ALBERTA

Report to the Minister of Justice and Solicitor General
Public Fatality Inquiry

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the Calgary Court Centre

in the City (City, Town or Village) of Calgary (Name of City, Town, Village), in the Province of Alberta,

on the 5th day of February, 2018 (year), (and by adjournment

on the 6th-8th days of February, 2018 (year)),

before Joshua B. Hawkes, a Provincial Court Judge,

into the death of Mackenzy Jane Woolfsmith, (Name in Full) 22 months (Age)

of Calgary (Residence) and the following findings were made:

Date and Time of Death: May 3, 2012 16:11 hrs

Place: Calgary Children's Hospital

Medical Cause of Death:
("cause of death" means the medical cause of death according to the International Statistical Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization – *The Fatality Inquiries Act*, Section 1(d)).

Multiple Blunt Force Injuries.

Manner of Death:
("manner of death" means the mode or method of death whether natural, homicidal, suicidal, accidental, unclassifiable or undeterminable – *The Fatality Inquiries Act*, Section 1(h)).

Homicidal

Circumstances under which Death occurred:

Introduction

[1] Mackenzy Jane Woolfsmith was a bright, energetic and happy 22-month-old girl. By all appearances she had a positive and loving relationship with her child care provider, Ms. Jarosz. In circumstances that may never be fully understood, Mackenzy died at the hands of Ms. Jarosz as described below. Criminal responsibility for those actions has been addressed. My role in this report is to explain as fully as possible the circumstances surrounding this tragedy, and to make recommendations to reduce the likelihood of similar tragedies.

[2] In this inquiry I had the benefit of hearing from several witnesses. Some were able to provide expert evidence and analysis regarding the circumstances of this death as well as broader concerns about the risks faced by infants and young children in unlicensed child care settings. A review of the evidence relating to this fatality, coupled with a broader examination of the experience of other jurisdictions and academic literature provides context and support for the recommendations that follow.

[3] The participation of Mackenzy's parents in the hearing was remarkable. In the face of this shattering personal and family tragedy they were key participants. They provided essential evidence and perspective, asked thoughtful, insightful questions, and made enormously helpful submissions. To the extent that any of the recommendations in this report are of assistance in preventing future tragedies and strengthening child care in Alberta, that is a direct result of their strength and composure in this process.

[4] I have made 10 recommendations, contained at paragraphs 63 (a-j). In doing so I am mindful of my obligation not to make specific legal conclusions or findings of responsibility. The conclusions that I reach in relation to the circumstances that contributed to this death are provided to ensure that both the circumstances of this tragedy and the basis for my recommendations are clear.

Recognizing a Complex Context

[5] The death of a child at the hands of a trusted caregiver is a parent's worst nightmare. That this nightmare is not an isolated incident, but part of a pattern in which children and child care workers are at elevated risk, is a serious public policy issue requiring urgent and sustained attention.

[6] Like many tragedies, the death of Mackenzy was not the result of a single failure, but the interaction of many factors. Understanding and acknowledging that complexity is critical for two reasons; to explain this tragedy as fully as possible for her parents, and the public, and secondly, to provide a context for the scope and scale of the recommendations that follow.

The Role of Mackenzy's Parents

[7] First, there was no error by Mackenzy's parents. They were careful and conscientious in their selection of Ms. Jarosz. The evidence clearly and conclusively establishes that they made use of all publicly available information, coupled with diligent reference checks and ongoing personal observation in ensuring that Mackenzy was safe and well cared for.

[8] There is a significant amount of publicly available information in Alberta regarding licensed and unlicensed child care. That information includes a web page describing the different types of child care available in Alberta, a guide to licensed care in Alberta, a list of suggested questions, and links to other resources.[1] The Woolfsmiths used this information in making their decision.

[9] They evaluated both licensed and unlicensed facilities. They concluded that the licensed facilities they visited were not a good fit for their circumstances. The inflexibility of some licensed programs and restrictions on parental access during the day, coupled with the waiting lists for licensed facilities were among the factors influencing their decision.

