MINISTRY OF EDUCATION
TE TĀHUHU O TE MĀTAURANGA

# MEMO

**To:** Iona Holsted

**From:** Jocelyn Mikaere; Sean Teddy

**Cc:** 9(2)(a)

**Date:** 22 September 2022

**Subject:** Abbey's Place Childcare Centre Licence Review Process and recommendations for improvement

## Purpose

The purpose of this memo is to respond to your concerns about the process undertaken to investigate whether Abbey's Place Childcare Centre could or should have done more to prevent serious harm to Malachi Subecz. This includes considerations made by Te Mahau staff in the Bay of Plenty during the review and the decision to issue a provisional licence to Abbey's Place Childcare Centre in May 2022.

## Recommendations

1. We recommend that you:

   a. **agree** a change to our internal processes for decision making in cases where a child has experienced serious harm so that decisions are passed through and approved by the **relevant** Hautū of Te Mahau | Te Tai Raro (North), Te Mahau | Te Tai Whenua (Central), or Te Mahau | Te Tai Runga (South), in consultation with the Hautū of Te Pae Aronui.

   **Agree / Disagree**

   b. **agree** that the Early Learning Operations group within Te Pae Aronui, in conjunction with te Takiwā Hautū, uses what we have learned through the review of Abbey's Place Childcare Centre following the death of Malachi Subecz to inform regulatory work, including:

      i. a current state assessment of how we monitor safety checking and Child Protection policies to make recommendations for change;

      ii. the delivery of a blueprint for being a modern regulator as part of the Te Mahau work programme, including the development of specific recommendations for ECE regulatory practice; and

      iii. the establishment of an education sector regulatory group for agencies with regulatory accountabilities for education.

   **Agree / Disagree**

c. **note** that on 21 July 2022, an item on child protection was included within He Pānui Kōhungahunga | The Early Learning Bulletin.

**Noted**

d. **agree** that this memo be provided to the Secretariat for the Joint Review into the Children's Sector: Identification and response to suspected abuse (the Malachi Subecz review).

**Agree / Disagree**

Iona Holsted
**Te Tumu Whakarae mō te Mātauranga**
**Secretary for Education**

30 /09/22

## Background

1. This review commenced when the Ministry became aware that Malachi Rain Subecz, who had attended Abbey's Place Childcare Centre in Tauranga until 29 September 2021, had died in November 2021 due to abuse.

2. Te Mahau staff became aware of the passing of Malachi and his association with Abbey's Place Childcare through media coverage in May 2022. At the time of Malachi's death, he was not attending the centre and was not enrolled in a school (Malachi turned five years of age on 28 September).

3. The review focused on the actions of Abbey's Place Childcare Centre while Malachi was in its care. The review also focused on the policies, processes and procedures of Abbey's Place Childcare Centre and whether these were appropriate and followed with respect to Malachi.

4. In May 2022, you were made aware of the decision that had been made to issue a provisional license to the Centre. You raised concern that the highly serious nature of this situation had not led to any escalation or consideration beyond our standard process for responding to incidents in early learning services. You asked us to provide advice to you about how these processes could be strengthened. The current memo further responds to that request.

**Review of Abbey's Place Childcare**

5. The process undertaken to review Abbey's Place Childcare Centre was as follows:

    a. A visit to the centre was arranged.

    b. Two Te Mahau staff visited the centre to interview staff, complete a full site visit and check accident books.

    c. The Education Review Office (ERO) was contacted and information on non-compliance requested.

    d. Centre policies and procedures were reviewed by two Te Mahau staff.

    e. Discussions took place occurred with National Office staff.

    f. Further information was requested from the centre including photos, a timeline of events, curriculum documentation for Malachi, policies and procedures, and attendance records.

    g. Discussions with the Ministry's Legal team to discuss the outcome of the review process.

    h. Peer reviews occurred throughout the process.

    i. Final queries were put to Abbey's Place Childcare Centre.

    j. Final documentation was completed and peer reviewed by regional and national office.

    k. A Manager made the decision on the centre's licence, taking into account the relevant evidence and recommendation of staff. The Manager Education is delegated to make the decision.

l. Te Mahau staff met with staff at Abbey's Place Childcare Centre to communicate, through meeting and in writing, the rationale to issue a provisional licence and to request an Action Plan to meet the conditions of the provisional licence.

6. Staff leading the review were 9(2)(a) (ECE Senior Adviser, Rotorua) and 9(2)(a) (ECE Senior Adviser, Rotorua). The delegated decision maker was 9(2)(a) (Manager Education). Other staff supporting the review were 9(2)(a) 9(2)(a) (Principal Advisor – Bay of Plenty Waiariki), 9(2)(a) (ECE Senior Adviser, Rotorua), 9(2)(a) (Manager, Regulatory Assurance and Practice), 9(2)(a) 9(2) (Lead Adviser, Regulatory Assurance and Practice), 9(2)(a) (Lead Advisor ECE Whanganui), and 9(2)(a) (Senior Solicitor).

7. On 3 May, Te Mahau staff called Abbey's Place Childcare Centre to make an appointment to visit the following day. The centre was told the reasons for the visit.

8. On 4 May, ERO were contacted and agreed to share their report which was not due to be released until 18 May 2022. This report showed that there were two non-compliance matters identified related to the centre's emergency plan and supplies and medicine administration. The report concluded that these matters had been rectified and that ERO was satisfied the centre was now compliant.

9. On 4 May 2022, Te Mahau staff visited the centre and interviewed managers and staff. A full site inspection was undertaken during the visit and documentation was sighted.

10. The conversation focussed on Malachi and whether the centre had noticed signs of abuse. There was one incident where staff had noticed bruising on Malachi on 27 September 2021. The centre staff described following up with Malachi's caregiver on the cause of the bruising. The explanation provided was that it was due to him falling off his bicycle and playing at Chipmunks. Satisfied with the explanation, the centre did not escalate or investigate this incident further.

