BENDIGO HEALTH

HEALTHY COMMUNITIES AND
WORLD CLASS HEALTHCARE

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23 March 2015

Coroners Court
Level 11
222 Exhibition Street
Melbourne Vic 3000

Dear Sir/Madam,

INQUEST INTO THE DEATH OF DEAN ALAN CARLSON LAYCOCK
COURT REFERENCE: COR 2009 005950

We refer to the inquest held in relation to the death of Dean Alan Carlson Laycock before Coroner Tregent on 5 and 6 March 2012; 10, 13 and 14 August 2012 and 17 and 18 December 2012.

Coroner Tregent delivered her findings on 22 December 2014. At the conclusion of her findings, Coroner Tregent made the following recommendations pursuant to the section 72(2) of the Coroners Act 2008 (Vic):

1. *There needs to be mandated minimum requirements of documentation that must transfer with the patient to PARC from an inpatient facility. There needs to be a policy formulated as to what this documentation need to be. At a minimum it would be an expectation that the patient's records from the previous 7 days (assuming they had been an inpatient for that long) would be made available. There should be minimal reliance on verbal handover of information.*

We provide the following response to the Coroner's recommendation.
Bendigo Health Care Group Psychiatric Services' "Health Record Management Guidelines" state under the heading "Health Record Transfer" that "The record should be transferred to the community setting (including PARC) within 24 hours of discharge. If this is not possible, for whatever reason, the inpatient team has the responsibility for ensuring that the record is transported to the community team as soon as is possible, and that as an interim measure all available electronic data is up to date and available. All paperwork should be transferred with the record." Further, the acute adult inpatient unit's Discharge Checklist has listed as a responsibility of a specific nurse (the allocated discharge nurse) to "Fax copies of discharge information sheet" (containing a variety of clinical information) and "Continuation sheets which include admission notes, Consultant Reviews and the last 5 continuation sheets" to the relevant team. It is acknowledged that currently these requirements are not detailed in a policy format, nor is it certain that the past 5 continuation sheets will necessarily contain records from the previous 7 days. BHCG undertakes to incorporate this recommendation from the coroner into its existing "Inpatient Units Admission, Discharge, and Transfer & Bed Management- Psychiatric Services" Policy and Protocol. The imminent development of a Digital Medical Record will also provide a means whereby clinical

documentation will be instantly available to all parts of the service simultaneously, which will render this recommendation obsolete. This process is anticipated to commence in a matter of weeks and be implemented by mid-2016.

2. *The BHCG should prepare its own policy surrounding the decision making process of granting permission for a leave of absence from PARC. This policy should reflect, to the extent relevant, the considerations as outlined in the Chief Psychiatrists guidelines on Inpatient leave for voluntary and involuntary patients. The policy should emphasise the importance of decisions as to periods of absence being made with a full understanding of the patient's background and personal circumstances. The policy should also ensure the patient and (where appropriate) the carer are consulted and involved in the discussion of any absences. In addition the patient and carer need to be provided with a fully informed explanation as to the reasoning behind the decision making process.*

We provide the following response to the Coroner's recommendation.
BHCG accepts the coroner's view that a period of absence from PARC is to all intents and purposes the same as leave from an inpatient unit, and so should be approached in the same way. In recognition of this, BHCG accepts this recommendation and undertakes to amend the existing Leave Policy (which currently applies only to inpatient units) to make specific reference to PARC.

3. *The BHCG needs to ensure that all policies that do exist are properly and fully explained to the staff. There needs to be regular and mandatory training of staff to ensure they are appraised of the Policies and how to implement them. The BHCG should consider facilitating a fixed program regarding ongoing education of staff. Inclusive of this training, is not only a familiarisation with the internal policies of BHCG by which they are governed, but also all of the Chief Psychiatrists guidelines that may have useful application of their care of patients.*

We provide the following response to the Coroner's recommendation.
BHCG has many policies, protocols, procedures and guidelines, many of which are highly specific to particular business and clinical units, and therefore irrelevant to the majority of staff. For Psychiatric Services staff, BHCG currently ensures that all new staff are oriented to the existence of the set of documents relevant to Psychiatry, and are given a detailed understanding of how to access these. This knowledge is audited annually and usage of the electronic policy repository is monitored by the hospital executive. Specific key policies are discussed in greater detail during new staff orientation. Detailed unit orientation to each employee's particular workplace includes further reference to the policies most relevant to that team. Changes to existing policies or the addition of new policies are advised to all staff through electronic, paper and face to face means, via newsletters, team meetings and meeting minutes. Training provided by the Psychiatric Services Professional Development Unit on specific topics always references the relevant policy(ies) framework. Such training occurs regularly and on an *ad hoc* basis. Every employee's position description contains specific advice as to their responsibility to know and comply with the hospital's policies and procedures. Policies which refer to Chief Psychiatrist's Guidelines contain a hyperlinked reference to the Guideline which is then immediately available to the employee for reference and further advice if required. BHCG accepts that all Chief Psychiatrists guidelines that may have useful application to the care of patients will be referenced in appropriate policies.

4. *If not already in place there needs to be a clear chain of responsibility as to who is responsible for overseeing an internal review of a patient's death.*

We provide the following response to the Coroner's recommendation.
This is accepted. BHCG now has clear policy guidance on the chain of responsibility for overseeing the internal review of a patient's death. This is elaborated in the "Notification Process and Mortality Review For a Death of a Registered Psychiatric Patient Protocol", approved in January 2010.

5. *A Clinical team meeting should not discuss a patient unless the consultant psychiatrist has actually met with the patient and reviewed his or her file. This should be more readily achievable given the additional days of attendance of a consultant psychiatrist. This is particularly important as ultimately the decisions on leave and other management of a patient are the responsibility of the psychiatrist.*

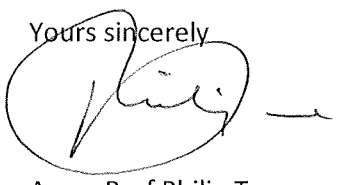
We provide the following response to the Coroner's recommendation.
As the Coroner noted in her findings, for some years the Consultant Psychiatrist time allocation to PARC has been considerably increased, compared with the time available in 2009. While agreeing in principle with this recommendation as representing the best practice standard, there are practical realities which mean that it may not always be possible. There are also many issues discussed in the clinical team meeting which rely on the expertise of other members of the multidisciplinary team and it could be to a patient's disadvantage if these issues were not progressed in a timely manner. Rather than making an absolute prohibition on discussing a patient in a Clinical Team Meeting unless the consulant psychiatrist has met with the patient and reviewed his or her file, BHCG accepts the clinical standard implicit in this stance and undertakes to reinforce this by ensuring this recommendation is put to the entire body of Consultant psychiatrists through the service's regular Psychiatrists meeting.

Bendigo Health Care Croup is confident the above initiatives and changes it has implemented will ensure improved patient care at PARC, as well as staff education and the mortality review process.

We trust this is of assistance to the Court.

Please do not hesitate to contact me if you have any queries.

Yours sincerely



Assoc Prof Philip Tune
Executive Director
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