IN THE CORONERS COURT
OF VICTORIA
AT BENDIGO

Court Reference: COR 2009 005950

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: Dean Alan Carlson Laycock

Delivered On:	22nd December 2014
Delivered At:	Bendigo Law Courts
Hearing Dates:	5th and 6th March 2012, 10th, 13th and 14th of August 2012 and 17th and 18th of December 2012
Findings of:	JENNIFER TREGENT, CORONER
Representation:	Ms E. GARDNER instructed by Loddon Campaspe Community Legal Service appeared on behalf of the relatives of the Deceased. Ms J. BENSON instructed by HQ Law appeared on behalf of Bendigo Health Care Group.
Assisting the Coroner	Sgt M. SNELL and S/C K. MANNES appeared to assist the Coroner.

I, Jennifer Tregent, Coroner having investigated the death of Dean Alan Carlson Laycock

AND having held an inquest in relation to this death on 22nd December 2014

at Bendigo Law Courts, 71 Pall Mall, Bendigo

find that the identity of the deceased was Dean Alan Carlson Laycock

born on 7th July 1985

and the death occurred 24th of December 2009

at 124 Wilsons Road, Heathcote

from:

1 (a) Hanging

in the following circumstances:

BACKGROUND

1. The deceased Dean Alan Laycock was 24 years of age at the time of his death on Christmas eve in 2009. Dean had lived of recent times with his mother at the Wilsons Road address in Heathcote. This was becoming increasingly difficult and the ultimate aim was that he would move to independent living.

2. Dean was the third child to Vickie Denise Laycock. Mrs Laycock was married to Peter Laycock for a period of 11 years and they had two children being Yvonne and Dean.

3. Early on it appears to have been recognised Dean had a learning disability and was diagnosed with a compulsive disorder. He found schoolwork challenging and battled through to year five level. He attended a special school to assist him. As a consequence of his intellectual disability Dean was not able to secure employment and was ultimately placed on a disability support pension.

4. After his parents separation they remained on good terms and though the children originally resided for most of the time with their mother, Mr Laycock exercised fortnightly access. They continued to communicate well on matters involving the care and welfare of their children.

5. When Dean was about 9 years of age he chose to live with his father in Melbourne and thereafter moved back and forwards between living with each parent. When he

was about 16 years of age Mrs Laycock became aware that Dean was using marijuana and describes his use as heavy and he was dependent upon it. Mrs Laycock believed he may also have been using other drugs but was not sure exactly what these were.

6. The use of the drugs had an impact on Dean's mental well being and at times he acted irrationally. In about 2007 Dean physically assaulted Mrs Laycock and threatened to burn the house down. On police attendance he was taken to psychiatric services in Bendigo. It took a number of years and other factors to intervene before Dean was finally being appropriately case managed in the Community. I am not critical of anyone as to why it took such a length of time as the need for intervention had not been recognised earlier.

7. In April of 2007 Dean met with Kerrie Norris a registered nurse with psychiatric qualifications who was employed by Bendigo Health Psychiatric Services. Ms Norris was Dean's case manager and in this role she would oversee the management of his mental state, his medications and his life in the community. Dean was also under the care of the John Bomford Centre in Bendigo and would attend to see a psychiatrist. At times he was admitted to the Alexander Bayne Centre (commonly referred to as the ABC), which is the inpatient psychiatric unit attached to the Bendigo Health unit.

8. Dean was well managed within the community and although at times his mental health deteriorated, requiring admission to the ABC or to the facility commonly known as PARC, he was generally compliant with what was required. PARC is an acronym for Prevention and Recovery Care. I will detail more fully what the role and function of PARC is later in this finding.

9. Mrs Laycock stated that approximately 12 weeks prior to Dean's death he was in a terrible state, talking to himself and acting oddly. As a consequence he was placed again into the Alexander Bayne Centre as an involuntary patient. At that time he was under the care of Psychiatrist Dr. Teslin Mathew. Whilst there Dean's condition was treated with a different medication called Clozapine. This appeared to have a positive result in stabilising Dean's mood and behaviour. He was by all accounts doing very well on this medication.

10. It was recognised for some time that Mrs Laycock had indicated that she did not believe she could cope any longer with Dean residing with her and that alternative accommodation needed to be sourced in the community. This was a sensible outcome

to seek to achieve as Mrs Laycock would not be able to provide for Dean forever and therefore a transfer to independent living was an appropriate strategy. It was noted Dean was reluctant and still desiring of living at home, but it appears prior to his death he was recognising of the fact that he would not be living at home after PARC.

11. In order to achieve this step it was decided that Dean would transition into PARC, as a "step-down" into the Community and from there to independent housing.

12. On the 22nd of December 2009 Dean was transferred to PARC. At that time Dean and his family were of the understanding that Dean would be permitted 4 days leave over Christmas, as agreed to whilst resident at the ABC. As it transpired however, on admission to PARC the question of leave over Christmas was subject to the review of the responsible parties at PARC. In the late afternoon of the 24th of December 2009 a decision was made after a clinical team meeting that Dean's leave period should be reduced to 2 days instead of 4 based on a belief that Mrs Laycock could not cope with Dean living with her.

13. On the afternoon of the 24th of December 2009 at around 10 to 4pm, just as Mrs Laycock was to collect Dean for leave they were informed of the decision that leave was reduced. That information was conveyed by David Sproles a mental health clinician who had been involved with Dean's care whilst at PARC. A mental health assessment of Dean was conducted by Mr Sproles prior to his leaving the centre and subsequent to being advised of the reduction of leave. Mr Sproles made the observation that Dean's mood was observed as slightly lowered but Dean denied any suicidal ideation or thoughts of self-harm.

14. Mrs Laycock described Dean's mood as altering significantly and that whilst on the car journey back to Heathcote he had made the comment "one way or another I am not coming back here" and that he may shoot through to Queensland. It is clear from Mrs Laycock's evidence that she was never of the view that Dean was likely to take his life.

15. On arrival home Dean's agitation remained and Mrs Laycock went to her bedroom expecting that he would calm down. On coming out of her room at around 8pm Mrs Laycock could not find Dean in the house and on investigating outside found him deceased in the shed.

16. The evidence of the police investigator was that Dean had stood on a ride on mower in the shed and tied a nylon rope to a roof truss. Dean looped the rope around his neck and stepped off the mower. The cause of death as ascribed by the Pathologist Dr. Murtolo was "Strangulation by Hanging".

THE FUNCTION AND PURPOSE OF THIS ENQUIRY

17. There are certain mandated statutory requirements on a Coroner when investigating the death of an individual. Pursuant to section 67 of the Coroner's Act 2008 (the Act) the Coroner must find if possible the identity of the deceased; the cause of death of the deceased; the circumstances in which death occurred; and any other prescribed matters.

18. It is clear the function of the Coroner's court is to investigate the circumstances of a death not to apportion blame, but to obtain information that may be used to make recommendations to ensure, that as far as possible, a death under similar circumstances may be avoided in the future.

