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Inquest into the death of Dean Laycock — a consideration of the decision to reduce the leave period of a voluntary inpatient at a mental health facility without consultation with the patient

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The *Inquest into the death of Dean Alan Carlson Laycock* (the Inquest) concerned the death of a voluntary mental health patient by suicide following discharge over the Christmas period. The coroner's findings focused on the necessity for the facility to have adequate policies and procedures in place for leave planning, including consultation with the patient and family members as appropriate.

Background

Mr Laycock (the deceased) was 24 years old when he took his own life on Christmas Eve in 2009.[1] Immediately prior to his death, the deceased was a voluntary patient at the Prevention and Recovery Care (PARC) facility. The PARC is commonly referred to as a "step up, step down" facility from the acute inpatient facility. The deceased's time at PARC was part of a "step down"[2] transition from the Alexander Bayne Centre (ABC), the inpatient psychiatric unit, where he had been an involuntary patient to independent living. Both the ABC and PARC are administered by the Bendigo Health Care Group (the BHCG).[3]

From an early age, the deceased was diagnosed with a compulsive disorder and it was recognised that he had a learning disability.[4] The deceased was also dependent on marijuana in his teenage years, which had an impact on his mental well-being.[5]

On 3 November 2009, 12 weeks prior to Christmas, the deceased was involuntarily admitted to the ABC as a consequence of an increase in his symptoms. It was also planned that he should transition to independent living from living at home with his family.[6]

At the ABC, the deceased was under the care of his treating psychiatrist. During his stay, the deceased had a number of conversations about his leave arrangements over the Christmas period.[7] It was ultimately decided that the deceased would have 4 days leave to spend with his family and this decision was communicated to Mrs Laycock to ensure that she could cope with the arrangement.[8] The ultimate plan was that the deceased was to spend one night with Mrs Laycock before travelling to Melbourne to spend time with his extended family.

However, when the deceased was transferred to PARC on 22 December 2009, the detailed arrangements were not communicated to the PARC staff. Consequently, the issue of the deceased's leave was discussed at a clinical team meeting on 24 December 2009 and a decision was made by the consultant psychiatrist that the deceased's leave be reduced to 2 days.[9] The consultant psychiatrist at PARC had not directly assessed Mr Laycock or reviewed his medical file, as he had not been rostered on before the team meeting and the medical file had not been transferred to the facility.

The basis for the decision to reduce the deceased's leave was a concern that Mrs Laycock would not be able to cope with the difficulties presented by her son's condition for 4 days The decision to reduce the deceased's leave to 2 days was communicated to the deceased by a mental health clinician when Mrs Laycock arrived at PARC to collect the deceased for his leave.[10]

Shortly after communicating the decision to the deceased, and prior to the deceased leaving PARC, the clinician conducted a mental health assessment[11] in which it was noted that the deceased's mood was lowered. However, he denied any suicidal ideation.[12] The deceased subsequently left PARC in Mrs Laycock's care.

In the car on the way home, the deceased appeared to his mother to be agitated and angry. Mrs Laycock gave evidence that her son had stated in the car "one way or another I am not coming back [to PARC]".[13] At home, Mrs Laycock went into her bedroom to give the deceased time to calm down, which Mrs Laycock noted had been an effective arrangement in the past. A few hours later, Mrs Laycock found her son deceased. Mr Laycock's cause of death was "Strangulation by Hanging".[14]

Issues for consideration at the inquest

The primary issue before the coroner concerned the clinical team meeting[15] during which the decision was made to reduce the deceased's period of leave from 4 days to 2 days over the Christmas period, without having directly assessed the deceased nor reviewed his medical record. The coroner also considered the timing and delivery of the decision to reduce the deceased's leave.

Evidence

The clinical team meeting

The clinical team meeting on 24 December 2009 was chaired by the consultant psychiatrist.[16] Evidence was led by the BHCG that these meetings were held twice a week and provided clinical and non-clinical staff with an opportunity to share information and make treatment decisions about patients.[17]

The consultant psychiatrist had not met Mr Laycock, as he had not been rostered on prior to the clinical team meeting.[18] In addition, he had not reviewed the deceased's medical file, with the coroner noting that the evidence suggested that this was because the file was not provided to PARC at the time of the transfer. Relevantly, the coroner found that there was no protocol in place at the time for transferring a patient's clinical file[19] and witnesses called to give evidence at the trial had a limited recollection of having seen any documentation.[20] The coroner also noted that the ABC did not prepare a discharge summary until sometime after the deceased's death.[21] In considering this issue, the coroner noted that "[i]t would have been desirable to have the complete file from [the deceased]'s admission transferred with him"[22] because the information in the file would have informed PARC staff about "[how keen the deceased] was to have Christmas leave and the details as to what was planned".[23]

The evidence as to the proceedings of the clinical team meeting also varied significantly and the coroner had the "overall impression" that staff members present at the meeting did not have a clear recollection of what was discussed at the meeting.[24] This issue was further compounded by the lack of detailed written notes of the meeting and by the fact that, at the time of the deceased's death, no mortality review was undertaken by PARC, which means that the staff members were not provided with an opportunity to make a statement of the events that took place at the meeting.[25]

The consultant psychiatrist's evidence was that he made the decision to reduce the deceased's leave, as a result of concerns regarding Mrs Laycock's ability to manage Mr Laycock's behaviour and the potential conflict between them over the 4-day leave period. Specifically, his recollection was that he had made this decision on the basis of the following:[26]

- a comment by a staff member present at the meeting that they had observed conflict between the deceased and Mrs Laycock; and
- a document that had been completed by a social worker who had completed the deceased's admission paperwork, which had "recorded a grading as equal to extreme to the question 'does this person have trouble living with others'".