[10] Although it is not my role to find fault, the most important observation and conclusion I can make is that I find no fault or blame whatsoever on the part of Mackenzy's parents. In arriving at that conclusion, I have carefully considered not only all of the information that was available to them, but also information that came to light after these events. In that regard, perhaps most significant is a professional risk assessment undertaken shortly after the death to evaluate the level of risk posed by Ms. Jarosz. This assessment was done prior to the conclusion of the criminal investigation. It was based on all of the information that would have been available to the Woolfsmiths, as well as information that was not known to them, and which they could never have obtained. That report concluded that the risk was "extremely low".

[11] There is nothing that they could have seen or done as loving parents to have foreseen this tragedy.

[12] That does not mean however that information that should have been available to them had no impact on their decision-making process. In fact, they indicated that if information regarding prior incidents where children suffered accidental injury while in the care of Ms. Jarosz had been available to them it would have changed their decision.

[13] These prior incidents were accidents that were not the result of any action on the part of Ms. Jarosz, but rather, incidents that would have raised enough concern about accidental injury that they would have looked elsewhere for child care. I will describe the evidence and conclusions regarding the reporting of such incidents both in licensed and unlicensed care in my recommendations regarding reporting of such incidents.

Complex Problems Require a Comprehensive Response

[14] The second critical observation arising from the complex and interrelated nature of the causes in this case underscores the need for a comprehensive and integrated response. This tragedy resulted from the combination and cascading effect of several risk factors. No single change will provide an adequate response. A meaningful and appropriate response requires the layering of protective factors to minimize risk.

[15] The tragedy in this case was finally and ultimately the product of the criminal actions of Ms. Jarosz, for which she has accepted responsibility and been dealt with by the criminal justice system. However, the fact of her sole and ultimate responsibility does not mean that there are not protective and supporting resources and elements that can significantly reduce the chances of similar conduct by others in the future.

[16] Ms. Jarosz recognized the need for that added support, and in fact, recognized it prior to the tragic events in this case. However, that support was not available or easily accessible to her

[1] This information is available online at http://www.humanservices.alberta.ca/family-community/child-care-find-child-care.html

as an unlicensed child care provider. That is also one of the great tragedies in this matter. Had that help and support been available, these events might have been prevented.

[17] This conclusion is also supported by the evidence of Ms. Woolfsmith who indicated that she viewed this tragedy as primarily a mental health issue, and that one of the key areas where change was needed was in providing greater support and assistance to child care providers.

Background of Ms. Jarosz

[18] Ms. Jarosz had no formal training or certification in child care. She had a first-aid certificate. She had positive experiences in providing care as a teenager, and ultimately decided to pursue child care to support herself.

[19] She was seriously injured while playing hockey approximately 15 years before this incident and suffered from migraines and back pain as a result. She had a low dose prescription medication that she could take at the onset of a migraine that would usually help.

[20] Initially, she began by providing care in a licensed environment through an approved Family Day Home Agency. She felt that this arrangement would provide her with needed support and assistance. However, she expressed dissatisfaction with the support she received, claiming that she only had one brief visit from an individual with the agency. She was approved by the agency on June 30, 2010 and took her first child in her new role on August 30, 2010. After an incident in which a child was injured as a result of an interaction with another child she terminated her relationship with them on September 28, 2010.

[21] She began to provide care as an unlicensed child care provider after this incident. She testified that she felt that she could get the support that she needed from an informal group of other providers operating in her area. She never made use of this group but would try to take time off based on the schedules of the children in her care. She advised that she was aware that she could close her day-home if she was ill and had done so on four or five occasions prior to this incident. She testified that she had been providing unlicensed day-care in her own home for approximately 2 years.

[22] Providing child care was her primary source of income, and she was now caring for more young children than when she was working with the agency. She agreed that she was able to make more money caring for additional children, and that running her own business did not have the same overhead and fees that she was paying when she worked in the agency. At the time of this incident, she was caring for a total of four children, ranging in age from 3 years to 19 months old. She acknowledged that caring for more children increased her income, but that caring for such very young children was very demanding. She agreed that in hindsight she had taken on too many children to adequately care for.

[23] In the months leading up to the fatality she was feeling increasingly stressed due to financial and personal issues, back troubles, and chronic migraines (an average of 4 per month). She indicated that she wished that there would have been more sources of support for individuals providing unlicensed child care, both through formal government programs and perhaps in a more structured way by agreement among other child care providers. She also testified that she found the process of applying for grants or other assistance complex and confusing.