11. A handwritten note is on file at the centre with details of the incident dated ***27 September 2021*** with the following information:

    a. *"Noticed a big egg/bruise on Malachi's forehead. Further noticing more bruises on his chin, and blackness under his eyes. Taken photos. Carer asked about bruises response = bike accidents. Asking Malachi if he fell from his bike answer was no. When asked about what happened he said Macala wont be happy and wanted a cuddle."*

12. Centre staff had not completed an incident report form. When asked if Oranga Tamariki had been contacted in relation to this incident, centre staff advised this had not happened.

13. Following a request from Te Mahau staff on 5 May 2022, a timeline of events relating to Malachi between March 2021 and September 2021 was received from Abbey's Place Childcare Centre. Notably, the information between 27 and 29 September 2021 stated:

    a. 27 September 2021: When Malachi was dropped on 27 September 2021 bruising was noticed on his chin and under his eye. When staff contacted the Manager of the centre who was on 9(2)(a) leave, she contacted the caregiver as per the centre's policy. The caregiver provided an explanation, pictures were taken, and a note was placed on Malachi's file. There had been no prior incidents noted that gave cause for concern and these steps were taken as a precaution, per the centres policy.

b. 28 September 2021: Malachi celebrated his fifth birthday at the centre. According to the centre, he brought in a cake and was his usual 'bubbly' self.

c. 29 September 2021: Malachi attended the centre for the last time. The school holidays were beginning, and the centre was informed that he was going to attend Te Puna Primary School. We have since learnt however that Malachi did not attend the school. We understand that when an attempt was made to enrol him, his carer did not have the appropriate documentation for the enrolment to be completed, so was unable to enrol.

d. The service did not identify any concerning non-attendance patterns or have any concerns with the reasons provided when Malachi was absent. There were some absences recorded. If he was away the service would follow up with a text message and these were responded to with explanations which were recorded.

14. During the course of the review, all documentation was entered into Kbase. A team of national and regional staff were involved in the review and the process of making recommendations. Documentation was peer reviewed at a regional and national level.

15. A full timeline of contact between Te Mahau staff with the centre since the case was reported is provided at **Annex 1**.

**Findings of Review – May 2022**

16. Following the review in May, Ministry regional staff were satisfied that the contents of the centre's child protection policy meets requirements. The policy documents are dated January 2021 and February 2021. The policy is due for review in 2023.

17. Ministry regional staff were also largely satisfied there is a procedure that sets out how the service will identify and respond to suspected child abuse and/or neglect.

18. However, they were not satisfied that:

a. the centre followed their policy and procedure, nor that they took reasonable steps to consider whether the information available to them indicated there was a risk to Malachi's safety;

b. effective governance and good management practices have been demonstrated in relation to this incident.

19. The regulatory requirements that were identified as not being satisfactorily met include: Reg 46 Health and Safety General and Reg 47 Governance, management, and administration. HS27 Medical assistance and incident management policy and procedure also failed to meet regulatory requirements. These regulations are set out in **Annex 2**.

20. On 17 May 2022, following their review of the centre's policies and practices, Te Mahau staff met with service provider 9(2)(a) and centre manager 9(2)(a) to communicate the rationale to issue a provisional licence. A letter was issued providing the detail in writing. Staff requested an Action Plan outlining how the service will meet the conditions of the provisional licence.

21. The provisional licence clearly set out the conditions the centre must meet. The centre provided a plan to show how it would rectify the areas of non-compliance. The centre was given until 22 July 2022, a period of around 9.5 weeks, to provide evidence in relation to this.

22. The compliance timeframe is set in relation to the specified conditions required. The Regulations say this will usually be a date no more than 3 months from the date the provisional licence is issued. We are also able to set very short timeframes, eg 1-2 weeks, if we consider there is a health and safety risk to children. In this case it was agreed the centre needed more time due to the conditions requiring a formal review.

**Action Plan and Support to Centre – May 2022**

23. Te Mahau staff made weekly visits to the centre regarding confirmation of next steps for the review process and engagement.

24. Abbey's Place Childcare Centre had a teacher only day on 27 May 2022 to begin addressing the Action Plan. Staff also participated with 9(2)(a) (Ministry of Education strengthening early learning opportunities (SELO) provider) on Child Protection professional development.

25. The centre manager had advised that they were in the process of changing the incident forms and processes.

26. A monitoring visit occurred on 14 June, at which it was noted that the centre had:

    a. participated in PLD with 9(2)(a) and completed reflections of the PLD provided;

    b. begun an internal evaluation process;

    c. started to address the actions set in relation to the regulations;

    d. appointed two head teachers who are developing processes to strengthen the chain of responsibility within the centre; and

    e. begun work to strengthen their processes for communicating with other agencies in relation to children in care, documentation and day to day contact.

27. The Senior Advisor reported that the centre was motivated to meet the criteria. Weekly visits continued until 22 July, when the evidence for meeting the conditions of the provisional licence was due. The service met the agreed timeframe for providing evidence.

**Your request to review our process**

28. In May 2022, you were made aware of the decision that had been made to issue a provisional license to the Centre. You raised concern that the highly serious nature of this situation had not led to any escalation or consideration beyond our standard process for responding to incidents in early learning services. You asked us to provide advice to you about how these processes could be strengthened. The current memo responds to that request.

**Subsequent events - Notice of Intention to Cancel (August 2022)**

29. After considering the evidence provided by the centre on 22 July, a preliminary decision was made to issue a Notice of Intention to Cancel (NIC) the centre's licence. This is because two of the conditions specified in the provisional licence had not been complied with by the date specified for compliance, as further detailed.

30. The assessment of evidence of the information provided to demonstrate compliance with the condition relating to regulation 46/HS27 showed that the service's amended

procedure and forms meet the minimum requirements for responding to injury, illness and incidents.

31. However, the assessment of the evidence relating to compliance with regulation 47, in relation to the internal review of the situation that occurred on 27 September 2021, does not demonstrate that the centre has adequately identified failures in process and areas for improving policy/procedures as required by the condition. Although several policies and procedures have been amended, and additional forms have been created, these changes are not aligned with each other, creating confusion about which process to follow.

