

## **Terms of Reference – Director of Mental Health Inspection of Canterbury Adult Inpatient and Associated Mental Health Services**

### **Purpose**

The purpose of this review is for the Director of Mental Health (the Director) to inspect the adult inpatient and associated mental health services provided by Te Whatu Ora – Health New Zealand Waitaha Canterbury, pursuant to section 99 of the Mental Health (Compulsory Assessment and Treatment) Act 1992 (the Act), to examine how these services are functioning.

This will enable the Director to determine whether there are any systemic or service issues, and if there are none, to assure the public on how the services are being run. If issues are found, then recommendations will be made on how to address those issues. This inspection is not about identifying any individual staff issues - it is about scrutinising the functioning and resilience of this forensic mental health service.

### **Background**

A serious incident occurred on Saturday 25 June 2022 in Christchurch where a patient subject to the Act on leave from forensic inpatient services at Hillmorton Hospital allegedly fatally stabbed a woman not known to him. This incident occurred in the context of concerns being raised around the safety and care being offered by these services.

### **Review**

#### *Reviewer and scope*

The Director will be conducting the inspection in accordance with section 99 of the Act, with the help of a small team to ensure there is a comprehensive examination of not only the operational, clinical governance and functioning of the adult inpatient and associated mental health services, but also, how that operational and clinical governance is overseen by wider organisational processes.

#### *Process*

The review will involve data analysis, interviews with relevant people and a clinical file review. All care will be taken to minimise the effects of this review on the clinical staff involved however it will be important to meet with clinical staff as part of this review.

It should be noted that the care of the patient involved in the critical incident on 25 June 2022 is now the subject of a full and independent review. The review is being led by Te Whatu Ora (Health NZ) officials who are independent of the service. Thus, while there will be some overlap, this inspection is not a review into that individual's care.

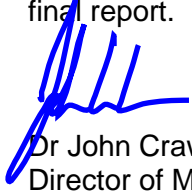
#### *Timing*

A preliminary scoping inspection of these forensic mental health service will be held on 6 and 7 July 2022. This will determine the nature and scope of the full inspection.

#### *Report*

A report of the full inspection will be published on the Ministry of Health's website at the completion of this work. In the interests of supporting open disclosure of information no details of individual interviews or information identifying individuals will be published. Participants can

be assured that what they say will be in confidence, but the issues will be summarised in the final report.

A handwritten signature in blue ink, consisting of several vertical strokes followed by a horizontal line and a small flourish.

Dr John Crawshaw  
Director of Mental Health  
6 July 2022