MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

5 August 2025

Tēnā koe

Official Information Act request

Thank you for your emails of 29 and 30 May 2025, requesting information about how the Ministry of Social Development (the Ministry) audits and evaluates contracted service providers. An interim response was sent to you on 23 June 2025 to respond to some of the matters you raised.

I apologise again for the delay in responding to your request.

I have considered your request under the Official Information Act 1982 (the Act). I will first respond to your request, before providing you with information about improvements that Disability Support Services (DSS) is undertaking in this area. For ease, please find my decision on each part of your request set out separately below.

1. *Pre-death monitoring: What checks, if any, did MSD/Whaikaha perform before these fatalities to ensure that the full funded hours (especially at mealtimes) were actually rostered and worked?*

Each year, the Ministry commissions an audit and developmental evaluation plan to cover a sample of contracted service providers. These audits/developmental evaluations have a strong alignment to DSS contractual expectations. They often complement the Ministry of Health's HealthCERT audits by acting as a mid-point assessment.

The sample of providers is managed on a rotation basis, which ensures that all providers involved in the delivery of residential care services have a sample of their residential homes audited at least once every five years.

Other audits can be commissioned outside of this process, where there are reasons to conduct more in-depth investigations.

Residential homes with five or more bedrooms and hospital level services (a definition that applies primarily to aged residential care) are subject to Certification against the Ngā Paerewa Health and Disability Services Standard according to the Health and Disability Services (Safety) Act 2001 (administered by the Ministry of Health). The audit reports will confirm that there are sufficient and safe staffing levels, but not details about the rosters.

Providers of those services may also be subject to review of any incidents / deaths notified under Section 31(5) of the Act and further action as necessary, including referral to DSS. Resources for Ngā Paerewa Health and Disability Services Standard | Ministry of Health NZ.

Please refer to the interim letter of 23 June 2025 for our response around staffing levels.

For providers delivering services under the High and Complex Framework (of which IDEA Services is a provider), there are additional compliance requirements, including statutory requirements under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (ID(CC&R)). The Ministry of Health has a role in administering those statutory requirements.

2. *Post-death verification: What auditing of rosters, payslips or timesheets has MSD/Whaikaha done since the deaths to confirm whether skimming was occurring in each house in the critical weeks leading up to the incidents?*

Following these instances of choking-related deaths involving IDEA Services, DSS commissioned an issues-based audit from Standards and Monitoring Services (SAMS). As a result of this issues-based audit, SAMS imposed several requirements and recommendations on IDEA Services.

The high-risk requirements, including double staffing during mealtimes, were met within 24 hours. The SAMS audit team confirmed that all other requirements made in the issues-based audit reports have been met to their satisfaction.

DSS commissioned a follow-up visit by the audit team to ensure that improvements have been sustained and embedded into standard practices and protocols. In relation to the choking-related deaths, DSS continues to work closely with IDEA Services and SAMS to monitor the safety of disabled people in their care.

IDEA Services is undertaking their own comprehensive review of the Safer Eating and Drinking (SEaD) plans and are open to how this learning can inform wider system improvements.

3. *Systemic controls: What permanent mechanisms—not one-off audits—have you now put in place to detect and eliminate skimming across all contracts?*
4. *Accountability: Will MSD claw back public funds where skimming is proven, and will it impose sanctions on providers that falsify or under-deliver hours?*

The Ministry does not monitor the resource allocation of staff at an individual provider or residential community group home level.

The Ministry has mechanisms in place where concerns of fraudulent activity can be identified and addressed. This includes regular contract management processes, performance monitoring, audits, and the complaint mechanisms. Where instances are identified of intentional activity that might point to fraudulent activity, including skimming, there are contractual provisions that allow the Ministry to seek legal redress, or terminate the service contract.

Please refer to our answer in question ten for further information on improvements to services.

5. *What evidence, if any, has MSD obtained around staffing levels in those homes before and after the deaths?*
6. *If no comprehensive investigation into potential skimming has yet been conducted for those homes, this must be initiated* ***immediately.***

I can confirm that the Ministry does not routinely monitor staff rosters.

In this instance, DSS has commissioned a follow up audit to ensure that improvements identified in the initial audit continue to be sustained. DSS continues to work closely with IDEA Services, and with SAMS to monitor the safety of disabled people receiving support through IDEA Services.

7. *A list of all choking-related deaths of IDEA Services clients from the past five years. For each death, include:*
    1. *Month and year*
    2. *Suburb (for Auckland)*
    3. *Town or city (for regions outside Auckland)*

Our highest priority is the safety and wellbeing of disabled people. It is our expectation that disabled people receive the support they need in a way that respects their rights, dignity and autonomy.

