding the investigation and followed it up with a report to the police.

After a discussion with the Centre's lawyer about the Member entering the building, KY requested that the Member have someone else drop off and pick up her children. The Member complied.

On December 30, 2016 a Mandatory Employer Report was submitted to the College and a letter of suspension was issued to the Member pending the CAS investigation.

When questioned about her relationship with the Member, KY stated that she had several discussions regarding how the Member managed behavior in the classroom and her particular frustrations. KY had also received comments from other staff regarding similar concerns. KY indicated that she had several meetings with the Member, observed her in the classroom, tried to be supportive and made clear to her that some behaviours were not acceptable. KY acknowledged that the Member had met with her and discussed her frustrations and feeling overwhelmed with the expectations of the classroom.

KY indicated that her relationships with the other staff members BW and AR, were very good. Her relationship with LM was initially good but deteriorated until LM was terminated in October 2017. LM was angry and upset about the situation involving the Member.

KY testified that the police communicated they would not be pressing charges against the Member following a thorough investigation January 2017.

On March 15, 2017, KY received a phone called from CC to advise about the outcome of the CAS investigation. This was followed up by a letter on May 24, 2017, stating that the allegations were unverifiable. KY testified that she disagreed with the CAS and stated so to CC.

A termination letter to the Member was issued May 26, 2017.

Evidence of BW (staff member at the Centre):

BW confirmed she began employment at the Centre in April 2012 and worked as an ECA in the preschool room. At the time of the Incident, BW was in the Preschool 2 classroom which is adjacent to the Toddler 2 classroom.

During the preschool nap time on November 30, 2016, BW heard loud crying coming from the hallway area which prompted BW to look out the door into the hallway. BW testified she saw the Member and the Child facing each other. The Member was demanding the Child apologize to AR while the Child continued to cry and scream. BW observed the Member place her hands on the Child’s upper arms to sit the Child down. The Member moved the Child to the washroom in the hallway and BW could no longer visually observe the incident. BW heard the Child continuing

to scream and then heard a muffled sound. BW confirmed the incident she witnessed lasted approximately 2 minutes.

BW did not report the Incident that day. BW testified that the observations made her feel upset and wanting to help the Child.

On December 1, 2016, BW observed the marks and bruises on the Child while in the photocopier room adjacent to the office. BW heard the Mother discussing the bruises with KY and immediately thought of the Incident that happened the day prior.

On Friday December 2, 2016, BW was interviewed at the police station about the incident.

BW testified that previous work experience with the Member caused some concerns, but BW never reported the concerns. BW confirmed she had a professional relationship with the Member.

BW testified that she had and continues to have a good relationship with KY and has known her since she was young.

Evidence of AR (staff member at the Centre)

AR testified that she began working at the Centre in 2013 and was an ECA in the toddler room. At the time of the Incident, AR was in the Toddler 2 classroom with the Member and LM.

Under questioning, AR had difficulty recalling the daily routines, such as breakfast and naptimes.

AR stated the Child was very active and spoke in full sentences. AR stated she did not remember how the Child communicated anger or frustration. She stated that the Child's relationship with staff was a regular student and teacher relationship. On the day of the Incident, AR recalled the Child was saying "no" often throughout the first half of the day and before lunch, was crying a lot.

AR stated she was having difficulty recalling some events. The Panel broke to allow her time to review the statement she gave to the police on December 1, 2016. After reviewing her statement, AR testified that the Child was saying "no" a lot, but she did not feel this was unusual toddler behavior. She could not recall why the Child was saying "no" and did not recall of any safety concerns or of behavior guidance challenges.

AR was unable to recall how the Member interacted with the Child before the Incident. AR was in the classroom for the first half of the naptime while LM and the Member were on their lunch break. AR was alone with the children for around an hour.

The Child did not want to sleep and they were sitting beside a cot. AR sat near the Child and possibly provided them with a book, but did not make physical contact to lay the Child down.

Under direct questioning, AR confirmed she did not grab the Child by the arms at any time.

By 2 P.M., LM and the Member returned to the classroom from their lunch break and the Child was still awake. As AR was leaving for her lunch break, the Child began to cry.

AR testified that the Member brought the Child to the hallway. AR recalled the Child walking to the hallway. As AR was leaving for her lunch break, she observed the Child sitting on the floor in the hallway with the Member standing; both facing each other. LM was in the classroom at the time. In the opinion of AR, the Member appeared frustrated as the Child continued to cry. AR observed BW standing in the doorway of her classroom, which was right beside where the Child was sitting. AR did not observe any physical interaction and did not report her observations.

At 3 P.M., AR returned from her lunch break and asked how the Child was and LM replied the Child was on their cot. AR observed the Child engaged in the afternoon program routine. The Member asked the Child to apologize to AR after naptime and lunch break.

AR was questioned in the office by KY on December 1, 2016. AR stated that she had not seen any marks on the Child and had not observed any physical interactions with them.

CAS interviewed AR a second time to review details of the Incident.

The College investigator interviewed AR in February 2019.

AR testified prior to the Incident, she had no concerns about the atmosphere at the Centre. AR stated that her relationship with the Member was collegial. AR testified the relationship between the Member and LM was similar.

AR didn’t recall conflict with staff or KY completing classroom observations.

AR testified she would not change what she did the day of the Incident.

Under direct questioning by the Member's counsel, AR testified that she didn't recall the following: the Child hitting her, asking the Child to apologize, and an incident report written by the Member about the scratch above the Child's eye.

Evidence of the Mother

The Mother enrolled the Child at the Centre at the age of 18 months. The Child began attending in the Toddler 1 classroom and transitioned to the Toddler 2 classroom in the fall of 2016.

The Mother testified that the parent-teacher relationship was positive with the Member, and that the Child did not have any challenges with staff. The Mother stated that the Child had limited verbal skills and displayed rocking behavior as a self-soothing mechanism when experiencing emotions at an intense level. The Mother indicated that staff were aware of the rocking behavior. Further, she indicated that at times the rocking could become so intense that the Child could hit their head and body on the wall or the chair.

The Mother indicated that the Child would understand the concept of apologizing, but would have trouble vocalizing it.

The Mother testified the Child had a doctor's appointment on the morning of November 30, 2016. At that time, no marks were evident on the Child. The Mother dropped the Child off at the Centre between 10 A.M. and noon and indicated that the Child was happy to return to be with their friends. The Mother advised staff at the Centre that the Child was late because they had been at the doctor's.

The Mother picked up the Child between 5 and 5:30 P.M. on November 30th and nothing particular was relayed to her by the Centre staff at the time. Nothing unusual was noticed regarding the Child. The Mother testified that the Child played with their siblings, including an older sibling in what was a daily evening routine. Though they were not in her direct line of sight at all times, the Mother could hear the children playing at all times. When asked about the nature of their play, the Mother indicated they would typically watch TV, play with their tablets and race cars.

Later that evening, the Mother observed significant bruising on the Child's arms and stated that they were not there when the Child was dropped off at the Centre. She stated that the bruising

appeared to be finger marks and thus, she checked to see if they matched the hands of any of her other children and concluded that they did not. At this point, she took pictures to document the bruising.

The Mother did not recall there being a mark on the Child's face that day.

The next morning, the Mother recalled that the Child was hesitant to leave the car when they were dropped off at the Centre. She contacted the Centre regarding the marks and left a telephone message for KY to inquire if something had happened at the Centre the day before that might have caused the bruising. The Mother wanted to give the benefit of doubt that there was an explanation for the bruises.

