Section 99 Inspection into Canterbury-Waitaha Adult Inpatient and Associated Mental Health Services – led by Dr John Crawshaw, Director of Mental Health, Ministry of Health.
August 2025

Background
On 25th June 2022, a patient on leave from Hilmorton's Hospital forensic services fatally stabbed a woman unknown to him. This tragic event raised urgent questions about the safety and quality of mental health (MH) services at Canterbury-Waitaha.
The Director of Mental Health (DMH) at the Ministry of Health has legal powers under Section 99 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 to inspect any hospital, or any ward, unit, or other part of a hospital, in which psychiatric treatment is given.
Why This Section 99 Inspection Happened
The DMH wanted to check whether there were systemic issues in Canterbury-Waitaha's adult inpatient and forensic MH services. This inspection was not about individual staff blame, but about whether the system as a whole is safe and working properly. The Report itself was released over three years later partly due to Cyclone Gabriel (from which a member of the inspection team had a severe impact), and the independent review report from Te Whatu Ora was not received until 31 May 2024.
Major Concerns Identified

- **Governance (Oversight and Leadership)**
  Committees and governance structures existed on paper, but were often unclear, outdated, or ineffective. Staff did not always know who made decisions or how risks were escalated. At district and national levels, **weak governance** has been a long-standing problem, limiting accountability and quality oversight.
- **Safe Staffing, Safe Environment**
  Nurses described the workplace as unsafe, with high levels of assaults by patients. Experienced nurses were near burnout, while new graduates were left in unsafe, unsupervised situations. The organisation identified that it has a **'missing middle'** in its nursing staff workforce, referring to nurses who are competent and experienced but still have a long career in front of them. Leadership staff were forced to cover ward shifts instead of providing guidance due to shortages. The Inspection Team recognised that the Nursing Director role, across forensic MH and intellectual disability, was an onerous one, that could not be achieved by one full-time employee.
- **Impact on Tangata Whaiora (patients)**
  Care was **compromised** by staffing and resource pressures: limited multidisciplinary input (mostly medical/nursing only); missed psychological therapies; delayed admissions for people in crisis due to capacity; and early pressured discharges leading to relapses and readmissions. The Staff were committed but stressed and struggling to deliver safe, therapeutic care.
- **Substance Use**
  Rising methamphetamine use increased the severity of psychotic illness and led to **more violence** in inpatient settings.
- **Te ao Maori perspectives**

Maori staff (kaimahi) reported feeling **undervalued and culturally unsafe**, with poor support from management. There were no clear pathways for Maori. Some staff described the service as in breach of Te Tiriti o Waitangi.

- **Lived Experience Input**
  The voices of people with lived experience of mental health were **underutilised**. Stronger integration could have helped the service better respond to pressures.

Improvements Underway (Post-Inspection)

- **Governance:** Commitment to make governance clearer and more transparent.
- **Training:** Violence risk assessment, relational security, and orientation programmes strengthened.
- **Tangata whaiora leave processes:** Now unified into one clear protocol, with tighter review and sign-off.
- **Workforce:** New Nurse Practitioner pathways being developed.
- **Maori leadership:** Plans for a cultural leadership reset and new education.
- **Lived experience roles:** To become a **"non-negotiable"** part of service delivery.
- **Facilities:** Funding approved for a new high-care forensic unit (Te Whare Mannaaki).

Key Messages

This Section 99 Inspection revealed serious problems with staffing, governance, safety, and cultural responsiveness in Canterbury-Waitaha's mental health services. These issues contributed to unsafe environments for both staff and patients, and in some cases compromised the quality of care.

While improvements are underway, the report highlights that these problems have been known for years, and stronger oversight (including by the DMH) and long-term strategies are urgently needed to protect staff, tangata whaiora, and the wider community.

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