15 December 2025

BY EMAIL

cpuresponses@court.vic.gov.au

Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Dear Mr Gabriels

Re: Investigation into the death of Jamie Nisbet
Your ref: COR 2021 005194

I write to you on behalf of Bendigo Health (the **hospital**) in respect of the above matter and Her Honour's Findings and recommendations dated 16 April 2025.

The Coroner made three recommendations to the hospital which are supported.

Recommendations

When a community mental health team patient who has been assessed as requiring a mental health assessment and risk assessment by a consultant psychiatrist and a comprehensive assessment was unable to be undertaken by a consultant psychiatrist due to aggressive behaviours and threats to the safety of staff (and in circumstances where an involuntary hospital admission is not a consideration):

1. *Review its Mental Health Service's escalation policy/protocol for its community mental health team to escalate the above circumstances to mental health senior/leadership for advice on how to address the clinical risks and needs of the client and to ensure appropriate information and training is undertaken to ensure that senior staff are familiar with the policy.*

   In response to the above recommendation, the hospital notes as follows:

   The hospital is presently undertaking a review of the hospital's Mental Health Service's escalation policy/protocol , with a view to ensuring that it encompasses scenarios in which it would be beneficial for staff to escalate a patient's case to senior practitioners for advice on risk management. Such scenarios include where patients require a mental health assessment and risk assessment but this is unable to be undertaken due to the patient's behavioural issues and/or threats to staff safety. Issues relating to clinical escalation are encountered in a number of documents, specifically the Treatment Planning Policy, the Psychiatric Assessment Protocol, the Clinical Risk Assessment Policy and the Model of Care document. The treatment planning policy review is currently underway and should be completed in the first quarter of 2026. The other nominated policies/protocols have also been reviewed to ensure that scenarios such as the one affecting Mr Nisbet are encompassed. Bendigo Health is satisfied that, subject to completion of the Treatment Planning Policy review, all references to clinical escalation in all of these documents encompass Mr Nisbet's circumstances. On completion of policy reviews staff are updated with changes via email notification, participation in regular mandatory training and in meetings and communications with their direct managers. The outcomes of mortality reviews and Coronial findings are also shared with relevant staff.

   Accordingly, the Coroner's recommendation is presently being implemented by the hospital.

100 Barnard Street,
Bendigo VIC 3550
(Access via Mercy Street)
PO Box 126, Bendigo VIC 3552
03 5454 6000
www.bendigohealth.org.au
ABN 26 875 455 912

2. *In circumstances where the decision is made to discharge the patient to the care of another practitioner that all reasonable attempts are made to directly contact that practitioner to ensure that they are aware of the patient's current presentation.*

In response to the above recommendation, the hospital notes as follows:

The hospital is aware of the importance of directly contacting any other clinicians usually involved in a patient's care, to ensure that they are aware of the patient's current presentation, and agrees that the highest standard of care of making all reasonable attempts is warranted in difficult circumstances.

In this respect, the hospital has policy and model of care documents which specify the requirement to share treatment plans with a patient's usual general practitioner. The hospital also has a well-established practice which requires doctors in outpatient settings to send a letter within seven days of a patient's contact, detailing the nature of that patient's treatment and management, which also includes the provision of a comprehensive discharge letter within seven days if the patient's case is closed. This requirement extends to other professionals, including other hospitals or specialists, who are taking over the patient's care. Since Mr Nisbet's death this requirement has been reinforced to all community clinicians by managers at their regular staff meetings and/or by email.

The Coroner's recommendation has been implemented.

3. *In circumstances where the decision is made to discharge the patient, that the community mental health team or other member of Bendigo Health, contact the patient's family or next of kin about the implications of the decision (subject to the patient's consent to their personal health information being released to their nominated family member / next of kin).*

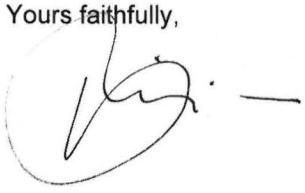
In response to the above recommendation, the hospital notes as follows:

The hospital has existing policies and a model of care for staff to conduct a follow up phone call to patients within seven days following their discharge. If the patient is uncontactable, staff are required to contact the patient's next of kin. If the patient or their next of kin are uncontactable, the hospital's policy dictates that this issue is to be discussed at the next clinical team meeting. Since Mr Nisbet's death this requirement has been reinforced to all community clinicians by managers at their regular staff meetings and/or by email.

Accordingly, the Coroner's recommendation has been implemented.

The hospital again offers its sincere condolences to Mr Nisbet's family and friends.

Yours faithfully,



Associate Professor Philip Tune
Clinical Director of Mental Health Services
Bendigo Health