19. It was further emphasised in the written submissions received on behalf of the Bendigo Health Care Group (BHCG), which is the umbrella organisation that administers both the ABC and PARC, that caution should be taken in gratuitous criticism of a public health body's practices, procedures and protocols without good reason. The fear is that such will undermine public confidence in the various health bodies. That is of course true, but if a level of criticism is necessary to lead to an altered state of practice or procedure, which will lessen the likelihood of a death, then that is how it must be.

20. In this finding I do not propose to summarise the evidence of each witness, as copies of their statements and transcripts of their evidence remain part of the Court file. I propose to deal with the evidence under various sub-topics.

DEAN'S ADMISSION AND DISCHARGE FROM THE ABC

21. As detailed previously due to Dean's relapse of psychosis he was admitted to the ABC on the 3rd of November 2009. On the 11th of November his treating psychiatrist at the time Dr Teslin Mathew started Dean on Clozapine in an attempt to stabilise his condition. At first Dean was reluctant about the change of medication but agreed to

the trial. As Dr Mathew noted Dean's mental state gradually improved. Mrs Laycock made the same observation.

22. During his stay at the ABC there was much discussion with Dean about what leave he would be able to utilise over the Christmas period. He had informed Dr Mathew that he wanted to spend time with his sister who was coming down from Queensland with her children and also wanted to spend time with his mother and father. Dr. Mathew was aware of what the arrangements were to be, whereby Dean would stay briefly at his mother's and then they would both go to his father's in Melbourne.

23. According to the evidence of Dr Mathew, Dean had originally wanted a weeks' leave but she had negotiated it down to 4 days. Dr Mathew communicated as much to Mrs Laycock on the 9th of December 2009 and Mrs Laycock stated that she could cope with this arrangement. The fact of this conversation was recorded in Deans file. As noted by Dr Mathew, Dean had already been successfully utilizing day leaves with his family and that fact would also have been evident from the records.

24. Mrs Laycock gave evidence of having told Dr Mathew that there were supports in place for her to be able to manage. Dr Mathew gave evidence that she discussed the monitoring of Dean's medication regime during his four days leave with Mrs Laycock. It appears that Dean also was happy about the time permitted. There was therefore no embargo on the view of Dr Mathew on Dean having the leave as requested. These arrangements had been able to be achieved after good and appropriate communication between the parties.

25. It was recognised that prior to transiting to independent living it would be necessary for Dean to move to a less restrictive facility which could provide him with extra psychosocial supports to help him organise his daily living with a view to living in the community. The location ultimately decided upon was for PARC as it was a place that Dean was familiar with, having stayed on at least three prior occasions.

26. It is best to describe briefly here what PARC is. It is generally referred to as "step up, step down" facility whereby in times of need the patient steps up into PARC for assistance when not coping in the Community or steps down to PARC from a inpatient facility, such as the ABC, in preparation for stepping back into the Community.

27. Unfortunately, as it transpired the leave authorisation that was given by Dr Mathew as the psychiatrist at the ABC was not binding on any decision that would later be made by those in charge of Dean's care at PARC. It was for that reason that the terms of leave were able to be changed. The fact of a possible alteration to the leave arrangements from PARC was never communicated to Dean or his mother. I have no doubt, if it had been then Dean and his family would have been in a better position to negotiate it otherwise.

28. It needs to be recognised that PARC is a very different facility from the ABC in that it is solely for voluntary patients. In the event a client chose to walk out of the facility they could do so. It may lead to them being breached on their Community Treatment Order, but the staff at PARC could not legally stop them from leaving. Under those circumstances the evidence of the witnesses from PARC was that it was not leave as such that was being granted but permission for them to be absent from PARC. It is to my view of little relevance what terminology applies. The fact is that Dean's approval to be absent from PARC was altered from what was his expectation whilst resident at the ABC.

29. The evidence of Dr Mathew was that the process of referral to PARC commenced on the 18th of December 2009 and approval was given on the 22nd of December 2009 and Dr Mathew informed Dean of the decision in her ward rounds on that day. Dean reacted positively to this news and he was moved on that day. Mrs Laycock was unaware of this fact until telephoned and advised of as much by Dean. I find this somewhat unsatisfactory that the patient himself is the one who is keeping his family informed of his movements and not the parties involved in his care.

30. There was also the question of the placement of Dean on a Community Treatment Order. Mrs Laycock was of the view that she and other family members would be entitled to participate in a meeting surrounding such an application. Mrs Laycock stated she was told the meeting had been cancelled yet a Community Treatment Order was in fact made by Dr Mathew on the 22nd of December 2009. The making of the CTO was no doubt facilitated by the move off an involuntary treatment Order whilst at the ABC and his admission to PARC. This was to ensure ongoing management of Dean in the Community. I am not critical of the making of the CTO but there again appears to have been a break down in communication or a misunderstanding.

31. Dr. Mathew conceded that it was usual and currently a mandatory requirement that there be a treatment plan attached to a CTO. The current Chief Psychiatrist's guideline "Treatment plans under the Mental Health Act" stipulates that as far as practicable the patient and his family or carers should be consulted as to what is the aim of treatment. Dr. Mathew recognised it was a failing on her behalf not to have completed such a document. The BHCG stated in submissions however, that this fact did not play a role in Dean's death. That may be so, but it was a further administrative oversight noted in the management of Dean's care.

32. At the time of Dean's transfer or "hand over" from ABC to PARC there was verbal information sharing, as was usual. The witness Rebecca O'Brien, a qualified social worker and employee at PARC, completed Dean's admission paperwork at 4pm on the 22nd of December 2009. Ms O'Brien had little involvement with Dean and his care subsequent to his admission. In giving evidence Ms O'Brien could not recall what information in documentary form was provided as part of the hand over of Dean from the ABC. She could not recall having seen the CTO paperwork but believes at a minimum she was advised of as much given she had ticked the relevant box on the admission form to say so. Ms O'Brien was aware of the fact that Dean was to have leave over Christmas but could not recall how it was that she knew of this fact.

33. There was certainly no protocol for the patient's clinical file to be transferred from the ABC to PARC at the time of the patient's admission. The evidence was that copies of some of the entries from the prior week of admission may come at the time of patient transfer or may come some days later or not at all. There was also usually a discharge summary provided from the ABC to PARC. It was recognised by BHCG that it was not until some time after Dean's death that this was prepared.

34. The witnesses called to give evidence who had been involved with Dean over his stay at PARC had limited recollection as to having seen any documentation that had transferred from the ABC. Dr Mathew could not recall having ever spoken to Dr Emmanuel, who became Dean's treating psychiatrist at PARC, and vice versa. There was therefore very limited exchange or sharing of information between the two facilities.

35. It would have been desirable to have the complete file from Dean's admission transferred with him. The facilities have a shared expectation about their involvement with a patient, if their mental health improves they go to PARC if it deteriorates they

go to the ABC. The advantage of the full clinical file being available is it provides the background of what has occurred of recent times. It provides a complete picture as to what difficulties were faced by the patient, the points for improvement and the prospects for the future. This is particularly so given the lack of provision here of a Treatment plan attached to the CTO and a failing to provide a Discharge summary until after Dean was deceased. It might be wondered what utility was sought to be achieved at that late stage by preparing such a document.

