Safer Care Victoria

Court ref: COR 2012 004865

SCV ref: CC2018-05

Coroner's Registrar
Coroners Court of Victoria
65 Kavanagh Street
Southbank VIC 3000
cpuresponses@coronerscourt.vic.gov.au

Dear

Re: Investigation into the death of Gerard Helliar

Thank you for your letter dated 19 April 2018 accompanying Coroner Peter White's finding into death with inquest of Gerard Helliar in November 2012.

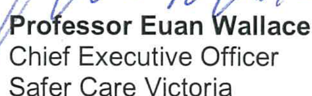
I note that **recommendation c** seeks for the Chief Psychiatrist to review the practice of people admitted to psychiatric hospital units bringing personal items of a potentially dangerous nature. **Recommendation d** is that Peninsula Health create a new audit team, chaired by an independent person with expertise in risk assessment, to assess risk related to ligature points within Ward 2b of Frankston Hospital and report these findings directly to the Chief Executive Officer of Peninsula Health.

Safer Care Victoria will support the implementation of these recommendations in the following ways:

- We are in the process of establishing a Safer Care Victoria Mental Health Clinical Network to work closely with the Office of the Chief Psychiatrist and the Department of Health and Human Service Mental Health Branch. I will ensure that the network receive a copy of the coronial findings.
- Safer Care Victoria will liaise with the Office of the Chief Psychiatrist to determine if the outcomes of the audit team **(recommendation d)** should be included on the agenda of the next quarterly Peninsula Health performance meeting.

I note that this case was reported by Peninsula Health as a sentinel event and that a report was received.

Yours sincerely,



Professor Euan Wallace
Chief Executive Officer
Safer Care Victoria

21/5/2018