32. In addition, in relation to regulation 46(1)(a), the assessment of the evidence provided does not demonstrate that the multiple procedures that set out how the service will identify and respond to suspected child abuse or neglect (including the "Child Protection Policy and Guidance") have been reviewed by all governance, management and staff, and that all such persons are familiar with the procedures.

33. The decision to issue the Notice of Intention to Cancel the centre's licence was supported by peer review and our legal team.

34. The Notice of Intention to Cancel (the notice) was issued on 18 August 2022. Under the statutory delegations framework, this notice was signed and issued by the Manager Education. The centre had two weeks to respond to the notice, per the legal process. They have the right to seek their own legal representation and have done so.

35. On 19 August 2022 we were advised that the centre had engaged 9(2)(a) to represent them; and that an extension of two working days, to 2 September 2022, was granted for response to the notice.

36. A large amount of information was submitted by the 2 September 2022 deadline and this is currently being reviewed by regional and national office teams, the Ministry's internal Legal team and external Crown Counsel.

**Support for the centre**

37. When the Ministry closes an early childhood service, a regional staff member is assigned to work with the families of the children. They provide information on all the services operating in the area and provide support to find another centre. The Ministry also has the option to engage an external contractor to carry out this work on our behalf.

38. We note the centre currently has around 40 children booked in daily. They are licensed for up to 47 children. The service has had new enrolments during the provisional licence period. We understand parents have asked about the work they are doing and are in support of the service.

39. The centre employs seven permanent staff, five of whom are qualified, certified teachers. It also employs two relievers, one of whom is qualified and registered, and one who is qualified and unregistered. We note there is a shortage of teachers in Tauranga and if the staff at the centre choose to continue to work in the sector, there should be an opportunity for employment should the centre close.

## Improvements to the review process and sanctions framework

### Our standard review process should provide graduated and escalating responses

40. This review was carried out in the same way and following the same process as any other review we would undertake into incidents at an early learning centre. In reviewing our initial advice, you identified:

    a. concerns that our single, standard approach to the review process may be inappropriate for the range of incidents that occur;

    b. a lack of confidence in a review process that includes documentation being entered into Kbase, but does not include a report for decision makers that provides information, advice on options, and records decisions;

    c. concerns that the review was not sufficient to determine whether staff took reasonable steps to consider whether the information available to them indicated there was a risk to Malachi's safety; and

    d. concerns that the review was not sufficient to help identify whether the system could or should have done more to prevent serious harm being done to Malachi, and whether there were any barriers that prevented staff from identifying if there was a risk to safety and responding appropriately to this risk.

### Applying the sanctions framework

41. You have also queried whether a provisional licence was a sufficient response given the potential of the failure to report injuries, which in turn could lead to the death of a child.

42. From least to strongest, the sanctions available include: issuing a provisional licence; or suspending the centre's licence.

43. In this case, cancellation was considered by the staff involved in the decision-making, but was not recommended since:

    a. Non-compliance with the regulations does not provide a direct pathway to cancel the licence. Depending on the severity of the non-compliance, we must first go through either the provisional licence or suspension pathway.

    b. Direct licence cancellation is only available in very limited circumstances, such as if a service provider has been convicted of an offence against the regulations, or an offence involving serious harm to children, violence, or fraud.

44. Suspension was considered, but was not recommended because:

    a. Suspension in the first instance was considered by the staff involved in the decision-making process to be a disproportionate response.

    b. We can suspend a licence if we are satisfied on reasonable grounds that it is not in the interests of the children attending or participating in the service for the service to continue to operate.

    c. The staff involved in making the decision considered whether the risk posed by the past non-compliances makes it unsafe for children who are currently attending the service. In this situation:

        i. The service did not have a history of significant non-compliance.

        ii. Te Mahau staff assessed the compliance with some key safety and wellbeing requirements, such as supervision by the Person Responsible,

staffing ratios, and first aid qualifications. These key requirements were met on the day the centre staff noticed Malachi's bruises.

iii. Te Mahau staff did not consider that there were reasonable grounds to conclude that the service cannot continue to operate while the non-compliance matters identified were rectified.

iv. There was no evidence to suggest the service was aware of a pattern of recurring physical injuries for Malachi.

45. The Manager Education made the decision to reclassify the centre's licence as provisional, taking into account the relevant evidence and recommendation of staff.

46. The Manager Education believed that the centre had put sufficient measures in place to ensure the safety of the children currently attending. They further considered that issuing a provisional license would enable follow up actions to be put in place so that all policies and procedures would be followed correctly in the future.

47. On balance, a provisional licence was considered fair and reasonable by the staff involved in the decision-making process. The provisional licence clearly set out the conditions the service must meet. A period of around 9.5 weeks was provided for the centre to provide evidence in relation to these conditions.

***Improving the review and sanctions process for incidents where a child has experienced serious harm***

48. We propose changing our internal processes for making future decisions following reviews of incidents where a child has experienced serious harm. This will provide Te Ohu Poutoko members with better information and oversight of the review process, and certainty that the outcomes are appropriate.

49. Depending on your preferences for oversight, the Early Learning Operations group within Te Pae Aronui can draft advice to change the process so that decisions are passed through and approved by the relevant Hautū of Te Mahau | Te Tai Raro (North), Te Mahau | Te Tai Whenua (Central), or Te Mahau | Te Tai Runga (South), in consultation with the Hautū of Te Pae Aronui.

50. We considered whether decisions should instead be passed through and approved by Te Tumu Whakarae mō te Mātauranga | the Secretary for Education. However, this would remove a point of escalation, and we are not recommending this as an option.

51. We have also identified that, given all current sanctions were considered, and a provisional licence was determined to be the more fair and reasonable response in this case, further work is needed to ensure that our regulatory levers, particularly those in early learning, are fit-for-purpose and are being used appropriately.

52. The specific work that will support improved regulatory practice includes the development of a roadmap for change. This work will see te Takiwā Hautū on the governance group for this work. It would be completed by early December, and will include:

a. a current state assessment to be completed by mid to late September of how we monitor safety checking and Child Protection policies to make recommendations for:

b. a regulatory practice initiative to review current practice and make recommendations for a desired future state by the end of October. This planned work will now be completed as part of the Te Mahau work to develop a blueprint

for regulatory and system stewardship (education wide, not just ECE). The outputs will include specific recommendations for ECE regulatory practice; and

c. investigating and scoping an education sector regulatory group for agencies with regulatory accountabilities for education. This needs to be scoped and developed, and a paper will be provided to Te Ohu Poutoko to agree the approach. This will also be developed as part of the Te Mahau work to develop a blueprint for regulatory and system stewardship.