[24] She agreed that she should have sought help for her personal and other problems, and that she had not been feeling well for some time. The isolation she was experiencing was clearly a factor compounding all the other difficulties in her life.

Description of Incident

[25] Ms. Jarosz was the only person with direct knowledge of what happened to Mackenzy on May 2, 2012. The evidence of medical professionals who dealt with Mackenzy following this incident differ from her account, summarized below. Notwithstanding the unique legal status of her testimony in this inquiry, (which by virtue of the *Canadian Charter of Rights and Freedoms*, the provisions of the *Canada* and *Alberta Evidence Acts* and the *Fatality Inquiries Act*, could not be used against her), she was unwilling or unable to provide additional detail regarding her actions. Her account was not consistent with the nature, severity, and number of injuries observed and documented by the expert witnesses.

[26] She testified that on the day of the incident she awoke with a migraine and did not take the medication as soon as she should have. The migraine was severe, and the medication was ineffective. She now recognizes that she should have closed her business for the day but did not do so.

[27] Apart from the ongoing migraine the morning was routine. She provided lunch to the children in her care and was in the process of taking them up the stairs when the incident occurred. She was following all four children up the stairs. Mackenzy was the last child in line, three or four steps in front of Ms. Jarosz. She testified that Mackenzy was startled when the dog barked and fell backwards. She extended her arm to try to catch Mackenzy, but she flipped over her arm, striking the back of her head on the carpeted stairs. Mackenzy was crying when Ms. Jarosz picked her up. When she carried her upstairs, Mackenzy stopped crying and her breathing became shallow and rapid. Ms. Jarosz testified that this caused her to panic, and that she shook Mackenzy. She could not recall how many times but acknowledged that Mackenzy struck her head on the floor once while being shaken.

[28] When emergency personnel attended, they found Mackenzy in severe distress, unresponsive, and unable to breathe on her own. Examination at the Alberta Children's Hospital revealed the catastrophic nature and extent of her injuries. She never regained consciousness and passed away as a result of these injuries on May 3, 2012.

[29] Dr. D'Mello, an expert in pediatric emergency care and child abuse at the Alberta Children's Hospital, described the injuries she observed on Mackenzy. She found multiple areas of bruising not consistent with a fall and single blow to the head. She also found bleeding and swelling of the spinal cord, and extensive retinal hemorrhaging in both eyes, indicative of very forceful shaking. These were catastrophic injuries.

[30] Subsequently, Dr. Millroy, a specialist in pediatric forensic pathology, was consulted. He concluded that based on the severe nature and number of the injuries present that there was "overwhelming evidence of homicide".

Prior Documented Incidents

[31] There were three prior incidents where children in Ms. Jarosz's care suffered injuries. These incidents arose from accidents either involving interactions with other children, or where a child fell and suffered an injury. The first occurred in September 2010, when she was working under a Family Day Home Agency, and the second sequence of incidents in February of 2011, when she was providing care in an unlicensed capacity.

[32] None of these occurrences were found to be the result of any action by Ms. Jarosz. However, injuries requiring medical attention occurred. The first incident was reported to the

Agency, but no formal action was taken apart from a recommendation for more support. This did not occur as Ms. Jarosz terminated her relationship with the Agency soon after this incident.

[33] The second sequence of two incidents in February 2011 resulted in a complaint and inquiry by Child and Family Services. Parents of one of the children involved removed the child from Ms. Jarosz's care. Child and Family Services authorities were notified, and all of these matters were reviewed. Child care licensing authorities were notified and the CFS file was closed.

[34] Ms. Woolfsmith was only aware of one of these incidents. Ms. Jarosz told her about the incident. It was a matter of serious concern, but they did not have any other sources of information regarding the matter. The explanation provided by Ms. Jarosz was plausible, and all interaction they observed between Ms. Jarosz and Mackenzy was positive.

[35] Ms. Woolfsmith stated that had she been aware of other incidents, she would not have selected Ms. Jarosz as Mackenzie's caregiver. The absence of independent information regarding prior incidents in the day home was a matter of serious concern and prevented the Woolfsmiths from obtaining necessary information.

