**Submission No 36**

# INQUIRY INTO EARLY CHILDHOOD EDUCATION AND CARE SECTOR IN NEW SOUTH WALES

**Name:** Name suppressed

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Dear Committee,

It is a relief to see the launch of the current and much-needed inquiry into the NSW early childhood education and care sector and its regulatory authority (RA). The information uncovered by the investigation preceding this inquiry is scary to say the least, and any positive change that this inquiry can bring to the state's childcare system and the wellbeing of young children will be welcomed by families and the dedicated professionals within the industry.

The stories recently uncovered by ABC investigators and Ms Abigail Boyd MLC detailing horrible safety breaches and the inaction of the RA have unfortunately sounded familiar to myself and my family. In February of 2023, my child was involved in a serious breach at their then-current centre, and both my partner and I were shocked at the nature of the incident itself, the seeming priority of the centre to ensure the protection of its reputation and staff over the safety of the children attending there, and the lack of transparency from the RA in the process and outcome of the investigation. Having now heard the stories detailed within the documents recently released from privilege, it seems that our experience is not unusual and this is deeply troubling. I hope that sharing our story can further assist this inquiry to identify which issues need immediate rectification in the current state system.

The safety incident that my child was involved in was a unique one and one that my partner and I were shocked that any child (including our own) would ever experience in a childcare centre. One afternoon when removing clothing from our dryer at home, I discovered a small glass vial of medication containing a white powder. I had no idea where it had come from and became even more confused when an internet search revealed that the name on the label belonged to an IVF hormone which certainly didn't belong to anybody in our house. After checking with my family and our visitors to figure out where it had come from, I was shocked to hear my youngest child tell me something to the effect of, "Oh, that's my bottle. I picked it up at the doctor's at my little school." Still unsure of whether they may have been confused, I accessed our daycare app to search for information and was shocked to find two photographs showing a small glass vial just like this one in the centre's "hospital corner" play space.

What followed was a frustrating experience. As this discovery had been made outside of centre hours, I called them the following morning to notify them and ensure that there was no ongoing risk of these substances within the play space. A staff member initially told me that they knew the vials were in the play space but not to be concerned because they had been obtained from a pharmacist that one of the educators knew and had been emptied and "filled with water" to make it appear as if they had actual medication inside. Awkwardly, I had to correct the staff member that told me this, explaining to them that the cap couldn't be removed from this vial, and that it contained a *powder,* not a liquid as she had described. Inconsistent and obviously inaccurate information such as this continued to be given to us by the centre and the centre's head office executive throughout the follow up process, and all that we felt was that it was more important to them to falsify, change and omit information to protect the centre and its employees, rather than protect the children who had been put at risk.

The centre eventually changed their original story (putting this change in information down to a kind of "misunderstanding") and disclosed that the vials supplied to the play space had been donated by one of the educators who was a room leader. They claimed that the educator had intended on only donating the "water-filled" vials that accompany the powdered medication in the two-packs that these vials come in and that they believed that this one single vial containing the powdered medication must have somehow ended up in the bag of donations "by mistake". We questioned how likely it would have been for our child to bring home the *only* vial of medication "accidentally" placed in the play space and also questioned why any educator would think that donating small glass vials for small children to play with was appropriate, regardless of what was contained within them. The centre agreed that this was an "error" on the educator's part and told us that "disciplinary action" had been undertaken but that they couldn't reveal the nature of this due to confidentiality. The educator who donated the vials was still employed as a room leader beyond the incident, and so we aren't sure what (if any) "disciplinary action" was taken. The information that we were given was that staff were now undergoing PD in response to what had happened and that the centre's policies and processes had been updated and improved. We did question, however, why these policies and processes weren't already in place as they should have been under the requirements of law.

Along with the inconsistent, vague and unsubstantiated information provided by the centre was other evidence of their prioritisation of centre/employee protection over the safety of children. When we asked the centre staff if they would notify the other parents of this incident to be sure that no other children were in possession of any other vials like this one, they explained that "while the children were at risk, because nobody was harmed, we don't need to notify parents." We expressed concern over this, pointing out that our child had brought this vial home in their pocket and that it was obviously a possibility that other children may have done the same with other vials that had also gone undetected. They dismissed this concern, stating that they had conducted a "thorough" search within the centre and were sure that there was no ongoing risk. We were confused by this response but were again under the impression that it was more about keeping the information hidden from parents than it was about ensuring other children's safety.