KY returned the phone call to the Mother and advised her that she was not aware that there had been any issues but would call back after investigating. Three hours later, KY called the Mother back and advised that there had been an Incident and that the CAS was notified. At that time, the Mother was asked to come to the Centre to speak with the CAS. The Mother went to the Centre, after which she called her family doctor to have the Child seen to ask if there could have been any damage to the Child because of the intensity of the bruises. X-rays were completed and showed that the bruising was deep enough to show up on an x-ray but there was no damage to the bones underneath. The doctor advised a follow up appointment with their pediatrician, which was completed. The bruises took approximately 6-7 days to heal.

The Child continued to attend the Centre. Though the Mother felt apprehensive, she was confident in the Centre's investigation and follow-up actions. The Mother recalled someone on staff apologizing to her, but did not recall who. The Mother indicated she had no further contact with the Member following the Incident.

The Mother testified she had telephone conversations with the CAS, but did not take notes because she was driving.

The Mother was informed the police would not be filing charges against the Member.

In March, 2017, the CAS advised the Mother that the allegations were unfounded and the case was closed. The Mother indicated she was upset and angry and questioned whether the CAS did the job they were supposed to do.

The CAS provided a mediated conversation between the Member and the Mother. The Mother did not remember when that meeting took place and she did not take notes during that meeting. The Mother testified she was nervous, upset, and angry, but agreed to the conversation because she was curious to hear what the Member had to say and felt it was a safe place to share her feelings. The Mother did not remember who spoke first at the meeting. The Mother stated that the Member said she held the Child to get them to stop rocking and calm down without the intent of hurting the Child. The Mother testified she left the meeting upset, angry, and frustrated. At the end of the meeting, the Mother exchanged phone numbers with the Member, although she never intended to keep in touch with her.

The Mother testified the Child was hesitant to get out of the car at the Centre for some time, but eventually moved on.

Evidence of LM (staff member at the Centre)

LM started working at the Centre in 2015 and was an ECA in the toddler room. At the time of the Incident, LM was in the Toddler 2 classroom with the Member and AR.

LM indicated her primary role and duties included supporting the RECE, programming, executing the daily routines, and tending to the overall well-being of children. She stated that the toddler classroom was licensed for 15 children at the time of the Incident.

LM testified her relationship with the Member in the classroom was fine and they were friends outside of work.

LM was able to identify the daily routine in detail and stated the toddler classroom was very active. Staff speculated there were some children who had needs that may have required assessment.

LM stated during naptime, the ratio in the toddler classroom was 1:8. All children were provided with an individual cot to rest, but are not forced to sleep. Children would be provided with quiet activities, such as books and puzzles, if they did not want to sleep.

LM stated staff in the classroom used a daily log for observations and any other incidents were documented through incident reports.

LM testified that if she saw another staff member using inappropriate behavior guidance strategies and it was a one-time incident, she would speak to the staff member, but if it occurred again, she would report it to the supervisor.

LM testified that the Child was very active, aggressive, and had difficulty settling. She recalled that at the time of the Incident, the Child spoke in short 2 to 3 word sentences. When the Child was upset, they would run away, yell, and/or repeatedly bang their head against the wall. LM stated that while an incident report was required for such behaviour, she was not sure if it was done.

LM indicated all staff in the room had a good relationship with the Child, however AR was noted as the Child's favorite staff. She indicated the Child's mood was fine the day of the Incident and nothing unusual was noted about the interactions between the Member and the Child. LM later recalled that the Child was late the day of the Incident and she agreed that when children arrive late, they generally have a more difficult day.

Under questioning by College counsel, LM stated her ability to recall the Incident and the day was a 7 on a 10-point scale.

LM recalled naptime usually began around 12 P.M. She initially stated her lunch break on the day of the Incident was from 12:30 P.M. to 1:30 P.M. and she went home for lunch while the Member and AR remained in the classroom. LM then confirmed she went on her lunch break with the Member and to shop at Dollarama. She testified that this meant that the room would have been out of ratio so someone must have come in to fill in. AR had a lunch break when they returned.

Upon returning from lunch, LM observed the Member and the Child in the hallway. The Child was extremely upset and was crying and yelling. The Member was squatting at the Child's eye level trying to get the Child to calm down. LM was able to observe this interaction from the doorway and could confirm she did not witness any other physical contact. LM observed the Member take the Child by the hand to the bathroom while they continued to cry and yell. Once in they were in the bathroom, she heard a slight banging on the wall. When questioned by College counsel regarding the banging sound in the bathroom, LM stated she would not have asked the Member because staff would have already known what the banging sound was.

She confirmed that the Member was using a firm voice, but not screaming.

When the Member and the Child returned to the classroom, the Child seemed calmer and was fine for the remainder of the day.

LM stated that she was not concerned about the interaction between the Member and the Child because she saw it as a continuation of the interaction between AR and the Child before she had left for lunch.

When questioned about the interaction between AR and the Child, LM recalled AR would generally put the Child to sleep because of their close relationship. On the day of the Incident before leaving for lunch, LM noticed the Child did not want to sleep. The Child kicked and hit AR and was getting up from their cot. In an attempt to control the situation, AR picked up the Child by grabbing the trunk of the Child's body under the arms and placed them down on the cot. The Child was crying and yelling during this interaction. LM stated this sequence of interactions happened approximately twice. LM stated she was seated approximately 3 feet from this interaction and noted the interaction was forceful. She was not concerned with this interaction because the Child had had previously challenging sleep time situations and was aggressive, but on reflection, she felt AR needed a break and should have stepped away. LM did not feel it was necessary to report or document the incident.

The Member was present in the room during the interaction between AR and the Child, but working to settle other children for naptime.

When questioned about the Member asking the Child to apologize to AR, LM recalled that the Child did not respond because the concept was not developmentally appropriate and the Child was too upset. The Member asked the Child twice to apologize.

LM testified that when the Member and the Child returned into the room, the Child settled and fell asleep in the Member's arms and she moved them into a cot.

LM stated she learned of the bruises on the Child on December 1, 2016, from KY and was concerned and taken aback. She stated she had no idea where the bruises came from. At this point, LM took a break to refresh her memory from KY's interview notes.

LM could not remember why she did not tell KY about her observation of AR repeatedly placing the Child on their cot and could not give a reason why she did not report it to KY, the CAS or the police.

LM testified she learned of the CAS investigation on December 1, 2016, and was instructed by KY not to discuss the investigation with anyone. She did not recall KY making notes of their discussions.

The CAS interview was completed at the Centre with the police present, and she understood her obligation to be truthful. The CAS worker cautioned LM not to discuss the investigation with anyone. LM confirmed that she did not discuss the investigation with anyone, however she did return boots and eyeglasses to the Member's home. LM testified she did not enter into any discussion with the Member about the Incident. LM did notify KY about her interaction with the Member and confirmed that KY was very upset when she found out about it.

LM confirmed she did not have any additional contact with the Member until the CAS investigation was closed and LM no longer worked at the Centre.

LM did not recall her College interview and refreshed her memory with the CAS notes and College interview summary. LM stated the notes are accurate statements of the Incident.

Evidence of TVB (College Investigator)

TVB began employment with the College in 2008 and at the time of the hearing, she was employed as Investigator Team Lead. Her role included providing administrative support to the Complaints Committee of the College and training to investigators. She was not an investigator in the case at hand and had no interest in the outcome. She confirmed that she had reviewed all of the documents held by the College and that staff had followed all the proper protocols. The documents were scanned into the system without any changes being made to them. Although there were changes in investigators, it did not impede the case as documents were logged in as soon as they were received.

All of documents presented at the hearing were those on file at the College.

TVB testified that an investigator with the College interviewed AR, LM, BW, KY and the Mother. The College investigator did not give these individuals any documents to review. As per College procedures, statements were forwarded back to witnesses to review and add information. Interviews were completed by phone. The investigator was required to take notes and all of the notes were saved in the College's file. It is expected that the investigator will ensure their notes include everything discussed, and where the investigator is directly quoting a witness, quotation marks are required to be used. A summary of the interview is to be created right away, and saved to the College's drive, and no changes are permitted to be made after.

