

A tragic incident in early childhood education and care in New Zealand

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Abstract: This report examines how parent expectations that early childhood education is safe for their child may be misplaced. It shows policy changes are needed so breaches in trust do not continue to occur.

In 2016 a child under two years of age choked on the apple he was provided to eat for afternoon-tea at an early childhood centre in Rotorua. Raw apple is a well-known high-risk food for a child of his young age. The toddler now has a hypoxic brain injury and severe cerebral palsy – he is unable to talk, swallow normally, or move his body.

What occurred was likely a serious breach in one or more clauses of the Education (Early Childhood Services) Regulations that require the providers of early childhood services to:

- take all reasonable steps to promote the good health and safety of children (Regulation 46, 1a),
- take all reasonable precautions to prevent accidents among children (Regulation 46, 1b), and
- ensure that no child is ill-treated (Regulation 56, 1).

But we will never know for sure because the Ministry of Education did not promptly nor properly investigate what happened. It seemed to treat the incident as an accident that could not have been prevented and the Centre's licence was not downgraded to provisional. The Ministry also did not question the first aid given to the child, for example was he first asked to try coughing? Why were (blind) mouth sweeps done and could this have contributed to the injury that resulted? The ministry made no contact with the family. The family were not informed of their right to make a complaint. The ministry's actions appeared aimed at keeping the incident quiet.

The incident did not lead to the Ministry changing its criteria used for assessing if a service is meeting regulations to specify that high-risk food should not be given unless the risk is reduced by altering its texture according to Ministry of Health guidelines – an addition it could easily and quickly make to the licensing criteria. It cannot be argued that the ministry did not know about the risk since a child died after choking on apple in very similar circumstances at a daycare centre some years earlier. And, the incident did not trigger a review of the effectiveness of first aid training for early childhood staff.

This investigative report details several findings and recommends changes to improve safety for children and the management of such serious incidents.

Note that: A year before the incident when the ministry did a full licensing check of the centre, it discovered serious safety breaches and the ministry received a reportedly “angry” phone call from the Auckland head office of the service provider. It may have been for this reason or for other unknown reasons that the Ministry of Education elected not to downgrade the centre’s licence until such time as it was compliant with the minimum regulations and got NZ Fire Service approval for the area of space it was using for children’s sleep and play.

How and why this report came to be written and dissemination

The child’s mother first made contact with me in April 2018. She emailed that she had been waiting for over a year to hear from the Ministry of Education and or Ministry of Health since her child had a near fatal event in 2016. She shared her story with me and asked if I had any advice.

On behalf of the family I first put in a request for information to the Ministry of Education under the Official Information Act. What we (the family and I) learnt from this, suggested to me that further investigation into what happened and the way the case was handled was needed. I then proceeded to look more fully into the case, collecting evidence, analyzing, and compiling this report. The family were part of this process and have checked and had input into this written report.

My aim in reviewing the evidence was to provide the family with answers as to what had happened. And, together we also wanted to see some good come out of the harm, with the goal being to get improvements so something similar would be less likely and hopefully never happen to another child in early childhood education, ever again.

In August 2018 I first raised the idea with the family of their telling their story to the media, on television. I felt it would help our goal if the family told their story, personally, at the same time as the written report was released. However, it was not a request of the family that I made lightly because the family had already been through so much and it was sad that this was even necessary. In October 2018 I contacted the producer of the Sunday TVNZ programme and asked if the Sunday programme would be interested in telling the family’s story and reporting the findings. Interest was expressed and so I asked the family if they would be happy to be involved in a documentary. The date for the documentary to screen is 31st March 2019.

The report will be available then to everyone. It is hoped that the findings will be widely discussed within our early childhood sector. It is hoped also that the Ministry of Education, the service provider (Evolve Education) and other agencies involved will consider what they can learn from it and make changes needed.

Every effort has been made to ensure that details within this report are correct as far as can be ascertained from the evidence made available. Should you have further information or notice any errors contact me asap for correction or to include in any Addendum.

Thank you for making time to read the report that follows and please also see the recommendations. *Sarah Alexander*

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Executive summary

Giving food, such as popcorn, nuts and raw apples, that young children can easily choke on is against health advice in New Zealand and internationally. Choking is a common childhood hazard. In NZ between 2009 and 2018, for children under-5 years there were one to two choking cases per week that required medical attention and an ACC claim. There is no data on cases that were resolved without requiring medical attention. The data includes all forms of choking but food-related choking is the most common cause.

In early childhood education, children who are within the known high-risk age range for choking of under-5 years and particularly under-3 years can be given raw apple and other food that can easily be choked on. There is no legal requirement that the texture of the food must be altered through cooking, grating or mashing to reduce risk. Parents appear to be warned insufficiently of this hazard in early childhood education.

This report presents an analysis of one case of choking at a daycare centre and the way it was handled. The case concerns a 22 month old boy who nearly died after choking on a slice of raw apple he was given for afternoon tea. The toddler had a cardiac arrest for 30 minutes and sustained a hypoxic brain injury that has left him severely disabled – he has lost the ability to move and talk.

The Ministry of Education is responsible for licensing and ensuring all services meet regulations that include taking all reasonable precautions to prevent accidents and promoting the good health and safety of children. However, the ministry has been silent and complacent in regard to the incident. The ministry failed to investigate and erred in not interviewing all staff present personally, and did not talk to the parents of the child. It did not undertake a new licensing check of the centre for potential non-compliance. The incident did not trigger any information release on injury prevention to the early childhood sector. The ministry did not subsequently revise licensing criteria to include that high risk food for choking must not be given to infants and young children.

WorkSafe was notified of the event and it investigated. WorkSafe regarded the toddler choking and nearly dying as an unpreventable event and its report may be seen to be lacking in rigour. A part of the responsibility of WorkSafe is to help reduce the risk or recurrence of harm to people. But WorkSafe did not follow through on its intention to do an “*industry-wide communication to be distributed outlining issues*”.