Other Evidence

[36] I also had the benefit of hearing from other witnesses who were involved in the investigation of Mackenzie's death. The observations of Dr. Jennifer D'Mello, a well-qualified expert in both pediatric emergency care and child abuse, were extremely helpful, as was the testimony of the lead investigator in this matter for the Calgary Police Service, Detective Cavilla. Both witnesses had key information and observations from their involvement in this case. They were also well equipped to provide broader insights and recommendations from their involvement in similar cases.

[37] Dr. D'Mello described the Child Abuse Case Conference process that would be used in every case where a child sustained a significant injury. The object of this process is to bring together all potential sources of information regarding that injury and determine what further steps might be required to protect the child and to commence formal child protection or criminal investigations. These multidisciplinary conferences are comprised of medical professionals, Child and Family Service representatives, investigators from specialized units of the relevant police agencies (Child Abuse, Homicide). This Case Conference Process allows for the early identification, investigation, and intervention in cases of suspected child abuse. While such Case Conferences are held in major centres in Alberta, a concern was raised regarding the availability of this process in smaller centres and remote areas.

[38] Dr. D'Mello testified that there were a "concerning number" of significant injuries to children in unlicensed child care. She indicated that of the cases of suspected child abuse not involving a parent or guardian, cases coming from unlicensed child care were much more common. She was unable to provide exact figures and was unsure if the nature of the care being provided in these incidents, (licensed or unlicensed), was systematically tracked and recorded.

[39] She testified that the distinctions between licensed and unlicensed care may not be clear to parents, and that those differences should be more clearly explained. She was also of the view that the current legislative and regulatory framework made it more difficult to investigate concerns arising in unlicensed day care.

[40] Detective Cavilla testified that when he took over as the primary investigator of this matter he had concerns regarding the conclusions from the initial autopsy that concluded that the

cause of death was undetermined. He sought and obtained the opinion of Dr. Millroy, described above.

Contributing Factors to the Death in this Case

[41] Based on the evidence relating to the death of Mackenzy, I make the following findings regarding the circumstances that contributed to her death:

a. Mackenzy was very young, 22 months, at the time of her death. Very young children are at increased risk of injury or death as a result of their level of dependence on adults and degree of physical development which makes them more susceptible to certain types of injuries. The mechanism of injury in this case, shaking, is one to which young children are particularly vulnerable. Statistical and other information supporting this conclusion is cogently summarized in the Investigative Review of the Office of the Child and Youth Advocate in relation to the deaths of children in care.[2]

b. Despite the best efforts of her parents, there was a lack of independent information available regarding prior incidents of concern with her child care provider. Had that information been available they would have made a different choice regarding child care.

c. Additional support for Ms. Jarosz would have assisted her in several respects. The absence of added support after the first incident when she was providing child care under the auspices of a Family Day Home Agency, was one of the significant reasons that she left the licensed sphere and began to provide unlicensed care. Where a serious incident occurs there should be a mandated protocol of review and additional support.

d. The provision of that support requires the ability to track serious incidents in both licensed and unlicensed child care. The criteria for such reports must be clear so that the obligation to report is well understood. Ambiguous or subjective criteria undermine the effectiveness of, and compliance with, mandatory reporting requirements.

e. Providing child care in an environment where the provider is the only adult can, and did in this case, lead to added stress and isolation. These factors combined with the pre-existing medical difficulties of Ms. Jarosz contributed directly to the tragic outcome in this case. More information should be made available regarding the stressors associated with providing child care, together with associated resources that would enable care givers to more accurately identify problems and get the necessary assistance.

General Evidence and Recommendations

[42] Ms. Suzanne Anselmo testified and provided essential background and context in relation to the regulation of child care in Alberta. At the time of her testimony she was the Executive Director of the Early Childhood Development Branch and had been in that role since 2013. She had also been the designated statutory Director under the *Child Care Licensing Act* (the *Act*) from March 2013 to December 2017 and had responsibility for the administration of the *Act* and its associated regulations. As a result, she was uniquely qualified to describe the policy

[2] *"Summary Report: Five Years of Investigations, April 1, 2012-March 31, 2017"*, page 23

framework and operation of child care in Alberta. She also had a thorough understanding of the major developments in child care in other jurisdictions in Canada.