53. A draft framework and process map is included at **Annex 3**.

### Reminding early learning providers about child protection

54. The review found that while Te Mahau regional staff were satisfied that the contents of the centre's child protection policy met requirements, they were not satisfied that the centre followed its policy and procedure or that reasonable steps were taken to consider whether the information available indicated there was a risk to Malachi's safety.

55. On 21 July 2022, we included an item on child protection in He Pānui Kōhungahunga | The Early Learning Bulletin. This item emphasised that everyone has a role to play in protecting children, the importance of being able to recognise the signs of abuse and neglect, and to know what to do if a child protection concern occurs. It also included links to child protection resources. While licences are issued in perpetuity, Service Provider Service Providers are required to meet on-going compliance with all regulations and licensing criteria. Licensing staff have a focus on child protection issues and assess these when they are undertaking licencing visits. We also regularly schedule reminders in the regular Panui on trending issues such as safety checking and child protection.

Annex 1

## Timeline of Ministry Actions

**Tuesday 3 May 2022**

- 9(2)(a) was phoned by Principal Advisor to identify if any knowledge was held regarding the incident in September 2021.
- 9(2)(a) emailed PA and manager to discuss service visit and possible SELO support if needed.
- Phoned Service Provider (SP) to discuss incident and arrange a visit to the service the next day and discussed the purpose of the visit and the request of possible documentation. Followed up with a confirmation email.

**Wednesday 4 May 2022**

- Emailed and phoned the SP to request information to be provided and the process that will be undertaken by MoE.
- Started File Note process on Kbase.
- Emailed 9(2)(a) to ascertain if Malachi was enrolled in a school as the time of his passing.
- Discussed media requests and the services response with 9(2)(a) via email.
- Completed interview 9(2)(a) at the service with the service provider, centre manager and teacher who initially sighted the bruises, uplifted documentation, completed site visit, checked accident books, bathroom, sick and soiled area, sleep room, kai areas, outdoor space and both play spaces.
- Contacted ERO to see if there were any non-compliances identified during their evaluation of the service that had taken place. ERO provided me with the confirmed report that would not be published until 18 May. Two non-compliances identified HS7 Emergency plan and supplies and HS28 Medicine administration but had been rectified and ERO was satisfied these were no longer non-compliant.
- Unpacked via phone call with 9(2)(a) an overview of the service visit and documentation that was provided to Ministry of Education.

**Thursday 5 May 2022**

- 9(2)(a) reviewed policy, procedures, and practice and added commentary to policies. Commented on what practice had not taken place and what was possibly non-compliant.
- Emailed 9(2)(a) seeking support and possible next steps.
- Communicated with 9(2)(a) that 9(2)(a) supporting the region through this process.
- 3rd review of documentation completed within the region by 9(2)(a)
- Emailed service requesting that photos to be scanned through as the copy we uplifted were in black and white.
- Received a timeline of events, curriculum documentation for Malachi and policy and procedures from the service.
- Created table for 9(2)(a) that included criteria to be met, documentation provided and regional commentary.
- Emailed service again requesting a colour copy of Malachi's attendance records and to also give an update on the Trauma team contact psychologist.
- Emailed service centre manager thanking for the updated information that was received and stated that I would be in touch with next steps.
- 9(2)(a) and I spoke 5 times to discuss the documentation provided to MoE and regional observations.

**Friday 6 May 2022**

- Emailed the service provider and centre manager with further questions regarding clarification as to who had day to day care of Malachi, the address of the caregiver, specific start date for Malachi and were they aware of any school transition visits that had taken place for Malachi.
- Received an email from 9(2)(a) Trauma team psychologist stating that he had been in contact with 9(2)(a) the centre manager and the service manager 9(2)(a) is going to meet with the team during their teacher only day.

**Monday 9 May 2022**

- Emailed 9(2)(a) the table of evidence and the regional commentary.
- Received answers to queries from the centre manager.

**Tuesday 10 May**

- Contacted service provider with further questions for response by the end of today.
- Discussion with 9(2)(a) included clarity around what Ministry of Education is interested in, *if the service followed their policy and procedure, whether the service had provided training and guidance as to how to engage with their policy and procedure and if the service had reviewed their policy and procedure within the last three years.*
- Emailed the service provider again and spoke to the service provider to ascertain and confirm ask the above questions.
- Emailed three Lead advisors to complete the out of region peer review for this incident.
- Emailed 9(2)(a) that the KBase process will be ready for her review and that the outcome has yet to be determined.
- Sent the Kbase process for the initial out of region peer review for HS31 Child Protection.
- Peer review completed review of the HS31 Child Protection policy and procedure. The peer reviewer emailed 9(2)(a) feedback directly to me and 9(2)(a) with her outcome which included possible breaches for Reg 46 and 47 General which I supported via email response.

**Wednesday 11 May**

- Discussed with 9(2)(a) the regional peer reviewer feedback and possible next steps and if legal can have an input to the outcome of the evidence reviewed. As the region and out of region peer review concluded that the service did not fully engage with their HS31 Child Protection policy and procedure.
- Service provider provided a response to queries.
- 9(2)(a) met with Legal to discuss initial outcome of the review process.

**Thursday 12 May**

- 9(2)(h)
- Created a document alongside 9(2)(a) that includes commentary as to why the HS31 Child Protection policy and procedure meets and that some of the processes could be strengthened. Documented the practice that had taken place that did not meet the regulatory requirements for Reg 46 Health and Safety General and Reg 47 Governance, management, and administration. HS27 Medical assistance and incident management policy and procedure does not meet regulatory requirements.
- 9(2)(h) 9(2)(h) Discussed with 9(2)(a) the possibility of the service being suspended, instead of a provisional licence. It was decided that a provisional licence was appropriate for this incident considering the death of Malachi did not happen at the service and the incident had taken place in the past.

