Ombudsman
Fairness for all

Case note

Unreasonable omission by WorkSafe to adequately consider hazard mitigation for serious incident

Legislation	Ombudsmen Act 1975, section 22
Agencies	WorkSafe New Zealand and Ministry of Education
Ombudsman	Peter Boshier
Case number(s)	500697
Date	August 2021

Complaint concerning the adequacy of WorkSafe's investigation into a serious choking incident at an early childhood service leaving a young child severely disabled – related concerns about the Ministry of Education's involvement – Chief Ombudsman of opinion that the WorkSafe investigation and post-investigation actions omitted to adequately consider hazard mitigation in relation to choking and first aid – Ombudsman considered there was a lack of clarity between agency roles – Ombudsman concluded that both agencies acted unreasonably – Ombudsman recommended that WorkSafe and the Ministry of Education apologise to the family, consider ex-gratia payments and develop a memorandum of understanding – Ombudsman also recommended that WorkSafe review its investigation processes and revisit its handling of the wider issues

Background

In 2016, a very serious incident occurred at an early childhood learning centre when a young child choked on a piece of sliced raw apple. The child suffered a cardiac arrest resulting in a brain injury that has left them with a severe lifelong disability.

WorkSafe investigated this incident and produced a report in 2017 concluding that no compliance action would be taken, as it did not identify any breaches of the Health and Safety at Work Act 2015 (HSAW). The family were advised accordingly.

The Ministry of Education (MoE) also investigated this incident and concluded that the requirements under the Education (Early Childhood Services) Regulations 2008 had been met by the early childhood learning service.

In 2017, the family complained to WorkSafe about its investigation, raising concerns about the accuracy of the report and whether all relevant factors were considered.

In response, WorkSafe highlighted that its investigation focused on what occurred, prevention and compliance with the HSAW Act. (WorkSafe subsequently advised the Ombudsman that investigation reports assist with decisions about any prosecution.) Otherwise, WorkSafe stated that the concerns raised by the family were outside the scope of its investigation and their complaint was best considered by the MoE.

WorkSafe advised that it would transfer the complaint to the MoE and contact the Ministry of Health.[1] However, WorkSafe did not transfer the family's complaint to the MoE until a year later, in 2018. At that stage, the complaint was handled at the local office level and it was decided that no action by the MoE was necessary.

Following a further complaint on behalf of the family to WorkSafe in 2019, the MoE undertook a review that resulted in the introduction of a number of changes to the licensing criteria for centre-based early childhood education (ECE) services.[2] For example, food preparation guidelines were to be amended to require early learning services to alter the texture of raw apple before it is served to children under the age of five.

The family remained dissatisfied about how the entire incident had been handled and complained to the Ombudsman about WorkSafe.

Investigation

The Ombudsman's investigation focused on the way that WorkSafe dealt with the investigation, including its actions after the investigation. The Ombudsman also decided to investigate the actions of the MoE.[3]

[1] The Ministry of Health has an advisory role in relation to the development of relevant guidelines, and is the lead agency for regulatory reform.

[2] The Education (Early Childhood Services) Regulations 2008 (Regulations) set out the regulatory standards and the process in which early learning services become licensed. The licensing criteria for centre-based education and care services 2008 sets out the day-to-day standards which services must follow to retain their licence, and are used to assess compliance with the minimum standards set out in the Regulations.

[3] Section 13(3) of the Ombudsmen Act 1975 authorises an Ombudsman to investigate proactively by "*own motion*" powers, as well as investigating specific complaints made by any person.

WorkSafe

Failure to adequately consider all relevant factors during investigation

Given the scope of its functions, the Ombudsman was not satisfied that WorkSafe's investigation adequately considered all the relevant factors in relation to hazard mitigation. The Ombudsman noted that while WorkSafe has a statutory function to investigate and determine whether there have been any breaches of law (under the HSAW Act), WorkSafe's role extends beyond enforcement.[4] The Ombudsman stated that to give proper effect to its functions under section 10 of the WorkSafe New Zealand Act 2013:

> *WorkSafe … should be mindful of any relevant legislation or regulations, guidance or best practice material to help inform whether health and safety practices are truly adequate or if changes are required.*

The Ombudsman considered that WorkSafe omitted to give due consideration to all the relevant parts of the Education (Early Childhood Services) Regulations 2008, Ministry of Health guidance on the risks of food-related choking in children, or factors such as the provision of first aid. Although these factors may not have had a tangible bearing on WorkSafe's investigation findings and its decision not to prosecute the early learning centre, they were relevant for identifying areas of improvement for hazard mitigation under section 10 of the WorkSafe New Zealand Act 2013. These factors should have been specifically considered during the investigation of the incident and informed the assessment of any other actions to be taken by WorkSafe in relation to the matter.

WorkSafe acknowledged that its functions include making recommendations on health and safety policy, regulation and legislation aimed at improving the effectiveness of the work health and safety system. However, WorkSafe considered that it was not within its role to examine the adequacy of legislated standards administered by other agencies in different legislative settings. WorkSafe stated that, during the investigation, it confirmed that the first aid administered was compliant with licensing criteria, prescribed in legislation and administered by the Ministry of Education.

The Ombudsman accepted that it was reasonable that WorkSafe's investigations are focused on compliance with duties under the HSWA. However, WorkSafe investigations should not be limited to compliance or evaluating grounds for prosecution. Given the health and safety concerns raised by the complaint, and its role as the steward of the health and safety system, WorkSafe should have considered whether some form of advisory or recommendatory action regarding the standards was warranted.

