Addendum One to the report: "A tragic incident in early childhood education and care in New Zealand"

An investigative report into a serious food-related choking incident involving a toddler at an early childhood centre was publicly released by ChildForum on 31 March 2019. It received much national and international media attention (go to the end of this document for a list of links to known news items and media stories within the first week or two of the report's release).

The report suggested that the Ministry of Education did not properly investigate the incident, it did not treat providing high-risk food to high-risk children as a safety breach, and it had made no contact with the child's family.

The Ministry of Education holds responsibility for administering the education regulations and licensing yet it declined requests for interviews and provided only written statements to journalists.

This addendum to the report presents and discusses the main arguments made by the Ministry of Education in its statements regarding the case and the report's findings.

The Ministry stated:

1. "We know young children are particularly susceptible to choking, even on things they may have eaten many times before or while under supervision, as was tragically the case here."
2. "WorkSafe NZ's report shows the centre followed first aid and supervision guidelines, had suitably trained staff and called emergency services immediately. Staff at the centre did all they could to help this little boy."
3. "Following WorkSafe NZ's investigation we worked with WorkSafe NZ to review our guidelines. "
4. "We reinforced the importance, more generally, of closely supervising children in our guidelines on hazard management. We communicated this to the sector through our early learning bulletin in May 2017."
5. "We categorically refute any suggestion that this situation was kept hidden."
6. "We started publicly releasing incident notifications in 2017 which was after this incident occurred."
7. "In any event our duty of care is to do what we can to support affected children and their families, to ensure these events are appropriately investigated, changes in practice introduced if required and to ensure Early Learning Services have access to the latest advice on best practice education and care. This is what happened following this accident."

Rebuttal

On examination, the Ministry's arguments do not all stand up well.

Rebuttal of Argument 1: "We know young children are particularly susceptible to choking, even on things they may have eaten many times before or while under supervision, as was tragically the case here. "

Yes, the Ministry of Education is correct on this but it is missing the point that very young children do not have all their teeth – second molars are needed to grind food. Young children have small air and food passages and they also need to time to learn to move food around in their mouths, how to bite, chew and grind food. Therefore, hard food such as raw apple must not be given unless the texture is altered to reduce the risk of choking by boiling, mashing or grating.

As well as knowing that young children are particularly susceptible to choking we also know that hot water can burn and that a young child cannot be expected to control the temperature of water even when an adult is nearby watching; that is why in its licensing criteria (PF24) the Ministry of Education requires early childhood centres to install a tempering valve or other accurate means of limiting hot water temperature.

The precedent is therefore set for controlling known risks which children are not able to control themselves. It seems unacceptable to differently treat choking on food as a risk that cannot be prevented or reduced for young children.

Rebuttal of Argument 2: "WorkSafe NZ's report shows the centre followed first aid and supervision guidelines, had suitably trained staff and called emergency services immediately. Staff at the centre did all they could to help this little boy."

That sounds good but the ministry is overlooking that WorkSafe's report also showed:

1. a failure of the service was serving raw apples, and
2. the risk was not included on the centre's hazard register.

"WorkSafe's investigation was focused on compliance with the Health and Safety at Work Act 2015." (Letter from Keith Stewart, Chief Inspector 11 August 2017). Its report template is designed primary for workplace incidents involving adults.

The incident occurred on 31st May and it was not confirmed that there would be an investigation until 24th June. Therefore the evidence available to WorkSafe was limited by the many days passed between the event and the investigation beginning. The scene was not preserved. Statements from all persons involved were not taken. The evidence that WorkSafe collected from the service was limited essentially to copies of documents provided by the service itself. On 13th July the centre manager told the ministry that WorkSafe wanted to interview her and did not want to talk with other teachers or persons involved. A lawyer may have been provided by the service to be with the centre manager at her interview with WorkSafe.

It is the Ministry of Education's job to administer the Education regulations but there is nothing to suggest that it even checked WorkSafe's report for any possible errors, deficiencies and omissions.

WorkSafe is not an expert in the area of early childhood education or the care of young children and could not be expected to know the right questions to ask to get at what really happened and

why. (For example: the area of staffing was not of major interest to WorkSafe but clearly there were challenges for the service on the afternoon of the incident. The child's own primary caregiver/ teacher went home sick one hour before the incident occurred. The manager stood in to supervise the children's afternoon tea. A teacher who formed part of the adult-child ratio for children in another part of the centre happened to be passing at the time of the choking and instead of going back to her room and children she found herself administering first aid to the choking toddler with the centre manager while the other toddlers in the room looked on. So, what really was the teaching ratio at the time? Were any children left unsupervised? What was the quality of supervision and support given to the toddler leading up to the choking?).