The first aid treatment given to the toddler at the centre was not questioned and there is some confusion in accounts of what treatment was given. When compared to the NZ Resuscitation Council’s recommendations on appropriate first aid treatment for young children, it is possible that the daycare may have failed to give him this treatment accurately. The Ministry of Education has not reviewed what improvements may need to be made in early childhood staff first aid training in light of the incident.

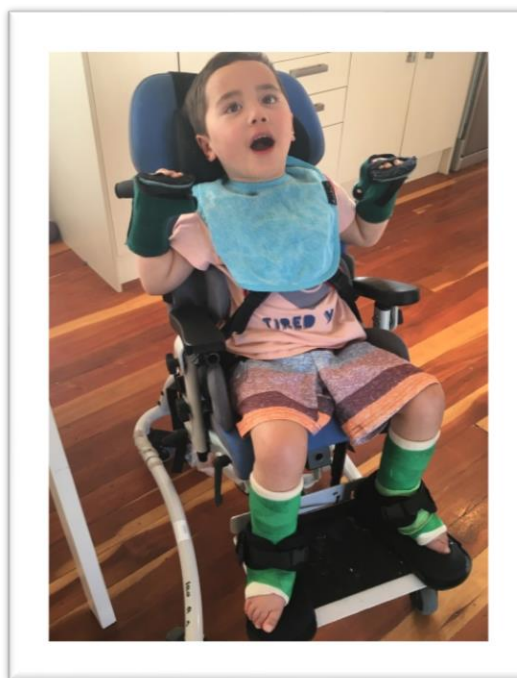
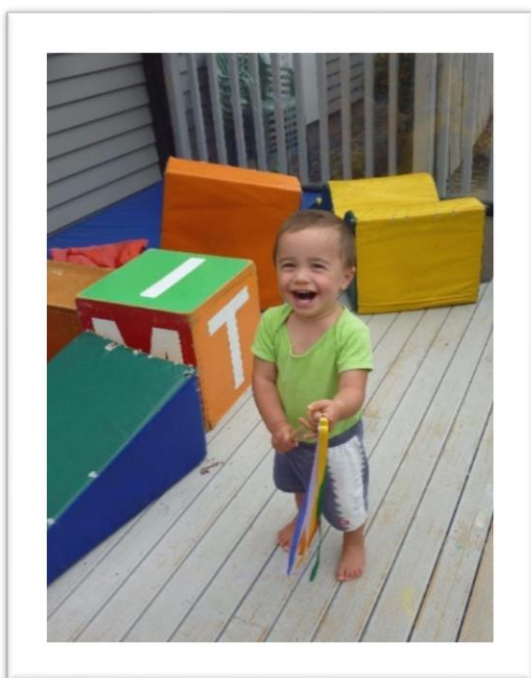
It would seem from the evidence that the Ministry of Education consciously or unconsciously hid the possibility of regulation breaches. Were, for example, “all reasonable precautions” to prevent choking really taken? It needs to be questioned why much effort and care was taken by the ministry to ensure the daycare business was as unaffected as possible by the event, while

the toddler's family received no correspondence or contact of any kind from the ministry. The service showed it did not have or did not follow a satisfactory procedure for communication with the family after the incident. It was left to teachers, as individuals in their own time, to see how the toddler was doing and talk to the family.

The findings of this report include an outline of what happened and the events that followed the incident. The actions taken by the service operator (Evolve Education Group Ltd), the Ministry of Education, and WorkSafe are reviewed and discussed. The report concludes with a set of seven recommendations for what must happen now.

An Appendix is included with further information on food as a choking hazard, an outline of what to do for a choking infant or young child, and links to food guidelines.

The toddler, his family and how the incident affected their lives



The child was 22 months old at the time of the incident.

He had been attending daycare with his twin sister for around 2.6 months for between 1½ to 2 full days a week.

The toddler's development was normal for his age and he had no health conditions or disabilities. As typical of children his age, he did not have a full set of teeth having neither first nor second molars (essential for grinding food). Children's second molars do not normally come through completely until they are over 2.6 years old. His mum described him as being very smiley and loving. He was also an active little boy - he loved to run and play outside, and he was a great dancer.

Owing to the incident at the early childhood centre, the toddler now has a hypoxic brain injury and severe cerebral palsy. He is unable to talk, swallow normally, or move his body. This means he cannot do things that are typical of children his age like sing songs, paint pictures, climb trees, or even drink from a cup – and he never will be able to. His twin sister no longer has a playmate and when they are 5 he will not be able to attend school with her.

The toddler was in hospital for just over 2 months (including 2 weeks in an intensive care unit). Since then he has been back to hospital many more times as he is now prone to chest infections. When he is not in hospital, there are usually multiple appointments each week related to the injury and physical therapy is necessary to do each day.

His mother, a fully qualified GP, had to give up her work as a doctor to manage his care – a loss to the NZ economy.

His family have experienced an enormous strain in dealing not only with how the incident has affected them but also in dealing with bureaucracy and not being given adequate answers as to what actually happened to their son and why.

The early childhood centre

The centre attended by the toddler was Little Lights Kindy in Rotorua. It is owned by the Evolve Education Group. Evolve purchased it in 2015.

Little Lights Kindy is licensed for 50 children including up to 16 children under-2 years of age (although confusingly the ministry's own licence status management report for the centre states that the licence includes up to 18 children under-2).

Younger children are cared for in a separate area of the centre to the older children. The floor plan shows a playroom for 18 months – 2 ½ years (Tuis room), a playroom for children under 18 months (Cherubs room), a joint dining area with highchairs, and an adjacent kitchen.

