Department of Justice and Community Safety

Justice Assurance and Review Office

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Our ref: 21024218
Your ref: COR 2018 0354

Coroner Bracken
Coroners Court of Victoria
65 Kavanagh Street
SOUTHBANK VIC 3006

Dear Coroner Bracken

I refer to your findings and recommendation made on 31 December 2020 regarding the death of Mr Brett McDonnell who died by suicide on 21 – 22 January 2018 while under the supervision of Community Correctional Services (CCS).

You made a recommendation directed to Corrections Victoria about tools used by CCS as follows:

> *That Corrections Victoria obtain detailed relevant professional advice about the adequacy and effectiveness of the "Suicide and Self-harm Risk Screening Suite" together with the qualifications and training of those who administer it as well as the manner in which it is administered with a view to improving insight into the state of mind of those upon whom the Screening Suite is conducted specifically in relation to the likelihood of proximate suicide and self-harm risk. Such advice ought to contemplate the best way to maximise effectiveness and efficiency and consider the utility of recommending a minimum time-period over which the Screening Suite ought to be administered and periodic 'refresher' training.*

Noting that Corrections Victoria is a business unit of the Department of Justice and Community Safety (DJCS), I confirm that this recommendation is supported. Corrections Victoria is seeking advice from mental health risk assessment experts and the Department of Health and will develop appropriate training should any new tools be adopted based on the advice.

Should you require any further information, please do not hesitate to contact Allison Will, Director, Justice Assurance and Review Office, DJCS on 0437 458 158.

Yours sincerely

Rebecca Falkingham
Secretary

30/03/2021

VICTORIA State Government