MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

19 September 2025

Tēnā koe

Official Information Act request

Thank you for your request from the beginning of the year to the Ministry of Disabled People – Whaikaha, requesting the following report:

- *REP/WHK/24/11/177 Data and talking points on critical incidents in residential care*

As you are aware, your request was transferred to the Ministry of Social Development (the Ministry), as following the transfer of Disability Support Services (DSS) to the Ministry in September 2024, your request is more closely connected with the Ministry's functions.

I would like to extend my apologies for the significant delay in responding to your request for information, which has been due to an increased volume of requests being processed by the Official Information team in recent months.

I have considered your request under the Official Information Act 1982 (the Act) and have decided to release a copy of the report in full. Please find a copy of the report attached.

As you will see, the report to the Minister (November 2024) appears to show that the number of critical incidents reported are increasing, particularly in the "Other" category, which includes people who are in restraint or seclusion and critical incidents that involve Police or emergency services.

It is important to note that this apparent increase has occurred in the context of DSS seeking to improve safety for disabled adults in residential settings, which can include secure environments and community residential care. As commented on in the report, incidents involving restraint or seclusion can often relate to a very small number of high-risk individuals in care, with multiple incidents, with each needing to be reported individually.

There has also been increasing focus on improving the reporting culture across all providers, which may be a contributing factor to the increases in critical incidents identified in the report. This also resulted in greater awareness among disabled

people and their whānau, coinciding with the profile of the Royal Commission of Inquiry into Abuse in Care.

DSS continues to closely monitor all complaints, issues and critical incidents that are reported, and has also refined its critical incident processes with effect from 1 July 2025. You can find out more about the reporting process and the work we are doing to improve the quality and safety of the disability supports and services we fund at the following links:

- www.disabilitysupport.govt.nz/providers/quality-and-safeguarding
- www.disabilitysupport.govt.nz/providers/reporting-of-critical-incidents-and-deaths

In May 2025, the Government announced a range of initiatives in Budget 2025 to strengthen the care system and improve redress for survivors in response to the Royal Commission of Inquiry into Abuse in State Care. This included $8.8 million of funding for DSS to recognise and respond to abuse of disabled people in care. You can find out more about the initiatives at this link:

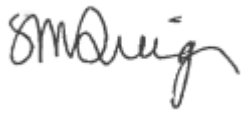
- www.disabilitysupport.govt.nz/about-us/news/dss-receives-budget-investments-in-response-to-royal-commission-inquiry.

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
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Whaikaha
Ministry of Disabled People

Scan for
NZSL name

Aide-mémoire

Date:	4 November 2024
For:	Hon Louise Upston, Minister for Disability Issues
CC:	
File reference:	REP/WHK/24/11/177
Security level:	In confidence

Data and talking points on critical incidents in residential care

Purpose

This paper responds to your request for information and talking points on data about abuse of disabled people and use of seclusion and restraint in residential care services, for discussion at the Ministerial meeting on the Crown Response to the Royal Commission on Abuse in Care, Tuesday 5th November.

Background

Papers circulated for Ministers involved in the Crown Response to the Royal Commission on Abuse in Care include an A3 titled "Pathway to full Government Response" to support discussions. You are concerned that this A3 does not reflect the amount of work and investment that may be needed to improve safety in the current care system; and also that disabled adults in residential care are invisible in the pathway set out in the A3.

This paper briefly sets out the most recent data that we have available about critical incidents including abuse and the use of seclusion and restraint for adults in residential settings.

Critical incidents data

All disability support providers are required to report critical incidents to us within 24 hours of the incident taking place. The Ministry reviews critical incidents to check that contracted providers are managing them appropriately and taking action to prevent future incidents to support better outcomes for disabled people. Most critical incidents are reported by providers of community residential services and secure services provided under the High and Complex Framework.

If a critical incident, or series of related incidents, suggest a provider quality issue, then the Ministry can commission an investigation into a particular service. If a critical incident identifies a safeguarding concern (e.g. abuse or neglect) then the Ministry can refer the situation to the Disability Abuse Prevention and Response team (DAPAR)[1].