WorkSafe's report mentioned that the centre had staff who were first aid qualified but it did not say whether the training had equipped them to give the recommended first aid for a child under-2 years who is choking, or if indeed the recommended first aid was given.

The Ministry of Education had not taken into consideration the child's family's complaints that the WorkSafe report lacked rigour when it told the media the centre had done everything right. The Ministry later admitted to the family that before publicly commenting it had not read the family's letter/ critique even though it had it on file.

Rebuttal of Argument 3: "Following WorkSafe NZ's investigation we worked with WorkSafe NZ to review our guidelines."

That would be a good thing to do but it would appear there was minimal contact between the two organisations following the completion of WorkSafe's report. A lead investigator with WorkSafe met with a Ministry of Education senior advisor for ECE regulations on 21 November 2016 and gave a copy of the report to the Ministry advisor. The Rotorua office of the Ministry of Education, the city in which the incident occurred, had to request a copy of the report from WorkSafe which was provided under the Official Information Act on 12 December 2016.

In October 2018 WorkSafe replied to the child's family concerning its query as to whether it had issued an industry-wide communication to the early childhood sector as stated it would on its report. WorkSafe replied that it later decided this was not its responsibility and the responsibility fell under the Ministries of Education and /or Health. It clearly had not communicated with the Ministry of Education on this as the Ministry of Education believed this was the responsibility of WorkSafe and did not know of this communication with the child's family.

Rebuttal of Argument 4: "We reinforced the importance, more generally, of closely supervising children in our guidelines on hazard management. We communicated this to the sector through our early learning bulletin in May 2017."

Perhaps the ministry did this but not in the bulletin it mentioned or in any other of its early childhood bulletins for 2016, 2017 and 2018. Nowhere in the May 2017 Bulletin is there any reference to food-related choking or the choking incident. Here is the online link: https://education.govt.nz/early-childhood/how-the-ministry-works/early-learning-bulletin/early-learning-regulatory-update-may-2017/#Child As you'll see the Bulletin is about managing strangulation hazards on play equipment following a child dying in November 2016 at an Auckland early childhood centre who was playing on a plastic slide with stilts that had cord attached. It's also about changes to the Education Act, cohort entry for children starting

school, rules around the seclusion and restraint of children, and safety checking of children's workers – and its not about the management or prevention of food-related choking.

Rebuttal of Argument 5: "We categorically refute any suggestion that this situation was kept hidden."

Can the ministry explain then why outside of the child's family and those immediately involved with the case and with the centre at the time, the first that others in the ECE sector and the public heard about it was through the investigative report published by ChildForum and the TVNZ documentary screened on the Sunday programme?

ChildForum had not heard about the situation until the child's family asked for its assistance in April 2018 because they had been waiting for over a year to hear from the Ministry of Education following their child's near fatal event resulting in severe brain damage.

There does not appear to have been a public press release by the Ministry of Education to inform or warn parents, a notice about it in ministry newsletters for the early childhood sector, or any other ECE industry communication.

The Ministry's traumatic incident team closed its job after only two days on checking that the service provider had PR support and supporting the centre to quickly return to running as normal. In other words, the Ministry of Education took the approach of a 'cleaner' and appears to have been more concerned about keeping the incident out of the public spotlight than about preventing something similar from happening again.

Rebuttal of Argument 6: "We started publicly releasing incident notifications in 2017 which was after this incident occurred."

Yes, the Ministry started publicly releasing incident notifications in 2017 but its 2017 release concerned incidents that occurred during 2016 so the choking incident would be expected to be included in it.

The centre had reported the serious incident and the ministry claimed it recorded it. Yet in its release of information on 2016 incident notifications there is no mention of the choking incident.

The annual information releases do not state the nature of any serious incidents or injuries that occurred in early childhood services and what actions the ministry took. So effectively whether or not the Ministry started publicly releasing incident notifications in 2017 makes no difference whatsoever to what the public knows about incidents that occur in any individual service.