Various documents were admitted into evidence through TVB, these included:

- interview summaries of AR, BW, and LM that were completed in February (she confirmed the College received the CAS file shortly after these interviews),
- the CAS interview with KY dated March 17, 2017,
- the CAS observation of the Child dated December 1, 2016, and
- the College's interview with the Mother dated February 20, 2019.

TVB testified that the initial notification of the complaint to the College was sent to the Member on November 22, 2018 and it included the Mandatory Employer Report, dated December 30, 2016. The Member responded to the notification by email on January 21, 2019. The College saved the Member's email without making any edits as per College practice.

The College sent further disclosure to the Member on April 2, 2019, which included: the book of documents and summaries of the interviews with the witnesses. These documents were provided to the Member for transparency and the Member responded April 17, 2019 by email to a College investigator,

On May 1, 2020, a letter was sent to the Member by a College investigator, which included an addendum and CAS and police documents. The Member was provided an opportunity to respond to the additional information.

The Member's final response was submitted to the College on May 19, 2020.

The Complaints Committee reviewed the file on May 28, 2020 and referred the case to the Discipline Committee. At this point there was no further communication with the Member.

TVB testified that the College's investigation was delayed due to responses from the CAS. Once the verification was received from CAS in November 2018, the College's investigation began on January 21, 2019. The entire CAS file was received by the College on February 12, 2020. The entire police file was received by the College on February 14, 2020.

Evidence of Tracy Saarikoski (Expert Witness)

Tracy Saarikoski ("**TS**") was qualified as an expert witness qualified to give evidence as to:

1. Appropriate behaviour guidance of children by RECEs; and
2. The application of legislation, regulations, the College's Code of Ethics and standards of practice and the College's guidelines in respect of behaviour guidance of children.

TS prepared an expert report dated August 29, 2021.

TS confirmed this was her first time testifying, writing a brief, and participating as an expert witness regarding child guidance, appropriate practices and the responsibilities of an RECE. She confirmed the documents she was provided with prior to writing her report, including the Centre's floorplan, pictures of the bruises, and a retainer letter from the College. She confirmed she has never been to the location of the Centre or had interactions with any individuals involved in the alleged incident.

TS testified about toddler development, positive child guidance, and responsive relationships that are supported by pedagogical documentation. The pedagogical documentations used to support her evidence included, but were not limited to *How Does Learning Happen* and various practice guidelines published by the College.

TS confirmed that rest time is a time for toddlers to quiet their bodies and minds, but there is not a requirement for toddlers to actually sleep as per the CCEYA. The children who are resting may receive a quiet activity, such as picture books, quiet toys, and/or engage in quiet conversations with staff. TS also confirmed that according to the CCEYA, sleep rooms cannot be completely dark for safety purposes. TS also confirmed sleep requirements for toddlers and indicated that every toddler may have their own unique needs with their sleep schedule. TS emphasized the

importance of following the child's lead and being in tune with their needs. She identified the RECE's role in recognizing and supporting stressors of individual children; being aware of their cues and potential triggers. Behavior should be guided in a manner that builds trust and security; fosters respect and self-worth of a child.

TS confirmed that the responsibility of the RECE included a leadership role pertaining to the children, families and the program overall. She identified the RECE's role in documenting and communicating, including through the preparation of incident and accident reports. When questioned about specific situations, TS emphasized the RECE's obligation to document, report, and communicate with all parties.

TS confirmed the importance of RECEs being self-aware of their own emotions before supporting a child in their self-regulation. TS stated the importance of RECEs asking for helping or taking a break when feeling overwhelmed. She identified prohibited practices that compromise a child's well-being and sense of belonging as outlined in the College's Standards of Practice and the CCEYA.

TS testified that the CCEYA toddler ratio is 1:5 (with a maximum of 15 children), with two-thirds of the ratio during rest time. The RECE's role is to balance individual and group needs to ensure quality group dynamics and to support various needs in the room. This includes fostering collaboration with all who work with children and their families.

When questioned about support from management, TS verified that though staff should feel a sense of belonging in their workplace, their professional obligation is to care for the children.

The Member's counsel inquired about TS's perspective on the word "frustrated" and TS defined the word to mean "not in a calm space". The Member's counsel inquired about how the facts were presented in the retainer letter she received from the College. TS confirmed she read the contents of the letter as alleged facts according to her own professional lens and understandings of childcare experiences.

The Member's counsel inquired about what may have occurred after the Incident in the washroom. TS responded with varying scenarios with what may have potentially occurred but acknowledged that she could not give an exact account of what had occurred.

TS confirmed that she had no clarity on the nature of what had happened when the Mother took the Child to see the Child's doctor the morning of the Incident including whether the Child had received medication, a shot, or a check-up.

TS gave evidence that it is dangerous for an RECE to physically move a child and suggested alternative strategies such as trading off with another staff, removing the rest of the children in the room, or asking for consent from the child to be moved. TS also stated that strategies would depend on the context of the child, room, and situation, and that RECEs would need to use their professional judgment.

TS gave evidence that if the Member had placed her hand over the Child's mouth as was described, this action was more aggressive in nature and therefore, did not demonstrate respect for the Child.

TS testified that though it is the duty of the management team to support and ensure ratio requirements are met at all times, it is the duty of RECEs to fulfill that responsibility as well. TS also confirmed that consistency in staffing is ideal but acknowledged that this may not always be possible in the sector.

TS gave evidence about what constituted a "tantrum" and defined the word as when a child may not have emotional control. TS stated that it is the role of the RECE to help children resolve a tantrum and talked about the importance of consent when physically engaging with a child.

TS testified that it would be inappropriate for an RECE to require an apology from a toddler.

TS clarified the term "consent" by explaining the importance of communicating with children to support them through transitions and help them anticipate changes. TS acknowledged this may not be possible in all situations.

<u>Evidence of the Member:</u>

The Member testified that she was employed as an RECE since 2011.

The Member testified that she began her employment at the Centre in July 2016 as the primary RECE in the Toddler 2 classroom with LM and BW. At the time of the Incident, KY was the director of the Centre. The Member recalled that the Toddler 2 classroom was located on the second floor. There were 15 toddlers, and the room was very busy. The Member recalled that daily transitions included assisting toddlers going up and down the stairs.

The Member stated that the team worked well together. However, the Member recalled that there were concerns with BW and cellphone use during program time. The Member spoke to management about this concern and BW was moved to another room a month later. A new RECE joined the team for about 1.5 months. As new toddlers moved up to the Toddler 2 room, this RECE moved to the preschool room with the transitioning children. AR then joined the team in the Toddler 2 room.

The Child and their siblings joined the Toddler 2 room in November 2016. The Member stated that she had a great relationship with the Child and recalled that the siblings were active and playful but had speech and auditory issues. The Member indicated that at the time of the Incident, the Child was using 1 to 2 words to communicate. She did not recall the Child communicating with teachers or peers in sentences. The Child responded to words such as “Stop,” “Yes/no,” “Up/down,” “Sorry,” and “Thank you.”

On the day of the Incident, the Member confirmed that 15 toddlers and three educators were present on the day of the incident and that the ratio in the toddler room was 1:5. The Child and their siblings arrived at the Centre around 10:30AM after a doctor’s appointment, right before lunch. The Child appeared not to be themselves and was clingy, whiny, and not engaging in play or with their peers. The Member indicated that AR had a special relationship with the Child because she was their caregiver in the Toddler 1 classroom. The Member testified that on the day of the Incident, the Child was continually hitting AR throughout the morning. AR was attempting to redirect the behaviour and had asked the Child to stop. The Member also attempted to redirect the behaviour by offering an art experience and the Child had declined the invitation.

