



16 August 2024

His Honour, Coroner Olle  
Coroners Court of Victoria  
65 Kavanagh Street  
SOUTHBANK VIC 3006

Dear Coroner Olle

**Investigation into the death of Jacob Kennedy - COR 2017 0595**

We refer to Your Honour's Finding into the death of Mr Kennedy, dated 24 May 2024.

At page 77 of the Finding Your Honour made the following recommendations, for Peninsula Health's (PH) consideration, in the interest of public health and safety that:

**Recommendation 6**

*PH consider reviewing their policy or protocol to ensure compliance with the Monitoring Recommendations in their Guideline which mandate vital sign observations for sedated patients admitted to their inpatient psychiatric units.*

In response to recommendation 6, we advise:

Since Jacob's passing and in line with our usual processes the '*Pharmacological Management of Acute Behavioural Disturbance in the Mental Health Inpatient Units*' Clinical Practice Guideline (CPG) has undergone several reviews. In light of His Honour's recommendation, PH will undertake a further review of this CPG with the intention of making the types of observations needed clearer, and including specific reference to circumstances where such observations would not be appropriate.

**Recommendation 7**

*PH initiate and undertake regular staff training measures for its mental health care workers to ensure the enforcement of a uniform monitoring regime to observe the vital signs of sedated patients.*

In response to Your Honour's recommendation 7, we advise:

In the years since Jacob's passing, as a result of a number of patient safety initiatives, compliance and understanding of the CPG has improved significantly.. PH continues to undertake audits, education, training and foster staff understanding of the importance of complying with the CPG.

**Recommendation 8**

*PH undertake an external review of all policies and training that relate to culturally competent and safe care, to ensure that they are fit for purpose.*

We acknowledge and pay respect to the traditional people of this region, known as the Myone Buluk of the Boon Wurrung language group of the greater Kulin Nation. We pay our respects to the land this organisation stands on today. We bestow the same courtesy to all other First Peoples, past and present, who now reside in this region.

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- *That review be led by an external, First Nations-identified individual or organisation.*
- *PH implement the recommendations of that review.*
- *PH introduce, and make publicly available on an annual basis, compliance monitoring for cultural competency and safety training, and statistics concerning complaints about the provision of such care*

In response to Your Honour's recommendation 8, we advise:

Cultural audits form part of PH's usual practice when reviewing our systems and processes. Our next cultural audit is scheduled for August 2024, with external local Aboriginal Community Elders conducting the audit. As the recommendations are as yet unknown, Peninsula Health is unable to confirm that all recommendations will be implemented.. However, historically, PH has considered and implemented all recommendations arising from cultural audits.

Peninsula Health already engages with Aboriginal and Torres Strait Islander people to seek their feedback regarding perceptions of care, barriers to seeking care, kinship, shared decision making, linking with other services, and ways to improve cultural safety across the organisation.

The National Safety and Quality Health Service (NSQHS) Standards, requires health services to implement specific actions to meet the needs of Aboriginal and Torres Strait Islander people as part of the hospital accreditation process. One of the required actions is cultural training. As such, PH has already implemented cultural training and audits the training compliance of its staff. In respect of PH's compliance with the NSQHS Standards we underwent and successfully passed accreditation in 2023.

Since 2017, there have been a number of state-wide initiatives implemented to obtain consumer feedback, monitor and report data regarding cultural safety and the experiences of First Nations people. The Victorian Agency for Health Information (VAHI) implemented improvements to the Victorian Healthcare Experience Survey (VHES), including aligning the survey to Safer Care Victoria's (SCV) Partnering in Healthcare Framework (2019), with this framework canvassing cultural safety. PH provides VAHI with all required data, with VAHI then determining what data becomes publically available. As there is already an established mechanism for publically reporting data collected from health services, PH does not consider it is necessary to publish this data itself.

I trust this information satisfies your request for a response to the recommendation under section 72(3) and 72(4) of the *Coroners Act 2008* (Vic).

Kind regards,



**Helen Cooper**  
Chief Executive  
Peninsula Health