36. The benefit that would have been derived with better information sharing in Dean's situation is that the information would be included about how keen he was to have Christmas leave and the details as to what was planned. It would have been evident that the sole responsibility for Dean by Mrs Laycock would have been for one night only. Thereafter he would be with extended family in Melbourne. In addition the Clinical Team meeting participants would have been able to read the notes of Dr Mathew's conversation with Mrs Laycock confirming she was happy with the arrangements for leave and able to cope. All this information if available would have impacted ultimately on the decision regarding Dean's leave of absence from PARC.

DEAN'S TIME AT PARC

37. As noted, this was Dean's fourth admission to PARC, so he was familiar with the set up and expectations whilst there. He was also known to some of the staff members who had been in attendance at his prior admissions. One such person was Mr David Sproles, who undertook Dean's risk assessment on the 23rd of December 2009 and was further engaged with him thereafter. Mr Sproles spoke of how Dean was happy to be out of the ABC and that he spoke in positive terms about his future plans. He spoke of saving for a car and of going home for Christmas. Dean reported his mood was good and he was no longer experiencing any auditory hallucinations.

38. The same observations were made by Ms Rachel Masiboy, who was also a Mental health clinician and, at the time of Deans admission to PARC, was employed as a psychosocial support worker with Mind Australia. Ms Masiboy spoke of how she saw Dean in the morning of the 24th of December 2009 and spent time with him. She said he asked if staff could follow up on his transitional housing arrangements with St Luke's, the organisation responsible for sourcing the accommodation. He spoke of the

goals he had including finding a job, working on his self esteem ,waking up early instead of sleeping in, becoming more assertive and making personal decisions instead of leaving it to others to decide matters on his behalf. Dean was spending time in the communal house and interacting well with others. As was a recurring feature of his time spent at the ABC, Dean spoke enthusiastically to all who would listen about his going home over Christmas.

39. It was Ms Masiboy's task to ensure that Dean had a risk management plan in the event he started to become unwell again. Dean stated that if he was feeling depressed he would get support, someone to talk to or go for a walk. He would talk to his mother about his personal feelings. Ms Masiboy noted that Dean had stated there were currently no thoughts of suicide. This assessments was of course conducted prior to the Clinical team meeting and prior to Dean being advised of the reduction in leave. Over the limited time that Dean had been at PARC all management and care was largely appropriate. He was happily engaged and showing good signs of recovery.

40. There was a shortcoming however, and that was that since his admission into PARC at 4pm on the 22nd of December 2009 and up to the time of leaving at 4pm on the 24th of December 2009 he had never been seen by the person who was to be his treating psychiatrist Dr Ajit Emmanuel. This in itself would not have been a difficulty if the status quo was to remain the same. Dean was appropriately medicated and had been stabilised accordingly prior to leaving the ABC. He had demonstrated compliance with his medication since arriving at PARC. There were no other changes, in terms of his management, that needed to be made. That is of course until it came to the discussion about leave.

41. It must be recognised it was not of Dr Emmanuel's doing that he was only rostered in the manner he was, which he gave evidence was three days per week being on Mondays from 2.30pm, Thursday from 1.30pm and Friday mornings. Dr Emmanuel had been the consultant psychiatrist at PARC since 2006, yet notwithstanding that fact somehow he had never been involved in Dean's treatment before. The timing was such that Dr Emmanuel had not met Dean prior to the Clinical Team meeting on the 24th of December 2009. I am advised in BHCG submissions that there has now been a change to the rostering since Dean's death and I understand that such a situation should not arise again.

THE CLINICAL TEAM MEETING

42. A crucial matter for consideration in this finding is an examination on how the Clinical team meetings were conducted at PARC. The evidence was that such meetings were routinely held two times per week and were effectively chaired by the consultant psychiatrist to PARC Dr Emmanual. The parties present at this meeting were, as far as possible, all of the clinical staff involved in the care of the patients. In his evidence Dr. Emmanuel stated that of the available ten beds in the facility on the 24th of December 2009, seven of those were occupied. It follows that it was only necessary to discuss the management of seven patients during the Clinical team meeting. These Clinical team meetings were an opportunity for the clinical and non-clinical staff to share information about the patients for decisions to be made about treatment.

43. It was in this Clinical Team meeting conducted on the 24th of December 2009 that the ultimate decision was made to reduce Dean's Christmas leave with his family from 4 days to 2. The reason significantly attributed to that decision was a belief that Mrs Laycock would not be able to cope with Dean over a more extended period. This explanation is somewhat contradictory, in that the opinion is formed that Mrs Laycock would not be able to cope alone with Dean for 4 days yet the reasoning was that she would be able to cope for 2 days.

44. There were many witnesses called who had attended this Clinical team meeting. Along with Dr Emmanuel there was David Sproles, Rebecca O'Brien, Rachael Masiboy, Helen Andison, psychiatric nurse Dorothy Boyd and Mind staff Heather Brown and Clare Chalkley. The overall impression, with which I was left, is that no one had a clear recollection as to what was said. In addition, there are significant variations in the evidence of the witnesses present at the meeting as to how much time it occupied and what was discussed. It is also unclear from where information was sourced that was then relied upon in the decision making process.

45. The process of reconstruction of the events was further hampered by a lack of appropriate record keeping of the meeting. It remained for much of the time over which this enquiry occupied a lack of understanding as to who exactly was present at the meeting given the paucity of notes available. A failure to conduct a mortality review (subject to discussion later) also meant that the participants were only asked to recall what was said to have occurred at the time of this enquiry, some years after the

events. If a mortality review had been done in a timely manner, it may have provided an opportunity for statements to have been obtained at that time or at least a review as to what actually occurred and whether such was satisfactory.

46. It appears to be common ground that the Clinical team meeting on the 24th of December 2009 commenced at 1pm. It was during this meeting that Dean's particular case and circumstances were discussed. The evidence is however equivocal as to exactly how much time was spent by the team in discussions about Dean. There was an estimate of ten minutes by Ms Masiboy, as compared to the estimate of one hour by Ms Boyd. There was significant variation between what witnesses recalled as to exactly what was discussed as to the reduction of leave. Ms Masiboy could not recall it being discussed at all.

47. Of the witnesses who could recall the discussion, it was as noted previously, centred on considerations of Mrs Laycock's ability to cope over the period. Mr Sproles in his evidence described himself as advocating on Dean's behalf for the retention of the four days leave. Dr Emmanuel on the other hand gave evidence that he could not recall any objection being made to the proposed reduction.