[43] She testified that there has been no significant change in the applicable statute, regulation or policy since 2012. Further, she confirmed that the legislation has not been comprehensively reviewed or amended since it was passed in 2008.

[44] Ms. Anselmo described the operational and legislative framework that governs the provision of child care in Alberta. That framework, based on the *Act* and its associated regulations creates and monitors a sphere of licensed child care, which may either be provided in a child care centre, or in a private residence operated under the auspices of a Family Day Home Agency. These agencies are operated under contract to coordinate, supervise, and provide support to operators who are considered self-employed when providing child care in their homes. There are approximately 69 such agencies operating in Alberta.

[45] The Act provides for licensing of specified child care programs or Agencies. These licenses are initially for a period of one year, and thereafter may be renewed for 3 years. They are non-transferrable.[3]

[46] The *Act* gives inspectors broad powers to enter and inspect licensed premises without permission or advance notice "at any reasonable hour". They may demand the production of relevant documents and records. Deficiencies are noted in reports, together with required remedial action. Court orders may be sought to enforce compliance where the license holder refuses access or necessary cooperation.[4]

[47] License holders must post their licenses, together with any conditions or restrictions or a probationary license, and any inspection or monitoring reports in a clearly visible and prominent place.[5] When a license holder is not in compliance with the *Act* or Regulations the Director may take a number of actions ranging from an order to stop providing care through orders to take remedial steps as required as a condition of licensing or issue a probationary license. The Director may also cancel a license immediately if the child care is provided in a manner presenting an imminent danger to the health or well-being of a child.[6]

[48] The regulations relating to the *Act* are detailed and include[7]:

a. 22 general sections and a separate schedule of application requirements

b. 5 schedules relating to day care programs (31 sections), group family child care programs (25 sections), innovative child care programs (3 sections), out of school care programs (28 sections), and pre-school programs (24 sections)

c. Each schedule is structured similarly, with the exception of regulations pertaining to innovative child care programs, and specifies:

    i. program requirements including discipline

    ii. emergency procedures and incident reporting

    iii. supervision and medication for sick children

[3] *Child Care Licensing Act,* S.A. 2007, C-10.5, ss. 3-8
[4] *Child Care Licensing Act, supra,* s. 10
[5] *Child Care Licensing Act, supra,* s. 9
[6] *Child Care Licensing Act, supra,* Part 2, ss. 11-8
[7] *Child Care Licensing Regulation,* Alta Reg 143/2008

iv. nutrition, meal requirements, prominent display of menus, ensuring that the manner and location of feeding is appropriate

v. detailed physical space requirements, including specifications as to size and outdoor play space and equipment and indoor furnishings and equipment

vi. staffing requirements, including training requirements, criminal and vulnerable sector checks, first aid and other training or certification requirements, and specified child / staff ratios and maximum group sizes.

[49] Although the *Act* contains specific references to investigations of unlicensed child care, and of powers to direct the operators of such programs to stop doing so, these investigations almost invariably relate to the size of the impugned program.[8] That is a function of the manner in which "child care" is defined in the *Act* – as excluding residential care, or a child care program of fewer than seven children.[9] Ms. Anselmo testified that if other concerns, such as unsafe or unsanitary conditions were discovered those concerns would be directed to other responsible entities under the *Child, Youth and Family Enhancement Act*, *Health Act*, or other applicable legislation.[10]

[50] Further, inspectors have more limited rights to enter and inspect places where unlicensed child care is provided. They must have reasonable and probable grounds to believe that a person is providing child care without a license and have either the permission of the person in charge of the premises, or after that permission is denied, obtain a court order. The Director may also apply for such a court order without first seeking the permission of the person in charge if that would compromise the purpose of the investigation.[11]

[51] Ms. Anselmo described the reporting requirements for accident, illness, or other incidents as described in the regulations.[12] These regulations require notification of the parent or guardian of the child involved. In response to these regulations a "critical incident" form and associated protocol has been developed. However, these reports only pertain to incidents that occur in licensed facilities. They are confidential, are used for the purposes of monitoring compliance with the *Act* and the Regulations and ensuring the safety of children in child care. They are not released to the public.

