Review into the Treatment and Management of a Mason Clinic Special Patient

Released September 2016

The scope of the review

The review team were asked to conduct an independent review of the treatment and management of Manjit Singh, and the management of his approved leave in the community, including the assessment and management of any risks to his safety and the safety of others.

The team was requested to investigate and identify contributory factors to the incident including but not limited to the following.

a. Whether the Mason clinic's assessment, documentation, management and review of Mr Singh's clinical condition and risk was consistent with reasonable expectations for a special patient in his circumstances.
b. Whether the Mason clinic's policies, processes and procedures as they relate to this incident were adhered to.
c. Whether timely notifications were made to the Forensic Director of Area Mental Health Services and Director of Mental Health about the incident involving Mr Singh.
d. Whether all actions that could reasonably have been taken to prevent this incident, based on the information available to staff, were taken by the Mason Clinic.

The review team was asked to make recommendations to improve clinical care and address any weaknesses identified during the review.

The review process

The review team were provided with copies of clinical files including comprehensive reviews, special patient reviews, Mental Health Review Tribunal report, risk assessment reports and a variety of other clinical documentation, including full printouts of electronic medical records from 23 December 2014 to 5 November 2015. The review team was also provided with copies of all relevant policies and procedures. Various other documents were accessed during the course of the review.

The review team visited Auckland and Hamilton, and interviewed the following relevant staff and family members.

i. Family Member A, Mr Singh's primary caregiver
ii. Family Member B, victim of the index event
iii. Clinician A, Director, Auckland Regional Mental Health Forensic Services and Forensic Director of Area Mental Health Services
iv. Clinician B, Consultant Psychiatrist and Responsible Clinician
v. Clinician C, Consultant Psychiatrist
vi. Clinician D, Consultant Psychiatrist
vii. Clinician E, former Manager, Community Forensic Team
viii. Clinician F, Registered Nurse, Key Worker, Community Forensic Team
ix. Clinician G, Social Worker, Community Forensic Team
x. Clinician H, Dual Diagnosis Clinician, Community Forensic Team
xi. Clinician I, Unit Manager, Rimu Unit.

Identification and discussion of key issues

During the course of the review, a number of themes and issues emerged. The key issues were identified as follows.

1. Overall standard of clinical care and documentation

2. Decision to discharge Mr Singh to the care of family rather than step-down bed
3. Reviews of progress, including Special Patient Review process
4. Communication amongst clinicians
5. Intermittent absence of responsible clinician
6. Communication between clinicians and family members
7. Absence of principal community carer for 2 months overseas trip
8. Monitoring of mental state, behaviour, and compliance with treatment
9. Monitoring of abstinence from drugs of misuse
10. Response to concerns relayed by Family Member B
11. Notifications following the index event
12. Adherence to relevant policies and procedures.

Findings

Overall, we find that the single most significant factor contributing to the index event was the decision taken by Mr Singh and maintained over time to deceive his caregivers – by ceasing to take his medication, and to repeatedly breach the conditions of his leave.

We also find that the second most significant factor was the deliberate collusion of immediate family members and caregivers in assisting Mr Singh to breach the non-contact rules of leave, and the deliberate withholding of information about these breaches from Mason Clinic staff. The justification for this course of action appears to have been a perception that Mr Singh remained well. This is perhaps reinforced by the fact that Family Member B did make contact with the Mason Clinic when it became clear to them that Mr Singh was becoming so unwell that he posed a threat to Family Member B and to others.

We consider that any shortcomings by the Mason Clinic need to be interpreted in the light of these overriding factors.

1 Overall standard of clinical care and documentation

We find that the overall standard of clinical care and documentation, and consequently the management of Mr Singh's condition and risk, was to a very high standard and consistent with the expectations for a special patient in his circumstances.

We are satisfied that the Mason Clinic identified and addressed the relevant risk factors that Mr Singh posed, and took appropriate steps to address these. In particular, clinicians addressed his history of deceitful behaviour and non-compliance with medication, and his overall level of insight into his situation. We note that all of the relevant risk factors were identified before he was released on leave, and arrangements were put in place to manage them.

2 Decision to discharge Mr Singh to the care of family rather than step-down bed

We find that this was a reasonable clinical decision in the circumstances, and that appropriate preparatory steps were undertaken.

3 Reviews of progress, including Special Patient Review process

We find that, in accordance with existing policy, there were reasons to maintain the frequency of Special Patient Reviews at 6-monthly intervals. With a transfer into a family placement in the community there was potential for environmental instability, even if Mr Singh remained clinically stable up to and after discharge.

We also find that there were grounds for stricter observance of the conditions of the scheduled overnight stays at Rimu Hostel. Mr Singh needed to arrive and leave at the stated times, in order to facilitate an hour or two of careful interviewing and observation by his regular care team.

4 Communication amongst clinicians

We are satisfied that there was good communication between clinicians, although the overall circumstances were less than ideal as a result of a chronic illness of the Responsible Clinician for much of the relevant time period.