48. It is also unclear as to how the discussion arose as to Mrs Laycock being unable to cope. Dr Emmanuel stated in his evidence that he had formed this opinion in part from a document entitled "Abbreviated Life Skills" that had been completed by Rebecca O'Brien. In that document Ms O'Brien had recorded a grading as equal to extreme to the question "does this person have trouble living with others". Dr Emmanuel also gave evidence that he was told by one of the people present at the meeting that they had observed conflict and arguments between Dean and his mother over the days of his admission at PARC. This purported observation was contradicted by the evidence of Mrs Laycock who stated she had not visited Dean over the time of his recent admission to PARC. Mrs Laycock first attended on the 24th of December at around 4 pm when she was there to collect Dean.

49. There was also a reference by some of the witnesses to having viewed a note that was made by Ms Norris wherein she states that Mrs Laycock had expressed concerns about Dean living with her. Ms Norris was not at the team meeting, therefore the context in which that notation was made could not be confirmed with her. The reliance on that information as being a basis to alter Dean's leave was erroneous. The note was a reference to the long-term plans for Dean that he could not continue to live

at home with his mother. There is, as was conceded by Mr Sproles, a distinction to living with someone as compared to staying with them for a limited 4-day leave period.

50. It is also unclear how much was known or discussed at the meeting in relation to the arrangements for Dean over the four-day period. Dr Emmanuel was very vague as to what his recollection was, yet Mr Sproles stated that he had outlined in the meeting what these plans were. Mr Sproles stated he had informed the meeting that Dean would be travelling to Melbourne and spending time with other family members. Dr Emmanuel conceded, had he been aware of these arrangements it would have alleviated some of his concerns.

51. Dr Emmanuel also confirmed he had not spoken to Mrs Laycock either before or after the decision had been made to reduce the leave. Dr Emmanuel stated he was aware that Dr Mathew had given approval for the four days leave but had not chosen to speak to her when making the decision to reduce the leave. Dr Emmanuel conceded that in hindsight it would have been preferable to have spoken to all of these people. He also conceded that there were other sources of information about Dean that he had not accessed prior to formulating his opinion. It would have been clear, from even a minimal examination of the records of those who had managed Dean at PARC over the preceding days that he was eagerly awaiting his leave and was happy and talkative of the prospect. Dr Emmanuel stated the discussion was entered into jointly with the participants but stated the decision as to the reduction in the leave was ultimately his to make.

52. I find the decision to reduce leave was not based, as submitted on behalf of the Laycock's, on well founded reasons. There had been no reservation spoken of by Mrs Laycock as to not being able to cope and she had not been spoken to about this suggestion. Dr Mathew had appropriately consulted with Mrs Laycock some weeks prior to confirm that she could manage the leave. As a consequence that leave was given approval to on the 9th of December 2009. It would be safe to presume Dean's mental state was therefore even more stable as of the 24th of December 2009. Dean's medication had been stabilised, he had transitioned to PARC or stepped down, and he was shortly to be released into the Community for independent living. Dean was, as described by Ms Masiboy the best she had ever seen him.

53. The evidence of all the witnesses was that it was never thought that Dean was a risk of suicide as a consequence of the decision to reduce his leave. Had that ever been the concern, his leave would have been cancelled in it's entirety and this never became a consideration. Dr Emmanuel did state that he was concerned, because of Dean's past history, that he would be more angry and irritable and how this would be managed. That is exactly how Dean's behaviour did manifest itself on his return home with his mother, he was angry and irritable. It was just this type of conflict that the reduction in leave was supposed to mitigate against. The anger and irritability did not translate to anyone as a possible risk of suicide.

THE TIMING AND DELIVERY OF THE DECISION TO REDUCE DEAN'S LEAVE

54. The Clinical team meeting having concluded, the task of communicating the decision to alter Dean's leave from 4 days to 2 was delegated to Mr Sproles. It had been thought that Dr Emmanuel would be responsible for undertaking that role but instead it fell to Mr Sproles. Dr Emmanuel gave evidence that he had another patient to see and hence instructed Mr Sproles to pass on the information. Dr Emmanuel said if there had been any problems as a consequence of the decision he could be spoken to further. He did concede he had not said as much to Mr Sproles.

55. Mr Sproles gave evidence of Mrs Laycock arriving at PARC at around 3.30pm or quarter to four. On seeing his mother Dean greeted her with a kiss and was happy to see her. It was at this point that Mr Sproles advised Dean and Mrs Laycock of the decision from the Clinical team meeting to reduce Dean's leave. He states that he advised Dean the decision was not punitive but it was felt four days off the program was too long for both him and Mrs Laycock. Mr Sproles conducted a risk assessment and Dean did not disclose any thoughts of self harm. Mr Sproles stated that he observed Dean's mood to be slightly lowered, which he described as not unsurprising having just received the news of the leave reduction. He described Dean as being less communicative towards his mother.

56. These observations are to be contrasted with that of other witnesses. Mrs Laycock described how on receiving the news of the reduction to his leave Dean appeared devastated. He was seated on a chair starring at the wall and his face was all red. He

was clenching his fists. There were similar observations made by the Mind employee's, Ms Chalkley and Ms Brown, that both Dean and his mother were upset with the outcome of the meeting. It was very shortly after that Dean and his mother left PARC.

57. It must be recognised the timing of the decision to reduce Dean's leave was far from optimum. Endeavours should be made in the future that news of a need for a significant change in plans not be delivered moments before the alteration is to take effect. I would anticipate that all patients who suffer from a mental illness coupled here for Dean having an intellectual disability that they take time to process information. This observation was made by many of the professionals engaged in Dean's care of this very fact. The risk assessment was conducted just prior to Dean leaving PARC, but it might be said that not enough time was permitted to otherwise outwardly gauge his reaction. He answered the questions that he was not at risk of harm, but had he been kept under longer visual observation his true mood may have become evident.

58. It was conceded by Mr Sproles that the timing was poor in relation to the decision to reduce leave. The usual course was that the decision would be made in advance of the leave that was to be taken. As Dean had only recently arrived at PARC the Clinical team meeting on the 24th had effectively been the first opportunity for leave to be reviewed. I enquired of Mr Sproles whether those treating patients with psychiatric conditions were more mindful of the importance to people of days of significance such as Christmas and Mothers or Fathers day. Mr Sproles stated they were and particularly over Christmas as he described this period of interaction with family and friends as causing increased mental stress. He stated it is at these times people can actually become more unwell. It would appear to me that the timing of meetings around decisions such as leave should be brought forward if required. There needs to be flexibility in rostering to achieve this. Decisions made on the cusp of someone's anticipated leave time are inappropriate, particularly where the outcome is adverse to the patient's hopes and expectations.

59. There was a different account by Mrs Laycock as to the reasons she was given for the leave alteration. Mrs Laycock states that Mr Sproles told her that Dean would lose his bed at PARC as they could not hold it for 4 days and that if that happened Dean would be back to square one. Mr Sproles denied making such a comment about the

availability of the bed but did confirm he may have made the observations that Dean would be back to square one. Mr Sproles stated this was a reference to if Dean became non-compliant with his medication. The evidence was that Dean and Mrs Laycock were not told the true reasons for the reduction of leave as it was felt this may create friction between them. It might have been that if Mrs Laycock had been informed of the view she would be unable to cope, she could have argued against such a proposition. It is of course all speculation and to what may have been.