After lunch, the Child was on their bed in between the block area near the window. AR was sitting with the Child. At this time, the Member and LM left for Dollarama to purchase materials for the Christmas concert. AR was in the Toddler 2 room with 15 toddlers. The Member stated that KY was aware that the Member and LM were leaving the Centre during their lunch break. The

Member stated that this trip was discussed a week prior with KY and that they had also communicated with KY on the day of. The Member was aware that AR would be alone in the room, which meant that the 2/3 ratio was not met. The Member confirmed that she did not ensure staff coverage before leaving AR. The Member testified she believed that it was KY's responsibility to ensure required staff coverage.

When the Member and LM returned to the Toddler 2 room, all the toddlers were sleeping but AR was talking to the Child. The Member testified that she could not hear the conversation between AR and the Child due to the naptime environment (AR was whispering to the Child, staff were positioned throughout the classroom, etc.). The Member confirmed that she did not witness any forceful interactions between AR and the Child and if she had any concerns with their interactions, she would not have left AR alone with the children. AR requested assistance with having the Child apologize for their behaviour. The Member testified that though there was no reason to intervene, she intervened upon AR's request for support. The Member asked the Child to apologize to AR, at which point, the Child began to cry. The Member asked the Child once to apologize. The Member anticipated a tantrum and lifted the Child up by the upper arms and moved them out of the room while they cried. The Member testified that she moved the Child to the hallway because the furniture in the classroom could be a safety hazard and described the nature of the Child's tantrum, which included yelling, screaming, wiggling, and crying.

At first, the Member insisted that the Child did not wiggle but after further questioning, the Member indicated that from the hallway to the washroom, the Child may have wiggled a bit. The Member testified that her interview with police in this regard would be more accurate, given the timeline. However, the Member indicated that she responded to the questions based on her own interpretations of them.

The Member was across from the Child in the hallway. The Child screamed and cried louder. The Member testified that her immediate reaction was to place her fingers on the Child's lips to quiet them. In retrospect, the Member understands that this response could possibly be viewed as silencing a child's voice. The Member lifted the Child up under the arms and took them to the washroom in the hallway. Her intention in moving the Child was out of concern for the Child's safety and the well-being (sleep) of the other toddlers in the classroom.

The Member then took the Child to the washroom because the hallway was too bright and she thought a smaller and dimmer space would help the Child calm down. The Member described the washroom as small in size and that it included a toilet and a sink. Originally, the Member placed the Child on her lap but the Child got up and sat on the floor, in front of the toilet against the wall. The Member, at this time, was sitting on the floor in front of the sink, facing the Child. The Child began rocking their upper body back and forth as the Member got up to get some tissue. The Member testified that the Child hit the back of their head against the wall about two to three times and that it could have been loud enough to be heard from the other classrooms. Seeing that the rocking motion was causing the Child to bang the back of their head against the wall, the Member moved the Child away from the wall. The Member confirmed that anytime a child bangs their head, it is a concern. The Member then used warm water on tissues to wipe the Child's tears. The Member indicated that the Child rocked their upper body back and forth as a means of self-soothing. Once the Child settled (which took approximately five minutes), the Member and the Child returned to the Toddler 2 classroom holding hands.

During this time, AR and BW were present in the hallway talking to one another and did not say anything to the Member or offer to help.

When the Member and the Child entered the Toddler 2 classroom. AR was present behind the door and left for lunch once the Member and the Child were inside the classroom.

Upon returning to the classroom, the Member asked the Child if they wanted to lie down. The Child declined and the Member sat the Child on her lap beside the cot. The Child fell asleep in the Member's arms and was moved onto the cot. At this time, all the other toddlers were sleeping, LM was in the room, and AR was on her lunch break.

The Member testified that she would have approached the situation differently in retrospect, including having a conversation with AR. The Member also agreed that she could have used calming and transitional strategies to prepare the Child and to potentially prevent stress. In retrospect, it was a mistake to request an apology from the Child and she should have communicated with AR. The Member also confirmed that she should not have taken the Child into the hallway and should have attempted to soothe them inside the classroom. The Member also confirmed that she should not have placed her hand on the Child's mouth. After naptime, the Child was playful and had a snack. The Member noticed a red mark on the Child's face so the

Member wrote an incident report. The Member confirmed that she did not write an incident report for the Child regarding the head banging because there were no marks.

After lunch, AR requested an apology from the Child. The Member suggested a hug, and the Child hugged both AR and the Member.

At the end-of-day pick-up, the Member had a conversation with the Mother about the incident report and the Child's day. She did not discuss the head banging in the washroom with the Mother.

The next morning, when the Member arrived at the Centre, KY asked to speak to her in the office. Two assistant supervisors were present with KY. KY showed the images of the Child's bruises. She raised her voice at the Member. The Member did not see KY making notes of this discussion. KY told the Member to retrieve her belongings and leave the premises. The Member indicated that she had no further interactions with KY.

KY indicated that she would be reporting this incident to both the police and CAS. The Member left the Centre immediately with her infant son. The Member confirmed that LM had brought the Member's boots and glasses to her home on the evening of December 1st, 2016. The Member testified that the interaction between the Member and LM was brief and they did not exchange any information about the Incident.

A police officer later contacted the Member and said they wanted her to answer some questions. The Member attended at the police station on a date during the first week of December at 11:30PM and answered questions. The Member followed up with the police station as she never heard anything further, however, the officer was on vacation and she did not receive any information. This caused a financial hardship on the Member because she was on a leave without pay and was hopeful to return to employment at the Centre once the case was closed.

In January 2017, she learned that the police would not be pressing charges. The police report verified that no charges were laid against the Member. The Member stated that the officer who communicated this information also shared their perspective that this situation might have been targeted against the Member. The Member did not return to the Centre as her position was terminated. The Member then began looking for another job, which led her to a supply position with her current employer.

After the police investigation, CC, on behalf of the CAS, interviewed the Member about the Incident. The CAS investigation was completed in March 2017 and the Member received a letter that the perpetrator (of the bruises) was unknown.

CC asked the Member whether she would meet with the Mother. She agreed and met with the Mother with CC. The Member and the Mother exchanged phone numbers but there were no future conversations. The Mother also acknowledged that this situation must have been difficult for the Member.

The Member testified that during the Incident, she was not frustrated, did not use excessive force, did not argue with the Child, and the Child did not resist or try to run away.

The Member confirmed that her relationship with LM was professional that included only one occasion where they went out socially outside of work hours with another colleague. After the Incident, LM texted the Member to see if she was OK but they did not keep in touch.

When questioned about LM's interview with the CAS and the police, the Member indicated that the statements were not accurate in terms of both details and timeline. The Member indicated that LM's recollection of the Incident had many inconsistencies with her own, including with respect to the tone and volume of her voice he physical and verbal interactions with the Child, and the whole dynamic of the incident. The Member stated that LM was in the Toddler 2 classroom supervising the children and therefore, could not have seen the interactions and incident.

When questioned about the Centre's behaviour management policy, the Member testified that she only remembers receiving the Parent Handbook, and her contract.

The Member confirmed that she had a conversation with KY two weeks prior to the Incident regarding the Member's tone and physical contact. The Member testified that physical contact with a child occurred once during a transition to prevent a toddler from falling down the stairs. The Member confirmed that there were many staff changes in the classroom within a short period of time which increased her stress levels and responsibilities in the classroom.

The Member agreed that she had three opportunities to respond to and provide clarification to the College regarding the allegations. College counsel presented five documents that had been sent to the Member from the College. The Member confirmed receiving the documents and the noted

the timelines associated with each document. However, the Member did not agree with all the details and content of the documents.