The Ministry has recently made improvements to the analysis and reporting of critical incidents data to allow us to provide monthly updates. This includes regularly reviewing incident reports as they come in and applying additional data quality steps such as data cleaning and prioritisation of critical incident categories where more than one category was reported.

The current reporting tracks incident numbers from April 2023 onwards, when new reporting categories came into effect, and allows us to regularly monitor incident numbers across different categories more effectively.

Table 1 shows a comparison of critical incidents in Quarter 3 2024 (July, August, and September) to the same Quarter in 2023.

Table 1: Critical incidents by category for Q3 (July-September) 2023 and Q3 2024
Random rounding (to base 3) has been applied.

Incident Category[2]	**Q3 2023**	**Q3 2024[3]**
Hospitalisation of a disabled person	198	207
Abuse or assault by a disabled person to a non-disabled person	129	189
Abuse or assault of a disabled person	126	141
Police or emergency services involved	78	165
Serious injury of a disabled person	36	33
Other[4]	45	216
Total	**606**	**951**

The data show that between the third quarter (July – September) 2023 and the same quarter in 2024:

- the total number of critical incidents has increased by 57%[5]

[1] DAPAR is a new approach, currently managed by VisAble, that works to safeguard the rights of disabled people and tāngata whaikaha Māori and responds to situations of violence, abuse and harm.

[2] Incident category is based on prioritisation of primary and secondary categories.

[3] Due to a lag in reporting that can occur, this data is provisional.

[4] Some categories have consistently small counts when broken down by month and therefore have been grouped into an 'Other' category, these categories are: Death of a disabled person, Incident related to external investigation or media, Missing person, Neglect of a disabled person, Restraint or seclusion, Unauthorised leave of a disabled person under Court Order, and Other.

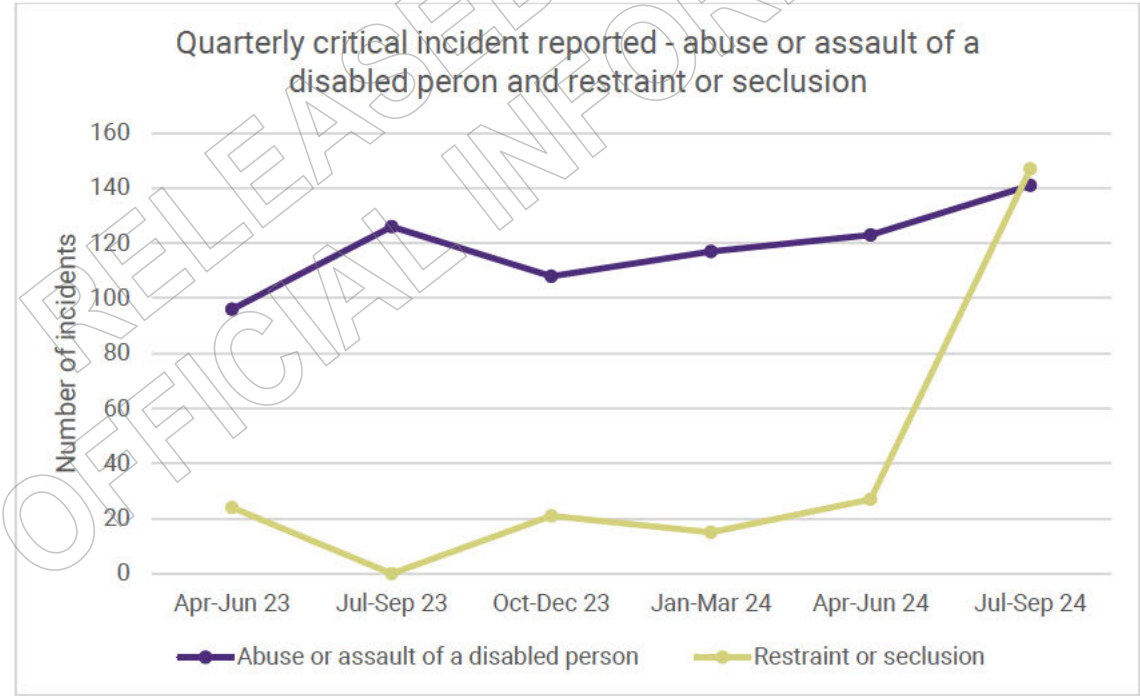
[5] Percentages are based on rounded data.