DEAN'S BEHAVIOUR AFTER LEAVING PARC

60. On leaving the PARC facility it was clear to Mrs Laycock that Dean was angry as demonstrated by throwing his belongings in the car and making the comment "one way or another I am not coming back here". During the trip back to her home in Heathcote, Dean was really quiet and only made a few comments that he may shoot through to Queensland and then that he could not as he was on a Community Treatment Order and had no drivers licence. Dean put a CD on and asked Mrs Laycock if she was aware the song that was playing was Jodie's favourite. Jodie was Dean's elder sister who had died in February 2008.

61. On arriving home at around 5pm Dean did not get his bags out of the car and remained angry and punching the walls. He appeared to be frustrated and annoyed that he would only be able to spend a limited amount of time with his sister Yvonne who was visiting from Queensland. As Dean was getting really "wound up", Mrs Laycock went to her room, which she has done in the past, as eventually Dean would calm down. This was the last time Mrs Laycock saw Dean alive.

62. At around 5.30pm Mr Laycock rang the home and spoke with Dean. Dean told him of the reduction in his leave. Mr Laycock stated he could tell by his manner and speech that Dean was "very wild and annoyed" at the decision. Dean had stated he did not think it was worth going to Melbourne due to only having two days. Mr Laycock tried to pacify him and told him to still come but Dean said "I'm going, I don't want to talk". This was the last contact Mr Laycock had with Dean.

63. It was around 8pm that Mrs Laycock made the discovery of Dean in the shed.

64. There was, in the submissions filed on behalf of BHCG, an assertion that "The events following the clinical team meeting which occurred between 4pm and 8pm on Christmas Eve it is submitted demonstrate a break in the chain of causation from the time the deceased left PARC and the time of his death, with a number of significant intervening events, material to the overall circumstances of his death not notified to psychiatric services at any time over that period".

65. In that submission there is also a quoting of Hedigan J in Commissioner of Police v Hallenstein [1996] 2 VR 1 where His Honour said at 17 "what was the cause of an occurrence is a question of fact which must be determined by applying common sense to the facts of each case...the fact that some feature constitutes an essential condition of an occurrence in the "but for" sense does not mean that for the purpose of ascribing fault or responsibility it is necessarily to be regarded as contributing to that occurrence in a causal sense, as a matter of either ordinary language or common sense." As cited further His Honour said at 18 " Moreover his Worship appears to have become enmeshed with the issue of foreseeability as part of the consideration of cause and contribution....reasonable foreseeability is not in itself a test of causation .....It is preferable to leave evaluation of contribution to be made on a common sense case by case basis guided by the general principles to which I have referred."

66. It is to be noted these submissions came at a point following the summary of the circumstances immediately prior to Dean's death and the engagement of Dean with both Mrs and Mr Laycock. The perceived failure of the family to notify the police, or triage or PARC of Dean's behaviour on leaving PARC led to the following comment in the BHCG submissions that "the end result could have been avoided with more timely and effective communication flowing from the family to psychiatric services".

67. I find these comments and observations to be particularly unhelpful. On the one hand the urging on behalf of the BHCG is that the purpose of a coronial finding is to not ascribe fault or blame to anyone for the outcome of the death. In these submissions however, that is effectively what is being done in suggesting that the parents if they had been more pro-active the outcome may have been different. The submissions go on to state that "Dean had experienced a sudden change in mood, which needed a clinical response which BHCG staff could not make because they did not know about it". This comment ignores the evidence of the other witnesses at PARC who spoke of observing Dean as visibly upset prior to leaving.

68. It is recognised, that as Mr Sproles stated in his evidence, the risk assessment is very much reliant on someone telling the truth. As a professional, and the others involved with his care, no one was of the opinion that Dean would take his life as a consequence of the reduction of leave. It was the professionals to whom the family looked and relied upon to make the assessments. The family cannot and should not be criticised for not having a greater level of insight by virtue of the fact Dean continued to demonstrate his anger at the change in arrangements. They also never thought that Dean would take his life.

69. It is clear from the decision of Hedigan J. as cited that foreseeability is not a test of causation. It is, as I agree, clear that no member of the staff from PARC was of the view that the outcome of the reduction of leave would result in such a catastrophic event. The same is of course to be said of his family. The question of foreseeability is however not the same question as one of causation. The BHCG submit the chain of causation was broken by intervening events. In order to establish causation it is necessary to look at the facts and make a judgement from them as stated by Hedigan J.

70. The facts here are that in the weeks leading up to his anticipated leave, Dean could speak of little else. In addition his medication had stabilised and he was feeling better and he had resigned himself to not living at home. He had spoken in positive terms to Mr Sproles in the day prior to his death about his move to independent accommodation. He had enquired of the staff to follow up on the progress of that accommodation whilst he was away. On the 24th of December 2009 his mood had been stable and he was happy when he greeted his mother. He was given news that changed what had been his plans for over a month as to how he would spend Christmas with family. Plans he was excited about.

71. When told of the news his mood was noted as being "lowered" and as stated other staff at PARC noted he and his mother were upset. On the drive home this led to anger and irritability and this remained Dean's state, which was directly referable to the decision to reduce his leave. There was no event or occurrence which could be said to have "broken the chain" of disappointment, frustration and anxiety that had otherwise commenced at PARC. The fact no one foresaw it would alter Dean's mental state to such an extent that he would take his own life is, as stated, a different question.

BHCG'S RESPONSE TO DEAN'S DEATH

72. There was a complete failure by BHCG to undertake a properly conducted mortality review. The extent to which Dean's death was analysed internally appears to be in the form of correspondence delivered by Professor Doherty to the Chief Psychiatrist Dr Ruth Vine. As much was conceded in the submissions prepared on behalf of BHCG. In addition in those submissions it was stated that there were a number of ways set out in the policy that was only "discovered" after the inquest had concluded, as to how a review of a death may be undertaken. It may be undertaken in an informal team review, a review by the triaging team or a formal root cause analysis, depending on the case.

73. It was submitted on behalf of BHCG that the event of Dean's death was not such as to require a root cause analysis. Irrespective of whether such an in depth analysis was required or not it appears to be that, with the exception of the correspondence between Professor Doherty and the Chief Psychiatrist, no other review was otherwise undertaken. I draw this conclusion as none of the witnesses testified as having participated in such an enquiry and there are no notes, file, record or outcome report that could be produced. I note Ms Andison, who was the manager in charge of Triage, CAT and the PARC programs at the time of Dean's death, believed such a report had been completed but it could not now be found. I find that somewhat surprising as there is no reason that a document that was created would not have been saved if not in hard copy but at least electronically. There is also no evidence that anyone can actually recall seeing such a document.