SUBMISSIONS OF THE PARTIES ON LIABILITY

College Submissions

Counsel for the College submitted that the evidence established on a balance of probabilities the factual findings consistent with the Statement of Allegations in the Notice of Hearing. The evidence established that the Member engaged in professional misconduct.

The College submitted that it had met its burden of proof and had established that the Member was responsible for the alleged interactions between the Member and the Child on November 30, 2016. College argued that an RECE’s fundamental responsibility is to maintain caring and responsive relationships with children.

The College submitted that the Member:

1. left a staff alone with too many children contrary to the required ratio;

2. engaged in a power struggle with the Child, even if unintentional;

3. caused the Child to be in emotional distress;

4. engaged in forceful and abrupt contact with the Child;

5. was frustrated and firm with the Child; and

6. did not document the Incident.

The College also argued that the evidence contained in close proximity is more reliable, specifically, the evidence and statements by the police and the CAS were recorded immediately after the Incident. The Member was provided with multiple opportunities to ensure that the statements accurately reflected the events at issue.

The College submitted that it was required to prove its case, and must do so on a balance of probabilities, rather than a criminal standard of proof beyond a reasonable doubt.

The College argued that the College's witnesses were credible and reliable and that there were issues with the Member's credibility and reliability.

College counsel also provided the Panel with four decisions by the Discipline Committee which established that similar conduct relating to the physical, emotional, and psychological abuse has been found to be professional misconduct.

The College submitted that that there was overwhelming evidence that the Member had engaged in the acts of professional misconduct as alleged and that the Panel should make findings on all of the allegations.

Member Submissions

The Member submitted that the College has not met its burden of proof and has failed to show on a balance of probabilities that the Member had engaged in professional misconduct.

The Member submitted that there were issues with the documentation of the Incident, in terms of how those notes were made and stored. The Member further noted that the projection of biases to other authorities involved in the investigation could have potentially impacted the investigation.

Counsel for the Member argued that there were some issues with the reliability of the evidence. First, witnesses who testified were not actually present during the Incident. Second, the written statements were not consistent with live testimony and that it is the testimony that is given under oath which needs to be considered. Third, the witnesses each dissected the evidence in different pieces due to what they could hear or see at the time of the Incident.

Counsel for the Member submitted that there was no medical evidence which established the cause for the bruises. The Child never blamed the Member for the injuries. There were other ways the bruises could have been caused (such as the Child roughhousing with siblings). The Member used enough force to lift the Child of that size, but not with the intent to harm or scare the Child

The Member placed her hand on the Child’s mouth but not with the intent to harm or silence the Child but to soothe and calm them. Additionally, no witness testified to the Member using excessive force nor was there any indications documented of their concerns during the Incident. Counsel for the Member submitted that no witness testified that they provided support at the time of the Incident.

Counsel for the Member submitted that no witness testified to the Member yelling at the Child to be quiet and to stop crying. Counsel for the Member submitted that no witness testified that the Child was overwhelmed for the rest of the day. Furthermore, counsel argued that the Member was acting within the scope of practice to comfort and calm a child.

DECISION ON THE ALLEGATIONS

After having considered and weighed the evidence presented by the College and the Member, the Panel finds that the College did not meet the burden of establishing, on a balance of probabilities, that the Member engaged in professional misconduct.

REASONS FOR DECISION

Credibility of the Witnesses

The Panel received submissions from the parties as to how to consider evidence, including with respect to assessing the credibility and reliability of each witness. Clearly, this is particularly important in cases such as this in which there is conflicting testimony from witnesses. The Panel received advice from its independent legal counsel outlining the factors that courts and tribunals are to consider in assessing witnesses’ credibility. These factors are as follows:

a. The extent of the witness’s opportunity to observe that to which they testified;

b. Common sense and the probability or improbability of the witness's version of events;

c. Whether the witness's statements were consistent or inconsistent with any other evidence in the case (i.e., that of other witnesses or documents), noting that in cases of inconsistency the significance of the inconsistency should be assessed;

d. Whether the witness was forthright in their evidence;

e. Whether the witness has an interest in the outcome of the case;

f. The appearance or demeanour of the witness;

g. Whether the witness's evidence was contradicted by that of another witness; and

h. Whether the witness previously gave a statement that was inconsistent with what they said in evidence.

The Panel considered the oral testimony of the witnesses and made the following assessments as to their credibility:

Credibility of KY (Director of Children's Services at the Centre):

The Witness's Ability to Observe and Recall – KY was not present and did not observe the Incident. The next morning, the Mother provided images of marks on the Child's upper arms. These images prompted BW to bring the alleged interaction between the Child and the Member to KY's attention. All staff present during the Incident were interviewed by KY and two supervisory staff. KY testified to making notes of these interviews. However, these handwritten notes were not provided nor observed by all staff who testified. When questioned about note-taking, KY stated that any such notes could not be located due to storage practices.

Whether the Witness's Evidence Accords with Common Sense and is Plausible/Reasonable - KY did take appropriate steps in immediately interviewing staff regarding the Incident. However, best practices pertaining to gathering information, documentation, and next steps including suspension of any staff were not implemented at the time. The Panel questions whether KY took notes during the interview process because other witnesses had stated that they do not remember KY taking

notes. Furthermore, no documents were submitted for the hearing and KY could not identify where the documents were located when questioned by the Member's counsel.

KY did take appropriate steps in immediately contacting local authorities and reporting the allegations.

Whether the Witness was Forthright in their Evidence – The Panel found KY to be somewhat forthright and clear in her evidence. KY presented herself as an RECE with the majority of her experience in a management position, which was evident in her recall of the managerial steps she took upon hearing about the alleged interaction. However, KY was not clear about each interview conducted with staff such as the type of questions asked, the order of questions asked, and other details that could identify her professional mannerisms and conduct presented during the various interviews. KY was also not clear about the documentation she allegedly made during interviews and the retention of the documents. KY was also not forthright about her personal relationship with BW and how she initially learned about the Incident from BW, which the Panel believes led to potential biases.

Whether the Witness had an Interest in the Outcome – There were several indicators that suggested that KY potentially had an interest in the outcome of the hearing. First, KY questioned the CAS outcome and demonstrated this by calling CC expressing her frustration and disbelief of the decision. This interaction was documented by CC on the CAS contact log and was identified as a concern. Second, the Panel believes that KY's personal relationship with BW may have impacted how the events unfolded and KY's potential biases towards the Member (BW saw the photos during interaction between KY and the Mother and spoke to KY of the interaction between the Member and Child before interviews were conducted). In addition, the lack of documentation of witness interviews conducted by KY presented into evidence further suggests KY's interest in the outcome.

Inconsistencies and the Panel's Conclusion on the Witness's Credibility - The Panel found KY to be not credible nor reliable. The Panel found KY's testimony not reliable as she was not present during the Incident. Furthermore, due to the absence of documentation of witness interviews conducted by KY, the Panel questioned the accuracy and integrity of KY's testimony. The Panel believes that KY is not forthright in her testimony pertaining to documentation of the alleged incident. If she was a competent professional that approached this incident in an objective

manner, she would have known to save every single piece of evidence, including rough notes, and completed a sign-off process that included each staff signature and date as per Ministry guidelines. Furthermore, all documents are required to be retained on site and accessible for Ministry review.

The Panel questioned KY's professional leadership as there were additional concerns regarding documentation. KY testified that she had previous conversations with the Member regarding concerns surrounding behaviour guidance and the behavioural log submitted as an exhibit was vague and lacking detail. Furthermore, the staff, including the Member, testified that they were not aware of the contents of the behavioural log and had no recollection of having conversations. Again, the Ministry requires that all concerns around professional performance should be documented appropriately, reviewed with staff, signed and dated according to the review, and retained on site for future reference. Overall, KY's testimony was inconsistent across the board and lacked credibility, reliability and professionalism. KY claimed she had completed all these managerial tasks however, there is no evidence of it nor are there any witnesses or evidence supporting her testimony.