It is believed that the manager of Little Lights Kindy had been working there for around 20 years. In 2014 she was named a runner-up in the NZ's most inspiring teacher campaign, a Warehouse Stationary initiative. She was the person that the Ministry of Education primarily communicated with concerning the choking incident and she had been one of the two main staff who administered first aid to the toddler

Little Lights Kindy is similar to other early childhood centres around the country in that it must operate according to the requirements set out by the Education (Early Childhood Services) Regulations 2008 and meet the ministry's licensing criteria.

Evolve Education Group has given the following public assurance concerning its commitment to ensuring children's safety:

Every parent who entrusts their child to our care can be sure that their child's safety, happiness and personal development is going to be at the forefront of everything we do (Evolve Education Group Annual Reports, 2017, 2018).

On Little Lights Kindy's website, it states that it aims "to create a caring and fun environment where each child feels secure, loved and respected."

The Education Review Office found the daycare to be "very well placed" when it carried out reviews in 2011 and 2014.

Younger children are well cared for in an attractive, home-like environment where they receive close care and affectionate support. These children enjoy warm and gentle relationships with adults and each other. Focusing on children's individual needs, and adapting their practices to children's ages and stages, is a priority for teachers. (Latest ERO report available on Little Lights Kindy, May 2014)

No licensing breaches were mentioned in the ERO reports. However, a Ministry of Education document noted that prior to its change of ownership in March 2015, the centre had an established history of non-compliance with regulations. This history remains hidden or protected. The Ministry refused a request to provide copies of all licensing applications, assessments/checklists since the centre opened, claiming that it would require "substantial collation" and take ministry "staff away from their core role of supporting Early Childhood Education services".

In 2010 the daycare relocated into a new facility on the same property and the ministry conducted a re-licensing visit for the new facility. On 12 March 2015 the ministry checked the centre as part of its change of ownership to Evolve. The ministry noticed that a loft with two mezzanine floors was being used as a sleep area for children and for play activities. When it had re-licensed the new facility in 2010 the ministry noted that the mezzanine floors were in the floor plans but not what the floors were being used for. The fire evacuation scheme approved in 2010 by the NZ Fire Service did not include using the floors for children's activities and sleep. To use the mezzanine floors legally the daycare would have had to apply to the NZ Fire Service for approval.

A ministry inspector recalled:

There are 8-10 steps to reach the top of the floor, the staircase is very narrow, and when I reached the third step from the top I had to stop as the roof was so low. The protective railing around the floor was covered by curtains to keep the lighting low. This is difficult to supervise the teachers [meaning any abuse of children would likely go unnoticed by others].

Ventilation was not ideal at all even though they had a fan blowing. There was very little space between each mattress. One teacher had to crawl along a narrow space between mattresses to tend to a child because she couldn't stand as the roof was low. The centre manager advised us that the loft space was utilised for activities and as a sleep space for children. When asked what the evacuation procedures for the sleep area were, the answer was there is none.

Other areas of non-compliance discovered that had not been picked up in 2010 or had occurred since were:

- Heavy shelving was not secured to walls.
- Boxes and other heavy items were stored on top of the shelving.

- Bag lockers were arranged so children using the higher lockers could not put their bags in properly and bags were falling down on children.
- A large fish tank standing in the front entrance was not secure to the wall.

The safety of food given to infants and toddlers appears not to have been looked into at this time or no non-compliance in this area was recorded.

The daycare was not placed on a provisional licence as should happen when there are breaches. This could have been due to pressure from Evolve or due to another undisclosed reason – see the following ministry notes.

1 April 2015: I've received a phone call from Evolve CEO stating that the non-compliances have been resolved. I'll be visiting the centre to check the alterations and to see whether the centre has a new operative evacuation scheme.

8 April 2015: Received a rather abrupt phone call from --- Chief Operations Officer for Evolve Education. --- was angry that we had progressed towards issuing a provisional licence for this centre. He asked what the ministry's processes were in giving out a provisional licence without consultation. I responded by informing him that my communication had been with the service provider contact ---- his reply was, who's that? He asked if we could move the deadline date to 20 June and allow Evolve to complete all of the breaches by the end of April, if they have not met the conditions on the action plan then progress towards issuing a provisional licence.

I made contact with the centre manager --- who assured me that the application for a operative fire evacuation scheme has been submitted to the NZ Fire Service. The carpenter was due in next week to begin fixing the shelving and fish tank to the walls, and a review of the sleep area has commenced.

1 July 2015: Could you please peer review this one for me. I have updated the Intervention Recommendations as to the reasons why the decision was made to not provisionally licence the service.

Reply 15 July 2015: Thanks for talking me through what was a very complex situation which you managed with the service provider. I have read all the information which provides the rationale for your recommendation to cancel the provisional licence and agree with the decision as all required actions have been completed and the service is now compliant.

15 July 2015: Thanks, I know it could have been quite confusing if we didn't have the discussion to clarify my reasoning for not issuing a provisional licence.

Findings

What happened

No detailed account exists of each of the actions that led to the incident which resulted in serious life-threatening complications. This should have been prepared following the incident to inform improvements in health and safety that could be made to reduce the chance of something similar happening to another child.

A rough outline only of what is alleged by various parties to have happened is possible to establish and is shown below. The outline has been compiled from the short handwritten accounts of two teachers and the centre manager, an email written by a Ministry of Education advisor to colleagues on the morning after the incident, a traumatic incident form completed by a Ministry of Education staffer, and a report by a WorkSafe investigator.

The incident happened on Tuesday 31 May 2016 at about 2.15pm.

The toddler's key teacher/primary caregiver went home sick at 1pm and the centre manager took her place as a relief teacher.

A diagram provided in the WorkSafe report showed four teachers were present at the time (Teachers, A, B, C, D) and it was claimed that all children were seated and supervised for afternoon tea. Plates of raw, peeled and sliced apple had been prepared in the kitchen and apple slices were given to the children to eat.