74. In the course of giving evidence as to what was actually undertaken Ms Andison frequently used the expression "I expect" or "I believe" as to some fact but without any actual recall as to it having happened. Having reviewed that evidence and that of the other witnesses I am confident in my conclusion that no such review took place at all. I find it a significant short coming that there was not a thorough and documented review in relation to the death of a patient that occurred whilst on a brief period of absence from the PARC facility.

75. It appears that the only report that was prepared was the correspondence as mentioned earlier from Professor Doherty to the Chief psychiatrist which consisted of two letters, one being a brief report as to the death and dated 4th of January 2010. In that letter there is a reference to the fact that it was anticipated that a more comprehensive report

from treatment staff would be forthcoming. It of course never was. In fairness to Professor Doherty his involvement was to take over from Dr Tune who was on leave. It appeared as a consequence he remained the person "in charge" of answering correspondence from the Chief psychiatrist. In any event neither Professor Doherty or Dr Tune had any direct involvement with Dean's treatment and certainly no involvement in the decision making on the afternoon of the 24th of December 2009.

76. There was a further letter directed to the Chief Psychiatrist again authored by Professor Doherty dated the 5th of July 2010. That letter was in response to a letter of complaint from Mr Laycock to the Chief Psychiatrist and copied to the Health Services Commissioner. Professor Doherty makes a comprehensive summary of Dean's history from Dean's medical records and the comments he makes up to a point appear accurate and are supported by the documented evidence in the file.

77. When it comes to addressing the question of leave, the observations are significantly inaccurate. In the correspondence Professor Doherty makes the erroneous statement as follows: "Dean and his mother attended a clinical meeting with PARC staff and clinical staff on the 24th of December 2009,the decision was made in consultation with the patient's mother that the period of leave initially thought to be four days would be reduced to two days as four days were considered too long and the mother expressed concerned (sic) about her ability to cope with Dean over that period of time. This matter was discussed with Dean". That is of course a completely inaccurate reflection on what actually occurred. It may be what should have occurred but it did not.

78. As noted earlier in this finding Mrs Laycock and Dean had no participation in the discussion and decision as to the reduction of leave. There were no concerns expressed by Mrs Laycock and there was no "discussion" as such on leave reduction, only on negotiation as to time of return. Later in Professor Doherty's correspondence there was also the comment "The leave arrangements were negotiated with the patient's carer, and Dean was included in the discussion". It is unclear how these facts could be extrapolated from the scant notes in the hospital records. The impression left on reading these comments is that the motivator in the decision to reduce leave was in fact Mrs Laycock.

79. Professor Doherty also responded to some of the concerns raised by Mr Laycock as to Dean having been placed on a Community Treatment Order and the family not being

advised of or present at the meeting when the decision was made. Professor Doherty agrees with the observation that the decision in relation to the placement of Dean on a CTO was done at the ABC and Mrs Laycock was not present. Professor Doherty stated that the Community Treatment Order was justified and would have been expected by both Dean and Mrs Laycock. In addition as Dean had been subject to a CTO previously he and Mrs Laycock would have been aware of the requirements of such orders.

80. It was not inappropriate to place Dean on a CTO given he was moving from inpatient to Community based care, it was the way it was undertaken. Mrs Laycock, who had participated in other decision making meetings at the ABC, should have been consulted and included as she had expressed an interest in as much. In addition there should have been phone communication between the ABC staff and Mrs Laycock advising of Dean's placement on the CTO and the fact of his move to PARC. It is a small expectation that family members or carer's will be kept appraised of the treatment and housing arrangements of the patient.

81. It is unclear what exactly was explained to Dean and how, in relation to his placement on the CTO. It was recognised by all that Dean had an intellectual disability and extra care was needed to ensure he fully understood the reasoning behind such an order and what was required under it. Any such explanation would best be achieved in the presence of a family member or carer, here of course Mrs Laycock. I am not of the view that the existence of the CTO had much influence on Dean's ultimate decision to take his life but it was a further illustration of limited or failed communication towards the patient and his carer.

THE CHIEF PSHYCHIATRIST'S GUIDELINES

82. As anyone who works with mental health patients would be aware, and particularly those who work in the field involving patients in accommodated care, the Chief Psychiatrist for the State of Victoria ,Dr Ruth Vine publishes guidelines to assist in managing their care. The guidelines as published are comprehensive and easy to digest and succinct in their expectations. As noted on the website the principles in the guidelines are "considered a requirement in good clinical practice".

83. On examination of the website for Victoria's Mental Health Services discloses there are currently 20 such guidelines in place. Of those there are two with primary relevance to the management of Dean's care namely the guideline headed "Working together with families and carers- April 2005" and "Treatment Plans under the Mental Health Act 1986- Department of Health August 2009". Copies of each of these were received into evidence at the inquest. In addition a guideline entitled "Inpatient leave of absence- September 2009" was also exhibited. The BHCG submitted this latter document was not binding or directed at PARC as it was dealing specifically with leave to be granted to an inpatient. As PARC was a community based facility where patients were free to come and go largely at their will, the expression of "leave" and granting of same was inappropriate.

84. It may be said that strictly speaking that was correct, but the reality was they still did provide permission or not to leave the facility for periods of time. In Dean's case the organisation advised Dean not only how long he was permitted to be absent from the establishment, but even down to the times he was required to re-attend. It was also negotiated or agreed that it would be permissible for Dean, after returning on the 26th of December, to leave the accommodation for outings with his family thereafter. To suggest the facility was not otherwise controlling Dean's movements in reality is a nonsense, even though legally they had no enforceable power to do so. The impression left with Dean and his family, was that they were obligated to abide by these decisions.

85. The BHCG in its submissions to the court stated that if the Chief psychiatrist were to issue any guidelines on leave arrangements in relation to patients who fell within PARC's care they would comply with those provisions. The submission referred to the evidence given of Ms Andison that a flexible approach on a case by case basis had to be made when considering leave. It might be said that approach has equal significance regardless of whether a patient is involuntary or voluntary.

86. The Chief psychiatrist's guideline on inpatient leave of absence, although not binding on the BHCG, provides a useful directive in how generally to deal with a person with a mental health problem in permitting them a leave of absence from a facility. In those guidelines, as with many of the others, there is an emphasis on communication and consultation with the patient and carer. The guideline also emphasises the need for the clear documentation and communication as to the purpose of granting leave. This

must be done with the patient, their primary carer (where appropriate) and relevant clinical staff.

87. It is further stated in that guideline that, where possible, leave should be planned well in advance. If a leave request is made after hours, at short notice or on weekends when the usual treating team is absent, the person responsible should ensure they are familiar with all aspects of the treatment and care provided, and are able to adequately weigh up the risks and anticipated benefits of the requested leave. Where adequate information is not available, a decision should generally be deferred until clinicians familiar with the full clinical picture of the patient are available.

88. The guidelines provide a sensible and common sense approach to dealing generally with the question of leave, irrespective of status of the patient. These guidelines would be instrumental, it would be thought, for organisations such a PARC to model their own internal policies and procedures on.