However, the coroner noted that the first point was contradicted by Mrs Laycock's evidence at the Inquest that she had never visited the deceased at PARC until she attended to collect the deceased for his leave on 24 December 2009.[27] In addition, the coroner noted that the document in the second point referred to the deceased's residential long-term arrangements and that the assessment should have taken into account that there is a significant distinction between having the deceased stay for a couple of days and actually living with the deceased.[28] It was conceded at the Inquest that it would have been appropriate to have discussed the change in leave arrangements with Mr Laycock prior to making the decision.[29]

On the basis of this evidence, the coroner found that the decision to reduce the deceased's leave was not made on "well founded reasons".[30]

Relaying the decision to reduce leave to the deceased

While it was initially planned that the consultant psychiatrist would relay the decision, this task was delegated to the mental health clinician because the psychiatrist was called to attend to another patient.[31]

The deceased did not disclose any "thoughts of self harm"[32] during the risk assessment conducted after Mr Laycock was informed of the changed leave arrangements. The coroner noted, however, that the fact that the risk assessment was conducted immediately after the decision was communicated to the deceased meant that it was possible that there was not enough time before the deceased left PARC to "outwardly gauge [the deceased's] reaction".[33] The deceased's mental illness was coupled with an intellectual disability, which meant that he would have required additional time to process the information that his leave had been reduced.[34]

The mental health clinician also gave evidence at the Inquest that, while the deceased's mood did appear to be lowered, he did not consider it surprising given the circumstances.[35] However, the coroner noted that this evidence was contradicted by Mrs Laycock, who described the deceased as "devastated" upon learning about his reduced leave.[36] This was also supported by evidence given by other staff members at PARC, who described the deceased's devastated state upon learning that his leave period had been reduced.[37]

Accordingly, the coroner commented that the timing of the communication with the deceased and his family was "far from optimum"[38] and that "[d]ecisions 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".[39]

There was also contradictory evidence at the Inquest as to the reason given to the deceased for the reduction in his leave. Mrs Laycock gave evidence that the deceased was told that the decision was made because otherwise, the deceased would lose his bed at PARC if he was on leave for a longer period of time.[40] However, this was denied by PARC staff. In addition, evidence was given that the real reason was withheld from the deceased because it was believed that it would "create friction" between the deceased and Mrs Laycock.[41] The coroner was critical of this decision to withhold the real reason for the decision, commenting that, had Mrs Laycock been informed that the consultant psychiatrist was concerned as to her ability to care for the deceased over the leave period, she would have been able to explain that the plan was for the deceased to travel to Melbourne after one night in her care.

Findings

The coroner noted that during the Inquest, the BHCG, in its submissions, were apparently critical of Mr Laycock's family failing to recognise and respond to the fact that the deceased was at risk of suicide. Relevantly, the BHCG submitted that "the outcome might have been very different had the family communicated back to BHCG or with the police given [the deceased's] changed behaviour"[42] when the deceased left PARC. Therefore, BHCG submitted that the casual connection between the reduced leave and the deceased's suicide had been broken by the events that occurred when the deceased left PARC and went home.[43]

The coroner was concerned that the BHCG persisted with these submissions, stating that they were "unhelpful".[44] The coroner found instead that there was a "clear causal connection between the decision to reduce [the deceased's] Christmas leave and his response in taking his life".[45]

The BHCG also submitted that caution should be taken when making criticisms about a public health body's practices and procedures without good reason because this undermines the public's confidence in the public health body. While agreeing with this submission, the coroner stated that where 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".[46]

Accordingly, the coroner found that the evidence before the court supported the following conclusions:

- while the failure to inform the deceased and Mrs Laycock that Dr Matthew's approval for leave was not binding on PARC "did not play any part in the decision by [the deceased] to take his life",[47] it highlighted the poor processes and procedures that were in place at the time in relation to appropriate communication, which is "a requirement that underpins the majority of the Chief Psychiatrists guidelines";[48]
- as conceded by BHCG, the deceased's transfer from the ABC to PARC was done with minimal documentation,[49] which meant that his clinical treating team did not have a "complete picture"[50] of the deceased's leave arrangements over the Christmas period. Had the deceased's medical record been reviewed, it would have revealed his "excitement and anticipation"[51] for the proposed leave and the plan for him to travel to Melbourne;
- the clinical team meeting was conducted without regard to "appropriate documented information".[52] Specifically, the consultant psychiatrist had not reviewed the deceased's medical record nor discussed the leave arrangements with the deceased or Mrs Laycock;[53]
- "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 [the deceased] over the period of Christmas leave".[54] This was because the consultant psychiatrist relied on this "inaccurate information" when making the decision to reduce the period of leave, "for which there otherwise was no foundation";[55]
- the timing of the decision to reduce the deceased's leave was "extremely poor"[56] because it meant the decision was communicated to him only just before he was about to go on leave; and
- while the "complete failure to appropriately record the details of the clinical team meeting"[57] did not impact on the deceased's decision to take his own life, it affected the BHCG's ability to "appropriately reflect in a timely manner how there may have been limitations or factors causal to [the deceased's] death that could do with improving".[58]