The link to the public release of incident notification in 2016 is:
http://www.education.govt.nz/our-work/information-releases/issue-specific-releases/2016-early-childhood-education-ece-complaints-and-incidents-report/ece-complaints-and-incidents-received-2016/

Rebuttal of Argument 7: "In any event our duty of care is to do what we can to support affected children and their families, to ensure these events are appropriately investigated, changes in practice introduced if required and to ensure Early Learning Services have access to the latest advice on best practice education and care. This is what happened following this accident."

Clearly the first two things the ministry stated as happening, did not happen. First, no support was provided to the child and family and it received no communication from the ministry. Second, the ministry did not undertake an investigation, nor carry out its own analysis of WorkSafe's report and consider possible errors and omissions.

Going by responses from teachers, managers and service owners in social media it is obvious that the Ministry of Education stuffed up in not introducing changes to practice and in not ensuring the latest advice was accessed, known, and implemented in the years following the 2016 incident (and going back as far as 2008 when it was known that a 14th month old died due to being given raw apple to eat at a centre).

Media coverage and stories following this report

TV1 Sunday programme 31 March 2019: https://www.tvnz.co.nz/content/tvnz/onenews/story/2019/04/01/rotorua-familys-life-changed-for-ever-after-son-chokes-on-apple.html

TV1 6pm News item 1 April 2019

TV1 7-Sharp 1 April 2019 https://www.tvnz.co.nz/shows/seven-sharp/episodes/s2019-e50

Stuff 1 April 2019: https://www.stuff.co.nz/national/education/111691919/rotorua-toddler-left-braindamaged-after-choking-on-apple-at-daycare

Stuff 3 April : https://www.stuff.co.nz/national/education/111719584/preschools-change-food-policy-after-toddler-braindamaged-choking-on-apple

NZ Herald 31 March 2019: https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=12217942

TV3 AM Show 4 April 2019: https://www.newshub.co.nz/home/lifestyle/2019/04/child-food-safety-should-be-a-priority.html

Rotorua Daily Post 6 April 2019: https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=12218267

Rotorua Daily Post comment article 6 April 2019: https://www.nzherald.co.nz/bay-of-plenty-times/news/article.cfm?c_id=1503343&objectid=12218335

Australia

9 News TV: https://honey.nine.com.au/2019/04/04/07/33/toddler-chokes-apple-daycare

Yahoo: https://nz.news.yahoo.com/toddler-brain-damaged-choking-apple-daycare-084848767.html

United Kingdom

The Sun: https://www.thesun.co.uk/news/8775805/toddler-paralysed-life-chokes-slice-apple/

Daily Mail: https://www.msn.com/en-nz/news/national/toddler-is-left-with-severe-brain-damage-after-choking-on-slice-of-apple-during-afternoon-tea-at-a-daycare-centre/ar-BBVyUCD

Mirror: https://www.mirror.co.uk/news/world-news/toddler-paralysed-life-after-choking-14224053

United States

New York Post: https://nypost.com/2019/04/02/toddler-paralyzed-for-life-after-choking-on-apple-at-daycare/

The Washington Time: https://thewashingtontime.com/toddler-paralysed-for-life-after-choking-on-slice-of-apple-at-nursery/

International Online

World news: https://theworldnews.net/nz-news/child-suffers-brain-damage-after-choking-on-apple

People: https://people.com/human-interest/toddler-becomes-paralyzed-after-choking-on-apple/

Press From: https://pressfrom.info/au/news/world/-115638-toddler-is-left-with-severe-brain-damage-after-choking-on-slice-of-apple-during-afternoon-tea-at-a-daycare-centre.html

Major internet site for mums: https://thestir.cafemom.com/parenting_news/218573/toddler-suffers-brain-damage-choking-apple-daycare

Expressive information: https://www.expressiveinfo.com/sad-toddler-paralysed-for-life-after-choking-on-slice-of-apple-at-nursery11/

US UK entertainment news: https://usauknews.com/toddler-paralyzed-for-all-times-after-choking-on-apple-at-daycare/

Families Online UK: https://www.familiesonline.co.uk/news/toddler-left-paralysed-after-choking-on-slice-of-apple-at-nursery

LifeVac Australia News: https://www.lifevac.net.au/news.html

Global news: https://www.readglobalnews.com/toddler-paralysed-for-life-after-choking-on-slice-of-apple-at-nursery/

Cyprus: https://news.amomama.com/143429-little-boy-paralyzed-life-choking-apple.html

Kidspot Australia: https://www.kidspot.com.au/news/toddler-suffers-severe-brain-damage-after-choking-on-an-apple/news-story/799bd2b589f1b5719c6b3115ebd55fad

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