[52] Inspection reports relating to licensed child care are the only publicly available sources of information. They are accessed through the online child care lookup tool.[13] The disclaimer associated with that tool stipulates that it is the responsibility of the user to "scrutinize, analyze,

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[8] *Child Care Licensing Act, supra,* Part 4, ss. 22-23

[9] *Child Care Licensing Act, supra,* ss. 1(b, c), s. 3

[10] It should be noted that while the *Child, Youth and Family Enhancement Act* mandates mandatory reporting of circumstances in which children are "in need of intervention", the focus of that defined term is on the responsibilities of guardians in relation to children, neglect, emotional injury, or non-accidental physical injury. These reporting obligations are not directed at the actions of child care providers who are not guardians, and may not adequately address the need to report circumstances giving rise to a risk to children that may be accidental or negligent. Witnesses agreed that these reporting obligations do not directly address the risks that may arise in the provision of either licensed or unlicensed child care.

[11] *Child Care Licensing Act, supra,* s.22

[12] *Child Care Licensing Regulations,* Alta Reg 143/2008, Schedule 1 (Day Care Program) ss. 6-7, Schedule 2 (Group Family Child Care Program), ss. 6-7, Schedule 4 (Out of School Care Program) ss. 6-7, Schedule 5 (Pre-School Program) ss. 6-7

[13] Available online at http://www.humanservices.alberta.ca/oldfusion/ChildCareLookup.cfm?s=search&sfid=&sinspd=&sinspc=&show=&sstype=pcode&pname=&pcity=&pcode=T2X&dcaretype=yes&chkboxPreSchool=yes&Lookup=Search

interpret, and apply the information properly." Further, the information is provided with the explicit caution that it is not guaranteed to be "accurate, complete or current at all times".[14]

[53] These inspection reports include information regarding any previous "incident reports". However, the information provided regarding these incidents is very general. All of the witnesses who were familiar with these reports agreed that they did not provide sufficient information to parents or guardians in relation to prior incidents and did not strike the appropriate balance between the rights of the individuals or organizations involved in these incidents and the rights of parents or guardians.

[54] These reports only pertain to licensed child care. No comparable source of information is available in relation to unlicensed child care.

[55] Ms. Anselmo also agreed that tracking patterns of concerning incidents would be difficult due to the limitations of the I.T. infrastructure put in place in 1995. Policies and procedures would also need to be updated in order to identify and track such patterns. Legislative changes would be required in order to identify incidents and patterns in unlicensed child care. Furthermore, dedicated investigation staff would need to be put in place in order to carry out these tasks. At present, only Edmonton and Calgary Child and Family Service regions have dedicated staff to carry out enforcement duties relating to licensed child care. In all other regions, these functions are simply added to the other responsibilities of staff.

[56] That staffing arrangement may not be adequate to meet the current statutory responsibilities. It would certainly be inadequate if those responsibilities were expanded to require inspection and enforcement of unlicensed child care.

[57] The witnesses agreed that restrictions or prohibitions on child care workers should be available in appropriate cases where a worker is involved in an incident causing significant injury or placing a child at risk. While the current legislation permits a two-year prohibition on applications for licensing in certain circumstances, and for the imposition of restrictions in others, these powers are limited.[15] They do not track individual child care workers, and they do not apply to those providing unlicensed child care.

Reports from other Jurisdictions

[58] The Ombudsman of Ontario released a comprehensive review of unlicensed child care in Ontario in October 2014. The impetus for the report was the deaths of four young children over a seven-month period, all in unlicensed care. At the time of that report Ontario used a legislative model similar to Alberta in that the only regulation directly targeting unlicensed child care related to the permissible number of children who could be accommodated.

[59] That 143-page report made 113 recommendations addressing the need for legislative and operational changes that would focus investigations, reporting, and assessing risk to children. The report also addressed the supporting information technology and organizational culture to enable effective investigation and monitoring of both licensed and unlicensed child care spaces and providers. It also made important recommendations regarding the information and access that must be provided to parents to ensure that they can fully and meaningfully participate in ensuring that their children are safe and receiving the best care.

[60] Many of these recommendations are reflected in legislative and operational changes brought about in response to this report. They are now found in the Ontario legislation. Ms.