As well, due to KY's interest in the outcome of the hearing, the Panel questioned KY's credibility. In addition to the observations noted above, the Panel questions KY's professionalism in relation to how she addressed CAS once their decision had been disclosed. The Panel found KY to demonstrate both a lack of community partnership and a clear bias when questioning CAS' decision. KY not only demonstrated a disrespect for professional authority but displayed her deficiencies as a leader and a mentor to the profession.

Credibility of BW (staff member at the Centre):

The Witness's Ability to Observe and Recall – BW was present for a part of the interaction between the Member and the Child in the hallway. BW could hear the interaction, which prompted her to reposition herself to have a quick view of the interaction between the Member and the Child facing each other in the hallway. However, BW's view was limited because she could not leave the room and was attempting to view the interaction through the half door.

Whether the Witness's Evidence Accords with Common Sense and is Plausible/Reasonable - BW's recollection of the interaction between the Member and the Child in the hallway is somewhat plausible and reasonable. Due to her position within the classroom and her responsibility to the children in her care, her ability to witness and observe was very limited. As such, she could not fully observe the interaction and therefore seems to have had to piece together parts of what she witnessed and heard. BW was not hearing and seeing the interaction at the same time.

The Panel believes that BW's observation was limited and therefore, she may have pieced together parts of what she witnessed and heard of the Incident, instead of testifying as to what she actually observed. BW's observation of the interaction between KY and the Mother was also limited. The Panel believes that based on a limited observation of the Incident, BW may have made assumptions about the situation and projected her perspective onto KY. This, in turn may have ignited KY's potential biases based on what the Panel knows about KY and BW's personal relationship.

Whether the Witness was Forthright in their Evidence – The Panel found BW to not be forthright and clear in her evidence. The Panel recognizes that BW was only able to witness and observe bits and pieces of the various interactions. Therefore, as a witness, the Panel found that there were significant limitations to BW's testimony.

Whether the Witness had an Interest in the Outcome – The Panel believes that BW had potentially had an interest in the outcome of the hearing due to her personal relationship with KY. Their personal relationship may have fueled each other's potential biases towards the Member. Furthermore, there had been previous alleged interactions between the Member and BW pertaining to professional conduct within the classroom that may have influenced BW's potential biases towards the Member.

The Panel believes that KY's personal relationship with BW may have impacted how the events unfolded and how KY's potential biases towards the Member may have been also influenced by BW. When BW saw the photos during what was meant to be a confidential interaction between KY and the Mother, BW immediately spoke to KY of the Incident, which she had a limited observation of. The Panel questions the nature of the conversation between BW and KY regarding the Incident because of their personal relationship. The Panel believes that this

conversation may have impacted KY's perspective of the Incident and therefore, how and the order the interviews were conducted.

Inconsistencies- The Panel found that there were material inconsistencies between the statements BW gave and her oral testimony at the hearing. The Panel did not rely heavily on her written statements.

The Panel's Conclusion on the Witness's Credibility - The Panel found BW to be not entirely credible nor reliable. Her testimony document on the police report, CAS report, and the CECE were not consistent and had variation in details. Though the Panel did accept her recall of the interaction between the Member and the Child, the Panel also understands that BW's observation of the interaction could only be limited to bits and pieces of what she saw and heard due to her professional responsibilities at the time. At the time of the alleged incident, BW remained within the preschool classroom next door and did not have a full view nor witness the entire interaction. The Panel also weighed her credibility with less value due to her potential interest in the outcome of the hearing.

Credibility of AR (staff member at the Centre)

The Witness's Ability to Observe and Recall and Inconsistencies – AR was present for the majority of the interaction between the Member and the Child, including the majority of the Child's day (including the Child's drop off, morning program, and nap time). AR observed parts of the interaction between the Member and the Child while preparing to leave for her lunch break. Her observation included the interaction between the Member and the Child in the classroom prior to the interaction extending into the hallway area. Following a brief observation of the interaction between the Member and the Child in the hallway, AR left for her lunch break.

AR's ability to recall was only somewhat reliable. Her recall around the timeline of the interaction appeared accurate. However, some of AR's details pertaining to the Child's abilities and behaviours were not reliable. For example, AR stated that the Child could speak in full sentences contrary to the testimonies of LM, JG, and the Member. Furthermore, AR's details around her interactions with the Child that day were not consistent with other testimonies. AR did not recall having any challenging interactions with the Child whereas both LM and the Member testified in

detail the nature of the interactions between AR and the Child. This prompted the Panel to question AR's ability to recall the events of the day in question.

Whether the Witness's Evidence Accords with Common Sense and is Plausible/Reasonable - AR's recollection of the interaction between the Member and the Child in the classroom and the hallway is reasonable and plausible. Due to her physical position and role in the classroom, AR was able to fully observe the interaction between the Member and the Child until she left for her lunch break. The Panel recognizes that due to her lunch break, there was an interruption in AR's observation of the interaction, specifically around the interaction in the washroom and the return to the classroom. Upon AR's return from lunch, her observations between the Member and the Child continued.

Whether the Witness was Forthright in their Evidence – The Panel found AR to not be forthright in her evidence. The Panel recognizes that AR was only able to witness and observe the interaction in the classroom, hallway, and after naptime and she was somewhat forthright of these details. However, AR did not disclose her unique relationship with the Child and the family. Furthermore, AR was not forthright of her recollection of her interactions with the Child throughout the morning program up until she left for her lunch break.

Whether the Witness had an Interest in the Outcome – The Panel believes that AR did not have an interest in the outcome of the hearing.

The Panel's Conclusion on the Witness's Credibility - The Panel found AR to be not credible nor reliable. The Panel did accept her recall of the interactions between the Member and the Child however, the Panel also understands that AR's observation of the interaction could only be limited to the pieces of what she saw and heard; this was evident in both her written and verbal testimonies. The Panel weighed her credibility with less value because she was not forthright of her recollection of her interactions with the Child throughout the morning program up until she left for her lunch break. Furthermore, the Panel believes that AR's potential biases due to her unique relationship and connection with the Child and their family may have impacted her credibility.

Credibility of the Mother (Mother of the Child)

The Witness's Ability to Observe and Recall – the Mother was not present for the interaction between the Member and the Child. However, the Mother was able to observe and recall the overall timeline of the Child's day (e.g., doctor's appointment, drop-off time) and the events upon discovering the bruises.

Whether the Witness's Evidence Accords with Common Sense and is Plausible/Reasonable - the Mother's description of the overall timeline of the Child's day and the events following the discovery of the bruises appear to be reasonable and plausible. The Mother's recollection of the overall timeline of the Child's day aligned with AR, LM, and the Member's testimony. The Mother's recollection of the events following the discovery of the bruises aligned with KY's, CAS, and police documentation of the investigation.

Whether the Witness was Forthright in their Evidence – The Panel found the Mother to be forthright in her evidence; the Panel was not concerned with her honesty.

Whether the Witness had an Interest in the Outcome – The Panel believes that the Mother had an interest in the outcome of the hearing in terms of her personal closure. The Mother did not believe that these allegations had a long-term impact for the Child but rather, she, herself, was seeking closure.

The Panel's Conclusion on the Witness's Credibility – The Panel found the Mother to be reliable and credible. The Mother was forthright in her evidence and she did not appear to have biases towards any individuals. This added to the Mother's credibility.