89. If I consider the framework of these guidelines in relation to Dean's particular circumstances it is clear that he and Mrs Laycock were not consulted at all about the leave request or the decision to alter prior approved leave. They were not advised that this could have been a possibility on transferring from the ABC to PARC. The decision making was not explained sufficiently or accurately to Dean or Mrs Laycock. If Mrs Laycock had been told that it was based on a perception that she would not be able to cope with Dean over the period, she may have advocated against such a suggestion. There was also an almost complete failure to document the decision for leave. The failure to well document any decision or basis for it means that those who come after are in the dark as to the reasoning behind it, particularly when seeking to possibly review the situation at a later time.

90. It must also be recognised that the decision making here was done at short notice and the clinical team had little information at hand on which to make a decision about leave. Those limitations have been covered earlier in this finding.

BHCG POLICIES AND PROCEDURES

91. It was not until after the close of the evidence at the inquest that the "Clinical Documentation and Reporting policy" was provided to the Court. In the submission filed on behalf of BHCG the comment was made that there is nothing sinister that should be inferred by the late "discovery" of this policy. I do not infer there was anything sinister as to that fact, but I do make the observation that it was unhelpful to this enquiry. There was no opportunity (without further opening the inquest up to evidence) to obtain information from other witnesses as to their knowledge of the existence of such a document.

92. In addition it was also very late in the proceedings and in the evidence of Ms Andison that the existence of a note book wherein matters of the Clinical Team meeting of the 24th December 2009 were recorded. This again was disclosed to the Court long after many witnesses had been called.

93. It was readily conceded by Ms Andison, that the notes as recorded in Dean's clinical file as to the outcome of the Clinical team meeting were inadequate. Ms Andison could not recall however, if the author of the notes had ever been spoken to of this fact. It is also unclear if any of the staff were ever made aware of the Policy, which appeared difficult to locate. There was evidence given by Ms Andison that Bendigo Health now have specific training for managers around a variety of tasks one of which is a training program around policy procedure development. Dr Emmanuel, in a statement received after he had given evidence, detailed that there was a monthly meeting of the Psychiatric Services Clinical Risk and Standards where policies were reviewed. These are no doubt very promising innovations or extensions on work previously undertaken in this area, but it does not give me any comfort that there is adequate communication or training to the staff who must enact the requirements of the policies. There needs to be a mandated and conscious ongoing education of staff on matters of this type.

94. It is clear BHCG still do not have any clear policy on how the granting of a period of absence by a patient should be determined. As noted earlier, Ms Andison gave evidence that such review needed to be done on a patient by patient basis. Ms Andison in her evidence agreed with all of the principles expounded in the Chief Psychiatrists "leave of absence guidelines". In addition she agreed that BHCG should adopt a similar set of principles. Ms Andison was of the view that BHCG already

considered those aspects anyway. It is my view they clearly did not, in relation to the decision making process in Dean's case as outlined before.

THE BHCG'S SUBMISSIONS ON WHAT HAS CHANGED SUBSEQUENT TO DEAN'S DEATH

95. In fairness to the BHCG I propose to fully document the practices and procedures that have been improved and streamlined by PARC since Dean's death. At the same time, where I feel it is necessary, I have made certain of my own observations that appear in italics;

96. Whereas in December 2009 there were two parallel sets of files kept (Clinical and Mind) there is now one consolidated file kept for each patient.

97. The Medical Registrar now routinely takes the notes of the discussion and outcome of the clinical team meetings for the file. The notes record who was in attendance at each clinical team meeting. If for any reason the Medical Registrar is unavailable, the lead clinician undertakes this role.(*This is a significant alteration and improvement to previous practice and it should be encouraged that the notes be as comprehensive as possible for future reference).*

98. The clinical team meeting is chaired by the consultant psychiatrist or in his/ her absence the Medical Registrar.

99. There have been increases in the medical full time equivalent staff at PARC. There is now a Registrar allocated on a .8 basis, dedicated to PARC; whereas in 2009 that role was split between responsibilities to triage and crisis assessment as well and not allocated on a .8 basis.(*The number of staff allocated to PARC was not a factor of relevance in this inquest).*

100. There has been an increase to double in the consultant psychiatrist's time at PARC from three half day sessions to six half day sessions weekly. This ensures to the maximum extent possible that he or she is available to see clients- and carers as required- within 24 hours of admission to PARC and prior to going on leave. (*This is also a vast improvement on the arrangements previously. In this way it will hopefully not occur again that a consultant psychiatrist is required to make decisions of significance without having met the patient. They will generally be better informed).*

101. Every patient is assessed for clinical risk factors and a mental state assessment prior to going on leave. The medical registrar or medical officer is required to conduct the risk assessment if he or she is the last person to see the client before going on leave. Wherever possible leave is discussed with the client's carer or family before leave takes place and will be subject to clinical judgement as necessary. (*It should be a mandatory requirement unless exceptional circumstances exist, that leave is discussed not only with the patient but also with their carer's. This is particularly so if the patient is to be placed on leave with that carer. Additionally the carer should be kept informed as to the movements of the person they are the carer of.)*

102. The BHCG accepts that it is of considerable importance to ensure and to constantly reinforce the accuracy of clinical hand over information, clear documentation, and timely tracking of mortality reviews.

103. The handover as between ABC and PARC has changed to a more comprehensive electronic system of documentation. It is online, saved and details of transfers and discharge information is more readily and speedily available.

104. Discharge information is now available in a more timely manner and at most within 2 days of discharge. (*It remains unclear to me why it still takes 2 days for such information to be compiled. I anticipate the psychiatrists are very busy but there is no reason that given the prior notice of a discharge approaching that the responsibility to document some of the more routine aspects of the summary cannot be delegated to another employee and then approved by the psychiatrist. The failure to have a discharge summary however had no relevance in Dean's death.)*

105. There is now a clearer understanding that, subject to privacy considerations and patient consent, the family of patients will continue to be involved in key clinical decision making. (*I cannot emphasis more strongly how important I believe this consultation process is. It is of course usual that the carer or family member will be the one with the most informed view of how a person is progressing. This approach is also reflective of the approach suggested in many of the Chief psychiatrists' guidelines.)*

106. Families of patients are now clearly made aware of options should anything go wrong or they have questions while a patient is on leave. The options generally are call triage

on the 1300 number (given to patients on a business card) or call PARC, or bring the client back to PARC for assessment and discussion.

CONCLUSIONS

107. The primary concerns raised in this inquest were the administrative defects which were recognised from both the ABC and PARC operations and the poor or absent communication either between facilities, staff, the patient and carers.

108. The first of such difficulties was the failure to adequately inform Mrs Laycock as to the meeting at which time the decision was made to place Dean on a Community Treatment Order. There was an absence of discussion with Dean or Mrs Laycock as to what exactly this all would mean. The mere fact Dean was placed on a CTO previously does not mitigate against having to further explain the anticipated outcome. There was also a failure by the treating psychiatrist Dr Mathew to complete a Treatment Plan to attach to the CTO as required by the Mental Health Act 1986.