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[14] http://www.humanservices.alberta.ca/documents/child-care-lookup-disclaimer.pdf

[15] ss. 4(2), 5(1), 11-16, *Child Care Licensing Act, supra*

Anselmo indicated that the changes made in Ontario were evidence-based and represented some of the best thinking and modernization on these issues. I have reviewed that report carefully, and specifically endorse several of the recommendations that address the risks identified in this inquiry. For ease of reference, I have included the recommendation numbers from that report in square brackets in paragraphs 63(a-i).

[61] While I will be making specific recommendations as to those areas of that report and resulting Ontario legislation, I am aware that legislation is not a "cut and paste" exercise. However, much can be learned from the experience of other jurisdictions.

Academic Literature

[62] Statistics and academic studies support four basic propositions related to the circumstances found in this case:

a. The risk of accidental or intentional injury to a child is greater for younger children.[16] Similarly, the level of care required, and the stress on caregivers is greater with younger children. While these realities are reflected in the regulations that apply to the provision of licensed child care, they only result in lower numbers of permitted young children in unlicensed care.

b. There is a need for improved and standardized reporting regarding serious incidents involving children in care.[17] That is also the case for incidents arising in unlicensed care.[18]Standardized data and reporting requirements will enable evidence based legislative change. Increased and detailed information about such incidents will also assist parents in making informed decisions regarding child care.[19] The lack of objective or detailed information regarding prior incidents was a significant factor in this case.

c. There is a need for greater mental health and other support for caregivers, particularly where they are providing care on their own or are otherwise isolated. Working in such an environment can be extremely stressful, and that stress contributes to several problems.

d. The absence of an explicitly "risk focused" regulatory and enforcement scheme governing all forms of commercial child care is surprising.[20] Child care shares many of the same features as other commercial activities that are regulated based on risk, including[21]:

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[16] See note 2, above, and *"Unintentional injuries in child care centers in the United States: A systematic review"*, Hashikawa, Newton, Cunningham, Stevens, in Journal of Child Health Care, 2015, vol. 19(1) 93-105, at p. 94, citing the Centers for Disease Control and Prevention conclusion that pediatric unintentional injury is among the most under-recognized public health problem facing the United States. The vulnerability of young children has also been identified in Canadian statistics – see for example *Family violence in Canada: A statistical profile, 2010* at section 3, and chart 3.3 and accompanying text available online at https://www150.statcan.gc.ca/n1/pub/85-002-x/2012001/article/11643/11643-3-eng.htm

[17] *Unintentional Injuries, supra,* at p. 101

[18] *Unintentional Injuries, supra,* at pp. 101-2

[19] See for example, *"Sector Quality Differences in Early Education"*, Bassock, Fitzpatrick, Greenberg and Loeb, in Child Development, September/October 2016, vol. 87, No. 5, at p. 1643

[20] *"Risk perception, regulation, and unlicensed child care: lessons from Ontario, Canada"*, White, Perlman, Davidson, in Journal of Risk Research, 2018, https://doi.org/10.1080/13669877.2017.1422786 at pp. 1, 3, 7

[21] *Risk perception, supra,* at pp. 4-5

i. The vulnerability of the group in question. Young children are particularly vulnerable to accidental or intentional injury given their dependence and degree of physical development.

ii. Accurate and independent information, particularly regarding unlicensed care is not readily available. This places parents and guardians at a significant disadvantage when making decisions about care.[22] It creates an information imbalance that places them at a distinct disadvantage, amplifying the risk to, and vulnerability of children.

iii. Society has an overriding interest and obligation in protecting children from harm. That obligation is reflected in legislation and policy across many other sectors.[23] The absence of that legislation and policy in the area of unlicensed child care is inconsistent with that obligation. Legislation in other jurisdictions has addressed this gap.

Recommendations

[63] Pursuant to section 53(2) of the *Fatality Inquiries Act*, I make the following recommendations that may assist in the prevention of similar deaths:

a. The legislative framework governing the provision of child care in Alberta should be comprehensively reviewed to address and reduce risk to infants and children in all forms of child care (licensed and unlicensed). [1, 2, 107, 108]

b. A specific focus of that legislative review should be to shift the focus from solely regulating the size of unlicensed daycare to a focus on reducing risk and increasing protective factors in all forms of child care. Academic research, the experience of other jurisdictions and the tragedy in this case all illustrate and support the need for risk focused regulation of child care. [107, 108, 109, 110, 112]