Credibility of LM (staff member at the Centre)

The Witness's Ability to Observe and Recall – LM was present for the majority of the interaction between the Member and the Child, including the majority of the Child's day (including the Child's drop off, morning program, and nap time). LM briefly observed parts of the interaction between the Member and the Child in the classroom and in the hallway. Her visual observation was limited due to her responsibility to supervise the toddlers in the classroom. However, LM was able to hear certain sounds during the interaction in the washroom. LM was also able to observe the

interactions between the Member and the Child upon returning to the classroom and throughout the rest of the day.

LM’s ability to recall, however, was challenging. Though she was able to recall some details independently, she required time to review documents to refresh her memory and as well, required questions to prompt her to recall certain details. Following her review of the documents regarding the day in question, LM recalled her observation of the interaction between AR and the Child during morning programming and during naptime. The details of the observation between AR and the Child during naptime was specific to LM’s testimony.

LM’s evidence differed in the level of details recalled when questioned by College Counsel versus Member’s counsel. With the College Counsel asking broader question which prompted general responses from LM while the Member’s counsel asked specific and detailed questions which prompted a more detailed response. The Panel found this to be relevant to her testimony because at a first glance, when questioned by College Counsel, her recall appeared to be somewhat vague, disorganized, and unreliable. When questioned by the Member’s Counsel, her testimony was concise and consistent. The Panel attributed this to the type of questioning by the two Counsels. After a review of her testimony, the Panel realized that though she was not able to immediately recall trivial details on the specifics of the day, LM was able to recall the details around the alleged incident.

Whether the Witness’s Evidence Accords with Common Sense and is Plausible/Reasonable - LM’s evidence is reasonable and plausible. Due to LM’s physical position and role in the classroom, she was able to observe a large portion of the interactions between AR, the Member, and the Child. LM’s observation of the interactions aligned with BM, AR, and the Member. With the College Counsel asking broader question which prompted general responses from LM while the Member’s counsel asked specific and detailed questions which prompted a more detailed response. This did not make LM’s testimony less plausible; it is a result of the different questioning formats.

Whether the Witness was Forthright in their Evidence – The Panel found LM to be forthright in her evidence. The Panel was not concerned with her honesty.

Whether the Witness had an Interest in the Outcome – The Panel believes that LM did not have an interest in the outcome of the hearing. The Panel acknowledges that LM and the Member had

a good professional relationship that included LM bringing the Member her essentials, but beyond this, they did not have a personal relationship.

The Panel's Conclusion on the Witness's Credibility – The Panel found LM to be not entirely reliable but credible. The Panel did accept LM's recall of the interactions between AR, the Member, and the Child; however, the Panel recognizes that LM required some aids and prompts to refresh her memory. The Panel also understands that LM's observation of the interaction between the Member and the Child could only be limited to the pieces of what she saw and heard. This was also evident in her written testimonies, which were also inconsistent due to her positioning in the room (she was limited to what she could see and hear and therefore, were putting pieces together) and also, her responsibilities in the classroom (supervising 14 toddler children) during the alleged Incident would have limited her ability to observe accurately. The Panel found LM to be credible because she was forthright of her recollections and did not appear to have biases.

Credibility of TS (expert witness)

The Witness's Ability to Observe and Recall – TS was not present for any aspect of the alleged interactions.

Whether the Witness's Evidence Accords with Common Sense and is Plausible/Reasonable - TS brought perspective and insight that were reasonable and made sense pertaining to early learning environments.

Whether the Witness was Forthright in their Evidence – The Panel found TS to be forthright in her statements; the Panel was not concerned with her honesty.

Whether the Witness had an Interest in the Outcome – The Panel believes that TS did not have an interest in the outcome.

The Panel's Conclusion on the Witness's Credibility – The Panel found TS to be credible. Her credentials and experience in the sector qualified her as an expert witness.

Credibility of the Member:

The Witness's Ability to Observe and Recall – The Member was present for the interaction with the Child. She was also present for the majority of the Child's day and was able to observe AR's interactions with the Child as well. The Member was able to recall independently. Her recall was accurate and it aligned with other witnesses.

Whether the Witness's Evidence Accords with Common Sense and is Plausible/Reasonable - The Member's evidence is reasonable and plausible. The Member's observation of the interactions aligned with those of BM, AR, and LM. Furthermore, the Member's decisions pertaining to soothing the Child and keeping them safe were reasonable and age appropriate. The Member's description of how she ensured the safety of the surroundings of the Child when the Child was experiencing emotional stress is plausible. The Member was also attentive to the Child's sensitivity to the bright lights in the hallway and immediately transferred the Child into the dimmer washroom. In the washroom, the Member used a warm cloth to soothe and cleanse the Child's face. And finally, after the Child had been soothed, the Member rocked them to sleep for nap. From the beginning of the Member's testimony, it was evident that she was in tune with the needs of the Child and the room based on her observations of the Child's interactions and mood on the day of the Incident, which reveals her experience and knowledge of the Child. Therefore, the Panel finds it plausible that the Member engaged in practices that were in tune with the Child's needs during the Incident.

Whether the Witness was Forthright in their Evidence – The Panel found the Member to be forthright in her evidence. The Member demonstrated this by making admissions that could have been adverse to her interests such as that she put her hands over the child's mouth and admitted that in hindsight, she should have acted differently. The Panel was not concerned with her honesty.

Whether the Witness had an Interest in the Outcome – The Panel believes that naturally, the Member has an interest in the outcome of the hearing since it pertains to the future of her career.

Inconsistencies and The Panel's Conclusion on the Witness's Credibility – The Panel found the Member to be reliable and credible. The Panel accepted the Member's recall of the interactions between her and the Child which were consistent with her written testimonies. The Panel found that any inconsistencies in her evidence were not material and/or were based on how questions

were being put to her, for instance; due to the nuance definitions of some words, which through her verbal testimony, the Member was able to clarify.

The Panel also found the Member to be credible because she was forthright in her recollections and did not appear to have biases.

Findings on the Facts

The Panel found that the witnesses who were present for the Incident, AR, LM, and the Member had consistent descriptions of the events of November 30, 2016. Having regard to the evidence, the Panel makes the following factual findings: On November 30th, 2016, the Member, LM, and AR were the educators in Toddler 2 Room. The Child arrived late to the classroom due to a doctor's appointment. The three staff in the room recalled that it was challenging for the Child to settle into the routine. The Member and LM had planned to shop for the holiday concert during their lunch break on November 30, 2016 and this had been approved by KY. The Member and LM left to shop without confirmation of the arrival of another staff, leaving AR alone with 15 toddlers. Upon returning, the Member observed a concerning interaction between AR and the Child in the classroom. At this time, AR asked for support from the Member. The Member intervened by asking the Child to apologize to AR. The Child responded with frustration and the Member anticipated an outburst from the Child. In response to the Child's emotional outburst, the Member picked up the Child and moved them to the hallway for the safety of the Child and the well-being of the other toddlers.

Once in the hallway, the Member attempted to calm the Child down by trying to talk to them (at their level, face-to-face) but observed that the bright lights were bothering the Child and therefore, decided to move the Child to the washroom in the hallway, away from the bright lights. The Member transitioned the Child to the washroom by placing her hands under their arms. During this interaction, AR was leaving for her lunch break and BW, who is the preschool educator in the classroom next door, was observing the interaction in the hallway through her half door. LM was alone in the toddler classroom with the sleeping toddlers. She observed some parts of the interaction between the Member and the Child in the hallway.

In the washroom, the Member sat with the Child in her lap in an attempt to calm the Child down. The Child repositioned their body to face the Member and began rocking their body back and forth (which the Member, LM, and the Mother testified the Child did as a self-soothing response). The Member observed the Child banging their head against the wall when rocking and moved the Child closer to her to ensure the Child's safety. Once the Child appeared to calm down, the Member wet a towel with warm water to wipe the Child's face and comforted the Child. When the Child was calm, the Member and Child returned to the classroom holding hands and the Child fell asleep in the Member's arms. AR returned from her lunch break and observed the Child was calm and engaged in the afternoon program. The Child was picked up, the Member communicated with the Mother about an Incident Report regarding a mark on the Child's eye.