109. There was also a failure to inform Dean and his mother that the leave approval from ABC was not then binding on PARC, and as such leave would need to be further negotiated. If this had been done Dean and his family would have prepared for a possible change and been more accepting of it. It would also make Dean and his family aware that they may need to make representations on this point. There was also evidence that Dean's transfer from the ABC to PARC was not communicated to Mrs Laycock by anyone from the ABC, it was instead only done by Dean himself. These oversights did not play any part in the decision by Dean to take his life. They do however demonstrate that there are poor practices and procedures in place for appropriate communication, which is as noted previously, a requirement that underpins the majority of the Chief Psychiatrists guidelines.

110. It was conceded in the submissions provided on behalf of the BHCG that the referral of Dean to PARC occurred with minimal documentation. It is unclear as to exactly what was transferred over with Dean. It should have included a copy of the clinical notes from his file at PARC, along with a discharge summary. As the evidence established this discharge summary from ABC was not completed until after Dean's death. There was a verbal hand over of the patient, but this has to be viewed as totally

inadequate as it informs only one person as to useful information. It needs to be backed up by way of written communication.

111. If the people who were treating Dean had access to this information they would have had a complete picture of issues regarding his planned leave over Christmas. They would have been fully aware that such leave had been discussed with Mrs Laycock and her stated view that she would be able to accommodate those arrangements. It would also have been clear the terms of the leave were for Dean to spend time generally with the extended family unit, not his mother alone.

112. A perusal of Dean's file and the numerous daily entries records his level of excitement and anticipation of his forthcoming leave. It might be said he spoke little of anything else. That fact would have been evident to anyone who had the opportunity to peruse Dean's file

113. The clinical team meeting was conducted without regard to appropriate documented information. Dr Emmanuel who was ultimately responsible for making the decision to alter Dean's leave, had not met him previously and had not had regard to his file at all either from the ABC or PARC. Dr Emmanuel did not discuss the leave arrangements directly with Dean or with his mother. It is clear no one did at this time. Dr Emmanual also chose not to attempt to contact Dean's prior treating psychiatrist Dr Mathew. This was despite Dr Mathew having given prior approval to leave and also being someone who had clearly been involved in his care and treatment over the time of his admission to the ABC. Dr Mathew would have been a source of useful information in the decision making process. Dr Emmanuel conceded in his evidence that had he spoken to Dr Mathew his decisions may have been different

114. The most detrimental aspect of the manner in which the clinical team meeting was conducted was the receipt of the hearsay comment by one of the participants that Mrs Laycock would not be able to cope with Dean over the period of Christmas leave. The truth of this comment was never confirmed with Mrs Laycock herself. It was in fact an observation that was historic and incorrect for the otherwise planned leave of absence. It was this inaccurate information that set the path for the cancellation of leave for which there otherwise was no foundation. It is, as I observed earlier, surprising if this was the stated concern that Dean was permitted any leave let alone a reduced leave.

115. The timing of the decision to reduce leave was also extremely poor as it meant that when the disappointing news was to be communicated to Dean, it was done as he was about to leave the facility. There was no real opportunity to observe the impact on him as to this decision. The lateness of this consideration of leave was due in part to the limited availability of the consultant psychiatrist at PARC. As noted at the time of Dean's death in 2009 the psychiatrist only attended for three half days. That has now been extended to six half days which, as stated previously is a significant improvement. The psychiatrist will now have more time to review a patients file, meet with the patient and discuss in advance with the patient and carer leave arrangements.

116. I want to make it very clear that in no way are any of these observations to be taken as a criticism of Mr Sproles who had to perform the unenviable task in delivering the decision to Dean of the reduction in his leave. It is to be recognised that he had attempted to advocate on Dean's behalf. As appropriately recognised by Dr Emmanuel the decision as to reduction of leave was ultimately made by him after consultation with the others in the Clinical team meeting.

117. I find there was a complete failure to appropriately record the details of the clinical team meeting. There was a lack of appropriate review undertaken by BHCG subsequent to Dean's death. These factors of course have no bearing on the fact that Dean took his life. They do however, affect the ability of the organisation to appropriately reflect in a timely manner how there may have been limitations or factors causal to Dean's death that could do with improving.

118. The conclusions as sought by BHCG in submissions to me were that it was questionable as to whether matters such as Dr Emmanuel having a conversation with Dr Mathew on the 24th of December 2009 would have resulted in a different outcome as to leave. They submitted it would probably not. I cannot agree with such a conclusion. It well could have had an impact which as noted, even Dr Emmanuel conceded. Dr Mathew would have been able to speak with an intimate knowledge of Dean's personal circumstances, not only in terms of his treatment, but also his family support. Dr Mathew had treated Dean on prior occasions and hence knew him well. In addition Dr Mathew had herself spoken with Mrs Laycock and had spoken on just the point of her ability to cope. If Dr Mathew had been spoken to about the current decision to limit leave she would have been in a position to "set the record straight" as to Mrs Laycock's ability.

119. It concerns me that the BHCG persist with the suggestion that the family or specifically Mrs Laycock could have done more to prevent this tragedy. They clearly articulate in the submissions that the outcome might have been very different had the family communicated back to BHCG or with the police given Dean's changed behaviour. I totally reject such a submission. There was nothing in any of the observations by the people involved in Dean's care, who are specialised in risk assessment, that caused them concern as to Dean's presentation, The fact he became angry and somewhat withdrawn, understandably did not translate to Mrs Laycock that Dean was at risk of self harm. It was as she said, something she never contemplated he would do. To suggest Mrs Laycock should have had greater insight than those who had been treating him is unwarranted.

120. There is a clear causal connection between the decision to reduce Deans' Christmas leave and his response in taking his life. It may be, as outlined in the submission filed on behalf of BHCG, that the decision to commit suicide because of a reduction of leave is not considered rational. It must be remembered that Dean was a person who suffered from a diagnosed mental illness and was intellectually impaired. It may be that many people who take their lives do so without what would, independently viewed, be judged as a rational decision.

121. It is very easy to speak in hindsight of what could or should have been done. The reality is that no one foresaw the likelihood of Dean taking his life. There is therefore nothing to be benefitted from suggesting an alternative outcome may have transpired if a different approach were adopted.

122. It is hoped that at least one outcome of this inquiry, as has already started, is that new or alternative protocols are put in place to enable better communication and information sharing in the future between organisations such as the ABC and PARC which provide important support to members of the community. It is in this context that I make the following recommendations additional to the changes already commenced by BHCG.

RECOMMENDATIONS

123. Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

124. 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 needs 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.

125. 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.

126. 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 to their care of patients.

127. 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.

128. 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.

- I direct that a copy of this finding be provided to the following:

Mrs Vicky Laycock

Mr Peter Laycock

Bendigo Health Care Group

Mind Australia

Chief Psychiatrist Dr Ruth Vine

Sgt J Olver Victoria Police

Signature:

Coroner's name: Jennifer Tregent
Date: 22nd December 2014