[4] Section 10 of the WorkSafe New Zealand Act 2013 outlines WorkSafe's overarching functions, including monitoring and enforcing compliance with health and safety legislation, and recommending changes to improve health and safety in the workplace.

Engagement with the family

The Ombudsman was also not satisfied that WorkSafe appropriately engaged with the family during its investigation. The family raised a concern that they were not provided an opportunity to comment before the investigation was finalised. The only direct engagement they had with WorkSafe was an interview during the initial stages of the investigation. This left them feeling like they were not heard throughout the process.

The Ombudsman highlighted that all relevant parties should be appropriately engaged during an investigation. This ensures natural justice and that all relevant information is obtained in order to generate robust findings. In response, WorkSafe acknowledged that relevant parties should be appropriately engaged with during any investigation. However, it considered that affected parties should not be given an opportunity to comment on draft reports in circumstances where this could prejudice the outcome of an investigation.

The Ombudsman acknowledged that in some circumstances, release of the full investigation report might not be appropriate if that would result in prejudice to the investigation. However, he highlighted that WorkSafe inspectors should consider when, what and how to consult affected persons as the investigation progresses rather than taking a blanket approach of non-disclosure. In this instance, the Ombudsman considered that WorkSafe failed to appropriately engage with the family. There was no information to suggest that WorkSafe considered providing any information to the family about the proposed findings. The Ombudsman formed the view that WorkSafe's lack of engagement with the family (aside from the initial interview) during its investigation was unreasonable and did not meet the requirements of procedural fairness.

Reasons for WorkSafe's decision

The family raised a concern that they did not receive an adequate explanation of WorkSafe's final decision, and were advised they would need to request the final investigation report under the Official Information Act 1982 (OIA). In terms of reasons, they were advised that WorkSafe did not intend to take any further action in the matter, as it had not identified any breaches of the HSAW Act, and were advised they were able to request a copy of the investigation report under the OIA.

WorkSafe commented that an investigation report must be requested by affected persons or their family under the OIA, in order to ensure that WorkSafe and third parties were protected against prosecution by section 48 of the OIA.[5] WorkSafe stated that the information contained within these reports goes beyond what affected persons are entitled to receive under the Victims' Rights Act 2002, and in some cases can include highly sensitive material about affected persons, witnesses, commercially sensitive information and legal advice.

The Ombudsman accepted that in some cases it may be appropriate for the affected party to request a copy of the investigation report under the OIA. However, this was not a substitute

[5] Section 48 of the OIA provides protection against civil or criminal proceedings for making available or publishing information in good faith following a request under the OIA. The protection extends to the agency, the author, and persons that supply the information.

for ensuring procedural fairness or WorkSafe's obligation to provide adequate reasons for its decisions. The Ombudsman considered that the reasons provided to the family fell short of providing an informed explanation of WorkSafe's decision. Being able to request the report under the OIA should not be relied upon as the method of providing an informed explanation of the reasons for WorkSafe's decisions, especially where the affected person and their whānau are concerned.

Consideration of complaint

The Ombudsman was concerned that the review of the initial complaint made to WorkSafe also appeared to have been based on the premise that WorkSafe was only responsible for breaches of health and safety legislation, and that its responsibility ended there. He was not satisfied that WorkSafe had appropriately engaged with the family's concerns, given its statutory functions, and had simply referred the matter on to the MoE, without any follow-up. He identified a lack of clarity between the roles of WorkSafe and the Ministry when responding to serious incidents in an education setting. The Ombudsman also considered that taking a year to forward the family's complaint to the MoE was unreasonable.

Ministry of Education

Engagement with the family

The Ombudsman was not satisfied that the MoE engaged with the family in a timely manner. The MoE did not communicate with the family when it initially received the referred complaint in 2018. In 2019, the MoE received the further complaint made direct to MoE on behalf of the family, and also meet with the family that year.

The Ombudsman noted that the MoE's internal guidance focused on the process that an early learning service should follow for serious incidents, and did not include guidance for MoE staff about engagement with the affected family. In response, the MoE accepted that it should have met with the family earlier. It also amended its internal procedures to include guidance about when and how the MoE should contact parents after a serious incident.

Failure to escalate WorkSafe's report

The Ombudsman formed the opinion that the MoE did not consider WorkSafe's report at the appropriate organisational level, and noted that there was no process to ensure that serious matters were escalated. In response, the MoE acknowledged that, given the gravity of the incident and findings, the WorkSafe report should have been escalated to the Secretary of Education for consideration.

Response to further complaint

In response to the further complaint, and since meeting with the family in 2019, the MoE made a number of changes to strengthen licensing criteria for early learning services, including early

escalation to the Secretary of Education in serious cases. The Ombudsman welcomed the changes that the MoE had made.

Outcome

The Ombudsman formed the final opinion that the actions of WorkSafe and the MoE were unreasonable. He recommended that WorkSafe and the MoE apologise to the family (including considering ex-gratia payments), and develop a memorandum of understanding (MOU) to clarify their respective roles and escalation points. In addition, the Ombudsman recommended that WorkSafe review its investigation processes and reconsider its approach to the relevant standards.

The MoE and WorkSafe accepted and implemented the recommendations. Both agencies provided ex-gratia payments to the family. WorkSafe also established a Victim's Service Team to support effective engagement with victims and their families.

This case note is published under the authority of the Ombudsmen Rules 1989. It sets out an Ombudsman's view on the facts of a particular case. It should not be taken as establishing any legal precedent that would bind an Ombudsman in future.