No staff documented or communicated regarding the interactions between the Member and the Child to the Mother or KY.

That evening at home, during their bedtime routine, the Mother observed bruises on the Child's arms. The Mother documented and compared the marks with her other children and was curious on how the marks appeared.

On December 1, 2016, the Mother brought the Child and their siblings to the Centre. The Mother called KY and left a message. KY met with the Mother at the Centre and the Mother showed KY the images that she had documented the night before. During this time while photocopying, BW witnessed the meeting, through the window, between KY and the Mother and saw the photos that were shared. Immediately, BW shared with KY her perception of the interaction between the Member and the Child in the hallway.

Upon receiving information from BW, KY began interviews with LM, AR, BW, and the Member. During the interviews, two supervisors were present. KY testified that she took notes. Staff did not observe notes being taken for documentation. No notes were provided as evidence and therefore, due to conflicting evidence, the Panel does not accept that notes were actually made during the interviews. During the Member's interview, the CAS was called, questioning was halted, and the Member was suspended without pay.

On December 1, 2016, the CAS arrived at the Centre to conduct interviews with staff in the afternoon. LM was questioned by police and the CAS at the Centre.

The following day on December 2, 2016, KY reported the Incident as a serious occurrence to the Ministry of Education. AR and BW were questioned by police and the CAS at the police station.

On December 4, 2016, the Member was questioned by police and the CAS separately.

On December 6, 2016, LM brought the Member's belongings to her home and had communicated this interaction to KY.

On December 28, 2016, the police investigation was closed by police without the laying of charges and the police report indicated that they could not identify the perpetrator.

On Jan 4, 2017, the Member received confirmation from police that the case had been closed.

On March 15, 2017, the CAS investigation case was closed and the CAS report indicated that the allegations were not verified.

On May 26, 2017, the Member was officially terminated from the Centre.

After the case was closed by the CAS, the Member and the Mother met for a mediated conversation to provide personal closure. They voluntarily exchanged phone numbers but there was no further communication.

Findings on the Allegations

Allegation 1 – Verbal Abuse – para 6 (a) in the Notice of Hearing

The Panel found that the Member did not verbally abuse the Child who was under her professional supervision. According to the testimonies and documents provided, the Member did not raise her voice to the point of concern. She did not use belittling or demeaning language towards the Child. The Member did request an apology from the Child, which is not verbal abuse. In addition, the request was not a repeated nor demanded request. This was consistent in all staff testimonies that the Member requested an apology only once or twice. The College did not establish that the Member engaged in verbal abuse of the Child.

Allegation 2 – Physical abuse – para 6(b) in the Notice of Hearing

The Panel found that the College did not establish that the Member engaged in physical abuse of a Child. The Member did not physically abuse the Child who was under her professional supervision. In considering whether conduct constitutes physical abuse, the Panel considered:

- The circumstances in which the conduct is alleged to have occurred: The Member anticipated the Child's self-soothing rocking behaviour and moved the Child into the hallway, a more open environment, to avoid physical injury. In the hallway, the Member observed that the sudden bright lights were a sensory trigger for the Child and then, moved them into the dimmer washroom.

- The nature of the conduct: The nature of the interaction was not degrading or demeaning because of the Member's intent was to soothe the Child and ensure that they were in a safe place to regulate their emotions and return safely to a classroom environment. The Member was relatively calm and responding to the Child's needs. This was testified to by the Member, AR, and LM. The staff were not concerned about the physical interactions that occurred and therefore, did not document the Incident. This was consistent from all staff testimonies.

- The words and/or gestures which accompanied the conduct: The Member moved the Child from the classroom to the hallway and from the hallway to the washroom by lifting the Child under their arms. Once the Child was moved, the Member placed her hands lightly on the Child's mouth in an attempt to soothe them. At the same time, the Member verbally reassured the Child using soothing words and tone.

- The nature and extent of the force applied by the Member: Though the Member used physical contact to move the Child, the nature of the physical contact was not forceful rather, it was more like a physical redirection. She did not use excessive force nor with the intent to harm or hurt the Child.

- The intent, purpose or motive of the Member in engaging in the conduct: The purpose and intent of the conduct was to provide the Child with a safe space to regulate their emotions as well as to support the collective group of toddlers as a whole. The Member's conduct was an attempt to support both the Child and the classroom simultaneously.

The Panel notes that physical abuse does not require proof of an intention to cause bodily harm, nor does it require proof that the conduct caused a hurt or injury that interferes with the health or comfort of the person. The Panel appreciates that the Child did have bruises. However, the Panel does not find that the College established that the bruises were caused by the Member's actions or that the Member's conduct constituted physical abuse.

Allegation 3 - Psychological and Emotional Abuse – para 6(c) in the Notice of Hearing

The Panel found that the Member did not psychologically or emotionally abuse the Child who was under her professional supervision. According to the testimonies and documents provided, the Member did not use inappropriate or an abusive tone and language while interacting with the Child. Throughout the interaction, the Member provided the Child with comforting and calming strategies to help regulate their emotions (i.e., wiping the Child's face with a warm towel, avoiding bright lights) which indicates that the Member was in tune with the Child's emotional needs. Furthermore, the Member anticipated the Child's self-soothing rocking behaviour and therefore supported and facilitated the Child's emotional regulation. Upon returning to the classroom, the Child fell asleep in the Member's lap. All staff in the classroom testified that the Child willingly participated in the afternoon program for the remainder of the day. The staff were not concerned about the psychological or emotional interactions that occurred and therefore, did not intervene or document the Incident. This was consistent from all staff testimonies.

Allegation 4 – Conduct Unbecoming – para 6 (f) in the Notice of Hearing

The Panel found that the Member did not conduct herself in a manner that is unbecoming of a member. The allegation of "conduct unbecoming" is viewed as including behaviour that reflects on one's integrity or competence to the point where public protection is required. The Panel finds that the College did not establish this head of misconduct based on a balance of probabilities. Keeping children healthy and safe is the paramount responsibility of all early childhood educators. Maintaining a safe environment by ensuring the proper supervision of all children under an RECE's care is fundamental to the trust placed in early childhood educators by parents and the

community. The Member's conduct demonstrated that she ensured that the Child's and the children's well-being and safety were a priority.

Allegation 5 – Failing to Maintain Standards

The Panel found that the College did not establish that the Member failed to maintain the standards of the profession.

First, the Member ensured a safe environment when she moved the Child away from the enclosed space to a more open space, which indicates her knowledge of the Child's self-soothing response. Second, the Member provided different strategies to soothe a distraught Child (i.e., holding the Child's hands, verbally assuring the Child, and applying warm compress on the Child's face).

Third, the Member changed the environment to remove triggers for the Child, such as bright lighting which demonstrates nurturing professional competencies.

Fourth, the Member demonstrated leadership by being flexible and responsive as she navigated the conflict in response to the needs of the Child and the children in the classroom. Fifth, the Member demonstrated leadership and professionalism by supporting the needs of the staff in the room (i.e., recognized that a staff needed a break from an interaction and stepped in).

And finally, the Member's response demonstrates her in-depth knowledge of the profession as well as child development.

Allegation 6 – Disgraceful, Dishonourable or Unprofessional Conduct – para 6(e) of the Notice of Hearing

The Panel did not find the conduct of the Member to be in a manner that was considered disgraceful, dishonourable or unprofessional according to allegations outlined in the Notice of Hearing.

I, CeCil Kim, sign this decision and reasons for the decision as Chair of this Discipline panel and on behalf of the members of the Discipline panel.

CeCil Kim, Chair

March 2, 2023

Date