The centre also refrained to put any of our correspondence about this incident in writing, despite my request for them to email me about our conversations several times. Except for sending emails to confirm a meeting and our withdrawal of enrolment, they would only speak to us on the phone and I felt that this was to ensure that there was no "paper trail" of information kept about this incident. In response to this, I would send them emails summarising what their staff had said to me on the phone. It was important to me to do this to keep track of what had been said each time, especially because their story kept changing.

In the end, the centre claimed that no one knew how the "accidentally donated" vial had made it from the bag of donations into the play space because many staff had been adding items to the space over several days. Despite them being aware of the educator who was responsible for donating the vials to the centre, this version of events meant that no one educator had to take responsibility for the medication ending up in the hands of children for several days. It was, instead, viewed as an "accident". This led

us to query supervision also because the photographs and other posts from the daycare app indicated that the vials had been in the play space for about a week, and yet no educators had noticed that children were playing with glass vials and glass vials containing medication during this time. They were unable to provide us with an adequate response to this query, with the answer to most of our questions being "we don't know".

The centre was mandated to report the incident to the RA and I also followed this up to ensure that it had been done. When speaking to someone from the RA, they asked me to email through all the information I had and that they would compare this with the information provided to them by the centre to ensure everything was consistent and that they would notify us with an outcome.

When we were notified, all that we were told was that the case had been closed and that due to confidentiality, no further information could be given. I questioned this further and thought this was a strange way to end things as we had been given no information whatsoever about the outcome of the investigation and really didn't know what had been done or changed. The staff member seemed discontented that I was dissatisfied with this low level of transparency and then told me that the centre had been found to be at fault in this instance (not the educator who donated the vials) because their processes and policies had been inadequate. They told me that the centre had been fined (with no amount disclosed) and said that they were happy with the changes the centre had made moving forward. I told them that I was concerned about the accuracy of the centre's version of events because they had kept changing their story when we had spoken to them, and additionally, I was also concerned that during one of my previous conversations with this same RA staff member, it seemed that they were unaware that the vials had been donated to the centre by one of the educators. The RA staff member was short-spoken on details and simply told me that "their information matched yours." I was confused by this because the centre's version of events didn't really seem to match ours at all and largely didn't make sense. It was disappointing to feel like the RA didn't investigate the accuracy of the information they were given from the centre, despite the documentation that I had provided them highlighting many issues with the accuracy and consistency of what had been reported. It is also interesting to note that the centre's 5-star rating was never impacted by this incident.

This incident was very stressful for my family and I, and it was disappointing to feel like it was more important to the centre and the regulator to "make it go away" than to ensure the safety of the children at the centre. It was also unsettling to see that investigating how accurate the information being provided about the incident didn't seem to be a priority, and we wondered how often the information given to the RA by centres about breaches of safety is truthful. It was also frustrating and confusing to see how a lack of transparency seemed to be perfectly acceptable within this process and how it was able to give the centre and the regulator a wall to "hide behind" so that accountability wasn't really required. Moving forward, we would hope to see:

- Centres being required to notify **all** parents of serious incidents and safety breaches, including what has been done (and will continue to be done) after such events.

- Consequences beyond PD or unspecified “disciplinary actions” for educators who are involved in serious breaches or incidents that breach national regulations and law.
- More thorough investigations of safety breaches or serious incidents whereby the accuracy of information provided by centres is scrutinised.
- Greater transparency from the RA with regards to what is found during investigations of safety breaches or other serious incidents and what the outcomes and next steps are.
- Centre ratings impacted when safety breaches or serious incidents occur as part of transparency to the public and to encourage compliance.

I hope this information is useful and would be happy to provide more details or documentation to assist in the inquiry process if needed. I still have the detailed documentation that we submitted to the RA about this incident and would be happy to provide it to the committee if it is useful. Thank you again for looking into this matter and these systems more thoroughly and for advocating for the safety and wellbeing of young children in NSW.