The service provider gave written accounts of what happened by Teachers, A, B, and E (a teacher working in another part of the centre) to the Ministry of Education. Written accounts by Teachers C and D were not provided or are missing. The written accounts of Teachers A, B, and E suggest only three staff present when the choking started: Teachers A, B, and D, with no mention of Teacher C.

Teacher A was the centre manager. Teacher E worked with the older children in another part of the centre. It was by chance that she was passing by the room and therefore went in to help.

There is no mention in any teacher account that the toddler was first encouraged to cough to see if he could bring up the apple on his own, as per recommended initial first aid treatment for choking.

Teacher A was sitting at the same table as the toddler. On noticing that the toddler was choking she picked him up and either did several chest thrusts or Heimlich – the information provided is not clear.

Teacher B put her finger in his "mouth to try and hook anything that was in there out but there was nothing." (Note that blind mouth sweeps are dangerous as this can lead to pushing the obstruction further in.)

Teacher E was walking past the area on the way back to her class downstairs. "I heard someone say "He's choking". I said something along the line of "slap his back". Teacher A slapped his back.

Teacher B could see his colour changing. She asked Teacher A if she should call an ambulance and Teacher A said “yes”. Teacher B went to the office to call the ambulance (2.22pm).

Teachers A and E noticed children were becoming upset and they moved the toddler to another room.

Teacher E performed chest thrusts – or Heimlich (it is not clear as the account provided to the Ministry of Education states chest thrusts but she told the toddler’s father she did Heimlich, and the ministry’s email correspondence states Heimlich).

As that did not work, Teacher E then put the toddler over her knee and slapped his back.

Teacher A did another blind mouth sweep as Teacher B had done at the start of the choking.

They laid him on a table and began compressions on his chest. He was now unconscious.

Teacher E gave two breaths and he vomited blood and mucus into her mouth. Teacher E and Teacher A turned him onto his side and nothing more came out. Teacher E wrote that she felt she couldn’t continue and Teacher A took over.

A phone was passed to Teacher E and the emergency people asked her if he was conscious and they said to keep up the compressions, and began counting 1, 2, 3, 4,.. 1, 2, 3, 4. Teacher E repeated this to Teacher A to keep her rhythm going. Teacher E and Teacher A alternated until the ambulance arrived at around 2.30pm.

The toddler was in cardiac arrest for around 30 minutes, a length of time that is medically associated with a very low chance of survival, before being resuscitated by ambulance staff. He was then taken by ambulance to Rotorua Hospital Emergency Department. At 8.45pm he was flown by helicopter to Starship Hospital in Auckland.

Chronology of events following the incident

31 May, Tuesday, 2016

At 4.40pm just over two hours after the ambulance arrived, the service provider (Evolve) left a voicemail on the Ministry of Education’s phone that a serious incident had occurred.

At 5.30pm a Ministry of Education traumatic incidents coordinator returned the call to Evolve to have an initial conversation about the incident.

1 June, Wednesday, 2016 – The ministry phoned the daycare and decided on its approach. The approach would be to provide assistance to ensure that normality could be restored after the incident and mitigate any risks to the daycare.

A Ministry of Education senior adviser based in Rotorua e-mailed two senior Ministry officials to report that at 7.30am she had contacted (name redacted by the Ministry) and was told:

- Under-2 year olds were having afternoon tea together and were supervised fully.
- The 22-month-old began choking while eating a piece of apple.

- Teacher A performed Heimlich Manoeuvre on the child but could not clear the obstruction.
- The toddler began turning blue so CPR was performed.
- Staff immediately called 111.

Later that morning, five Ministry of Education staff called a meeting to develop a plan for responding:

Team discussed potential risks [to the centre] and how to minimise the severity of the incident – e.g. centre developing statement when fielding phone calls/enquiries, templates that can be used for media releases.

Three Ministry of Education staff formed the ‘traumatic incident response team’ for the daycare and met (name) at the centre to “gather more details about the incident, assess risks and ensure mitigation, and offer support.”

Templates were provided to the daycare for media communications and what to tell (reassure) other parents at the centre. The Ministry was informed that Evolve had its own PR personnel to handle communications.

The centre programme and routines were noted by the Ministry to be “continuing as per normal”.

Teacher A phoned the toddler’s mother at Starship Hospital and asked if the area manager and CEO of Evolve could visit. The mother declined to meet at that time for Evolve’s purposes as her son was in a critical state and she did not have time to meet people she did not know, people who had not been present at the time of the incident or people who did not know her son.

2 June, Thursday 2016 – The ministry withdrew its Traumatic Incident Team, without doing an inspection and/ or carrying out an investigation and analysis of the actions and issues that led to the incident.

The “Traumatic Incident Job” was closed and the education ministry indicated that the final TI report would be forwarded to Evolve.

On the same day as the TI team withdrew/completed its job, Teacher A emailed the local Ministry senior adviser to say:

Sorry I didn’t get back to you yesterday. I will follow this up with some reports from --- who rang the ambulance and ---- who was with me during the incident. (Name) from Evolve visited us yesterday afternoon which was nice to have there (sic) support.

3 June, Friday 2016 – The first and only time that an education ministry official questioned the availability of guidance for centres on reducing the risk of a child choking on apple in relation to the incident.

A Ministry of Education senior adviser emailed a Ministry lead adviser in ECE Operational Policy Design regarding whether the Ministry of Health had put out some guidance for ECE services

... about apples etc and the need to be careful and that for young children, the apple should be put into muslin so that (sic) can be chewed/sucked. We have had a bit of a look for it (the guidance) but can’t find anything on Te Tahuhu, have you heard of this??

13 July, 2016 – WorkSafe starts to collect evidence to prepare a report on the incident.

Teacher A informed an education ministry senior adviser that she had supplied information WorkSafe had requested and that WorkSafe had asked to interview only her as she was the duty holder and “they are not wanting to interview the other teachers”.