**Friday 13 May**

- Final documentation completed outlining the details of how Reg 46 Health and safety practices standard: general and Reg 47 Governance, management, and administration were non-compliant due to the engagement with the services HS31 Child protection policy and procedure.

**Monday 16 May**

- Kbase completed and sent for regional and national office peer review.
- Manager approval completed.
- Contacted service provider to arrange a meeting for the next day to deliver the provisional licence.

**Tuesday 17 May**

- Met with service provider 9(2)(a) and Centre Manager 9(2)(a) to communicate the rational to issue a provisional licence. Requested an Action Plan as to how the service is going to meet the conditions of the provisional licence and how to display the provisional licence in the service.
- Emailed the service provider and centre manager the provisional licence for display in their reception area and to confirm their teacher only day to start the policy review process.

**Wednesday 18 May**

- Centre manager emailed me 9(2)(a) and had a few questions regarding the requested action plan. Gave examples as to what this could look like to complete the review.

**Wednesday 18 May**

- Created timeline of events for 9(2)(a)

**Thursday 19 May**

- Reissued the licence due to a clerical error in the criteria to be met and emailed it to the service. Received action plan. Requested a copy of the self-review template that will be used for the internal evaluation.

**Monday 23 May**

- Received the StoryPark internal evaluation review process which includes regulatory requirements.

**Monday 23 May**

- Centre manager contacted me regarding queries she had about when and how the service documents information relating to the children that are enrolled in their service who are under the care of Oranga Tamariki. We discussed the need for court orders that state who has legal care for children and if they do not have this then who to contact and when this needs to be actioned. We also discussed when children come to the centre with marks on them and when to investigate and how this should be done.

**Wednesday 25 May**

- Service provider contacted me for further clarification regarding documenting information from Oranga Tamariki. He stated that they were in the process of creating new forms for any staff member to add information. We also discussed the Privacy Act and where they would store this information and who has access to this.

**Thursday 9 June**

- Centre manager contacted me to see if there was a possibility for the meeting to be postponed due to whānau challenges.
- Contacted the service back to arrange a meeting for the 14 June.
- Service stated that the teacher only day went ahead and that they have started the self-review and that staff and centre leaders/owner has attended 9(2)(a) Child Protection policy and procedure.
- The centre manager also stated that the service is continuing to work alongside 9(2)(a) for further support and guidance.

**Friday 10 June**

- Discussed with my manager 9(2)(a) changing the standard monitoring process with the service to weekly service meetings.

**Tuesday 14 June**

- Monitoring visit and review of the work the has taken place during the last month.

- The service has reviewed an updated their action plan and spoken into the actions that they have achieved and actions that they are continuing to work towards.

***HS27 Medical assistance and incident management***

- A service staff member has reviewed the policy and procedure. Changes have been made to strengthen the services response to serious accidents or illness that includes calling for an ambulance. The service has created a new Houora template for staff to complete to ensure that the whole team are aware of and can support tamariki with their health and well-being. Discussion during our monitoring meeting reflected further depth could be added to communicate for staff what a serious accident or illness could look like but not limited to. First draft of the review can be located on Kbase.

***Reg 46 Health and safety practices: general standard***

- The service has created another step in gathering information about children for their health and well-being for tamariki. This new Houora process will contribute to the services Child Protection policy and procedure that ensure "provisions for the service's identification and reporting of child abuse and neglect", and a procedure that sets out hour the service will identify and respond to suspected child abuse/or neglect".
- The owner, centre manager and some of the teaching staff attended 9(2)(a) Child Protection workshop.
- The whole team has attended Child Matters Child Protection professional development during their teacher only day.
- The service now has a copy of 9(2)(a) child protection policy and procedure which they are now reviewing and making their own.
- 9(2)(a) will continue to support the service with any further queries they may have.

***Reg 47 Governance, management, and administration***

- The service provider/owner has created two new head teacher roles that will support the centre manager and ensure that the service can manage the day-to-day operation if the centre manager is absent.
- The owner, centre manager and some of the teaching staff has attended 9(2)(a) Child Protection workshop.
- The service now has an updated copy from 9(2)(a) who delivers the Ministry of Education SELO professional development.
- 9(2)(a) will continue to support the service with any further queries they may have.

***Next steps identified at the 14 June meeting***

- Review the induction process for the two newly created roles for the head teachers to ensure that they are aware of their responsibilities as to how they manage the day-to-day operation of the service if the centre manager is absent.
- Review the next stages of the HS27 policy and procedure review to include what serious accident, illness and injury could look like but not limited to.
- Monitor and discuss each point in the criteria to be met to ensure this is incorporated in the internal evaluation.
- The service to review some of the reflective questions that are included in the internal evaluation to ensure that they are addressing the criteria to be met.
- Seek further information from the Ministry of Education website for HS31 and HS27 to support your internal evaluation and review of the policy and procedure for medical assistance.
- Continue to ensure that the service can provide evidence and documentation to support each stage of the internal evaluation.
- Continue to review the action plan and internal evaluation.

**Wednesday 22 June**

- Monitoring visit and review of the work the has taken place during the last week
  - Today's discussion included the purpose of creating an induction for the two new head teachers and how this process can support an understanding of their new role and responsibilities.
  - We also discussed how the induction process can support teachers practice and align with their professional growth cycle.
  - The internal evaluation "Noticing" section was discussed as to how the service could ensure that all the conditions are included, reviewed, and addressed.
  - We discussed the process as to what is required from a regulatory response when the service makes a Report of Concern to Oranga Tamariki and what information MoE will possibly request dependent on the incident observed.

***HS27 Medical assistance and incident management***

- The service has had a centre meeting on Monday 20 June to complete the 2nd review of the policy and procedure. These have been emailed through for MoE to review and feedback by Tuesday 28 June.

