



Systemic Improvement Investigation – Terms of Reference

Ministry of Health

26 October 2018

This document sets out the terms of reference for a self-initiated investigation by the Chief Ombudsman into the practices of the Ministry of Health concerning the recording and reporting of deaths of people with Intellectual Disability (ID).¹

Purpose of the investigation

The purpose of this investigation is to examine current practices in the recording and reporting of ID deaths to identify whether the Ministry has reasonable policies and processes that are consistent with good administrative practice, transparency and accountability, and relevant international conventions, including the United Nations Convention on the Rights of Persons with Disabilities.

The investigation will include consideration of the Ministry's administrative structures, policies, processes and practices concerning data collection for the deaths of persons with ID.

The investigation will identify areas of good practice and make suggestions for improvement if any areas of concern are identified.²

Scope of the investigation

The investigation will examine the Ministry of Health's system of information collection, analysis and reporting in relation to the deaths of people with ID who live in secure or supervised care or, alternatively, live fulltime in community-level supported residential care.

The investigation covers the deaths of people with ID who resided in DHB and NGO community facilities, including individuals subject to the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, individuals with higher and more complex needs and people with ID

¹ See sections 13(1) and 13(3) of the Ombudsmen Act 1975 (OA).

² Formal recommendations under the OA will only be made if the Chief Ombudsman forms an opinion that a decision, recommendation, act, or omission by the Ministry was unreasonable or contrary to law under section 22 of the Act.

who live away from home. The investigation will not extend to considering any deaths that occurred in respite care or the deaths of people with ID who lived in their own homes and received Disability Support funding from the Ministry.

The investigation will consider the Ministry's records concerning deaths of people with ID in High and Complex facilities and community-level residential settings in the last 2.5 reporting years (from January 2016 until 30 June 2018). This will include deaths that have occurred in the following settings:

- Community Residential Support Services (CRSS), including support in a home-like setting, people with ID under 65 living in aged care facilities and '*out-of-family*' residential support services for children and young persons with ID.
- People with ID who received care under the High and Complex Framework, being:
 - Regional Intellectual Disability Supported Accommodation Services (RIDSAS); and
 - Regional/National Intellectual Disability Secure Services (RIDSS/NIDSS).

The investigation will establish how the framework for collecting information about deaths operates in practice and how the Ministry analyses and responds to such information. This will include quality assurance processes and how the data informs decision-making about ID services. As well as consideration of general data collection, analysis and reporting arrangements, the investigation will review detailed records, in particular concerning the deaths of persons with ID in Auckland, Christchurch and Wellington.

Investigation process

The Manager Systemic Improvement Investigations will work with a team of Senior Investigators to assist the Chief Ombudsman to conduct the investigation. The investigation team will liaise with the Ministry's nominated contact official during the investigation. Information may be gathered through the processes set out below.

Information gathering

General

The information for the investigation will be gathered through research, a review of relevant documentation held by the Ministry, meetings or interviews with key staff, and engagement with relevant third parties. As usual, any requests for information during this investigation will be made pursuant to section 19 of the Ombudsmen Act 1975 and are subject to the confidentiality and secrecy provisions in sections 18(2) and 21(2) of that Act:

- Section 19 of the Ombudsmen Act authorises an Ombudsman to require any person to furnish information relating to any matter under investigation. This provision empowers the Ombudsman to gather evidence, including by way of interview.

- Section 18(2) of the Ombudsmen Act provides that every investigation by an Ombudsman shall be conducted in private. Section 21(2) of the Act requires an Ombudsman and staff to maintain secrecy and the information obtained during an investigation will not be disclosed, except in accordance with the proviso at section 21(4), which authorises an Ombudsman to –

... disclose such matters as in the Ombudsman's opinion ought to be disclosed for the purposes of an investigation or in order to establish grounds for the Ombudsman's conclusions and recommendations.

Research

The research will include a review of publicly available information including the legislative framework, the Ministry's annual reports, strategic intentions documents, and any other material made available on its website.

Review of Ministry documentation

The review of the Ministry's systems and practices will include the relevant:

- Strategic plans, work programmes, operational plans.
- Policies, procedures and guidance.
- Quality assurance processes.
- Reports on compliance.
- The information collected, analysed and reported by the Ministry about the deaths of persons with ID in the last 2.5 reporting years.
- A detailed review of a sample of information held by the Ministry in particular concerning individual deaths in Auckland, Wellington and Christchurch, including:
 - Background information about the individuals (e.g. legal status, care plans);
 - Notification and reporting to the Ministry by relevant agencies;
 - Internal or external reviews of the deaths, including Coronial processes; and
 - Any actions taken by the Ministry associated with the deaths.

Meetings

In addition to reviewing Ministry records, the investigation team will meet with key Ministry staff with responsibility for the following aspects of the Ministry's systems and practices concerning ID services:

- Leadership, policy and strategic direction.
- Organisational/operational performance.

- Contract management.
- Quality assurance.
- Knowledge management.
- Operational matters, including
 - processing and analysing information about ID deaths
 - responding to ID deaths; and
 - reporting of information.

Scheduling of Meetings

There will be an initial meeting soon after the complaint is notified to establish the manner in which the Ministry holds information relating to the deaths of people with ID. The investigation team will seek an overview of the Ministry's information systems as they relate to the investigation. It is envisaged that the initial meeting will take several hours in order to allow for a period of discussion and for the Ministry to demonstrate to the investigation team how information is recorded.

Shortly after the initial meeting, a request for relevant information held by the Ministry will be made. Any further meetings will be scheduled after the Ministry has provided the information requested and it has been analysed by the investigation team.

Interviews

The investigation team may decide to interview certain Ministry staff, in order to obtain as much relevant information as possible about the matter under investigation. These interviews will be recorded. The Ministry will be advised which staff members are to be interviewed. The investigation team will then contact the interviewees directly to schedule the interview. Any Ministry staff selected as interviewees will be provided with information about the interview process including the legal framework and the purpose of the interview. It is envisaged that interviews will take between 1-2 hours.

Third party information

The investigation team will also gather relevant information from third parties involved in the provision of ID services, in order to add context to the information provided by the Ministry. The investigation team will also seek input from an independent expert in the field of ID. For the avoidance of any doubt, the Ministry is the only agency under investigation by the Chief Ombudsman.

Reporting

Draft report

The draft report will outline the Chief Ombudsman's provisional findings, including the evidence relied on and the analysis. Where relevant, the draft report will identify any suggestions and/or recommendations that may be made to improve the Ministry's practices. The draft will be provided to the Chief Executive of the Ministry for comment. The Chief Ombudsman may also seek comment from third parties who are referred to in the report. Third parties must be given an opportunity to comment if it appears that they may be adversely affected by, or the subject of adverse comment in, an Ombudsman's opinion or recommendation.³

Final report

Comments received on the draft report will be considered for amendment of, or incorporation into, the final report. The Chief Ombudsman will provide the final report to the Chief Executive of the Ministry. The final report will be published on the Ombudsman's website and tabled in Parliament.

After the investigation

Following completion of the investigation, there will be ongoing monitoring of actions taken by the Ministry in response to any recommendations or suggestions by the Chief Ombudsman. The Chief Ombudsman will also conduct a review exercise as part of his Continuous Improvement programme. The Chief Ombudsman will seek the views of the Ministry's senior managers on their experience of this systemic investigation, its value and relevance to improving their work practices, and how future investigations may be improved when applied to other agencies.

³ Sections 18(3) and 22(7) of the Ombudsmen Act 1975.