20 July, 2016

An education ministry senior adviser and Teacher A had a phone conversation. No details have been provided by the ministry as to what was discussed or transpired.

21 October 2016

The WorkSafe investigator completed her written report.

7 November 2016

The toddler’s family requested a copy of the WorkSafe report from WorkSafe (which was handled as an Official Information Act request rather than as an automatic right of the family to know what was in the report).

10 November 2016

The WorkSafe report was signed off by a WorkSafe manager and chief inspector

11 November 2016

The WorkSafe investigator spoke to a representative from the Ministry of Health and sent her a copy of the report.

21 November 2016

The WorkSafe investigator met a lead adviser for ECE regulations at the Ministry of Education and provided her with a copy of the report. On the same day, WorkSafe released a copy of the report to the family under the Official Information Act.

12 December 2016

An education ministry senior adviser based in Rotorua was provided a copy of the WorkSafe report after putting in a request for it under the Official Information Act. (Note that a copy had been provided to a ministry official at the ministry’s national office on 21 November and yet it seems that the local ministry person who dealt with the daycare and was responsible for overseeing that it complied with all licensing conditions and requirements needed to make an OIA request before receiving a copy.)

13 April 2017 – Family requests review of the WorkSafe report

The toddler’s family wrote to the Ombudsman, requesting a review of the WorkSafe report:

... as we believe the review has flaws, lacks detail, fails to fully consider all the available information, and lacks a convincing recommendation for action.

4 May 2017

The Ombudsman referred the family to WorkSafe’s CEO instead.

22 May 2017

The toddler’s family sent its written critique and request for a review of the WorkSafe report to the CEO of WorkSafe.

11 August 2017 – Request for review of the WorkSafe report declined. Family’s criticisms of the report and WorkSafe’s corrections were not shared by WorkSafe with the education ministry.

A WorkSafe chief inspector replied to the family’s letter and stated that the report was final and there would be no review because he believed the outcome of the investigation would be the same if it were reviewed – “*there was not a breach of the Health and Safety at Work Act 2015*”.

He wrote that he intended to provide a copy of the family’s letter and his response to the Ministry of Education and Ministry of Health. He added that he would also provide an addendum to the report to correct factual errors. (Information supplied on 9 August 2018 through an OIA request to the Ministry of Education suggested that the ministry did not have a copy of the family’s letter to WorkSafe regarding the WorkSafe report. There was no addendum on the ministry’s copy of the WorkSafe report to correct factual errors. That the information was not passed on to the education ministry has subsequently been confirmed.)

16 May 2018

I (Sarah Alexander) made an Official Information Act request to the Ministry of Education for information it had concerning the incident and Little Lights Kindy. OIA requests must be answered within 20 working days making 14 June 2018 the latest date for the Ministry of Education to respond.

1 June 2018

The Ministry of Education informed me I could expect a response to the request by 12 July 2018.

12 July 2018

The Ministry of Education informed me it would release the information ‘in the coming days’.

3 August 2018 – two years after the incident the toddler’s family receives its first contact (a voice message) from the Ministry of Education.

I emailed the Ministry of Education to ask when the information request would be met. The Ministry replied that the delay was because it had been trying to contact the family before the information release and it was “*hopeful that we will be able to do this next week*”. (This was an odd reply as the ministry surely would have had the family’s details on its record of the incident and/or staff in the Rotorua region would have known how to contact the family).

So I forwarded the email of the ministry contact person dealing with the information request to the parents and asked them to contact the ministry and confirm they knew that I had asked for information on the incident. The family received its first contact from the Ministry of Education since the incident in 2016 by way of a voice message on the mother’s phone on 3 August 2018.

9 August 2018

The Ministry of Education released information with some details/parts redacted. The information supplied and a letter attached revealed that the education ministry seemed to have taken the role of a ‘cleaner’ after the serious incident. It had taken steps to hide/minimise the incident. Its primary concern was to support the service.

- The education ministry had not carried out a full licensing inspection of the daycare to physically check compliance with all licensing standards. (It may have assumed without any inspection and checking of policies and procedures that the daycare was operating

well and there were no breaches in standards? Or perhaps there may have been some other reason such as its previous experience in dealing with Evolve Education in 2015 when it was non-complaint?)

- The education ministry had not documented the scene, interviewed staff, parents or others at the scene, apart from talking with the centre manager.
- Even though the toddler and his family were the people most affected by the incident the ministry had made no contact with the family. It had not asked for the family's reactions and views on the incident to assist it in determining what course of action to take with the daycare.
- The education ministry had not carried out any form of review of first aid training for early childhood teachers after the incident to see what improvements could be made (it could find no documents relating to having done this).
- The WorkSafe report stated that "*the only failure of the kindy*" was that it served raw apples to toddlers but the Ministry of Education redacted/blacked out the phrase "*the only failure*" in its copy of the report it supplied to me which suggests it does not want this to be known (or perhaps it disagrees with WorkSafe on this but does not wish to say so?)

12 September 2018

The toddler's family wrote to WorkSafe's chief executive concerning timelines and whether it had passed on the family's response to its report to the Ministry of Education as promised.

17 September 2018

A WorkSafe investigator replied to the family's letter:

I unreservedly apologise that your letter (from May 2017) and my reply were not passed to the Ministry of Education in August 2017.

1 October 2018

The family asked WorkSafe about the advice it had issued following its investigation:

On the WorkSafe investigation into my son's accident in 2016, it is handwritten on the report that [name], Mgr Comms? (I can't read it) has the report and is preparing an industry wide communication outlining issues to be sent out - . Could you please direct me to where I can find this communication?