***Reg 46 Health and safety practices: general standard***

- The service has had a centre meeting on Monday 20 June to review the Child Protection policy and procedure that was provided by 9(2)(a)
- The service has provided MoE with the position descriptions, and employment contracts.
- The service has emailed through both head teachers' inductions this afternoon following our discussion this morning.
- The Child Protection policy and procedure will be reviewed by MoE, and feedback will be given to the service before the services next monitoring visit.
- The teaching team have discussed the PLD that they participated in from 9(2)(a) and Child Matters to inform and contribute to changes to the Child Protection policy and procedure.

***Reg 47 Governance, management, and administration***

- The service has had a centre meeting on Monday 20 June to review the Child Protection policy and procedure that was provided by 9(2)(a)
- The teaching team have discussed the PLD that they participated in from 9(2)(a) and Child Matters to inform and contribute to changes to the Child Protection policy and procedure.
- The Child Protection policy and procedure will be reviewed by MoE, and feedback will be given to the service before the services next monitoring visit.
- The service has provided MoE with the position descriptions, and employment contracts.
- The service has emailed through both head teachers' inductions this afternoon following our discussion this morning.

***Next Steps identified at 22 June meeting***

- The service is going to strengthen the "Noticing" section of the internal evaluation to include the criteria to be meet as indicators within the reflective questions.
- The updated internal evaluation will be provided to MoE by the next monitoring visit.

**Wednesday 29 June**

- Monitoring visit and review of the work the has taken place during the last week.
  - Today we discussed the next steps for the report of concern that the service has made to Oranga Tamariki. I have requested that the service continue to email through communication between the service and Oranga Tamariki.
  - Discussion was also had as to what the overall internal evaluation will look like for the final review and assessment. The service will create a folder that will include sections that reflect each stage of the review process and supporting documentation.

- The initial review of the Child Protection policy and procedure requires changing old agency names, providing more details regarding processes to enable clear transparency as to what is expected.
- Discussed providing MoE with the supporting policies and procedures that are referred to in the Child Protection policy and procedure. These will be reviewed to ensure compliance.

***HS27 Medical assistance and incident management***

- The service has provided a procedure as to how they will respond to injury.

***Reg 46 Health and safety practices: general standard***

- The service has amended some of the reflective questions included in the criteria to be met but the remainder of the actions requires inclusion for the service to meet the criteria for the provisional licence.
- Further reflections have taken place as to teacher practice and understanding as to the actions that have been undertaken to date. Changes have been made to the services Child Protection policy and procedure.

***Reg 47 Governance, management, and administration***

- The service has amended some of the reflective questions included in the criteria to be met but the remainder of the actions requires inclusion for the service to meet the criteria for the provisional licence.
- Further reflections have taken place as to teacher practice and understanding as to the actions that have been undertaken to date. Changes have been made to the services Child Protection policy and procedure.

***Next Steps identified at 29 June meeting***

- Update the action plan and provide to MoE.
- Requested the service to provide Ministry of Education further documentation for HS27 Medical assistance and incident management that includes a procedure outlining the services response to illness and incidents, including the review and implementation of practices as required.
- The service has been encouraged to engage with the Ministry of Education website to ensure that all policies, procedures, and practice meet the Licensing criteria for centre-based education and care services (2008).
- Implement the requested changes to the Child Protection policy and procedure to ensure the services procedures are clear and transparent for staff members to follow.
- Provide MoE with Child Protection policy and procedure supporting policies and procedures, GMA7 Human resource management-induction procedure, GMA7A Safety checking policy and procedure, and C10 Positive Guidance for review to ensure compliance.
- Continue with documenting the internal evaluation on StoryPark. As Ministry of Education does not have access to StoryPark therefore the service has been asked to create a hard copy of the internal evaluation that can be scanned onto Kbase.

**Wednesday 6 July**

- Monitoring visit and review of the overarching work the has taken place during the previous week.
  - Briefly discussed the services media response is consistent with what 9(2)(a) had communicated on Friday 1 July.
  - Reviewed the updated changes made to the Child Protection policy and procedure and the supporting policies and procedures.
  - Agreed upon the plan going forward for the remainder of the provisional licence.
  - Discussed the progress made with the three reviews and how the service has now created three internal evaluations that aligns with the criteria to be met.
  - Agreed upon several different mediums for whānau and Kaiako to contribute to the review of the updated policies and procedures.
  - Discussed what the three reviews will look like for MoE to upload to their system for the purpose of reviewing the information for each criteria to be met.

***HS27 Medical assistance and incident management***

- The service has changed the format of the review for this criteria to be met onto StoryPark.
- The review process is now consistent with the other two remaining internal evaluations.
- The service has sought guidance from peers in the sector as to what should be included in the policy and procedure that aligns with the licensing criteria for centre-based education and care services 2008.
- The policy has depth to the procedures for how the service will respond to accidents, illness, and incidents.

***Reg 46 Health and safety practices: general standard***

- The service had created one internal evaluation that encompassed all the requirements for Reg 46 and Reg 47 criteria to be met.
- Once the discussions had taken place that each criteria to be met had to be addressed and included in the internal evaluation the service decided to create an internal evaluation for each criteria.
- The Noticing section includes all the requests from National office.
- The service is following their process and reviewing and updating policies and procedures each week. This is then added to the internal evaluation.
- The service understands that if a piece of information is used for both evaluations that they must include this in each one.

***Reg 47 Governance, management, and administration***

- The service had created one internal evaluation that encompassed all the requirements for Reg 46 and Reg 47 criteria to be met.
- Once the discussions had taken place that each criteria to be met had to be addressed and included in the internal evaluation the service decided to create an internal evaluation for each criteria.
- The Noticing section includes all the requests from National office.
- The service is following their process and reviewing and updating policies and procedures each week. This is then added to the internal evaluation.
- The service understands that if a piece of information is used for both evaluations that they must include this in each one.