c. Significant operational and staffing changes must accompany any legislative changes to ensure that timely and effective investigations regarding risk in all child care settings. Operational changes include adding the necessary I.T. capacity to track serious incidents and the providers who are involved in such incidents. [3, 4, 5, 11, 12, 14, 15, 16, 17, 18, 39, 40, 42, 79, 80, 108, 109, 111]

d. The 2014 report of the Auditor General of Ontario regarding the inspection and review of licensed child care in that jurisdiction revealed that legislative change, while necessary, is insufficient to create an effective enforcement regime. The objective of that report was to determine if the responsible Ministry had effective management and oversight practices to ensure effective regulation of this sector. The report noted that more than 29,000 "serious occurrences" were reported to the Ministry over a five year period from 2009-14. The Auditor General made nine specific recommendations relating to enforcement and oversight. [1, 2, 3, 4, 5, 6, 8, 9, 10]. Those recommendations should be considered, both in the current legislative framework to ensure that adequate oversight and enforcement actually

[22] *Risk perception, supra,* at pp. 5-6
[23] *Risk perception, supra,* at pp. 4-5

occurs with licensed facilities and providers in Alberta, and in the context of examining the revised "risk focused" legislative review I have recommended.[24]

e. The new enforcement culture should be a proactive, rather than a reactive, complaint driven process. [8, 9, 10]. Mechanisms to track ongoing investigations and to audit or review investigations are essential components of such a culture. Other elements of an effective enforcement regime are described in these recommendations from the Ombudsman Report. [21, 22, 25, 26, 27, 28, 29, 30, 31, 33, 34, 35, 36, 44, 47, 48, 50, 51, 58, 59, 60, 62, 63, 64, 67, 68, 73, 74, 77, 78]

f. Information sharing regarding critical incidents where significant injury or the risk of significant injury occurs in a licensed or unlicensed day care is essential. Specific investigation and information sharing protocols should be examined regarding critical incidents. In particular, the rights of parents or guardians to information regarding critical incidents should take precedence over the privacy rights or commercial interests of child care providers or workers regarding essential information in those reports. The related recommendation from the Ombudsman Report is recommendation 55.

g. All witnesses who were asked about the report form and requirements currently in place for licensed daycares in Alberta agreed that they do not strike the appropriate balance between protecting the privacy of child care workers and providers and providing detailed and meaningful information to regulators, parents and guardians regarding these incidents,

h. The *Children First Act,* (S.A. 2013, c.12.5), and its associated regulation, *Disclosure of Information Regulation,* (A.R. 231/2013), must be examined and revised where necessary to ensure that information regarding critical incidents can be shared and disclosed appropriately.

i. Effective enforcement also requires that the legislation provide for an appropriate range of remedial powers and sanctions, applicable to all forms of child care providers. These must include the power to immediately close unsafe daycares, issue remedial orders and monitor compliance, and to restrict or prohibit individuals from providing child care services. [75, 76, 79, 80, 104]. All of the witnesses in this inquiry agreed that the legislative authority and operational capacity to identify, restrict, and prohibit individuals from providing child care services was essential.

j. Providing child care is demanding work that is often stressful. That stress can be amplified by the number and age of children and is also exacerbated when that care is provided in an isolated setting without other adults present for support. Tools for self-assessment, and for support should be readily available and accessible. Mandatory support and assistance should be considered for all involved in reported critical incidents.

[24] This chapter, 3.02, of the Auditor General's 2014 Report is available online at http://www.auditor.on.ca/en/content/annualreports/arreports/en14/302en14.pdf.

Conclusion

[64] Mackenzy's death at the hands of her trusted caregiver was a shocking tragedy and terrible loss for her parents and family. It is hoped that the recommendations in this report will give rise to a careful re-examination of the legislative, policy, and operational framework that governs child care in Alberta. As the facts in this case demonstrate, the risks to the very young and vulnerable are real. Other jurisdictions have carefully reviewed all forms of child care from a risk based perspective. That review led to legislative change.

[65] I strongly recommend such a review in Alberta in order to reduce the likelihood of a recurrence of events like these.

DATED

November 26, 2018

at Calgary, Alberta.

Original signed

Joshua B. Hawkes
A Judge of the Provincial Court of Alberta