23 October 2018

WorkSafe replied to the family's question on its promised industry-wide communication:

.. after further consideration it was decided that this type of information provision falls under the Ministries of Education and/or Health, not WorkSafe. It would be up to them to consider if any industry-wide communication is required.

WorkSafe's response

It would appear that WorkSafe fell short in meeting its three primary purposes which are to:

1. Provide an informed explanation of what occurred.
2. Help reduce the risk of the occurrence or recurrence of harm to people or adverse effects on the environment arising from similar hazards or situations.
3. Identify and respond appropriately to any breaches of regulation.

WorkSafe concluded that there had been no breaches of the Health and Safety at Work Act, 2015 at the daycare. Even so:

- The report noted that *"Little Lights Kindy had not listed choking as a hazard on its hazard register, but choking is a well-known risk when dealing with young children and toddlers."*
- The evidence suggests that WorkSafe failed to look into the first aid administered to the toddler by the daycare staff and whether this may have been a contributory factor in his going into cardiac arrest and suffering serious and permanent injury.
- The evidence suggests that WorkSafe did not consider the responsibility of the duty holder (who possibly was the centre manager) in providing a menu that included food known to be a high choking risk, and not removing the potential choking hazard on seeing it being served to the children. It did not consider the responsibility of her employer (Evolve Education) to ensure staff had training in hazard identification and health and safety.
- It would appear that it interviewed only the centre manager and did not personally interview all staff.
- It did not check facts fully. For example, WorkSafe reported that the centre manager told it "that parents were aware of the type of food given to the children ... menus are prepared and available for all parents to view and comment on". However, the toddler's parents said that when enrolling at the daycare they had asked for a copy of policies and were given a booklet with no information on food in it and they were not aware that there were any menus to view.
- WorkSafe could not, and did not identify if the daycare had breached any regulations for the protection of children and health and safety under the Education (Early Childhood Services) 2008 Act. Therefore why did WorkSafe not consult with the Ministry of Education more and make sure that if it could not identify and respond appropriately to any breaches in regulations then the ministry would?

WorkSafe concluded that all reasonable steps had been taken to prevent injury by *"peeling the apple and slicing the apple into bits"*. But according to health guidelines a young child can choke on a bit of raw apple, peeled or unpeeled. To reduce the risk, apple must be cooked until soft or grated or mashed -- or perhaps eliminated from the menu.

WorkSafe did not follow-up with the Ministry of Education as it had promised the family it would, to ensure the ministry establishes if *"foods such as apples, carrots, pears and celery"* should either be *"eliminated"* or *"finely grated to help to minimize the risk of choking"*.

WorkSafe did not provide the ministry with a copy of the family's detailed critique of its report as and when promised.

The family believed that WorkSafe had issued an industry-wide communication following the incident, and more recently learnt (after directly asking) that this did not happen.

The Ministry of Education's response

Nothing is more important than the safety and wellbeing of our children.

(Deputy Secretary of sector enablement and support Katrina Casey, 11 July 2018 commenting on the ministry's ongoing commitment to giving parents confidence in the early childhood sector when it released statistics on complaints against ECE services in 2017)

An examination of the evidence suggests that in this case supporting the operation of the daycare business was more important to the education ministry than the safety and wellbeing of any child.

The ministry failed to investigate the actions that led to the incident. It erred in not interviewing all staff present personally, and did not talk to the parents of the child.

The incident was very serious yet the ministry did not undertake a new licensing check of the centre for potential non-compliance.

The education ministry was unconcerned about the first aid given to the child at the centre and did not look into this even though accounts appeared confused. A blind finger sweep of the mouth risks pushing the object in more deeply and the Heimlich Manoeuvre (abdominal thrusts) is not recommended first aid for young children who are choking.

The incident did not trigger a review of the effectiveness of first aid training required of staff working in the early childhood sector.

The Ministry of Education holds responsibility for licensing services and ensuring services fully comply with the Education (Early Childhood Services) Regulations 2008. The regulations state that the service provider (defined as "the body, agency, or person who or that operates the centre" must:

- take all reasonable steps to promote the good health and safety of children (Regulation 46, 1a),
- take all reasonable precautions to prevent accidents among children (Regulation 46, 1b), and
- ensure that no child is ill-treated (Regulation 56, 1).

The Ministry of Education sets criteria for meeting the regulations and it uses the criteria to assess service compliance with the regulations. Within its criteria there is nothing that specifically says that it will not allow centres to give high risk food such as raw apple to children. *"Rather the requirement is about ensuring children are provided with foods that meet their nutritional needs. It is crucial that children are supervised while eating"*, (ministry response to a question put to it on this matter in September 2018).

The WorkSafe report on the incident stated that Evolve Education volunteered to stop providing food known to be a high risk choking hazard - an admission perhaps that it knew it had not been

taking all reasonable steps and precautions (even though the Ministry of Education had not asked it to do this or indicated that it needed to do this to meet regulations).

The incident would not have happened had raw apple not been on the menu and provided to the toddler. The risk of choking could have been reduced by grating or cooking the apple until soft. A mandatory requirement that services follow the Ministry of Health guidelines to reduce the risk of food related choking should be added by the Ministry of Education into its licensing criteria. But, the ministry has not yet made this change to its criteria. Ten years ago in 2008, a 14-month-old at a daycare centre choked on a piece of apple during morning tea and died six days later after his life support machine was turned off. His mother lobbied the education ministry to make it a requirement that apple is not given unless its texture is changed to reduce the risk of choking.

Legal opinion is needed to determine that when a service does not take all reasonable steps to ensure a child does not choke on food and all reasonable precautions are not taken to prevent accidental choking by following health advice, could this be seen as not meeting the intent of Regulations 46(1a, b)? Further, when the service provider and/or the centre manager approves food to be on the menu that is known to be high risk for children and a child subsequently suffers injury could this be seen to be ill-treatment or abuse and a breach of Regulation 56(1)?