***Next Steps identified at 6 July meeting***

- Thursday 7 July- Complete an update of the Action plan and email to 9(2)(a) by 5pm.
- Friday 8 July- 9(2)(a) will have completed a review of the services HS31 Child Protection policy, procedure, and supporting policies and procedures, and the services HS27 Medical assistance and incident management. The feedback will be added to each policy and procedure and returned to the early learning service by midday Friday.
- Tuesday 12 July-Abbey's place will email 9(2)(a) by midday the updated policies and procedures for review. 9(2)(a) will email any further feedback to the early learning service by 5pm.
- Wednesday 13 July-Complete service visit. Discuss any final amendments for policies and procedures before they go out to whānau and Kaiako for review. Service will upload the policies and procedures to StoryPark for whānau and Kaiako for review. Service may also discuss the reviews in person with whānau and Kaiako and include communication the services private Facebook page.
- Friday 15 July- Service will collate the feedback from whānau and Kaiako and add these to each of the three internal evaluations.
- Wednesday 20 July- 9(2)(a) will complete a final monitoring visit to ensure that all three internal evaluations include all supporting documentation, and that the overarching reviews follow the services process. Feedback will be given if any changes are required.

- Friday 22 July- Final service visit by 9(2)(a) to uplift the three internal evaluations. This will be uploaded MoE internal system, and the review process will take place.

**Wednesday 13 July**

- Monitoring visit and review of the overarching work the has taken place during the previous week.
  - Discussed the services process for a report of concern for a child who is enrolled at their service.
  - Requested that the service follow up with the report of concern and provide MoE with an update as to the child's general health and well-being and if they have any further concerns.
  - The service has provided MoE with the requested policies and procedures. This was confirmed to the service via email yesterday.
  - The service is continuing with their review process and 9(2)(a) has stated that they will consult with their whānau community and teaching team for any feedback on their reviewed policies and procedures.
  - 9(2)(a) also stated that they are continuing to update their internal evaluation.
  - Discussion regarding next week's Wednesday visit where 9(2)(a) will confirm with us an appropriate time to uplift the final documentation on Friday the 22 July.

***HS27 Medical assistance and incident management***

- The service has confirmed that they are continuing with their internal evaluation process.
- The service has also stated that they are adding analysis of their investigations, and evaluations of their findings to the internal evaluation.
- The service has stated that as part of their internal evaluation process they will provide reviewed policies and procedures to whānau and the teaching team for feedback.

***Reg 46 Health and safety practices: general standard***

- The service has confirmed that they are continuing with their internal evaluation process.
- The service has also stated that they are adding analysis of their investigations, and evaluations of their findings to the internal evaluation.
- The service has stated that as part of their internal evaluation process they will provide reviewed policies and procedure to whānau and the teaching team for feedback.

***Reg 47 Governance, management, and administration***

- The service has confirmed that they are continuing with their internal evaluation process.
- The service has also stated that they are adding analysis of their investigations, and evaluations of their findings to the internal evaluation.
- The service has stated that as part of their internal evaluation process they will provide reviewed policies and procedure to whānau and the teaching team for feedback.

***Next Steps identified at 13 July meeting***

- Requested that the service will provide me with an updated action plan.
- The service will continue to process the incident regarding the report of concern with Oranga Tamariki.
- Requested that the service contact Oranga Tamariki for an update as to their response for the report of concern.
- We have requested the service provide an update for the health and well for the child who the service made a report of concern to Oranga Tamariki.

**Wednesday 20 July**

- Monitoring visit and the overarching review of the work the has taken place during the previous week.
  - Discussed updating the services Action plan to included dates next to the weekly update.
  - Followed up with the Report of concern for 9(2)(a) ..no further communication from Oranga Tamariki regarding 9(2)(a) that the service should be aware of. 9(2)(a) commented that she will follow up with OT. The mother dropped off 9(2)(a) at the service today.
  - The service is going to email me to confirm what time they will either drop the information off to Ministry of Education Tauranga office or if they would like me to pick it up and what time they will be ready for this on the 22 July. I did also inform 9(2)(a) that the office closes at 4:30 pm.
  - We also discussed an accident that had taken place at the service and the process that they have undertaken. The service is going to email me all the documentation. The child who has had the accident is under the care of Oranga Tamariki. An incident will be created and uploaded on Kbase.
  - 9(2)(a) asked if there was a possibility what could the outcome be from the report to Teaching Council. My response included that I couldn't comment on Teaching Council processes and that she could contact them.
  - 9(2)(a) also stated that she has submitted her responses pertaining to her personal involvement for the criteria to be met for the provisional licence, to her lawyer for review.

***HS27 Medical assistance and incident management***

- The service commented that they are tweaking their internal evaluation process and documentation.
- The service has also stated that they are adding analysis of their investigations, and evaluations of their findings to the internal evaluation.

***Reg 46 Health and safety practices: general standard***

- The service commented that they are tweaking their internal evaluation process and documentation.
- The service has also stated that they are adding analysis of their investigations, and evaluations of their findings to the internal evaluation.

***Reg 47 Governance, management, and administration***

- The service that they are tweaking their internal evaluation process and documentation.
- The service has also stated that they are adding analysis of their investigations, and evaluations of their findings to the internal evaluation.

**Friday 22 July**

- Received all the documentation and evidence from Abbey's Place by 3pm.

**Monday 25 July**

- Early Learning team met to plan the process for examining the details of each specific breach and gather preliminary thoughts.

**Tuesday 26 – Wednesday 27 July**

- 9(2)(a) and members of the team required for peer review met to detail the conditions needing to be met and matching the evidence provided to each specific breach.
- Logging and progressing of further complaints and incidents (mostly from ex-staff members and involving staff: child ratios) as they contribute to the overall picture.

**Thursday 28 July**

- Progression of initial analysis and finding out of the region for peer review.

**18 August 2022**

- Notice of Intention to Cancel issued to the centre

**Annex 2**

## Regulations

### 1. Education (Early Childhood Services) Regulations 2008

**Regulation 46(1)(a)**

46 Health and safety practices standard: general

(1) The health and safety practices standard: general is the standard that requires every licensed service provider to whom this regulation applies to—

(a) take all reasonable steps to promote the good health and safety of children enrolled in the service.