5 Intermittent absence of responsible clinician

We accept that this circumstance is likely to have had some impact on patient care, but it is difficult to assess its impact. We are satisfied that senior staff at the Mason Clinic acted reasonably in obtaining and following expert advice from an occupational physician.

6 Communication between clinicians and family members

We note that there were problems in communication with Family Member B. In particular:

a. The proposed means of contact (mobile phone) created an unanticipated barrier, in that Family Member B did not want to meet the costs of making a call;
b. The clinical team undervalued the significance of child access arrangements in the eyes of both Mr Singh and Family Member B; and
c. There was no contact by the clinical team with Family Member B throughout the period of community leave, with the result that a poor relationship with the community team marked by suspicion was allowed to persist. This in turn hindered a quick response when Family Member B did provide accurate information to the clinical team.

We are satisfied that there was a good and appropriate level of communication from the clinical team to Family Member A, the principal caregiver. Unfortunately, Family Member A did not respond in the same manner, and failed to maintain a satisfactory level of communication with the clinical team.

7 Absence of principal community carer for 2 months overseas trip

We have identified this as an area of concern. While this state of affairs was brought about principally by a lack of communication from Family Member A, there were a number of other factors that contributed to the overall situation that developed subsequently. In particular:

a. There is no evidence of a proper risk analysis within the Forensic Community Team of the situation after learning of Family Member A's proposed absence, with consideration being given to what adjustments could be made to compensate for the change in circumstances;
b. The Forensic Community Team did not advise the Director of Area Mental Health Services, who was responsible for approving the leave arrangement, of this significant change, thus removing an opportunity to formally review the situation; and
c. The frequency of Special Patient Reviews had been reduced to 12-monthly, thus removing another opportunity that would have formally brought the issue under careful consideration.

8 Monitoring of mental state, behaviour, and compliance with treatment

We find that the Mason Clinic staff acted reasonably based upon the information that was available to them.

9 Monitoring of abstinence from drugs of misuse

We find that the monitoring of abstinence from drugs of misuse was adequate and consistent with reasonable practice.

10 Response to concerns relayed by Family Member B

We are satisfied that the decisions and actions of the clinical team were satisfactory and appropriate based upon the information available to them at the time.

However, we also note that it is likely these concerns would have been communicated by Family Member B to the clinical team significantly earlier if there had been different contact arrangements – in particular:

a. A freephone number; and
b. Scheduled contact with Family Member B by a member or members of the clinical team.

11 Notifications following the incident

We are satisfied that the process of notification followed in response to the incident was prompt and appropriate, and that all procedures were properly followed.

12 Adherence to relevant policies and procedures

We did not find any evidence of a lack of adherence to any relevant policy or procedure, subject to comment regarding the frequency of Special Patient Reviews (see [3] above).

Recommendations

1 We do not recommend any general tightening of controls around Special Patients in response to this incident, which occurred in the context of a combination of specific and unfortunate circumstances that are unlikely to be repeated. No system can be totally foolproof; and a system that values rehabilitation must of necessity tolerate a level of risk. The aim must be to provide a sound and reliable system for managing an acceptable level of risk. The combination of good clinical care, sound clinical judgment and strong working alliances with families and other community support structures remains the proper basis for safe management and rehabilitation of a Special Patient.

2 The issue of the time period between Special Patient Review hearings needs to be carefully considered for each Special Patient, paying particular attention to the guideline criteria for frequency of review as well as particular and relevant circumstances of each individual case. Any significant change in circumstances should prompt a further reconsideration of the appropriate time frame for review at the time such change is identified.

3 Consideration should be given to further discussion between the Ministry and Forensic Services around the strength of the presumption in favour of 6-monthly Special Patient Review hearings, and the factors relevant to a determination of whether this presumption is displaced in any particular case.

4 Any significant change in the circumstances or monitoring arrangements of leave for a Special Patient in the community, especially if this is unanticipated, should always be brought to the attention of the Director of Area Mental Health Services who has authorised the leave.

5 Patients, families and significant others need to be provided with copies of written conditions and expectations of leave, together with clear instructions as to what to do and who to contact if there is any mishap or breach of conditions. In certain circumstances these instructions may need to be translated into languages other than English.

6 Services need to ensure that any potential barriers to communication with family members or other significant community supports are minimised. In the circumstances of this case the use of a free telephone number and occasional proactive contact on the part of clinical staff would likely have been sufficient steps. In other circumstances, the appropriate steps will no doubt differ.

7 When a Special Patient returns overnight from leave, the times of arrival and departure from hospital need to be carefully maintained and there needs to be allowance for sufficient time interacting with clinical staff in order for a proper assessment to be completed, rather than a patient merely returning to sleep overnight.

8 Close coordination needs to be maintained between a hospital unit where a patient returns from leave and the community team responsible for their care.

9 It would be helpful for the Director to clarify the policy around 72 hour reassessment admissions for special patients on leave, in order to ensure that clinical staff are not constrained in acting promptly and decisively when a problem occurs and that there is no scope for misunderstanding.

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Dr Nick Judson
Psychiatrist

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David Niven
District Inspector