Recommendations

In light of the coroner's findings, the coroner made a number of recommendations pursuant to s 72(2) of the Coroners Act 2008 (Vic) in connection with the deceased's death. While BHCG submitted that it had implemented a number of changes to its practices and procedures in light of the deceased's death, such as ensuring adequate

notes are recorded for clinical team meetings[59] and discharge information is now available in a more timely manner,[60] the coroner was not satisfied that BHCG had a clear policy on decision making prior to granting a period of leave of absence.[61]

Accordingly, the coroner made recommendations that BHCG develop policies that cover the following:

- the "mandated minimum requirements of documentation"[62] that is required when a patient transfers from an inpatient facility to PARC; and
- "the decision making process for granting permission for a leave of absence from PARC",[63] including the considerations outlined in the Chief Psychiatrist's guidelines on inpatient leave for voluntary and involuntary patients. In addition, the policy should clearly state the importance of making such a decision with a "full understanding of the patient's background and personal circumstances"[64] and should direct decision makers to consult with the patient and their primary carer (where appropriate) prior to making any decisions about periods of leave.

The coroner also made a recommendation that BHCG develop systems and processes to ensure staff are aware of the internal policies and the Chief Psychiatrist's guidelines and how to implement them, such as mandatory training and ongoing education.[65]

Furthermore, the coroner made a recommendation that BHCG implement a process to ensure that unless the consultant psychiatrist has actually met the patient and reviewed their medical record, that patient should not be discussed at a clinical team meeting.[66] This is because the consultant psychiatrist has ultimate responsibility for any decisions made relating to periods of leave for the patient.

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Footnotes

1. *Inquest into the death of Dean Alan Carlson Laycock* (VIC COR 2009 005950 (22/12/2014)) at [1].
2. Above, n 1, at [11].
3. Above, n 1, at [19].
4. Above, n 1, at [3].
5. Above, n 1, at [5].
6. Above, n 1, at [22].
7. Above, n 1, at [22].
8. Above, n 1, at [23].
9. Above, n 1, at [12].
10. Above, n 1, at [13].
11. Above, n 1, at [13].
12. Above, n 1, at [13].
13. Above, n 1, at [14].
14. Above, n 1, at [16].
15. Above, n 1, at [42].
16. Above, n 1, at [42].
17. Above, n 1, at [42].
18. Above, n 1, at [40].
19. Above, n 1, at [33].
20. Above, n 1, at [34].
21. Above, n 1, at [33].
22. Above, n 1, at [35].
23. Above, n 1, at [36].
24. Above, n 1, at [44].
25. Above, n 1, at [45].
26. Above, n 1, at [48].
27. Above, n 1, at [48].
28. Above, n 1, at [49].
29. Above, n 1, at [51].
30. Above, n 1, at [52].
31. Above, n 1, at [54].
32. Above, n 1, at [55].
33. Above, n 1, at [57].
34. Above, n 1, at [57].
35. Above, n 1, at [55].
36. Above, n 1, at [56].
37. Above, n 1, at [56].
38. Above, n 1, at [57].
39. Above, n 1, at [58].
40. Above, n 1, at [59].
41. Above, n 1, at [59].
42. Above, n 1, at [119].
43. Above, n 1, at [64].
44. Above, n 1, at [67].
45. Above, n 1, at [120].
46. Above, n 1, at [19].
47. Above, n 1, at [109].
48. Above, n 1, at [109].These guidelines are published by the Chief Psychiatrist for the State of Victoria to assist in managing the care of mental health patients in accommodated care. Of relevance to this Inquest are the guidelines headed "Working together with families and carers — April 2005" and "Inpatient leave of absence — September 2009", which, as the coroner

noted, although not necessarily binding on the BHCG, do provide 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.

49. Above, n 1, at [110].
50. Above, n 1, at [111].
51. Above, n 1, at [112].
52. Above, n 1, at [113].
53. Above, n 1, at [113].
54. Above, n 1, at [114].
55. Above, n 1, at [114].
56. Above, n 1, at [115].
57. Above, n 1, at [117].
58. Above, n 1, at [117].
59. Above, n 1, at [97].
60. Above, n 1, at [104].
61. Above, n 1, at [94].
62. Above, n 1, at [124].
63. Above, n 1, at [125].
64. Above, n 1, at [125].
65. Above, n 1, at [126].
66. Above, n 1, at [128].