Caring about the child and family

The Ministry of Education made no contact with the family to explain what happened, or to say it was sorry for their grief and hurt, or to check how they were, or to ask if they wished to make a complaint or ask if they had any questions.

The role of the Ministry of Education does not extend to advocating for the child and supporting the child's family when there is a serious incident involving the child. As the government's lead advisor on the education system the ministry's stated role is to contribute to government goals for education and support education providers – hence why the Ministry's Traumatic Incident team focused on ensuring that the centre business would be affected as little as possible by the incident. (role description retrieved 10 November 2018: <http://www.education.govt.nz/our-work/our-role-and-our-people/what-we-do>).

The service provider, Evolve, was no different. Individual teachers in their own time personally offered their sympathy and support to the family. Evolve however, made no acknowledgment, not even a letter to the family to say they were thinking of the toddler. Evolve lacked any real connection with the family and did not show an ethic of care. As an early childhood service operator it failed to work with and engage in positive and meaningful relationships supporting the child, parents and whānau (whanaungatanga).

Discussion

A breach of trust

The toddler's parents trusted that Little Lights Kindy, a Ministry of Education licensed and funded centre - that the Education Review Office reported very positively on - would have necessary safeguards in place to prevent harm. But their son was harmed, seriously and permanently, as a result of attending it.

Moreover, other children would likely have been affected by seeing one of their peers in severe distress and knowing that he was taken away in an ambulance never to return. The teachers administering first aid to the toddler noted that other children were upset and took the toddler to another room. Early emotional trauma can have implications for children's brain development.

Parents would be justified to question why the daycare centre in question was not taken to task over what the evidence suggests were abysmal failings in the appropriate care of its children.

Does the evidence point to a cover-up?

At any one time, 98% of services meet or exceed licensing standards.

(Katrina Casey, 7 October 2015 in the NZ Herald defending the quality of early childhood education and the ministry's monitoring of it)

This case raises two issues that bring into question the accuracy of the Ministry's claim about the proportion of services meeting or exceeding licensing standards.

First, the ministry has not told the public that there was a serious incident at the daycare. It took actions to keep the incident quiet. It did not check if the centre was meeting licensing standards. It dealt with the incident as it would deal with an unavoidable accident, such as a child falling over and scraping a knee, which would not be of public interest.

Second, other unrelated evidence obtained as part of the OIA request on the daycare suggests previous compliance issues did not result in downgrading the centre's licence to provisional. As outlined earlier in this report, in 2015 when the daycare changed ownership to Evolve, the ministry discovered there had been possible long-term use of floor space that did not have NZ Fire Service approval and other safety breaches but it allowed the daycare to continue to operate on a full licence.

Therefore it would seem that when there is a serious incident, licence checks of a service are not always undertaken to identify potential breaches. And, a non-compliant service can at the ministry's discretion continue to operate on a full licence and therefore be counted in ministry statistics as meeting or exceeding standards.

Who is ultimately responsible?

There were some major shortcomings on the part of WorkSafe, particularly in not carrying through on its intention to put out an industry wide communication on the issue and not passing on the family's response and amendments to its report to the Ministry of Education.

However, the Ministry of Education as the regulator is responsible for ensuring early childhood centres are safe places for children to attend and that no harm is inflicted on any child.

The serious choking incident at Little Lights Kindy was not the first to have occurred in early childhood education and it won't be the last unless changes are made. As mentioned above, the Ministry of Education was lobbied 10 years ago to make changes to reduce the risk to children of food-related choking, by the mother of a 14-month-old who died after also being given raw apple to eat at his daycare.

Recommendations

Arising from the above review of the evidence relating to the case of the toddler choking at an early childhood centre the key changes recommended are:

1. For the avoidance of any doubt and to make it very clear that high-risk food should not be given to children the Ministry of Education must not continue to delay adding the following into its licensing criteria: *"no child is to be provided food known to be a high risk for choking where the texture has not been altered to reduce risk, according to Ministry of Health guidelines for food safety."*
2. The first aid training requirements must be reviewed. Changes recommended are that: (a) all staff who are counted as first aid qualified in a centre must be able to correctly demonstrate in practice the recommended first-aid for an infant and a young child who is choking, and (b) more than the 1 teacher currently per 50 children should be required to hold a recognised first aid qualification especially in case of a serious incident that may require at least two adults to be involved in administering first aid, and in each classroom within a centre there should be at least one or more adults who are first-aid qualified.
3. Following every serious incident involving hospitalisation or death the Ministry of Education must carry out a full licensing inspection of the early childhood service. It should not be left to grieving family members or others to make a complaint against a service before the Ministry undertakes a compliance inspection.
4. The Ministry of Education must take steps to communicate with families following a serious incident, demonstrate an ethic of care to the child and family, and show it expects the same of service providers.
5. When a serious incident involving a child occurs the Ministry of Education must act to properly investigate and make its report publicly available. The report must include details on the actions and factors that led to the incident and what can be learned to reduce the chance of something similar happening again, thereby improving safety.
6. Better public education on foods that are high risk for choking and what adults and early childhood services can do to prevent food-related choking is something that the Ministry of Education needs to work with the Ministry of Health on.

7. And finally, in the early childhood sector we really need to see the Ministry of Education accepting responsibility along with it learning to be more open and transparent in its response to serious incidents.

Appendices

Food as a choking hazard

Claims accepted by the Accident Compensation show that on average more than one child under 4 years is choking each week in New Zealand. To require medical attention and an ACC claim means that it was a severe event, as most cases of choking are resolved. The statistics cover all causes of choking but food related choking is the most common cause.