As noted earlier in this letter, we have taken a number of steps in relation to IDEA Services in response to choking-related death which includes a focus on safer eating and drinking. DSS continues to work closely with IDEA Services and SAMS to monitor the safety of disabled people in their care.

DSS takes very seriously all reports of critical incidents and is continuing to improve its processes in the management of complaints and critical incidents. This will include how we strengthen our ability to receive incident reports from providers, our ability to undertake analysis to inform local and system-wide improvements, and to respond to providers with meaningful information in a timelier manner.

Quality is an integral consideration into how we strengthen the future of DSS.

The Ministry collects information from providers regarding the deaths of individuals in their care through Critical Incident forms and Initial Death Review forms. While providers inform the Ministry of the circumstances of an individual's death, it is important to note that neither the Ministry nor the providers are qualified to officially determine a cause of death. This responsibility is held by medical professionals or a Coroner.

You can read more about these processes, and how the Ministry responds to critical incidents and deaths on the DSS website, here: https://www.disabilitysupport.govt.nz/providers/reporting-of-critical-incidents-and-deaths.

Within the past four years, the Ministry has been notified of eight instances of people dying that involved choking. We are unable to confirm whether choking was the primary cause of death, as this can only be determined by a medical professional, as previously stated.

A further breakdown of these eight deaths is refused under section 9(2)(a) of the Act, to protect the privacy of natural persons. The need to protect the privacy of these individuals outweighs any public interest in the release of this information.

8. *All information held by MSD/Whaikaha regarding food restrictions imposed by IDEA Services.*

All providers are expected to have processes and protocols in place to respond to the individual needs of all disabled people in their care. Each disabled person in care has their own personal plan which is agreed to with the individual and/or their whānau. It is an expectation that those individuals who are identified as at risk of choking will be on a Safer Eating and Drinking (SEaD) plan, which may include instructions for a texture modified diet.

IDEA Services have taken steps to ensure that staff in each of their community group homes understand the importance of safe eating and drinking. Additionally, IDEA Services is working with a commercial food company to pilot moulded food to assist people with swallowing difficulties.

The Ministry is not aware of any blanket food restrictions imposed by IDEA Services, or any other provider. As such, this aspect of your request is refused under section 18(g) of the Act as the information is not held by the Ministry and I have no reason to believe it is either held by or more closely connected to the functions of another department, Minister of the Crown or organisation.

9. *Any advice you have received or given concerning blanket restrictions rather than individualised safety plans.*

The Ministry has not provided or received advice or instructions regarding blanket food restrictions. This aspect of your request is refused under section 18(e) of the Act as the information does not exist.

10. *Details of any oversight mechanisms to ensure food bans are not being used as blanket punitive measures.*

DSS has a complaints and critical incident management system in place, through which anyone can make a complaint about disparity of support services. You can read more about this here: https://www.disabilitysupport.govt.nz/about-us/contact-us/complaints/complaints-about-disability-services.

Complaints about services are reviewed by the Ministry's quality team. Where necessary, an investigation will be conducted.

Providers are required to have their own complaints process, with guidance about this published on their website. DSS expects complaints to be managed as close to the source as possible.

Improvements to services

DSS is undertaking a number of improvements that will further strengthen how we ensure high quality services are being provided for disabled people in care. DSS is planning to:

- Embark on a strengthened audit programme.
- Improve the system for complaints and critical incident management.
- Work with other agencies to inform workforce development initiatives.
- Work on guidance for providers around their responsibilities for care records management.

DSS has also established two new initiatives that will promote a focus on system improvement:

- DSS has established the National Quality Leaders' Group that will look at quality and safeguarding system-wide issues, with a view to continuous improvement.
- DSS has initiated a regular series of provider quality forums for sharing and learning across a variety of quality and safeguarding topics. DSS plans to host a forum every two months where other stakeholders or providers will have the opportunity to present, depending on the topic.

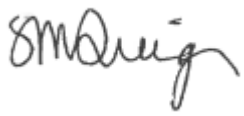
Prevention of choking and guidance around safer eating and drinking are potential topics of focus through these initiatives. As the initiatives have been established only recently, DSS will monitor their effectiveness and impact.

I will be publishing this decision letter, with your personal details deleted, on the Ministry's website in due course.

If you wish to discuss this response with us, please feel free to contact OIA_Requests@msd.govt.nz.

If you are not satisfied with my decision on your request, you have the right to seek an investigation and review by the Ombudsman. Information about how to make a complaint is available at www.ombudsman.parliament.nz or 0800 802 602.

Ngā mihi nui

pp. 

Anna Graham
General Manager
Ministerial and Executive Services