**Regulation 47(1)(a)**

47 Governance, management, and administration standard: general

(1) The governance, management, and administration standard: general is the standard that requires every licensed service provider to whom this regulation applies to ensure that—

(a) the service is effectively governed and is managed in accordance with good management practices;

### 2. Extracts from Licensing criteria for Early Childhood Education & Care Services 2008

**HS7 Emergency plan and supplies** *Criteria – Health and safety practices criterion 7*

There are a written emergency plan and supplies to ensure the care and safety of children and adults at the service. The plan must include evacuation procedures for the service's premises, which apply in a variety of emergency situations and which are consistent with the Fire Evacuation Scheme for the building.

Documentation required:

A written emergency plan that includes at least:

1. An evacuation procedure for the premises.
2. A list of safety and emergency supplies and resources sufficient for the age and number of children and adults at the service and details of how these will be maintained and accessed in an emergency.
3. Details of the roles and responsibilities that will apply during an emergency situation.
4. A communication plan for families and support services.
5. Evidence of review of the plan on an, at least, annual basis and implementation of improved practices as required.

*Rationale/Intent:*

*The criterion aims to uphold the safety of children by:*

- *ensuring that the service has an adequate evacuation procedure for a range of emergency situations, and resources*
- *sufficient emergency supplies and resources for the children and adults likely to be at the service.*

*Amended May 2015*

**HS27 Medical assistance and incident management** *Criteria – Health and safety practices criterion 27*

All practicable steps are taken to get immediate medical assistance for a child who is seriously injured or becomes seriously ill, and to notify a parent of what has happened.

Documentation required:

1. A record of all injuries, illnesses and incidents that occur at the service. Records include:
    - the child's name;
    - the date, time, and description of the injury, illness or incident;
    - actions taken and by whom; and
    - evidence that parents have been informed.

2. A procedure outlining the service's response to injury, illness and incidents, including the review and implementation of practices as required.

*Rationale/Intent:*
*The criterion aims to uphold the health and safety of children by ensuring that children who fall ill or are injured are given appropriate care.*

*Amended May 2016*

**HS28 Medical administration** *Criteria – Health and safety practices criterion 28*

Medicine (prescription and non-prescription) is not given to a child unless it is given:

- by a doctor or ambulance personnel in an emergency; or
- by the parent of the child; or
- with the written authority (appropriate to the category of medicine) of a parent.

Medicines are stored safely and appropriately, and are disposed of, or sent home with a parent (if supplied in relation to a specific child) after the specified time.

Documentation required:

1. A record of the written authority from parents for the administration of medicine in accordance with the requirement for the category of medicine outlined in Appendix 3.

2. A record of all medicine (prescription and non-prescription) given to children attending the service.

Records include:

- name of the child;
- name and amount of medicine given;
- date and time medicine was administered and by whom; and
- evidence of parental acknowledgement. Related to clause 46 (1)(b) of standard.

*Rationale/Intent:*
*The criterion aims to uphold the health and safety of children by ensuring that children are given proper care, and that medication is not administered inappropriately by services.*

*Amended May 2015*

**HS31 Child Protection** *Criteria - Health and safety practices criterion 31*

There is a written child protection policy that meets the requirements of the Vulnerable Children Act 2014. The policy contains provisions for the identification and reporting of child abuse and neglect, and information about how the service will keep children safe from abuse and neglect, and how it will respond to suspected child abuse and neglect.

The policy must be reviewed every three years.

Documentation required:

1. A written child protection policy that contains:

a. provisions for the service's identification and reporting of child abuse and neglect;
b. information about the practices the service employs to keep children safe from abuse and neglect; and
c. information about how the service will respond to suspected child abuse and neglect.

2. A procedure that sets out how the service will identify and respond to suspected child abuse and/or neglect.

*Intent:*
*Child protection policies support children's workers to identify and respond to vulnerability, including possible abuse and neglect.*

*Amended 26 February 2016*

| | Regional ECE Te Mahau team | | Regional Te Mahau Hautū | ECE Regulatory Practice and Assurance | Legal services | Te Pae Aronui Hautū | CE office |
|---|---|---|---|---|---|---|---|
| Become aware of incident | • Initiate and follow process for managing incident notifications.<br>• Gather as many facts as possible and escalate to RAPS and Hautū<br>• Engage Traumatic Incident team as appropriate<br>• Notify/engage appropriate agencies* | Keep up to date records in Kbase incident workflow – including attaching Hautū decision making | • Assume responsibility for the situation and delegated decision making | • Engage with regional team.<br>• Gather as many facts and brief ADS, TPA Hautū<br>• Brief legal as necessary | | • Review material and information to support CE from national perspective | Advise Minister' s Office as necessary |
| Consider provisional licence or suspension | • Recommendation to Hautū (regardless of recommendation) | | • Make decision and communicate with service provider | • Provide support for regional team | | | |
| Manage incident process | • Conduct investigation<br>• Draft investigation report (including relevant documentation) and forward to RAPs | | • Oversee/support regional team incident process. | • Provide support for regional team<br>• Refer draft investigation report to legal;<br>• Brief ADS, TPA Hautū | • Provide advice on draft investigation report | • Engage with regional Hautū and CE as necessary | |
| Incident outcome | • Final investigation report including recommended actions/outcome to Hautū and RAPs | | • Make decision | • Provide support for regional team<br>• Refer recommendation to legal as necessary;<br>• Brief ADS TPA Hautū | • Provide advice on recommendation and draft communications to service provider as necessary | • Review recommendation to support CE | |
| Licence status management | • Recommendation to Hautū<br>• Review evidence received and refer to RAP with any further recommendation/s | | • Make decisions and communicate with service provider | • Provide support for regional team<br>• Review evidence received and refer to legal as necessary<br>• Brief ADS, TPA Hautū | • Review evidence received and provide advice on any further recommendation/s as necessary | • Engage with regional Hautū and CE as necessary | |
| Meeting with the service | • Meet with service when Ministry becomes aware of incident<br>• Meet with service after outcome decision made | | • Meet with service when Ministry becomes aware of incident<br>• Meet with service after outcome decision made | • Provide support for regional team as necessary | | • Engage with regional Hautū and CE as necessary | |
| Meeting with whānau | • Obtain contact details for whānau | | • Contact whānau (as/when appropriate) and offer any support | | | • Engage with regional Hautū and CE as necessary | |

## Kbase incident workflow process