TABLE 1: Count of choking-related claims for children lodged with the ACC between 1 July 2010 and 30 June 2018

| Age at Accident | Claim Count | | | | | | | |
|-----------------|-------------|-----------|-----------|------------|-----------|-----------|-----------|-----------|
| | 2010/11 | 2011/12 | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
| 0 | 31 | 42 | 27 | 45 | 38 | 25 | 33 | 37 |
| 1 | 29 | 10 | 11 | 25 | 31 | 21 | 25 | 38 |
| 2 | 9 | .. | 13 | 14 | 20 | .. | 9 | 9 |
| 3 | <4 | 6 | 5 | 5 | <4 | 8 | 6 | 8 |
| 4 | <4 | <4 | 8 | 13 | .. | <4 | 4 | 4 |
| Total | 72 | 64 | 64 | 102 | 98 | 62 | 77 | 96 |

Notes: A financial year is 1 July to 30 June. Only claims with an Accepted cover decision have been included.

Cell suppression of claim counts less than 4 is used or show as .. to ensure client privacy.

People at any age are susceptible to choking but children less than 5 years are particularly susceptible and especially children under 3. The Ministry of Health states that 70–90 percent of all choking incidents reported are in children under 3. Under-3s can choke easily as they have small air and food passages, are learning to move food around in their mouths and are learning how to bite, chew and grind food. They do not have all their teeth - second molars are needed to grind food successfully before swallowing and these are not usually fully erupted into the mouth and functioning until children are 2-1/2 years of age or older.

Small hard food is one example of foods that poses a high choking risk. Nuts, hard dried fruit, pieces of raw carrot, celery, apple, and corn chips and other small hard foods pose a high choking risk because these are difficult to bite through or break down enough to swallow safely. Altering the texture of food through cooking, grating and mashing can help to reduce the risk of choking. To reduce risk to a young child eating apple, the apple should be either cooked until soft or finely grated.

Reference: Ministry of Health (2008). *Food and nutrition guidelines for healthy infants and toddlers (aged 0 – 2). A background paper. Partially revised Dec 2012.* Wellington: Ministry of Health.

What to do for a choking infant or young child

An ambulance should be called if a child is not able to cough or cannot breathe.

Making sure the child is leaning slightly forward, tell the child to cough and encourage the child to keep coughing. Do not reach into the child's mouth unless the object can be seen to pull it out easily (a blind finger sweep of the mouth risks pushing the object in more deeply).

Treatment is necessary when a child does not have an effective or strong cough to force the object out.

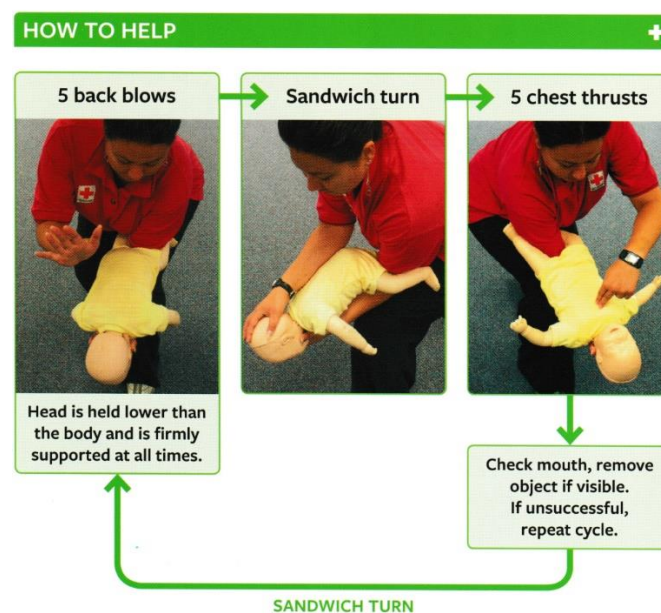
An infant or child who is small enough to be held should be treated in the following way:

- Holding the child across your thigh with head held lower than the chest, deliver up to five sharp back blows with the heel of one hand in the middle of the back between the shoulder blades (unless the object comes out before five are completed).
- If this does not work turn the child over and deliver up to five sharp chest thrusts to the breastbone with the child on their back, until the object comes out.
- If this does not work, repeat the back blows and chest thrusts until the object comes out.

But should the child become unconscious then CPR must be started immediately.

The NZ Red Cross, Essential First Aid Manual (2017, p. 30) provides a clear illustration of the appropriate actions to take (the illustration is reproduced below).

The actions for dealing with choking in a conscious infant are as follows:



A bigger child can be held standing and leaning slightly forward and treated in the following way:

- Between the shoulder blades deliver up to five sharp back blows with the heel of one hand in the middle of the back between the shoulder blades.
- If the object does not come out then give up to five chest thrusts. Do this with the child in front of you, wrap your arms around their chest and make a fist with one hand. Place one fist, thumb side, against the middle of the breastbone. Grasp the fist with the other hand. Give a quick inward thrust.
- Keep repeating five back blows then five chest thrusts until the object comes out.
- Should the child become unconscious then start CPR immediately.

References:

ANZCOR Guideline 2016, No. 4 – Airway. Retrieved from

<https://www.nzrc.org.nz/assets/Guidelines/BLS/ANZCOR-Guideline-4-Airway-Jan16.pdf>

NZ Red Cross (2017). *Essential first aid manual*. Wellington, NZ: NZ Red Cross.

Links to safety and food guidelines for ECE Services, Parents and Teachers

Lunch-box tips (an article for parents) <https://www.myece.org.nz/health-safety/63-lunch-box-what-to-pack>

Guidance for teachers and ECE services on ways to reduce the risk to children of food-related choking <https://www.childforum.com/education/care-safety-health-transitions-and-changes/healthy-and-safe-children/1045-prevention-choking.html>

Food and nutrition guidelines for healthy infants and toddlers

<https://www.health.govt.nz/system/files/documents/publications/food-and-nutrition-guidelines-healthy-infants-and-toddlers-revised-dec12.pdf>

ENDS.....