**Department of Justice**

Acting Secretary

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Coroner Audrey Jamieson
Coroners Court of Victoria
Level 11, 222 Exhibition Street
**MELBOURNE VIC 3000**

Dear Coroner Jamieson

**Response to coronial recommendations arising from the coronial inquest into the death of [redacted] on 24 August 2009**

On 6 September 2012, you issued findings following the inquest into the death of [redacted]. The inquest determined that [redacted] death was the result of 'carbon monoxide poisoning' and produced two recommendations. Pursuant to section 72(3) of the *Coroners Act* 2008, the Department of Justice has considered the recommendations and provides the attached response.

If you have any queries regarding this matter, please contact Liana Buchanan, Director, Office of Correctional Services Review on telephone 9947 1748.

Yours sincerely

**Dr Claire Noone**
Acting Secretary

State Government Victoria

| Response to coronial recommendations arising from the coronial inquest into the death of [redacted] | |
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| **Recommendation** | **Department's response** |
| *Recommendation 1:*<br><br>To increase the safety of patients who are also registered sex offenders, the Department of Health Mental Health, Drugs and Regions Division and Department of Justice Community Correctional Services, review their application of the 2008 Protocol between Mental Health, Drugs and Regions Division and Community Correctional Services. Particular emphasis should be given to addressing any perceived barriers to communication between services and a patient's right to privacy. | **The Coroner's recommendation has been implemented**<br>In November 2012, Corrections Victoria and the Department of Health reviewed the 2008 Protocol between Mental Health, Drugs and Regions Division and Community Correctional Services.<br><br>The Protocol was revised and endorsed by both parties in November 2012 and now includes guidance to Area Mental Health Services (AMHS) to consider sharing relevant information to minimise risk '[w]here there is a serious and imminent risk to a person's life, health or safety, or where a person is showing suicidal intent or behaviour.'<br><br>The Protocol states that 'AMHS staff should refer to the clinical practice guideline *Working with the suicidal person* and notes that 'it is good practice for triage to follow up with a person after a suicide attempt, to ensure the person's support needs are being met.' |
| *Recommendation 2:*<br><br>To increase community safety and reduce the risk of sex re-offending, the Sex Offender Management Branch review the process of criteria, assessment, wait listing and commencement of a Sex Offender Program to enable sex offenders who are required to complete the program as part of their parole to participate in the program in a timely manner. | **The Coroner's recommendation has been implemented**<br>Corrections Victoria's Sex Offender Management Branch has reviewed the current delivery of waitlisting, assessment and treatment. A number of improvements have resulted from this review, including a refined assessment process, which was implemented in September 2012.<br><br>It is anticipated that the new assessment process will reduce the assessment timeframes. Corrections Victoria has also recruited additional clinicians to increase the capacity of the Sex Offender Program (SOP) team to provide access to treatment in a timely manner. |