- the number of 'Abuse or assault of a disabled person' incidents has increased by 12%. In the most recent quarter, abuse or assault of a disabled person made up 15% of critical incidents reported.
- There has been a large increase in the 'Other' category, up 380%, making up 22% of all incidents. Most of this increase relates to 'Restraint or seclusion' which increased by 144 incidents between Q3 2023 and Q3 2024. The majority of these incidents relate to a small number of individuals under the High and Complex Framework.

Note, the use of seclusion and restraint is permitted as a last resort in situations where all other strategies for de-escalation have been unsuccessful and there are no alternatives to maintain safety for disabled people, staff and others. However, there are a wide range of Crown initiatives, policies and work programmes focused on both reducing seclusion and minimising the negative impacts of seclusion and restraint, and on ensuring seclusion and restraint activities are recorded and monitored sufficiently.

Figure 1 shows quarterly incident data for 'Abuse or assault of a disabled person' and 'Restraint or seclusion'. This shows that the number of abuse or assault of a disabled person has been trending upwards slightly since this time last year, whilst the number of restraint and seclusion incidents has increased sharply over the last quarter. Some of the increase seen may be due to better reporting practices.

Figure 1: Quarterly critical incidents, April 2023 to September 2024



You have commissioned advice on options to improve safety for disabled adults in residential settings. This work includes options for improving our complaints and assurance processes in the short term, as well as identifying longer-term initiatives that would focus more on prevention, identification and response.

Suggested talking points

- I am concerned that the pathway presented on the response to the abuse in care inquiry does not have sufficient focus on improving the safety disabled adults in residential care.
- The Ministry have recently made improvements in how they collect, analyse and report on critical incidents data, including on abuse of disabled people and the use of seclusion and restraint in adult residential settings. These improvements allow the Ministry to regularly monitor critical incidents more effectively. I expect the data to continue to improve over time, including through better reporting from providers and streamlined data practices.
- The current data show that between the third quarter (July – September) 2023 and the same quarter in 2024:
    - the total number of critical incidents has increased by 57% to 951.
    - the number of 'Abuse or assault of a disabled person' incidents has increased by 12% to 141.
    - there has been a large increase in the 'Other' category, up 380% to 216.
- Most of the increase in the 'Other' category relates to 'Restraint or Seclusion' which increased by 144 incidents between Q3 2023 and Q3 2024. The majority of these incidents relate to a small number of individuals under the High and Complex Framework.
- The number of abuse or assault of a disabled person incidents has been trending slowly upwards since this time last year, whilst the number of restraint and seclusion incidents has increased sharply over the last quarter due to a large increase in incidents for a small number of individuals. Some of the increase seen is likely due to better reporting practices.
- It is critical that we make a commitment to a robust and evidence-informed framework for preventing abuse in government residential funded services for disabled people. This work, which is currently being commissioned within the disability portfolio, should form part of the Government's commitment to "ensuring the safety of the current care system" for disabled people.
- Work is underway to identify both improvements in the short term to assurance and complaints processes; and longer-term options that would be more focused on prevention, identification, and response. I anticipate that these longer-term options will be well aligned with some of the recommendations of the Royal Commission and will require close coordination with the work programme being led by the Crown Response Office.
- There are a number of other existing complaints and quality mechanisms including the Code of Health and Disability Services Consumers' Rights complaints to the Health and Disability Commissioner, Disability Support Services complaints, audit processes under Ngā Paerewa and lastly the Ombudsman.

However, all of these mechanisms are post-fact, rather than focussing on prevention, which is our primary objective in this work.

End

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