



## Department of Justice and Community Safety

Secretary

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Our ref: EBC 22046186  
Your ref: COR 2017 481

Coroner Caitlin English  
Coroners Court of Victoria  
65 Kavanagh Street  
SOUTHBANK VIC 3006

Dear Coroner English

I refer to your findings and recommendations delivered on 30 March 2022 regarding the death of Mr Charles Squires at the Geelong Hospital on 29 January 2017.

The Department of Justice and Community Safety (DJCS) accepts your recommendations, as detailed below.

*Recommendation 1 – That Justice Health reports into prisoners' deaths detail the materials relied on, and specifically reference any applicable Guidelines relevant to medical care and compliance or otherwise. As all deaths in custody are reportable to the coroner, Justice Health should conduct interviews with staff involved and consider the forensic pathologist's report, so the Justice Health review has accurate details regarding the prisoner's cause of death.*

Justice Health is currently reviewing its Death in Custody Procedure. The revised Procedure will support an initial meeting with relevant Health Service Providers to gather information, explore timelines of the event of a prisoner's death and, if required, identify appropriate staff to be interviewed.

The revised Procedure will also outline the process for interviewing staff who may have been directly or indirectly involved in the prisoner's health care or the event of their death, to ensure vital information is gathered as soon as possible after the event.

In relation to Mr Squires' death on 29 January 2017, I understand that DJCS did not receive a copy of the forensic pathologist's report until 16 June 2017 – approximately three weeks after the Justice Health report was provided to the Coroners Court of Victoria.

In acknowledgement of the importance of considering the cause of a prisoner's death when reviewing the health care provided to that prisoner, Justice Health will not commence interviewing staff for a Death in Custody review until the Medical Examiner's Report and associated toxicology results have been received by DJCS.

For that reason, I would appreciate the Court's assistance in providing copies of relevant forensic pathologists' reports to Justice Health and Justice Assurance and Review Office as soon as possible following the submission of a Coroners Court of Victoria Form 45 request.

Justice Health is also liaising with Safer Care Victoria, to explore opportunities to improve death in custody review and reporting in the custodial setting.

*Recommendation 2 – That Correct Care Australasia ensures the Induction Program for nursing staff employed in Victorian correctional facilities includes education and advice about the relevant and applicable Guidelines including Emergency Guidelines.*

Justice Health is working with the Health Service Provider, Correct Care Australasia (CCA) to ensure the CCA Induction Program for nursing staff employed in Victorian correctional facilities includes education and advice about the relevant and applicable Guidelines including Emergency Guidelines.

It is anticipated that the Induction Program and relevant Guidelines will be finalised by 31 December 2022.

Should you require any further information, please contact the DJCS Office of the General Counsel at [OGC@justice.vic.gov.au](mailto:OGC@justice.vic.gov.au)

Yours sincerely



**Rebecca Falkingham**  
Secretary